UK COVID-19 PUBLIC INQUIRY

MODULE 2C – DEPARTMENT OF HEALTH (NI) CORPORATE STATEMENT – WAVE 2 OF THE COVID-19 PANDEMIC **16/02/2024**

CONTENTS

Witness Name:
Statement No.:
Exhibits:
Dated:

UK COVID-19 INQUIRY

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

---

UK COVID-19 PUBLIC INQUIRY
MODULE 2C – DEPARTMENT OF HEALTH (NI) CORPORATE STATEMENT – WAVE 2 (15/02/24)

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. This is my second corporate statement in relation to Module 2c and relates to the second wave of the pandemic (hereafter referred to as the "second wave" or "Wave 2"). In this statement: "Coronavirus is referred to as "Covid-19", "Coronavirus" or "the virus"; "the Wave 1 statement" refers to the Department's corporate statement covering the first wave of the pandemic; the Northern Ireland Assembly is referred to

as “the Assembly”; the Northern Ireland Executive is referred to as “the Executive”; Robin Swann MLA, Minister of Health is referred to as “the Minister”; the Department of Health (Northern Ireland) is referred to as “the Department”.

THE SECOND WAVE

5. As previously stated in paragraph 122, of the Wave 1 statement, there is no agreed definition of what constitutes a pandemic wave. With this in mind, the Department considers that the second wave of the pandemic in NI occurred during the period late August 2020 to April 2021 (following the ending of the first wave in July 2020). This second corporate statement therefore follows on from the Department’s corporate statement covering Wave 1. In the Wave 2 corporate statement we continue to set out the role of the Department in relation to the key decisions made by the NI Executive. The Executive’s decisions include those related to NPIs which were implemented to save lives and mitigate the impact of the second wave of the pandemic on the health and social care system during the period 1 August 2020 to 31 May 2021.

6. This statement also describes the embedding of the Department’s and the HSC’s leadership and decision-making structures established in June 2020. These leadership and decision making structures evolved from the initial, short-term planning and governance arrangements at the start of the Covid-19 outbreak, which were set out in the Department’s Emergency Response Plan 2019 **[PM/440 INQ000103645]** (DoH ref: MMcB5001], to the new business model **[PM/441 INQ000130385]** (DoH ref: PM0229), **[PM/442 INQ000130346]** (DoH ref: PM0116)]. The new business model established new temporary governance arrangements for the HSC and a new temporary Management Board, ‘Management Board for Rebuilding HSC Services’, in order 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 (see paragraphs 609 to 619 of the Wave 1 statement).

7. A public consultation on the temporary amendments to the Health and Social Care Framework Document closed on 4 December 2020 **[PM/443 INQ000276283** (DoH ref: PM2000)]. The analysis report was published on the Department’s website **[PM/444 INQ000276284** (DoH ref: PM2001)] with the outcome of the consultation that the temporary changes to the Framework Document and the Rebuilding Management Board should remain in effect at least until June 2021.

8. On 18 June 2020 the Minister met with the HSC Chairs' Forum [**PM/445 INQ000276285**] (DoH ref: PM2002)] to discuss the temporary management and governance arrangements. The Forum comprises the Chairs of all of Northern Ireland's 18 HSC organisations, as set out in paragraph 17 of the Wave 1 statement and provides a vehicle for the chairs to discuss health and social care issues about which they have a shared interest. The Chairs met with the Minister on a six-weekly basis during the pandemic to ensure that he had a full picture of the position across HSC organisations, and that the Department's emerging strategy to rebuild service delivery was well informed and understood. Following each meeting of the Rebuilding Management Board, the Minister wrote to the Chairs to update them on issues discussed by the Rebuilding Management Board. The update letters were also published on the Department's website. [**PM/446 INQ000276286** (DoH ref: PM2003), [**PM/447 INQ000276287** (DoH ref: PM2004) [**PM/448 INQ000276289** (DoH ref: PM2005), [**PM/449 INQ000276290** (DoH ref: PM2006), [**PM/450 INQ000276291** (DoH ref: PM2007)].

9. The Department also continued to implement its Strategic Framework for Rebuilding HSC Services [**PM/451 INQ000137403** (DoH ref: PM0234)] (see paragraph 620 in the Wave 1 statement), whenever possible during the second wave. However, this was against the background of unprecedented pressures on health services, caused by the surges in inpatient demand for critical care from Covid-19 patients during this period. The surge in demand for critical care required the Department to develop a new Surge Planning Strategic Framework, which set the overarching context for individual HSC Trust surge and winter planning, and an Emergency Departments' Response Plan to ensure that urgent and emergency care services across primary and secondary care could be maintained. Both documents are covered in detail later in this statement.

SECTION A: DEPARTMENT OF HEALTH – ROLE, FUNCTIONS, RESPONSIBILITIES, STRUCTURE, LEADERSHIP AND FUNDING DURING THE SECOND WAVE

10. The Department's role, functions, responsibilities, structure, leadership, and funding remained the same during the second wave as described in Section A, pages 10 to 29 of the Wave 1 statement. Paragraphs 89 to 104 of the Wave 1

statement, describe the initial changes to the governance, staffing and structures of the Department at the start of the emergency which evolved into the establishment of the 'Management Board for Rebuilding HSC Services' in June 2020. From summer 2020 to May 2021 the Management Board, operating through a number of workstreams[1], played the central role in planning and directing the Department's approach to rebuilding HSC services, and taking steps to reset the Department's medium to long-term programme for transforming HSC secondary healthcare services, which had been paused during the first wave.

11. 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. Previously this response was managed through Gold Command (see paragraphs 102 to 103 of the Wave 1 statement) during the first wave, but the Department's approach was revised during autumn 2020, in anticipation of the further surges expected over the winter months of 2020/21. This change involved the Department taking a business continuity approach to managing the response to the second wave, instead of the emergency management approach which had been adopted during the first wave. The revised arrangements were set out in a memo issued by the then Permanent Secretary, Mr Richard Pengelly, on 22 October 2020 **[PM/452 INQ000137358** (DoH ref: MMcB029a), **[PM/453 INQ000137359** (DoH ref: MMcB029b), **[PM/454 INQ000137360** (DoH ref: MMcB029c), **[PM/455 INQ000137361** (DoH ref: MMcB029d)]. The primary purpose of these arrangements was to effectively manage future Covid-19 waves, including the second wave, by avoiding duplication of effort, simplifying the decision-making process, and ensuring sustainable working arrangements.

12. This shift also represented a desire on the part of the Department to focus in parallel on the restoration or rebuilding of ordinary HSC services while also addressing the demands of the pandemic. As set out the RMB Terms of Reference:

---

[1] Management Board for Rebuilding HSC Services' Workstreams: Daycase Elective Care; Imaging Services; Orthopaedics; Workforce Strategy; Leadership Strategy; Pathology Services; Acute Care at Home; Adult social care; Ambulance Services Modernisation; Cancer Services; Children's social care; Dental Services; Mental health and learning disability services; Ophthalmic Services; Personal Protective Equipment (PPE); Pharmacy Services; Planning for further Covid-19 Waves/Surges; Primary Care Services; Rapid Learning Initiative; Screening Services; Service delivery Innovation implemented during the Covid-19 Emergency; Urgent and Emergency Care Services; Paediatric Health Services.

"The mission of the Management Board is: To incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing Covid-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing Covid-19 situation..."

Despite the pressures of the second wave, it was clear that the downturn of services, which had necessarily taken place during the first wave of the pandemic, would have a profound impact in the longer term, particularly in view of existing service challenges. On this basis, the approach taken in moving to a 'business continuity approach' to managing the response to the second wave was intended to support the resumption of service capacity, within the overall limits of the pandemic response and to also develop plans for the future of the HSC in the post pandemic landscape.

13. The business continuity approach also reflected the view that the pandemic was likely to persist for a pro-longed period and that the emergency response arrangements adopted during Wave 1 were unlikely to be sustainable. This was because the emergency response arrangements involved daily sitreps and bronze / silver / gold meetings, processes which were incredibly resource intensive. The move away from arrangements within the Emergency Response Plan towards a "Business as Usual" model was informed by the 'in-flight' assessment of the Health & Social Care service coordination in response to the pandemic [**PM/456 INQ000103720** (DoH Ref: PM0228)] and allowed the Chief Medical Officer to focus on the ongoing and developing public health response to Covid-19, co-ordinated by a number of key oversight groups which he had established.

14. The new arrangements involved the establishment of an integrated Covid-19 Gold Command Group, consisting of senior Departmental officials, alongside senior Health and Social Care Board and Public Health Agency officials. This Covid-19 integrated Gold Command Group was chaired by the Permanent Secretary, whilst during the emergency management approach in wave 1, the Gold Command was chaired by the Chief Medical Officer. A key difference between the business continuity approach and the emergency response approach was that during the former the Gold Command Group included officials from the Health and Social Care Board and the PHA, whilst this was not the case in the latter approach. This ensured a more integrated approach to resolving issues with the business continuity approach. The frequency of Gold Command Group meetings and the frequency of

Sitreps was managed flexibly throughout the business continuity approach, whilst during the first wave there were daily sitreps and Gold meetings.

15. The Permanent Secretary's memo of 22 October 2020 **[PM/457 INQ000276292** (DoH ref: PM2008)] referred to establishing a Departmental Covid-19 Taskforce to support the integrated Covid-19 Gold Command Group. However, while ultimately the proposed Taskforce was not established as a formal entity, four existing Departmental Directorates (Surge Directorate, Rebuilding Directorate, Secondary Care Directorate and General Healthcare Policy Directorate), along with HSCB Silver staff involved in processing and managing daily HSC Trust SitReps, operated on an integrated basis directed by the integrated Covid-19 Gold Command Group. In addition, this work was supported by two new Directorates established within the Chief Medical Officer Group: the Covid-19 Response Directorate was formally established in October 2020 and a small Covid-19 Strategy Directorate was established in June 2021.

16. The Covid-19 Response Directorate provided a dedicated resource, which grew incrementally, to oversee policy in relation to Covid-19 testing and contact tracing. The remit of the Directorate was to provide policy direction and oversight for: the Covid-19 testing policy for NI, including the interface with the National Testing Programme led by the Department of Health and Social Care; and, for the Test, Trace, Protect Strategy which detailed the approach to contact tracing in NI. To inform policy options, the Directorate worked extremely closely with and secured inputs from senior professional colleagues (including CMO, DCMOs and CSA), Departmental policy officials, and a range of other key stakeholders and partners including principally the Department's Expert Advisory Group on Testing, the Test Trace Protect (TTP) Strategic Oversight Board and public health professionals from the PHA.

17. The role of the Covid-19 Strategy Directorate developed during the third wave of the pandemic when it took on responsibility for the multi-agency Covid-19 Wastewater Surveillance Programme, from September 2021as well as maintaining links with the then Joint Biosecurity Centre in the Department of Health and Social Care, to ensure NI benefitted from networks and information sharing about the virus. This role developed with the establishment of the UK Health Security Agency in

October 2021 and the Directorate became the key link between NI and the UK Health Security Agency at a strategic level.

18. To support the management of these business continuity structures, integrated policy cells[2], which escalated issues to the integrated Covid-19 Gold Command Group on a by exception basis, were also stood up [**PM/457** **INQ000276292** (DoH ref: PM2008)]. The number and membership of these cells was kept under review, in order to adopt an agile approach. Furthermore, as part of these business continuity arrangements, a Departmental Covid-19 Operations Centre was established to be operational during normal business hours Monday to Friday. A proportionate Sitrep process to ensure effective information flow from the HSC to the integrated Gold Command Group was also put in place. The integrated Gold Command Group met for the first-time during wave two on 29 October 2020 [**PM/458** **INQ000276293** (DoH ref: PM2009)] and held its last meeting on 4 March 2022 [**PM/459** **INQ000276294** (DoH ref: PM2010)].

19. The following sections of this statement set out the key actions and decisions taken by the Department during the second 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. We describe the role of the Department in providing medical and scientific advice to inform decisions taken by the Northern Ireland Executive concerning NPIs and other measures, and the Department's role in providing guidance to other Executive departments during this period. This statement also details the continued liaison with the administrations of the other UK jurisdictions and the Republic of Ireland, demonstrating the collaboration on cross-jurisdictional efforts to combat the impact of Covid-19 on the population. The following sections also cover the Department's internal decision-making process, as well as the information available to the Department concerning Covid-19 which informed its strategic and policy response to

[2] Integrated Cells: Accommodation Cell; Briefing Cell; Cancer Cell; Clinical / Professional Advisory Cell; Clinically Extremely Vulnerable (CEV) Cell; Communications Cell; Contact Tracing Cell; Digital Cell; Elective Care Cell; Finance Cell; General Dental & Ophthalmic Cell; Infection Prevention & Control (IPC) Cell; Mental Health Cell; Modelling Cell (NI COVID-19 Modelling Group); Population Health Cell; PPE Cell; Supplies / Medicines Cell; Surge Cell – Acute; Surge Cell - Adult Social Care; Testing Cell / Expert Advisory Group on Testing; Unscheduled Care Cell / No More Silos Network; Vaccination Cell; Workforce Cell; EU Transition Cell

the pandemic, in respect of those policy areas for which the Department had sole responsibility.

20. As stated in paragraph 144, of the Wave 1 statement, 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. Whilst officials and the Minister took part in bilateral and group discussions, (and there may also have been discussions in the margins of those meetings), leading up to the taking of key decisions or reflecting upon important information provided by a range of sources, it is not considered that these exchanges were either informal or private communications. This also was the practice during the second wave. Discussions and meetings would continue intermittently over several days leading up to an Executive meeting to finalise papers submitted by the Department to the Executive. The submitted paper and associated other documents (for example emails) were filed as the formal record of these discussions and meetings. Over the winter months of 2020/21 the situation faced by the Department was often as volatile as that experienced in the initial emergency phase, due to the need to quickly develop policy solutions to combat the increase in transmission of the virus throughout NI and to respond to the surges in demand for critical care required for Covid-19 inpatients. The Department's and HSC's staffing pressures (see paragraph 93 of the Wave 1 statement) continued to be a serious concern to the Minister and the Department's Top Management Group.

Access to Information and Expert Advice

21. The details of internal 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. The Minister and senior officials continued during the second wave to participate in, or avail of, 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 in relation to the second wave.

22. The Strategic Intelligence Group, chaired by the CSA as discussed in paragraphs 146 to 148 of the Wave 1 statement, considered scientific and technical evidence from SAGE, SAGE subgroups and other sources in the specific context of the state of the epidemic in NI. Membership and minutes are recorded in the relevant papers. The evidence and analysis conducted by Strategic Intelligence Group informed the deliberations of the Department's modelling group, and in addition the advice provided by CMO and CSA to Minister and the NI Executive.

SECTION B: THE PUBLIC HEALTH RESPONSE DURING THE SECOND WAVE

23. Consistent with its approach to decision making during the first wave of the pandemic, the Executive continued to make the key decisions concerning the public health response to mitigate the impact of Covid-19 in respect of the implementation of NPIs in NI during the second wave. The Department understood that the Executive's decisions concerning population wide NPIs were informed by the medical and scientific advice provided by the Department. The medical and scientific advice provided by the Department included data and information concerning the local NI context of the trajectory of the pandemic including estimates of R (see paragraphs 46 to 47 of the Wave 1 statement); local modelling; and analysis of the scale of pressure faced by the HSC system. The medical and scientific information and advice presented to the NI Executive by the Department was also informed by the available information on the trajectory of the pandemic across the UK and the Republic of Ireland. During the second wave the Minister continued to take key decisions concerning the implementation of NPI measures in relation to HSC settings which involved changes in extant policy and guidance, or the development of new policies and guidance. The Department continued to keep the Executive informed about such decisions during the second wave. The Executive was updated in a variety of ways: verbally by the issuing of Executive papers from the Minister; and by presentations by officials on a range of issues. Those presentations included issues relating to: Covid-19 testing; contact tracing; care home outbreaks and wider support to the care home and community sectors; and the HSC workforce.

24. In May 2020 the Executive agreed a five-stage plan for how NI would move out of NPIs, and the approach that would be taken when deciding how to ease NPIs

and wider restrictions. The Executive had determined that in reaching such decisions the three key criteria would be: the most up-to-date scientific evidence; the ability of the health service to cope; and the wider impacts on our health, society and the economy. Therefore, informed by the Department's medical and scientific advice, the Executive continued to consider the public health response, while also recognising the importance of keeping society and the economy as open as possible. Critical to achieving this aim was the robust and sustained public health response to the pandemic which, in addition to the central role played by NPIs, included, for example, the successful development and roll-out of the immensely important Covid-19 Vaccination Programme, innovations such as the workplace testing programme for key sectors of the economy, and extending population access to the 'StopCOVID NI' Proximity App as part of the NI Test, Trace Protect Strategy **[PM/460 INQ000145664** (DoH ref: PM0057)]. These developments are described in detail later in this statement.

25. The restrictions placed on international travel also continued to make an important contribution to the public health response to the pandemic and became more complex during the second wave. Measures were aimed at delaying and slowing the introduction of new coronavirus variants which emerged globally during the second wave. The Department's policy response is set out in the subsection covering International Travel (see paragraphs 126 to 142 below).

26. Up until August 2020 there had been a gradual relaxation of restrictions, with Executive decisions guided by the plan published by the Executive in May 2020, entitled 'Coronavirus – Executive Approach to Decision-Making' **[PM/461 INQ000137371** (DoH ref: MMcB039)]. On 25 June 2020, the Executive agreed an indicative timeline of further relaxations during June, July and August which would be implemented if the R rate remained below 1. However, by mid-August 2020 there were signs that the number of Covid-19 cases was again on the increase. At their meeting on 20 August 2020 the Executive considered two papers, one tabled by the Minister of Health, the first review of the Health Protection (Coronavirus, Restrictions) (No. 2) Regulations (Northern Ireland) 2020 **[PM/462 INQ000276510** (DoH ref: PM2192)], and the other tabled by the First Minister and deputy First Minister. The Department's review paper recorded concerns about significant local rises in virus transmission, signalling the potential need for local restrictions, but recommended that a voluntary approach be adopted at that stage. The Department also proposed tightening restrictions on indoor and outdoor gatherings, both in public spaces and private dwellings, as a matter of urgency to reduce virus transmission. These

proposals were presented in the paper from the First Minister and deputy First Minister on the same day. The Executive agreed to tighten restrictions on gatherings, and the amendment regulations came into force from 25th August 2020.

27. The views of the Department on the "Eat Out to Help Out" scheme were not sought, and the Department itself did not seek and was not given any specific medical / scientific advice in relation to this scheme. The decision to implement the "Eat Out to Help Out Scheme" was largely a decision made at a UK level and implemented in NI by the Department of Economy. The CMO / CSA advice was consistently that any measure which increased contacts between individuals in indoor settings would have some impact in increasing virus transmission, but that advice acknowledged that decision making needed to also take into account wider factors including economic and societal considerations. However, at the time of the scheme the CMO and the CSA did express concern about the progression of the pandemic and advised that Ministers should reconsider their decision to reopen non-food serving pubs and bars in Northern Ireland on Monday, 10 August 2020 **[PM/463 INQ000353628** (DoH ref: CSA2015)].

28. Given the numerous changes which occurred in August – September 2020 (including "Eat out to help out", schools reopening, and return to work after summer holidays) and lack of granular data, it was not possible to assess any specific impact of the "Eat Out to Help Out" scheme on virus transmission. The Department did not consider if it was possible to analyse the impact that 'Eat Out to Help Out' had on the increase in virus transmission in autumn 2020, as the interconnection of this with other factors (such as schools reopening, etc.), meant that it would not have been possible to isolate the increase as a consequence of the Eat Out scheme. The increase in virus transmission in autumn 2020 was in all likelihood inevitable, given limited population immunity, ease of transmission and increased interactions indoors as weather worsened, although the relaxation of measures around this time would have somewhat accelerated the process.

29. A particular feature of the early months of the second wave was the Executive's decision to introduce restrictions in localised geographical areas of NI, for specified periods, in order to interrupt community transmission occurring in certain postcode areas where the prevalence of cases was significantly higher than the regional level. These developments are described in detail later in this section of the statement. There are also descriptions of the scaling up of restrictions that were necessary to curtail virus spread in the weeks leading up to and following Christmas

2020. The Executive Office developed the document 'Moving Forward: The Executive's Pathway Out Of Restrictions' published by The Executive Office on 2 March 2021 **[PM/464 INQ000276511** (DoH ref: PM2193)]. This set out a step-by-step approach to the relaxation of the restrictions introduced during the second wave. The Department's contribution to the development of this document is set out in paragraphs 97 to 99 below.

Coronavirus Domestic Non-Pharmaceutical Interventions (NPIs)

30. NPIs were introduced in NI via three administrative vehicles. Firstly, by way of statutory regulations. Secondly, by way of changes to extant policy or the introduction of new policies, particularly in the areas of health, social care and education which did not require a change to legislation. Thirdly, by way of updating extant guidance or issuing new guidance which often followed changes to policy, again particularly in the areas of health, social care, and education. NPIs continued during the second wave to contribute to the robust and sustained public health response to the pandemic in NI. The response in this policy area at the end of the first wave consisted of the incremental easing of the restrictions by the Executive.

31. During the period July to September 2020, restrictions were eased in specific areas of economic and social activity in order to enable society to return to a semblance of normality. The main exception to this was the use of face coverings in certain indoor settings, including shops which were made mandatory on 10 August 2020 (see paragraph 102 below).

32. In a statement to the Assembly on 28 July 2020 the Minister informed Members that for the 14th consecutive day, up to 27 July 2020, NI had recorded no Covid-19 related deaths **[PM/465 INQ000276488** (DoH ref: PM2180)]. In a statement on 30 July 2020 the Department announced that R was estimated at 0.5 – 1.0 (see paragraphs 46 and 47 of the Wave 1 statement describing The Value of 'R') **[PM/466 INQ000276512** (DoH ref: PM2194)]. R continued to show a high degree of volatility and to be heavily influenced by small local clusters. However, by 6 August 2020, the Minister warned in a statement that the latest total for new Covid-19 cases provided a "wake-up call for the complacent" **[PM/467 INQ000276513** (DoH ref: PM2195)]. This remark was prompted by the fact that the Department's Covid-19 Dashboard reported a daily increase **PM/468 INQ000276685** (DoH ref: PM2364), **PM/469 INQ000276585** (DoH ref: PM2365) of 43 positive cases. The Minister continued: "This figure underlines the fact that the threat from the virus remains very real. If

anyone still thinks Covid-19 is going to fade away, let them think again. We must all do everything we can to stop the spread of this virus."

33. In a joint statement on 9 August 2020, the CMO and the CSA warned against carelessness and fatigue. In their statement the CMO and CSA highlighted their concerns about the increase in confirmed Covid-19 cases and the R number. They recognised the sacrifices already made by many to protect those more vulnerable to the effects of the virus and themselves. Expressing concern about the consequences of a sharp peak in cases in the autumn and winter they asked for continued vigilance and adherence to the public health advice. **[PM/470 INQ000276514** (DoH ref: PM2196)].

34. Unfortunately, the concerns expressed by CMO and CSA proved to be accurate and over the course of the autumn and winter of 2020 the Executive incrementally approved the reintroduction of restrictions to combat the spread of the virus and to prevent the health service from being overwhelmed by excessive demand from Covid-19 patients. Purely from the point of view of Covid-19 transmission in the short term, retention of restrictions would have ameliorated the extent of the pandemic in the autumn and winter. However, this would have been at the cost of increased harms in other areas as a consequence of the restrictions. Decisions about the balance required were a matter for the Executive, taking into account advice from the Department in addition to other considerations.

35. To illustrate the decision-making processes followed, the Department of Health would cite six incidences of escalation and de-escalation in particular during this period which the Department considers to be key decisions taken by the Executive in relation to NPIs. They are: the introduction of localised restrictions effective from 16 September 2020 (see paragraphs 43 to 51 below); a range of significant time-bound circuit breaker interventions effective from 16 October 2020 (see paragraphs 52 to 61 below); measures introduced during November 2020 (see paragraphs 62 to 73 below); measures introduced during December 2020 (see paragraphs 74 to 85 below) and measures introduced during the period January 2021 to May 2021 (see paragraphs 86 to 96 below); and Moving Forward: The Executive's Pathway Out of Restrictions' (see paragraphs 97 to 99 below).

36. During the second wave the Department believed that The Executive Office's approach to providing advice to the Executive to inform decisions to be taken about the escalation and de-escalation of domestic restrictions changed from the approach taken during the first wave. In the first wave the majority of the decision papers

presented to the Executive comprised the medical and scientific advice and recommendations submitted by the Department, whereas during the second wave the Executive Office increasingly led on the tabling of decision papers for meetings of the Executive. Some of The Executive Office papers contained the Department's medical and scientific advice, as appropriate to the particular issue to be decided. Many were informed by discussions at the TEO-led Covid-19 Cross-Departmental Working Group which met regularly (weekly during this period) and in which the Department participated. On other occasions Executive papers making recommendations about NPIs were drafted solely by the Department of Health and submitted to the Executive. A further development during the second wave involved advice being provided directly by other Executive departments to the Executive concerning social and economic factors impacting on the decisions to be taken by the Executive to de-escalate and variously to escalate domestic restrictions. This change in approach to the decision-making process is reflected in the illustrations we have provided below. The Department also continued to carry out the required review of the domestic restrictions regulations and take forward the subsequent amendments to the regulations arising from the Executive's decisions, as was dictated by the primary legislation. The relevant regulations, being The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020 were revised and replaced by The Health Protection (Coronavirus, Restrictions) (No.2) Regulations (Northen Ireland) 2020 and The Health Protection (Coronavirus, Wearing of Face Coverings) Regulations (Northern Ireland) 2020 on 23 July 2020.

37. The Department of Health welcomed the above change in administrative approach as a constructive improvement in the support given to the Executive by the NI Civil Service in discharging its decision-making responsibilities by placing The Executive Office as the lead department in preparing and submitting papers to the Executive in collaboration with other Executive departments. This was an appropriate role for The Executive Office which was best placed to ensure that the Executive was given comprehensive advice about the likely impact of its decisions on all aspects of social and economic life in NI affected by the pandemic. The Department of Health is of the view that this change in approach could be enhanced for future emergencies by The Executive Office being given the necessary statutory authority and resources to be in a state of readiness to take forward any urgent legislative changes which might be consequent to Executive decisions taken during the course of any future emergency, including making and amending regulations and leading on Assembly scrutiny procedures. The Department is aware that this would be greatly facilitated by

amendments to the primary legislation (Public Health Act (Northern Ireland) 1967) to allow departments other than the Department of Health to make legislation in these circumstances. However greater administrative support could be planned for in future, even if the Department of Health remained responsible for signing off all regulations. This would provide a seamless, joined-up, robust approach to the development and execution of policy changes approved by the Executive.

38. As stated in paragraphs 146 to 147 of the Wave 1 statement the Department's Strategic Intelligence Group was a key source of advice and expertise to inform the HSC response to the pandemic. The Group first met in April 2020 and was chaired by the CSA. The details of its membership and terms of reference are provided in **[PM/471 INQ000103642** (DoH ref: PM0047)]. The Strategic Intelligence Group considered 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 the Strategic Intelligence Group informed the advice which the CMO and CSA provided to the Executive concerning domestic NPIs as illustrated in the following six incidences of decisions taken by the Executive.

39. 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/472 INQ000137356** (DoH ref: MMcB027).

40. 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.

41. Outputs from the Department's modelling group (at an NI wide level) were used as a basis for Trust-specific modelling. However, Trust specific modelling in addition needed to account for local factors. Work to ensure alignment was carried out by the HSCB/PHA COVID-19 Modelling Group which, working within the parameters provided by the Department's modelling group, forecast demand on hospitals for the 5 Trusts. The purpose of these projections was to enhance Trust decision-making, and as a reference point for interpreting a dynamic situation, not as a direct prediction of the future.

42. The Department's internal decision-making process in relation to formulating advice concerning NPIs for the Minister to approve and submit to the Executive broadly followed a generic approach throughout the second wave. This involved bilateral and multi-lateral discussion amongst senior officials (principally the then Permanent Secretary, the CMO and the CSA) which informed the drafting of the Department's input to The Executive Office papers and the Department's individual papers. The CMO and the CSA worked closely together and provided medical and scientific advice to the Minister of Health. In doing so they took account of and considered information and inputs from sources within the Department (for example the Strategic Intelligence Group, the Modelling Group and the Information Analysis Directorate) and from external sources (for example PHA, SAGE, its subgroups and other UK Government advisory groups, UK CMOs and senior clinicians' groups, JBC / UKHSA, ROI, ERDC, WHO and the wider scientific and grey literature[3]). Advice from the CMO and the CSA to the Minister was based on their consolidated view of available evidence and data with regard to Covid-19 and was subsequently developed, if required, to take account of Ministerial views and further information requests from the Minister to inform wider policy considerations by the Executive. Advice and updates were provided proactively on a regular basis throughout the pandemic, and additionally if specific requests for advice or modelling were made. Papers submitted by the Minister to the Executive took account both of medical and scientific advice from the CMO and the CSA and wider policy and political considerations, if relevant. The Minister provided his political perspective concerning the likely public reception to particular proposals discussed with senior officials as part of this process.

[3] 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.

NPI Illustration 1: Localised Restrictions introduced on 16 September 2020

43. The number of Covid-19 cases per day was very low at the beginning of July 2020, and began to increase gradually from that time. The trajectory of the pandemic remained under close review with the weekly publication of the R paper, and regular presentations by the CMO and the CSA to the NI Executive. The Executive twice considered papers prepared by the Department which included a brief consideration of the option of imposing enforceable local measures in response to increases in cases in certain geographical areas of NI, on 23 July 2020 and 20[4] August 2020 [**PM/473 INQ000276515** (DoH ref: PM2197) [**PM/462 INQ000276510** (DoH ref: PM2192)]. On each occasion, it was agreed that the time was not right for such measures. The Department understands that the key considerations in the Executive not enacting these measures, as recorded in the minutes of the meeting, were: the enforcement and potential demands on the Police Service of Northern Ireland; the proportionality of the response; doubts about the feasibility and potential effectiveness of such measures; timeliness; challenges in setting appropriate geographical boundaries; and acceptability to local communities.

44. The Department's Strategic Intelligence Group met on 7 September 2020 to consider the current state of the pandemic [**PM/474 INQ000276516** (DoH ref: PM2199)]. There had been a progressive rise in Covid-19 cases over the proceeding 10 weeks, from 3 to 4 cases per day in early July 2020 to around 90 cases per day in the week preceding the Strategic Intelligence Group meeting. In addition, the percentage of positive tests had risen from less than 0.5% to between 2 and 3% over the same period, indicating a true rise in community transmission. Cases had risen to 33/100k, above the level where the UK was imposing quarantine requirements for travellers from foreign countries. Data was presented which included cases at a postcode level, and identified a number of postcodes where recent seven-day incidence was substantially above levels where postcode restrictions had been imposed in the rest of the UK. There was not as yet any increase in hospitalisations or deaths, and the majority of cases were in the under 60s. However, it was considered inevitable that these would follow after a lag period.

45. After discussion, the Strategic Intelligence Group agreed that it would be appropriate to recommend either NI-wide restrictions or restrictions focussed on high incidence areas (more than 80 cases / 100k / seven days). It was considered that

[4] This Executive took place on 20 August 2020. Subsequent Department of Health paper has a typographical error stating that the Executive meeting was on 10 August 2020.

restrictions should be focussed on reducing contacts and accompanied by NI wide messaging. This could include consideration of restricting visitors to Care Homes and advice to the elderly and those previously shielding to be particularly careful.

46. Following consideration of the available options for introducing further NPIs to address the increased prevalence of the virus at this time the Department submitted a paper to the Executive **[PM/475 INQ000276517** (DoH ref: PM2200)] recommending that localised restrictions should be introduced and including a range of possible options to be considered. The Executive agreed to introduce local restrictions in areas of high incidence, concerning the mixing of households in private dwellings (considered likely to be moderately effective and with little cost to the economy, though with considerable social impact), and guidance curtailing visits to Care Homes and hospitals in order to reduce risks to the most vulnerable (with an exception for palliative care facilities and those receiving end of life care).

47. A verbal pre-brief was provided to the First Minister and deputy First Minister on the evening of 9 September 2020, prior to the Executive meeting the following day, at their request. In addition, a briefing was held with the Ministers of Justice and Communities on 10 September 2020 ahead of the Executive meeting, at their request. The CMO's diary indicates that this briefing had been requested by Ministers Mallon and Long. Those in attendance at the briefing were Minister Mallon, Minister Long, Minister Swann, Mr Richard Pengelly, the CMO and the CSA. This briefing detailed the available options for introducing further NPIs at this time.

48. On 10 September 2020, an update was provided to the Executive by the Minister of Health, the CMO and the CSA which included developments in the Covid-19 pandemic, including the R number; the position in Care Homes; number of deaths; admissions to hospitals; contact tracing figures; capacity of the testing system; the impact of schools reopening on Covid testing demand; and variations in Covid incidence in different locations. In addition, the Minister introduced a paper on the need to consider local or general restrictions to reduce progression of the pandemic. Executive minutes indicate that there was discussion about a need to balance messaging about the pandemic with the need to permit ongoing economic activity **[PM/475 INQ000276517** (DoH ref: PM2200)].

49. The paper submitted to the Executive **[PM/475 INQ000276517** (DoH ref: PM2200)] summarised the progression and the current state of the pandemic, as had been discussed at the Strategic Intelligence Group on 7 September 2020. Data was included which presented cases at a postcode level, and identified a number of

postcodes where recent seven-day incidence was substantially above levels where postcode restrictions had been imposed in the rest of the UK.

50. Three main options suggested in the paper were: (i) to take no immediate action (based on no upward trend in hospital admissions or deaths); (ii) to impose local restrictions; or (iii) to impose NI-wide restrictions. The Minister in the paper recommended a range of restrictions should be implemented in a pragmatic and focussed way in those local areas with the highest Covid case incidence, and that the impact of this should be kept under review.

51. The Executive decided to introduce with effect from 16 September 2020 localised restrictions in areas of NI where infection rates were highest and rapidly rising. These related to mixing of households, tightening the existing restrictions on the number of people permitted to gather indoors and outdoors in private dwellings. Visits to Care Homes and hospitals were also curtailed across NI at this time. The areas covered by the localised restrictions were the Belfast City Council area, Postcode area BT28, Postcode area BT29, the town of Ballymena and Postcode area BT43. This reflected the population flows and public transport linkages and Belfast identity of these specific districts. The restrictions were to be kept under review and it was decided that areas would be added or removed from the list as required. The restrictions were subsequently announced [**PM/476 INQ000276519** (DoH ref: PM2202)] and regulations drawn up alongside appropriate public messaging. BT60 was added to the areas under local restriction effective from 18 September 2020 due to escalating infection rates in this postcode area.

NPI Illustration 2: Circuit Breaker Restrictions introduced on 16 October 2020

52. There was a progressive rise in Covid-19 cases following the introduction in September 2020 of the localised restrictions in those local areas with the highest Covid case incidence. As had been agreed at the Executive meeting of the 10 September 2020, the impact of these localised measures on the trajectory of the pandemic remained under close review with the weekly publication of the R paper and the CMO and the CSA providing regular presentations to the Executive. On 22 September 2020 the restrictions on household mixing were extended to the whole of Northern Ireland. There were additional localised restrictions introduced in the Derry City and Strabane Council area, on 1 October 2020, for a time limited period of a minimum of two weeks, to be reviewed weekly. These restricted all indoor gatherings to members of one household and limited numbers at outdoor gatherings to a maximum of 15.

53. On 8 October 2020, an update was provided to the Executive by the Minister, the CMO and the CSA which included developments in the Covid-19 pandemic, including the R number; the position in Care Homes; number of deaths; admissions to hospitals; contact tracing figures; capacity of the testing system. At the meeting the Minister of Health provided a paper which modelled the course of the pandemic **[PM/477 INQ000276520** (DoH ref: PM2203) ,**[PM/478 INQ000276521** (DoH ref: PM2204),**[PM/479 INQ000276522** (DoH ref: PM2205)] and recommended to the Executive that an intervention to reduce R to 0.7 was required as soon as possible in order to prevent the hospital system from being overwhelmed and to prevent deaths.

54. A verbal pre-brief was provided to the First Minister and deputy First Minister on the evening of the 7 October 2020 and with the First Minister on 12 October 2020 prior to the Executive meetings of the 8 October and 13 October 2020 at their request. The Executive minutes from the meeting on 8 October 2020 record that as part of the discussion the Economy Minister asked for early discussion of her paper on the economic impacts of restrictions. The Executive agreed that "Ministers would meet individually or in small groups with the Minister of Health, the Chief Medical Officer and the Chief Scientific Adviser over the coming days to consider and discuss a range of matters relating to future measures to combat the COVID-19 pandemic."

55. The Minister of Health submitted a paper to the Executive on the 13 October 2020 **[PM/480 INQ000276523** (DoH ref: PM2206))**[PM/478 INQ000276521** (DoH ref: PM2204),**[PM/478 INQ000276521** (DoH ref: PM2205) ,**[PM/481 INQ000276526** (DoH ref: PM2209)] which summarised the further progression and current state of the pandemic. The paper confirmed that the Covid-19 pandemic in NI had reached a phase of exponential growth and that immediate consideration and decisions were required by the Executive to prevent the hospital system being overwhelmed, and to prevent adverse direct and indirect health consequences, including significant morbidity and mortality from Covid and non-Covid related conditions as a consequence of the impact on health and social care services. The paper confirmed that there was evidence that the household restrictions applied on a postcode basis and subsequently NI wide had had some impact on reducing transmission and slowing the rate of increase in new cases. The paper also indicated that NI had also begun to see some of the counter effects of Executive decisions on the opening of higher and further education colleges and "wet pubs" as well as some seasonal impacts.

56. From a scientific perspective the paper indicated that it was unlikely that the then current NI-wide restrictions combined with an extension of the additional measures introduced for from 1st October in Derry City and Strabane local government district would be sufficient to bring R back to less than 1 and highly improbable that this would reduce R to less than 0.7. A significant package of interventions would therefore be required to prevent a further exponential rise in transmission of the virus and that no single wider interventions was likely to be sufficient. A package of measures with a level of adherence similar to the impact of the full lockdown in late March 2020 was now required. The paper outlined in detail the significant challenges faced by the health service and community care including Care Homes. The paper drew parallels with a comparable period in Wave 1 when R was significantly above 2 and the decision to move to a complete lockdown on the 28 March 2020. Modelling was presented for a range of scenarios including reducing R to 0.7 or 0.9 for varying periods of time of between three and six weeks to illustrate the impact of difference decisions.

57. The Department of Health's paper presented four options for the Executive to consider:

- Option 1) an intervention to include the following components[5] to commence as soon as possible but no later than 16 October 2020 and lasting for between three to six weeks;
- Option 2) four-week intervention with the same restrictions as in Option 1 but with school open in weeks one and four;
- Option 3) six-week intervention with same restrictions as on Option 1 but with schools open in week one and weeks four to six;

---

[5] Maintenance of then existing household restrictions. Bubbling to be limited to a maximum of 10 people from 2 households. No overnight stays in a private home unless in a bubble. Work from home unless impossible to do so. Closure of schools with delivery of distance learning - Universities and further education to deliver distance learning to the maximum extent possible
Closure of the hospitality sector apart from deliveries. Closure of indoor shopping centres and retail which cannot be accessed from outside. Closure of close contact services apart from those meeting essential health needs. No indoor sport of any kind or organised contact sport involving household mixing other than at elite level, No mass events involving more than 25 people regardless of risk assessment (except for allowed outdoor sporting events). Churches remain open for private prayer. Wedding ceremonies to be limited to 25 people with no receptions. Funerals to be limited to 25 people with no pre- or post-funeral gatherings. No unnecessary travel.

- Option 4) six-week intervention to allow for other minor relaxations or reduced compliance compared with Wave 1.

The paper **[PM/480 INQ000276523** (DoH ref: PM2206)] concluded that both the CMO and the CSA recommended Option 1, an intervention to include the measures listed in the paper for implementation as soon as possible and no later the 16 October 2020. It was suggested that this should ideally last for a period of six weeks or between four and six weeks to prevent the health service being overwhelmed and avoid direct and reduce indirect adverse health consequences including excess deaths.

58. The Executive discussed the Department's paper and a further paper submitted by The Executive Office, "Consolidated Impact Assessment and Proposals for Restrictions" paper. This Executive Office paper summarised the proposals in the Department's paper alongside consideration of the economic impact of restrictions. The Executive Office paper recommended that the Executive agree that interventions aimed at a major reduction in the rate of transmission were needed immediately; and that the Executive consider the options on what those interventions should be.

59. The deputy First Minister advised the Executive meeting that the Health Minister's paper had been largely transcribed into The Executive Office's consolidated paper with some amendments, including reference to sales of alcohol in off licenses and supermarkets ending at 8.00 p.m., and indoor shopping centres to remain open, combined with urgent engagement with the retail sector to ensure that it was doing everything it could to help suppress the virus.

60. The substantive discussion at the Executive was of the recommendations included in The Executive Office paper. The minutes of the Executive meeting describe the discussions which took place and the decisions agreed by the Executive. The minutes also record a number of different concerns raised individually by the Minister of Agriculture, Environment and Rural Affairs; the Minister of Justice; the Minister for Infrastructure; the Minister for the Economy; and the Minister of Education. These included concerns about the proposed restrictions: the scientific basis for the restrictions; the impact on weddings and funerals; the economic impact; and the educational impact. However, the Executive agreed a four-week period of interventions, which took regulatory effect from the 16 October 2020, and which was scheduled to expire at midnight on 12 November 2020. This was subsequently announced, and regulations drawn up alongside appropriate public messaging. The

decisions taken by the Executive at this meeting included an extended half term school holiday for two weeks. The trajectory of the pandemic remained under close review during the four weeks with weekly publication of the R paper and regular update presentations by the CMO and the CSA to the Executive.

61. In a statement on 19 October 2020 [**PM/482 INQ000276528** (DoH ref: PM2211)], the Minister acknowledged that these additional restrictions on daily lives were extremely challenging. He said: "*My Department provided the Executive with detailed scientific and medical assessments over recent weeks, underpinning the need for decisive interventions to counter the growing spread of the virus. These assessments reflected evidence amassed by SAGE, evidence which is now in the public domain. It was entirely appropriate for the Executive to assess the health advice alongside the potential implications for the economy and society as a whole. These are very difficult decisions, and I am pleased that we were able to agree a way forward together last week*".

NPI Illustration 3: November 2020 Circuit Breaker Extension and further restrictions

62. In a submission to the Health Minister [**PM/483 INQ000276529** (DoH ref: 2212)], emailed on 2 November 2020, the CMO recommended that the four-week circuit breaker restrictions, due to end on 12 November 2020, should be extended for a further two weeks beyond this date. On 3 November 2020 an updated version of the submission, which included a draft Executive paper, was shared [**PM/484 INQ000276530** (DoH ref: PM2213) , [**PM/485 INQ000276531** (DoH ref: PM2214) by the CMO with the CSA and the then Permanent Secretary with a covering email stating, "*Following the discussions this morning I have updated the Submission and Executive [paper] to reflect the significant constraints and implications of patients requiring augmented and intensive care. Even if we avoid this at this point, decisions made in coming days will impact on our ability to avoid this scenario in coming weeks and months. The implications need to be fully understood by all of the full impact of decisions on Thursday.*"

63. The Minister submitted the paper to the Executive for discussion at its meeting on 5 November 2020 [**PM/486 INQ000137345** (DoH ref: MMcB019)]. The minutes for that meeting record "*The Minister for the Economy advised that she would engage with the Minister of Health, the Chief Medical Officer, the Chief Scientific Adviser and the business sector on how to operate safely and would circulate a paper for consideration.*" …. "*The First Minister advised that an early*

Executive meeting would be required to consider and decide on issues relating to interventions and potential easements, and that any pronouncement on the way forward should be made by means of a statement to the Assembly."

64. On 6 November 2020 the Minister made a written statement to the Assembly **[PM/487 INQ000276533** (DoH ref: PM2215)] in which he stated: "*This week I submitted a paper to the Executive, informed by the latest medical and scientific advice, and I hope that early next week a decision can be made. If we do not take action we almost certainly will have to intervene more significantly if we are to avoid our health service being overwhelmed*".

65. On 8 November 2020 in an email from The Executive Office the First Minister and deputy First Minister asked the Minister to model and provide advice on the impact of a number of possible changes to restrictions **[PM/488 INQ000276534** (DoH ref: PM2216)]. The Minister met by Zoom with the CMO and the CSA to discuss these suggestions. The Department's Modelling Group provided slides **PM/489 INQ000276535** (DoH ref: PM2217), **[PM/490 INQ000276537** (DoH ref: PM2218)] modelling the impact of these proposals. On 8 November 2020 the CSA provided a modelling update to the Health Minister in response to the request from the First Minister and deputy First Minister **[PM/491 INQ000276690** (DoH ref: PM2371)]. The update stated: "*It is not possible to model for individual relaxations, as there is too much uncertainly around the impact of the individual changes described above to allow this to be done with an acceptable level of confidence*." Treating the relaxations as a group, modelling considered a range of possible impacts of relaxations on R, which could rise to a variable extent. The update stated: "*We have assumed that R will rise to 1.0 (low), 1.15 (medium) or 1.3 (high) from 13th November. From 16th November R will rise to 1.2 (low), 1.3 (medium), or 1.5 (high). Under all of these scenarios, further intervention to prevent hospital capacity from being overwhelmed will be required at some point between 1st and 15th December*." A further update to this modelling was provided by CSA the same day which allowed for hospitality opening in a graduated way **[PM/492 INQ000276538** (DoH ref: PM2219)].

66. On 9 November 2020, an update was provided to the Executive by the Health Minister, the CMO and the CSA which included developments in the Covid-19 pandemic, including the R number; the position in Care Homes; number of deaths; admissions to hospitals; contact tracing figures; capacity of the testing system. At this meeting the Minister provided a paper modelling the course of the pandemic and recommended to the Executive that an intervention to reduce R to 0.7 was required

as soon as possible to prevent the hospital system from being overwhelmed and to prevent deaths [**PM/493 INQ000276539** (DoH ref: PM2220)]. The paper recommended that the four-week circuit breaker restrictions introduced on 16 October 2020 (see paragraph 52 above) should be extended for a further two weeks. The discussion of the Minister's paper of 9 November 2020 continued in reconvened Executive meetings on the 10th, 11th, and 12th of November 2020. It is understood that these additional meetings were required to enable the Executive to reach agreement on the Minister's recommendation. The Executive minutes of 9 November 2020 record the following: *"The deputy First Minister advised of her and the First Minister's wish to achieve Executive consensus on the way forward. All Ministers gave their views on the paper provided by the Minister of Health; and on proposed approaches to COVID related measures to ensure protection for the health service while recognising the importance of facilitating economic activity. Ministers discussed a range of proposals regarding amendments to the restrictions currently in place, and the partial reopening of some sectors of the economy, and the potential risks associated with each position, including of no decision being taken on extending the regulations."*

67. While initially some Executive Ministers supported the Minister's proposal, it failed to pass a cross community vote. Following this impasse, written correspondence was received from Conor Murphy MLA, Minister for Finance [**PM/494 INQ000276540** (DoH ref: PM2221), **PM/495 INQ000276541** (DoH ref: PM2222)], Nicola Mallon MLA, Minister of Infrastructure [**PM/496 INQ000276542** (DoH ref: PM2223)] and Naomi Long MLA, Minister of Justice [**PM/497 INQ000276543** (DoH ref: PM2224)]. On 10 November 2020 the Minister for the Economy, Diane Dodds MLA, introduced a paper entitled "Economic Impact of the Four Week Circuit Breaker and Proposed Recommendations (DFE)". On 11 November 2020 the CMO received a Joint Letter from the Finance and Justice Ministers [**PM/498 INQ000276544** (DoH ref: PM2225)]. On 11 November 2020 amended proposals from the Economy Minister entitled "'Executive Options Outline", were circulated. A subsequent proposal from the Health Minister [**PM/499 INQ000276691** (DoH ref: PM2372)] which responded to the latest proposals from the Economy Minister proposed that the Executive should agree a one week extension of the restrictions, but this also failed to secure the agreement of the Executive. On 11 November 2020 the Health Minister wrote to Executive colleagues commenting on proposals from the Justice Minister and highlighting the need to respect the Ministerial code with regard to Executive decisions [**PM/500 INQ000276545** (DoH ref: PM2226)]. The same day

there was further discussion on proposals which had been made by the Justice Minister.

68. At the conclusion of the meeting on 12 November 2020 the Executive agreed a paper brought by the Economy Minister, which provided for a one-week extension of the four-week circuit breaker restrictions with a partial reopening of some sectors from 20 November 2020[6] including:

a. Close contact services including driving instructors would reopen by appointment on 20 November 2020;
b. Hospitality would reopen on a graduated basis, with unlicensed premises such as cafes and coffee shops opening on 20 November 2020, with restricted opening hours to 8.00pm. This would not include the purchase or consumption of alcohol on such premises;
c. Support would be provided for mitigations to reduce risk within the hospitality sector, including improved ventilation and requirements for the recording of customer information for contact tracing purposes;
d. Pubs and bars would be permitted to sell sealed off-sales on 20 November 2020; and
e. The remaining restrictions, which came into being on 16 October 2020, would be extended and come to an end at midnight on 26 November 2020, leaving all elements of hospitality including hotels able to open on 27 November 2020.

69. The Executive also agreed steps in relation to financial support for affected businesses; vaccination; strengthening adherence/compliance to restrictions; contact tracing; testing; and other mitigating measures for the hospitality sector. The final minutes of this Executive meeting record the range of opinions expressed by Executive Ministers regarding this decision. In this instance the minutes of the Executive meeting record that the Minister of Health had supported the Executive's decision, to agree a one-week extension to restrictions, as a compromise measure, but that his preference would have been for a two-week extension of the regulations as outlined in his original paper. The minutes of the meeting also record the advice provided by the CSA and the CMO.

---

[6] The Health Protection (Coronavirus Restrictions) (No.2) (Amendment No.15) Regulations (Northern Ireland) 2020

70. In a written statement on 13 November 2020 **[PM/501 INQ000276546** (DoH ref: PM2227)] the Minister of Health remarked: "*this has not been a good week for the Executive. Whilst the pandemic has undoubtedly confronted us with many immensely difficult decisions, the people and businesses of Northern Ireland deserved so much better than the leadership and political stewardship they were given. There is huge work required to repair the damage that has been caused but I would urge Ministers to look forward to the very real issues at hand rather than repeat the arguments that have been exhausted over recent days. At the forefront of all our minds is that the pandemic remains an immediate and serious public health threat. We must also remember why we decide to take the decisions we do*."

71. The Heath Minister presented a paper to the Executive meeting on 19 November 2020 entitled "Modelling the course of the COVID pandemic and the impact of different interventions and recommendations" **[PM/502 INQ000137370** (DoH ref: MMcB038)]. This paper outlined the current position and likely course of the pandemic. The paper confirmed that while there had been a reduction in cases per day of approximately 50% since the introduction of restrictions on 16th October 2020, numbers of cases, admissions and hospital inpatients, ICU occupancy and deaths remained at a relatively high level. Indeed, these numbers were higher than was reached in Wave 1, and were declining only very slowly, and as a consequence of this, the hospital system and staff remained under very significant pressure. The paper highlighted that the planned relaxations of the next two weeks, agreed by the Executive on the 12 November 2020, beginning from 20th November 2020 would result in R rising significantly above 1, with a subsequent increase in cases, admissions, inpatients, and ICU occupancy becoming apparent in December 2020. The Minister indicated that this likely course had been considered by the Modelling Group and was presented along with the paper. The paper highlighted that the Executive had a number of possible actions and interventions to consider, and these were outlined. It was highlighted that if no intervention occurred in late-November 2020 it was likely that the hospital system would be overwhelmed in mid-December 2020 with a significant increase in Covid and non-Covid deaths, and that even a full lockdown beginning around the 14 December 2020 would be insufficient to prevent the then current levels of hospital pressures being significantly exceeded.

72. The Minister's paper [see exhibit **[PM/502 INQ000137370** (DoH ref: MMcB038)] highlighted that the only intervention which has been proven to date to effectively reduce transmission of the pandemic involved the use of restrictions, and in summary, that a two-week period of restrictions to start on the 27 November 2020

would offer the best prospect of avoiding the need for further interventions before January 2021. The paper highlighted that the experience from NI and discussions at SAGE suggested that non-essential retail and churches contribute around 0.2 to R, and that the opening of schools contributed around the same value. Most effective intervention would therefore involve closing these sectors along with close contact services, leisure, and entertainment sectors. The modelling paper demonstrated the impact with and without schools closed. The paper also recommended that individuals should work from home where possible, and otherwise stay at home except for certain purposes. The paper further highlighted the importance of securing maximum public adherence. The paper concluded with the recommendation that the Executive consider the information in the paper and conclude on the appropriate response. The Executive discussed the paper and then the meeting adjourned briefly to enable the Minister, the CMO and the CSA to provide a summary of their proposals for the Executive to consider. These were then discussed, and the final decisions of the Executive were recorded in the Executive minutes.

73. The Executive decided to introduce significantly tighter restrictions for two weeks from the 27 November 2020[7]: The Executive also agreed that the Minister for Health would make a statement **[PM/503 INQ000276547** [DoH ref: PM2228)] to the Assembly and that these restrictions would be communicated as a time limited "circuit breaker" to end on 10 December 2020. During this two-week circuit breaker schools would remain open and from 27 November 2020, a controlled 'click and collect' service for retail would be able to operate.

[7] Closure of all retail except essential retail that was permitted to stay open in March. Off licences will remain open, with an 8pm closing. Closure of close contact services, and driving instruction (not motorcycles), except close contact for Film and TV production; those ancillary to medical, health and social care services; and elite-sports therapeutic services - i.e. – as 13 October- 19 November. Closure of all hospitality (except for accommodation for essential travel). Takeaway and delivery, and food and drink in motorway services, airports and harbour terminals remain open. Closure of all leisure and entertainment (to include all soft play areas, gyms, swimming pools etc). Sporting events only permitted for elite sports. Individual/household outdoor exercise and school PE to continue. Elite sports events behind closed doors without spectators. No household gatherings of more than one household, other than current arrangements for linked households (bubbles), with current exceptions for caring, maintenance, house moves, etc. Closure of places of worship, except for weddings, civil partnerships and funerals. Remain with 25 max for weddings and funerals. Stay at home, work from home if at all possible, otherwise only leave for essential purposes such as education, healthcare needs, to care for others or outdoor exercise. Schools and childcare to remain open. Universities / FE to provide learning at distance except where it is essential to provide it face to face. Public parks and outdoor play areas remain open. Stay at home in guidance, with liaison with PSNI on policing and police visibility.

NPI Illustration 4: Measures introduced during December 2020

74. In the run-up to Christmas the Department modelled a range of scenarios including the impact of implementing restrictions or not relaxing restrictions in the pre-Christmas and immediate post-Christmas period, and the results of this modelling were provided to Ministers. There was no particular pressure to take an approach consistent with that of the UK Government by imposing restrictions after rather than before Christmas. There is no doubt that the imposition of restrictions before Christmas would have been more effective in reducing the incidence of Covid-19 in the post-Christmas period. However, in making decisions about the timing of restrictions Ministers needed to balance this with other factors, including economic impacts and impacts on family life at an important time of the year.

75. At Executive meetings on 23 and 24 November 2020, the First and deputy First Ministers provided updates on discussions with the UK Government and other devolved administrations about Christmas restrictions. On 24 November 2020 a UK Government press release **[PM/504 INQ000276548** (DoH ref: PM2229)] announced the "UK-wide Christmas arrangements agreed by the UK Government and the Devolved Administrations." The minutes of the Executive meeting on the 26 November 2020 record that the deputy First Minister "*briefed the Executive on agreement reached by COBR on a common approach to Christmas in the context of COVID-19, advising of matters to be decided on by each administration, including Christmas Bubbles, and restrictions and arrangements for Christmas. She advised that the views of the Chief Medical Officer and the Chief Scientific Adviser would be sought; and that account would be taken of the arrangements to be put in place by the Irish Government.*"

76. On 3 December 2020, the Executive considered two papers prepared by The Executive Office focusing on restrictions from 11 December 2020 and Christmas 'Bubble Arrangements' respectively. Both papers included the advice of the CMO and the CSA in respect of each of the possible restrictions including potential relaxation of some restrictions. The Executive meeting also considered a paper from the Department for the Economy on the economic impact of restrictions. These papers reflected discussions which had been ongoing between the UK Government and the Devolved Administrations for several weeks and which were aimed at aligning Christmas arrangements across the UK four jurisdictions, focusing on domestic settings, household bubbling and with a preference for a short period of time for relaxation of restrictions, possibly from 24 to 27 December 2020. However, it

remained the responsibility of the Executive to ultimately decide the Christmas arrangements for NI. The R paper **[PM/505 INQ000276549** (DoH ref: PM2230) , PM/X - **INQ000276551** (DoH ref: PM2231)] presented at the meeting records that the estimate of R was around 1 (0.9 to 1.1). The paper advised "*Given the current restrictions, we anticipate that numbers will decline slightly or remain stable until shortly before Christmas 2020 when they will begin to rise again. The rate of increase will depend on how much Rt increases following the 11 December 2020. If Rt can be maintained at 1.6 or below, then intervention would not be required until the end of December/beginning of January. However, if Rt was to rise as high as 1.8 then intervention would be required a few days earlier than this*." The minutes of the modelling group **[PM/507 INQ000276552]** (DoH ref: PM2232)] held on 1 December 2020 record that an R of 1.8 would represent a doubling time of one week.

77. The Executive's decision recorded in the minutes of the 3 December 2020 meeting about Christmas 'Bubbling' was that this would be one bubble over Christmas with up to two other households from 23 to 27 December 2020. The Executive also noted the detail of additional supports and advice for the vulnerable, and noted that advice for Care Homes, residents and families would be developed. These minutes also recorded the Executive's decisions on restrictions from 11 to 19 December 2020 (inclusive) including the opening-up of non-essential retail, close contact services, sport and leisure activities and places of worship. The details of these changes to restrictions and of planned Christmas Bubbling arrangements were announced in an Executive Office press release **[PM/508 INQ000276553** (DoH ref: PM2233)] on 4 December 2020

78. The Department's Modelling Group met on 15 December 2020 **[PM/509 INQ000276554** (DoH ref: PM2234)]. The minutes record that the Group considered various scenarios which were variously, based on: (i) no intervention; (ii) restrictions being implemented from 26 December 2020; or (iii) restrictions being implemented from 2 January 2021. Under the 'no intervention" option, the likelihood was that the hospital system would be faced with occupancy greater than 6,000 Covid hospital inpatients by the end of January 2021 against a capacity of 2,900 beds across the HSC sector.

79. On 17 December 2020 the Executive considered a paper submitted by the Department on post-Christmas restrictions. The paper **[PM/510 INQ000276555]** (DoH ref: PM2235), **[PM/511 INQ000276556** (DoH ref: PM2236)] offered options including taking no action or implementing restrictions from one of the following dates: 19

December 2020; 26 December 2020; or 2 January 2021. The paper highlighted that the R number for new cases was now between 1.0 and 1.2 with both the 7 and 14 day incidence increasing to 175 and 340 per 100k respectively. This indicated a disappointing impact of the two weeks of restrictions introduced on 27 November 2020. The paper outlined the existing pressures and impact on the health system. It also anticipated the impact of a surge of cases post-Christmas and outlined the need for action to prevent the hospital system becoming overwhelmed and the need to reverse the current trend. The minutes record that the Executive agreed the introduction of extensive restrictions[8], which amounted to a lockdown, from 26 December 2020 for a period of six weeks (subject to review after four weeks. The Minister issued a press release **[PM/512 INQ000276557]** (DoH ref: PM2237)] detailing the restrictions coming into effect for six weeks from 26 December 2020[9]. The announcement of these changes in restrictions for NI **[PM/513 INQ000276558** (DoH ref: PM2238)] was a day in advance of similar steps by the UK Government, Scottish and Welsh administrations on 19 December 2020.

80. Prior to these announcements the First Minister and deputy First Minister met with the other administrations and the Chancellor of the Duchy of Lancaster on the morning of 19 December 2020. The readout from that meeting **[PM/514 INQ000276559** (DoH ref: PM2239)] records that attendees received a briefing on the changing epidemiology. In the South and South East of England and London disease activity was increasing significantly despite Tier 3 restrictions, by up 50% in some areas within the last week, with growth in younger age groups and also more concerningly in 60+ age group. At this time hospital activity was increasing

---

[8] The Health Protection (Coronavirus, Restrictions) (No.2) (Amendment No.24) Regulations (Northern Ireland) 2020

[9] Closure of hospitality and non-essential retail with a stricter demarcation between essential and non-essential retail than that deployed during the recent circuit breaker. Click and collect retail will not be permitted, and homeware will not be categorised as essential retail. Off sales (including from bars) will be permitted from 08:00 on Monday to Saturday, and from 10:00 on Sunday, until 20:00 on any day. Hospitality businesses will only be allowed to offer takeaway and delivery food. Closure of close contact businesses. Places of worship can remain open under strict conditions. In addition, there will be a one-week period of additional restrictions from 26 December 2020 to 2 January 2021. Between 20:00 and 06:00 during this period all businesses which are able to remain open as part of the restrictions must close between these hours. No indoor or outdoor gatherings of any kind would be permitted after 20:00 and before 06:00, including at sporting venues. Outdoor exercise would be permitted only with members of your own household. No household mixing would be permitted in private gardens or indoors in any setting between these times, except for emergencies or the provision of health or care services or where households have chosen to form a Christmas bubble for a period of time between 23 to 27 December with provision for travel a day either side when absolutely necessary.

considerably. South Wales was also experiencing similar pockets of increased disease activity and hospital pressures.

81. At the meeting, the UK CSA gave a short update on the new variant which was that there was increased transmissibility but as yet there was no evidence on whether the increased transmissibility was impacting the clinical disease pattern or of an impact on immune response or vaccine response. Experiments and scientific work were continuing in these regards. The meeting was told that the Prime Minister would announce at 4 pm that afternoon the following measures for England: South/South East/ London – new enhanced Tier 4 restrictions, to come in at midnight on 20 December 2020[10]. This was to be a similar lockdown to that in November 2020: with a strong stay at home message; the closure of all non-essential retail and personal services; and that Christmas arrangements would not go ahead as planned, and people were asked not to extend bubbles further beyond what they already had in place; that churches should remain open for worship in a Covid secure environment; travel would be restricted to within Tier 4 areas (into regulation); in the rest of England – tiers as they currently were, with a strong emphasis on 'stay at home'; and that there were to be 3x household bubbles for Christmas Day only. It was further indicated that the above was subject to ongoing discussion and could be refined through the day prior to the PM's announcement.

82. The Executive held an emergency meeting on Sunday 20 December 2020. The meeting considered an update paper **[PM/515 INQ000276560** (DoH ref: PM2240)] submitted by the Department. The paper outlined the evidence on the new variant[11] of Covid, based on evidence from Public Health England. On 17 December 2020, the Belfast Virology Laboratory had reported that it had detected four positive cases with an unusual test profile which may be indicative of the new variant. The paper recommended: a reduction in Christmas bubbling arrangements; further engagement between the Education and Health Departments around the return to school in January 2021; and emphasised the stay at home message to the public. Following discussion, the Executive agreed that the Christmas Bubbling arrangements which had been agreed at the Executive meeting of 3 December 2020 would be amended to reduce the permitted period from five days to one day, with

---

[10] SI 1611

[11] The variant has been named as 'VUI – 202012/01' (the first Variant Under Investigation in December 2020).

flexibility on which day between 23 and 27 December people could come together, to accommodate those working on Christmas Day.

83. At a meeting on 21 December 2020 the Executive agreed that "*guidance should immediately be developed and issued advising against all but essential travel between Northern Ireland and Britain and the Republic of Ireland, with immediate effect. This should include asking all new arrivals here to self-isolate for 10 days following entry to Northern Ireland; and would be kept under regular review to ensure it remained appropriate.*" This was in response to a paper submitted by the Minister **[PM/516 INQ000276561** (DoH ref: PM2241)),

84. On 22 December 2020 the Executive agreed an Executive Office paper which clarified a number of definitions and decisions with regard to the six weeks of restrictions which were to begin on 26 December 2020. Clarification included the definition of essential retailing and hardware, as well as decisions regarding, for example non-essential retailing and horse racing.

85. On 23 December 2020 the Joint Biosecurity Centre **[PM/518 INQ000276563** (DoH ref: PM2243)] in its report to the four UK CMOs concluded that "*a COVID-19 pandemic is in general circulation; transmission is rising exponentially, and it is highly likely that across much of the UK, the NHS will exceed its assumed COVID-19 contingency capacity in the next 21 days*". The same update was repeated on 29th December 2020.

NPI Illustration 5: Measures introduced during the January 2021 to May 2021 period

86. The Department's Modelling Group met twice over the new year period, on 29 December 2020 **[PM/519 INQ000276564** (DoH ref: PM2244)] and 5 January 2021 **[PM/520 INQ000276565** (DoH ref:PM2245)]. At the first meeting the minutes record that there was limited information on the prevalence of the new variant (Alpha) in NI. The group agreed that the latest estimate of the R number was above 1 between 1.4-1.8 for cases. The R number, based on hospital admissions, was agreed as 1.0-1.2. It was agreed that a reasonable scenario would be for the R number to remain at 1.4 to 1.8 for two weeks before reducing to 0.8 to 1.0 as the latest restrictions took effect.

87. On 29 December 2020 the Minister wrote to the Minister for Education **[PM/521 - INQ000276566** (DoH ref: PM2246)] to provide an update on the pandemic over the

holiday period. On the same day, the CMO and the CSA wrote to the Permanent Secretary in the Department of Education [**PM/522 INQ000276567** (DoH ref: PM2247)] to ask that "*careful consideration should be given to the other options which have been highlighted before, including an extension of the Christmas holidays, face to face teaching for key years only, alternate weeks of distance learning and face to face teaching, and half classes only to be taught face to face on alternate weeks.*" This was in advance of a meeting held on 30 December 2020, attended by the CMO, the CSA and Department of Education officials.

88. On 4 January 2021, the Joint Biosecurity Centre issued their update which largely repeated their updates of 23 and 29 December 2020, and concluded that "*a COVID-19 pandemic is in general circulation; transmission is rising exponentially; it is almost certain that across much of the UK the NHS will exceed its assumed COVID-19 contingency capacity in the next 21 days; and there is a material risk of healthcare services being overwhelmed in England, Wales and Northern Ireland.*" [**PM/523 INQ000276568** (DoH ref: PM2248)]. The 4 UK CMOs and the NHSE Medical Director met and agreed the following update: "*There has been sustained pressure on the health systems across the four nations now for a number of weeks and this is still increasing in many parts of the country. They considered the impact of the new variant and the fact there is currently very high incidence rates in the community, with continued rises almost everywhere, on a background of already high Covid caseloads. In the light of this they are no longer confident that the health system can handle a sustained rise in cases and if this happened, there is a material risk of the NHS being overwhelmed in many geographies within 21 days without further action. There is, therefore, unanimous agreement that we should advise Ministers that all 4 nations of the UK should move to alert level 5 as soon as is operationally feasible.*" [**PM/524 INQ000276569** (DoH ref: PM2249)]. On the same day the Prime Minister announced that everyone in England must stay at home, except for permitted reasons during a new coronavirus lockdown expected to last until mid-February 2021. All schools and colleges were directed to close to most pupils and switch to remote learning from 5 January 2021.

89. An emergency meeting of the Executive was held on 4 January 2021. The deputy First Minister advised that this meeting had been convened in light of very serious developments in the Covid-19 pandemic and advised of a call earlier in the day involving herself, the First Minister, the Minister of Health, the First Ministers of Scotland and Wales and the Chancellor of the Duchy of Lancaster in relation to the progression of and response to the pandemic. The Executive noted the public

expectation that decisions would emerge from the meeting and it was agreed that: "*a public statement should emphasise the fact that the Executive had made a pre-emptive move to introduce restrictions from 26 December, but that further measures, to include an extension of remote learning and the translation of the Stay at Home message into enforceable regulations had been agreed; the 'Stay at Home, Save the NHS' message; that a further meeting would take place the following day to consider the detail of the additional restrictions; and that a statement would be made in the Assembly on Wednesday 6 January.*"

90. The meeting of the Department's Modelling Group on 5 January 2021 recorded that the seven day average of new cases had tripled over the Christmas period **[PM/520 INQ000276565** (DoH ref: PM2245)]. However, there was some evidence in recent data that the trend in case numbers and the positivity rate was starting to level off. The group agreed that the R number was between 1.5 and 1.9 for new cases and 1.2 to 1.4 for hospital admissions. The Group estimated that the number of hospital inpatients with Covid-19 would rise to at least 700, but potentially could exceed 2,000 by mid to late January 2021.

91. On 5 January 2021 the Executive considered a paper from the Department on strengthening restrictions **[PM/525 INQ000276571** (DoH ref:PM2251)]. In the week prior to this Executive meeting there was engagement between the Departments of Health and Education around the impact of schools re-opening on R and the health system. The Department's paper did not make recommendations on schools but commented "*The Executive has agreed the continuation of Education must be a priority however it must be noted that closure of schools and a switch to remote learning for all pupils would lead to a faster reduction in Rt. This would reduce the likely required duration of these most stringent of restrictions*." The Department's paper set out a number of options for tightening restrictions. The Executive minutes for this meeting recorded that the Executive agreed that the additional restrictions outlined in Annex B of the paper should be introduced with effect from Thursday 7 January 2021; that a power for the Police Service of Northern Ireland to direct persons home should be reintroduced; that a requirement should be introduced for all employers to conduct a risk assessment where employees were required to be in premises away from their home for work; that these restrictions would be in place until 6 February 2021 with a review point of 21 January 2021, in line with the restrictions agreed prior to Christmas; and that work on reducing crowding in retail settings would be progressed.

92. At the same meeting the Minister for Education submitted a paper on education provision during lockdown. The paper recommended that "*all mainstream education providers, including pre-school education settings, primary and post primary schools required to provide remote learning at home to their pupils rather than face to face teaching in school until the half term break in the middle of February.*"

93. On 21 January 2021 the Executive considered a paper concerning the sixth review of the Coronavirus (No 2) Regulation **[PM/526 INQ000276572** (DoH ref: PM2252)] submitted by the Department and agreed that the current restrictions should be extended until 5 March 2021 (a four-week extension) and that the restrictions should be reviewed on or before 18 February 2021.

94. The Joint Biosecurity Centre update for the 11 February 2021 concluded that the "*NHS continues to work under severe pressure, threatening patient safety*" **[PM/527 - INQ000276573** (DoH ref: PM2253)]. The following day the 4 UK CMOs recommended that the Alert level should remain at Level 5 **[PM/528 INQ000276574** (DoH ref: PM2254)]. The Department's Modelling Group met on 16 February 2021 **[PM/529 INQ000276575** (DoH ref: PM2255)]. The group considered future impacts if R rose following relaxations of restrictions. Under an R of 1.4 the number of new cases would be expected to peak at just over 1,500 per day in June 2021 with hospital patients peaking at over 500 in July 2021. The respective figures for an R under 1.8 were 12,000 new cases per day in May 2021 with hospital inpatients rising to over 4,000 in June 2021 with cumulative deaths of more than 3,000 over the modelling period.

95. The Executive met on 18 February 2021 and considered the Department's paper, the seventh review of the Coronavirus (No. 2) Regulations **[PM/530 INQ000276576** (DoH ref: PM2256)]. The Executive agreed that the current restrictions should remain in place until 1 April 2021, subject to review and would be formally reviewed on or before 18 March 2021. The Executive also agreed some changes in relation to contactless click and collect for non-essential retail businesses to begin on 8 March 2021. This decision was against a background of new, more transmissible, variants; uncertainty about how effective vaccines would be against these variants; ongoing pressures on HSC hospitals; and concerns about the impact on HSC staff of having been on the front line dealing with covid for almost a year. At the same meeting the Executive considered a paper entitled "Options for Schools Return from 8 March 2021" tabled by the Minister for Education. The Executive

agreed Option 2 presented in the paper: "*A phased return on 8 March 2021 with agreed priority cohorts, such as key year groups and/or exam/assessment years coming back first, with all pupils back by 12 April 2021 or as soon as possible thereafter*" but with an amendment that remote learning, rather than Easter Holidays, would be extended for a week for P1 – P3 pupils.

96. From 8 March 2021 to 24 May 2021 the Executive, in a series of decisions and announcements, incrementally eased or removed the restrictions that had been introduced from August 2020 at the start of the second wave of the pandemic to help protect the population and the health service from the impact of Covid-19. To a large extent these decisions were informed by papers tabled at Executive meetings by TEO, which in turn had been informed by the TEO-led Covid-19 Cross-Departmental Working Group and CMO and CSA advice.

NPI Illustration 6: 'Moving Forward: The Executive's Pathway Out Of Restrictions'

97. 'Moving Forward: The Executive's Pathways Out Of Restrictions' document published on 2 March 2021 [**PM/531 INQ000276577** (DoH ref: PM2257)], was developed by The Executive Office's Covid Taskforce in collaboration with departments including the Department of Health. The Executive Office led on its initial development then involved other departments in refining the approach. The Department contributed to the development of the document when it was brought by The Executive Office to the weekly Covid-19 Cross-Departmental Working Group, led by The Executive Office. There were focused meetings of the working group around this subject, and this was followed by specific, direct engagement by The Executive Office with the CMO and the Deputy CSA.

98. The Executive Office held a bilateral meeting on 22 February 2021 with the Department about the pathway they were developing, including both the CMO and Deputy CSA, as well as senior officials who had been participating in the working group discussions and workshops. The Executive Office officials gave presentations to the Executive about the development of a 'pathway out of restrictions and towards recovery' on 18 and 25 February 2021. The CMO and Deputy CSA were present on 18 February and the CMO was present on 25 February 2021.

99. The Executive Office approached the Department asking for the CMO to comment on 24 February 2021 [**PM/532 INQ000276578** (DoH ref: PM2258) , [**PM/533 INQ000276580** (DoH ref: PM2259)] and sent the draft pathway to Executive

Ministers on 25 February 2021 [PM/534 INQ000276581] (DoH ref: PM2260) , [PM/535 INQ000276583] (DoH ref: PM2261)]. The draft pathway was discussed at the Executive meeting held on 1 March 2021, and the CMO was in attendance. It was agreed that engagement at Ministerial and official level should continue to consider outstanding matters before a further Executive meeting to be held the following day. The CMO provided written comments and suggestions on the advanced draft [PM/536 INQ000276584] (DoH ref: PM2262) , [PM/537 INQ000276586] (DoH ref: PM2263)], which were informed by his internal discussions with the acting CSA and officials and were cleared by the Health Minister before being provided to The Executive Office. The final version of 'Moving Forward: The Executive's Pathway out of Restrictions' was agreed by the Executive at its meeting on 2 March 2021. The CMO was in attendance at that meeting.

Face Coverings

100. On 7 May 2020 the Minister provided an Executive paper [PM/538 INQ000276587] (DoH ref: PM2264)] outlining the emerging scientific evidence and public health benefits for the introduction of mandatory face coverings. The paper quoted from advice provided by the Strategic Intelligence Group that: evidence for the benefit of face covering in the community was weak overall and benefits were likely to be small; evidence was stronger for reducing transmission of infection by infected individuals than for protecting healthy individuals from infection; on balance, there was sufficient evidence to recommend (but not mandate) face covering in enclosed environments where social distancing cannot be maintained, for short periods. In practice this meant public transport and retail environments in the main; evidence was not sufficient to recommend face covering outdoors or in enclosed environments for long periods; and cloth face coverings were recommended to avoid risk of shortages of respiratory masks which should be prioritised for the highest risk settings. Following discussion, the Executive agreed to recommend (as opposed to require) that the public consider the use of face coverings for short periods in enclosed spaces, where social distancing was not possible.

101. In its statement of 8 July 2020, the Executive ratified its commitment to the mandatory use of face coverings on public transport, effective from 10 July 2020, unless an individual was in an exempt group. On 23 July 2020 the Executive considered a paper from the Minister [PM/539 INQ000276588] (DoH ref: PM2265) , [PM/540 INQ000276591] (DoH ref: PM2266) , [PM/541 INQ000276592] (DoH ref: PM2267)]) and agreed to legislate to take the power to make the use of face

coverings mandatory in a number of indoor settings, although this would not be implemented immediately as had been proposed by the Department. The Department's paper stated that in the absence of clinical trials demonstrating the quantifiable benefit in reducing transmission, indirect evidence (including laboratory experiments and ecological / epidemiological studies) increasingly was suggestive of significant potential overall benefit in reducing the transmission of the virus. Evidence supporting the potential effectiveness of face coverings came from analysis of: (1) the incidence of asymptomatic and pre-symptomatic transmission; (2) the role of respiratory droplets in transmission, which can travel as far as 1-2 meters; and (3) studies of the use of homemade and surgical masks to reduce droplet spread. Analysis suggested that the use of face coverings could reduce onward transmission by asymptomatic and pre-symptomatic wearers if widely used in situations where physical distancing is not possible or predictable. If correctly used on this basis, face coverings, including homemade cloth masks, can contribute to reducing viral transmission." The paper included as Annexes two papers summarising the scientific evidence. On the basis of this updated evidence the paper recommended that the Executive agree to amend legislation to include the provision to provide for the mandatory use of face covering when in enclosed public settings where social distancing cannot be maintained for limited periods of time, such as retail environments, from 1 August 2020; and to engage with the public until 20 August 2020 to raise awareness of the benefit and to build public support. It was decided by the Executive that, in the interim, a publicity campaign would encourage the wearing of face coverings, and the Executive undertook to consider the impact of this campaign in August 2020. It was considered that if there had not been a significant increase in the use of face coverings by this stage, the Executive would implement the power to make this mandatory. In a statement [**PM/465 INQ000276488** (DoH ref: PM2180)] to the Assembly on 28 July 2020 the Minister recognised that the issue of face coverings divided opinion in wider society but repeated the point that the medical and scientific advice was clear; wearing face coverings in retail settings would help to protect the public.

102. On 6 August 2020 the Executive decided that the use of face coverings in certain indoor settings, including shops, would be mandatory from 10 August 2020. Children aged under 13, or those who could not wear a mask because of health or disability reasons, were exempted from this requirement. Individuals who did not comply with the requirement, without a reasonable excuse, risked being issued with a fixed penalty notice by the PSNI.

Compliance

103. The response by the public to the introduction of NPIs was mixed; for the majority of the population adherence was remarkable, with high levels of support throughout the pandemic. However, there was clear evidence of patchy or poor adherence by a minority of the population, and overall levels of adherence showed a tendency to decline as the pandemic proceeded. The Department took account of evidence emerging from the Scientific Pandemic Insights Group on Behaviours (SPI-B) when submitting briefing papers to the Executive which included advice in relation to behaviour interventions to improve adherence, including the approach to enforcement alongside encouragement and education through public messaging.

104. In an Executive Paper tabled on 10 September 2020 **[PM/493 INQ000276539** (DoH ref: PM2220)], the Minister highlighted his concerns in relation to enforcement and suggested that the Minister for Justice should urgently convene a working group of relevant organisations to develop a robust action plan to ensure that the Executive's decisions on restrictions were respected across the community. At a meeting of the Executive on the same date, it was agreed that a working group on compliance and enforcement of the regulations should be established but led by The Executive Office rather than the Department of Justice and chaired at Ministerial level. The CMO and the CSA supported the engagement of this group with a range of sectors including faith leaders, the retail and hospitality sectors, representatives from the sporting codes, and wider civic society. As part of the Executive's Covid Taskforce, an Adherence Group was also established and chaired by the then Permanent Secretary in the Department of Justice. The Department and PHA were represented and provided public health and scientific advice.

Clusters and Outbreaks

105. The Department issued a statement on 25 February 2021 publishing data on the main settings which were at that point associated with clusters and outbreaks of Covid-19 in NI. The information, captured through enhanced contact tracing and public health risk assessments, showed that during the four-week period between 18 January and 14 February 2021 there were 100 outbreaks identified and 258 clusters. Clusters and probable outbreaks identified during this period were mainly associated with workplace and retail settings. A smaller number were associated with other settings including fast food or take-away outlets. The majority of cases were not associated with clusters and outbreaks and therefore there was

uncertainty about specific sources. The intelligence arising from analysis of the PHA Cluster and Outbreak reports was used to inform sectoral engagement and public health action and messaging by the PHA to contain outbreaks and to improve adherence with public health advice. This also included liaison with local government representatives, and as necessary, wider engagement by the Executive Offices Enforcement Group. The Minister supported by the CMO and CSA provided weekly updates to the Executive.

New Variants

106. RNA[12] viruses such as SARS-Cove- 2, have a high likelihood of mutating and changing their genetic material when compared to DNA viruses. Throughout the pandemic new variants of the virus emerged over time, some of which created additional challenges as they were more transmissible, with varying ability to escape previously acquired immunity or to cause more severe disease. A number of these variants such as the Alpha and Delta variants in late 2020 and Omicron from November 2021, contributed to increased community transmission and outbreaks and health and social care surge pressures.

107. The overall general public health approach was to monitor for the emergence of new variants, assess their potential significance clinically and from a public health perspective. The approach was also to seek to contain the initial spread of new variants when first detected through local surge testing, the deployment of mobile testing units, and enhanced contact tracing, where appropriate. This ensured testing of the greatest number of people who had possibly been exposed and offered the best chance of curbing onward spread.

108. Regular verbal and written updates were provided to the Executive on the emergence of new variants and their potential significance in terms of community transmission, outbreaks, and hospital pressures. The analysis of the potential impact of these new variants was contained in the weekly R paper and also informed the advice of the CMO and the CSA to the Minister and the Executive on NPIs and other public health measures. While genomic sequencing technology has been used over the past decade, and in previous outbreaks and pandemics, such as during the Ebola outbreak of 2014 and the H1N1 influenza 2009 pandemic, the SARS-CoV-2 pandemic marked a step change with the UK and other countries investing in

[12] An RNA virus is a virus—other than a retrovirus—that has ribonucleic acid (RNA) as its genetic material.

sequencing large numbers of virus genomes. This is covered more comprehensively in the UK CMO Technical Report, Chapter 1 and we will not replicate in this statement the discussion in the Technical Report. Genomic sequencing allowed for epidemiological tracking and also provided for the rapid detection of new variants as they emerged in the UK.

109. Genomic sequencing on its own was not sufficient to understand the emergence of new variants or to undertake risk assessments to inform policy responses. The sequencing was combined with other analyses, including how the virus was behaving in the population, to what extent it was outcompeting other established variants, or escaping previous immunity, and in particular, the clinical severity of the associated infection. Such analysis required detailed larger scale epidemiological sampling and analysis of clinical data sources. This data was not, and could not be, immediately available and took time to assemble and assess.

110. Wastewater sampling (WWS) began as an all-Ireland pilot in December 2020 across two sites. A full NI surveillance programme was initiated by DAERA commencing April 2021 (32 wastewater treatment sites, 4 samples per week), with the Department leading the programme from September 2021. With a reduced budget, from August 2022, NI's WWS continued with sampling taken twice weekly across 24 treatment sites, until March 2023, when the DoH WWS Programme formally closed, with any ongoing surveillance then to be taken forward by the Public Health Agency under business-as-usual arrangements. WWS helped give early warning of circulation of SARS-CoV-2 variants of concern and allowed the tracking of new lineages and variants of SARS-CoV-2. This sampling combined with whole genome sequencing of clinical isolates from those testing positive was used in Northern Ireland to inform targeted public health responses by the PHA, assisting in the attempted containment of initial transmission of more transmissible variants or those with increased disease severity.

111. Whole genome sequencing has advanced hugely in the course of the pandemic and the UK was world-leading in terms of genomic epidemiology, identification of novel variants and understanding the evolution of the virus in real time. Northern Ireland participated in the development of the Covid-19 Genomics UK consortium (COG-UK), the outputs of which informed understanding of variant spread and significance. This Consortium was established in April 2020 as a group of public health and academic institutions to collect, sequence and analyse genomes of SARS-CoV-2. It has been important to bring together multidisciplinary groups of

public health academics including epidemiologists, genomics scientists, bioinformaticians and virologists to rapidly assess new variants. COG-UK deliver large-scale and rapid whole-genome virus sequencing to local NHS centres and the UK government. The data derived from COG-UK was used to help Public Health Agencies to manage the COVID-19 outbreak in the UK and inform vaccine research efforts.

Alpha

112. Throughout the summer of 2020 there was no significant evolution of SARS-CoV-2 within the UK, and only a few minor and fairly inconsequential mutant lineages emerged. Many of those lineages were carried to the UK by travellers. Towards late 2020, however, rising case rates (initially in the south-east of the UK) were investigated and subsequently found to correlate with a negative result for the S gene target, one of the commonly used probe sets for quantitative polymerase chain reaction (qPCR) tests. This variant was later labelled the 'Alpha' variant and its spread was relatively easy and fast to track using S gene target failure in PCR testing for Covid-19 infection. This underscored the importance of using several different PCR targets in combination for large scale testing of an RNA virus; and had this not been done, Alpha infections would have gone undetected until later in the wave.

113. The Alpha variant drove a large wave of cases in the winter of 2020 to 2021, and genome sequencing revealed many mutations throughout its genome The Alpha variant was subsequently confirmed to have increased transmissibility as a result of changes in receptor binding and also changes in immune control. With the emergence of Alpha (and Beta which was detected in Southern Africa), effort was further expanded to sequence and rapidly identify and characterise any other new variants arising across the UK, including in NI. The Department understand that similarly such capacity was increased in the ROI. Information on the emergence of new variants was discussed at UK CMO meetings, SAGE and in weekly meetings with the ROI.

Delta and Kappa

114. Unfortunately, by early 2021 there were emerging observations in India of potential new variants, with a significant surge in cases reported and increased hospitalisations. These variants were later classified as Delta and Kappa. In the UK, cases of Delta and Kappa were initially detected predominantly in those travelling from India (see, UK CMO Technical Report Chapter 8 on NPIs, for further

epidemiological context on travel restrictions). Initially, Kappa was thought to pose the larger threat, as imports into the UK consisted mostly of that variant, which contained a mutation at spike position 484 (484Q) that was flagged as a likely antigenic escape mutant due to its similarity to E484K (found in Beta and Gamma). However, Delta began to exhibit a much more rapid growth rate and went on to become dominate globally in 2021.

115. This rapid growth rate occurred at the same time as the UK was rapidly vaccinating its population and gradually lifting NPIs. Laboratory studies and epidemiology showed that Delta was more transmissible than previous variants. It also showed some modest immune escape properties, potentially allowing it to break through the protection and immunity as a consequence of vaccination or prior infection from wild type SARS-CoV-2 with greater efficiency than Alpha. The Executive, informed by the Department, adopted a precautionary approach advising travellers from elsewhere in the UK not to travel if symptomatic and to test prior to departure if staying overnight. While NI delayed Delta becoming dominant as compared to elsewhere in the U.K, probably as a consequence of geographical location and advice on travel within the CTA, it eventually became dominant.

Omicron

116. By November 2021 many countries worldwide, including the UK, were reaching their highest rates of sequencing. Sequencing in Southern Africa and travel-related sequencing in Hong Kong allowed the rapid identification of a new variant of concern. This identified Omicron as soon as the first 4 sequences had been uploaded by Southern African researchers to the online sequence database GISAID.

117. Omicron was characterised by a very large number of mutations, including 35 across the spike gene. The large antigenic distance or differences between Omicron and the wild type spike protein, combined with waning immunity in the population, resulted in poor neutralisation of Omicron by those previously vaccinated. This necessitated the rapid implementation of vaccine booster programmes to counter immunological waning associated with the establishment of this variant.

118. During the pandemic and in the light of some potentially misleading media commentary, on the extent of whole genome sequencing being performed in Northern Ireland **[PM/542 INQ000276524** (DoH ref: PM2207)] the Department issued a statement on 24 January 2021 **[PM/543 INQ000276525** (DoH ref: PM2208)] to detail the ongoing work in NI to identify new variants of the SARS-CoV-2 virus.

Communication with the public, transparency and addressing misunderstandings were important aspects of the pandemic response.

Schools

119. On 6 August 2020, the Executive agreed the Education Minister's plan for schools to return to more normal patterns of operation and attendance from the week beginning 31 August 2020. The Executive further decided that revised guidance would be published, setting out an updated approach to the full reopening of schools. The Department provided ongoing scientific and public advice to the Department of Education and the Education Minister which informed their policy consideration and the development of associated guidance. This advice along with other considerations was factored into policy decisions by the Education Minister. This advice was provided in bilateral meetings between Ministers and officials, or in separate meeting between the then Education Ministers and his officials and the CMO and the CSA. Regular scheduled meetings were also held between the Department of Education (DE), the Education Authority, the Public Health Agency and Departmental officials to discuss any emerging issues, for example to inform testing and contact tracing in schools. The Department also supported the DE in engagement with Head Teachers and Trade Union representatives in meetings.

120. As stated in paragraph 66 above, the Heath Minister presented a paper to the Executive meeting on 19 November 2020 **[PM/502 INQ000137370** (DoH ref: MMcB038)] which highlighted that the experience from NI and discussions at SAGE suggested that opening of schools contribute around 0.2 to Rt. The modelling paper demonstrated the impact with and without schools closed. The Executive announced on 19 November 2020 that there would be a two week 'circuit breaker' lockdown which would be effective from 27 November 2020. **[PM/544 INQ000276593** (DoH ref: PM2269)] This circuit breaker was designed to slow the spread of Coronavirus in the community and protect the health service. At this point, NI reverted to the lockdown situation that had applied earlier in 2020 during the first surge of the pandemic. The major difference in this lockdown was that in this circuit breaker, the schools remained open.

121. Minister Swann, in an oral statement to the Assembly's Ad Hoc Committee on 21 December 2020 **[PM/545 INQ000276594** (DoH ref: PM2270)] commented that whilst the Executive had agreed that the continuation of Education had to be a priority, he had written to the Education Minister, and had stressed the need for further urgent engagement. The Minister did not believe that a return to school as normal in January

2021 was a sustainable position, and he made that clear in his letter in which he stated: "*we cannot disregard the evidence as it evolves and in order to suppress transmission of the virus both within schools and amongst the wider public, at such a critical phase of the pandemic all options should be considered*". I understand that Minister Swann's view on this matter was informed by advice from the CMO and the CSA.

122. Advice from SAGE and observed experience in NI suggested consistently that when schools were open, Rt increased by around 0.2. Consistent with this evidence, the Modelling Group and CSA provided advice that it would be very difficult to maintain Rt at less than 1 with schools open during the early period of 2021. The impact of restrictions with and without schools opening was modelled by considering the effect of range of achieved Rt values and this information was provided to Ministers.

123. On 29 December 2020 the CMO and the CSA wrote to the Permanent Secretary in the Department of Education to ask that "careful consideration should be given to the other options which have been highlighted before, including an extension of the Christmas holidays, face to face teaching for key years only, alternate weeks of distance learning and face to face teaching, and half classes only to be taught face to face on alternate weeks." **[PM/522 INQ000276567** (DoH ref: PM2247)]. This was in advance of a meeting held on 30 December 2020, attended by the CMO, the CSA and DE officials.

124. In an oral statement to the Assembly Ad Hoc Committee on 6 January 2021, the Minister briefed the Assembly on additional measures agreed by the Executive on 5 January 2021 to build on the six-week lockdown from 26 December 2020 **[PM/546 INQ000276595** (DoH ref: PM2271)]. The additional measures involved an extended shift to remote learning for school pupils until the half term break in February 2021. The Executive agreed that these requirements should be temporary and would remain under review by the Executive.

125. On 28 January 2021, the Executive agreed a Department of Education proposal to extend remote learning for all educational settings until 5 March 2021, in line with other Executive restrictions.

Coronavirus International Travel Regulations

126. The Department's approach to decision-making concerning the implementation of border health measures in NI during the first wave of the pandemic is set out in paragraphs 166 to 186 of the Wave 1 statement. This approach

remained in place during the second wave, including providing advice to inform decisions taken by the Executive.

127. The Department's policy development in relation to border health measures, which was underpinned by International Travel Regulations, continued to be guided by information on the risks associated with international travel, provided from UK Government national analysis. This information came from the Joint Biosecurity Centre, and in a fashion, from more limited information based on ROI Passenger Locator Form data, where available on international travellers entering the Republic of Ireland before transiting to NI. Liaison continued with the Home Office (Border Force) in relation to compliance by carriers/ operators (airlines and cruise operators) in respect of those travelling to NI. Following the introduction of the 'Travel Corridors' in July 2020 (see paragraph 181 in the Wave 1 statement), subsequent amendments to the 'list of exempt countries' followed over the period 12 July 2020 to 16 January 2021, and was based on the scientific evidence and public health risk assessments at that time.

128. The Department provided the Executive with medical and scientific advice, so as to assist it in its decision-making role during the second wave. Areas in which the Department advised the Executive included: measures to address the SARS-CoV-2 Variant and other potential variants; travel within the island of Ireland; self-isolation; and the UK Government's 'International Travel Issues – Global Travel Taskforce Report'.

Measures to Address the SARS-CoV-2 Variant and other Potential Variants

129. On 6 November 2020 the Health Protection (Coronavirus, International Travel) (Amendment No. 18) Regulations (Northern Ireland) 2020 [SR 2020 No. 241] were made at pace to remove Denmark from the list of 'exempted countries', in the Travel Corridor. This action was taken on foot of advice from Joint Biosecurity Centre to the effect that health authorities in Denmark had reported widespread outbreaks of SARS-CoV-2 in mink farms, with a variant of the virus spreading to local communities. The CMO subsequently wrote to his counterpart in the RoI **[PM/547 INQ000276596** (DoH ref: PM2272)] and discussed concerns in relation to a mink farm in Donegal at the regular weekly meeting.

130. Further regulations came into operation on 7 November 2020, being The Health Protection (Coronavirus, International Travel) (Amendment No. 19) Regulations (Northern Ireland) 2020 [SR 2020 No. 243] which enhanced the

measures in relation to arrivals from Denmark to Northern Ireland. Those regulations removed the exemption from the requirement to self-isolate for arrivals from Denmark, to include those who had arrived in NI from elsewhere but had been in or transited through Denmark in the 14 days preceding their arrival. The regulations also required people residing at the same address as Denmark arrivals to self-isolate. Relaxation of these measures came into operation on 28 November 2020, on foot of The Health Protection (Coronavirus, Travel from Denmark) (Revocation) Regulations (Northern Ireland) 2020 SR 2020 no. 288.

131. In an oral statement to the Assembly Ad Hoc Committee on 21 December 2020 Minister Swann 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/545 INQ000276594** (DoH ref: PM2270)]. This variant was identified following proactive and enhanced epidemiological analysis in response to the recent increase in cases seen in Kent and London.

132. In his Executive paper of 21 December 2020 **[PM/516 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 Health 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. Monitoring for signals of emergence of new variants was undertaken through whole genome sequencing of positive isolates in those testing positive and, in addition, through Waste Water Surveillance (WWS). From a public health perspective, once a new variant of concern was detected, given its potential for increased transmissibility and/ or more severe disease, an enhanced public health response was mounted by the PHA, which involved increased targeted local testing, enhanced contact tracing and additional public health advice with the aim of containing the spread of the new variants. The Department was actively involved by

the PHA in the approach to such developments. Regular verbal and written updates were provided to the Executive on the emergence of new variants and their potential significance in terms of community transmission, outbreaks and hospital pressures **PM/516 INQ000276561** (DoH ref: PM2241), **PM/526 INQ000276572** (DoH ref:PM2252), **PM/530 INQ000276576** (DoH ref: PM2256)].

133. In a statement on 23 December 2020, the Department confirmed a positive test for the new variant of the SARS-CoV-2 virus in NI, which had been detected in increasing numbers in the southeast of England [PM/X - INQ000276518 (DoH ref: PM2201)]. Genome analysis had been conducted on a small number of suspected NI cases, producing one positive result. Given the known transmissibility of the new variant and technical considerations in respect of sequencing, it was believed that the variant was likely to have been present in NI for a period of time.

134. A written Ministerial statement was issued on 8 January 2021 advising that anyone arriving in NI from within the Common Travel Area who planned to remain in NI for at least 24 hours, must self-isolate upon arrival for 10 days in the same way as international arrivals. The background to this decision and the Executive's agreement is provided in the following exhibits. **PM/516 INQ000276561** (DoH ref: PM2241), **PM/548 INQ000276597** (DoH ref: PM/2273), **PM/549 INQ000276518** (DoH ref: PM2201),), **PM/551 INQ000276599** (DoH ref: PM2275)]

135. On 18 January 2021 a further amendment to the International Travel Regulations was made to suspend the 'Travel Corridor' list and require all international arrivals to self-isolate for 10 days upon arrival in NI. This policy was introduced owing to the increased risk posed by new variants of Coronavirus being detected worldwide [The Health Protection (Coronavirus, International Travel) (Amendment No. 4) Regulations (Northern Ireland) 2021(SR 2021 No.9)]. This amendment followed advice from the Minister to the Executive **PM/552 INQ000276600** (DoH ref: PM2277)] that owing to the increased risk of mutated variants of coronavirus being detected worldwide, the four UK CMOs and the UK COVID-Operations Committee, a Cabinet Office committee, had advised the removal of all exempted countries on the Travel Corridor exemption list. Therefore, from 18 January 2021, travellers from all international destinations arriving in NI after this date, were required to self-isolate for 10 days. The list of sectoral exemptions from self-isolation were also reduced with effect from this date. The Department understood that the First Minister and deputy First Minister had a call with Michael

Gove MP, UK Secretary of State, on 15 January 2021, to discuss this change to the regulations due to the urgency of the matter [PM/553 INQ000276601 (DoH ref: PM2278), [PM/554 INQ000276603 (DoH ref:PM2279)].

136. Enhanced measures, agreed by the Executive, came into operation on 21 January 2021 by way of The Health Protection (Coronavirus, International Travel, Pre-Departure Testing and Operator Liability) (Amendment) Regulations (Northern Ireland) 2021 [SR 2021 No 10]. These regulations introduced a requirement for persons travelling to NI from outside the Common Travel Area (United Kingdom, the Channel Islands, the Isle of Man and the Republic of Ireland) to possess a notification of a negative coronavirus test upon arrival in Northern Ireland, a 'pre-departure test or PDT'. The regulations also introduced requirements for persons operating commercial transport services for passengers travelling to NI from outside the Common Travel Area to ensure that passengers who arrived in NI on such services had completed a Passenger Locator Form and possessed notification of a negative test result. The regulations provided that an operator found to be in breach of these requirements would be guilty of an offence. Passengers arriving from countries not on the travel corridor were still required to self-isolate, irrespective of their PDT result. These measures were introduced to contribute to reducing the spread of Covid-19 in the light of the increasing domestic incidence of Covid-19, building on the implementation of national lockdowns across the UK, and as a precautionary intervention to help in tackling the emergence of various mutant strains of the virus which could be resistant to vaccines. The rationale behind pre-departure testing was to reduce the proportion of people travelling whilst infectious and from entering the UK whilst infectious. The risk to other travellers in transport could therefore be reduced [PM/555 INQ000276604 (DoH ref: PM2280), PM/556 INQ000276605 (DoH ref: PM2281)].

137. The Department issued a statement on 23 February 2021 announcing that three confirmed cases of the South African variant of Covid-19 (the beta variant) had been detected in NI [PM/557 INQ000276606 (DoH ref: PM2282)]. These were the first confirmed cases in NI. A detailed health protection risk assessment and contact tracing response had been deployed. The risk of transmission was judged to be low at this time. The Department issued a statement on 6 May 2021 announcing that it had been notified by the Public Health Agency of seven confirmed cases of the Variant Under Investigation VUI B.1.617.2 (India) Coronavirus variant in NI. These were the first confirmed cases of this variant (the Delta variant) in NI.

Travel Within The Island of Ireland

138. In the third review of the International Travel Regulations in August 2020 **[PM/558 INQ000276607** (DoH ref: PM2283)] the issue of Dublin to Donegal travelling via Northern Ireland was given consideration. Technically, residents of the Republic of Ireland travelling from Dublin ports to Donegal via NI were required to complete a Passenger Locator Form. Whilst in practice this was something that was unlikely to be enforced since such travellers would not encounter any border force staff, it was considered prudent to amend the Regulations to remove this legal requirement. The Assembly's Health Committee and the Committee on the Administration of Justice had raised concerns regarding persons transiting through NI en route to other destinations in the Republic of Ireland **[PM/559 INQ000276608** (DoH ref: PM2284), **PM/560 INQ000276609** (DoH ref: PM2285)]. Subsequently, on 15 August 2020, the International Travel Regulations were amended by The Health Protection (Coronavirus, International Travel and Public Health Advice for Persons Travelling to Northern Ireland) (Amendment) Regulations (Northern Ireland) 2020 [SR 2020 No. 179] to ensure those who were travelling to a part of the Republic of Ireland from another part of the Republic of Ireland who passed through Northern Ireland en route were not required to complete a passenger locator form, provided that they remained in their vehicle at all times.

Self-Isolation Period

139. In December 2020, the four UK Health Ministers agreed a reduction in the self-isolation period from 14 days to 10 days for passengers from countries not in the 'Travel Corridor'. This reduction was based on the scientific analysis at that time which suggested that seven days isolation captured 90-95% of secondary infections. This reduction would be for close contacts of positive cases, and international arrivals from non-exempt countries. This change was implemented in England, Scotland, and NI from 14 December 2020. Wales had announced that they would implement this change with effect from Thursday 10 December 2020. However, Departmental officials advised the Minister that the earlier date would not be prudent, particularly as operational changes to the Passenger Locator Form would not be ready until 14 December 2020. **PM/561 INQ000276610** (DoH ref: PM2286), **PM/562 INQ000276611** (DoH ref: PM2287)].

UK Government's 'International Travel Issues – Global Travel Taskforce Report'

140. The UK Government's 'International Travel Issues – Global Travel Taskforce Report' published in April 2021 set out the Government's proposals regarding a potential roadmap to easement of travel restrictions. It proposed a risk-based framework Red-Amber-Green (RAG) for reopening travel that would also enable border and safety readiness. The RAG system categorised countries, based on the risk to public health and the vaccine rollout. Countries were assessed by the Joint Biosecurity Centre and given a RAG risk rating accordingly. The RAG status was reviewed every three weeks. Further to the publication of this report, on 16 April 2021, The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2021 [SR 2021 No. 99] came into operation. These regulations delivered a package of enhanced border measures, namely the introduction of a new Traffic light system, a Red-Amber-Green (RAG) risk classification for countries based on analysis from the Joint Biosecurity Centre. Varying border health measures were applied based on the RAG status of the country of arrivals into NI. The Managed Isolation (Managed Quarantine Service) was introduced for Red list arrivals. Managed Isolation was introduced to prevent, as far as reasonably possible, the entry of a variant of concern into Northern Ireland [**PM/563 INQ000276612** (DoH ref: PM2288), **PM/564 INQ000276613** (DoH ref: PM2289), **PM/565 INQ000276614** (DoH ref: PM2290)].

141. Also in April 2021, a dedicated set of travel regulations in relation to operators of commercial transport services was created, [The Health Protection (Coronavirus, International Travel, Operator Liability and Information to Passengers) Regulations (Northern Ireland) 2021 [SR 2021 No. 102]. These regulations placed duties on operators requiring them to: provide information to passengers whom they are transporting to NI; to check that passengers had completed a Passenger Locator Form; had notification of a negative PDT; had purchased a post-arrival testing package; had purchased a managed isolation package (red list only); and had ensured that red list arrivals only arrived at designated ports. These regulations created measures to ensure that transport operators played their part in ensuring compliance with the measures introduced. In particular, passengers were clearly informed of requirements, to help ensure that passengers did not arrive in NI without completing a Passenger Locator Form (to ensure traceability). This was also designed to help ensure that passengers did not board an aircraft/vessel without possession of a negative PDT; to help ensure that passengers did not arrive in NI

without an appropriate post-arrival testing package; and to ensure that red list arrivals had booked a Managed Isolation package before arrival in NI, and only arrived at designated ports. The overall aim of these regulations was to protect fellow passengers, to protect the health of the public in NI and to assist in the wider public health response.

142. Subsequent amending regulations[13] made within the period of the second wave focused mainly on adding and removing countries from the RAG lists of countries. The Minister informed the Executive of these amendments and did not seek their agreement, on the basis that agreement to the introduction of the RAG policy had already been given.

Covid-19 Test, Trace and Protect Strategy

143. In a statement to the Assembly on 28 July 2020 **PM/565 INQ000276614** (DoH ref: PM2180)] the Minister reiterated that the establishment of an effective contact tracing service was a key priority for him. Contact tracing helped the transmission of Covid-19 in NI to be understood and helped to reduce transmission, when used in tandem with all other measures. Minister Swann informed the Assembly that there was a strong international consensus that this work was a critical measure for bringing down the value of R, and thereby preventing or minimising further waves, whilst allowing restrictions to be lifted. The following key actions and decisions were taken by the Department during the second wave in relation to the Department's Covid-19 Test, Trace and Protect Strategy.

144. The Department remained linked into the National Testing Programme led by the Department for Health and Social Care in England throughout the second wave. A key development in this period was the rapid expansion of testing for Covid-19 of people across the UK who did not have any symptoms (or were asymptomatic). This programme of testing involved the use of new and emerging testing technologies, such as Lateral Flow Device (LFD) and LAMP testing (Loop-mediated Isothermal Amplification). Given Northern Ireland's geographical separation from the UK based national testing laboratories it was recognised and agreed that analysers in university facilities in NI could usefully be deployed to augment Health Service laboratory capacity in Northern Ireland, in addition to the National Testing Programme. In due

[13] SR 2021 No. 108, SR 2021 No.121, SR 2021 No.132

course, at the CMO's request, the Expert Advisory Group (EAG) on Testing supported the development of a NI Covid-19 Testing Scientific Consortium comprising of both Northern Ireland Universities, the Agri-Food Biosciences Institute and the ALMAC Group, boosting Pillar 1 testing capacity within NI.

145. In a statement made on 8 September 2020 **[PM/566 INQ000276615** (DoH ref: PM2292)], the Department announced that the Minister had contacted the Secretary of State for Health and Social Care seeking action on issues facing the UK National Covid-19 testing system. These issues included fixing the glitch in the UK-wide online booking system offering some people in NI tests in Great Britain. The Minister also emphasised the need to urgently build capacity for the National Testing Programme to address the pressure that had arisen in the days preceding 8 September 2020, due to significantly rising demand for testing, which was thought to have been linked at least in part to the re-opening of schools.

New Rapid Test for Emergency Departments

146. In a statement made on 13 January 2021 **[PM/567 INQ000276616** (DoH ref: PM2293)], the Department announced that a new rapid test for Covid-19 would be rolled out to all HSC Trusts' Emergency Departments across NI. Described as an important development, the Lumira DX is a rapid nasal swab test that delivers results in 12 minutes. At that point Emergency Departments were experiencing significant pressure, given that patients with Covid-19, and those with other medical conditions, converged on the same location. The Lumira DX test permitted medical staff to identify more quickly that a patient did not have the SARS-CoV-2 virus, and so improved patient flow in the Emergency Department and the wider hospital system.

Workplace Covid-19 Testing for Key Sector Employers

147. In March 2021 the Department launched the workplace Covid-19 testing programme for NI key sector employers, which provided access to the UK National Testing Programme as part of a targeted expansion of asymptomatic testing **[PM/568 INQ000276617** (DoH ref: PM2294)]. Extensive clinical evaluation from Public Health England and the University of Oxford showed lateral flow tests as specific and sensitive enough to be deployed for mass testing, including for asymptomatic people. This programme aimed to benefit employers and society as a whole as it was designed to help keep infection rates down across NI. Lateral Flow Tests (LFTs) were used in the workforce testing programme. The initial employers to use the programme were Translink, NI's public transport operator, and the NI Fire and

Rescue Service. The programme was further extended in early April 2021, from employers in designated sectors with more than 50 employees who could not work from home to all private sector employers with more than 50 employees who could not work from home. It was further extended in late-April 2021 to all organisations with 10 or more employees or volunteers, who could not work from home. Some larger businesses were enabled to set up and run Assisted Testing Sites, to oversee the regular (recommended twice weekly) workforce testing and to upload the results. Smaller businesses were able to access tests for distribution to their employees to conduct the tests at home, while managed within the parameters of the employer organisation's workforce testing policy.

148. From December 2020, the Department also worked with a range of partners to deliver an expansion of the availability of a regular programme of asymptomatic Covid-19 testing across a range of different sectors including university students, hauliers traveling to France, visitors to Care Homes and across a range of health and care settings.

Programme of Regular Covid-19 Testing in Schools

149. In March 2021, the Health and Education Ministers announced a programme of regular asymptomatic testing for Covid-19 to be introduced in schools in NI **[PM/569 INQ000276618** (DoH ref: PM2295)]. The programme offered regular, twice weekly asymptomatic testing using Lateral Flow Device tests. Participation in testing was encouraged but, ultimately, was voluntary. Initially, all pre-school, primary and post-primary staff (including teaching and support staff) and older students in Years 12-14 attending schools and other education centres were included within the scope of the programme. Expansion of testing to other students (in years 8-11) commenced in June 2021.

Testing in Special Schools

150. On 27 January 2021 **[PM/570 INQ000276619** (DoH ref: PM2296)], the Minister also announced a programme of weekly testing of pupils and staff to be introduced in special schools in NI at the start of February 2021. This programme used a new testing technology called LAMP (loop-mediated isothermal amplification), which is a saliva-based test, aimed at making testing easier than swab testing for children attending special schools. This programme of testing was led by the Public Health Agency, working collaboratively with delivery partners in the NI Education Authority

and Queen's University Belfast, and was jointly sponsored by the Departments of Health and Education.

Wastewater surveillance

151. On 1 March 2021, the Minister together with the Minister for Agriculture, Environment & Rural Affairs (DAERA) announced the development of a programme of wastewater surveillance to help monitor overall SARS-Cov-2 activity in the community **[PM/571 INQ000276620** (DoH ref: PM2297)]. Wastewater surveillance testing can detect the SARS-Cov-2 virus in both symptomatic and asymptomatic populations. As such, wastewater surveillance complemented clinical surveillance by providing information on the prevalence and spread of disease in the population and played an important role in monitoring overall viral activity and in identifying any new variants that may have emerged. This work involved collaborative working with a number of partners including the Public Health Agency, Queens University Belfast, the Regional Virology Laboratory at Belfast Health & Social Care Trust and NI Water, the regional utility provider.

Self-isolation

152. In a statement on 30 July 2020 the UK Chief Medical Officers announced the extension of the self-isolation period from 7 to 10 days for those in the community who had coronavirus symptoms or a positive test result [see exhibit **[PM/572 INQ000137383** (DoH ref: MMcB048)]. Evidence, although still limited at that time, had strengthened showing that people with Covid-19 who were mildly ill and recovering have a low but real possibility of infectiousness between seven and nine days after illness onset. The Chief Medical Officers said: "*we have considered how best to target interventions to reduce risk to the general population and consider that at this point in the pandemic, with widespread and rapid testing available and considering the relaxation of other measures, it is now the correct balance of risk to extend the self-isolation period from 7 to 10 days for those in the community who have symptoms or a positive test result. This will help provide additional protection to others in the community*".

153. In a subsequent statement on 11 December 2020, the UK Chief Medical Officers announced that the self-isolation period for close contacts of a confirmed positive case would be reduced from 14 days to 10 days (to be applied from 14 December 2020) **[PM/573 INQ000137384** (DoH ref: MMcB049)]. The decision was based on the available evidence at the time regarding the likelihood of a contact

being infectious after 10 days of self-isolation, and also took account of modelling papers from Public Health England and SPI-M, and advice from SAGE. The UK Chief Medical Officers' statement said: "*after reviewing the evidence, we are now confident that we can reduce the number of days that contacts self-isolate from 14 days to 10 days. People who return from countries which are not on the travel corridor list should also self-isolate for 10 days instead of 14 days*".

StopCOVID NI Proximity App

154. Paragraphs 229 to 233, of the Wave 1 statement, describe the background to the Department's decision to develop the StopCOVID NI Proximity App, launched in July 2020. As part of the NI Test, Trace Protect Strategy **[PM/460 INQ000145664** (DoH ref: PM0057)]. The Strategy included a detailed explanation of how mobile phone-based Proximity Apps could assist with Contract Tracing. The NI App would be interoperable with the one already in use in the Republic of Ireland and also highly likely to be compatible with Apps to be introduced in GB UK and Europe. The NI App was one of the first instances of such a solution worldwide; and the first example of such Apps operating in an interoperable manner. The Department announced on 14 August 2020 that the App had had more than 250,000 downloads during its first two weeks of operation. It was evident to the Department from information considered by SAGE and published on GovUK **[PM/574 INQ000276295** (DoH ref: PM2011)] and the conclusions reflected in the later minutes of the SAGE Subgroup meeting of 16 April 2020 **[PM/575 INQ000370969** (DoH ref: PM2369)] that breaking the chains of Covid transmission in the post-primary age group could help reduce overall prevalence. Therefore, building on earlier work with the Information Commissioners Office (ICO) in design and deployment of the app, officials engaged with the ICO and the NI Commissioner for Children and Young People (NICCY) to design and agree an age-appropriate process for extending use of the app to the post primary age group. The Department announced on 1 October 2020, that the App was available to 11-17-year-olds and was the first region in the UK to extend use to this age group. Design of this version of the App included consultation with 11–17-year-olds. **[PM/576 INQ000276296** (DoH ref: PM2012)]. This was considered to be an important boost for the fight against Covid-19. It was believed that the App would help schools, further education colleges and universities to provide additional protection to their students and staff. A further modification to the App was launched in November 2020, with a feature added enabling the App to confirm the date when a user's self-isolation period would end. Between 01 August 2020 to 31 May 2021, 15,057 citizens uploaded a positive test result into the App, resulting in 41,821 self-isolation

notifications being issued to the close contacts of those uploading a result. For initial contact notifications, the Proximity App complemented and helped enhance the manual contact tracing service, particularly on the 'lead-time' in issuing a notification to a close contact.

Covid-19 Public Information Dashboard

155. Paragraphs 234 to 235, of the Wave 1 statement, describe the background to the Department's decision to develop the Covid-19 Public Information Dashboard for NI, launched in April 2020, to provide region wide summary information about the progression of the virus including the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19. The Dashboard was managed by the Departmental statisticians and was continuously reviewed and developed, as a result of horizon scanning of world-wide reporting by the professional statistician team and in response to user engagement with a range of stakeholders. The Department therefore announced on 3 September 2020 that the dashboard would provide additional information on testing data, including the number of individuals testing positive, the rate of individuals testing positive per 100K population, and the total number of individuals tested by Local Government District. It would also provide breakdowns of the number of individuals testing positive during the last seven days by Local Government District and age bands. The practice of releasing further comprehensive data was aimed at raising public awareness and informing NI's response to the virus. By consolidating information from across the HSC, the Dashboard provided an accurate view of the metrics needed to track and understand the spread of the virus, and the capacity in the healthcare system to deal with it.

156. In December 2020 the Department's Statistical Reporting Team won a prestigious UK-wide Analysis in Government Award for its work on the Covid-19 Dashboard, winning the top award in the Impact category for the Dashboard. The award recognised the major impact the Dashboard had made through its use by the public and decision makers during the pandemic. Between 1 April and 9 December 2020, the Dashboard had almost 925,000 unique page views. In addition to this, there were almost 50,000 unique page views of the daily EXCEL and PDF files each month. During November 2020, there were almost 190,000 unique page views of the dashboard and the EXCEL and PDF files. There were also 950,000 unique viewers of the Department's Covid-19 related web pages, including the Dashboard, with over

880,000 of these from the UK and 36,000 from the Republic of Ireland. Around 11,500 viewers were from the United States and 5,000 were from Australia.

157. Additional information and analysis were added to the Public Dashboard as the pandemic response evolved and better quality data became available. Common definitions and presentation of information were adopted to permit comparison across the UK four nations and to enable UK wide reporting.

Information Sharing with the Republic of Ireland

158. Paragraph 236 of the Wave I statement sets out the affirmation of Ministers from the NI Executive and the Republic of Ireland Government on 14 March 2020 to ensure: "*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*" **[PM/577 INQ000276621** (DoH ref: PM2298)]. The cooperation during the first wave (see paragraphs 236 to 238 of the Wave 1 statement) continued during the second wave through regular liaison meetings and information sharing. This took broadly the same form in both waves.

159. In an oral statement **[PM/578 INQ000276622** (DoH ref: PM2299)] to the Assembly the Minister reported on the North South Ministerial Council meeting in the Health and Food Safety sectoral format, which was held by video conference on 2 October 2020. The Minister and Executive Junior Minister Declan Kearney MLA represented the NI Executive at the meeting. The Irish Government was represented by Stephen Donnelly TD, Minister for Health. The North South Ministerial Council renewed its expression of appreciation to all those who had played a part in the response to the Covid-19 pandemic, in particular the health and social care workers who led the front-line response. The North South Ministerial Council welcomed the close and productive cooperation between Health Ministers, Chief Medical Officers and health administrations, North and South, to deliver an effective public health response. Since the meeting of 14 March 2020 (referred to in paragraph 236 of the Wave 1 statement) senior representatives of the NI Executive and the Irish Government, and their Chief Medical Officers continued to meet regularly to discuss the ongoing Covid-19 response. The North South Ministerial Council noted that the Chief Medical Officers met on 25 September 2020 to review the overall response to

the pandemic, including consideration of the particular challenges being faced in the North West region. They recalled the Memorandum of Understanding on Public Health Cooperation on Covid-19 Response agreed between Departments of Health, North and South, which had been entered into on 7 April 2020. The North South Ministerial Council noted the further Memorandum of Understanding for the sharing of anonymous 'diagnosis keys'[14] generated by each jurisdiction's Covid-19 Proximity Apps agreed between Departments of Health, North and South, entered into on 30 July 2020, and welcomed the achievement of interoperability, on an all-island basis, of the apps deployed in each jurisdiction. The North South Ministerial Council noted that Health Ministers would continue to meet, both within and outside the structures of the Council, to discuss the response to the pandemic.

160. Speaking following their meeting on 25 September 2020, the NI CMO and the Republic of Ireland's Acting CMO said "*Given the current number of new cases in Donegal and neighbouring areas of NI in Derry/Londonderry, Strabane and Fermanagh we would appeal to everyone to avoid all but necessary travel across the border. It is also recommended that employers on both sides of the border make every effort to facilitate employees to work from home in so far as is possible. We realise that for those living in border areas this will not be welcome news, but we must prevent further spread of this virus and we can only do so by working together to protect each other.*" **[PM/579 INQ000276623** (DoH ref: PM2300)]. The meeting discussed the growing prevalence of the virus in both jurisdictions and underlined the need for ongoing cooperation between NI and the Republic of Ireland, including the respective public health teams under the existing Memorandum of Understanding. The CMOs jointly appealed to the public across the island to continue to follow public health advice to keep themselves and others safe. They noted specific concern with regard to the significant proportion of cases in young people in both Donegal and Derry/Londonderry and appealed to teenagers and those in their twenties and thirties in particular to reduce their social contacts.

161. This approach to public health communication on an all-island basis was repeated in a further joint statement made by the CMOs on 15 January 2021 **[PM/580**

[14] Diagnosis key refers to the random ID's generated daily by the various Proximity Apps that met the global standards in use. These ID's (also known as identifier beacons) were stored locally on an individual's phone (originally for 14 days) and shared with the app "backend processing systems" for release to other App if an app user registered on the app that they had received a positive test result and approved release of this information. Each Proximity App checked for the existence of such information every two hours and if a match was detected in the close contact information recorded by the individual proximity app, the user was alerted to potential infection.

INQ000276624 (DoH ref: PM2301)] when they voiced their concerns about the high levels of Covid-19, urging everyone to stay home, stating: "*as CMOs, we are gravely concerned about the unsustainably high level of COVID-19 infection we are experiencing on the island of Ireland. This is having a significant impact on the health of our population and the safe functioning of our healthcare systems. Unfortunately, due to the surge of infections we have experienced over the past few weeks, we have seen an increase in mortality figures and our health systems have been placed under immense pressure. We are likely to see ongoing increases in hospitalisations, ICU admissions and mortality in the weeks ahead….We will continue to work together to protect public health across the island, as we have done throughout this pandemic, but we need everyone to play their part by staying at home and protecting themselves and their communities*". This approach was reflected in a further statement on 1 April 2021 **[PM/581 INQ000276625** (DoH ref: PM2302)] following a meeting of NI's CMO and the Republic of Ireland's Deputy CMO when they jointly appealed to the public across the island to continue to follow public health advice to ensure everyone could have a safe Easter. They said: "*Easter is a time when, traditionally, many of us spend time with our families and loved ones. Unfortunately, this Easter, we still have a very dangerous, very transmissible virus, circulating in our communities that continues to spread and cause serious illness and, sadly, death…….We must ask that, once again, we work together to prevent a further wave of infection by celebrating this Easter safely. Please continue to stick with the public heath advice and avoid visiting other homes at this time*".

162. In a further statement **[PM/582 INQ000276626** (DoH ref: PM2303)] to the Assembly in June 2021, the Minister reported on the North South Ministerial Council meeting in the Health and Food Safety sectoral format, which was held by video conference on 26 March 2021. The Minister and Junior Minister Declan Kearney MLA represented the NI Executive at the meeting. The Irish Government was represented by Stephen Donnelly TD, Minister for Health, and by Roderic O'Gorman TD, Minister for Children, Equality, Disability, Integration and Youth. The North South Ministerial Council received a briefing from the CMOs on the public health situation at that time. The ongoing response to the Covid-19 pandemic and the continued close and productive cooperation that had taken place between Health Ministers, Chief Medical Officers and health administrations in both jurisdictions in delivering an effective public health response, was also discussed. The North South Ministerial Council welcomed the signing of a Memorandum of Understanding between both Departments of Health to address co-operation and mutual support in critical care

delivery. The North South Ministerial Council noted the ongoing co-operation with regard to contact tracing, including the established process in place for the sharing of the necessary details between the NI Public Health Agency and the Republic of Ireland's Health Service Executive. The North South Ministerial Council welcomed the ongoing collaboration between the two jurisdictions on the further development of the proximity app and noted the ongoing discussions between the two administrations on a data sharing agreement in relation to passengers arriving into each jurisdiction. The North South Ministerial Council noted that officials from both jurisdictions continued to consider the relevant learnings from the various phases of the pandemic, and exchange views to foster commonality in their approach, where possible, and provide a progress update at a future North South Ministerial Council Health Meeting.

Memorandum of Understanding: 'Covid-19 Response – Cooperation on an All-Island Basis in Regard to Provision of Critical Care'

163. A further Memorandum of Understanding, entitled 'Covid-19 Response – Cooperation on an All-Island Basis in Regard to Provision of Critical Care', between the Department of Health, Ireland (and its agencies) and the Department of Health, Northern Ireland (and its agencies), was signed by both departments on 9 November 2020. The Memorandum of Understanding recognised existing constraints on critical care surge capacity in both jurisdictions and set out the criteria that could trigger emergency assistance or critical aid. It also agreed that patient transfer and escalation protocols would be developed to enable clinicians and provider organisations to provide emergency assistance or mutual aid in the event of a high surge in demand on the critical care infrastructure in either jurisdiction. A protocol was subsequently developed and agreed between clinical and commissioning leads in both jurisdictions, however despite further surges in critical care occupancy, it was not necessary for this to be triggered at any time, i.e., critical care patients were not transferred from one jurisdiction to another due to Covid critical care occupancy being at or above capacity at any time.

Infection Prevention & Control

164. The Department established an Infection Prevention and Control (IPC) Cell within its integrated Gold business continuity arrangements. The Cell was chaired by the Public Health Agency's Executive Director of Nursing, Midwifery & Allied Health Professions **[PM/583 INQ000145672** (DoH ref: PM0167) INQ0000]. The core

membership of the IPC Cell was comprised of: PHA Nursing and Health Protection representatives; IPC leads from the five HSC Trusts & NI Ambulance Service Trust; HSCB Social Care; Regulatory and Quality Improvement Authority Inspectors; HSCB Primary Care; GP and Dentistry representatives. Representatives from other internal and external organisations were invited to attend the IPC Cell meetings to discuss any specific issues relating to them. The Cell reported through silver command into the Department's integrated Gold Strategic Cell. The chair of IPC was provided with professional support and guidance as needed through the Department's Chief Nursing Officer.

165. The Cell was established to provide resolved expert IPC advice to the HSC including:

- **Health & Social Care Trusts:** This was complementary to the expertise that HSC Trusts already had within their infrastructure in terms of expert IPC nurses and practitioners. All Trusts across NI were already required to adhere to the regional IPC Manual which provided detailed guidance for implementation and standardisation across Trusts and was amended/updated as new evidence emerged;
- **Primary and Community Care:** Most primary or community care settings and services in NI do not have IPC nurses/practitioners within their structures; and
- **Voluntary and Independent Sector care providers,** similarly, many such service providers in NI do not have IPC nurses/practitioners within their structures, which could cover one facility or a group of facilities.

166. The IPC Cell provided a forum to discuss, develop and provide input to IPC guidance, arrangements and policies across the region, providing an opportunity to share learning and innovative ideas used in HSC Trusts to minimise the risk of transmission.

167. The Gold IPC Cell's link into the UK 4-Nations IPC Cell was an important aspect of its role. This allowed a NI input to the shaping and influencing of expert advice and guidance. A senior IPC practitioner (Registered Nurse) from the Gold IPC Cell acted as the NI representative member in the UK 4-Nations IPC Cell, which generally met daily from January/February 2020, moving to twice weekly in April/May 2020, and then weekly from August/September 2020 through to 2022. Resolved

expert advice was provided by the UK 4-Nations IPC Cell to each of the nations who then would assess the guidance with a view to adopting and/or advising re its implementation in their respective jurisdictions.

Covid-19 Vaccination Programme

Background

168. Vaccination policy in the UK is informed by the recommendations and advice provided by the independent Joint Committee on Vaccination and Immunisation (JCVI). Under the NHS constitution, the Department of Health and Social Care in England and Wales is obliged to implement all JCVI recommendations whereas different arrangements apply in Scotland and NI. In NI it is for the Minister of Health to decide if the JCVI recommendations are implemented. To date NI has always implemented JCVI recommendations. At a 4 UK Health Ministers meeting on the 5 November 2020 the Minister agreed to follow a number of principles, one of which was – "*We all agree to take due regard of the Joint Committee on Vaccination and Immunisation's (JCVI) advice in developing its policy position on prioritisation and utilisation of any successful Covid-19 vaccine(*s)" [**PM/584 INQ000276627** (DoH ref: PM2304) , [**PM/585 INQ000276628** (DoH ref: PM2305)].

Legislative framework for the administration of vaccines

169. The Human Medicines Regulations 2012 set out a comprehensive UK-wide regime for the authorisation of medicinal products; for the manufacture, import, distribution, sale and supply of those products; for their labelling and advertising; and for pharmacovigilance. These regulations therefore provided the legislative framework for the administration of the Covid-19 vaccine in NI.

Governance and Structures

170. In May 2020 the Department was linked into the UK-wide governance structure [**PM/586 INQ000276629** (DoH ref: PM2306), [**PM/587 INQ000276630** (DoH ref: PM2307)] which had been established to prepare for a possible Covid-19 vaccination programme, should a vaccine be approved and become available in sufficient quantities.

171. Within this governance structure, a UK-wide Covid-19 Vaccination Programme Board ('the Board') was established by Public Health England (PHE) and first met on 18 May 2020. The aim of the Board was to plan for the implementation of

a safe and effective Covid-19 vaccination programme to help protect the UK population from the threat of Covid-19. This Board initially met every two weeks and had representation from both the Department and the NI Public Health Agency.

172. Minister Swann participated in a UK Health Ministers weekly meeting during which updates on vaccine development and vaccination plans were noted. In addition, each of the devolved nations appointed a senior responsible owner for the roll out of the Covid-19 vaccination programme. They were senior officials from within the respective Government health departments. Their role was to oversee effective deployment of vaccine within their jurisdictions, as well as coordination and alignment of policy and communications relating to the vaccine deployment across all four nations. The Senior Responsible Owner group met weekly to share preparation plans and discuss outstanding issues. The NI Senior Responsible Owner is one of the Department's Deputy Chief Medical Officers.

173. A NI Covid-19 Vaccination Programme Oversight Board was established by July 2020, chaired by the CMO. Its role was to set the direction for the Covid-19 vaccination programme, oversee the progress of the development and implementation of the vaccination programme, as well as manage the strategic interfaces between the expanded 2020/21 seasonal flu vaccination programme and the expected Covid-19 programme [**PM/588 INQ000276631** (DoH ref: PM2308)]. The Oversight Board was accountable directly to the Minister for Health, and recommendations concerning strategic policy issues were submitted to the Minister for decision via oral or written briefings, while operational decisions were taken by the CMO. The Oversight Board's membership included representation from across the Department including, Pharmacy, Nursing, Health Care Policy group, Health Protection, Emergency Planning, as well as the Public Health Agency, Health and Social Care Board and the Regional Pharmaceutical Procurement Service. Membership of the Oversight Board changed as necessary as the programme was implemented.

174. An Implementation Group was also established, with the first meeting taking place on 28 October 2020 This included key stakeholders from across the wider Health and Social Care system and the Implementation Group was tasked with coordinating and planning the actions required at ground level to enable a Covid-19 vaccination programme to begin once adequate supplies of an approved vaccine(s) were available in NI. When the programme began on 8 December 2020, the Implementation Group was expanded to include representatives from the Police

Service of Northern Ireland, Northern Ireland Ambulance Service and a local government liaison officer for District Councils.

Programme Implementation Arrangements

175. The Public Health Agency was initially expected to be commissioned by the Department to lead on the planning and implementation of the vaccination programme in NI. However, due to ongoing pressures on the Public Health Agency to manage other pandemic related measures and given the high importance of a Covid-19 vaccination programme, in early October 2020 the CMO decided that the Department would directly manage all operational planning of the Covid-19 vaccination programme. On 5 October 2020, the Department appointed a Programme Lead for the Covid-19 Vaccination Programme to oversee and drive the planning and delivery of the vaccination programme, and a small core Departmental vaccination team was established. The Department also appointed a retired Senior Medical Officer to provide additional public health policy advice to the Department in relation to the vaccination programme. This Senior Medical Officer worked closely with the head of the programme, and Departmental and Public Health Agency colleagues on the preparations for implementing the programme.

176. A letter was issued by the Department on 28 October 2020 to formally update the Public Health Agency on the governance structure change **[PM/589 INQ000276632** (DoH ref: PM2309)]. The Department consequently led on all policy issues and operational delivery matters from December 2020 to April 2022 when responsibility for the operational delivery element reverted to the Public Health Agency.

177. To ensure delivery of the vaccination programme a significant schedule of work was rapidly undertaken in a challenging environment. Deployment plans at this stage were heavily constrained by uncertainty with vaccine characteristics as well as timing around authorisation and vaccine supply. JCVI had issued an interim prioritisation list on the 25 September 2020, which helped focus decisions on delivery plans. The ranking of priorities was a combination of clinical risk stratification and an age-based approach, aimed to optimise both targeting and deliverability. The Minister was updated orally on developments and by submissions on 4 November and 16 November 2020 **[PM/584 INQ000276627** (DoH ref: PM2304), **[PM/590 INQ000276633** (DoH ref: PM2310), **[PM/591 INQ000276634** – (DoH ref: PM2311)].

178. Several key work streams were established from the Implementation Group which focused on particular areas of the programme, these were: Pharmacy, Storage and Distribution; Logistics and Workforce; Surveillance, Communications, IT and Resources. The vaccination team also held regular meetings with the Health and Social Care Trusts, a GP liaison committee (which included Royal College of General Practitioners NI and the British Medical Association NI General Practitioners Committee representatives) and a community pharmacy commissioning and representative group.

Vaccine Approval and Distribution

179. All vaccines used in Great Britain must be authorised by the independent medicines' regulator, the Medicines and Healthcare products Regulatory Agency (MHRA) before they can be placed on the UK market and advertised or promoted for use by the manufacturer. Since 1 January 2021, under the terms of the NI Protocol[15], novel and innovative medicines, including vaccines, required for use in NI are approved by the European Medicines Agency (EMA) under the EMA's Centralised Procedure. This can lead to differences in the timescales for vaccine authorisation between Great Britain and NI, although in circumstances such as a pandemic, the MHRA can temporarily authorise a vaccine for use in NI or across the UK on public health grounds under Regulation 174 and Regulation 174a of the Human Medicines Regulations 2012 (as amended). These provisions help to ensure that pandemic vaccines can be authorised and deployed in NI at the same time as in Great Britain, should EMA timescales for authorisation lag behind those of MHRA. In practice there was no practical delay in rollout arising from differences in approval timescales.

180. The Department decided, based on JCVI and MHRA advice where each vaccine approved for use would be deployed in NI. Data from the NI Statistics and Research Agency (NISRA) on populations and cohort size within HSC Trust areas, along with predicted maximum run-rate statistics, assisted with modelling and subsequent decisions on the deployment of vaccines.

---

[15] This refers to a Protocol of the Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community [2019/C 384 I/01] -The Protocol on Ireland/Northern Ireland, commonly abbreviated to "the Northern Ireland Protocol".

Workforce

181. Prior to the Covid-19 pandemic, the Human Medicines Regulations 2012 required that only 'appropriate practitioners' administer vaccines, as they are a parenterally administered (by injection) prescription-only medicine. Appropriate practitioners are defined under Regulation 214 as doctors and other qualified prescribers.

182. Regulation 214 is subject to a range of exemptions as outlined in Part 12, Chapter 3 of the Regulations, which include provision for administration under a Patient Group Direction by defined registered healthcare professionals. Regional Patient Group Directions were developed for use by registered professionals at vaccination providers by the Health and Social Care Board, and Public Health Agency. Alternatively, vaccines can be administered on a patient-specific basis (that is, by or on the directions of an appropriate independent prescriber such as a doctor).

183. Given these limitations and capacity constraints of the current workforce eligible to administer vaccines, amendments to the Human Medicines Regulations 2012 were taken forward on a UK-wide basis to introduce provisions for an expanded workforce to be able to safely administer Covid-19 vaccines.

184. A CMO/Chief Pharmaceutical Officer letter of 21 December 2020 was issued to inform health professionals of The Human Medicines (Coronavirus) (Further Amendments) Regulations 2020 which were introduced to support the rapid and effective rollout of a Covid-19 vaccine in the UK [**PM/592 INQ000276635** (DoH ref: PM2312)]. Regulation 247A of the Human Medicines Regulations, as inserted by The Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020, allowed the Secretary of State, the Scottish Ministers, the Welsh Ministers or the Minister for Health in Northern Ireland during a pandemic situation, to approve protocols that would allow healthcare professionals who do not normally vaccinate, and people who are not registered healthcare professionals, to safely administer a licensed or temporarily authorised Covid-19 vaccine. These protocols provide the flexibility to define the training and competence requirements of vaccinators, and the clinical considerations they must follow to ensure patient safety is maintained, including but not limited to clinical treatment of any potential reaction to the administered vaccine.

185. The Department's officials developed various Vaccination Protocols throughout the course of the vaccination programme, authorised by the Minister, to

facilitate the delivery and administration of Covid-19 vaccines by an expanded workforce. This enabled additional staff groups to support the vaccination programme to operate more effectively in large scale vaccination centres, without the need for an individual patient prescription to be in place. The protocols provided an additional legal mechanism for the administration of the Covid-19 vaccines by appropriately trained persons in accordance with regulation 247A of the Human Medicines Regulations. This was in addition to the existing provisions for administration by registered professionals under a Patient Group Direction, or on a named-patient basis, following assessment and direction by an independent prescriber. Each Protocol was given clinical authorisation by the NI Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer jointly, before final authorisation by the Minister [**PM/593 INQ000276636** (DoH ref: PM2313) , **PM/594 INQ000276637** (DoH ref: PM2314) , **PM/595 INQ000276638** (DoH ref: PM2315) , **PM/596 INQ000276639** (DoH ref: PM2316) , **PM/597 INQ000276640** (DoH ref: PM2317)]. Responsibility for developing vaccination protocols transferred to the HSCB in October 2021 when the Pharmaceutical Advice & Services Directorate (PASD) sought Ministerial approval for these on behalf of HSCB.

186. To ensure the effective implementation of the Covid-19 vaccination programme, it was recognised that a large workforce would be required over the course of the programme. The vaccination workforce included some core members such as Occupational Health staff, HSC Trust peer flu vaccinators, as well as GP based staff, who had a proven track record of delivering vaccination programmes to thousands of patients every year. To expand this workforce, an Expression of Interest was issued by the Department in November 2020 to all registered health care professionals (including Pharmacists, Nurses, Dentists and Allied Health Professionals) to become sessional vaccinators. These individuals were trained up and brought into the programme over the following weeks/months as and when required. In addition, help was also sought from health care assistants, administration staff, and volunteers to support the vaccination programme and free up the time of vaccinators. The vaccination programme was implemented in two phases based on JCVI advice from December 2020, continuing throughout the remainder of the period of the pandemic. The key decisions taken by the Department within Phase 1 and Phase 2 are detailed below.

Phase 1

187. On 26 November 2020, the Minister approved a submission and presentation to the NI Executive along with a press release detailing the vaccination plans in NI [**PM/598 INQ000276641** (DoH ref: PM2318), **PM/599 INQ000276642** (DoH ref: PM2319)] in the anticipation of a vaccine being approved shortly. On 2 December 2020, JCVI published their updated advice on prioritisation for vaccination [**PM/600 INQ000276643** (DoH ref: PM2320)].

188. The first Covid-19 vaccine, the Pfizer BioTech vaccine, was granted approval by the MHRA for use in the UK on 2 December 2020, and in preparation for commencement of the vaccination programme, a shipment of the vaccine was delivered into NI on 2 December 2020. Following media reports of the potential for triggering Article 16 of the NI Protocol, Departmental officials engaged with UK counterparts to clarify the reported position, to obtain assurances on the continued availability of vaccines to NI, and to confirm there was no impact on vaccine delivery or deployment.

189. A Chief Professionals letter, setting out the early deployment framework for the programme, was issued to the Health Service on 7 December 2020 [**PM/601 INQ000276303** (DoH ref: PM2019)]. A number of Chief Professionals letters would be issued throughout the course of the vaccination programme, updating the sequence of changes and advances to the programme.

190. In the early stages of the vaccination programme, a number of other groups, and professions, such as teachers and police officers, requested that they should be included as a priority group. At least one Minister and other politicians wrote to the Minister for Health; for example, the Minister for Education wrote on 22 December 2020 to request that the education workforce receive early prioritisation in the roll out of the programme [**PM/602 INQ000276644** (DoH ref: PM2321)]. The Minister confirmed that NI would continue to follow JCVI advice on priority groups, to reach those considered to be at greatest risk from the effects of Covid-19.

191. In addition, health professionals were reminded of the Green Book, which is an online resource from Public Health England, and is regularly updated to reflect the latest evidence, guidance and recommendations on all vaccinations for vaccine preventable infectious diseases in the UK. The Green Book Covid-19 vaccination chapter was first published on 27 November 2020 and offers guidance on storage,

safety, administration dosage, priority groups and potential adverse effects [PM/603 INQ000276645 (DoH ref: PM2322)].

192. The model for vaccine deployment in NI was designed to be pragmatic, agile, and flexible to help ensure the vaccination programme was accessible for all sections of the community and to ensure minimal wastage of vaccine. Initial deployment plans were constrained due to the strict handling conditions of the Pfizer BioTech vaccine as well as availability of sufficient doses due to manufacturing capacity. The Department for Business, Energy & Industrial Strategy led on the procurement of Covid-19 vaccines on behalf of the whole UK, and it was agreed each UK country would receive its Barnett[16] share of the total available approved vaccines. For NI this meant that it received 2.85% Barnett share of the available vaccines approved for use at that time.

193. The 4 UK Senior Responsible Owners for the roll out of the Covid-19 vaccination programme decided that 8 December 2020 should be the launch day for the vaccination programme in all 4 UK countries. The first vaccines in NI were administered at the Royal Victoria Hospital Belfast vaccination centre and were administered to those health and social care workers who would be vaccinators during the programme. On the same day a mobile team from Belfast Health and Social Care Trust also vaccinated residents and staff at Palmerston Care Home in Sydenham, Belfast. Additional Trust led vaccination clinics went live over the next few days vaccinating frontline staff, while Trust mobile teams were rolled out across NI to visit Care Homes. The GP element of the programme started vaccinating from 4 January 2021.

194. As set out in the submission of 4 November 2020 [PM/584 INQ000276627 (DoH ref: PM2304)], the first 2 priority groups of Phase one were treated as one group with Health and Social Care workers invited to get vaccinated in an HSC Trust vaccination centre. HSC Trust mobile teams also developed a system which enabled them to use their own supply of vaccine to vaccinate in Care Homes, while complying with the strict handling conditions of the Pfizer vaccine set by MHRA. Initially all individuals required two doses 21 days apart. It was also agreed that due to

[16] The Barnett formula is a mechanism used by the Treasury in the United Kingdom to automatically adjust the amounts of public expenditure allocated to Northern Ireland, Scotland and Wales to reflect changes in spending levels allocated to public services in England, Scotland, Wales and Northern Ireland, as appropriate. For Covid-19 vaccine supply it was agreed the 4 countries would receive the following split in vaccines: England 84.09%, Scotland 8.28%, Wales 4.78% and Northern Ireland 2.85% of the total vaccines authorised for use.

uncertainty around further deliveries, half of the doses received should be held back to ensure individuals could receive their second dose on time.

195. The Pfizer BioNTech vaccine was a novel mRNA vaccine and so presented several logistical challenges that were very different to other vaccines routinely used across the HSC system. Safe and effective deployment required detailed planning involving input from pharmacy teams in all HSC settings. This included the need for supply chains that allowed the vaccine to be kept at ultra-low temperatures (-90°C to -60°C), which are vital for retaining the stability and efficacy of the vaccine. In addition, when the vaccine was defrosted it initially had a 5-day shelf life, which was subsequently extended to 30 days following the manufacturer's submission of additional stability data to the MHRA and EMA. The vaccine was provided in multi dose vials of 5 doses per vial which required reconstitution and was only available in large packs of 975 doses. Large packs could not be supplied to one vaccine provider such as a GP practice for subsequent use by multiple other providers without the receiving practice holding a Wholesale Dealers Authorisation (WDA).

196. These constraints severely restricted how the vaccine could be deployed in NI in the first phase of the programme and it was agreed by the Oversight Board that the Pfizer BioNTech vaccine should only initially be deployed exclusively by HSC Trusts. This meant all storage, preparation and administration of the vaccine came under each organisation's single corporate and clinical governance framework and applied to vaccine administration in all hospital sites, temporary premises being utilised as Mass Vaccination Centres, and administration by HSC Trust employees working in community settings such as Care Homes. Professional and legal responsibility for safe and secure handling of the vaccine rested with the HSC Trust Head of Pharmacy and Medicines Management. Later easements of the handling of the Pfizer BioNTech vaccine and the approval of other vaccines made it easier to deploy outside of HSC Trust vaccination sites. Throughout the vaccination programme, vaccine wastage remained extremely low despite the tight handling constraints due to the stock control and handling processes developed and overseen by HSC Trust pharmacy teams.

197. There were initially 7 HSC Trust-led vaccination centres operating at the start of the vaccination programme as set out in the plan of 26 November 2020, which were located either on HSC Trust sites or in council premises which helped ensure the centres were accessible for the public as the programme worked through the JCVI priority list.

198. Throughout this phase the Department led on all vaccination related announcements and kept the NI population updated on vaccination plans by press releases, news reports, and via information on the Department's website and the NI-Direct website. These channels were used to inform people about which population cohorts were eligible and where and how they could book their vaccination.

199. The Department published an updated plan, approved by the Minister, for implementation of NI's programme on 12 January 2021. This provided detail to the public on the delivery model and anticipated start date for the various population cohorts [**PM/604 INQ000276646** (DoH ref: PM2323)]. As the programme progressed, details of vaccine coverage were also released, and information was issued to help counteract misinformation about the Covid-19 vaccines [**PM/605 INQ000276647** (DoH ref: PM2324)].

200. Uptake throughout Phase 1 of the vaccination programme in NI remained very high for the 50 year+ age group and other priority groups.

Care Homes

201. A key target population group for the vaccination programme was the vaccination of residents and staff in Care Homes. Prior to the programme launch, HSC Trusts had been instructed by the vaccination lead official to draw up a delivery schedule that would enable all Care Homes, of which there are 483 in NI, to be visited for their first dose by the end of December 2020, subject to any restrictions due to outbreaks. This was largely achieved, and most Care Homes, not in outbreak, were visited.

202. NI was the first part of the UK that developed a system which enabled the deployment of the Pfizer BioTech vaccine in Care Homes, while complying with MHRA's strict handling conditions. With careful planning, HSC Trusts operated mobile teams which drew down vaccine supply from their own Trust based vaccination clinics, the vaccines could then be legally transported and administered to residents and staff in Care Homes. Any unused vaccine was then returned to the Trust vaccination site for use which ensured minimal wastage. All Care Homes in NI had the vaccination roll out completed, and all residents and staff had been offered two doses by 26 February 2021. The HSC Trust mobile teams were then redeployed to residential and supported living settings, while teams operating from the vaccination centres started to visit hospital wards to vaccinate eligible long-term patients in line with JCVI advice on prioritisation. Consideration was given to the

fitness of patients to receive the vaccine, and constraints due to the characteristics of the vaccine itself to minimise high wastage.

Health and Social Care workers

203. In line with JCVI advice that stated, "*the first priorities for any Covid-19 vaccination programme should be the prevention of Covid-19 mortality and the protection of health and social care staff and systems*," staff working in high-risk areas for exposure were prioritised for vaccination. This was communicated to all staff in the Chief Professionals letter issued on 7 December 2020 **[PM/601 INQ000276303** (DoH ref: PM2019) . To reduce vaccine waste and use up vaccine from an open vial, HSC Trusts also vaccinated a small number of non-frontline staff while rolling the programme out to the wider staff groups and support services. This included domiciliary care workers and those working in the independent sector and by mid-January 2021 this had been extended to Dental, Pharmacy and Optometry staff. In early January 2021 following a discussion with the lead HSC Trust directors, it was agreed that as 'looked after children' were the responsibility of the HSC Trusts, HSC Trust foster carers should be offered vaccination as frontline staff through the HSC Trusts' programmes.

Primary Care based Programme

204. Due to logistics and strict handling conditions attached to use of the Pfizer BioTech vaccine it was very difficult to deploy in a GP setting as most of the 321 practices in NI are small, with insufficient numbers of eligible patients to use a full tray of the Pfizer BioTech vaccine. It was not until the AstraZeneca vaccine was approved on 30 December 2020, that the GP element of the programme could go live, with effect from the 4 January 2021, at which stage some practices started to vaccinate their patients aged 80 years and over **[PM/606 INQ000276527** (DoH ref: PM2210)]. Due to the quick turnaround from vaccine approval to vaccine deployment as well as the amount of vaccine available, not all GPs were ready to start vaccination from 4 January 2021. Therefore, only those who confirmed they could physically vaccinate eligible patients during the week commencing 4 January 2021 were initially allocated vaccine, while all remaining Practices could order vaccine from 11 January 2021. The use of the AstraZeneca vaccine also supported the housebound programme, which was mainly delivered by District Nurses, who operated from lists supplied by GPs.

205. GPs worked through the eligible cohorts of those aged 50 years and over, but as the programme was rolled out, a twin track approach was developed with many people opting to receive their vaccine via an HSC Trust led centre. In Phase 2 GPs played a much smaller, but nonetheless valuable role.

Interval dose change

206. On 30 December 2020, JCVI issued advice on the dose interval schedule recommending that it be increased from three weeks to up to twelve weeks to ensure that as many eligible people as possible in Phase 1 should receive their first vaccine dose rather than a smaller number receive two doses within 21 days. Extending the interval between doses was expected to protect the greatest number of at-risk people overall in the shortest possible time which would have the greatest impact on reducing mortality, severe disease and hospitalisations, as well as protecting the health service.

207. This advice was accepted by the 4 UK Chief Medical Officers, and they issued joint clinical advice on the prioritisation of first doses to inform the public and professionals of this change [PM/607 INQ000137311] The Minister accepted this advice and issued a statement to the Assembly about the new dosage interval [PM/608 INQ000276570] (DoH ref: PM2250), [PM/609 INQ000276648] (DoH ref: PM2325), [PM/610 INQ000276649] (DoH ref: PM2326), [PM/611 INQ000276650] (DoH ref: PM2327)]. This new advice was strongly opposed by the BMA who lobbied for the original interval schedule to remain in place for health workers. The Minister agreed that the new dosage interval would be set at 10 weeks in NI for all eligible individuals in order to try and maximise the numbers offered a first dose but also ensure second doses were completed within the 12-week timeframe suggested by JCVI. This differed slightly from other UK countries but remained in line with JCVI advice while allowing a two-week grace period for those who missed their second appointment. This was followed up by Health and Social Services letters [PM/606 INQ000276527] (DoH ref: PM2210), [PM/612 INQ000276651] (DoH ref: PM2328)].

208. The Oversight Board agreed at their meeting on the 29 December 2020 that as some care home residents and staff had already received their second dose when JCVI recommended to extend the interval between doses, that that all care home residents and staff should receive their 2nd dose (after 21 days) as planned. [PM/613 INQ000276652] (DoH ref: PM2329)].

209. The vaccination programme could be accelerated and expanded given that two Covid-19 vaccines were at that stage available for use. This, along with an improved delivery schedule, meant that population cohorts were called forward earlier than expected. As stocks of vaccine increased, and the bulk of earlier cohorts had been vaccinated, the programme was extended to further JCVI priority groups. To make best use of available vaccine, a twin track approach was approved and announced by the Minister [**PM/614 INQ000276653** (DoH ref: PM2330), **PM/615 INQ000276654** (DoH ref: PM2332)]. This started with those aged 70 to 79 years of age being invited for vaccination by their GP shortly before those aged 65-69 years of age were advised that they could book a vaccination slot at one of the regional vaccination centres [**PM/616 INQ000276655** (DoH ref: PM2333), **[PM/617 INQ000276656** (DoH ref: PM2334)]. As additional cohorts became eligible, careful planning, and agreement between HSC Trusts and HSCB GP liaison leads was essential to try and avoid duplication of effort.

210. To assist the twin track approach, a telephone booking line, operated by NI Direct for Trust vaccination centres, was introduced on 2 February 2021 for those unable to use the online system. The telephone booking line enabled NI residents to make bookings. For those who could not book an appointment, such as GB residents who were temporarily staying in NI or Republic of Ireland, details were emailed to the Department to assist. The Department assisted with the vaccination of hundreds of people who could not make an appointment in the routine way.

Carers

211. In preparation for the vaccination of priority group 6, which included carers, the vaccination programme team established that in NI there was no central register of carers. A 'carer' was defined as anyone who cared for family members who were clinically extremely vulnerable or who had underlying health conditions which put them at higher risk of serious disease and mortality. The vaccination team met with relevant Departmental leads from Social Care and with representatives from the NI Carers Forum on 11 February 2021 (overarching forum for dedicated carers groups) and concluded that as there was no definitive way for individuals to produce evidence that they were a carer, flexibility would be needed to ensure protection of this important group. The Minister agreed to allow individuals to self-identify as carers with no requirement to provide proof [**PM/616 INQ000276655** (DoH ref: PM2333), **PM/617 INQ000276656** (DoH ref: PM2334)].

212. On 17 February 2021, carers aged over 60 were invited to book (online or through NI Direct) a vaccination at one of the seven regional centres. This included those in receipt of Carer's Allowance or Carer's Credit; registered care home Care Partners; and main carers of an elderly or disabled person whose welfare may be at risk if the carer falls ill. People were asked to respect this criterion when booking **[PM/618 INQ000276657** (DoH ref: PM2337)]. Over the next few days, booking was extended to carers aged 50+ and then all carers aged 18+. There was high demand among this population cohort and slots were filled quickly. After the initial vaccination sessions for carers took place, the vaccine team in the Department met again with the carers' groups, to get feedback on uptake. Based on this feedback the Department was content that appointments had mainly been taken by eligible individuals. However, as press stories started to circulate on ways to 'queue jump' it was decided by the vaccination team and in consultation with the Minister that a separate process was required for booking. In agreement with HSC Trusts and Carer Groups, it was arranged that any remaining carers needing vaccination should contact their local Trust carer coordinator (contact details were available on the Department of Health website) and Trust vaccinating teams would contact them to arrange an appointment. Public announcements were made through the media to advise of this update. A smaller number were vaccinated through this arrangement, with feedback from the NI Carers Forum indicating that most of the carers in their groups had been vaccinated through the initial call out. On 13 May 2021, with approval from the Minister, it was agreed to close the programme to carers and publish a revised NI vaccination plan **[PM/619 INQ000276658** (DoH ref: PM2338) , **PM/620 INQ000276659** (DoH ref: PM2339) , **PM/621 INQ000276660** (DoH ref: PM2240)].

213. As NI moved quickly through the eligible population cohorts, we saw an increasing number of ineligible people, including residents of Republic of Ireland, trying to book an appointment in NI. As the UK was the first country to launch a Covid-19 vaccination programme, it generated a large interest from people residing in the Republic of Ireland, whose programme was not as far advanced through the age cohorts. Although many who enquired or presented were not eligible, there were categories of Republic of Ireland residents that were eligible and who required assistance booking an appointment. This included UK residents, based in Republic of Ireland, Republic of Ireland residents who worked for the HSC service in NI, or Republic of Ireland residents who were still registered with a GP in NI. These enquires took up considerable time for the vaccination team and put HSC Trust

vaccination centres located near to the border with the Republic of Ireland under pressure when assessing the eligibility of those attending for vaccination.

Phase 2

214. By the time the vaccination programme was completing, Phase 1 NI specific data in respect of hospitalisations due to Covid-19, indicated that a substantial number of admissions occurred in people under the age of 50 years who would not have been eligible for vaccination in the first phase. The Minister approved the Phase 2 element of the vaccination programme in the submissions exhibited [**PM/62 INQ000276661** (DoH ref: PM2341), **PM/623 INQ000276662** (DoH ref: PM2342), **PM/624 INQ000276663** (DoH ref: PM2343), **PM/625 INQ000276664** (DoH ref: PM2344)]. JCVI subsequently published their statement on the priority groups for Phase 2 of the vaccination programme on 26 February 2021. This included 3 further eligible groups i.e., all those: aged 40 to 49 years; aged 30 to 39 years; and aged 18 to 29 years.

215. By the 15 March 2021, all those aged 50 years and over were entitled to book a vaccination appointment, meaning all groups included in JCVI's Phase 1 priority list were now eligible.

216. JCVI Phase 2 commenced on 31 March 2021 with those aged 45-49 years of age becoming eligible to book a vaccination slot. This coincided with the opening of a mass vaccination centre at the SSE Arena in Belfast, which went live from the 29 March 2021, as well as Community Pharmacies beginning to offer the AstraZeneca Covid-19 vaccine from the 30 March 2021. The introduction of community pharmacies was a major development in the programme, and eventually over 300 stores were available which provided a convenient, localised vaccination service across NI.

217. The establishment of a large mass vaccination centre at the SSE Arena, Belfast was only possible following a decision to activate the Military Aid to Civil Authority (MACA) requesting military assistance to Health and Social Care in NI [**PM/626 INQ000276665** (DoH ref: PM2345), **PM/627 INQ000276666** (DoH ref: PM2346), **PM/628 INQ000276667** (DoH ref: PM/2347), **PM/629 INQ000276668** (DoH ref: PM2348)]. This was approved by the Ministry of Defence and a total of 100 Combat Medical Technicians were stationed at the SSE Arena, from 22 March 2021 to 31 May 2021, to assist with the delivery of the vaccine.

218. The mass vaccination centre was established by the South Eastern Health and Social Care Trust, which had been tasked by the Department to scope the feasibility, planning, and delivery of a Covid-19 Vaccine Centre in the Greater Belfast area. A Project Team considered the feasibility of a short list of potential options for a centre. Based on the need to ensure the centre could be operationally ready from late March 2021 onwards and given the type of infrastructure required to ensure the site was safe, effective and could operate in all weather conditions, the Project Team recommended the SSE Arena. This recommendation was put to the Minister in a submission who approved the use of the SSE Arena [**PM/630 INQ000276669** (DoH ref: PM/2349), **PM/631 INQ000276670** (DoH ref: PM/2350)].

219. In early April 2021, following concerns raised about the AstraZeneca vaccine, JCVI announced that the vaccine should not be given to anyone under 30 years of age. This was further revised in early May 2021 to include anyone aged under 40 years of age. The Health Minister was informed of this in the submissions exhibited [**PM/632 INQ000276671** (DoH ref: PM2351), **PM/633 INQ000276672** (DoH ref: PM2352), **PM/634 INQ000276673** (DoH ref: PM2353), **PM/635 INQ000276674** (DoH ref: PM/2354), **PM/636 INQ000276675** (DoH ref: PM2355)]. This development had a major impact on the community pharmacy element of the programme which could only use the AstraZeneca vaccine at that stage. It was considered likely that it would also have an impact on the pace at which the programme could be delivered, affecting the timescale for completion. It was anticipated at that stage that all first doses would not be completed for everyone aged 18 years and over until the end of July 2021, while it could be mid-September 2021 before all second doses were completed [**PM/637 INQ000276676** (DoH ref: PM2356), **PM/638 INQ000276677** (DoH ref: PM2357), **PM/639 INQ000276678** (DoH ref: PM2358)]

220. Despite the restrictions on the use of the AstraZeneca vaccine, the vaccination programme continued to quickly move down through the remaining cohorts and by 27 May 2021, the programme was opened to all adults, aged 18 and over [**PM/640 INQ000276679** (DoH ref: PM2359)]. This was partially due to the lower uptake rates being achieved in each age cohort band. At earlier stages of the vaccination programme, when an age cohort was included, the bookings were high, and it could be several weeks before the cohort was completed. However, as the programme moved down through the younger cohorts, particularly in Phase 2, bookings gradually became much slower and additional cohorts were allowed to book to ensure all the available slots were used.

221. Feedback from Public Health Agency surveys of younger people indicated that they preferred a walk-in option at vaccination centres rather than pre-booked appointments to enable them to attend with friends. To facilitate this, all of the vaccination centres allowed a mixture of walk-in as well as pre-booked appointments. With greater availability of vaccine, the twin track approach was expanded further to a multi-track approach, which allowed individuals to choose their preferred place and time for vaccination in either a community pharmacy, General Practice, an HSC Trust vaccination centre, or via an outreach clinic with either booked or walk in appointment options.

Data collection and analysis

222. Data collection, and in particular an analysis of uptake rates, became more important as the programme proceeded, and uptake rates reduced. Initially uptake data was gathered using daily vaccination totals collated from HSC Trust statistical returns. This was replaced in early January 2021 by a daily report combining HSC Trust and GP data compiled by Gartner[17], which showed a breakdown of uptake by Trust area and for individual population cohorts. This information was shared daily with the Minister and other key stakeholders and was used to target media activity from the Department/Public Health Agency to encourage uptake in particular cohorts.

223. A public dashboard charting the progress of the vaccination programme went live on 10 March 2021. The daily report produced by Gartner was available until the end of April 2021 when it was superseded by the Vaccine Management System (VMS) which began in early April 2021. The Vaccine Management System dashboard allowed more in-depth analysis of uptake data by postcode and super output area. Using this information, the Department directed the Public Health Agency to develop a plan specifically aimed at improving vaccination rates in low uptake areas/population groups with messaging based on feedback from surveys on the likely causes of such hesitancy.

224. The programme responded to information of areas with higher infection rates, including some border areas. In response, additional efforts were made in these areas in terms of communications, and HSC Trust pop-up clinics were used to try to improve uptake rates in the local population. Senior officials in the Department

[17] Gartner, Inc. is a technological research and consulting firm retained to support data collection and analysis as well as the development of the VMS system

had regular contact with their counterparts in Republic of Ireland to discuss a wide range of pandemic related issues, including the vaccination programme.

225. A new public information campaign to further boost the vaccination drive was launched on 10 May 2021 and ran until 13 June 2021. The advertising included TV, radio, outdoor and a variety of social media platforms. The campaign had been planned by the Public Health Agency and was aimed at maintaining strong uptake rates. It had been timed to launch just as the vaccination programme started to reach the younger age groups, who the Department was aware, needed more convincing to get vaccinated, believing themselves to be at less risk from the virus. For example, as feedback suggested that more young women showed hesitancy due to fears of this affecting fertility, an information campaign from doctors and midwives was used to target such misinformation.

Liaison with the NI Executive

226. The Department's officials provided regular briefings to the Executive: the initial briefing took place on 26 November 2020, and these briefings continued throughout the course of the vaccination programme. These written and verbal briefings generally covered vaccination plans, workforce, vaccine supply, uptake levels, implementation issues and actions planned to target low uptake areas [**PM/641 INQ000276680** (DoH ref: PM2360)].

Liaison with the NI Assembly

227. The Health Minister provided regular updates to the Assembly Health Committee, such as the written briefing on 9 December 2020, which was at their request. This briefing detailed the early vaccination roll out plans [**PM/642 INQ000276682** (DoH ref: PM2361)]. The Health Minister also provided regular statements to the Assembly, for example, see the attached exhibits [**PM/643 INQ000276683** (DoH ref: PM2362), **PM/644 INQ000276684** (DoH ref:PM2363)]. The Department's officials provided regular briefings to the Health Committee as well as to individual MLAs, on request, throughout the course of the vaccination programme.

Liaison with other NI Key Stakeholders

228. The vaccination team established links with NI District Councils, Trade Unions, churches and faith groups, inter-ethnic forum, various charities, volunteer groups, special interest groups, as well as the Commissioners for Older People and

Children and Young People. These relationships proved invaluable at certain key stages of the programme for both providing and receiving information.

229. The Senior Responsible Owner and/ or Head of the vaccination programme gave updates and responded to queries at the weekly meeting of The Executive Office's Northern Ireland Emergency Planning Group (NIEPG). Senior officers of all NI local councils, Police Service (PSNI), Military personnel, Public Health Agency and Governmental emergency planning leads were all represented and participated in these NIEPG meetings.

Liaison with other UK Health Authorities

230. The Department was represented at a wide range of UK groups. This included groups who met weekly such as: the 4 Nation Ministerial Group; the CMO group/ Deputy Chief Medical Officer group; the 4 Nation Senior Responsible Owner Group; the UK Covid-19 Vaccination Programme Board; and the Vaccine Taskforce Group.

231. A consultant from the NI Public Health Agency is a co-opted member of JCVI for NI, and the Department has a representative invited to JCVI meetings. This is normally a Senior Medical Officer, however due to this post being vacant, a senior policy official of the vaccine programme team attended all Covid-19 related meetings on behalf of the Department. A retired Senior Medical Officer was employed prior to the launch of the vaccination programme to provide expert advice to Departmental officials. This Senior Medical Officer also attended JCVI meetings along with policy officials.

232. The Department for Business, Energy & Industrial Strategy led on the procurement of Covid-19 vaccines on behalf of the whole of the UK, and it was agreed each UK country would receive its Barnett share of the total available approved vaccines. For NI this meant that the province would receive a 2.85% Barnett share of the total UK stock of Covid-19 vaccines that were approved for use.

233. The Minister participated in a UK Health Ministers weekly meeting, during which updates on vaccine development and vaccination plans were noted. In addition, the Senior Responsible Owner in each country, took part in the Senior Responsible Owner group meetings, which were held weekly, to share preparation plans and discuss outstanding issues.

Liaison with the Republic of Ireland

234. A CMO/Deputy CMO Republic of Ireland/NI group met weekly to discuss a wide range of pandemic related issues, including the vaccination programme. Minutes of the meetings can be accessed at **[PM/468 INQ000276685** (DoH ref: PM2364)].

235. Senior officials in the Department, who were responsible for the vaccination programme, had regular contact with their counterparts in Republic of Ireland. The Head of the NI Vaccination Programme had a number of calls with her counterpart, providing advice on a number of aspects, such as roll-out of the programme in Care Homes and the establishment of mass vaccination centres.

Health Inequalities

236. An Equality Screening, Disability Duties and Human Rights Assessment (EQIA) for the vaccination policy, which at that stage was to offer every adult aged 50 years and over Covid-19 vaccination, was completed and signed off on 24 November 2020 **[PM/645 INQ000276686** (DoH ref: PM2365)]. All Section 75 categories of the NI Act 1998 were classed to benefit from the policy, especially older people and persons considered as clinically extremely vulnerable or clinically vulnerable. The Screening assessment was revisited and updated when further JCVI advice was received to ensure that the initial assessment remained valid.

237. By April 2021, the Public Health Agency had developed a plan aimed at improving uptake in particular areas, such as in communities with high levels of deprivation. The Head of the Health and Social Wellbeing Improvement Unit, Public Health Agency, presented these plans at the Oversight Board on "*promoting uptake among hard-to-reach groups*" and attended the Oversight Board weekly thereafter, and shared behavioural insights and provided updates from the Public Health Agency's 'low uptake' group.

238. In targeting these hard to reach areas and groups, the Public Health Agency, working with HSC Trust teams, organised a series of initiatives, such as pop-up vaccination clinics. The Public Health Agency also worked with local councils and community pharmacies to organise bespoke vaccination clinics in particular housing estates, sports clubs and shopping centres, to ensure easy access to vaccination. In addition to this, the Department's vaccination team and the Public Health Agency engaged with key industries such as the meat, poultry and fishing sectors, all of

which were known to employ a high number of migrant workers, in order to encourage uptake, and in some cases set up specific vaccination clinics.

Influenza (flu) Immunisation Programme

239. 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. During 2020/21, it was more important than ever to take measures to reduce GP consultations, unplanned hospital admissions, pressure on Emergency Departments and staff sickness levels. The measures were also intended to reduce pressure on Care Homes and the Public Health Agency, particularly following the impact of Covid-19 on these services and settings.

240. The influenza vaccination programme officially began on 1 October 2020 (in line with previous years), however those administering the vaccine were advised that they could and should begin offering the vaccine as soon as they received their first delivery of vaccine, prioritising the groups as set out in the HSS Influenza letter **[PM/646 INQ000276687** (DoH ref: PM2366) , **PM/647 INQ000276688** (DoH ref: PM2367) , **PM/648 INQ000276689** (DoH ref: PM2368)]. The ordering system for influenza vaccine opened on 17 August 2020. The programme was delivered within the remits of the IPC guidelines relating to face coverings and physical and social distancing and additional funding was provided to GPs and community pharmacies for set-up costs and to support social distancing measures.

241. One of the objectives of the 2020/21 influenza vaccination programme was to help reduce the risk of concomitant circulation of influenza and Covid-19. Evidence at the time suggested that co-infection was associated with increased mortality of over two-fold compared to those infected with Covid-19 alone. The 2020/21 influenza programme aimed to reduce this risk by maximising the flu uptake rates in all eligible groups. The programme aimed to ensure the most vulnerable members of society and health and social care workers were given the best protection against influenza. This was also to help to protect the health service and enable it to respond to further waves of the pandemic.

242. Eligible groups for the flu vaccination programme are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI). For the 2020/21 programme it was agreed that, in addition to the routine eligible groups, i.e., those aged 65 and over, those aged 2 to 64 years of age in a clinical at risk group and

frontline HSC workers, the flu vaccine should also be offered, on request, to the household contacts of anyone who received a shielding letter during the pandemic. Additional vaccine was also purchased to try and maximise uptake rates across all eligible groups. In line with JCVI advice, it was agreed to extend the school-based children's programme to include all year 8 (first year) pupils in secondary schools in NI. JCVI was also supportive of the temporary expansion of the flu vaccination programme to all healthy 50 to 64-year-olds and this was introduced in January 2021.

243. Despite the circuit breaker in autumn 2020, and enhanced restrictions following Boxing Day in 2020, including school closures, considerable effort was made to rearrange school visits and impressive uptake rates were achieved across the board. This resulted in the most influenza vaccine doses having been delivered during an influenza vaccination programme up to that point, as the eligible group was bigger than ever before due to an aging population and the expansion in the school-based programme. For all children attending primary 1 to primary 7 an uptake rate of 72.9% was achieved, which was compared to 72.1% achieved at the end of March the previous year. For the first time, Year 8s in secondary schools were offered the vaccine, which accounts for around 25,000 additional children, and 66.6% of those pupils received the vaccine. By the end of the 2020/21 vaccination programme, 52.4% of all HSC Trust employed front-line Health Care workers were vaccinated, which was an increase of 11.2% on the previous year, while 40.8% of HSC Trust employed frontline social care workers had been vaccinated, an increase of 18% from the previous year.

SECTION C: THE HEALTHCARE SYSTEM RESPONSE DURING THE SECOND WAVE

244. As stated in paragraphs 10 to 12 above, the 'Management Board for Rebuilding HSC Services' and the integrated Covid-19 Gold Command Group, both of which were chaired by the Department's Permanent Secretary, played the central role in the Department's management and oversight of the healthcare system response to the pandemic during the second wave. 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.

Primary and Community Care

245. In order to move forward from the measures introduced in primary and community care (General Medical Services) during the first wave of the pandemic (see paragraphs 263 to 264 of the Wave 1 statement) and meet the ongoing challenges presented by Covid-19, a number of actions were taken that aimed to provide an integrated solution to improve patient pathways, increase system capacity, better manage demand and ensure the safety, quality and sustainability of services. Full details of the priorities for General Medical Services and the proposals are set out in the attached exhibit **[PM/649 INQ000276297** (DoH ref: PM2013)]

246. The 'telephone first' consultation approach, introduced at the start of the pandemic, continued to be provided during the second wave to ensure that GP services were provided to patients and to help prevent the spread of infection by limiting the number of patients attending GP surgeries. To help support this, in 2020/21, non-recurrent funding of £1.7million was made available to be used by GP practices towards purchasing new telephone systems and increasing the number of telephone lines into their practices. Specific emphasis was placed on providing a direct dial telephone number to staff in nursing homes, pharmacies and laboratory services in local HSC Trust areas. The suspension of some elements of the GP contract that had been introduced at the start of the pandemic also continued. During this period, GPs played a key role in the roll out of the Covid-19 vaccination programme as well as an extended flu vaccination programme.

Primary Care Covid-19 Centres

247. As stated in paragraph 265, of the Wave 1 statement, the Department established Primary Care Covid-19 Centres during the first wave of the pandemic with the aim of using 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 for those patients who showed Covid-19 symptoms.

248. Throughout the second wave, the staffing and operation of the Centres continued to be managed locally by GP Federations in response to local demand, with reductions/increases in the number of staff and shifts in response to the number of referrals. Each centre had contingency plans in place to ensure that there was sufficient capacity to respond to any local surge in the number of referrals.

249. Between April 2020 and April 2021, Primary Care Covid-19 centres enabled over 42,000 Covid-19 symptomatic patients to be quickly and safely assessed. These Centres were critical in ensuring GP practices continued to deliver vital face to face non-Covid services to patients and greatly reduced the flow of patients to Emergency Departments.

Clinically Extremely Vulnerable

250. 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. Shielding was therefore paused from 31 July 2020 with the situation to be kept under review. In an urgent written Statement on 23 October 2020 the Minister informed the Assembly that the CMO had looked at the position again in light of the increased numbers of cases of Coronavirus in NI. Since shielding was first advised, a number of important changes had taken place in our approach to managing Coronavirus and reducing its transmission. This included a greater awareness of the importance of social distancing, the requirement to use face coverings, Covid secure workplaces and greater adherence to respiratory and hand hygiene. After careful consideration, the CMO advised the Minister that shielding should remain paused. The statement noted that the position would be kept under review.

251. On 26 November 2020, the Department announced that adults with Down's syndrome had been added to the Clinically Extremely Vulnerable list. Recent evidence indicated that adults with Down's syndrome were in the high-risk category. The CMO wrote to adults with Down's syndrome to advise them that they had been included on the list and advised them what this meant for them **[PM/650 INQ000276298** (DoH ref: PM2014)]. An easy read version of the advice was also available.

252. On 23 December 2020 the Department announced that it had updated the advice to Clinically Extremely Vulnerable people to help them keep safe through the Christmas period and beyond. Clinically Extremely Vulnerable people were reminded to consider very carefully any plans for a Christmas bubble over the festive period, with the safest option being to not form a Christmas bubble, and to avoid attending shops, pharmacies, and hospitality settings unless absolutely necessary. The advice in relation to Clinically Extremely Vulnerable people attending the workplace was also changed. From 26 December 2020, Clinically Extremely Vulnerable people who were working and unable to do so from home, were advised not to attend the workplace. This advice was in place for six weeks initially, with a review after four weeks, in line with the review of restrictions more generally. In a further statement on 24 March 2021 the Department announced that, in recognition of the improving picture in terms of the activity of the virus in the community, a graduated easing of the advice for Clinically Extremely Vulnerable people was to commence on 12 April 2021.The first step involved the easing of the advice around going to the workplace. Future steps saw the gradual easing of other elements of advice for Clinically Extremely Vulnerable people, linked to easing of restrictions more generally. A letter was issued to people who were Clinically Extremely Vulnerable which could be used as evidence for employers **[PM/651 INQ000276299** (DoH ref: PM2015)].

253. From 30 April 2021, there was further easing of restrictions for people who were Clinically Extremely Vulnerable across a range of settings, including socialising in gardens, overnight stays in self-contained accommodation, retail, gyms and indoor facilities and hospitality. The advice given to Clinically Extremely Vulnerable people was that they may participate in the gradual re-opening of society. However, they were advised that it was vitally important that they continued to exercise great care, for example going to places at quieter times, wearing face coverings and observing social distancing. During the pandemic, the NIDirect website provided information and advice for Clinically Extremely Vulnerable people, with information updated by the Department as guidance and advice changed and developed.

General Dental Services

254. The re-establishment of General Dental Services in NI commenced in July 2020 and was a significant step in the resumption of non-urgent / routine dental care, including aerosol generating procedures. Practices restored services in line with enhanced infection prevention and control measures, such as using additional

personal protective equipment, leaving fallow time after aerosol generating procedures, and carrying out more frequent deep cleaning. These enhanced procedures reduced the capacity of General Dental Services to provide services resulting in a significant impact on patient access to care.

255. As the General Dental Services increased their activity, the necessity for urgent dental care centres decreased, resulting in a decision in August 2020 to scale down urgent dental care centre provision in a phased manner between September 2020 and April 2021.

256. Operational Guidance for dental practices was updated to maintain consistency with the UK Infection Prevention and Control guidance in September 2020, October 2020 and February 2021.

257. Significant changes to the Operational Guidance for dental practices was released on 21 October 2020 **[PM/652 INQ000276300** (DoH ref: PM2016)] in line with amendments to the UK IPC guidance and a recently released Rapid Review of Aerosol Generating Procedures in Dentistry, completed by the Scottish Dental Clinical Effectiveness Programme **[PM/653 INQ000276301** (DoH ref: PM2017)]. This introduced significant changes to categorisation of dental procedures and PPE requirements, risk assessment of practices for calculation of fallow times between aerosol generating procedures and guidance on ventilation and air cleaners/purifiers.

258. On 11 November 2020, the four UK Chief Dental Officers issued a joint letter to the dental profession **[PM/654 INQ000276302** (DoH ref: PM2018)], in which they expressed their support for the dental profession's continued efforts to work in challenging conditions.

259. Dentists, dental hygienists and dental therapists were offered the opportunity to participate in the wider Covid-19 vaccination programme as sessional vaccinators and in December 2020, General Dental Service staff were assured that they were to be included in the Covid-19 vaccination programme which was a significant development **[PM/601 INQ000276303** (DoH ref: PM2019)].

260. On 19 February 2021, the Department announced funding of £1.5 million to help improve patient throughput at dental surgeries in NI **[PM/655 INQ000276304**

(DoH ref: PM2020)]. The risk of Coronavirus transmission in dental practices had been minimised using strict infection control measures, but these had also significantly reduced the number of patients that dentists could see each day. The new grant scheme was designed to provide financial support to dental practices for upgrading or installing new ventilation systems to help increase the volume of treatment and care provided to patients and help reduce the number of patients who had been unable to obtain appointments. The funding was in addition to the £51.9million allocated in 2020/21 through the Financial Support Scheme to General Dental Services.

261. In February 2021, minimum activity thresholds were introduced **[PM/656 INQ000276305** (DoH ref: PM2021), **PM/657 INQ000276307** (DoH ref: PM2022)] to the Financial Support Scheme to help direct available funding to support those practices more in line with activity.

Ophthalmic Services

262. Optometry contractors implemented local and national guidance and communicated with patients on new ways of working. With the prevalence of the Covid-19 virus and increasing numbers of people self-isolating during the latter part of 2020 and into 2021, there was significant disruption to service provision on a regular basis. Domiciliary eye care (that is eyecare provided to people who are in nursing / residential and their own homes) and, optometry services provided in the prisons, were significantly impacted through this latter period also because as a 'visiting service' to these locations, decisions on when services were to be provided were not within the direct control of the optometry contractor. Furthermore, the HSCB had no direct control over access to independent care facilities, including prisons and Care Homes, for visiting clinical services. These care settings operate to their interpretation of national and local guidelines and adopt access protocols according to their interpretation of risk. The pathway for the management of eye emergencies remained in place. Booking and administration of eye clinics in the independent Care Home setting is managed by the homes themselves and the provision of optometry services in prisons is managed by the South Eastern HSC Trust Healthcare in Prisons team in conjunction with the NI Prison Service. However, in recognising the potential for vulnerable groups to be disproportionately impacted by the pandemic, a joint HSCB and Department of Health letter was issued to independent sector Care Homes **[PM/658 INQ000276308** (DoH ref: PM2023)] **[PM/659 INQ000276309** (DoH ref: PM2024)] to remind them of the importance of eyecare as

an essential clinical service. New contractual arrangements for the prison eye service were put in place in March 2021, with objective a) of the service specification requiring a commitment: "To provide an accessible, equitable, quality and safe Optometry service within the Northern Ireland prisons, with particular focus on those most in need." Future learning might include that a letter/resource reminding both the Healthcare in Prisons team and the Northern Ireland Prison Service of the importance of needs-prioritised eyecare might usefully be deployed, similar to that produced for Care Homes.

263. There was reduced capacity in Ophthalmic Services as contractor practices had to limit/restrict the number of patients who could attend because of social distancing requirements, reduced staff quotas and the need to maintain effective infection control measures. To achieve reduced footfall into practices, face-to-face consultations were provided where necessary, with alternatives offered when appropriate. Optometry contractors and their staff worked with the wider-HSC and intra-professionally to ensure that patients had access to safe care, including to those patients whom the hospital eye services could not offer appointments to, and who were afforded care in community practices.

264. The Department provided financial support amounting to £5.47million in the financial year 2020/21 to Ophthalmic Contractors who were providing eyecare services to patients in the primary care setting. Optometry practices remained accessible/open through the course of the pandemic, initially providing only urgent and essential eyecare, followed by re-establishment of core and enhanced services commencing at the end of June 2020 and continuing on a phased basis until mid-September 2020, at which point all services were reinstated.

Medicines and Community Pharmacy

Medicines

265. In September 2020 a rapid review of changes in HSC pharmacy services implemented in response to the first wave of the Covid-19 pandemic was published **[PM/660 INQ000276491** (DoH ref: PM2025)]. The review, commissioned by the Department's Chief Pharmaceutical Officer, was led and coordinated by the Medicines Optimisation Innovation Centre, with input from pharmacy teams in all sectors. The review described the wide range of interventions by pharmacy teams that were necessary to ensure that patients and the public had access to medicines

and pharmaceutical care throughout the initial stages of the emergency. The Medicines Optimisation Innovation Centre is a regional centre based within the Health and Social Care Service in the Northern HSC Trust. The Medicines Optimisation Innovation Centre is commissioned by the Department of Health to provide research, project management and offer professional expertise on projects that will improve patient care on medicines use.

266. The review was an endorsement of the commitment and professionalism shown by pharmacists and pharmacy teams working in hospitals, general practices, community pharmacies and support services. It was also a positive reflection of the support provided to the frontline pharmacy workforce by the Health and Social Care Board and the Department and stressed the benefits of partnership working with pharmacy professional and representative bodies and the community and voluntary sector.

267. The review made recommendations for actions needed to prepare for future waves of the pandemic and inform changes needed to support the longer-term rebuilding of HSC services. These recommendations were presented by the Chief Pharmaceutical Officer to the Minister and the HSC Rebuilding Management Board for consideration at its meeting on 16 September 2020.

268. The recommendations in the review informed the development of a Pharmacy Services Surge & Rebuild Plan which was presented to the HSC Rebuilding Management Board on 4 November 2020 **[PM/661 INQ000276310** (DoH ref: PM2026) 0]. This plan outlined the contribution of pharmacy services in general practice, community pharmacy and HSC Trusts to the rebuilding of the HSC after the first wave and actions undertaken to prepare for subsequent surges.

269. Following the publication of the rapid review in pharmacy, pharmacists and pharmacy staff across the HSC in NI continued to support emerging elements of the Covid-19 pandemic response, including the rollout of the Covid-19 vaccination programme and access to Covid-19 novel therapeutic agents, with other recommendations incorporated into normal practice. The Medicines Optimisation Innovation Centre are undertaking a follow up review during 2023 to identify lessons learned from changes to pharmacy practice made throughout the pandemic, to identify what worked well, and to make recommendations for future improvement.

Community Pharmacy

270. Following the Department's initial response to the first wave (see paragraphs 305 to 310 of the Wave 1 statement), further review and augmentation of the resilience within the medicines and community pharmacy sector was undertaken. Services that had been stood down during the first wave recommenced, for example, the Minor Ailments service. During the period from August to October 2020, further work was undertaken to ensure business continuity processes were established, including situation reporting (sit rep) from pharmacies and clustering arrangements in localities [**PM/662 INQ000276311** (DoH ref: PM2027)] [**PM/663 INQ000276312** (DoH ref: PM2028)]. Reports of issues relating to the ordering and supply of prescriptions arising from continued restricted access to GP practices led to guidance being published for GP practices and community pharmacies in October 2020 [**PM/664 INQ000276313** (DoH ref: PM2029), **PM/665 INQ000276314** (DoH ref: PM2030)].

271. From September 2020, community pharmacies were used as a service provider for an expanded seasonal flu immunization service which saw pharmacies providing vaccination to HSC Workers and those in the age group 50-64 years old [**PM/666 INQ000276315** (DoH ref: PM2031), **PM/667 INQ000276316** (DoH ref: PM2032), **PM/668 INQ000276317** (DoH ref: PM2033)].

272. Covid-19 vaccination commenced in December 2020 with a phased roll-out and community pharmacy staff were eligible for vaccination in January 2021. On 29 March 2021, the Minister launched a community pharmacy Covid-19 vaccination service, involving almost 350 community pharmacies across NI (see paragraph 309 of the Wave 1 statement) [**PM/669 INQ000276318** (DoH ref: PM2034)]. Community pharmacy significantly contributed to the Covid-19 vaccination programme, and as of 24 February 2023 has delivered 437,910 Covid-19 vaccines.

273. In April 2021 the Department, HSCB and Community Pharmacy NI, the representative body for community pharmacy, agreed a commissioning plan for community pharmacy services for the year ahead. The Commissioning Plan built on the services provided in 2020, during the first and second waves of the pandemic, and delivered further enhancements to benefit and support patients over the coming 12 months, including contributing to the rebuilding of services [**PM/670 INQ000276319** (DoH ref: PM2035, **PM/671 INQ000276320** (DoH ref: PM2036)].

Population Screening Programmes

274. In April 2020, a number of routine screening programmes were paused for 3 months (see paragraph 311 of the Wave 1 statement). This pause affected 5 programmes, namely routine cervical screening, routine breast screening, bowel cancer screening, abdominal aortic aneurysm screening and routine diabetic eye screening and surveillance monitoring. Screening continued to be offered for people who required higher risk breast screening, diabetic eye screening for pregnant women, newborn bloodspot screening, newborn hearing screening, antenatal infections screening and smear tests for non-routine cervical screening. In June 2020, the Public Health Agency established a 'Screening Restoration Group' to coordinate the process of restoring screening programmes and individual programme-specific plans were developed. The group sought a consistent and as far as possible an evidence-based approach, to ensure programmes were reintroduced in a planned and safe way. To this end, the restoration process was guided by the following principles, derived from Public Health England guidance.

- **Principle 1:** Emerging capacity, both within screening services and across the HSC in general, should be targeted at people assessed as 'higher risk'. The nature of this varies across the screening programmes. Restoration was therefore not been a simple 'recommencement' (based upon inviting those delayed longest first) but was based upon a risk assessed and phased approach within each programme.

- **Principle 2:** The benefits of screening should be greater than the clinical risks associated with COVID. This benefit/risk assessment varies between programmes and between groups of people eligible for screening.

- **Principle 3:** There must be adequate staffing and facilities to undertake screening, provide diagnostic services, and deliver high quality treatment and programme management thereafter. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits.

275. Applying these three principles, the decision was taken for cervical screening to be restarted at the end of June 2020, early July 2020 for abdominal aortic aneurysm, mid-July 2020 for breast screening and August 2020 for diabetic eye

screening and bowel screening [PM/672 INQ000276321 (DoH ref: PM2037)]. The timing of restoration was individualised for each programme in terms of, for example, redeployment of staff, capacity, vulnerable population and impact on facilities. The programmes were therefore restarted as to when they were individually ready to do so, rather than on any basis of one being more urgent than others. In support of the restoration of services, individual screening restoration funding bids to cover items such as catch-up clinics, additional hours etc, were submitted to the Department, although these were all eventually withdrawn as the funding was found from within Public Health Agency resources. Progress updates were provided monthly to the HSC Rebuilding Management Board. Examples of the updates provided in July and September 2020 are provided in the attached exhibits [PM/673 INQ000276322 (DoH ref: PM2038), PM/674 INQ000276323 (DoH ref: PM2039), PM/675 INQ000276324 (DoH ref: PM2040), PM/676 INQ000276325 (DoH ref: PM2041)].

276. It is estimated that over 100,000 invitations for screening were not issued during the pandemic. The screening programmes continue to implement recovery plans, where appropriate and within ongoing budgetary constraints. The Public Health Agency continue to monitor any backlog as a result of the pause to screening services. For the Abdominal Aortic Aneurysm programme, it is anticipated that all existing delays within the programme will have been addressed by the end of the financial year March 2024. For Breast screening, the optimal screening interval is 36-month (called the round length). This means inviting people to have their next breast-screening appointment so that it occurs within 36 months of their previous screen. As of February 2023, the NI breast screening round length was 36 months plus five weeks. For Bowel screening, from end August 2022, the programme has fully recovered from the delays which arose during 2020. In Cervical screening, there remains a five-month delay in the issue of routine letters to women to advise that their next test is due. While in Diabetic Eye Screening, the delays which arose from the pause during 2020 have not yet been recovered.

Guidance on Visiting Hospitals, Care Homes & other Healthcare settings

277. On 30 June 2020, [PM/677 INQ000103666 (DoH ref: PM0073)] the Minister announced changes to restrictions on visiting across all care settings from Monday 6 July 2020. Following publication by the Executive on 12 May 2020 of the five-step approach to relaxing lockdown restrictions, it was considered timely to review the extent and application of restrictions on visiting across all care settings. As part of

this review process, the Department's Strategic Clinical Advisory Cell undertook a review of the evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission. A summary of the evidence used is included in the resulting revised guidance [**PM/678 INQ000103667** (DoH ref: PM0074)], which recognised the right of people to visit their loved ones in hospitals and Care Homes, while balancing the ongoing risk from Covid-19. The development of the updated guidance was further informed by consultation with a range of key stakeholders, including IPC professionals, HSCT Directors of Nursing, the Commissioner for Older People, Mental Health Advocacy Organisations, the Commissioner for Children and Young People and Families Involved Northern Ireland (FINI).

278. With the increased level of transmission of the virus during August and September 2020, the Department announced on 23 September 2020 revised visiting guidance for hospitals and Care Homes, [**PM/679 INQ000276326** (DoH ref: PM2042), **PM/680 INQ000276327** (DoH ref: PM2043)]. This revised guidance was predicated on a phased approach to visiting, linked to the Regional Alert Level. All health and social care facilities in NI were advised to move to facilitate one face-to-face visit per week by one person to protect patients, residents and staff from Covid-19 while recognising the importance of human contact to health and well-being. Additional advice on compassionate visits was also included in the guidance.

279. Within the update to the visiting guidance issued in September 2020, Care Homes were encouraged to develop new Care Partner arrangements, a scheme which allowed the identification of an appropriate person to assist in maintaining each resident's physical or mental health. Care Partners were defined as more than visitors, likely having previously played a role in supporting and attending to their relative's physical and mental health, and/or provided specific support and assistance to ensure that communication or other health and social care needs could be met due to a pre-existing condition. Without this input, a resident could experience significant and/or continued distress.

280. The Department engaged with representatives of families and other statutory organisations involved with the independent care home sector to look into concerns regarding the implementation of Care Partner arrangements in some settings. Department staff then engaged with the Independent Care Home Providers involved, and relevant HSC Trust staff involved in commissioning care in those settings, to provide focussed support to individual Care Homes around the introduction of the

Care Partner concept. While the Care Partner arrangements were introduced under the auspices of the Regional Guidance Principles, and not mandatory or underpinned in legislation, there was a clear expectation that the scheme would be fully implemented in all Care Homes and for all residents who desired it. To that end, the Minister announced additional funding on 22 October 2020 [**PM/681 INQ000276403** (DoH ref: PM2115)] to be allocated to providers to ensure the necessary infrastructure and other necessary arrangements could be established. The expectation was that the steps necessary to introduce the Care Partner scheme should be completed by early November 2020, but a small number of care home providers continued to require some intervention from the Department, HSC Trusts, PHA and RQIA from time to time, after the initial implementation period, to encourage ongoing compliance.

281. The Department issued an update [**PM/682 INQ000276328** (DoH ref: PM2044)] to the Regional Visiting Guidance on 5 November 2020. The "*Principles for visiting people (adults) with life limiting or progressive conditions, including visiting at the patient's time of death*", was added as an appendix to the regional guidance. This update was included at 'Appendix 7' of the full guidance. In addition, on 12 November 2020 the Department's Chief Nursing Officer (CNO) and Chief Social Work Officer (CSWO) issued a guidance letter to Residential and Nursing Home Care Providers entitled 'Implementation of Care Partner in Care Homes in Northern Ireland' [**PM/683 INQ000276486** (DoH ref: PM2178)]. This was followed by a letter to HSC Trust Chief Executives and Directors of Older People Services on 13 November 2020 [**PM/684 INQ000276487** (DoH ref: PM2179)].

282. On 16 December 2020, a joint letter to the care home sector was issued by the CNO, CSWO and CMO [**PM/685 INQ000276490** (DoH ref: PM2186)]. The letter informed the sector that the care home regulator, the Regulation and Quality Improvement Authority, would assess the approach being taken to visiting when it was undertaking inspections of residential and nursing homes, and considering compliance with the relevant care standards. The letter also advised that the visiting policy and appropriate implementation of the policy into practice would therefore be a material consideration in the inspection and regulation of each care home. The letter also indicated that the current income guarantee funding support measure (see paragraph 409 of the Wave 1 statement) was likely to be linked in future to the implementation of appropriate visiting arrangements (the income guarantee support was introduced at an early stage in the Covid-19 pandemic to provide a guaranteed

level of funding for Care Homes, regardless of occupancy levels). As an additional assurance, the letter advised that Covid-19 testing would be made available to one visitor or care partner per care home resident per week over the Christmas 2020 period and up to 8 January 2021, and that the testing would be bookable at existing testing facilities, using the established PCR tests. The letter emphasised that safe visiting could already be accommodated as set out in regional guidance documents and should not stop after 8 January 2021.

283. Guidance for Christmas visiting in Care Homes was issued by the Department on 9 December 2020 **[PM/686 INQ000276329** (DoH ref: PM2045)]. This advised that the regional visiting guidance continued to apply during the Christmas period. It also stressed that Care Homes should recognise the importance many people attach to seeing family and friends over the Christmas period, and the right to a family life for those in Care Homes. Care Homes were asked to make particular efforts to facilitate visiting over the Christmas period, with specific advice set out in "Christmas Visiting guidance".

284. However, on 17 December 2020, the Executive announced new public health measures, which were effective from 26 December 2020. Given the introduction of additional restrictions and the identification of a new strain of the virus, the guidance for Christmas family visiting in Care Homes was revised and additional requirements to facilitate safe visiting to reduce the transmissibility of the virus introduced **[PM/687 INQ000276330** (DoH ref: PM2046)].

285. Following the recommendation by the four UK CMOs that the UK should move into Alert level 5, an urgent review of the existing visiting guidance was completed, adding in some additional text to provide clarity for patients, residents, care providers and the public, and the new guidance took effect from 15 January 2021 **[PM/688 INQ000276331** (DoH ref: PM2047)]. This meant that no face to face visiting to general hospitals (including ICU) would be permitted, and that end of life visiting would be considered following a risk assessment and ensuring a Covid-secure environment. Visiting to hospices and Care Homes was still allowed.

286. Following the recommendation by the four UK CMOs that the UK should move back from level 5 to level 4, the Department confirmed an easing of the restrictions on visiting arrangements for all care settings from 26 February 2021

[PM/689 INQ000276332] (DoH ref: PM2048)]. The revised position was subject to local risk assessment and kept under review.

287. Recognising the distinctions between the circumstances applying in Care Homes, compared to other care settings, on 15 March 2021, the Department commissioned the Public Health Agency to re-examine the guidance covering visiting in Care Homes, with a view to developing an indicative "journey back to business as usual" for care home residents. The Public Health Agency was asked to collaborate with all relevant stakeholders, when providing the required public health and clinical advice to inform an agreed plan for the care home sector to move to a more normalised situation with regards to visiting, services into the care home and care home residents being able to leave the care home.

288. The Department reviewed arrangements for visiting in all other healthcare settings, primarily hospitals and hospices, using the available evidence and recommendations from other parts of the UK, and identifying the key points of concern raised in correspondence over the preceding year around such access arrangements.

289. The resulting revised guidance to facilitate increased visiting in health and social care settings in NI came into effect from 7 May 2021. The revised guidance was set out in two documents, with bespoke advice provided dependent on the category of care setting involved: 'A Pathway to Enhanced Visiting' [PM/690 INQ000276333] (DoH ref: PM2049)] set out a new approach to visiting in hospices and hospitals, including maternity and other services; and 'Visiting With Care – A Pathway' [PM/691 INQ000276334] (DoH ref: PM2050)] was developed as described above in partnership with the Public Health Agency, using a co-production approach with input from representatives from the statutory sector, representatives from various relatives' groups and independent healthcare providers. It set out a phased "Pathway" approach by which safe and proportionate visiting arrangements in Care Homes could be gradually relaxed in line with the relevant guidance. This included updated arrangements for the safe management of care home residents receiving visitors, as well as residents being able to visit other households, community facilities and take part in excursions.

290. As part of the process of returning to arrangements more in line with the visiting arrangements which applied pre-pandemic, both pathways were regularly reviewed with recommendations made to the Minister on whether progress along the

pathways was appropriate as dictated by the available scientific data, and the expertise of those responsible for its delivery [**PM/692 INQ000276335** (DoH ref: PM2051)].

291. The updated approaches to visiting effective from 7 May 2021 incorporated a periodic review process to allow public health officials to consider progress, and in line with available data and experiential evidence, to decide whether progress along the Pathways would be appropriate [**PM/692 INQ000276335** (DoH ref: PM/2051)].

292. Throughout the period 7 May 2021 to 31 August 2022 evidence was collated and reviewed by the PHA's Public Health Consultant around the impacts of visiting in Care Homes. Progress meetings were chaired by the PHA and the Department and involved a standing working group of stakeholders broadly in line with the group that had co-produced the "Visiting with Care" Pathway document. These meetings were held approximately on a 4-weekly basis in respect of Care Homes, and the resulting recommendations were submitted to the Department [**PM/692 INQ000276335** (DoH ref: PM2051)], and the Minister for a decision on next steps. As a result, progress was made along the Pathway culminating in reaching the final stage of restrictions in summer 2022. Based on that progress, the Public Health Agency reconvened its review group and developed a new guidance document "Visiting With Care – the New Normal" [**PM/693 INQ000276336** (DoH ref: PM2052)] which in effect removed all Covid-19 related visiting restrictions in Care Homes not in outbreak, with clear instruction on effectively dealing with access during outbreaks. This was launched on 1 September 2022.

293. Similarly, arrangements in hospitals and hospices were kept under regular scheduled review by the Department's Chief Nursing Officer's Group, the five HSC Trusts Executive Directors of Nursing and senior leaders from the Hospice sector. Consideration was given to the evidence around transmission rates and the potential impact on those of any potential move along the visiting Pathway. To reflect the local pressures that could apply in specific hospital settings (due to estate issues, local transmission spikes, etc) all five HSC Trusts could apply additional, risk-assessed, proportionate but timebound restrictions should local circumstances have required it, but the expectation was that compliance with the applicable stage of the guidance pathway was the default position. Progress to the final stage of that pathway was also achieved in summer 2022. The "new normal" document for these settings "Enabling Safer Visiting" [**PM/694 INQ000276337** (DoH ref: PM2053)] was developed

by the Department with input from the Public Health Agency and in consultation with the HSC Trusts. Following Ministerial approval on 27 October 2022 the document was launched to take effect from 31 October 2022.

HSC Workforce

294. The workforce wellbeing framework published by the Department on 16 April 2020 (see paragraph 334 of the Wave 1 statement) continued during the second wave to provide a range of initiatives across HSC organisations to enhance psychological wellbeing of staff. These initiatives included access to Psychological Support Helplines manned by psychologists (care home and GP staff also had access to these helplines in each HSC Trust area), a broad range of online resources and drop-in services in critical facilities.

295. In an urgent written statement on 30 October 2020, the Minister reported to the Assembly that while he welcomed the plateauing of cases, due to recent NPI interventions, he also warned against complacency because of the potential adverse impact on the HSC system and its dedicated staff who remained under intense and unprecedented pressure. The welfare of patients, both Covid and non-Covid, and of staff continued to be the overriding priority. Many staff were physically and mentally exhausted and the welfare of staff was at the forefront of the Minister's mind as next steps for NPIs after 13 November 2020 were considered by the Executive.

296. The peak of the combined HSC staff absence due to sickness, covid sickness and covid-related self-isolation during the first wave of the pandemic was in the April-June 2020 quarter when the percentage of hours lost was 11.33%. During the second wave, the percentage of hours lost rose to a peak of 9.36% in the October to December 2020 quarter and was 8.61% hours lost in the January to March 2021 quarter. This data is sourced from the Human Resource, Payroll, Travel & Subsistence system (HRPTS) and due to the time lag required for recording data on the system, reporting is considered robust following payroll closedown in the month following the one that is to be reported on e.g. the month of April data would be reported after payroll closedown in late May. The data provided details of the quarterly change in the percentage of scheduled hours lost due to sickness, covid sickness and covid-related self-isolation during waves 1 and 2 of the pandemic.

297. In view of the increased pressure on staffing, the Department took several actions. These included relaunching the Workforce Appeal on 2 October 2020 [**PM/695 - INQ000371365** (DoH ref:PM2054)] to boost HSC staff numbers to assist in the battle against Covid-19; and introducing several measures to ensure that staff were properly compensated, within the resources made available to the Department, in recognition of the additional pressures arising from the pandemic.

298. The initial Workforce Appeal in March 2020 resulted in 1,702 doctors, nurses and other ancillary staff being successful in their application to work for the health service.

299. By the end of March 2021, the Workforce Appeal had generated almost 18,000 Expressions of Interest delivering almost 11,000 applications. The Appeal delivered a total of 1,822 appointments, covering both Health & Social Care (1,157) and Clerical & Admin (665). In addition, the Appeal worked in recruiting for the vaccination programme aimed at delivering Health Professionals, Healthcare Support Workers and Administrators. The HSC Trusts directed all those who were successful through the Workforce Appeal to the areas across HSC most in need.

300. The level of appointments made by the HSC Trusts were based on demand alongside the specific requirements for the roles which needed to be filled against the available applicants. Candidates may not have been successful in being offered a post or being appointed for a variety of reasons such as the suitability and availability of the candidates may not have always matched the specific requirements of the roles being offered. It was common for candidates only being able to commit to specific hours on specific days which unfortunately did not match the demands of the positions being offered by the HSC Trusts. Other candidates were seeking permanent employment, however, the Workforce Appeal was always designed with the aim of securing temporary employment in an effort to support the HSC Trusts through the pandemic. An estimated 20% of applicants either withdrew, declined an appointment, ceased to communicate or were rejected from the Appeal, however, all of the appointments made through the Workforce Appeal played a vital role in assisting the health and social care service to cope with the additional demands placed upon it during the pandemic.

301. During the second wave, the Department reintroduced free car parking for HSC staff working at HSC Trust sites, and a recognition payment scheme for HSC staff.

302. On 25 January 2021, the Minister issued a direction to the Department [**PM/69 - INQ000276338** (DoH ref: PM2055)] approving the payment of a flat, one-off, special payment of £2,000 to qualifying students on specific nursing, midwifery, allied health professional, social work and physician associate pre-registration programmes commissioned by the Department over the period 1 October 2020 to 31 March 2021. This was provided in recognition of their contribution to the delivery of healthcare while on associated clinical placements during the unique and unprecedented operational challenges presented by the pandemic.

303. The Minister also approved a temporary variation of Agenda for Change Terms and Conditions, allowing HSC Trusts' Band 8a employees (senior managers) to claim overtime from September 2020 to April 2021 [**PM/697 INQ000276339** (DoH ref: PM2056)]. This enabled senior management oversight to ensure service delivery over weekends, public holidays etc in the face of ongoing pressure experienced by HSC Trusts during the second wave.

304. The Department also announced the Special Recognition payment of £500 to all HSC staff in January 2021 [**PM/698 INQ000276341** (DoH ref: PM2057)] to recognise the efforts of staff during the pandemic and to hopefully help maintain morale. For full-time staff, this amounted to £735 before tax and NI deductions to ensure a net payment of £500 per person. Part-time staff received a proportionate payment.

Children's and Maternity Services

305. Towards the end of the second wave, following engagement between the Minister and the Royal College of Paediatrics and Child Health, and in the context of the Department renewing focus on the Strategic Framework for Rebuilding HSC Services, the Rebuilding Management Board endorsed a proposal on 28 April 2021 to develop a Covid-19 rebuilding plan for HSC paediatric services [**PM/699 INQ000276342** (DoH ref: PM2058), **PM/700 INQ000276343** (DoH ref: PM2059)]. This aimed to complement HSC Trusts' general rebuilding plans and address the impact

of the pandemic specifically on children's services by identifying priority areas where short term action by HSC commissioners and HSC Trusts could be targeted to stabilise and improve these services.

306. Unfortunately, staff resource constraints delayed the progressing of the proposed paediatric services rebuilding plan. The resource constraints were due to staff across the HSC system continuing to be redeployed to the Covid-19 response, dealing with high levels of demand for unscheduled care, winter pressures and relatively high staff absence rates. However, a wider plan to tackle hospital waiting lists including paediatric waiting lists – the Elective Care Framework – was subsequently published by the Health Minister on 15 June 2021. The Elective Care Framework will be covered in the Department's corporate statement for the period of the third wave of the pandemic. The Department also convened an ad hoc 'paediatric linkages' group of relevant policy lead officials and clinicians which met in September 2021 and December 2021 to improve collaboration and ensure appropriate focus on rebuilding children's services across a number of parallel service development initiatives whose remit covered services for all age groups (specifically the Elective Care Framework and ongoing reviews in orthopaedic surgery and general surgery).

Second Wave Surge of Increased Demand for Covid-19 Treatment Services Provided within Primary Care, Secondary Care and Acute Hospital Settings

307. As stated in paragraph 10 to 12 above, the 'Management Board for Rebuilding HSC Services' and the integrated Covid-19 Gold Command Group, both chaired by the Department's Permanent Secretary, played the central role in the Department's management and oversight of the healthcare system response to the pandemic during the second wave. The following paragraphs describe the key decisions and actions to manage the health system's response to the surge in demand for critical care services during the second wave and at the same time attempt to rebuild HSC services. This twin-track approach was required to deliver a strategic response to the impact of Covid-19 on the HSC and maintain safe services during the second wave; a period of unprecedented pressure on the HSC in NI.

308. Paragraphs 23 to 31 above set out the background to NI emerging from the first wave of the pandemic in July 2020, only to return to a serious resurgence of the virus from autumn 2020 to spring 2021. This created a potentially high-risk situation

for the HSC reflected in the surges in demand for critical care services, from increasing numbers of Covid-19 patients over the winter months, and the need to scale back elective care services to create the necessary capacity to treat these patients. A total of 3,023 elective care (Inpatient Admission and Day Case) procedures were cancelled, due to Covid-related pressures, over the 2021 Winter period from 1st December 2020 to 28th February 2021.

309. Immediately prior to the start of the pandemic, at 31 December 2019, the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI was 400,550 (211 patients per 1,000 population). When NI entered the second wave of the pandemic the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI had increased to 412,285 (217 patients per 1,000 population). By the end of the pandemic in June 2022 the number of patients waiting for a first Outpatient or Inpatient/Day case admission in NI had further increased to 505,298 (265 per 1,000 population). It should be noted that statistics are produced in relation to commissioning targets which differ across the nations and should be used only as an indication of the situation in the separate nations. **[PM/701 INQ000276503** (DoH ref: PM2183), **PM/702 INQ000276504** (DoH ref: PM2184), **PM/703 INQ000276505** (DoH ref: PM2185), **PM/704 INQ000276506** (DoH ref: PM2188), **PM/705 INQ000276507** (DoH ref: PM2189), **PM/706 INQ000276508** (DoH ref: PM2190)] .

310. Prior to 2005, hospital waiting times in Northern Ireland were the longest in the UK. There were several factors that contributed to this, primarily the imbalance between capacity and demand. Overall demand for hospital based elective care services has increased and been impacted by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs.

311. By 2009, the situation had stabilised and with the continued use of non-recurrent funding to support waiting list initiatives, remained relatively stable until 2013. At this point, however, the wider national financial position led to a suspension of additional waiting listing initiatives and since then, the annual budget allocated to the Department of Health has not been sufficient to keep waiting times to an acceptable level and the backlog of patients waiting longer than ministerial targets has continued to rise. In addition, there was an increase in patients attending Emergency Departments and requiring admission. This had a significant impact on

planned elective as, all too often planned elective procedures were cancelled to focus resources on emergency procedures.

Strategic Framework for Rebuilding HSC Services

312. In a statement to the Assembly on 28 July 2020 the Minister reiterated that in publishing the 'Rebuilding Health and Social Care Services Strategic Framework' on 9 June 2020 (see paragraph 620 of the Wave 1 statement), he had been clear that increasing activity would be a significant challenge due to the impact of Covid-19 on how the HSC delivers health and social care services. While the Minister had been clear about the need to increase service activity as quickly as possible, there remained a need to prioritise services, given the significant constraints that HSC services continued to face. Social distancing, use of PPE, staff availability and the need to plan for future potential Covid-19 surges were just some of the issues that continued to weigh on the HSC ability to diagnose and treat patients. In this context, the HSC Trusts published their first three-month Rebuilding Plans on 10 July 2020, covering the three months until end-September 2020. The intention was that these Plans would be followed by further successive three month plans in due course. However, publication of the next phase of HSC Trusts' three-month Rebuilding Plans, to cover the period October to December 2020, was deferred as the rapid increase in Covid-19 infections during autumn 2020 was likely to unavoidably impact on the capacity of the health system to maintain delivery of mainstream services.

313. During the second and third waves of the pandemic, the HSCB working with the PHA reviewed the HSC Trusts' Rebuilding Plans and related activity information. This review was to assess whether the plans provided a satisfactory level of detail on the progress of each Trust in delivering services and rebuilding, in response to pandemic-related pressures. The Health and Social Care Board's assessments were submitted to the HSC Rebuilding Management Board to consider and sign-off before the plans were published. This process was implemented on the basis of nine phases of the plans, reflecting the three-monthly planning cycles. During the second wave, papers covering the processing of the plans were submitted to the Rebuilding Management Board on 24 June 2020, 26 August 2020, 23 September 2020, 30 September 2020, 13 January 2021, 10 March 2021, 31 March 2021, 19 May 2021 and 26 May 2021.

314. The Department also developed the 'Building Better, Delivering Together: Framework and Action Plan to Rebuild HSC services 2021-2022, which received Ministerial approval on the 20 May 2021, to provide one clear set of actions to rebuild services, whilst also taking account of the continued need to be flexible in response to the demands on the HSC system arising from the pandemic. This involved amalgamating the extant HSC transformation programme at that time, with a set of key actions to rebuild services over the next 12 months. The Framework also aligned with contributing to the NI Executive's overarching plan for the recovery of public services [**PM/707 INQ000276344** (DoH ref: PM2060) , **PM/708 INQ000276345** (DoH ref: PM2061) , **PM/709 INQ000276346** (DoH ref: PM2062)].

315. The Minister also announced key decisions concerning the way forward for rebuilding two important services, day procedure centres and orthopaedic surgery. The Minister published a Policy Statement for Elective Care Day Procedures and a Blueprint for Orthopaedic Care. Both initiatives were designed to address NI's waiting times for elective care, which were the worst in the UK, and even prior to the pandemic, were totally unacceptable. The Minister informed the Assembly that he believed that it was in the public interest to move forward with the implementation of these service changes as quickly as possible, to address the adverse impact of the Covid-19 pandemic on elective care waiting times, and to enable the HSC to have in place dedicated treatment centres ahead of potential further waves of the pandemic. This would allow the HSC to maintain robust infection control preventative measures at dedicated sites to enable procedures to continue during any future outbreaks of Covid-19. While it could not be guaranteed that this could be achieved under all circumstances, it did however give a high level of confidence in the ability of the HSC to continue to deliver these services, while other hospitals were treating Covid-19 patients.

Policy Statement for Elective Care Day Procedures

316. The 'Policy Statement for Elective Care Day Procedures' [**PM/710 INQ000276347** (DoH ref: PM2063)] was published on 28 July 2020. Day Procedure Centres are designed to provide a dedicated resource for less complex planned day surgery and procedures. In the summer of 2020, the HSC Rebuilding Management Board started work with the intention of making inroads into reducing the numbers of patients waiting for elective care (building on the prototypes established pre-

pandemic). The overall aim of the Day Procedure Centre model was to deliver high volume, low complexity routine procedures. However, given the pressures across the HSC system during the first wave surge period of the pandemic, and the subsequent downturn in elective activity, the Minister gave approval to the Day Procedure Centre at Lagan Valley Hospital to be used to support the region by treating high priority patients across a range of elective care specialities. In practice, this meant working within extremely constrained timescales to identify appropriate patients and ensure that all the necessarily pre-operative checks were completed to facilitate the transfer of patients to the Day Procedure Centre at Lagan Valley Hospital, in the South Eastern Trust. To put this in context, over the 15-month period from January 2021 and March 2022 approximately 5,900 procedures were undertaken in Lagan Valley Hospital (excluding local endoscopy). Of these procedures approximately 64% were for suspected cancer and urgent patients. This regional support has continued as elective capacity is restored incrementally on the other hospital acute services sites.

Blueprint for Orthopaedic Care

317. The 'Blueprint for Orthopaedic Care' **[PM/711 INQ000276348** (DoH ref: PM2064)] was published on 28 July 2020. During the first wave of the pandemic, most elective orthopaedic procedures were halted, to ensure both the availability of resources and patient safety for those affected by Covid-19. The Blueprint aimed to focus efforts on the regional rebuilding of the service which provided an unparalleled opportunity for positive change while ensuring that services were re-established as safely as possible.

Cancer Services

318. In an urgent written statement on 25 September 2020 the Minister informed the Assembly that the Executive had endorsed his Department's draft Policy Statement for Cancer Oncology and Haematology services. The Statement set out short and medium term plans to rebuild and stabilise these services to address the serious detrimental impact of the Covid-19 pandemic on the HSC's delivery of these services across NI. The impact of Covid-19 had added a worrying new dimension to the HSC's underperformance in meeting waiting time targets for these services. There was a significant fall in red flag referrals during the pandemic surge and it was anticipated that the service was likely to see a surge in referrals over the coming

months, with the potential for an increase in late stage presentations of patients experiencing symptoms. The immediate need was to rebuild services following the Covid-19 first wave and maintain service delivery for red-flag and urgent referrals for the year ahead. The Rebuilding Plan for Cancer Services therefore contained 17 actions to maximise available capacity across cancer services. The Oncology Stabilisation Plan included 5 key elements, including funding to support development of new consultant posts in Northern Ireland Cancer Care to address single handed / vulnerable practice and pressures. The Health and Social Care Board also developed a Stabilisation Plan for Haematology Services given its close association with Oncology services to address the capacity pressures also faced by this service. All HSC Trusts brought forward individual plans which provided enhanced capacity to meet the increase in demand for services whilst simultaneously providing a more resilient service through the development of more sustainable teams.

319. In an urgent oral statement to the Assembly on 6 October 2020 the Minister announced his intention to publish on 7 October 2020 a policy statement setting out important plans for rebuilding and stabilising cancer services as well as Oncology and Haematology. These plans aimed to take immediate action to increase capacity and ensure that the services were sustained over the weeks and months during the second wave of Covid-19. The estimated investment profile for the Cancer Services Rebuilding Plan was £2.5m revenue recurrent and £151K capital. The overall estimated cost of the Oncology and Haematology Stabilisation Plans was £12.36m revenue also over two years. This investment was initially supported through Covid funding. The Executive agreed that this investment would be rolled-out across 2 years through to March 2022 and be recurrently funded from 2022/23.

New Regional Approach to Elective Surgery

320. In a written statement on 8 January 2021, the Minister informed the Assembly that he had approved the establishment of a new regional approach to ensure that any available theatre capacity across NI was allocated for those patients most in need of surgery.

321. The pandemic presented a number of operational challenges for HSC Trusts and managing the clinical risk associated with the reduction in operating capacity required a regional approach to ensure that theatre capacity was prioritised for those patients with the greatest clinical need. To address this risk, Ministerial approval was

given in January 2021 for the HSCB to implement a regional process for the allocation of the limited available HSC in-house and Independent Sector capacity, based on clinical priority irrespective of postcode. The planned approach for the allocation of the available capacity responded to the need to significantly downturn all services, in response to staff absences and the expected increase in bed occupancy levels, as indicated in the inpatient and ICU modelling projections at that time. On 8 January 2021 the Minister approved the proposals set out in a submission dated 6 January 2021 **[PM/712 INQ000276349** (DoH ref: PM2065)]. An update paper was provided to the HSC Rebuilding Management Board on 19 May 2021 **[PM/713 INQ000276350** (DoH ref: PM2066)].

322. The Regional Prioritisation and Oversight Group **[PM/714 INQ000276351** (DoH ref: PM2067)] was therefore established in January 2021 to ensure that the relative clinical prioritisation of time critical/ urgent cases across surgical specialities and HSC Trust boundaries was consistent, transparent and provided oversight on theatre allocation for priority cases requiring transfer to other HSC Trust or Independent Sector facilities. The work of the Group was underpinned by the application of the Federation of Surgical Speciality Associations guidelines for surgical prioritisation during Covid by all HSC Trusts **[PM/715 INQ000276352** (DoH ref: PM2068)]. The Federation of Surgical Speciality Associations guidelines set out categories to help clinical and managerial teams to plan and prioritise the allocation of surgical resources.

323. HSC Trusts submitted weekly prioritisation data by close of play each Friday to the Performance Management and Service Improvement Directorate of the HSCB and an analysis by specialty and HSC Trust was undertaken in advance of the weekly Regional Prioritisation and Oversight Group meeting. This data helped identify emerging pressures and allowed for early interventions, including inter-HSC Trust transfers or increased access to theatre capacity both inhouse and in the Independent Sector. Examples of co-operation included: the provision of all day theatre lists in the South West Acute Hospital, located in the Western HSC Trust hospital at Enniskillen, for the Belfast HSC Trust red flag gynaecology patients; provision of regional urology lists in Craigavon Area Hospital, Southern HSC Trust; and inter-Trust transfers of colorectal, urology and breast patients.

324. In an oral statement on 13 April 2021, the Minister updated the Assembly on the HSC Trusts' immediate plans for rebuilding HSC services **[PM/716 INQ000276353**

(DoH ref: PM2069), **PM/717 INQ000276354** (DoH ref: PM2070), **PM/718 INQ000276355** (DoH ref: PM2071), **PM/719 INQ000276356** (DoH ref: PM2072), **PM/720 INQ000276357** (DoH ref: PM2073), **PM/721 INQ000276358** (DoH ref: PM2074)]. The plans, which covered the three months period for April to June 2021, were also published on 13 April 2021. The publication of the HSC Trusts' Rebuild Plans came as NI emerged from the severe second Covid-19 wave. The Plans were based on the following five principles:

- de-escalate ICU as a region (i.e., critical care surge plans and escalation processes were used to increase critical care beds across NI to meet demand coming into the system. This was achieved in a planned way with beds increasing on a daily / weekly basis in line with the surge plan. When critical care demand reduced a de-escalation plan and process was put in place which reduced the number of critical care beds in the region in a planned way. The plan was reviewed daily and adjusted accordingly based on demand changes.);
- enabling re-deployed staff to be afforded an opportunity to take entitled annual leave before returning to their posts;
- ensure that elective care was prioritised regionally to ensure that those patients classified as being in the most clinical need received their surgery first, regardless of place of residence;
- all HSC Trusts to seek to develop green pathways with the aim to maximise theatre throughput;
- the Belfast City Hospital Nightingale facility to be prioritised for ICU de-escalation. As most of the major complex cancer surgery is carried out in the Belfast City Hospital, it was agreed that the Belfast City Hospital Nightingale unit would reduce critical care beds ahead of other units, this would allow the theatre nurses working in critical care to be redeployed back to main theatres to increase regional complex surgery capacity as quickly as possible.

325. In terms of the fifth principle, the Minister confirmed that the Belfast City Hospital Nightingale facility had closed, with the last remaining ICU patients vacating the site on 9 April 2021. These principles, including the closure of the Belfast City

Hospital Nightingale, were agreed regionally through the Rebuilding Management Board and then by the Minister on 17 February 2021 **[PM/722 INQ000276359** (DoH ref: PM2075), **PM/723 INQ000276360** (DoH ref: PM2076), **PM/724 INQ000276361** (DoH ref: PM2077)]. A Data Annex, which sets out the Trust activity projections for the three-month period April to June 2021, was published with the Rebuild Plans **[PM/725 INQ000276362** (DoH ref: PM2078) , **PM/726 INQ000276363** (DoH ref: PM2079)]. The activity projections for May and June 2021 were indicative at this stage, to be reviewed in early May 2021 reflecting the ongoing high degree of uncertainty about the course of the pandemic. A revised Data Annex was published for June 2021 **[PM/727 INQ000276364** (DoH ref: PM2080)].

326. In an oral statement on 13 April 2021, the Minister informed the Assembly that his Department was finalising a Cancer Recovery Plan, 'Building Back - Rebuilding Better'. This plan (which was subsequently published in June 2021) made recommendations to redress the disruption to cancer services caused by the pandemic. The Plan was fully aligned with the short-term recommendations in the later published Cancer Strategy (which was in early development stages at that time) and focussed on a three-year period until March 2024. The recommendations covered 11 key areas from screening through to palliative care. There were substantial costs associated with the delivery of the Recovery Plan and the Cancer Strategy (which was formally launched in March 2022, and superseded the Recovery Plan). To support cancer services the Minister had used both transformation and Covid-19 funding to set up two grant schemes. The first used transformation funding of £600,000, which covered the period from December 2020 to 31st March 2021 and enabled charities to deliver a range of key services to support people living with cancer during the pandemic. The Minister provided a Ministerial direction for the development of the second grants scheme on 29 March 2021 **[PM/728 INQ000276365** (DoH ref: PM2081), **PM/729 INQ000276367** (DoH ref: PM2082)] to Departmental officials to proceed with the establishment of a fund to meet high level outcomes which would support cancer charities to undertake their valuable role in supporting HSC services, to the value of up to £10 million, plus the management fee. The grant scheme developed was the 'Cancer Charities Support Fund' and this was administered and managed by the Community Foundation NI **[PM/730 INQ000276368** (DoH ref: PM2083)].

327. In his oral statement to the Assembly on 13 April 2021, the Minister also announced his intention to publish an Elective Care Framework. **[PM/731 INQ000276373** (DoH ref: PM2084)] This Framework would refresh the Elective Care Plan published by the Department in 2017 with a view to rebuilding and increasing elective activity at HSC regional level. The Elective Care Framework was published by the Department on 15 June 2021 and will be covered in the Department's corporate statement for the third wave of the pandemic.

Surge Planning and Response

Surge Planning Strategic Framework

328. In an urgent oral statement to the Assembly on 6 October 2020 **[PM/732 INQ000276509** (DoH ref: PM2191)] the Minister updated Members on his Department's surge planning agenda. He published a new Surge Planning Strategic Framework **[PM/733 INQ000276502** (DoH ref: PM2182)], intended to set the overarching context for individual HSC Trust surge and winter plans, which were also published. He indicated that a second wave would likely coincide with winter pressures on the HSC system. The Framework provided the overall structure and parameters within which HSC Trusts would develop plans for managing the response to Covid-19 in the event of further waves of the pandemic. The Framework sought to: highlight important learning from the first wave; set out the approach to surveillance and modelling; review actions to minimise Covid-19 transmission and impact; summarise key regional initiatives to organise health and social care services to facilitate effective service delivery; highlight actions around the key issues of workforce, medicines and testing; confirm a number of principles for HSC Trusts to adopt when developing their individual surge plans.

329. The Minister informed the Assembly that the coming period was highly uncertain. At that time in the autumn of 2020, the increase in Covid-19 cases was deeply concerning, foreshadowing the continuing threat of further waves. The development of the impact of the virus in a second wave would depend on a range of factors, including: the future approach to social distancing; population adherence to these measures; washing hands often and well; good respiratory practice; and appropriate use of face coverings.

330. The Minister reflected that the planning for the initial surge, during the first wave, was carried out at a time when there was limited data available on the pandemic trajectory. Plans, set out in paragraph 261 in the Wave 1 statement, were therefore put in place to deal with an extreme level of surge. As a result, every patient requiring hospital admission and respiratory support for Covid-19 was able to receive appropriate clinical care while other essential high-priority services were maintained. However, the creation of so much additional capacity had a significant impact on other HSC services. The scale of this impact is outlined in the Rebuilding Health and Social Services Strategic Framework June 2020 **[PM/734 INQ000276374** (DoH ref: PM2085)].

331. While the Department emphasised the need for the public to use HSC services wisely, it also stressed the importance of seeking urgent care when necessary. For example, in an oral statement to the Assembly Ad Hoc Committee on 6 January 2021, the Minister in briefing Members, appealed to everyone to use services appropriately. He also urged the public that if they suddenly started experiencing chest pain not to sit at home, but rather they should ring 999 or attend hospital. The Minister said: "they are there, and they are safe. If you feel a lump or something unusual, don't delay, get it checked out. At the same time, people must use services responsibly. Don't do anything that you think could endanger yourself and place even more strain on an already stretched service. Staying at home can reduce weather related slips and trips and indeed traffic accidents. Once again, I have to emphasise the crucial importance of personal responsibility".

332. In parallel to the finalisation and publication of the Surge Planning Strategic Framework, the Director of Commissioning, Health and Social Care Board requested HSC Trusts to draw up resilience plans to address Winter Pressures and any subsequent waves of the Covid-19 pandemic during the remainder of 2020/2021. HSC Trusts developed individual plans which were approved by their respective Trust management boards before submission to the Health and Social Care Board for consideration. Following a positive assessment by the Health and Social Care Board and Public Health Agency service lead officials, the plans were forwarded to the HSC Rebuilding Management Board to be signed-off for submission to the Minister for approval. The plans were signed-off by the Rebuilding Management Board on 20 September 2020, subject to a number of minor revisions within the financial sections. The final drafts were published on the Department's website following approval by the Minister **[PM/735 INQ000276376** (DoH ref: PM2086), **PM/736 INQ000276377** (DoH ref: PM2087), **PM/737 INQ000276378** (DoH ref: PM2088), **PM/738 INQ000276379** (DoH

ref: PM2089), **PM/739 INQ000276380** (DoH ref: PM2090), **PM/740 INQ000276381** (DoH ref: PM2091)]

333. In April 2020, the Minister granted approval for work to begin on exploring the site and specification for a second regional Nightingale facility in advance of the anticipated second wave of Covid-19, which it was believed could coincide with winter pressures. This included assessment of a number of potential sites and the identification of the most suitable clinical and technical requirements **[PM/741 INQ000276382** (DoH ref: PM2092)]. A Project Board was established which recommended that the new facility should focus on step-down provision for inpatients. The Whiteabbey Hospital site, located in the Northern HSC Trust in the greater Belfast area, was identified as the preferred option to be put to the Minister **[PM/742 INQ000276383** (DoH ref: PM2093)]. The Minister granted approval for the new facility on 1 September 2020 **[PM/743 INQ000276384** (DoH ref: PM2094), **[PM/744 INQ000276492** (DoH ref: PM/2095)] following assurances around the legacy usage of the facility **[PM/745 INQ000276493** (DoH ref: PM2096), **PM/746 INQ000276494** (DoH ref: PM2291)].

334. Work on the new facility began immediately, with the Northern HSC Trust Board granting approval for the necessary capital works **[PM/747 INQ000276495** (DoH ref: PM2097)]. The facility was opened on a phased basis, with the first patients received in the unit on 20 November 2020. While plans were in place for capacity up to 100 beds, the phased nature of opening saw 23 beds opened initially, rising to 28 beds in January 2021. Staffing was the key limiting factor to opening additional beds, with the unit, ultimately, never extending beyond the 28 beds opened by mid-January 2021 **[PM/748 INQ000276496** (DoH ref: PM2098), **[PM/749 INQ000276500** (DoH ref: PM2099)]. While all of the available 28 beds were utilised for Covid-19 patients over the 2020/21 winter period, this need had subsided by February 2021 and the unit didn't reach capacity again until the move to the legacy usage in spring 2021, when it was being utilised by patients without Covid-19. Although the facility retained the ability to 'flip' quickly back to a Covid-19 facility, this was not activated for future waves, with the focus on supporting efforts to rebuild services being deemed a greater overall use for the facility.

Emergency Care Plan

335. In an urgent written statement on 16 October 2020 **[PM/750 INQ000276386** (DoH ref: PM2100)], the Minister informed the Assembly of the Department's response plan in respect of hospital Emergency Departments, which focused on ten key actions that would be rapidly implemented in order to ensure that urgent and emergency care services across primary and secondary care could be maintained and improved in an environment that is safe for patients and for staff. The Plan, 'Covid-19 Urgent and Emergency Care Action Plan – No More Silos', was published on 16 October 2020 **[PM/751 INQ000276387** (DoH ref: PM2101)]. No More Silos was a reference to the increased collaboration between primary and secondary care in managing urgent care demand, for example the introduction of Emergency Care Centres resourced by both GPs and Emergency Care doctors. This was required to address the rising numbers of Covid-19 positive in-patients and significant numbers of HSC staff self-isolating. All HSC Trusts were experiencing pressures in Emergency Departments. Primary Care clinicians were also reporting rising numbers of patients presenting to general practice with urgent care needs. Prior to the pandemic, there was clear evidence that urgent and emergency care services were already under increasing pressure. However, the impact of Covid-19, and the accompanying focus on infection prevention and social distancing, had driven home the urgency needed to make these changes. The 10 key actions set out in the Plan focused on structured collaboration between primary and secondary care; working towards a 'phone first' model to improve access to clinical advice and reduce unnecessary attendance at Emergency Departments; scheduling urgent care through appointments to reduce waiting room overcrowding and waits for treatment; avoiding unnecessary admission to hospital; and, timely discharge from hospital. The underlying intention of the Plan was to make sure patients could access the care they need, in the right setting, as quickly as possible. The Minister confirmed his intention to establish the "The No More Silos Network' on 1 August 2020 **[PM/752 INQ000276388** (DoH ref: PM2103)] and the Network's inaugural meeting took place on 7 August 2020. The Network was co-chaired by a primary care clinician and an ED consultant, and brought together senior managers, clinicians and service users to manage implementation of the Plan.

336. On 16 November 2020 the Department announced that a new 'Phone First' service was being trialled across a number of hospital Emergency Departments. The 'Phone First' service would ensure patients could get direct access to the right care, avoid busy Emergency Departments, and further improve patient safety in terms of

preventing overcrowding and reducing long waits in Emergency Departments, and so, help to reduce the risk of Covid-19 infection and transmission.

Planning for Post-Christmas 2020 Surge

337. In advance of the anticipated surge in Covid-19 cases post-Christmas 2020, the Department commissioned an exercise to test the HSC critical care plans to assess their continued ability and effectiveness for dealing with the reasonable worst case scenario. The Department invited a Military Assessment Team, comprising regular and reservist personnel with local HSC Trust knowledge, to carry out this assessment to determine how robust the plans were in the face of various Covid-19 modelling scenarios. The focus of the exercise was on ICU capabilities, drawing on similar work undertaken in GB to inform this exercise. Following the completion of this exercise, the HSC Critical Care Network NI met on 14 December 2020 to review the plans in the light of the recommendations of the Military Assessment Team **[PM/753 - INQ000276389** (DoH ref: PM2104)].

338. The Critical Care Network NI explored all options to maximise the number of ICU beds available across the HSC. As with many Covid-19 related issues, staffing was identified as the key limiting factor in the ability to flex capacity, particularly the number of available Intensive Care Consultants and specialty trained critical care nurses. The Critical Care Network NI produced a revised surge plan, which involved drawing upon all available resource locally, while also staffing the regional Nightingale facility at the Belfast City Hospital Tower at the extreme levels of surge. All HSC Trust Chief Executives signed up to this plan, which involved up to seven levels of surge, with the maximum number of beds potentially stretched to 177 in the most extreme circumstances; however, the Critical Care Network NI was clear that this could only have been maintained for a very limited period of time **PM/753 - INQ000276389** (DoH ref: PM2104)]. Staff with previous critical care training working in other parts of the hospital, as well as staff from anaesthetic and theatre departments were redeployed to enable an expansion of critical care capacity. Existing training documentation and processes had been developed by the Critical Care Network as part of escalation processes. However, these were supplemented and updated by the Critical Care Network Lead Clinician and Nurse early in the

pandemic to enable further theatre and anaesthetic staff to be redeployed. This training documentation was also complemented by additional induction training at Trust level for staff that were redeployed. Part of the process ensured that there was experienced supervision for all redeployed staff and that staff were supported in their redeployed role.

339. A further Military Assessment Team recommendation involved the introduction of a clinically-led, regional command and control structure with the authority to manage the surge plan and direct individual HSC Trusts and hospitals on critical care bed placement and patient transfers. This regional structure was seen as necessary to ensure equitable treatment for ICU patients across the region, meaning any burden on staffing ratios would be shared and that transfer decisions would be made centrally and at pace. On 4 January 2021, the Department's integrated Gold Command agreed that this Hub should be led by a clinical Director from Belfast HSC Trust [**PM/754 INQ000276393** (DoH ref: PM2106)]. The Hub worked to ensure that patients across NI received a critical care bed when they required a bed, that the Nightingale facility in Belfast City Hospital had the required staff to open beds and that staff were supported to look after critical care patients.

340. By February 2021, the focus began to shift on to critical care de-escalation and elective care rebuild, although it was recognised that pressures on critical care remained severe, so this would need to be a gradual process [**PM/755 INQ000276394** (DoH ref: PM2107)]. With the Belfast City Hospital Nightingale facility having closed on 9 April 2021, the Minister made a statement in the Assembly on 13 April 2021 outlining the immediate plans for rebuilding services, along with some longer-term rebuilding initiatives [**PM/756 INQ000276395** (DoH ref: PM2108)]. As referenced in paragraph 324 above, as part of this statement, the Minister outlined the five principles upon which rebuild would be based.

341. The modelling of demand projections potentially arising from Covid-19 patients' admission to hospitals was undertaken at HSC Trust level by the Resource Modelling Group established in April 2020 [**PM/757 INQ000276396** (DoH ref: PM2109)]. The Group was established and chaired by the HSC Trusts to provide guidance, support and an interface between the HSC Trusts, Public Health Agency and the Health and Social Care Board on an understanding of the potential impact of Covid-19 on HSC Trust services, so that they could plan how to manage the

response to the pandemic. The Group did not take any decisions, but rather took the information developed by the modelling for use within each respective HSC Trust. The accountability arrangements for this work followed the internal governance structures for each organisation represented.

342. The Acute Bed Modelling Group was established in October 2020 and reported to the Interim Director of Commissioning in the HSCB **[PM/758 INQ000276397** (DoH ref: PM2110)]. The Acute Bed Modelling Group comprised membership from HSCB Commissioning Directorate, HSCB Head of Information, PHA Consultants and Nurses, and the Data Analytics Research & Exploitation Unit of the Strategic Investment Board.[18] Its purpose was to support a co-ordinated and coherent approach to demand forecasting, thereby strengthening the HSC-wide response to Covid-19, and to plan for the impact of the pandemic on hospital and other services. The Acute Bed Modelling Group also supported planning for the de-escalation of critical care and respiratory services, as well as the rebuild and delivery of hospital and other services. A weekly 14-day forward look report was circulated by the HSCB Commissioning Directorate to the Department, Public Health Agency and HSC Trusts for information and action as appropriate **[PM/759 INQ000276398** (DoH ref: PM2111)]. This was the only engagement HSCB had with Trust and Primary Care Clinical Teams around what the regional modelling was indicating in the second wave.

343. The system dynamics model was developed by the Strategic Investment Board and used the ages of community patient cases to forecast hospital admissions and occupancy. The responsibility of the HSCB/PHA members of the Acute Modelling Group was to source and provide all input data requested by the Strategic Investment Board for the modelling to support the development of the 14-day forward look report. In developing the model for NI, age and gender were used on the basis that they were considered to be the best available predictor of admissions to hospital. This model was based on low, medium and high predictions of hospital admissions and occupied beds.

Requests for Military Aid to the Civil Authority (MACA)

[18] The Strategic Investment Board Northern Ireland is an executive non-departmental public body sponsored by The Executive Office. The SIB's specialist advisers are available to provide expert assistance to both central and local government.

344. Following the establishment of the Critical Care Hub in January 2021, Critical Care information was also collated daily to establish trends and advice on bed escalation and de-escalation. Paragraph 319, of the Wave 1 statement, describes the Military Aid to the Civil Authority UK protocol published on the 4 August 2016 **[PM/760 INQ000390021** (DoH ref: PM0149)]. During the second wave the Department issued two Military Aid to the Civil Authority requests. In January 2021 the Department requested Combat Medical Technicians to assist across the system. Combat Medical Technicians are trained to provide basic lifesaving skills and medical support and could be used to support existing nursing staff. This request was made against the background of the HSC under severe and sustained pressure arising primarily from rising demand due to Covid-19 hospital admissions. As of 13 January 2021, there were 809 Covid-19 inpatients in hospital across the system and there were 56 Covid-19 patients in ICU. Modelling suggested that this situation could deteriorate over the coming weeks. At the same time, there were 629 staff absent across the HSC Trusts due to Covid-19, with a further 826 HSC Trust staff recorded as absent due to self-isolation. In total, there were 494 nurses or midwifery staff absent either due to Covid-19 or self-isolation. These additional staff absences added to the normal absence rates and the significant vacancies across the system, particularly in nursing.

345. The Minister approved the request for military assistance to be submitted on 15 January 2021. This was approved by the Ministry of Defence, through the UK Minister for the Armed Forces, on 20 January 2021 **[PM/761 INQ000276399** (DoH ref: PM2112), **PM/762 INQ000276400** (DoH ref: PM2113), **PM/763 INQ000276401** (DoH ref: PM2114)]. 110 Combat Medical Technicians were deployed from 25 January 2021 to 28 February 2021 across the Belfast City Hospital Nightingale facility, the Ulster Hospital and Antrim Area Hospital.

346. In March 2021, the Department requested military assistance for rolling-out NI's Covid-19 vaccination programme **[PM/626 INQ000276665** (DoH ref: PM2345)].

SECTION D: THE CARE SYSTEM RESPONSE

Care Homes

347. The new Surge Planning Strategic Framework for the HSC (see paragraph 9 above), published by the Department on 6 October 2020 outlined action to capture learning in relation to Care Homes to mitigate future transmission of the virus in care home settings.

Written Guidance

348. Information on the Guidance on Visiting Hospitals, Care Homes and other Healthcare settings issued by the Department is provided in paragraphs 277 to 304 above.

Funding

349. Throughout the second wave, there was evidence of a range of pressures facing Care Homes in relation to: implementing a rolling programme of testing; seeking to follow guidance on safe visiting; facilitating and enabling the introduction of the Care Partners initiative; and managing the consequences of the rising number of care home workers who were required to self-isolate.

350. On 22 October 2020, the Minister announced funding of £27m to help Care Homes address these issues **[PM/681 INQ000276403** (DoH ref: PM2115)]. This funding was in addition to the £6.5m announced in April 2020 (with payments issued on a graduated basis depending on the size of the home) and the £11.7m announced in June 2020 (which was to support enhanced cleaning, improved sick pay and to fund key equipment). The total funding provided to Care Homes from the start of the pandemic was therefore £45.2m.

351. £9m of the £27m funding announced in October 2020 was paid to homes based on the number of residents they had. While homes had to confirm they were implementing the regular testing programme and that they were implementing the visiting and care partner guidance in order to receive these funds, they did not have to complete an application form or provide evidence of spend. Once this confirmation was received, HSC Trusts worked to pay funds to Care Homes as swiftly as possible.

352. The remainder of the £27m was available to cover issues, including additional PPE costs, enhanced sick pay, additional staffing costs, IT costs, insurance and other professional costs, additional cleaning equipment and cleaning costs, physical infrastructure improvements to deliver enhanced Covid-19 secure environments and equipment/ furniture to support safe visiting.

Testing Programme

353. In a statement to the Assembly on 28 July 2020 **[PM/465 INQ000276488** (DoH ref: PM2180)], the Minister announced that a planned programme of regular Covid-19 testing for all residents and staff in 'green homes' (i.e., those which did not have a confirmed outbreak of Covid-19) would commence on Monday 3 August 2020. This involved testing all staff on a fortnightly basis and all residents on a monthly basis. On 3 November 2020, the Minister announced his intention to increase the frequency of Covid-19 testing for staff working in Care Homes across NI **[PM/764 INQ000276489** (DoH ref: PM2181)]. Regular testing of staff would increase from once every two weeks to once a week. The Minister stated that this should commence as soon as possible, rolling out from week commencing 9 November 2020.

Rapid Learning

354. Paragraphs 496 to 499, of the Wave 1 statement, set out the background to the Care Homes rapid learning initiative. The rapid learning initiative adopted a collaborative approach between HSC organisations, the independent sector and users, to produce knowledge as quickly as possible over a three-month period to identify recommendations for action.

355. On 9 September 2020 the Department published the 'Rapid Learning Initiative Report on Care Home Pandemic Experiences' **[PM/765 INQ000276404** (DoH ref: PM2116)]. The Rapid Learning Initiative brought together a wide range of stakeholders through both its Steering Group and four Subgroups who undertook the work of the Initiative. The Subgroups examined four key areas[19] in Care Homes and

[19] Key Areas Examined

- The experience of residents, staff and families in Care Homes;
- Symptom monitoring and intervention and care planning;

identified 24 recommendations within six themes[20] to be used to focus learning from the transmission of Covid-19 into Care Homes during the first surge to mitigate the impact on residents and staff of a potential second surge.

356. Further to the Minister's announcement on 17 June 2020 **[PM/766 INQ000103712** (DoH ref: PM0169)], concerning plans for a new framework for nursing, medical and multidisciplinary in-reach into Care Homes (see paragraph 498 of the Wave 1 statement), the Deputy Chief Nursing Officer submitted a paper to the Rebuilding Management Board on 12 August 2020 in relation to the development of an Enhanced Clinical Care Framework for Care Homes **[PM/767 INQ000276405** (DoH ref: PM2117)], and a Departmental group was established to take this forward.

357. The framework was published in August 2023.

Data and Information on Care Homes

358. On 12 November 2020, the Department published the research (carried out by Dr Niall Herity), which analysed discharge patterns from HSC hospitals across NI during early 2020 and explored any link with Covid-19 outbreaks in Care Homes looking at discharges of patients to Care Homes **[PM/768 INQ000276408** (DoH ref: PM2118)). This research was commissioned by the Department to both reflect on decisions taken during the early stages of the pandemic and also importantly to further inform our understanding of Covid-19 to effectively support future policy

---

- Infection Prevention Control;
- Physical distancing of residents (e.g., isolation, cohorting, visiting restrictions, staff turnover, footfall).

[20] Six themes to focus learning from the transmission of Covid-19 into Care Homes during the first surge to mitigate the impact on residents and staff of a potential second surge:

- Technology: Leverage technology to keep people, knowledge and learning connected;
- Information: Manage information and guidance to and from Care Homes more efficiently and effectively;
- Medical support: Provide consistent medical support into the Care Homes;
- Health and wellbeing: enhance the health and wellbeing interventions for residents, families and staff;
- Safe and effective care: enhance safe and effective practices including access to training for Care Home staff;
- Partnership; enhance partnership working across all organisations.

considerations. The research looked at data for discharges, as well as considering if there was any correlation between discharges from hospitals and infection rates in Care Homes. The study was circulated to the care home sector to highlight the findings regarding correlation between care home outbreaks and hospital admissions and community transmission.

359. The analysis identified a decline in the numbers of people discharged from hospitals, including to Care Homes, from mid-March onwards. This was reflective of an overall decline in Emergency Department attendances and hospital admissions at that point. The study examined two specific weeks in 2020 where the number of people discharged to Care Homes after an unscheduled hospital admission was slightly higher than the typical weekly average. Among 465 patients discharged to Care Homes during these two weeks five people (1.1%) tested positive within two weeks of discharge and 460 (98.9%) did not. This did not support a hypothesis that this group of people was a substantial cause of Covid-19 outbreaks in Care Homes. Hospital discharge, which is a matter for clinicians, can be a very complex and challenging area. No evidence was found to support a view that Ministerial or Departmental communications changed clinicians' discharge decision-making during the first pandemic surge, including decisions to discharge people to Care Homes. The review was an important piece of work to help further inform the Department's learning and understanding of Covid-19 and its spread.

Domiciliary Care and Supported Living

Guidance

360. On 3 August 2020, the Department published guidance for people receiving Direct Payments, entitled 'Coronavirus (Covid-19): Northern Ireland Guidance for People Receiving Direct Payments'. **[PM/769 INQ000120752** (DoH ref: PM0175)] The guidance was developed in collaboration with HSC Trusts and the Health and Social Care Board. The guidance was updated in December 2020 to include the roll out of 'emergency one-off direct payments' throughout the HSC Trusts **[PM/770 INQ000276418** (DoH ref: PM2124)].

Financial Support

361. On 6 August 2020, the Minister approved an extension of the Coronavirus (Covid-19) – Financial Support for Independent Domiciliary Care Providers, until the

end of August 2020 [PM/771 INQ000276409] (DoH ref: PM2119), [PM/772 INQ000276410] (DoH ref: PM2120)], which was previously outlined in Covid-19 Guidance for Domiciliary Care published in May 2020 [PM/773 INQ000276411] (DoH ref: PM2121)]. On 25 September 2020 the Minister issued a further approval to extend this support until 31 October 2020 [PM/774 INQ000276412] (DoH ref: PM2122), [PM/775 INQ000276413] (DoH ref: PM2123)].

362. In a statement on 17 November 2020 [PM/776 INQ000276419] (DoH ref: PM2125)], the Minister announced a £5m funding package for Domiciliary Care and on 5 March 2021, the Minister approved a fund of up to £5.2m to cover additional costs faced by the independent sector as a result of Covid-19, to cover the period 1 April 2020 to 31 March 2021. This fund was issued via grants, whereby providers outlined their additional costs to HSC Trusts, who then verified the claims.

Rapid Learning Review

363. In a statement on 17 November 2020, the Minister announced the completion of a rapid learning review, 'The Rapid Learning Review of Domiciliary Care in Northern Ireland', looking at the experience of domiciliary care during the pandemic. The review engaged with a wide range of stakeholders including service users, carers, providers and commissioners to help shape plans moving forward. The final report made nine recommendations which would inform surge plans and longer term plans for the sector. The recommendations covered areas including improving recognition and profile of the domiciliary care workforce; improving recognition and support for family carers; workforce support; systemic issues and future planning for domiciliary care [PM/777 INQ000276420] (DoH ref: PM2126), [PM/778 INQ000276427] (DoH ref: PM2127)].

Unpaid carers

364. The Department published updated advice for Informal (unpaid) Carers and Young Carers during the Covid-19 pandemic on 3 August 2020 [PM/779 INQ000276428] (DoH ref: PM2128)]. This guidance was revised and updated throughout 2020 and 2021 to align with wider developments and guidance. The guidance was updated to align with developments regarding contact tracing, eligibility for testing, eligibility for vaccines (and when this ceased), and updates on access to

PPE, alongside updates on supports for carers e.g., introduction of a carers ID card as well as the winter fuel/covid-19 heating payment.

365. On 9 February 2021, the Department issued flyers to all households in NI signposting unpaid carers to guidance, information, and advice for use throughout the pandemic [**PM/780 INQ000276429** (DoH ref: PM2129)].

366. In a statement on 19 April 2021 [**PM/781 INQ000276430** (DoH ref: PM2130)], the Minister provided details of a £4.4m scheme to support unpaid carers, which was funded from the Department's Covid-19 budget allocation. The grant scheme, entitled the 'Support for Carers Fund', would be administered and managed by the Community Foundation NI, and open to community and voluntary sector organisations with charitable purposes offering support to carers and operating within NI.

Mental Health Policy

367. The Coronavirus Act 2020 implemented temporary modifications to mental health and mental capacity legislation, as contained in the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (NI) 2016. During the second wave those modifications continued, with the aim of ensuring continuity of service delivery, and offering flexibility around some of the deprivation of liberty safeguards (as outlined in paragraph 540 of the Wave 1 statement).

368. The impact on mental health services did not follow the same pattern as Covid-19 infection rates, rather there was a delay in peaks in the strain on mental health services. As a result, mental health in-patient bed pressures were increasing at the point when the Wave 1 infection peak was reducing. In response to this, the Department commissioned a short-term task and finish group in July 2020 to consider immediate actions to mitigate the pressures in Adult acute in-patient services. [**PM/782 INQ000276501** (DoH ref: PM2102)] This included creation of a regional bed management system to allow a more agile response to in-patient pressures. On 22 September 2020, the Minister approved the establishment of a Regional Mental Health Bed Network and it was mostly implemented in the second half of 2020 [**PM/783 INQ000276431** (DoH ref: PM2131), **PM/784 INQ000276432** (DoH ref: PM2132)].

369. Due to the increasing pressures relating to the pandemic and restrictions, on 18 January 2021, the Department revived emergency provisions of the Coronavirus Act 2020 relating to the Mental Health (NI) Order 1986. The Department also made new emergency amendments to the Mental Health (Northern Ireland) Order 1986 which related to the requirement to obtain a second medical opinion to ensure it was possible to treat patients in accordance with legislation (see paragraph 541 of the Wave 1 statement). The Department's officials cooperated with the members of the Adult Mental Health Sub Group, HSCB, PHA, Trusts and the Mental Health Champion and also sought legal advice, privilege in respect of which, is not waived, on the reintroduction of the emergency provisions due to the significant pressures on adult in-patient services, which limited the Trusts' ability to provide the right staff at the right time. There were significant shortages in the availability of mental health staff, as a result of Covid-19 outbreaks, and these shortages contributed to the pressures experienced in the sector. Reported pressures included increased levels of acuity in mental health inpatients due to the pandemic which led to increasing requirements of special observations; an adult acute bed occupancy continuously over 100%, with patients cared for in staffing areas and on sofas and chairs; a number of separate Covid-19 outbreaks affecting staff and patients; and staff shortages, including the redeployment of staff from community mental health to in-patient services and the stepping down of services to ensure sufficient staffing levels. The extra pressures and outbreaks affected the ability of staff to carry out normal functions and unless mitigated, could have limited the ability to carry out the statutory functions of the Mental Health Order. This brought back the emergency legislative provisions that had been in force during the first wave, and which had subsequently been stood down in the summer of 2020. This also included amendments to guidance in respect of carrying out statutory functions remotely and reporting by the Regulatory and Quality Improvement Authority. The emergency provisions widened the pool of second opinion doctors and increased the time period when a second opinion is required for continued medication of detained patients from three months to six months to ensure that patients could be detained and treated in line with the Mental Health (Northern Ireland) Order 1986. HCS Circular AMHU 1/21 **[PM/785 INQ000276435** (DoH ref: PM2133)] was issued to inform Trusts and a temporary Code of Practices was provided **[PM/786 INQ000276437** (DoH ref: PM2134)]. In keeping with ongoing engagement, on 28 January 2021, the Health Committee was briefed by Departmental officials on the revival of the mental health provisions in the Coronavirus Act 2020 and was advised that the issue of standing down the

provisions were a standing order at a weekly Covid-19 mental health meeting, attended by service users, HSCB, PHA and the Department.

370. During this time, the Department's officials continued to liaise with officials in Great Britain and the Republic of Ireland on how to respond to the increase in infections across mental health services. Due to the smaller and more fragile workforce in NI, the additional measures outlined above were put in place to ensure that mental health services were deliverable to the population, even if a significant part of the workforce was unavailable, for example due to illness.

371. The need for the emergency legislative measures was continuously evaluated through the Mental Health Sub-Group (see paragraph 523 of the Wave 1 statement). On 10 March 2021, it was decided that the measures were no longer required as the HSC Board and HSC Trusts indicated that the direct impact of Covid-19 pressures had been significantly reduced. Both the Coronavirus Act provisions, and the Mental Health Order amendments were formally suspended on 10 May 2021.

372. In an oral statement to the Assembly on 13 April 2021 **[PM/787 INQ000276438** (DoH ref: PM2135)] the Minister announced an important mental health support scheme, that would be appropriately resourced to provide greater levels of mental health support and interventions. In a press release published on 5 July 2021, **[PM/788 - INQ000276439** (DoH ref: PM2136)], the Minister provided further details of the £10m mental health fund providing support to mental health charities. The grant scheme, entitled the Mental Health Support Fund, was administered and managed by Community Foundation NI, and was open to community and voluntary sector organisations with charitable purposes which offered services for people with mental ill health throughout Northern Ireland.

Domestic and Sexual Abuse

373. The Department participated in fortnightly PSNI-led teleconferences with other government departments and delivery partners in the voluntary and community sector to share statistics and ensure a joined-up approach as part of recovery planning (Department of Health, Department of Justice, Department for Communities, PSNI, Women's Aid, Men's Advisory Project, Nexus NI, Domestic and

Sexual Abuse Helpline, Northern Ireland Housing Executive, Victim Support Service, Rainbow, NSPCC, Northern Ireland Courts and Tribunal Service).

374. On 30 April 2020 the Department shared a 'Safety Planning by Phone During Covid-19' Presentation (created by the South-Eastern Health and Social Care Trust) with members of the Domestic and Sexual Abuse Stakeholder Assurance Group for voluntary and community groups to adapt when working with victims.

375. On 19 June 2020 the Chief Social Worker wrote to the relevant Directors in the HSCB and HSCTs drawing attention to 'Guidance on Domestic Abuse', setting out the support services available for those at risk or suffering from domestic abuse. This Guidance, which was produced by the Department of Health in partnership with the Department of Justice, was also aimed at those who may be concerned about someone else, such as a friend, family member or neighbour.

376. On 1 July 2020, the Department of Health and the Department of Justice published the 'Guidance on Domestic Abuse' for the general public. **[PM/789 INQ000276440** (DoH ref: PM2137)].

377. In response to the pandemic, on 19 June 2020, the Department of Health, through the Health and Social Care Board, provided £60k of funding to Women's Aid over a three-month period to provide an initial care package for families who were experiencing, or had been a victim of, domestic abuse. This package provided food parcels, home based resources and games for families, laptops for children currently without access and provision of mobile phones for mothers for the specific purpose of safety planning.

378. In November 2020, during the 16 Days of Action campaign, the Health Minister took part in a video message from all of the Executive Ministers which was released on social media asking victims to come forward to seek help and support.

379. The 'Ask for ANI' pharmacy code word scheme, launched by the UK Government, was also introduced in NI in January 2021 **[PM/790 INQ000276441** (DoH ref: PM2138)]. This was a new way for victims of domestic abuse who may be isolated at home to access support services. The scheme allows those at risk or suffering from abuse to discreetly signal that they need help and access to support.

By asking for 'ANI', a trained pharmacy worker can offer a private space where they can understand if the victim needs to speak to the police or would like help to access the 24 hour Domestic and Sexual Abuse Helpline. Participating pharmacies have promotional material on display in store to signal that they are taking part. Local support organisations such as Women's Aid, Men's Advisory Project and the Domestic and Sexual Abuse Helpline (run by Nexus) were involved in quality assuring training materials and participating in a Home Office Steering Group to inform the scheme's development.

380. In April 2021 the Department of Health facilitated the display of Domestic and Sexual Abuse Helpline posters in each of the Covid-19 vaccination centres. Posters were also sent to a Belfast Health and Social Care Trust site where asylum seekers were being vaccinated.

Family and Children's Policy

381. On 19 February 2021, the Minister announced further funding of £755K for foster carers, bringing the total support provided to them to £1.39million since the start of pandemic [**PM/791 INQ000276442** (DoH ref: PM2139)].

382. The Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) Regulations (Northern Ireland) 2020, which were made during Wave 1 (see paragraph 555 of the Wave 1 statement), remained in place during Wave 2 and were due to cease to apply on 7 November 2020. The Department made a further Statutory Rule on 30 October 2020 [**PM/792 INQ000371105** (DoH ref: PM2171)] to extend the operational period of the modifications set out in the Regulations for a further period of six months, until 7 May 2021 [Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) (Amendment) Regulations (NI) 2020]. In advance of doing so, officials consulted with the NI Commissioner for Children and Young People and notified other key stakeholders, including the Northern Ireland Human Rights Commission and the Children's Law Centre. The Assembly Health Committee approved the further extension, following an oral briefing provided by officials on 19 November 2020.

383. The Department continued to monitor implementation of the Regulations and to report monthly to the Assembly Health Committee and key stakeholders on the nature and extent of reliance by HSC Trusts and other relevant bodies on the

flexibility provided by the temporary modifications (see paragraph 555 of the Wave 1 statement). These monthly reports continued to be provided through to March 2021. [PM/793 INQ000276443] (DoH ref: PM2140), [PM/794 INQ000276444] (DoH ref: PM2141), [PM/795 INQ000276445] (DoH ref: PM2142), [PM/796 INQ000276446] (DoH ref: PM2143), [PM/797 INQ000276447] (DoH ref: PM2144), [PM/798 INQ000276448] (DoH ref: PM2145), [PM/799 INQ000276449] (DoH ref: PM20146)].

384. On 8 April 2021, the Department launched a consultation to extend modifications to children's social care regulations due to the pandemic [PM/800 INQ000276450] (DoH ref: PM2147), [PM/801 INQ000276451] (DoH ref: PM2148), [PM/802 INQ000276452] (DoH ref: PM2149), [PM/803 INQ000276453] (DoH ref: PM2150)]. This consultation ran until 22 April 2021. Twenty-four responses were received, which overall were finely balanced. Where respondents agreed to modifications being extended, they mostly emphasised that they should be a measure of last resort and be used in exceptional circumstances only. Children's advocate organisations raised concerns about extending the period for modifications any further, and children and young people themselves made a persuasive case for the return of face-to-face contact with social workers. As a result of the outcome of the consultation, and also taking into consideration: the declining infection rate at that time; the reduction in the rate of staff absence due to Covid-19; the vaccination programme; and the easing of public health restrictions, a decision was made by the Minister not to remake the Regulations and the modifications fell away on 7 May 2021.

385. In September 2020, the temporary pre-employment vetting policy, which was introduced in April 2020, was stood down as pressures around staffing had eased. Around the same time, AccessNI closed the emergency Barred List Check mechanism which had been put in place to facilitate the safe recruitment of staff more quickly. The introduction of both are outlined in paragraph 449, of the Wave 1 statement. The Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 remained in operation at this time in case there was a need to stand up the temporary pre-employment vetting policy again at short notice.

386. The Department continued to liaise on a regular basis with safeguarding policy officials in England, Scotland & Wales through the Covid-19 Four Nations Child Safeguarding Officials Group, which continued to meet fortnightly since its establishment during Wave 1 as outlined in paragraph 560, of the Wave 1 statement.

387. The Department provided funding of £10,500 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. Details of this awareness campaign are included in paragraph 568 of the Wave 1 statement. [**PM/804 INQ000276459** (DoH ref: PM2151), [**PM/805 INQ000276460** (DoH ref: PM2152)].

388. From 18 September – 13 November 2020, the Department facilitated a public consultation via Citizen Space on a Covid-19 Vulnerable Children and Young People's Plan, which was produced on a cross-departmental basis (see paragraph 553 of the Wave 1 statement). MLAs and those listed in The Executive Office guidance on the distribution of consultation documents were notified of the consultation, along with relevant organisations listed on the Department's section 75 consultee list. Other Departments also notified organisations in their respective consultee lists of the consultation.

389. The Vulnerable Children and Young People's Contingency Framework, which was informed by joint working across health and education during Wave 1, was designed to become operational when public health restrictions impacted on the ability of vulnerable children to access school. The framework detailed the provision that vulnerable children and young people could expect to receive from schools and education settings, the EA and HSC services at each of 4 levels along a continuum of schools being fully open for all children and young people through to them being closed to all. The framework was utilised in January 2021 (see paragraph 554 of the Wave 1 statement).

390. The Department continued to provide support and guidance to children's social care settings (see paragraphs 557 to 558 of the Wave 1 statement) and the childcare sector (see paragraphs 552 to 554 of the Wave 1 statement) during the second wave.

SECTION E: PPE

391. Progress on the actions outlined in the Rapid Review of PPE Report (paragraphs 355 to 358 of the Wave 1 statement refer) continued to be monitored by the PPE Strategic Supply Cell. 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.

SECTION F: HEALTH INEQUALITIES

Coronavirus Related Health Inequalities Report

392. On 16 December 2020, the Department published the 'Coronavirus Related Health Inequalities Report' **[PM/806 INQ000137377** (DoH ref: MMcB043c)]. 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, death rates and admission rates. The information in the report relates to the position as at 27 October 2020.

393. The key findings in respect of individuals with a positive test were as follows. The infection rate in the 10% most deprived areas (3,052 cases per 100,000 population) was almost two-thirds higher than the rate in the 10% least deprived areas (1,859 cases per 100,000 population) and more than one and a half times the NI average (1,972 cases per 100,000 population). The rate among females (2,050 cases per 100,000 population) was 8% higher than the rate for males (1,893 cases per 100,000 population). The infection rate among those aged over 65 was four-fifths higher in the 10% most deprived areas (3,187 cases per 100,000 population) than in the 10% least deprived (1,773 cases per 100,000 population) and almost double the NI average (1,643 cases per 100,000 population). While infection rates were highest in the 10% most deprived areas; the 10% least deprived areas had the second highest infection rate for over 65s. The rate in urban areas was over a third higher than the rate seen in rural areas, however the rate was highest in mixed urban/rural areas (3,677 cases per 100,000 population).

394. The key findings in respect of admissions to hospital were as follows. The admission rate for COVID-19 (confirmed cases) in the 10% most deprived areas (275 admissions per 100,000 population) was more than double the rate in the 10% least deprived areas (126 admissions per 100,000 population). The admission rate for under 75s in the most deprived decile (167 admissions per 100,000 population) was approximately three times that in the least deprived decide (55 admissions per 100,000 population). In comparison, the 75 and over rate for the most deprived decile was almost three-fifths higher than the rate in the least deprived decile. While

deprivation was found to be an important factor of the likelihood of admissions, age was found to have a greater impact. The standardised rate for the population aged 75 and over (890 admissions per 100,000 population) was over 9 times that for the under 75 population (97 admissions per 100,000 population).

395. The key findings in respect of deaths were as follows. The Covid-19 death rate in the 10% most deprived areas (77 deaths per 100,000 population) was almost two-fifths higher than the rate in the 10% least deprived areas (56 deaths per 100,000 population) and almost one and a half times the NI average (53 deaths per 100,000 population). The rate among males (67 deaths per 100,000 population) was one and a half times the rate for females (44 deaths per 100,000 population). Similar to mixed urban/rural areas, the death rate in urban areas (63 deaths per 100,000 population) was double the rate seen in rural areas (32 deaths per 100,000 population). The standardised Covid-19 death rate for the population aged 75 and over (477 deaths per 100,000 population) was 9 times that for all ages (53 deaths per 100,000 population). The over 75 Covid-19 death rate was highest in the 10% most deprived areas (717 deaths per 100,000 population) where it was three-tenths higher than the rate in the 10% least deprived areas (549 deaths per 100,000 population) and one and a half times the NI average (477 deaths per 100,000 population).

Monitoring of 'Making Life Better' Indicators

396. During 2020 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 Northern Ireland, Making Life Better.

397. Reports were produced in:

a. May 2020 **[PM/807 INQ000276461** (DoH ref: PM2153) and **PM/808 INQ000276462** (DoH ref: PM2154)]
b. July 2020 **[PM/809 INQ000276463** (DoH ref: PM2155) and **PM/810 INQ000276464** (DoH ref: PM2156)]
c. August 2020 **[PM/811 INQ000276465** (DoH ref: PM2157)]
d. November 2020 **[PM/812 INQ000276466** (DoH ref: PM2158)]
e. January 2021 **[PM/813 INQ000276467** (DoH ref: PM2159)]
f. February 2021 **[PM/814 INQ000276468** (DoH ref: PM2160)]

g. May 2021 [PM/815 INQ000276469 (DoH ref: PM2161)] and focus on Physical activity and domestic violence [PM/816 - INQ000276470 (DoH ref: PM2162) and PM/817 INQ000276471 (DoH ref: PM2163)]
h. Focus on educational attainment June 2021 [PM/818 INQ000276472 (DoH ref: PM/2164)]
i. July 2021 [PM/819 INQ000276473 (DoH ref: PM2165)]
j. August 2021 [PM/820 INQ000276474 (DoH ref: PM2166)]
k. December 2021 [PM/821 INQ000276475 (DoH ref: PM2167)]

398. Reports were shared within the Department and were used to inform the development of Executive papers reviewing the coronavirus restrictions regulations.

Abortion Services

399. Paragraphs 602 to 608, of the Wave 1 statement, describe the background to NI's five HSC Trusts introduction of a non-commissioned Early Medical Abortion Service for women in NI during the first wave of the pandemic. By March 2021 the pressure on the Department's and HSC's staff resources to manage the response to the pandemic had receded around the ending of the first wave. The Department was therefore able to reallocate some staff to resume policy work on a number of service change and development projects. This included a resumption of work by the Project Board for the commissioning of Abortion Services, which had been stood up initially prior to the introduction of Abortion Regulations by the UK Government in March 2020, and which had been stood down shortly thereafter, due to the need to redeploy departmental staff to the emergency pandemic response. Staff were recruited to resume the commissioning planning work by June 2021. The Department estimated that it would take a further 8 to 12 months to have commissioned abortion services in place, subject to business case approval and available resources, as well as Executive agreement under the Ministerial Code. In the meantime, the HSC Trusts continued to provide the non-commissioned Early Medical Abortion Service for women in NI.

SECTION G: INNOVATION AND LEARNING

400. A priority of the Rebuilding HSC Services Management Board was to capture learning derived from innovation in the delivery of HSC services by HSC Trusts during the first wave of the pandemic. A draft Programme Initiation Document [PM/822 - INQ000276476 (DoH ref: PM2168), PM/823 INQ000276478 (DoH ref: PM2169)] to take forward this work was presented to the Rebuilding Management Board on 10 June 2020. Several workstreams were identified and the then Chief Executive of the Western HSC Trust was assigned to lead this Service Delivery Innovation Project [PM/824 INQ000276479 (Doh ref: PM2170)]. A final report of the project [PM/825 INQ000276480 (DoH ref: PM2172), PM/826 INQ000276481 (DoH ref: PM2173)] was submitted to the Rebuilding Management Board on 30 September 2020. The report identified three themes: use of virtual technology to support virtual visiting; use of technology to support virtual consultations; and supporting staff psychological safety during Covid-19 [PM/827 INQ000276482 (DoH ref: PM2174)] as key innovations delivered during the first wave. Further updates and presentations on this work were submitted to the Rebuilding Management Board on 4 November 2020 [PM/828 INQ000276483 (DoH ref: PM2175)] [PM/829 INQ000276484 (DoH ref: PM2176)] and on 26 May 2021 [PM/830 INQ000276485 (DoH ref: PM2177)].

STATEMENT OF TRUTH

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

Signed: Personal Data

Dated: 16/2/24