Witness Names: Maria McIlgorm, Linda Kelly & Charlotte McArdle
Statement No. :
Exhibits:
Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CHIEF NURSING OFFICER(s) FOR NORTHERN IRELAND:
Charlotte McArdle (until 31 October 2021)
Linda Kelly (1 November 2021 – 11 March 2022)
Maria McIlgorm (14 March 2022 to date)

We, Charlotte McArdle, Linda Kelly, and Maria McIlgorm, will say as follows: -

Background

1. We, Charlotte McArdle, Linda Kelly and Maria McIlgorm, Chief Nursing Officer ("CNO") for Northern Ireland, make this joint statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry") dated the 4th of December 2023 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring us to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3. While each of us sign the full statement, each of us specifically offer this input in respect of our individual time in post within the relevant period as set out in the title above.

2. In preparing this statement, support has been provided by staff in the CNO Group who have conducted a thorough review of the documentary evidence held by the Department of Health (the Department). Given the sheer pace and complexity of events, the number of key decisions made and the passage of time, it is inevitable that some recollections may be incomplete. Given the changes to normal working arrangements and the time taken to recruit and reallocate staff, there may be some gaps in the written records and recollections of early meetings.

3. Where recollections are less clear, we have considered the available written records to assist in the preparation of this statement. Input has also been sought from other colleagues within the Chief Nursing Officer's Group and across the Department to help prompt recall of events and we have indicated where we have done so. In all such circumstances, the recollections and observations which are included in the text of this statement are our own. Where we are unable to recall the specific details, we have indicated what would have normally occurred in the context of the circumstances in question, and this has also been made clear in the statement where appropriate. To assist the Inquiry and to address specific aspects of this response, we have also referenced work that other professional and policy colleagues took forward.

4. The substance of this statement has also been discussed with senior colleagues, who were involved first-hand in the development and delivery of the matters described.

The Pandemic

5. The Covid-19 pandemic had an impact on the people of Northern Ireland the like of which has not been experienced since the 1918 to 1919 influenza pandemic. This required a significant response from the public and government of Northern Ireland (NI), and in particular the health and social care sector, with profound and enduring consequences for all. The impact of the pandemic was felt by individuals, families, and communities across Northern Ireland, with many lives tragically lost, and many people impacted either personally or through family or other connections left living with direct and indirect consequences. Tragically also, many individuals with non-Covid-19 conditions faced delays in diagnosis and treatment which may have led to poorer clinical outcomes. Many others were adversely impacted as a direct consequence of the measures that were required to be introduced in response to the pandemic based on the emerging evidence at the time.

The Role of the Chief Nursing Officer for Northern Ireland

6. My role is head of the Chief Nursing Officer Group (CNOG) within the Department of Health, which consists of Nursing, Midwifery and Allied Health Professionals, and is supported by a Northern Ireland Civil Service (NICS) policy team. I report directly to the Permanent Secretary and am a member of the Department's Top Management Group (TMG), and the Departmental Board.

7. Each of the UK CNOs carry a different portfolio, and unlike my counterpart in England, I do not have responsibility for operational matters around service delivery, so my primary responsibility and accountability, and that of my Group, is to advise the Minister for Health (the Minister) and the Department on all aspects of policy which impact upon or interface with Nursing, Midwifery and Allied Health Professionals in Northern Ireland and at UK level. I was, at the outset of the pandemic, supported by 2 Deputy Chief Nursing Officers (DCNOs), and a professional Midwifery Officer. From 24 February 2020, Linda Kelly was in post as one of my DCNOs before taking up post as Interim CNO after I (Charlotte McArdle) left my post as CNO on 1 November 2021. On 14 March 2022 Maria McIlgorm assumed the post as CNO for NI.

8. As head of the Nursing and Midwifery professions (approx. 27,000 nurses across four fields of practice, and 1,200 midwives), I am responsible for the professional leadership, performance against professional standards, and development of these professions in NI and provide strong professional leadership for nurses and midwives across all sectors in NI. I work closely with all nursing and midwifery leaders in the Health & Social Care (HSC) system, university and education providers, independent and voluntary sector nursing care providers, trade unions, regulatory and professional bodies. I work within the Department's *"Framework Document"* (INQ000188742) which clearly sets out the roles of Executive Directors of Nursing in the five HSC Trusts and Public Health Agency (PHA) and their professional responsibilities to their own arm's length body independent boards.

9. I am also responsible and accountable for the strategic leadership and contribution of Allied Health Professions (AHP). I work closely with the Department's Chief AHP Officer (CAHPO) who reports directly to me and holds a remit which includes responsibility for professional leadership of some 5,000 AHPs across fourteen distinct Allied Health Professions.

10. As the Department's most senior advisor on nursing and midwifery issues, I provide independent expert professional advice and support to the Minister, and thereby the Executive, the Permanent Secretary, and senior administrative and professional colleagues within the Department and across the HSC, on all aspects of nursing, midwifery and AHP policy. I have a lead role in establishing, promoting, and reinforcing the strategic direction for nursing, midwifery and AHP services, agreeing programmes of action, setting goals and targets, and ensuring that progress is monitored and evaluated.

11. I also work very closely with the other UK and RoI CNOs, with other European Countries, the World Health Organisation, the International Council of Nurses, and the Commonwealth Nurses Federation. I lead the development of nursing and midwifery policy and contribute to

the development and implementation of health and social care policy at national and international level. A five country CNO (UK and RoI) group meeting had been established since long before my tenure as CNO. The chair was rotated around the five countries. We met quarterly over an evening and following morning and focused on strategic nursing and midwifery policy issues including regulation, policy (devolved, national, and international), education, workforce, and practice issues. The nature of, and subject matter covered by this meeting changed to reflect the demands of the pandemic and is referenced as appropriate throughout this statement.

12. I lead the Departmental policy on patient experience, co-production, and the nutrition strategy for NI. I, Charlotte McArdle, led the development of the 10-year cancer strategy published in 2022. I led the policy on intermediate care (IC). Intermediate care is an overarching description for four different and distinct service models: Hospital at Home; Bed-Based IC; Home-Based IC; and Re-ablement. I led on the development of a regional and standardised approach for the delivery of intermediate care services across NI. From the outset of the pandemic, however, much of my normal line of business policy related work had to be stood down as the Department moved into contingency planning mode in line with the business continuity plan. Throughout this emergency, I was expected to continue to discharge the roles and responsibilities as described above as far as was possible. This is something which each of us respectively did to the best of our ability throughout the period of our tenures through the pandemic period from January 2020 to October 2021, November 2021 to March 2022, and from March 2022 onward. The response to the pandemic was very demanding, challenging and all consuming, and to account for this my roles and responsibilities and those of CNOG changed and evolved as I assumed significant new and additional responsibilities (para 13 & 14 below), although not by any means exhaustive, gives an indication of the additional duties which fell to me arising from the pandemic response.

13. Consequently, I took on the responsibility of leading on the development of guidance around visiting arrangements in all healthcare settings across Northern Ireland, the specifics of which are set out in greater detail below and my involvement in the joint UK CMO/CNO senior clinicians meeting included in para 42-43 below provided advice on a range of issues including Infection Prevention & Control (IPC). I supported the IPC Cell which at this time was led by a senior nursing officer from the PHA and engaged in supporting and disseminating its guidance around Personal Protective Equipment (PPE) and other IPC measures as required.

14. The advice I provided throughout the pandemic was based on the most current available evidence at the time. It is a fact that the understanding of the virus, its transmission and the

disease impact took time to emerge as did the scientific, public health and clinical research undertaken to provide an understanding of these aspects, and to improve the information for policy decisions including research to improve treatment and to develop medical countermeasures.

15. On behalf of the Department, Minister, and Departmental Accounting Officer, my CNOG team acts as sponsor for two distinct arm's-length bodies:

    - The Northern Ireland Practice Education Council (NIPEC): NIPEC is a Non-Departmental Public Body established to support the development of nurses and midwives by promoting high standards of practice, education, and professional development. NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

    - The Patient Client Council (PCC): PCC was established on 1st April 2009 to provide a powerful independent and influential voice that makes a positive difference to the health and social care experience of people across Northern Ireland.

16. CNOG staff work to ensure the maintenance of effective relationships with both PCC and NIPEC through regular engagement and formal sponsorship meetings ensuring the right balance between PCC/NIPEC operational independence and appropriate and proportionate Departmental oversight and governance.

17. As the pandemic period progressed, my role expanded significantly to cover a range of different responsibilities as set out throughout this statement. Throughout the pandemic period, and as a member of the Department's Top Management Group (TMG) and by extension Health Gold Command and the Strategic Cell (see paras 26-30 below for details), I was involved in the consideration of a range of decisions relating to the response of the Healthcare system in NI. I was in regular contact with the Minister to provide independent professional advice on issues related to my areas of responsibility, reporting also to the Health Committee and from time to time to the First and Deputy First Ministers and the Executive alongside other professional colleagues from the Department. I also engaged with the public by means of the regular televised daily briefing sessions, which were also shared widely via online platforms.

18. As CNO, I have a key role in communicating with the public on key public health issues that are important to protect and improve public health and wellbeing. This communication role was a key element of my responsibilities during the pandemic and took the form of providing advice,

information and data on issues including measures the public could take to protect themselves from the virus and reduce transmission, assurances regarding nursing care especially during surge and information regarding restrictions on visiting and explaining the necessity for same. Details of these are included below.

19. I do, however, need to be clear that as CNO I did not, and do not, have any operational role in the design or delivery of care to patients and/or residents. While as explained throughout this statement I work closely with colleagues in HSC Trusts, Care Homes and other healthcare settings, I had no operational role in maintaining healthcare and treatment plans for patients, either with or without Covid-19, for non-Covid-19 conditions, such as heart disease, those facing cancer diagnoses, orthopedic needs or those requiring Mental Health Services.

Operational background of the Chief Nursing Officer Group

20. In terms of our professional backgrounds, these can be summarised as follows:

a) Charlotte McArdle MSc, PGCert, BSc, FQNI, FFNMRCSI.

I am a registered nurse on the NMC and Nursing and Midwifery Board of Ireland since 1991. Following nurse training in Beaumont Hospital Dublin Ireland, I continued my nursing career there until 1993. I then moved to Northern Ireland, taking up a post in Musgrave Park Hospital in Belfast in Rheumatology, initially as a Staff Nurse and then as a Senior Staff Nurse until 1996 and then Ward Sister until 1998.

In 1998 I moved on to take up the role of Ward Sister in the Medical Directorate of the Royal Hospitals, Belfast. In 2000 I became Divisional Nurse and lead nurse for surgery still within the Royal Hospitals group, and then in 2003 I became Deputy Director of Nursing there. In 2007 I was appointed Director of Nursing, Primary Care and Older People in the South-Eastern Health and Social Care Trust, where I remained in post until my appointment as Chief Nursing Officer for Northern Ireland on 5 April 2013 and was in post until 31 October 2021. I am currently employed at NHS England as Deputy Chief Nursing Officer.

I have continued my own professional development through academic study and leadership development with a Florence Nightingale Scholarship in 2012 and at global nurse policy development institute at International Council for Nurses. I have expertise in safety and quality and completed the Institute for Health Care Improvement Programme improvement advisor's programme. I am an accredited Global nurse

consultant with the CGFNS (Commission on Graduates of Foreign Nurses Schools) in USA.

I am a Visiting Professor at the Ulster University, a Trustee and Vice Chair of the Royal College of Nursing Foundation and am a Board Member of the Faculty of Nursing and Midwifery in the Royal College of Surgeons in Ireland.

b) Linda Kelly RN, MSc, PGCert, BSc

I first registered as a nurse in 1990. Over the next 10 years, I completed a BSC (Hons) in Nursing and Post Graduate Diploma in Public Health Management and worked across acute and community nursing posts in Northern Ireland. I have worked as a registered nurse throughout my career. With a background of District Nursing, Care Management and Governance Lead posts, I took up post as Assistant Director of Nursing: Safe and Effective Care, in the South Eastern Health and Social Care Trust in 2011.

Adding to my MSc in Public Health, I have progressed my interest in continuous improvement through completion of the Institute of Health Improvement (IHI) Improvement Advisor Programme in 2016 and more recently, in 2019 I graduated with a Post Graduate Diploma in Healthcare Management from London South Bank University following completion of the Aspiring Nurse Director Programme.

I assumed the role of Deputy Chief Nursing Officer in the Department of Health, Northern Ireland in March 2020. I supported Charlotte McArdle in her role as CNO, across a range of policy areas, including the development of visiting arrangements throughout the pandemic, until her departure in November 2021, when I assumed the role of interim CNO. I moved to become Chief Executive Officer in NIPEC in March 2022, with Maria McIlgorm having been formally appointed as CNO for the Department.

c) Maria McIlgorm RN (& formerly RM), BSc (Hons)

My experience has been across hospital and community settings within professional, operational, and strategic roles. I first registered as a general nurse in 1989 and a midwife in 1991 and have worked as a nurse and a midwife throughout my career. I worked as a Midwife at Queen Charlottes and Hammersmith Hospitals from 1991 until 1993. I completed my BSc Hons in 1993 at the University of the West of England,

Bristol. On completion of my degree, I worked as a Charge Midwife at Ashford Middlesex Hospital from 1994 and 1995 before returning to work at Queen Charlottes I worked within the one-to-one midwifery scheme. From 1997 – 2001 I worked in both practice education and risk-management/clinical governance and part-time as a Nurse advisor within NHS Direct prior to moving to Edinburgh in 2001.

In 2001 I worked part-time in Bupa Health care before taking up the post of Team Leader in Edinburgh East Community Midwifery Team. In 2003 I was appointed Principal Midwife in Edinburgh Royal Infirmary. In 2005 I was appointed chief midwife/nurse for women's services within Women's and Children's Directorate, NHS Lothian, Scotland following a reconfiguration of services. As part of the senior management team my remit included Maternity (Hospital and Community), Gynecology, Infertility, and neonatal services across NHS Lothian, also during this tenure my portfolio included chief nursing responsibility for the Department of Clinical Neurosciences. In 2015 I assumed the chief nurse role for the Edinburgh Health and Social Care Partnership and Integrated Joint Board. This role included responsibility for community mental health and learning disability nursing, older people's nursing and hospital services, district nursing, rehabilitation services including the brain injury unit and sexual health service. From Jan 2018 to March 2022, I worked as a professional nurse advisor within the Chief Nursing Officer Directorate, Scottish Government where my portfolio included Transforming Nursing, Midwifery and AHP roles, care home and community nursing, and the review of the Framework for Clinical and Care governance for Integrated Joint Boards. I was appointed Chief Nursing Officer for the Department of Health for Northern Ireland in March 2022.

21. The CNO is supported in the delivery of their duties by the CNO Group, which comprises regulated professionals in the form of Nursing Officers covering the range of fields of nursing, Midwifery Officers, and Allied Health Professional Officers. These professionals are appointed based on their skills and expertise in the areas they cover.

22. My Deputy Chief Nursing Officers (DCNOs) and (broadly) NICS Grade 6 equivalents, while able to provide significant support across the wide range of professional issues arising, each carry specific responsibilities as noted below, as well as taking on additional responsibilities in response to the pandemic. These are described throughout this statement.

    a) **DCNO Workforce and Education:** This role involved the provision of professional advice on all matters relating to nursing workforce, education, and regulation,

including policy input as required. A key responsibility within the role is leadership of the regional post registration education commissioning process for nursing and midwifery, including the associated budget. A further element of the role is the professional and administrative oversight for the CNO of the Central Nursing and Midwifery Advisory Committee (CNMAC). The role also requires provision of professional advice and close liaison with the Department's Workforce Policy Directorate on matters pertaining to workforce planning, recruitment, and retention. Additionally, regular communication and engagement with relevant stakeholders including HSC Trusts, PHA, Health and Social Care Board (HSCB) /Strategic Planning and Performance Group (SPPG), Higher Education Institutions, HSC Clinical Education Centre, NIPEC, RCN/RCM, TUS, Independent Sector, the Nursing and Midwifery Council (NMC) and other UK/ROI Professional counterparts.

b) **DCNO Regulation and professional practice:** This involves representing CNOG on professional matters relating to nursing standards of care and practice. The post holder oversees a dedicated professional portfolio of work, providing professional advice across several fields of nursing, including Mental Health, Learning Disability, Older People (to include adult social care, adult safeguarding and care homes, and Emergency and Unscheduled Care). This involves profession and administrative oversight of the CNO Business Meeting. This role requires provision of professional advice and close liaison with relevant Departmental Policy Directorates on matters relating to nursing and midwifery practice, standards of care and transformation. The DCNO is required to facilitate effective communication and engagement with relevant stakeholders including HSC Trusts, PHA, HSCB/SPPG, Higher Education Institutions, HSC Clinical Education Centre, NIPEC, RCN/RCM, TUS Independent Sector the NMS and other UK/RoI counterparts.

c) **Midwifery Officer (MidO):** Working alongside Departmental policy colleagues, the MidO provides professional advice and guidance on matters relating to midwifery, women's health, and neonatal and children's nursing across all sectors. This includes completing a review of Enabling Safe, Quality Midwifery Services and Care in Northern Ireland, contributing to the development of a new Midwifery and Neonatal Strategy, work around the commissioning of Abortion services, implementation of Nursing and Midwifery Task Group recommendations, creating

a Nursing and Midwifery Quality Assurance Framework for NI, and progressing the Continuity of Midwifery Carer Programme.

NB: at the outset of the pandemic the MidO role was graded at broadly NICS Grade 7 equivalent, but due to the increasing complexity of the duties required as the pandemic progressed, I agreed a temporary regrading to broadly NICS Grade 6 with effect from 1 September 2021, and in August 2023 instigated a formal process of regrading which was formally confirmed in December 2023. The current post holder is now styled Chief Midwifery Officer.

d) **Chief Allied Health Professionals Officer (CAHPO):** Reporting to the CNO, the CAHPO is professionally responsible to the Minister and the Permanent Secretary and other senior members of management, for advising on all matters affecting the care of patients and service users by the AHPs based in hospitals, primary and community care settings. The CAHPO holds responsibility for interfacing with other departments, agencies, and community/voluntary sector organisations on AHP matters which impinge on their organisations. This includes strong engagement with Healthcare Professionals Council (HCPC) on behalf of the CNO. During the pandemic period, the CAHPO took a lead in managing the increasing access to the workforce of AHP students, and this required significant liaison across the 14 AHP professional bodies.

23. Supporting those regulated professionals is a small team of Departmental Northern Ireland Civil Service (NICS) officials who provide support in the development of policy along with advice and guidance on the processes applicable for working in a significant Government Department such as the Department of Health, and the delivery of robust Machinery of Government support for Ministers and senior officials.

24. As CNO, I was a member of the Department's Top Management Group (TMG), and by extension of Health Gold Command and the Strategic Cell when they were stood up during the Covid-19 pandemic. I provided nursing and midwifery leadership and expert advice, working alongside the Chief Medical Officer (CMO), the Deputy Secretary in Healthcare Policy Group, and the Covid-19 Strategic Surge Planning Director as a leadership group within the Strategic Cell, coordinating the Department's policy input to the surge planning approach for the health service. This leadership group worked closely with the PHA Chief Executive, HSCB Director of Commissioning and the five HSC trusts to ensure that the development of the Department's policy was responsive to the evolving situation within HSC Trusts and fully

informed by expert medical and nursing and midwifery advice provided by the HSCB and Public Health Agency.

25. This was particularly relevant for me in respect of our approach to IPC and PPE, requiring a close working relationship with the IPC cell as well as working with the critical care network senior nurse and medical clinicians.

Governance Arrangements during the initial pandemic response period

26. The role of CNO, in response to the emergency is described in the Department's Emergency Response Plan ("ERP") (INQ000184662) which was last updated in 2019 and is currently being reviewed. The full range of individual roles, structures, systems, and processes to be enacted in an emergency are defined in the ERP. The ERP describes the roles and responsibilities of Senior Officers and business areas within the Department as well as the roles of various organisations which are expected to play a role in the response to an emergency. The Department's ERP was activated in January 2020 [see INQ000137322 and INQ000137323], with the stand up of the Emergency Operations Centre ("EOC") on 27 January 2020.

27. The EOC, led by the Chief Medical Officer's Group (CMOG), was responsible for managing information flows, producing situation reports (SitReps), and maintaining a watching brief of the incident particularly through monitoring SitReps from Health Silver and the Northern Ireland Fire and Rescue Service. The EOC is designed to operate separately and independently of the Strategic Cell which together with the EOC comprise the Department's Health Gold arrangements. The subsequent activation of the Strategic Cell included the establishment of multiple subject-specific Cells (Groups) focusing on specific areas of response to the pandemic and addressing matters raised by Health Silver. As such, each of the Cell leads provided key leadership to areas of the response and support to the Strategic Cell. All of this required the ability to respond to new and complex emergent issues through the development of new processes, guidance and policies, and the ongoing review and updating of this as new evidence emerged.

28. The principle of subsidiarity applied within these arrangements with the subject specific policy Cells and the respective Cell leads making decisions and only where necessary, or particularly complex, complicated, or cross cutting were such matters escalated to Health Gold Strategic Cell. The respective leads of the subject specific policy Cells played a key role in the pandemic response and its coordination across the health service in keeping with the arrangements outlined in the ERP. As the pandemic response evolved these arrangements were flexed and

scaled accordingly with the addition of further subject specific policy cells and the later development of specific directorates as appropriate.

29. The diagram provided at [INQ000103633] provides the overall organisational structure for Health Gold Command which was comprised of the Strategic Cell and of 13 subject-specific policy cells. This was during the 'Emergency' phase of the pandemic which is one of the scenarios which the Department's Emergency Response Plan (ERP) was developed to address. The decision to activate the Strategic Cell (as part of Health Gold) was agreed at an emergency meeting of TMG on 4th March 2020 [INQ000103631] and it was established on 9th March 2020. The Strategic Cell was a strategic decision-making group, usually chaired by the CMO, and I was a member alongside key policy leads from across the Department.

30. The remit and staffing for each of the linked policy cells is set out in the document at [INQ000103634]. In most instances, these policy cells were chaired by lead officials from the Department's business areas who were also members of the Strategic Cell.

31. By the summer of 2020, it became apparent that the pandemic would be protracted and require an ongoing response of long duration. Therefore, on 12 August 2020 a strategic decision was made by the Department to move from the Emergency Response Plan structures to business continuity arrangements. This strategic decision was taken with the approval of the Minister, and he approved the establishment of a new temporary Management Board for Rebuilding HSC Services. This was known as the Rebuild Management Board (RMB) (INQ000137342) with representative bodies as follows:

    - Department of Health
    - Public Health Agency
    - Health and Social Care Board
    - Business Services Organisation
    - Northern Ireland Ambulance Service Trust
    - All 5 Health and Social Care Trusts

32. I was a member of the RMB, which was chaired by the Permanent Secretary, and I provided professional advice and support and reported on areas of work for which I was responsible. If I was not in attendance due to other commitments including supporting the Minister at the Executive or other meetings, I was, in most instances represented by a DCNO. This Board

remained in place for the duration of my tenure in post, and for the majority of Linda Kelly's tenure as Interim CNO from 4 November 2021.

33. Following an internal review in spring 2022, the Management Board was stood down and replaced by the HSC Performance and Transformation Executive Board which was established in June 2022 as part of the new governance arrangements for the Transformation of Health and Social Care services and the Performance and Transformation Executive Board (PTEB). The integrated Covid-19 Gold Command Group was finally stood down on 4 March 2022 towards the end of the third wave of the pandemic.

Engagement with Departmental and External Colleagues

34. I should be clear that Northern Ireland, uniquely in the UK, operates an integrated model of health and social care provision, reflecting the unique political and societal challenges and priorities of the region and is seen as a way to improve the well-being and quality of life for its citizens. The five HSC Trusts are responsible for providing both health and social care services in their areas of operation. This contrasts with the position in England, Scotland, and Wales, where provision of social services remains the responsibility of Local Authorities. Due to the integrated nature of healthcare in Northern Ireland therefore, and unlike the rest of the UK, my role relates to the provision of nursing and midwifery advice in regard to both the health and the social care sectors, so it would not be reflective of my role to omit reference to social care in addressing the impact of COVID-19 pandemic on the healthcare system in Northern Ireland.

35. I maintained a fully engaged and close working relationship with the Minister, his Private Office, and Special Advisor. The Minister listened carefully to my independent advice and sought out my advice when needed. We discussed complex issues and came to agreed positions in relation to the areas of the pandemic for which I was the lead, for example visiting policy as set out in the relevant section below. There were no unresolved disagreements of any significance.

36. I maintained open and frank relationships with TMG colleagues and other senior officials. In particular, I would note a strong and collegiate professional relationship with the CMO, his team and the Deputy Secretary (Healthcare Policy Group) and the Covid-19 Strategic Director of Surge Planning. As the CNO working with CMO my clinical and operational management experience provided an ability to translate the implications of policy decisions to patients and people using healthcare, as well as to frontline staff, very quickly. This was particularly relevant during surge planning and establishment of the nightingale facilities.

37. As outlined in para 34 above, my role covers policy advice related to both health and social care sectors. From early on in the pandemic I worked very closely with the Chief Social Worker and his team, providing strong clinical and nursing advice and interventions in relation to social care. An example of this was leading the development of training videos and materials for health and social care workers in donning and doffing where I personally recorded the correct techniques by video, which was made available to all staff, including both domiciliary and care home staff. In my view we worked well as a small team to support each other to resolve complex policy issues, interpret complex scientific information based on the emerging evidence at the time, and at all times acted in the best interest of the public and frontline staff providing services. I often undertook roles, tasks, and actions to get things done quickly and efficiently as part of good team working and supporting colleagues.

38. Alongside the Chief Social Work Officer, I co-chaired the Adult Social Care Governance - Surge Planning COVID-19 Working Group (INQ000103715) (the Working Group). This group was established, by invitation issued on 10 August 2020, to consider and coordinate the various strands of ongoing work connected to COVID-19 across adult social care including care homes, domiciliary care (home care), supported living and all learning disability services. Its membership was drawn from across the HSC, with representatives from the Department, the PHA, and the HSC Board (now SPPG).

39. As part of its work, the Working Group focused on ensuring agile and robust plans were in place to effectively deal with any second wave of COVID-19. The Group's remit, which was at all times led by the science, considered issues around:

- Community transmission.
- The monitoring data in relation to care home outbreaks and taking early preventative action where necessary.
- Co-morbidities.
- Winter flu season.
- Testing plans including for those who are asymptomatic.

40. As well as oversight of HSC Trusts' and regional plans, the Working Group drew upon the learning identified through the Rapid Learning Initiative (INQ000276404) (see paras 319-322) and considered learning which might be initiated in other areas such as domiciliary care, the clinical support framework and issues concerning discharge.

41. The Working Group also considered the effective allocation and targeting of funding to ensure the sector could be fully prepared and best placed to deal with any second surge of COVID-19 should it arise. Focusing on Workforce issues, IPC control issues and service resilience, it sought to ensure that all key areas were aware of each other's COVID-19 funding bids and ensure a coordinated approach.

42. Noting the crucial need for clear, concise, accurate communication, the Working Group also linked into the Rebuilding HSC Services Strategic Framework, providing monthly reports to the Rebuilding HSC Services Management Board.

43. Across the UK, in each jurisdiction the CNO provided independent advice to their respective Ministers whilst working together on public health policy, generating evidence, and independently advising respective Ministers as decision makers. CNOs provide collective leadership and guidance to their professions across the United Kingdom on a range of clinical and professional matters. My actions and decisions were also informed by my attendance at the UK CMO/CNO joint clinical meeting chaired by Professor Sir Chris Whitty.

44. The UK Senior Clinicians Group provided a forum for discussion and sharing of papers and research from within the UK and around the globe touching on almost every conceivable aspect of our response to Covid-19 including provision of critical care, PPE, Guidance, Care Homes, Testing and Tracing, periods of infectiousness, isolation periods etc.

45. As mentioned previously, the UK and RoI CNOs already had an established forum. During the pandemic, this forum became a shorter and more regular meeting to share information and make national nursing and midwifery decisions. At the start of the pandemic our meetings became 'as required,' frequently daily or several times a week and often at night or on weekends. Where relevant, we moved these meetings to weekly. Over the course of 2021, the meetings were weekly then bi-weekly in the latter half of the year. Notes of these meetings were normally taken and held by colleagues from CNO England's office.

46. Enhancing and supporting the workforce was a key focus early in the pandemic and details of this are set out below, including discussions with the NMC regarding the temporary register. Work on emergency standards options and decisions for third year nursing and midwifery students to spend significant time on clinical placement and entering the workforce earlier than expected is also set out below. Each CNO provided a country update and verbal sitrep type report. Other areas discussed included emerging new evidence on IPC and vaccination. For example, on 1 October 2021 we discussed a concern over vaccination rates for pregnant

women with me describing steps taken through social media in NI to encourage pregnant women to come forward as a possible helpful intervention.

47. In relation to my relationship with the Chief Nursing Officer for Ireland, the CNO (RoI) was a member of the 5 country CNO group described earlier.

48. With regard to co-operation across the island of Ireland, we continued to liaise on an ad hoc, informal basis to discuss professional and cross border issues, appraising each other of developments as appropriate. We shared information in relation to the provision of nursing and midwifery care and at times our thinking on increasing the workforce supply issues. Where the provision of ICU beds was close to capacity, I liaised with my counterpart in the event of requiring mutual aid or the transfer of patients across the border. This was in the context of the signed MoU outlined below which, while agreed, was never required.

49. A Memorandum of Understanding on Public Health Cooperation on Covid-19 Response between Departments of Health, North and South, was agreed on 7 April 2020 (INQ000371487) and areas of collaboration are outlined below. These areas were discussed, and relevant information was shared, at the regular CMO meetings. While Ministers made the final policy decisions on a number of areas of cooperation and information sharing, all relevant areas would also have been routinely discussed at bilateral Ministerial meetings between the Health Minister in NI and his counterpart in the RoI. There was routine sharing of information between NI and RoI, including:

- Work on the border areas.
- Sharing data and research.
- Sharing of learning from vaccine deployment in NI.
- Sharing of information on the approach to care homes.
- Regular sharing of respective epidemiology situation; and
- Agreement regarding mutual aid in respect of Intensive Care, and health service capacity

Professional Engagement

50. Given the CNO's role as head of profession for nurses and midwives in Northern Ireland, a key approach is that of ensuring consultation, co-operation, and co-production with a range of

senior leaders across the profession here. Aside from normal, regular line of business contacts around specific issues as they arise, this is facilitated via two main formal means:

- The quarterly Central Nursing and Midwifery Advisory Committee; and
- The monthly CNO Business Meeting

51. The Central Nursing and Midwifery Advisory Committee (CNMAC) was established under Article 24 of the Health and Personal Social Services (Northern Ireland) Order 1972. It is thus a statutory advisory body whose function is to advise the Minister and the Department through me as CNO on matters concerning nursing and midwifery in Northern Ireland, including those matters relating to the regulation and education of the profession and the safety, quality, and experience of patients/service users. CNMAC can also provide advice in relation to policy development and the implications for nursing and midwifery practice. That advice is expected to be responsive to the contribution that nurses, midwives, and support staff can make to the delivery of health and social care services, while maximising resources for success and supporting learning and development.

52. The position of Chair of CNMAC is held by me as CNO. The Department and/or CNO may ask CNMAC to undertake specific tasks, whether commenting on major consultative documents or deliberating on wider professional topics. This advice forms a key component to the continuing development of services to meet the needs of patients and the public throughout Northern Ireland. CNMAC may also initiate matters to be brought under consideration including the identification of appropriate areas for research and development and/or policy development to improve practice, patient experience, and outcomes. It should be noted that CNMAC provided a forum for engagement, and through its membership facilitated communication to be cascaded across the system – while CNMAC continued to function as per its TORs, it was not charged with undertaking any specific tasks related to the pandemic during the period covered by this statement.

53. The Chair and members of CNMAC are formally appointed by the Minister of Health, with most members, including CNO as chair, being appointed due to their position held (ex-officio). The remaining members are appointed following a selection process. Membership (INQ000437953) is representative of nurses and midwives in practice, education, research, and management roles from a range of care settings. Members are appointed for their knowledge and experience and membership of CNMAC is designed to reflect a spread of expertise. It is important to note that the Royal College of Nursing and the Royal College of Midwives both have representatives on CNMAC, and this strong relationship enabled a strong

level of communication and cooperation on all aspects of the nursing and midwifery response to the pandemic.

54. CNMAC was supported by a Strategic Workforce & Education (SWE) sub-committee, with CNMAC Members invited to serve on that sub-committee to advise on relevant issues or on specialist committees to respond quickly and authoritatively to the need for specific advice as identified by CNMAC. For example, the SWE sub-committee discussed the most prevalent workforce and education issues facing the sector during the pandemic to facilitate a regional coordinated response, including matters such as student placements, international recruitment, and safe staffing. At the time there was also a focus on the imminent launch of the Nursing and Midwifery Task Group report, launched on 10th March 2020, but the implementation of this was subsequently delayed by the focus on the response to the pandemic. Midwifery issues were also considered and reviewed by CNMAC, and in September 2021, it was formally agreed to establish a Strategic Midwifery sub-Committee, to enable a specific focus to be aimed at issues in Midwifery practice arising from the pandemic, including the impact of restrictions on women being supported at appointments and during labour and birth, the temporary closure of Midwifery Led Units, as elaborated in the ***Midwifery and Children's Services*** section below.

55. The meetings (INQ000437954, INQ000437955, INQ000437956, INQ000437957, INQ000437958, INQ000437959, INQ000437960, INQ000437961, INQ000437962, INQ000437963, INQ000437968) were generally held quarterly and during the pandemic this continued. The focus of the meetings continued to be on wider professional issues and included regular updates on NMTG report, perioperative nursing project, regional review of urgent and emergency care, a regular NMC update as well as education and workforce issues. However, CNMAC was also a forum to brief colleagues on COVID- 19 issues including development with COVID- 19 Vaccination programme and to hear of any concerns from the group, for example around visiting and IPC measures.

NB: the document exhibited as INQ000437959 is inaccurately titled in the Departmental record – it intended to, and does, refer to the minutes of the meeting of 21 September 2021, while the titling of the document incorrectly suggests it refers to the 25 June 2021 meeting.

56. The Chief Nursing Officer (CNO) Business Meeting has been a long running, regularly scheduled means of convening Nursing and Midwifery leaders from across Northern Ireland's Health and Social Care (HSC) sector with the CNO and CNO team in the Department of

Health. It was established in recognition of the requirement for such leaders to build and maintain close working relationships, to achieve system wide Nursing and Midwifery engagement and collective decision making on nursing and midwifery policy and professional practice as well as discussions on my strategic priorities as the CNO. It is a forum for sharing and learning and has a strategic focus rather than operational. It is important to note that Directors of Nursing remain accountable to their boards for safety, quality, and effective governance in line with the accountability framework. However, the identification of key issues effecting the profession may have both operational and policy implications such as recruitment and retention. The CNO Business Meeting allows me to regularly meet with senior nursing leadership from across the HSC as it was normally attended by the Executive Directors of Nursing in each of the HSC Trusts, the Director of Nursing in the PHA, the Head of CEC, the CEO of NIPEC, alongside, my DCNOs, the MidO, with support as necessary from my NICS team.

57. In April 2022, in recognition of the close working relationships between the professions and Allied Health Professionals (AHPs), the decision was taken to ensure AHP leadership representation at all future meetings by extending membership to the DoH Chief AHP Officer and widen inclusion to nursing leadership from Northern Irelands Ambulance Service and RQIA.

58. The Department of Health and CNO may ask members to comment and provide advice on major consultative documents or deliberate on wider professional topics. This advice forms a key component to the continuing development of services to meet the needs of patients and the public throughout Northern Ireland. CNO Business Meeting members may also initiate matters to be brought under consideration.

59. The CNO business meetings were generally held monthly during the pandemic. The focus of the meetings continued throughout this time on wider professional issues such as progress on the implementation of the Delivering Care Policy, on workforce support and retention, education commissioning and continued focus on learning and service development. However, CNO Business meeting also served as a forum for collaborative discussion and agreement on COVID-19 professional issues such as COVID-19 vaccination and testing programmes, implementation of restricted visiting guidance, emergency standards, student placements and emergence from the pandemic. The format of the CNO Business meeting enabled collective decision making and information sharing through facilitating all members contribution to agenda.

60. There are many examples of shared decision making between me as CNO, the Trust Directors of Nursing, and other senior nursing and midwifery leaders from PHA, CEC and NIPEC. Following discussions with colleagues in March 2020 the decision was taken to temporarily stand down the regional reporting of Trust safety KPI compliance, to the PHA, with the agreement that Trusts would continue to put in place local governance processes as required (INQ000437975 and INQ000437976). This decision was kept under review and following assurance provided via a monitoring exercise of the outcomes in falls and pressure ulcer incidents I was sufficiently confident in the effectiveness of the temporary arrangements that I made a further decision following the CNO Business meeting in November 2020 (INQ000437989) that the suspension of regional monitoring should continue whilst Trusts would ensure their local governance processes continued. Whilst I provided correspondence to HSC Trusts that reporting of KPIs to PHA could be stood down due to the pressures, it is worth noting that some HSC Trusts did continue to report to PHA throughout. KPI reporting was resumed by all Trusts in late 2021.

CNO liaison with RCN/RCM

61. Throughout the pandemic period, as was the case before and subsequent to it, I, along with my professional team, as well as the CMO, maintained significant contact with colleagues in the Royal College of Nursing and the Royal College of Midwives as required. As detailed above, representatives from both were involved in the CNMAC meetings where information was discussed, and professional bodies had an opportunity to raise concerns. Both Royal Colleges frequently corresponded with both me and the Minister about issues of concern as the pandemic response progressed, in the same way as would have been the case before and since. For example, on 19 June 2020 Pat Cullen, the then NI Director of RCN, contacted me to raise queries around a draft statement issued by the Department in relation to a PPE fit testing issue. In response, I advised that the guidance had since been superseded and that the Department had commissioned the PHA to bring forward a regional fit-testing assurance framework to ensure all fit testing was standardised across the region.

CNO / PHA Nursing & Midwifery Huddle Group

62. At the outset of the pandemic I, Charlotte McArdle as the Chief Nursing Officer (CNO) established a CNO's nursing and midwifery huddle group which included the Trust & PHA Directors of Nursing, Head of CEC, and Chief Executive of NIPEC. On the occasions that I was not available to attend, this huddle was led by the Director of Nursing in the PHA who subsequently shared outcomes with me. This provided an opportunity to discuss key

challenges, such as a SITREP critical issues report from Silver, surge plans, Infection Prevention and Control, and students and returners registering. Regularly discussing these key issues ensured all attendees remained informed on the most up to date guidance and facilitated the coordination of efforts in combatting the impact of the virus on patients and the healthcare system. The huddle met regularly, and in the initial stages, often daily/twice daily, later at least weekly, and then on a less frequent basis as necessary from April 2020 to December 2021, as part of the joint professional response to the pandemic. There is a significant volume of minutes of these meetings, held by colleagues in PHA, which can be provided to the Inquiry upon request, but examples of those involving visiting discussions are attached (INQ000475218, INQ000475219, INQ000475220, INQ000475221, INQ000475222)

63. The huddle was a vehicle which allowed senior leaders to discuss guidance around the pandemic response which was often issued at pace. It allowed for identification of any operational difficulties, for example the application of restrictions to visiting across a range of different settings and allowed for further clarification on the guidance as needed.

CNO Support for the well-being of the workforce

64. Along with my colleagues in the Department I was acutely aware of the profound impact of the pandemic from regular engagement with senior leaders within health and social care. This included knowledge of published research of increased rates of anxiety, depression, psychological distress, post-traumatic stress symptoms and burnout (for example Greenberg et al 2021[1]). Throughout the pandemic response my UK CNO colleagues and I communicated in writing and via video (INQ000438020 and INQ000438021) our support to the nursing, midwifery and AHP professions. Similarly other Chief Professionals including the 4 UK CMOs did likewise with colleagues in the medical and other related professions.

65. In addition to this, on 19 April 2020, Minister Swann launched a new framework which set out a range of practical measures to protect the psychological health and wellbeing of HSC staff and volunteers during the pandemic (INQ000353599). The Framework was based on evidence and best practice guidance and set out how the well-being of health and social care staff would be addressed as a key priority throughout the ongoing COVID-19 pandemic.

[1] N Greenberg, D Weston, C Hall, T Caulfield, V Williamson, K Fong, Mental health of staff working in intensive care during Covid-19, Occupational Medicine, Volume 71, Issue 2, March 2021, Pages 62–67, https://doi.org/10.1093/occmed/kqaa220

66. A member of my team represented CNOG on the Regional Workforce Wellbeing Network which was established in April 2020 when the potential impact of Covid-19 on the wellbeing of the NHS workforce was becoming evident. This group was tasked to oversee service delivery and to review the implementation of the Framework. The implementation of the Framework continued throughout the pandemic, providing a range of initiatives across HSC organisations to enhance psychological wellbeing of staff. These initiatives included access to Psychological Support Helplines staffed by psychologists. This support was extended to care home and primary care which signposted to a broad range of online resources and drop-in services in critical facilities.

67. The recommendations of a UK Study on staff health and wellbeing undertaken jointly by Ulster University and Queens University Belfast were presented to CNMAC on 12th March 2021 (INQ000438023). The UK wide study took place over three data collection cycles. The authors drew on conclusions and shared good practice recommendations for employers during the pandemic. Of particular note was the reported impact of the pandemic on mental wellbeing of the workforce, with 19.79% of the workforce reporting that they felt overwhelmed by increased pressures, and all professions reporting that their overall quality of life had decreased. Other findings included that respondents appeared to be using positive coping strategies less and negative coping strategies more and that burnout scores were highest for respondents who felt overwhelmed by increased pressures as a result of the pandemic. Good practice recommendations included:

- To offer flexibility around working hours and location - including working from home if possible
- To provide clear and relevant communication as and when needed and avoid overwhelming staff with irrelevant emails
- To flatten hierarchies for decision-making and trust that staff are accountable and can get on with their work
- To provide the means for connection with colleagues and managers
- To maximise visibility of management, either in person or virtually
- To take staff's altruistic concerns for patient wellbeing while services disrupted on board, and provide support

68. I noted these ongoing concerns and engaged in discussions with professional bodies to identify solutions across all staff irrespective of factors such as sex, age, ethnic or socio-

economic background or disability. Unfortunately, no substantive minutes of those discussions are available, but I do recall that the Thrive programme was a significant outcome from them.

69. Whilst I was not directly involved in decisions around staff deployment or redeployment (which would have been the responsibility of employing bodies), through my close communications with senior nurse leaders and front-line nursing staff I was aware of the impact on staff. Many had been redeployed into high-risk settings from their normal duties and so were dealing with the reality of the pandemic, concerns for their own families' safety, and their own well-being. I was aware of the need for additional skills and support, and this is expanded upon below. In response to emerging findings on the impact of COVID-19 on the psychological health and wellbeing of staff, I sought expert advice from Regional Trauma Network and took a briefing paper to Gold on 5 November 2020 (INQ000438024), seeking agreement at Gold Command to provide more intensive support on pilot basis at the Belfast HSC Trust.

70. This proposal included the implementation of a further step 4 of the Supporting the Well-being Needs of our Health and Social Care Staff during COVID-19: A Framework for Leaders and Managers. This was unanimously approved, and a decision was subsequently taken by Gold to pilot the proposal BHSCT ICU services. This pilot (which became known as Thrive) launched on 24 May 2021 was a confidential specialist psychological therapy service tailored to meet the needs of staff who had worked in HSC during the pandemic. Thrive was an enhanced occupational health service ensuring that staff who may benefit from specialist psychological support and therapy could do so. In the first instance Thrive was accessible to all staff who worked in the intensive care/nightingale during the pandemic

71. All staff employed in BHSCT ICU settings during the pandemic were sent an internal email which provided a short explanation of the new Thrive service and an access link to a short confidential self-assessment questionnaire, which was also available online, and comprised of standardised assessment measures. Staff accessed and completed the questionnaires only if they wished to do so. Completed questionnaires were sent to a confidential email address at occupational health and then reviewed by a clinician with appropriate experience who then contacted the staff member to arrange a discussion and onward referral to specialist psychological services. It included all redeployed staff from any Trust. As of 23 February 2022, it had received 180 self-referrals from staff working in ICU in BHSCT.

72. The pilot was developed and implemented in partnership by a small working group from BHSCT, HSCB and DoH, using a co-production approach, informed by emerging evidence.

The service monitored for emergence of psychological disorder and, where indicated, offered more intensive interventions, using empirically validated treatments.

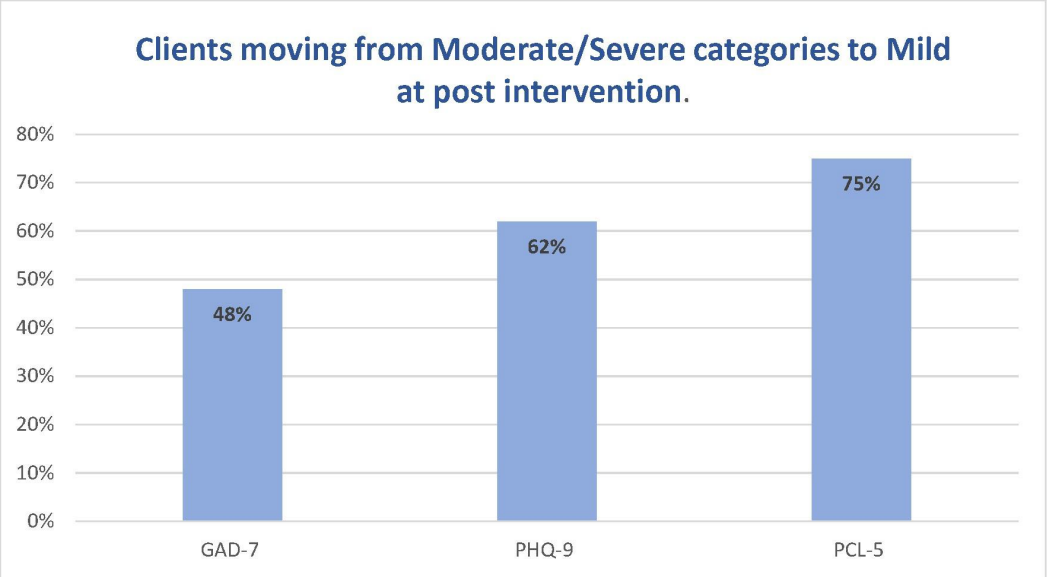
73. Thrive was coordinated by existing occupational health services in partnership with other services including the regional trauma network. This service was incorporated into existing occupational health services to reduce stigma associated with mental ill health and promote parity between physical and mental health services for staff.

74. A breakdown of BHSCT professions who self-referred is included below:

- Nurses (including Health Care Assistants (HCAs) – 135
- Medical staff – 21
- AHPs – 28
- Support services staff – 2
- Admin – 3
- Students - 1

75. A person was considered to have "recovered" if they were a clinical "case" at the start of treatment and not a clinical "case" at the end of treatment. "Caseness" is a term which denotes that a person has clinically significant symptoms of depression or anxiety (or both). Individuals who were rated as moderate or severe on the screening measures were considered to be a clinical "case" and recovery was defined as moving from this category to a mild category.

76. The below graph, taken from the Regional Thrive Progress Report May 2021 – October 2022, shows that 48% of those who self-reported Generalised Anxiety Disorder 7 (GAD 7), 62% of



those who self-reported depression symptoms (PHQ-9), and 75% of those who self-reported presence and severity of PTSD symptoms (PCL-5) recovered post intervention.

77. Thrive therefore demonstrated success in both reaching significant numbers of ICU staff in distress, and in delivering timely and appropriate interventions which reduced levels of symptomatology.

78. In Executive papers the Minister reflected his concerns and those of Departmental officials including myself about the impact of the pandemic on health and social care staff. In an urgent written statement on 30 October 2020 (INQ000438033), the Minister reported to the Assembly that while he welcomed the plateauing of cases, due to recent Non-Pharmaceutical Interventions (NPIs), he also warned against complacency because of the potential adverse impact on the HSC system and its staff who remained under intense and unprecedented pressure.

79. The welfare of patients, both Covid-19 and non-Covid-19, and of staff, continued to be my overriding priority. The welfare of staff was at the forefront of the Minister's consideration as next steps for NPIs after 13 November 2020 were considered by the Executive. At this stage, many staff were physically and mentally exhausted. The peak of the combined HSC staff absence due to sickness, Covid-19 sickness, and Covid-19 -related self-isolation during the first wave of the pandemic was in the April-June 2020 quarter. While I do not have complete figures on the numbers of staff who were absent, it was reported that 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.

80. My response was to ensure that effective actions were taken to address the increased pressure on staff and staff levels. My DCNO worked very closely with colleagues to relaunch the Workforce Appeal on 2 October 2020. I personally made several direct appeals to staff through press statements and media interviews to encourage staff to join the workforce. These were in addition to the multiple occasions where I issued letters of thanks and encouragement to the nursing and midwifery workforce, as well as filming video messages for sharing on social media (INQ000438020) & (INQ000438021) in a similar vein. I do recall that in around October 2020 I contacted the CNO in Ireland to seek assistance around staffing in our ICUs; she was unable to provide access to any staffing resource but upon discussion with her Minister, she did confirm willingness to accept patients on transfer if necessary. Ultimately, we did not take

up this offer, as our own provision, thankfully, proved sufficient. Further I recall an informal conversation with CNO England around her capacity to help us in terms of temporary loan of staff. While I cannot recall the exact date of this conversation, I do recall that she was not able to accede to this.

81. Further to these approaches, I also worked to increase the available workforce to support existing staff. An initial Workforce Appeal, in March 2020 (INQ000371476), resulted in 1,702 nurses, midwives, doctors, and other ancillary staff being successful in their application to work for the health service. From April 2020, and throughout the second wave, the Workforce Appeal handled almost 60,000 Expressions of Interest, and generated over 35,000 formal applications. This level of interest delivered a total of 5,949 new temporary appointments across the HSC of which almost 2,800 were health and social care appointments in various disciplines. Of the almost 2,800 appointments 447 were Nurses & Midwives; over 1,353 were Nursing Support and 216 were Allied health Professionals.

82. The Workforce Appeal also commenced work in recruiting for the vaccination programme with a total of over 1,700 applications generated leading to 271 healthcare professionals being appointed to the vaccination programme and available to cover shifts as and when required by the Public Health Agency.

83. The level of appointments made by the Health and Social Care 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 Health and Social Care 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 Health and Social Care Trusts through the pandemic.

84. 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.

Military Assistance

85. With robust business continuity and flexible emergency planning arrangements in place DoH is expected to manage most crises without the need for military assistance. However, it is recognised that in certain situations, where all other avenues have been exhausted, DoH can then request military assistance from the Ministry of Defence (MoD). It must be understood however, that this is merely a request – there is no guarantee that any military support or assets will be released. When a Military Aid to the Civil Authorities (MACA) request has been made and agreed, Military personnel can provide invaluable support in an emergency or crisis situation.

86. Given the severity and scale of the national, indeed worldwide, emergency arising from the impact of the pandemic, a number of decisions to activate Military Aid to Civil Authority (MACA) were made. Examples of this included use of military transport to transfer a small number of patients who required ECMO (extra corporeal membrane oxygenation) to a specialist unit in England (INQ000375567). These transfers were discussed and agreed by clinicians here and in the specialist unit, since there were no beds with the agreed specification available in NI and no commercial providers with the appropriate equipment to transfer the patient, leaving MACA as the only option available.

87. I am aware that in total nine Covid-19 patients were transferred to specialist hospitals in Great Britain from 27 April 2020 to 8 December 2021, as follows:

- Patient 1: 27 April 2020 – military transfer;
- Patient 2: 11 May 2020 – military transfer;
- Patient 3: 3 June 2020 – military transfer;
- Patient 4: 6 June 2020 – military transfer;
- Patient 5: 16 June 2020 – military transfer;
- Patient 6: 31 January 2021 – military transfer;
- Patient 7: 23 June 2021 – military transfer;
- Patient 8: 20 August 2021 – Coastguard transfer; and
- Patient 9: 8 December 2021 – Coastguard transfer.

88. Recognising the need to secure additional support for the workforce, in particular those ICU settings which were under significant pressure, I commenced work with colleagues to seek to secure assistance through the use of additional military personal known as Combat Medical Technicians (CMTs), delivered through further MACA request in January 2021 (INQ000185423). The HSC was under severe and sustained pressure arising primarily from rising demand due to COVID-19 hospital admissions. At the time of the submission there were 809 COVID+ inpatients in hospital across the system and there were 56 COVID+ patients in ICU. Modelling suggested that this situation was likely to deteriorate over the coming weeks.

89. At the same time, I was aware that over 600 staff were absent across all our Trusts due to COVID-19, with over 800 other Trust staff recorded as absent due to self-isolation. In total, there were almost 500 nurses or midwifery staff absent either due to COVID-19 or self-isolation, and while I do not have access to comparative data, it is clear that these additional staff absences, added to the normal absence rates and the significant ongoing vacancies, impacted heavily across the system, particularly in nursing.

90. Discussions with military liaison suggested that Northern Ireland could potentially access a substantial number of Combat Medical Technicians (CMTs) to assist across the system. CMTs are trained to provide basic lifesaving skills and medical support and could be used to support existing nursing staff. CMTs worked as senior nursing assistants under the supervision of a registered nurse. They provided comfort care to patients and assisted with personal care, carrying out roles such as monitoring vital signs, nutrition and hydration and offering key supports in ICU.

91. Following engagement with Directors of Nursing, we asked for a total of 110 CMTs to be deployed as follows:

- Belfast City Hospital: 50
- Ulster Hospital: 20
- Antrim Area Hospital / Whiteabbey: 40

92. At a sign off meeting on 20 January 2021, MOD officials agreed to put final preparations in place to start deployment of CMTs with effect from Monday 25th January in consultation with me and my team (INQ000400872).

93. In March 2021, I also led on the subsequent further MACA request (INQ000416453) for support in the delivery of the vaccination programme. I had assessed that since Northern

Ireland's COVID-19 vaccination programme would be in a position to rapidly accelerate at that time, with the expectation that it would be able to ramp up significantly in the period from the end of March to the end of the summer, some additional expertise and assistance would be required in order for the province to achieve its regional vaccination requirements.

Capacity / Surge Planning

94. Between late January and April 2020, the Health Service faced a rapidly evolving and uncertain environment as the outbreak of Covid-19 spread rapidly to become a pandemic. I understand that Health Silver wrote to Trusts on 10 February 2020 regarding managing patient flow at both containment and surge phases of Covid-19. This correspondence requested nominees from Trusts for each of the Continuity / Surge Planning Support Groups which were being convened, by Health Silver, to support a coordinated approach to strengthen the capability of Health and Social Care to respond to the impact on health and social care of any surge associated with Covid-19.

95. Sufficient healthcare capacity in terms of beds, and in particular the availability of respiratory and ICU capacity to care for those requiring respiratory support and ventilation, was a significant concern. On 1 March 2020 there were 88 critical care beds in Northern Ireland. There were a further 18 cardiac intensive care beds and 12 paediatric intensive care beds.

96. The Chief Medical Officer anticipated that it was likely that Health Gold would be leading the strategic policy response to the surge and giving direction to the regional coordination of the response to the surge. Therefore, to facilitate the enhanced strategic management of the surge, the Chief Medical Officer asked the Deputy Secretary, responsible for the Department's Healthcare Policy Group, and me (Charlotte McArdle) as the Chief Nursing Officer to assist him with the coordination of the Department's policy input to surge planning for the health service.

97. The Deputy Secretary of the Healthcare Policy Group immediately established a Covid-19 Strategic Surge Planning Directorate to provide leadership to the Surge Policy Cell of the Emergency Operations Centre and report into the Strategic Cell. This new Directorate was headed by a dedicated Director at Senior Civil Service Grade 5 level.

98. On 3 March 2020, I understand that the Deputy Secretary of the Healthcare Policy Group emailed the Health and Social Care Board's Director of Commissioning to inform her that the Chief Medical Officer had asked him to oversee the Department's policy input and coordination to Health and Social Care surge planning covering workforce, primary and secondary care.

The Deputy Secretary proposed that, as the Health and Social Care Board's Director of Commissioning was leading on surge planning at Silver level, it would be useful to have an early meeting to scope out and agree the lines of communication and arrangements for engagement. I recollect that daily action logs were completed, but these were not routinely copied to or held by my team.

99. There followed intensive engagement between the Department (including myself), HSCB, the PHA, and the Trusts resulting in the publication, on 19 March 2020, of the Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020 (INQ000103714). The Plan summarised the key actions to be taken by the Health and Social Care system from mid-March to mid-April 2020, examples of which are included below, to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period.

    a) With regards to COVID-19 testing, the Department of Health established an expert testing advisory group to consider options to rapidly scale-up testing in order to further increase HSC capacity.

    b) With regards to primary and community care, GP practices optimised the input of other members of staff such as practice based pharmacists and nurses to assist with increased pressures.

    c) With regards to services provided within acute hospital settings, all Health and Social Care Trusts identified additional bed capacity to respond to the needs of people with COVID-19 who needed hospital admission.

100. This was a dynamic plan, which was to be constantly refined considering the emerging issues, and in my view the actions taken adequately prepared the healthcare system for the bed demand expected in mid-March to mid-April, but only due to the efforts of staff in ensuring its success. This also included some staff relocating from home to designated accommodation, working in different locations, and working within different teams with different skill mixes.

101. The Surge Plan was kept under constant review, with several iterations applicable throughout this period as key areas were developed to address the challenges being placed on the system by COVID-19. Changes / developments to key areas included updating the specification of the clinical and technical requirements, identification of optimal sites to increase critical care capacity, the deployment of military personnel, and the establishment of facilities to provide regional relief to all HSC Trusts, such as the Whiteabbey Nightingale facility.

102. The Regional Surge Plan used information provided by the Department's Covid-19 modelling group. This modelling group was chaired by the Chief Scientific Advisor and reported to the Chief Medical Officer. Its functions are described in the Department's corporate statement on Module 3.

103. During the surge period, the four UK CNOs, NMC, RCN, UNISON, CC3N, BACCNUK critical care nursing alliance, Intensive care society and the National critical care network issued a joint statement (INQ000227427) which set out actions needed to make additional critical care capacity available to meet the demand. Examples of the areas the Chief Nursing Officers pledged to support include:

    a) Supporting staff in the development of skills and knowledge alongside their colleagues ensuring a focus on positive health and wellbeing.

    b) A flexible, pragmatic, staged approach to additional capacity in line with national surge escalation plans.

    c) An emphasis on team working and ensuring that critical care leadership in the multi-professional teams was clear and explicit to provide support to staff.

    d) Staff to work outside of their normal practice area, including delivering critical care in non-critical care environments.

    e) The dependence on and support required for returning nurses, recognising that critical care and hospital wards have changed in recent years and that these nurses may have practiced in a very different environment.

104. I recognised that optimum staffing levels and skill mix as outlined in the Delivering Care Staffing Policy (DoH 2014) may be difficult to sustain. Under these conditions, nursing or midwifery staff needed to consider how the 'new team' was managed, using a more task-based approach based on professional judgement to maximise team members' knowledge and skills. Through the NIPEC website and communication platform, advice was provided on using this task-based approach, which allowed for the matching of delegated tasks and duties with the skills of individuals in the team. The NIPEC webpage offered advice on different models of division of workload in the recognition that could be used during these periods, and in times of large numbers of temporary staff, including:

    a) **Total patient care**: one registrant is responsible for providing all care to a particular patient on a shift.

b) **Team nursing**: a team is responsible for providing all care to a group of patients on a shift.

c) **Primary nursing**: one nurse is responsible for planning all the care for a particular patient over the whole episode of care.

d) **Task allocation**: individual members of the team have particular tasks to all patients on the ward each shift.

105. This would require staff to use a risk-based approach to varying staffing levels, by identifying the key risks to patient safety and making them a priority. Therefore, a risk-based approach requires an assessment of risk and an appropriate reaction to those risks. In periods of surge demand where it is necessary to vary the Nurse to Bed Ratio (NTBR) requirements, advice was provided to utilise the 'Safer Nursing Care Tool' in the formulation of a contingency plan. In considering the 'task-based approach' the application of this tool takes account of the complexity and acuity of clinical care needs in specific areas. This meant both, increasing the NTBR and/or decreasing the ratio depending on the skill and experience of the senior/ specialist nurses which will inform the level of support required. As CNO, I did not advise on specific staff to bed ratios however recognized that changes may be required based on specific circumstances presented on a shift. Therefore, principles to support Trusts to use a risk-based approach to varying staffing levels, commensurate with the demands placed on services as a result of the COVID-19 pandemic were provided to the system and hosted on the NIPEC website.

106. Consequently, I wrote to the HSC Directors of Nursing on 22 April 2020 (INQ000438043) to acknowledge that due to the pressures caused by the pandemic surge that they might need to stand down the implementation of the Delivering Care policy framework using a dynamic risk-based approach and using the guidance issued by NIPEC, outlined below in the '*Enabling Professionalism during Covid-19 microsite for Nurses & Midwives'* section.

107. As the then CNO I, Charlotte McArdle, was the Senior Responsible Officer for the planning and implementation of the Nightingale Hospitals at the outset of the pandemic response. My goal was to ensure sufficient critical care beds during surge with the associated medical equipment including ventilators, drugs, and gas oxygen supplies. This escalation in capacity involved significant staff redeployment and reconfiguration of clinical space in hospitals. I led the nursing care response and worked closely with HSC Trusts' Directors of Nursing and the Critical Care Network Northern Ireland (CCaNNI) to agree staff training, redeployment, skill mix and patient care ratios. A Covid-19 Strategic Surge Planning Directorate set up by the Deputy Secretary of Health Care Policy Group (HPG) in May 2020 assisted with the

coordination and leadership to the Surge Policy Cell of the EOC, reporting into the Strategic Cell. The terms of reference for the Covid-19 Strategic Surge Planning Directorate are provided in (INQ000325160).

108. Informed by the reasonable worst-case scenario modelling I, along with the Deputy Secretary of Healthcare, initiated a rapid assessment of potential sites, external to the HSC, on which to locate a Nightingale Hospital facility to provide additional critical care beds if needed. This assessment was supported by officials from Health Estates (Department of Finance), representatives of the CCaNNI, a nursing adviser, and the Military. This work included assessing the Titanic Exhibition Centre, Belfast Harbour Studios, and the Eikon Exhibition Centre at Balmoral Park, Maze, Co. Antrim, as potential sites. I personally visited some of these sites as time permitted.

109. The Department had the ability to activate the UK protocol requesting Military Aid to the Civil Authority (MACA) as referenced above. During April 2020, the Minister approved several decisions to request assistance from the Military, primarily to facilitate transfer of patients for treatment in Great Britain. I was fully engaged with these decisions and took a lead role with the military as well as providing clinical advice and support to the Director of Surge Planning in the preparation of submissions to the Minister. The first decision related to the need to redistribute medical equipment between hospitals across NI to ensure that all hospitals had the necessary equipment including ventilators required to fully enact their surge plans. The second decision related to the provision of technical advice and assistance to explore the potential for the development of the proposed temporary Nightingale Hospital facility.

110. In parallel to the assessment of these external sites for a Nightingale Hospital facility, assessments of options for reconfiguring HSC hospital sites to increase critical care capacity were also underway. I had a clinical key leadership role in negotiating the most appropriate solution and in enabling CCaNNI and the 5 HSC trusts to input to the final decision.

111. Following our assessment (INQ000304951) of the external sites and discussions with the clinical medical, and nursing leads of the Critical Care Network and the Chief Executive of the Belfast Trust, the Belfast City Hospital's Tower Block emerged as the preferred site for locating Northern Ireland's first Nightingale Hospital for the anticipated surge of Covid-19 patients requiring intensive care in the weeks ahead.

112. While the Eikon Exhibition Centre offered the optimum potential for a Nightingale Hospital facility on an external site, the Belfast City Hospital (BCH) Tower Block could be more quickly adapted than the Eikon Centre. This was evident from my visits to both. This factor swayed

the decision in favour of the BCH Tower Block to provide a 230-bed regional facility staffed by a medical and nursing team drawn from across Northern Ireland. I engaged on behalf of the Department with the detailed assessment and plans required to make this option possible and I with the Departmental team obtained the agreement of the chief executives of the HSCB, PHA and HSC Trusts to the preferred site. BHSCT was responsible for the operation of the facility and will be able to provide information on the number of patients admitted and treated at the BCH Nightingale.

113. I remained intensely engaged with the management team of the Belfast Trust on a several times of the day and night basis to oversee the successful operation of the Nightingale hospital. I provided additional nursing support through a secondment of a senior nurse advisor with an ICU background to support the lead nurse in CCANI and the BHSCT with staffing models and training plans. The BHSCT led on the development of the training for redeployed staff and staffing ratio which was agreed and monitored between the BHSCT executive lead, executive director of Nursing and my senior nurse advisor who kept me regularly appraised.

114. On 1 April 2020 (INQ000103653) / (INQ000346769) / (INQ000439817), the Health Minister agreed a submission which advised that immediate action was needed to ramp up surge capacity in the Belfast City Hospital (BCH), and that up to 230 (or potentially 250) ventilated beds could be achieved by gradually folding all other ICUs into the BCH as pressures on capacity increased. I announced this decision at the daily media briefing on behalf of the Minister on 2 April 2020 (INQ000103653].

115. The Covid-19 Strategic Surge Directorate in the Department wrote to HSC Silver and advised that, to meet the critical care bed demand expected, a surge plan would need to be developed which would demonstrate some units down-turning critical care beds in order to create additional capacity on a large regional Nightingale at the Belfast City Hospital Tower Block.

116. I was also aware of the need to provide further Surge plans outside the Nightingale facility should they be needed more urgently for clinical or other logistical reasons, and I worked with the Director of Surge Planning to also include the development of further critical care capacity at Altnagelvin and Ulster Hospital sites as part of a phased approach to the surge plan. Establishing this Nightingale facility would require significant temporary reconfiguration of existing critical care provision across the HSC hospital network. I visited the Nightingale Hospital with the Minister on 7 April 2020 (INQ000371488) in advance of its opening to review progress and show support to the team and lead nurse who was appointed to oversee the critical are capacity. I was extremely impressed by the speed and expertise by which the BCH

hospital team delivered their plans for the additional critical capacity. The facility opened two weeks following the announcement on 2nd April 2020. The Chief Pharmaceutical Officer also worked with British Oxygen Company (BOC), (the largest provider of industrial, medical, and special gases in the UK and Ireland), to ensure suitable oxygen supply to all sites providing critical care. This was monitored very carefully during the surge period by the medicines Cell chaired by the Chief Pharmaceutical Officer.

117. During March and April 2020 critical care units across NI implemented the Regional Critical Care Surge Plan, providing the capability for the system to significantly increase critical care capacity to 198 level 3 beds, close to three times the normal capacity. This escalation in capacity involved significant staff redeployment and reconfiguration of clinical space in hospitals. The Covid-19 related critical care occupancy peaked at 57 patients between the 6th and 11th of April 2020. On the 8 May 2020 as Chair of Health Gold CMO approved the start of planning for de-escalation for critical care across the network. The Department reduced the escalation level for critical care to 'Low Surge.' The Nightingale hospital had not been required to deliver its full capacity and was stood down.

118. On reflection I believe the HSC system worked in collaboration to make the Nightingale Hospital a viable option in line with the surge plan. Whilst it was not used to its full capacity it provided the necessary back up and support for critical care patients and in my opinion remained the most viable option. As a result, I am not aware of major significant issues either in the provision of available ICU beds or oxygen supplies during the pandemic. That is not to say it was easy but as situations arose action was taken swiftly to mitigate the concerns or rectify the situation. There was undoubtedly extreme pressure on critical care, and I am clear that it was only because of the detailed surge plans and the overwhelming response by HSC staff teams were we able to get through the highest periods of surge.

119. 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. I led this work alongside the Director of Surge Planning.

120. I established and chaired a Project Board which recommended that the new facility should focus on step-down provision. I, as part of the project board identified the Whiteabbey Hospital as the preferred option to be put to the Minister. I visited the site to inspect its suitability, and on 1 September 2020, the Minister made the decision to establish the new Nightingale Hospital

following assurances around the legacy usage of the facility. Work on the new facility began immediately, with the NHSCT Board granting approval for the necessary capital works.

121. We, the Project Board instructed Central Procurement Directorate (CPD) to carry out a site analysis, with CPD identifying five potential sites for the second Nightingale facility. Of the five, the Eikon Exhibition Centre and Whiteabbey Hospital site were shortlisted as the two most suitable locations. CPD ultimately concluded that the Whiteabbey Hospital site provided the most affordable and lowest risk option for delivery of a temporary COVID-19 hospital within the required timescales. This was endorsed by the Project Board, with the Minister deciding on 1 September 2020 (INQ000276384) to move ahead with the proposal.

122. NHSCT was responsible for the operation of the facility and will be able to provide information on the number of patients admitted and treated at the Whiteabbey Nightingale.

123. It was recommended by the Project Board and agreed by the Minister on 1 September 2020 (INQ000276384) that step-down facilities should be the focus of the second Nightingale due to the complexity of delivering critical care (oxygen requirements / workforce considerations / diluting resources etc.) and the perceived regional requirements of Nightingale facilities across the UK nations. It was concluded that it was less likely for clinicians to be willing to transfer acute patients to a regional facility, again strengthening the case for developing an intermediate facility. The project board had concluded that although the main pressures on beds would be at the acute level, much of this was due to the need for better flow through the system. Since the development of additional intermediate capacity would improve this flow and free up acute capacity Minister decided that there was no need to reconfigure existing critical care provision because of the decision to establish the Whiteabbey Nightingale, which would provide additional capacity for intermediate care patients, rather than provide additional acute capacity, like that provided at the BCH Nightingale.

124. The Whiteabbey Nightingale was therefore originally established to provide step-down care for Covid-19 positive patients and those recovering from Covid-19. It was intended to be a 100-bed facility, with a phased approach to delivery to allow beds to come online as quickly as possible in light of increases in Covid-19 cases.

125. Twenty-three beds were opened at the facility on 20 November 2020, with this number increased to 28 by mid-January 2021. These beds were all contained in the first unit delivered in phase one. While the capital works on the additional units were completed in early-December 2020, workforce became the key limiting factor to opening additional beds. By the end of January 2021, consideration began to be given to the legacy usage of the facility and,

with occupancy down below 50% by mid-February, efforts to recruit staff for the additional units were paused until the outcome of the legacy discussions were known.

126. NHSCT was responsible for the operation of the facility and will be able to provide information on staff recruitment, deployment, and redeployment at the Whiteabbey Nightingale as well as providing information on the different types of treatment available, the capacity and capability to provide care for patients with COVID-19 or other conditions there. NHSCT will also be able to provide information on how patients were admitted and transported to the Whiteabbey Nightingale.

127. In February 2021, the Minister agreed that (INQ000438048, INQ000438049 & INQ000438051) the Nightingale Project should develop a programme of work to determine and implement legacy arrangements for the Whiteabbey facility, with an initial focus on potential use by fracture, orthopaedic and stroke patients. While the rest of the system was under pressure to rebuild, it was not desirable to have an underutilised (due to falling numbers) Covid-19 facility. Interim arrangements saw Whiteabbey focus on general intensive rehabilitation services for non-Covid-19 patients. The last Covid-19 patient left the unit on 7 April 2021, with the first non-Covid-19 patient being admitted on 9 April 2021. One important aspect of the legacy usage for the facility was retaining the ability to flip-back quickly to Covid-19 usage, should the need arise. This ability was retained until March 2022, although it was never utilised.

128. On 5 January 2021, the Department wrote to the HSC Chief Executives across Northern Ireland (INQ000276393) and advised that, at the Covid-19 Health Gold Command Group meeting on 4 January 2021, it had been agreed that a new command and control structure needed to be put in place to implement a revised Third Wave Critical Care Surge Plan. This would help ensure that collectively NI could deliver the level of critical care likely to be required during the third wave of Covid-19. With professional input from myself and other colleagues this correspondence set out the structure of the Critical Care and Respiratory Operation Hub (CCRoHub) and provided authority for the CCRoHub to strategically manage critical care and respiratory admissions and transfers on a regional basis. I provided daily ongoing professional input and support to the establishment and functioning of the new model. In addition, I seconded a retired senior nurse to further support the operations hub.

129. The Third Wave Surge Plan produced in January 2021 mapped critical care beds between 88 baseline beds and 177 critical care beds through 7 steps incorporating CRITCON levels 0-4. CRITCON is a scoring system to reflect the real time observation and assessment of strain and pressures across an intensive care system, network, or region. Occupancy levels within

Critical Care started to fall in February 2021 and de-escalation plans were put in place to reduce beds. These plans were the reverse of the surge plan. The de-escalation plan resulted in Northern Ireland reducing to its commissioned bed numbers by mid-March 2021. The CCRoHub was stood down formally by the Permanent Secretary at the end of February 2021, however continued to meet until 8 March 2021 to finalise the de-escalation. A small core team continued to monitor critical care capacity and take forward pieces of work. An update on the current position was conveyed at the CNO business meeting in April.

Elective Care

130. At the start of the pandemic widespread community transmission cases rose rapidly leading to the first wave and the health service saw a surge in demand. At this point it was necessary to simultaneously manage rising Covid-19 care demands alongside existing health needs, rapidly scaling up the arrangements for the clinical care of patients requiring hospital care - including intensive care as described in the development of surge plans but also reducing the risk of transmission within healthcare settings. Therefore, as care for Covid-19 patients with urgent and extensive healthcare needs was prioritized, routine and non-urgent services were paused. This enabled redeployment of HSC elective care staff to increase critical care capacity but resulted in the cancellation or postponement across all Trusts of non-urgent appointments, investigations and procedures across outpatients, day case, inpatient, and diagnostic services. The treatment of cancer and other urgent procedures were an exception to this. My role in this was the provision of professional advice regarding the deployment of nursing staff to the Minister, Department and supporting the HSC system to implement arrangements for and coordination of the Covid 19 surge plan which included HSC trusts deployment of staff. An 'Elective Care Framework' (INQ000374049) was published on 15 June 2021 which contained a range of short term, medium term and longer-term actions intended to address a waiting list crisis which at that point had been building up for some seven years. The plans detailed in this document included:

- implementation of "green pathways" with every effort made to keep elected care services entirely separate from any exposure to Covid-19;
- expansion of the elective care centre model with surgeries provided in ring fenced specialist hubs;
- a relentless regional NI-wide approach rather than a disjointed postcode lottery system;

- delivery of mega clinics for outpatient, assessment, and pre-operative assessment clinics;
- improved data, reporting and accountability;
- continued focus on performance management;
- ongoing close cooperation with the independent sector;
- development of in-house HSC capacity including continued investment in staffing and use of temporary, enhanced rates for targeted shifts.

Private Hospitals

131. To compensate for the cancellation and postponement of non-urgent care, I am aware that in his opening Statement (INQ000130411) to the Assembly's Ad Hoc Committee meeting on 15 April 2020, the Health Minister informed members that HSC Trusts were accessing Independent Sector hospitals to treat urgent, non-Covid 19 patients across a number of elective specialties.

132. Contracts with the Ulster Independent Clinic, the Northwest Independent Clinic and Kingsbridge Private Hospital were provided between 1 April 2020 and 29 June 2020 through the HSCB on behalf of the five Health and Social care Trusts. My only other involvement with private hospitals was on one occasion to negotiate the redeployment of their nursing staff into critical care settings, but only when all other options had been explored. This was conducted by telephone to the CEO of one private hospital and while there was a willingness to support the HSC with a call out to all nursing staff ultimately it was unsuccessful as they had no excess of staff to make available to the HSC.

133. I am aware that in the initial stages of the pandemic the Department's Emergency Operations Centre assisted with the coordinated transfer of Covid-19 patients to specialist hospitals in England for extra corporeal membrane oxygenation (a time-critical therapy for advanced respiratory failure that is, by definition, a risk to life). This involved liaison with the Northern Ireland Office and the Ministry of Defence for transfer of these patients by Military transport. The Department also coordinated the transfer of non-Covid seriously ill patients from NI for treatment in specialist hospitals outside the jurisdiction as required. However, I had no significant involvement in the management of these arrangements.

134. The Northern Ireland Critical Care Network, along with the Health and Social Care Board and Public Health Agency, agreed regional criteria for Band 5 - Band 6 uplift for critical care nurses

as an interim measure from 1st October 2020 to March 2021. Similarly, regional criteria for a Band 5 - Band 6 uplift for nurses working on respiratory wards, taking on additional responsibility that could be applied as an interim measure was agreed by the HSC Trusts and PHA during that same period.

135. On 9th December 2020, I sought approval from the Minister of Health to proceed with interim arrangements to progress an uplift from Band 5 to Band 6 Agenda for Change (AfC) payment, to nurses working in critical care and enhanced respiratory wards who met the agreed criteria aligned (INQ000438055) This was in recognition that respiratory and critical care nurses were doubling their responsibility and accountability as registered nurses, over and above those commensurate with their Band 5 pay scale. They were also supervising non-ICU staff some of whom were from other professional backgrounds and meaning they were responsible for more than one patient at a time which is normal practice in ICU. There was regular discussion and update on this item at CNO business meeting and on 25th Sept 2021 recorded in CNMAC that Minster approved extension of band 5-6 until March 2022

Enhancing the Workforce

136. The Covid-19 pandemic placed significant stress on the entire workforce across the HSC in Northern Ireland. In response to the resulting urgent need to upskill the nursing workforce, I wrote to the Head of the HSC Clinical Education Centre (CEC) in March 2020 (INQ000438076), requesting that all non-Covid related education programmes be stood down with immediate effect and that CEC develop a number of new Covid-19 specific programmes to support the workforce.

137. In addition, I asked CEC to make all programmes available free of charge to all sectors and all healthcare staff. This continued throughout 2020/21. Additional funding was provided by the Department to continue free access to CEC education programmes to staff from other sectors including care homes, GP Federations, GP Practices and Domiciliary Care during 2021/22. While an annual budget is provided to CEC through the CNO budget on behalf of the Department for HSC staff education and training these other sectors do not ordinarily have access to CEC without payment.

138. At a later point in the pandemic (INQ000438076), I also asked CEC to provide vaccinator education programmes to support healthcare professionals to deliver the COVID-19 vaccinator programme.

139. In terms of steps taken to develop means of increasing workforce capacity, I also worked with colleagues from the Department's Workforce Planning Directorate (WPD), Trade Union Side,

Professional regulatory bodies, and others to increase and enhance the workforce, by allowing partially qualified students across all disciplines to join the workforce early.

140. The NMC in its role as regulator of the Nursing and Midwifery professions is responsible for setting standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare. On 12th March, a teleconference (INQ000300131) discussion took place between the 4 UKCNOs and their teams with the NMC. The NMC outlined their plans to support the delivery of nursing and midwifery care during the pandemic. At that point they did not have powers to enact an emergency register but anticipated that it would be included in provisions of the Coronavirus Bill.

141. Several practical measures were discussed that needed to be considered in preparation for changes in legislation for both nurses and midwives returning to the register and increasing the clinical placement options for third year nursing and midwifery students. This was a difficult matter as collectively we recognized the disruption it would cause to student learning, the anxiety it may cause for students and their families and the huge demands it would place on our nursing and midwifery students. We recognized that expanding the temporary register would need a risk-based approach. However, we had little option as there was an urgent need to bolster the workforce given the demands of the pandemic.

142. On 16th March 2020, a meeting including the four UK CNOs and their respective teams, NMC, RCN, RCM, Unison, Unite, Council of Deans for Health, Health Education England and representation from Department of Health in England was convened. The context was to discuss the extraordinary times we were in due to the pandemic. Recognising that due to the scale and challenge ahead that decisions needed to be made at pace with the best information available at the time. The focus was expanding the workforce and included detailed discussion on the possible deployment of students. Some concerns were voiced, mainly regarding working conditions, pay and an option for those who did not wish to participate in this voluntary arrangement.

143. A further meeting took place at 5pm the same day and the CNOs undertook to discuss the proposal with respective ministers and how the concerns could be addressed by each nation. NMC issued further related guidance following approval by its Council on 25 March 2020 (INQ000232027).

144. Emergency legislation was enacted to enable a Covid-19 temporary register to be established. This legislation, the Coronavirus Act 2020 (enacted 25 March 2020), allowed for temporarily registering fit, proper, and suitably experienced people, so that they could practice and

contribute to the national response to the pandemic if they wished. The emergency legislation also provided for changes to the undergraduate nursing and midwifery standards for education and assessment.

145. On 18 March 2020, I made a submission to Minister Swann (INQ000137419), seeking his approval for this approach for students to enhance the workforce. Similar discussions in respect of other professions were ongoing at the same time, and the Minister would have received corresponding submissions from my equivalent heads of profession around this time.

146. My submission sought approval for students undertaking nursing, midwifery, and allied health professions programmes to be utilised to support the HSC workforce in paid positions during the final six months of their training.

147. On the 19 March 2020 following Minister's approval a joint statement on expanding the nursing workforce was issued on behalf of the UK CNOs, NMC, the Council of Deans for Health, RCN, Unison and Unite. A further joint statement was issued on the same day regarding plans to expand the midwifery workforce. This statement included RCM in place of RCN and chief midwifery officers from the four countries. (INQ000232032).

148. I undertook to develop appropriate deployment guidance for employers, professionals and students bespoke to Northern Ireland including terms and conditions and renumeration (INQ000438082). Deployment was optional and support and guidance was provided for students to help make these decisions. This was a significant undertaking and was led by my DCNO and midwifery officer for both professions working closely with WPD, HSC, the three universities in NI, RCN, and RCM.

Nursing and Midwifery Workforce

149. The effect of this was that the 880 final year nursing and midwifery students in Northern Ireland then entering the last six months of their courses would be enabled to undertake those last six months in clinical practice as paid members of staff with the option of joining the NMC temporary register. It was recognised that this may not be suitable for everyone, particularly those students with underlying health needs and family circumstances. However, in such circumstances there was provision, for example, for students to assist by undertaking non-clinical roles.

150. This offered the optimum solution for supporting the students to consolidate their clinical skills, using a phased approach to build up their confidence and be recognised for their role as part

of the workforce team by being financially remunerated. Arrangements were put in place for transitioning unto the permanent NMC register at completion of the final six months.

151. Considerable discussion took place at the frequent huddle meeting regarding concerns raised including from Universities regarding student support, deployment to appropriate settings and the deployment of year 2 students depending on their university programme flexibility. Following a submission (INQ000438083) to Minister on 24 March 2020, a UK-wide agreement on the role of first- and second-year undergraduate nurses and midwives and third year students in the first six months of study was reached and issued. The objective of doing this was to maximise the contribution such students could make to providing care, but also to ensure that these more junior students were appropriately deployed and properly supported during this time.

152. In recognition of the potential challenges being presented to students in joining the workforce earlier than expected, I requested a member of my staff develop a guide for the students, focusing on the potential psychological effects of the pandemic for the public, patients, and themselves. I issued the booklet to Universities to share with students on 20 May 2020 (INQ000438104).

153. Moreover, as part of the work to support students, I requested NIPEC establish processes to facilitate support for transition relating to the Emergency Standards as outlined below.

154. I communicated on social media and other communication channels with the students stating "I know these are extraordinary times and N+M students will have concerns. I want you to know you will be supported by your nursing and midwifery colleagues. You are valued and needed by the HSC, and we really appreciate your contribution."

The Emergency Standards for Nursing and Midwifery Education

155. In 2018, the Nursing and Midwifery Council (NMC) published new proficiencies and Standards for Nursing and Midwifery education & Midwifery standards in 2019. The intention was to maximise practice placements for students and enhance their learning experience. Introduction of the new standards required significant changes in course curriculum content and documentation for practice assessment to demonstrate student learning. This was led by the three universities in NI and had to satisfy the NMC that these new requirements were met. The programme was overseen by the Future Nurse Future Midwife FNFM programme which I co-chaired with the DoH Director of Workforce Policy. Therefore, relevant stakeholders in NI

were fully engaged with the NMC in the development of the standards but the decision to implement any new standards always remained one for the NMC.

156. On 25 March 2020, the NMC published Emergency Standards for Nursing and Midwifery Education (INQ000438109) in response to the Covid-19 pandemic to ensure students would have the appropriate supervision and support during a time when the workforce would be under significant pressure. These Emergency Standards allowed for the implementation, during the pandemic period, of an adapted version of the new Standards for Student Supervision and Assessment (SSSA) standards.

157. The programme of work to implement the NMC emergency standards in NI was overseen by FNFM Project Board, which I continued to co-chair. This work enabled NI to implement the new Standards for Student Supervision and Assessment (SSSA) with immediate effect. Of particular note is the difference between the existing Standards for Learning and Assessment in Practice (SLAP) and the new SSSA was a difference in mentorship requirements allowing for more flexibility with the introduction of practice assessors and practice supervisors. I believe the introduction of the emergency standards and this new flexibility were supportive to protecting students and staff during the pandemic without overburden on a pressurised registered workforce.

158. On 3 April 2020, I wrote a letter to the relevant professional stakeholders (INQ000438110) outlining the arrangements needed to introduce the NMC Emergency Standards and implications for practice. This letter outlined the arrangements for implementation of the NMC standards in NI as agreed with the DoH, AEIs, Practice Partners and the NMC: for students in their final six months, 2nd year students and first year students.

159. On 4 April I issued a letter (INQ000438115) to Third Year Nursing Students and Third Year Midwifery Students (In final 6 months of their programme) explaining that the four UK countries have worked with the Nursing and Midwifery Council (NMC) and others to publish joint statements on expanding the nursing and midwifery workforce in the Covid-19 outbreak, outlining how the contribution of students can be maximised. I also issued accompanying guidance 'Support guidance for nursing and midwifery students, in the final six months of their programme' (INQ000438116). This guidance document provided information to nursing and midwifery students, on what this means for them during this time and focussed on how students could support the Health and Social Care (HSC) system during this time of emergency.

160. Whilst I maintained oversight responsibility through my role as co-chair of the FNFM Programme Board, I commissioned NIPEC to oversee the implementation of the SSSA Emergency Standards and make the necessary information available for Nursing and Midwifery workforce in NI. Resources were subsequently made accessible on HSC Trust Intranet sites and NIPEC webpage. I am aware that NIPEC undertook a project management approach resulting in the successful delivery of this complex programme. The process outlined below applies to both nursing and midwifery standards throughout the pandemic.

161. The FNFM Programme Board continued to function, with support from established FNFM Working Group and the Midwifery Expert Reference Group (MERG). Membership of all groups included a NMC representative. As such an update from the NMC was a standing agenda item, which was of critical importance particularly during the pandemic period.

162. NIPEC, with my oversight, led a programme of engagement and education which supported students, education providers and employing organisations throughout the transition between adoption of the different NMC standards over the pandemic.

163. On 2 July 2020 the NMC Council ratified the Covid- 19 Recovery Standards. These standards replaced the Emergency Standards on 30 September 2020, aimed at normalizing nursing and midwifery education, while still allowing flexibility in the way programs were delivered.

164. As Covid-19 progressed to a second wave, On 23 November 2020, the 4 country CNO and NMC issued a joint statement to provide clarity to students. This statement indicated that there was not the intention to return to the previous emergency standards therefore students would remain supernumerary and not deployed to further paid placements. (INQ000421189).

165. In NI the FNFM Project Board continued to oversee the implementation of the implementation of the standards to successfully commence of Future Nurse pre-registration programme in the agreed timescales.

166. On 13 January 2021, the NMC Chief Executive and Registrar received a letter from the Secretary of State for Health and Social Care, supported by the Chief Executive of the NHS in England, requesting that the emergency standards be reintroduced in relation to final year nursing students only, so that they could support the response to Covid-19. This was in response to the fact that the UKCMOs had raised the alert level to level 5.

167. This was discussed with the UK CNOs and whilst recognizing the pressure to deliver care we were reluctant to disrupt further students' education programme which may have delayed their

opportunity to join the permanent register unless absolutely essential. The emergency education standards were reopened, and two additional standards were introduced relating to first year nursing and midwifery students and supervision and assessment in practice.

168. These additional emergency standards allowed first year nursing and midwifery students to focus on academic and online learning rather than participating in clinical placements as we collectively recognized and supported that this was the right approach.

169. In addition, the second emergency standard allowed the same person to act as practice supervisor and practice assessor which I believed would reduce the time burden on qualified nursing staff.

170. On 27 January 2021 I issued a letter (Exhibit **INQ000489427** to all NI Nursing and Midwifery Students explaining that in NI the progress of the Covid-19 pandemic although presenting significant challenges, was not at the same stage as in England, where some regions had decided to adopt the emergency standards, this however was not replicated within Scotland and Wales. As a consequence, I indicated that it was not appropriate to disrupt student programmes through withdrawing clinical placements for any year group, or authorising deployment of final year students into paid clinical placements at this time. Our key priority in Northern Ireland continued to be ensuring the timely graduation of final year students with students retaining their supernumerary status and their position in the clinical area as learners.

171. In addition, I thanked students for their contribution over the period of the pandemic and following agreement with the Minister I was able to confirm to students that in recognition, the Minister of Health had announced a one-off payment for students (non-salaried) undertaking pre-registration programmes from 1 October 2020 until 31 March 2021.

172. On 27 January 2021, I also issued a letter (Exhibit **INQ000489426** to Heads of School and Directors of Nursing, HSC Trusts. This letter outlined our key priority to ensure the protection of student's supernumerary status whilst on clinical placement and the timely graduation of final year students. This position was to be kept under constant review, but it is important that as many students as possible complete all aspects of their nursing and midwifery programmes to meet the requirements of future workforce needs. To balance this and recognising the pressure the HSC sector was under, students who felt they wished to contribute additional support to service at this time could be facilitated with the opportunity to undertake Bank contracts, taking cognisance that it does not directly interfere with their ongoing programmes of study.

173. As a consequence of the actions and processes established outlined in paragraphs above, the FNFM curriculum was formally implemented to agreed timescales in NI: Future Nurse in September 2020 and Future Midwife in September 2021.

174. In February 2021, the NMC introduced an additional recovery standard to enable nursing students to practice and learn through simulated practice learning (for up to 300 hours) where conventional clinical practice is not available or is not possible. I supported this wholeheartedly as a means to ensure students continued on their trajectory and had an appropriate learning environment if required.

175. It is important to note that the application of the emergency standards in 2021 were optional. Following consideration, the FNFM project board agreed that to continue with the process for planned implementation of the FNFM curriculum and the new emergency standards were never utilized in Northern Ireland. These standards were subsequently withdrawn in May 2021.

176. Regarding Post Registration, in May 2020, (INQ000438121) I issued a letter to the HSC Trust Executive Directors of Nursing and Education Providers, to outline changes to the post registration education programme. In my correspondence I recognised the uncertainty regarding the need to continue to reconfigure services, and the likely impact on staffing across all organisations. However, I also noted that it was important to remain mindful of the need to complete a range of post-registration programmes. I outlined how it was crucial that every effort is made to finish programmes, in particular those that had been commissioned to ensure we have the right number of staff across service areas, otherwise this would impact in the near future on the capacity and capability of the workforce to respond to patient and client needs across the life course (for example district nursing, health visiting, school nursing).

Nursing and Midwifery Workforce - temporary register

177. At the start of the pandemic in 2020, the UK Government introduced emergency legislation which allowed nursing and midwifery professionals to support the response to the Covid-19 pandemic by joining a temporary register. In March 2020, the NMC undertook to write out to those people who had left the register over the previous three years inviting them to join the NMC Covid-19 temporary register waiving any fees to facilitate this as a matter of urgency to address the urgent need for qualified registrants. This was about 50,000 people.

178. In relation to the expansion of the temporary register to include those people who had left the register for no more than three years a risk-based approach was used, and sufficient steps were taken to reduce risk through the introduction conditions of practice for those on the temporary register. In Northern Ireland, the conditions of practice were applied in that no one

on the temporary register was in charge of an area and must work under the supervision of a registered nurse on the permanent register. No concerns were raised with me around nurses or midwives on the temporary register, for example their deployment and/or any regulatory issues.

179. On 15 April 2020, NMC invited around 21,000 nurses and midwives who left the permanent register within the last 4 to 5 years to return to practice and join the Covid-19 temporary register. This included people who had started but not completed Return to Practice Programmes. The same conditions of practice applied to them.

180. On 06 April 2020, the NMC invited around 2,000 overseas applicants, including both nurses and midwives, who had completed all parts of their NMC registration process except the final clinical examination (OSCE), to join the Covid-19 temporary register. This was because the OSCE centres were temporarily closed. The numbers of overseas nurses in this category in NI was very low and no midwives were included either. Restrictions on practice were in place for overseas qualified nurses and additional checks were required by employers. No concerns were raised with me around the impact of these staff joining the register.

181. On 2 July 2020, the NMC announced that OSCE centres would reopen on 20th July 2020 and the normal process for registration was restarted. There was a specific student nurse and midwifery part to the Covid-19 temporary emergency register which would be voluntary and include specific conditions of practice to ensure appropriate safeguards were in place. In relation to midwifery students, it was always the case that these students would remain in midwifery, and it was never intended for them to join the temporary register.

182. As 880 final year nursing and midwifery students in Northern Ireland entered the workforce in the last six months of their courses as paid members of staff there was no need or desire for the nursing students to join the temporary register. On 7 May 2020 NMC confirmed that it would not establish a specific student part of the temporary register for nursing students.

183. A further announcement by the then Secretary of State, Therese Coffey MP, on 22 September 2022, included a proposal for UK regulators to extend the emergency registers held by the healthcare regulators by a further two years beyond the original timeframe of September 2022.

184. In relation to the extension of the NMC temporary register, the NMC wrote to CNO on 21 October 2022 and again on 17 November 2022 with a draft and updated proposal to enable temporary registration to continue safely.

185. The NMC Extended temporary register was an agenda item on the CNO Business meeting of 31 October 2022, and a follow up briefing was completed on 23 November 2022.

186. On 5 Dec 2022 I wrote to the NMC (INQ000438124) confirming that I was content with the NMC measures to minimize the associated risk and to protect the population of NI in their approach to maintain the temporary register. The number of registrants affected in NI are relatively small.

187. The NMC advised that they are implementing changes as to how they maintain the temporary register, effective from 21 March 2023. The proposed approach was to:

- Retain people who left the permanent register less than three years ago: they will make no change to this cohort but will apply conditions of practice when it becomes more than three years since they left the permanent register.

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

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

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

188. As CNO I was involved by way of outline discussion and agreement on who and how people could join the COVID 19 temporary register. Whilst my team and I were engaged in the discussion and practicalities of facilitating the temporary register the decision to establish a temporary register for nurses and/or midwives who had either left the profession, were nursing and midwifery students or were overseas qualified professionals who had not yet joined the permanent register sat with the NMC. The formal process of devising plans for an emergency register was the responsibility of the NMC. However, I was not aware that the NMC had not

been directly consulted on the plans to retain the emergency register until 2024 until after this had been agreed.

The 'Enabling Professionalism during Covid-19 microsite for Nurses & Midwives'

189. In the early months of the pandemic, I requested NIPEC develop a set of resources to inform the safe deployment of nurses and midwives (including students) in all sectors across the region to increase capacity during the pandemic. My intention was to support and enable professionalism throughout the challenging circumstances of the provision of health and social care services in such a rapidly changing situation.

190. A microsite[2] went "live" on 2 October 2020, as a mechanism to facilitate 24/7 online access to professional advice, guidance and resources to HSC Trusts and other organisations during the Covid-19 pandemic to support the nursing and midwifery workforce through periods of high service demand.

191. The site was further expanded, as required, as added resources became available through a range of credible sources as follows:

- *Regulatory Context NMC*
  This included collaboration with the other UK CNOs and the NMC and led to the issuing of joint statements on expanding the Nursing Workforce, expanding the Midwifery Workforce, advice on indemnity and developing immediate critical care capacity. Further, it included Covid-19 advice from RCN & RCM.

- *Guidance on Redeployment – Covid-19*
  All staff redeployed or allocated to clinical settings where they would not normally work required the following principles of good orientation to be delivered to ensure their understanding of how nursing or midwifery practice was organised in their particular clinical setting. Guidance was provided on:
  - *Supervision*
  - *Delegation*
  - *Teams and Staffing*

[2] The website is no longer live. It was managed by NIPEC who will be able to provide any required additional information or extracts.

- *Organisation of Care and prioritisation of tasks and duties*
- *Assessment & Record Keeping*
- *Health and Well-being*

Support for Nurses and Midwives through the CNO Covid-19 Professional Digital Communication Platform

192. As Covid-19 related information/guidance was regularly reviewed and updated during the pandemic period, it was important that I had timely, and proactive communication processes established. In partnership with NIPEC, my team developed a webpage on NIPEC's main website which was updated and shared widely on a regular basis. This process enabled me to provide nurses and midwives, healthcare support staff and nursing/midwifery students with access to the most up-to-date and important Covid-19 information.

193. The platform went "live" on 30 April 2020 and focussed on sharing pandemic related advice and guidance, CNO and NMC briefings, good news stories and key public health messages of interest to the professions. The use of Twitter and Facebook, established mailing lists for NIPEC's newsletter (SCAN) allowed information sharing across a broad range of stakeholders, including Independent and Voluntary Sectors. In the first two months, the platform was updated and shared on a minimum of weekly basis, then as required until end of March 2022.

194. The activity on the CNO Covid-19 Professional Digital Communication Platform is detailed in the Chart below. The Platform proved useful to push information out to the wide nursing and midwifery family which was important for them in relation to their practice, education, and professional development. As the platform was limited to providing updates on Covid-19 related information and therefore with the reduction in new information the platform became less useful and I, Linda Kelly, as Interim CNO approved standing down from March 2022.

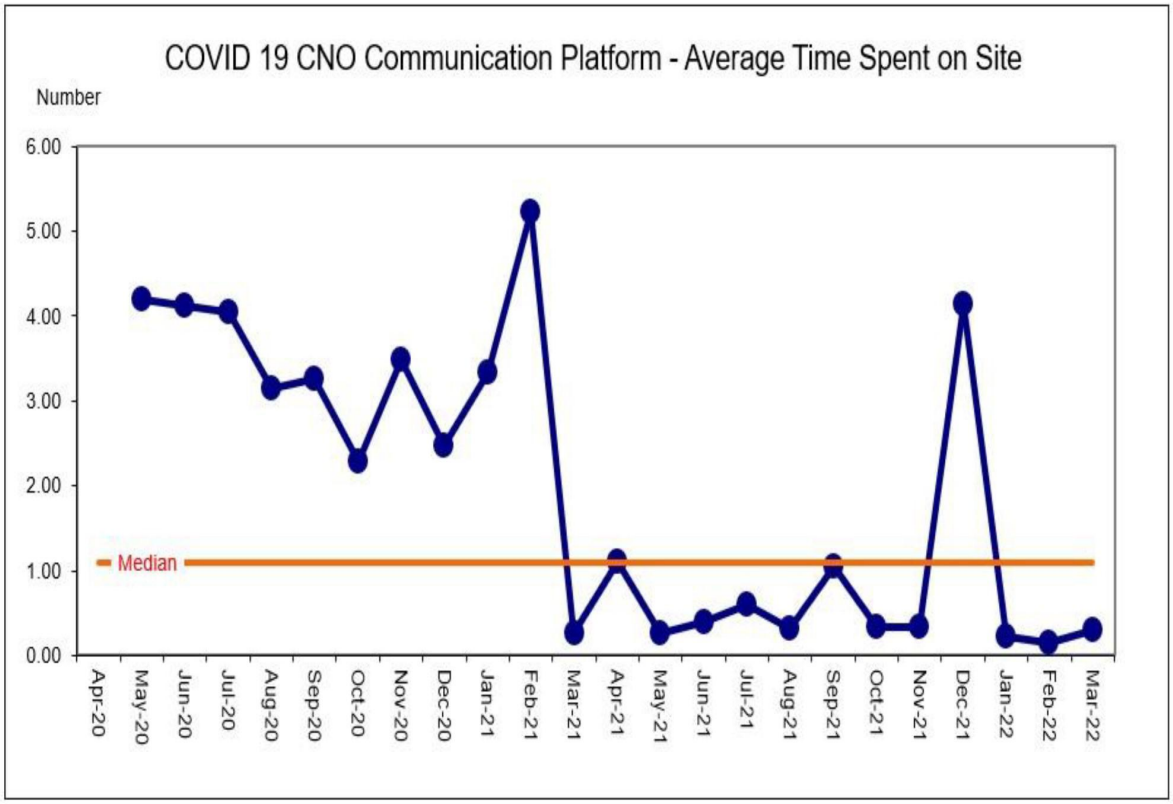


Table 1: Activity on CNO Covid-19 Professional Digital Communication Platform 2020-2022

Allied Health Professions

195. My submission (INQ000137419), as referenced at para 145 above, had also covered the approach applicable to Allied Health Professionals, with the Health Professions Council (HCPC) agreeing to establish an online temporary HCPC register for Allied Health Professionals (AHPs) to include final year students who had completed all their clinical practice placements.

196. Final year AHP students in Northern Ireland in their last six months who had completed all their clinical practice placements and were on an online COVID-19 temporary register could be paid as registrants.

Outcome

197. Minister gave approval to my submission (INQ000137419), as referenced at para 145 above, later that same day.

Do Not Attempt Cardio-Pulmonary Resuscitation Orders

198. The Northern Ireland policy on Do Not Attempt Cardiopulmonary Resuscitation followed the recommendations of the Resuscitation Council and advice from the General Medical Council for cardiopulmonary resuscitation to not offer cardiopulmonary resuscitation in cases where resuscitation would be futile. Cardiopulmonary resuscitation is a treatment that could be attempted on any individual in whom cardiac or respiratory function ceases.

199. In the initial stages of the pandemic the Chief Medical Officer established the Covid-19 Ethics Forum and commissioned it to develop a Framework for advice and guidance to clinicians for clinical decision making during the pandemic period and to support the work of the individual Health and Social Care Trust Clinical Ethics Committees. I was not personally a member of the forum, but the CNOG was represented by a senior nurse advisor seconded to my nursing team.

200. I, Charlotte McArdle am aware that all HSC Trusts established Clinical Ethics Committees linked to the regional Forum and participated in the development of regional guidance. At the request of CMO, the Covid-19 Guidance: Ethical Advice and Support Framework was developed to support decision-makers to address the particular ethical challenges presented by the COVID-19 pandemic at all levels of health and social care, since this was not something that existed at that time. It was published on 5 June 2020 and further updated on 21 September 2020 (INQ000396822 & INQ000381325) Part 1 set out the framework and ethical principles and Part 2 provided practical guidance which included issues of ethical decision making in practice and processes for accessing clinical ethics support. This Framework was based on published national guidance, taking account of the requirements under local legislation, such as Section 75 of the Northern Ireland Act 1998 and the overarching HSC values of excellence, working together, openness and compassion.

201. I am not aware that any issues or concerns in relation to DNACPR guidance, including any blanket issuing of DNACPR notices in relation to groups of patients due to their characteristics such as old age, disability or neurodivergence, were brought to my attention during my time in post.

Clinically Vulnerable / Clinically Extremely Vulnerable / Shielding

202. Throughout the pandemic period the Department placed a significant focus on protecting the most vulnerable in society. The most obvious outworking of that from an early stage was the introduction of "shielding" for those who were at significant increased risk of contracting Covid-

19. The policy approach was predicated on identifying those who were 'clinically vulnerable' (CV) such as older people, those with specific underlying medical conditions and those of all ages in extremely specific and targeted groups or categories who were at extremely high risk in the community and were thus recognised and designated as clinically extremely vulnerable (CEV). Specific advice, guidance and supports including as to how each of these groups might shield themselves so as to avoid being infected with the virus was targeted at the CEV populations and those who were in contact with them. The overall policy intent, including the definition of Clinically Extremely Vulnerable initially used by all four jurisdictions in March 2020, was agreed by the four United Kingdom Chief Medical Officers (CMOs) and therefore the policy in Northern Ireland, as agreed by the Minister, was broadly aligned with that elsewhere in the United Kingdom, with only a small number of local variations agreed by CMO and his advisers. As CNO, I had no responsibility for the categorisation of pregnant women and new mothers as clinically vulnerable.

203. While as CNO and a member of the Department's senior team at that time, I was aware of the development of this approach, I, Charlotte McArdle, must be clear that it was led by colleagues in the CMO's team, with support from the Primary Care Directorate. In terms of the Covid-19 specific risk assessments to be undertaken for nursing and midwifery staff, and their family members, particularly those who were clinically extremely vulnerable, or from an ethnic minority background responsibility for this would have remained with the employer. In terms of student provision, it was always the position that students would have an option to decide whether they wished to go into practice based on their own, and their families' health needs.

Testing / Isolation arrangements for staff and others

204. Whilst I was aware of the development of the required approach to the provision of testing for all healthcare staff, and the isolation requirements for such staff following a positive test, I must again be clear that this policy was led by colleagues in the CMO's team, and I, Charlotte McArdle, was not engaged in its delivery. Where issues were identified affecting any member of staff, or group of staff members (including nurses or midwives), these would have been raised with the CMO's team for action and resolution. I would also acknowledge the benefits of new technical solutions to managing information around transmission, such as the advent of the COVID-19 contact tracing app. This did provide staff and, for example, potential visitors with additional information to consider to inform their decisions as to whether attending work, or visiting their loved one was appropriate had they been exposed to someone testing positive, and proved a useful tool as it was rolled out across the population.

205. Similarly, where those isolation requirements, or any COVID related sickness absences led to staffing challenges within nursing and midwifery, the responsibility for addressing and resolving those challenges, as operational delivery issues, sat with HSC Trusts or other care providers. Staff isolation clearly impacted on workforce availability which was monitored closely via the SitRep report at Silver. Clearly the work that I, Charlotte McArdle, led around enhancing the nursing, midwifery and AHP workforce enhancement as detailed above was to help mitigate the risk by increasing the availability of staff; this would have been the extent of my involvement in respect of self-isolation.

206. At the outset of the pandemic extensive work was undertaken with the Royal College of Obstetrics and Gynecology (RCOG) and representative organizations and trade unions to develop Covid-19 guidance for pregnant women especially those working in environments such as health and social care where they might be exposed to Covid-19 infection (INQ000280449). No concerns were raised regarding this with me as I was not involved in the testing and isolation arrangements. In NI in the first wave of the pandemic the Workforce policy cell engaged directly with key stakeholders including the Human Resource Directors in Trusts and Trade Union representative organisations to develop and disseminate appropriate evidence-based guidance [INQ000408124].

Long Covid – background and response

207. Long Covid is a multisystemic condition comprising often severe and debilitating symptoms that follow acute respiratory SARS-CoV-2 infection. Before the emergence of SARS-CoV-2, multiple viral and bacterial infections were known to cause postinfectious illnesses such as myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), and it appears that Long Covid may share some of the same characteristics. It is undoubtedly the case that many people's lives continue to be severely affected by Long Covid and further research to improve our understanding of the causes and most effective treatments is required.

208. Following a request from the Minister, the CMO established a Clinical Working Group to review the needs of those recovering from Covid-19, specifically following a hospital admission. A series of meetings were held over the summer of 2020 with a wide range of healthcare professionals from throughout NI. The aim was to identify how the needs of post Covid-19 patients were currently being met and how this could be improved through the development of patient care pathways, clinical guidance, and protocols. These meetings had representation from medical, nursing, allied health profession (AHP), psychology and social work recognising the diverse impacts of the post Covid condition and Long Covid. Following the conclusion of

the work in December 2020, the National Institute for Health, and Care Excellence (NICE), published a rapid guideline on post Covid-19 syndrome which was accepted for Northern Ireland. While nursing was represented in the above group, responsibility for the development of pathways, guidance and/or protocols lay with CMO Group.

209. I became aware of work on long COVID undertaken by Dr Elaine Maxwell a senior nurse working for the National Institute for Health and Care Research (NIHR) in England. Dr Maxwell worked with a range of experts to synthesize published evidence (UK and International) into an overview of the current state of knowledge about post covid sequelae and potential ways of providing care and support. I shared this with CNMAC on 24 September 2021 and on 30 September 2021 at my request, a regional one-day Long Covid Consensus Event took place targeted at clinical nurse specialists and nurses with lived experience of Long Covid.

210. Dr Maxwell led the event and facilitated discussions on transferable nursing knowledge and skills that could help people living with Long Covid. Dr Maxwell produced and provided a subsequent report to me [INQ000438125) and following this the CEC was asked to develop and deliver a Long Covid Awareness programme at the request of the Department of Health, with the purpose of increasing awareness among nursing staff of Long Covid symptoms and management options available. It was not to support nursing staff suffering from Long Covid, but rather to assist them with identifying the symptoms and management options within their patient cohort. The programme's learning outcomes were to:

- Provide an example of an individual's experience of living with Long Covid;
- Highlight the sequelae of symptoms that individuals experience with Long Covid;
- Outline the most recent evidence base to support the management of those with long Covid; and
- Briefly discuss the psychosocial support and signposting individuals with Long Covid may require.

211. The programme's target audience was for Registered Nurses and Midwives. As this was an awareness programme it was delivered within a two-hour session to participants. Each programme allowed for up to 100 participants to attend. A total of nine programmes were delivered from April 2022- March 2024, with attendance rates shown in the table below.

Programme Date	Attended
Apr-22	41
Jun-22	27
Aug-22	15
Oct-22	5
Nov-22	14
Jan-23	4
Mar-23	12
Jun-23	13
Mar-24	8
Total	**139**

212. CEC provided all programme attendees the opportunity to complete a programme evaluation. 99% of respondents (132 participants) stated that the programme learning objectives had been met. A service-user's lived experience was also included in the delivery of this programme to provide an example of an individual's experience of living with Long Covid and also to highlight the sequelae of symptoms that individuals experience.

213. The programme was delivered with input from all fields of Nursing practice and Midwifery. The programme content provided an awareness of:

- Long Covid Clinics
- NICE Recommendation Guidance
- Long Covid Screening Tools
- Primary care community Post Covid 19 syndrome for adults
- Post Covid 19 syndrome hospital discharge pathway for adults
- Signposting for Long Covid support
- Health & Wellbeing consideration

Infection Prevention & Control (IPC)

214. IPC advice was developed on a four-country basis. This was to provide both consistency of practice and clear messages. It also enabled learning and sharing of best practice across the four countries. Regular updates were provided at the Senior Clinicians meeting described in para 43-44 above. These discussions informed the strategic development of further policy guidance. As it was a time of heightened anxiety for healthcare workers and the public our aim was to provide clear guidance and messages based on the best available evidence including advice and recommendations from the World Health Organization. Providing UK COVID 19 IPC guidance required both consensus and collaboration across a range of different agencies and organizations. Reaching consensus with such a wide range of organizations including

professional bodies, health and safety regulators and trade unions was difficult and sometimes not fully achieved but ultimately helped to provide the guidance to our healthcare systems.

215. Nursing has always played a key role in both the development of IPC guidelines and their implementation. The IPC Cell provided expert IPC advice to Health & Social Care Trusts complementing the expertise that HSC Trusts already had within their infrastructure in terms of expert IPC nurses and medical and public health practitioners.

216. IPC issues were a feature of the majority of nursing and midwifery leadership meetings described at paras 50-60 above. It was important for me to provide mechanisms to distribute timely information as quickly as possible in a changing environment. Additional conference calls with executive directors of nursing and IPC leads. All Trusts across NI were already required to adhere to the NI regional IPC Manual which provided detailed guidance for implementation and standardization across Trusts, and this was amended and updated as new evidence emerged. I am aware that early in the pandemic sometimes new guidance issued from the National (4 country UK) IPC cell caused some degree of logistical difficulties and confusion for staff. Such guidance often came out at the end of the week, and this created a challenge to disseminate it over the weekend. It was potentially confusing for staff coming back on duty following time off for rest or sickness absence.

217. The regional (NI) IPC cell brought this to the attention of the national cell and asked that it was issued earlier in the week or not for implementation over the weekend. However sometimes this was unavoidable. The regional IPC cell sent information out through local networks where staff would be more likely to see it, while also developing posters and supporting guidance to make it quicker and easier for staff to understand. An example of this was local donning and doffing guidance.

218. Whilst IPC practices are commonplace in secondary care the additional requirements needed for COVID 19 in for example the care home sector in NI required additional support. In addition, there were other patient related considerations for example, in mental health and learning disability services. Interpreting IPC guidance given its complexity, ongoing review, and updates, created a risk that the guidance would be inconsistently applied, particularly in the context of the rapidity of asks of clinicians in health and social care settings. I personally undertook the development of training videos to support all staff. This took a significant period of time and had to be repeated as guidance changes. At the start of the pandemic and due to fear of fatal illness many staff felt they should be wearing FFP3 masks even though the guidance limited tis to areas with aerosol generating procedures. The guidance had to be

reinforced and communicated widely. I am not aware of any instances of inconsistent application of the guidance occurring in practice.

219. The development of IPC guidelines and their implementation is a key Nursing function. As set out below, while I did not have hands-on involvement in this crucial policy area, as CNO I had a significant professional oversight role (referred to in paras 220 - 223 below) in this regard. In Northern Ireland, the Department established an 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, with the core membership of the IPC Cell comprising:

- Public Health Agency Nursing and Health Protection representatives.
- IPC leads from the five Health and Social Care Trusts & Northern Ireland Ambulance Service Trust.
- Health and Social Care Board Social Care.
- Regulatory and Quality Improvement Authority Inspectors.
- Health and Social Care Board Primary Care; and
- General Practitioner and Dentistry representatives.

220. 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. As Department's Chief Nursing Officer, I provided professional support and guidance to the chair of the IPC Cell. This advice would have been via telephone conversations and was mainly an opportunity for me to provide professional supervision by talking through potential problems, providing a second opinion, or giving early thoughts on potential ways forward. An example of this would be our discussion of alternatives to fluid shield masks that had loops preventing a good fit and the option to utilise clips to provide a tighter fit. In this case I supported the proposed approach based on infection prevention and control input and that the IPC cell should carefully monitor feedback. Another example was providing advice on an early version of guidance to support the use of colour-coded zoning aligned to appropriate PPE. In this case my advice was that it was a good idea but that the guidance leaflet needed further clarification and careful interpretation of the colour zoning approach. I also offered to seek further input form CMO colleagues. This guidance is no longer available to exhibit.

221. The IPC Cell provided a forum to discuss, develop and provide input to Infection and Prevention Control guidance, arrangements, and policies across the region, providing an opportunity to share learning and innovative ideas used in Health and Social Care Trusts to minimise the risk of transmission. Examples of the learning and innovative ideas shared in this forum in relation to minimising transmission risks are:

- The innovation and introduction of the clips applied to looped fluid shield masks to secure a tight fit.
- Changes made to staff rest rooms to allow for social distancing in one trust and shared with others.
- The introduction of donning and doffing stations by one trust and shared with others.
- Introduction of dedicated nursing support for care homes to support infection prevention and control procedures.

222. The Gold IPC Cell linked into the United Kingdom 4-Nations IPC Cell, and this allowed Northern Ireland to have an input in the shaping and influencing of expert advice and guidance. Resolved expert advice was shared from the United Kingdom 4-Nations IPC Cell to each of the nations who then would assess the guidance with a view to adopting and/or advising in respect of its implementation in their respective jurisdictions. I am aware through my role in supporting the IPC Cell as CNO that representatives from other internal and external organizations 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.

223. A senior IPC practitioner (Registered Nurse) from the Gold IPC Cell acted as the Northern Ireland representative member in the United Kingdom 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, and I provided professional support to them in my role as CNO.

224. A nosocomial Cell was established by the Department and the first meeting took place in December 2020.

225. One of my professional Nursing advisors was a member of the nosocomial cell and had a key role in the Visiting Subgroup of the NSC. The subgroup was established and tasked with undertaking visits to acute hospital across NI to offer a 'fresh eyes approach' to executive and

operational teams in HSC Trusts regarding their respective work programmes to prevent, mitigate and manage the impact of nosocomial Covid-19 infection. The Subgroup identified areas of good practice, as well as areas requiring attention and/or further improvement. The Subgroup also undertook to identify and share learning emerging through the pandemic response delivered by HSC Trusts to the point they received a visit. It was not an objective of the subgroup to monitor the implementation of recommendations for improvement. Findings and recommendations encompassed both areas of good practice and areas requiring attention / further improvement, and were categorised under six separate headings:

- Environment
- Leadership and Organisational Culture
- Infection Prevention and Control
- Staff Behaviours
- Communication
- Regional Guidance

Such learning was identified, for example, in Craigavon Area Hospital, and included recommendations around patient flow and structural issues in the Emergency Department, clear means of implementing risk assessed decision-making on bed closures during an active outbreak, and exploration of how the 24/7 operating times for laboratories could best be facilitated.

Personal Protection Equipment (PPE)

226. While PPE, both in terms of provision, quality and guidance for use does not fall within my remit as Chief Nursing Officer, I was engaged with other senior TMG colleagues in discussions around the known issues particularly around supply and quality and the guidance issued for its use. During the initial response to the pandemic, Public Health England coordinated the management of the Pandemic Influenza Preparedness Plan stockpile items and letting of Just in Time supply contracts across the UK. The Department's Emergency Planning Branch participated in calls on a UK four nations basis to discuss stock levels and planned procurement volumes and approvals. Emergency Planning Branch managed stock levels until the Health Gold PPE Cell was established.

227. At a UK level, I, Charlotte McArdle, am aware that there was engagement with the other jurisdictions through a range of fora. The Department collaborated closely with them on all aspects of the UK-wide PPE Action Plan which was published on 10 April 2020 (INQ000050008]. The plan was set around three strands; guidance, distribution, and future

supply, which was aimed at ensuring that everyone got the PPE they needed. This engagement allowed for a collaborative working arrangement which included mutual aid, whilst enabling each nation to continue with its own procurement plans. At this time through engagement with the UK CNOs I was able to gain agreement under mutual aid to supply 25,000 gowns to colleagues in England who were experiencing extreme shortages and at a time when we had better availability in the NI stockpile. The gowns were supplied on 18 April 2020.

228. The Department established a PPE Supply Cell specifically to address PPE issues along with an additional Infection Prevention and Control Cell located at the Public Health Agency (PHA). I was aware through initial reports on mainstream and social media, as well as discussions at TMG, Gold/Silver structures and concerns being raised by staff that PPE was either not available to all staff in a timely fashion, or that there were concerns around how this was being managed and shared around those who needed it. Responsibility for actioning these concerns lay with the PPE Cell and I supported the PHA Director of Nursing in his role as a member of the cell, and ensuring the identified needs of nurses and midwives were highlighted. The mechanisms for becoming aware of issues were mainly managed via bronze, silver, and gold structures as and when matters arose. A second mechanism was through the daily huddle meetings with HSCT Directors of Nursing. Matters of concern regarding PPE were raised in both these forums and the PPE cell was present at GOLD command so the cell would be made aware of the issue at the same time. Where information came from the huddle, I used the opportunity at Gold to raise this to PPE cell. In addition, I communicated to the Director of Nursing PHA who further raised the issues at the PPE cell. Fluid shield masks became an issue when the tie at the back product was not available, and they were replaced by looped over the ear products. From memory this was raised in both forums. At another stage - I cannot recall the exact time - a similar concern was raised regarding the quality of plastic aprons. The same process was used to alert the PPE cell to take steps to work with supplies teams to find alternative products. As a result of concerns raised regarding PPE a product review group was established by the PPE and IPC cell to clinically review products before they were introduced to the clinical environment.

PPE Mailbox

229. Reacting to this widespread concern, on Friday 17 April 2020, I met with Minister Swann to discuss how we could offer a solution, or at least a means by which issues could be raised and addressed. Following that discussion, Minister announced that the Department had established a new dedicated mailbox to allow concerned members of staff across the Health

& Social Care workforce as well as other interested stakeholders to raise issues of concern over the supply, quality, and usage of Personal Protective Equipment.

230. A team in CNOG was charged with the management of this mailbox, and procedures established to address the issues raised. As of 31 December 2020, this mailbox had received 95 queries, broadly falling into four main themes.

- Offers to supply PPE.
- Concerns regarding access to PPE supplies.
- Concerns regarding the correct use of PPE supplies.
- Concerns regarding the quality and decontamination of some items of PPE.

231. CNOG staff considered all the requests received, offering guidance/support, or referring correspondents on to the appropriate service. Subsequently. a review report (INQ000438126) was produced identifying those key themes and lessons learned from the content of the emails received. This was shared with Minister on 12 February 2021, and then with the sector for consideration and appropriate action.

Issues with Fit-Testing of Face Masks

232. The Health and Safety Executive requires that where respiratory protective equipment (RPE) is used, it must be able to provide adequate protection for individual wearers. As above, in terms of the general arrangements for PPE supply, quality and guidance for use, these are operational matters for HSC Trusts, and outside the remit of the Chief Nursing Officer. However, given the extraordinary situation that the pandemic was presenting, as Chief Nursing Officer, a senior leader in the Department and the leader of the largest profession in the HSC, whilst not directly responsible, I was involved in discussions around respiratory protection equipment and the number of concerns which were being raised around failures in the fit testing of masks. Fit testing compliance for female staff required a range of face mask type and sizes to be available. HSC supplies were distributed with this in mind. There were shortages of FFP3 masks that were suitable for certain facial features from time to time. Contingency measures would have been put in place by Trusts to ensure they were reserved for those that needed them most. As part of that contingency Trusts would have the ability to review and change the rota should a certain FFP3 mask not be available for staff. To my knowledge this was not instigated as the central coordination through the PPE cell ensured

mutual aid between Trusts. This was one of the reasons for securing local design and manufacture of masks through I&S a local NI company.

233. During May 2020 there was ongoing discussion at the CNO/PHA huddle that a specific ear loop masks were causing fit difficulties across the entire HSC. I was kept informed by the chair of the IPC cell who undertook to investigate reasonable adjustments. Following a workshop on fluid shield masks the IPC cell confirmed a number of masks not fit for purpose and these were now subject to independent assessment. These were subsequently removed from clinical areas.

234. I am aware that the PHA through the chair of the IPC Cell established a product review team designed to support the testing of PPE in a clinical environment. This helped ensure the maintenance of PPE standards.

235. Timely updates on the emerging best evidence and advice in regard to IPC and use of PPE were shared on my CNO communication platform when endorsed and available. Examples of information shared included the development of IPC learning videos on donning and doffing and media campaigns to inform the public and staff in relation to health care professionals coming into a home.

Chaplaincy guidance

236. From the outset of the pandemic, it was clear that for many patients or care home residents, and particularly for those who may have been approaching the end of life, access to pastoral, spiritual and religious support was a crucial issue of concern. Reflecting the risks inherent in managing footfall, it was felt necessary to re-examine the role of the formal Trust Chaplaincy Service, as well as reconsidering the access possible for other Ministers of Faith to offer pastoral care where desired.

237. At the start of April 2020, at my request my team worked with the Trust Directors of Nursing, NIPEC and the PHA to develop clear guidelines for the delivery of pastoral care for patients who required it, including the development of resources for staff to use in urgent circumstances where appropriate faith leaders were not available. This included liaison with, for example, leaders in faith communities to source appropriate prayers which staff could use to comfort patients when circumstances required. I am very conscious of the impact that this exceptionally emotionally challenging duty had on the very many nurses and midwives to whom this responsibility fell. Nurses were often the only person present with a dying person when no one else could and often undertook a role in pastoral care. One could argue that is an important

nursing role but the scale of the pandemic and its indiscriminate nature of attack on young and old was extraordinary. I am aware that different Trusts put different arrangements in place to coordinate and communicate with families where staff could assure them that their loved one was not alone. In my regular conversations with senior Trust nursing leaders at that time we all acknowledged the importance of supporting staff in the delivery of such a highly emotive care service to their patients at such a challenging time for everyone across society and strived to offer as much support as possible to all concerned.

238. The importance of pastoral support was recognised in the Regional Visiting guidance published to take effect from 7 July 2020 (INQ000103667), and in all subsequent iterations of that guidance. When the Pathway guidance documents (INQ000276334 & INQ000276333), which plotted a route back to more normalised visiting, were launched in May 2021, again we were very careful to ensure that pastoral care provision, be it through the Chaplaincy Service or via a personal Minister of Faith, were accommodated as far as possible while still ensuring that the protection of patients/residents and their ministers of faith from the risk of transmission remained paramount.

Guidance on Visiting Hospitals, Care Homes & other Healthcare settings

Background

239. As CNO I was also responsible for the Department's policy guidance, developed and issued to all healthcare settings to allow safe and compassionate visiting arrangements to be put in place for patients, residents, and others. This guidance was developed to apply equally in nursing and residential Care Homes and other community settings. Details of the process of development and implementation of this guidance is set out below.

240. Throughout the pandemic response, I and my team remained committed to ensuring that any restrictions to patients and residents receiving visitors were only implemented to the extent that was necessary to manage the risk of transmission. While many of the decisions, particularly at the outset of the pandemic, were made at pace and implemented as a matter of urgency, I was always careful to ensure that the decisions taken around the application of restrictions were arrived at following consultation with professional colleagues across the HSC sector, taking account of the evidence available. Discussions with the appropriate professionals allowed for understanding of the rationale for restrictions to be applied, and for staff implementing those restrictions to have the ability to explain that rationale when challenged by patients, residents, or their loved ones.

241. I acknowledge the challenges and the impact on members of the public that were affected by the restrictions to visiting that were put in place. This was always done with safety and consideration of the experience impact balance in mind. While throughout the pandemic period many incredibly significant restrictions were applied to visiting, we always aimed to ensure that some form of visiting was possible even if that was only by means of taking a virtual approach. In fact, our advice was that virtual visiting should be the preferred option in the majority of cases as this would significantly reduce footfall in healthcare settings and hence the risk of spread of COVID-19. This was truly not the experience I would have wished for any patient, resident, or any of their families within any of our Health and Social Care settings, but at all times our focus was on taking appropriate steps to protect the most vulnerable.

242. I would wish to highlight that my team and I took an empathetic approach to dealing with the issues that were raised, and the impact of visiting restrictions on patients, residents, and their loved ones. This involved close liaison with the care providers in Trusts, Hospices, Care Homes, and any other setting where the restrictions applied to ensure that a personal approach to particularly challenging circumstances could be offered.

243. There are many instances where my team worked out of hours to address concerns, or to help broker solutions to allow access during particularly important and often poignant times in patients' / residents' lives. Often these arose through representations from elected representatives (we received hundreds of contacts from members of the public, Councillors, Members of the (NI) Legislative Assembly (MLAs), and Members of Parliament (MPs), specifically relating to the impacts of restrictions), but frequently it was through contact from families directly who were seeking help at their lowest times during the worst of the pandemic. Consequently, there were many instances where families were able to be accommodated to be together with dying loved ones, or when residents could receive visits at important times, and my team played a significant role in facilitating these.

244. On reflection, it is important that we never lose sight of the many stories that remain untold. While there were tough decisions to be taken my team and I endeavored throughout the pandemic to ensure that policy and guidance always took account of the potential personal impact, whilst taking into consideration the need to protect the most vulnerable people in our care.

245. In developing the visiting guidance, we aimed to do so in a co-produced way. Wherever possible we sought input from clinical and social care professionals, advocates (including PCC, Commissioner for Older People for NI), and family representatives at various stages as

set out below (for example in the Care Home Visiting Stakeholder engagement group). In my opinion, Northern Ireland led the way in ensuring that when essential restrictions were applied, that this was done in a person-centred way, as far as was possible. I know that the pandemic impacted across society and many individuals, families and carers had to go through extremely painful and challenging times.

Initial Response

246. The Department issued a statement on 12 March 2020 (INQ000103659) alerting the public that HSC services were under growing pressure due to the increase in cases of coronavirus. It set out the expectation that normal business would not be possible as the HSC moved into the next phase of the pandemic. In terms of restrictions to visiting, as CNO I issued the first iteration of visiting guidance for healthcare settings in Northern Ireland on 17 March 2020 (INQ000120717). I had commissioned the Northern Ireland Practice Education Council (NIPEC) to prepare draft visiting guidance, and this work was completed at pace, due to the emerging evidence and public protection concerns. When issued the guidance was recommended to equally apply in hospitals, hospices, nursing and residential care homes, and other community settings.

247. On 26 March 2020 I wrote to the HSC Trusts (INQ000438142) to inform them that with immediate effect, based on clinical advice, all visits to hospitals were to be stopped in the interests of protecting patients, their families and HSC staff. There were limited exceptions to this:

- Restricted visiting was permitted to patients receiving palliative / end of life care. Patients in ICU settings could also receive some limited visits.
- While visiting was not permitted in either ante-natal or post-natal ward areas, women in established labour could be accompanied by one birthing partner through the birthing process.
- Children admitted to Paediatrics settings, including Neonatology/Paediatric ICU could be accompanied throughout by a parent.

248. Taking account of constantly emerging evidence, I worked at speed with a group of senior nursing leaders from my DoH team, CEC, NIPEC and the PHA to oversee the dynamic development of guidance and its subsequent implementation across the healthcare system. This allowed the preparation of updated guidance, issued on 26 April 2020 (INQ000087760)

which detailed further information applicable across the Healthcare Sector, including care homes, regarding the necessary visiting restrictions, and particularly included advice around suitable arrangements for visiting at end of life.

249. Further modifications to the visiting arrangements were made on 11 May 2020 (INQ000120721). These modifications relaxed restrictions in certain circumstances, allowing family, friends or loved ones to be facilitated to safely visit dying patients, treating dying patients with dignity and compassion. Again, the modifications applied equally to care home settings and other community settings as well as hospitals.

250. At each stage of the development process for this guidance material, I actively engaged with senior nursing leaders across the HSC to ensure that the rationale for such was understood, and open to discussion and agreement, as necessary. This allowed me to bring resolved recommendations to the Minister, seeking and receiving his endorsement for the guidance to be launched.

251. There was a recognition that information / evidence was emerging at pace, and the Department's response was updated to reflect the new information equally at pace, but changes to guidance were developed in a spirit of co-operation and co-production ensuring that those tasked with implementing it were engaged in its development as far as possible.

Regional Guidance

252. Following publication by the Northern Ireland 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. At my request, the Strategic Clinical Advisory Cell (SCAC), Department of Health, 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 was included in the resulting revised guidance which recognised the right of people to visit their loved ones in hospitals and Care Homes, while balancing the ongoing risk from Covid-19.

253. The resulting updated guidance was announced by Minister Swann and published on 30 June 2020 (INQ000103667) and detailed the changes to restrictions on visiting to apply across all care settings from Monday 6 July 2020. It was posted on the Department's website as well as being widely circulated across the sector.

254. In the guidance document clear advice was provided around the restrictions that should apply across a range of settings, including Health and Social Care (HSC) Trust inpatient services, Maternity Services, Care Homes, Mental Health and Learning Disability Hospital Inpatient Services, Children's Hospital Services.

255. This updated version of the visiting guidance was again careful to recognise the right of next of kin, partners, children, parents, and carers to visit their loved ones while in health and social care facilities and independent care sector facilities across Northern Ireland, while also recognising the need to minimise the risk of transmission of the virus.

256. It restated the position that where possible virtual visiting should remain the preferred option as this would reduce the risk of spread of COVID-19. To support this all settings were expected to facilitate virtual visiting and assist patients/residents in utilising this means of contact with loved ones. While I acknowledge that this was not an ideal solution, particularly for patients/residents for whom the required technology was not familiar, it did offer at least some means of regular contact during periods of significant restrictions applying, while reducing the risks to the most vulnerable patients / residents.

257. Recognising that the pandemic was likely to continue for some time, the updated guidance document was structured to allow the active management of visiting arrangements in a more flexible manner. By referencing the particular restrictions which would apply in a range of settings based on the extant surge level, defined in the guidance as high, medium, or low surge levels, it was possible to flex the restrictions in response to peaks and troughs in viral transmission. This enabled a more open and transparent process for applying changes based on public health protection levels/legislation and best evidence.

258. As changes to the level of applicable restrictions were found necessary, I ensured the Minister was fully advised and his endorsement was sought and given at each stage.

259. 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 (INQ000256450). This revised guidance was again predicated on a phased approach to visiting, with the Regional Alert Level (INQ000270105). as assessed by the 4 UK CMOs at any given point in time dictating the level of restrictions consequently applicable.

260. The UK Health Security Agency (UKHSA) provided advice to the UK chief medical officers (CMOs) who in turn advised ministers on the UK coronavirus (COVID-19) alert level. The alert levels were originally defined in the UK government's COVID-19 recovery strategy

(INQ000137239) in May 2020 (most recently revised in August 2022) and communicated the current risk at a UK-wide level.

261. The alert levels were, and remain:

- **level 1:** COVID-19 is present in the UK, but the number of cases and transmission is low.
- **level 2:** COVID-19 is in general circulation in the UK, but direct COVID-19 healthcare pressures are low, and transmission is declining or stable.
- **level 3:** COVID-19 is in general circulation in the UK.
- **level 4:** COVID-19 is in general circulation in the UK; transmission is high and direct COVID-19 pressure on healthcare services is widespread and substantial or rising.
- **level 5:** as level 4 and there is a material risk of healthcare services being directly overwhelmed by COVID-19.

262. The guidance for appropriate visiting arrangements across a range of care settings was again summarised in a grid format, illustrating the impact of the UK's Regional Alert Level on the extent of visiting to be allowed.

263. This 23 September 2020 version of the guidance recommended that all health and social care facilities in NI should 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.

264. Once again, as set out in para 34 above, it is important that I refer to my role in developing visiting guidance which applied across health and social care sectors. Thus, a key additional measure introduced in this version of the guidance was the formalisation of the concept of "*Care Partners*" (INQ000374211). Listening and reflecting on the feedback and experience of residents, patients, their loved ones, the public, our staff, and political representatives, I and my team recognised that the lived experience of those residents living in care homes was being massively impacted by the restrictions applied to visiting. The Minister received a significant amount of correspondence from relatives of residents who felt that the impact of restrictions to visiting was causing untold damage to their loved ones.

265. On reflection I felt that in the specific case of care home residents, long-term separation from loved ones, particularly those who would have been regular, supportive visitors prior to the pandemic, a more nuanced approach was appropriate, so the Care Partner scheme was developed, and included in the 23 September 2020 update, with the expectation that care homes work to develop and introduce arrangements for delivering the scheme for those residents who sought it by early November. Fuller details of the scheme and how it was actioned are set out below.

266. The next published update to this Regional Visiting Guidance was issued on 5 November 2020 following the completion of the latest review. 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.

267. My team had been engaging informally with colleagues from across the UK who held responsibility for care home visiting arrangements across England, Scotland, and Wales. While the structure of health and social care services is different across the various devolved administrations, some degree of overlap would apply in terms of approach to maintaining safety, and efforts to prevent transmission of the virus to vulnerable residents in care home settings. Obtaining early sight of proposed English guidance on visiting social care institutions over the imminent Christmas period helped inform the development of our own approach and guidance for this crucial period for families, residents, and staff.

268. Guidance for Christmas visiting in care homes was issued by the Department on 9 December 2020 (INQ000276329). This advised that the regional visiting guidance should continue 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 addressed the right to a family life for those living in care home settings. The expectation was that after a long, almost 9 months of restrictions impinging on almost every aspect of people's lives, a flexible approach to facilitating visits over the Christmas period might offer some respite and allow families to be together with loved ones in care homes for what in many cases may have been the last Christmas.

269. However, on 17 December 2020, considering emerging evidence around increasing transmission levels, the Executive announced new public health measures, which were to take effective from 26 December 2020. This was in part a recognition of the impact of the pandemic response on every member of the public, as the restrictions which had been applied for many

months impacted across most aspects of life. It was felt that, to give a feeling of hope and respite from the wide impact of the pandemic, additional restrictions should be held off until after Christmas to allow families to meet, mix and come to terms with the massive upheaval that the pandemic was presenting.

270. 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 (INQ000276330).

271. Following the recommendation by the four 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 8 January 2021 (INQ000276331). 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.

272. This continued in force until late February 2021, when following the recommendation by the four CMOs that the UK should revert from level 5 to level 4, the Department confirmed that Minister had approved an easing of the restrictions on visiting arrangements for all healthcare settings (including hospitals) from 26 February 2021 (INQ000276332). The revised position was subject to local risk assessment and kept under review.

Development of Setting Specific Guidance

273. As explained in para 34 above, my remit covered both the health and social care sectors. Recognising the distinctions between the circumstances applying in Care Homes, compared to other care settings, on 15 March 2021, I commissioned (INQ000417477) 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. From my team, I charged one of my DCNOs and a policy Grade 7 to oversee the effective progression of this work.

274. The care homes visiting review group drew its membership from a wide range of key stakeholders, including:

- The Public Health Agency (Nursing & Medical professionals)
- The Department's CNO Group
- The Department's CMO Group and Social Services Policy Group
- HSC Trusts
- The Patient & Client Council
- The Commissioner for Older People in Northern Ireland.
- The Regulation & Quality Improvement Authority
- The HSC Board (which became SPPG in the Department)
- The Independent Care Home Providers organisation
- Service Users and their representatives

275. I asked my DCNO to establish a group of professionals from Trusts, Hospice sector and PHA to review 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.

276. 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'*** (INQ000276333) set out a new approach to visiting in hospices and hospitals, including maternity and other services; and

'***Visiting With Care – A Pathway'*** (INQ000276334) 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.

NB: It should be noted that the Care Partner scheme (see section below) was not affected by this updated approach to visiting arrangements. Care Partners were defined as more than visitors, so the access arrangements facilitated under the scheme were to continue as appropriate.

277. Both these updated approaches to visiting, effective from 7 May 2021, incorporated a scheduled 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 (INQ000348956) for full list of meetings and decisions). Following each review, I made a formal recommendation to the Minister on whether progress along the pathways was appropriate, based on the available scientific data as assessed by public health professionals from the PHA, and the expertise of those responsible for its delivery.

Care Home arrangements

278. As explained in para 34 above, my remit covered both the health and social care sectors. To facilitate the review of the Care Home pathway, 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 co-chaired by a senior nurse from the PHA and a member of my policy team. and involved a standing working group of stakeholders broadly in line with the group that had co-produced the "Visiting with Care" Pathway document.

279. These review meetings were normally held on a 4-weekly basis in respect of Care Homes. The PHA's Public Health Consultant collated and reviewed the impacts of visiting restrictions in Care Homes and contrasted the risk of relaxing those restrictions against the current evidence around (among other things) transmission rates, Covid-19 related deaths, and vaccination rates for residents and staff. The resulting recommendations were submitted to the Department for Ministerial decision and agreement on next steps. Consequently, progress was made along the Pathway only as far and as swiftly as the evidence allowed.

280. With effect from 20 October 2021, following the completion of the then latest review, the Minister accepted my advice, based on the PHA recommendation, that the restrictions on visiting in care homes should move into the 'Gradual Easing' phase as set out in the 'Visiting With Care - A Pathway' document. The main change involved an increase in the frequency of visits permitted and in the number of people permitted to visit care homes at the same time. Up to four people from no more than two households were able to visit together, with a

maximum of four such visits per week being allowed. In addition, the Department provided further clarity around visits from clergy, with further advice added concerning how residents could be facilitated to leave their care home to go about normal business.

281. On 17 February 2022, the Department announced that following the latest advice from the PHA, the Minister had agreed that restrictions on visiting in care homes would move from 'Gradual Easing' to 'Further Easing'. This change meant that there would no longer be a restriction on the number of people who may visit but visits remained limited to two households per day. Overnight stays were also to be facilitated for care home residents.

282. Full details of the changes were published in the 'Visiting With Care – A Pathway' document on the Department website. The Minister commented (INQ000383235): "*This is a positive step forward and something that I know people have been wanting to see for some time. It is down to the effectiveness of our COVID-19 vaccination programme and the reduced threat from the Omicron variant that we have been able to progress to the next step of the pathway. However, it's important that we remain mindful of the risk that Covid presents and that visitors should continue to follow the public health advice. We would ask visitors to continue to wear face coverings, maintain good hand hygiene and take lateral flow tests regularly*."

283. Alongside this announcement, it was also confirmed that the Care Partner Scheme would be extended to hospitals and hospices. This reflected the success of the scheme in care homes and allowed for those undergoing inpatient treatment in healthcare settings to be able to avail of support from nominated friends/loved ones, complementary, yet additional to that offered by the staff in the setting.

284. Progress from *'Further Easing'* to the final stage of the Pathway, *'Preparing for the Future,'* was achieved at the end of June 2022. This effectively ended any restriction on the number of visits or visitors that each resident could receive. Since progress along the Pathway had completed, the Public Health Agency and the Department reconvened the review group with the intention of developing a new guidance document "***Visiting With Care – the New Normal***" (INQ000276336) 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 formally launched on 1 September 2022.

Hospital and Hospice Settings

285. Taking a similar approach to that taken for care home arrangements, in April 2021 I asked my DCNO to oversee the ongoing review of the arrangements for visiting in hospitals and hospices as set out in the *Pathway to Enhanced Visiting* document (also effective from 7 May 2021)

which were also to be kept under regular scheduled review. These reviews were completed through regular, scheduled review meetings, attended by an established group comprising the DCNO and policy officials from the Department's Chief Nursing Officer Group, the 5 Trust Executive Directors of Nursing and senior leaders from the Hospice sector (INQ000348956) for full list of meetings and decisions).

286. Throughout the pandemic period, each region of the UK took a nuanced, occasionally different approach to risks around visiting arrangements. Visiting arrangements in Hospital settings in NI was driven by my engagement with and listening to the experience of the Directors of Nursing and other senior leaders in Trusts across the region, with localised exemptions also applied where risks were identified. This was informed by knowledge of local clinical settings, clinical environments which differ from facility to facility and staff availability to logistically manage an increase in footfall on wards and departments with a clear focus on preventing nosocomial infection.

287. To reflect these local pressures that could apply in specific hospital settings (due to estate issues, local transmission spikes, etc.) I recommended to Minister that he authorize the use of a protocol (INQ000438159) through which any of the five HSC Trusts or Hospice providers 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. This protocol was shared with HSC Trusts on 17 February 2021 for immediate implementation.

288. Given the ongoing level of public interest in how visiting arrangements continued to be applied in healthcare settings, my team sought weekly updates from the Trusts in which they confirmed their compliance with the extant pathway guidance position, or a full detailing of any applicable variance alongside a rationale for that variance. The protocol required HSC Trusts to liaise with the PHA Health Protection Team regarding any issues or concerns and to seek advice that may support risk assessment and decision making regarding visiting restrictions. No such issues were raised directly with me or my team. The role of my Directorate was to record and share subsequent HSC Trust decisions, accompanied by relevant evidence bases, with the Minister through his Special Advisor on a weekly basis. This process continued for the remainder of the pandemic period while any regional restrictions were applicable.

289. To ensure that the public were kept aware of the restrictions applicable in all healthcare settings, my team ensured that the DoH website was kept updated with the most up-to-date guidance, and we also asked Trust colleagues to ensure that the visiting sections on their

websites were maintained to provide accurate information to the public. When significant changes were introduced, the Department and Trusts normally ensured that these were also disseminated using notifications on social media.

290. Following successful progress to the final stage of that pathway, which was also achieved in late June 2022, a similar 'new normal' document for these settings *'Enabling Safer Visiting'* (INQ000276337**)** 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.

Care Partner Scheme

291. As set out in para 34 above, I held responsibility for both the health and social care sectors. Within the update to the regional visiting guidance issued in September 2020, care homes were encouraged to develop new Care Partner arrangements. This was a scheme which allowed the identification of an appropriate person to assist in maintaining each resident's physical and/or mental health (INQ000374211).

292. Based on the interactions that I and my team had with those impacted by the application of restrictions to visiting in care homes, I was aware that there were some significant impacts that needed to be addressed. I recognised the fact that visiting and those significant connections with families, carers and others are themselves important strategies for reducing the risk of preventable harm since those who know the resident best can be uniquely attuned to changes in their behaviour or status. I also acknowledged the view set out by some correspondents that imposing a ban on visiting could have serious implications in terms of potential breaches of Article 8 of the European Convention on Human Rights, the Right to respect for private and family Life.

293. While many residents were able to manage the time during which they could not receive regular visits, although not happy about the restrictions, they could accept the underlying rationale for this change. Others were experiencing such significant health and social challenges, particularly those with cognitive impairments such as dementia etc., that sadly the impact of limited visiting was perhaps more pressing on their loved ones than upon themselves.

294. However, there was a clear cohort of residents in care homes upon whom the impact of limited or fully restricted visiting placed a tragic burden. Those who needed constant encouragement to eat, to take medication, to exercise, or even to socialise with fellow residents were left in a really challenging situation when the staff in their care home, despite best efforts, could not

routinely offer the timely care that may have provided that encouragement. Many of these residents were used to their loved ones being there with them so regularly to provide such support that the seemingly sudden removal of that contact with them must have been almost unbearable. It was these residents primarily, although not exclusively, that the care partner scheme was developed to assist.

295. To help shape the description of the care partner, a range of people and organisations including representatives of families, care home staff and Independent Sector Providers, Trust staff, including those providing support to care homes, and DOH officials with relevant policy responsibility had been asked for views about what they thought being a care partner would entail. These contributions were analysed with some common themes evident throughout the feedback. This was used as the basis for describing the "Care Partner Concept", which was kept subject to ongoing review in the light of experience of the operation of the care partner role.

296. The Care Partner role was defined as a practical, care providing role, complementary to care delivered by staff within a facility. This role was defined as being more than simply visiting, with a Care Partner likely having previously played a role in supporting and attending to the resident'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.

297. While initially launched in the 23 September 2020 guidance, a lead in period of around 6 weeks was allowed for care homes to consider how to put in place the necessary procedures to facilitate the Care Partner scheme. My team undertook widespread engagement during this period, supporting the testing of the concept in volunteer homes. Further, my team worked with the PCC to facilitate two virtual engagement meetings with families of residents and DoH representatives. The rationale was to explore the concept of Care Partners and to discuss experiences / key areas of focus so that the engagement opportunity would provide an understanding of the challenges and opportunities that Care Partners might present.

298. During the sessions the DoH team provided more context on the topic via a short presentation, which provided a platform for dialogue to explore the subject further aligned to the experiences of families and relatives within care homes.

299. To support the full implementation of this key support role, on receipt of advice from me and the Chief Social Worker (INQ000185430), the Minister announced additional funding on 22

October 2020 (INQ000276403) which was intended 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.

300. There is no easy answer to the challenge faced in reducing the serious harm caused by Covid-19 transmission in care homes and there are challenges which care homes, as distinct from other health and care settings, face in protecting all residents from infection. Undoubtedly the rates of infection and consequent rates of deaths was a matter of serious concern to some care home managers, and this then caused some to be reluctant to facilitate the increase in footfall that care partners could present. Due to these and other ongoing concerns 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. My team continued to engage across the sector to address issues in certain settings as they appeared.

301. On 12 November 2020 along with the Chief Social Work Officer (CSWO) I issued a guidance letter (INQ000256455) to Residential and Nursing Home Care Providers entitled 'Implementation of Care Partner in care homes in Northern Ireland' This was followed by a letter to HSC Trust Chief Executives and Directors of Older People Services on 13 November 2020. (INQ000256374)

302. The Department engaged with a range of stakeholders, including representatives of families, Independent Care Home Providers, HSC Trusts' staff, including those providing support to care homes, and representatives of other statutory organisations involved with the independent care home sector, to listen to concerns regarding the implementation of Care Partner arrangements in some settings.

303. Consequently, I tasked staff from my CNO Group to work alongside PHA colleagues to engage with the Independent Care Home Providers involved, and with all relevant HSC Trust staff involved in commissioning care in those settings, to provide focussed support to individual care homes to help provide support 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.

304. On 16 December 2020, a joint letter to the care home sector was issued by the CNO, CSWO and CMO (INQ000437944). The letter informed the sector that the care home regulator, the

Regulation and Quality Improvement Authority (RQIA), 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.

305. The RQIA thereafter reported weekly to the PHA, and where issues around compliance were identified, my team worked with the relevant HSC Trusts and PHA colleagues to maintain contact with the care home management to identify solutions and encourage that compliance.

306. The letter also indicated that the current income guarantee funding support measure was likely to be linked in future to the implementation of appropriate visiting arrangements (the income guarantee support[3] 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).

307. 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.

Lessons Learned

308. The outworking of the decision-making around visiting arrangements across both the health and social care sectors led to a significant amount of Ministerial correspondence, both in terms of Assembly Questions and also a substantial number of letters from MLAs and from the public. All of these contributed to my team's understanding of the sometimes almost unbearable

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

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

impacts of the restrictions, and certainly informed our approach to reviewing ongoing restrictions, and enhancing the messaging around the reasons for how safe visiting was to be managed. We recognise from feedback from service users and families/carers during the course of the pandemic that the application and interpretation of the guidelines did vary across settings and locations. This was often due to issues presented in different estate settings in which different assessments of risk applied. Where concerns were raised directly with us every effort was made to work with the individual setting leads to support the individual requests based on appropriate and proportionate risk assessment. We deeply regret the impact of this on the lives of many people, as it was not the experiences we would have wished to have seen. The experiences of service users and their families/carers was used to help inform our responses and learning at all times. This included taking due consideration of the nature and volume of correspondence received either directly from families or through their elected representatives and in doing so ensuring that the guidance was as clear, relatable, and understandable as possible. We worked to ensure that people understood the need to apply restrictions, but that those restrictions were as minimal as possible to avoid unnecessary harm.

309. Throughout the main pandemic period, but perhaps particularly at the outset we did receive a large volume of enquiries arising from the constant changes to the guidance issued by the Department around visiting. Some nursing staff and healthcare workers, particularly those working in Care Homes, felt that the rules were being imposed on them without consultation, while others felt that they were not always adequately briefed on the changes when they were introduced. This may have occasionally led to conflicts with residents and/or their visitors who expected the current guidance to apply. As the pandemic progressed, our approach to developing and sharing the guidance was improved (see paras 264-268 above), with a consequent reduction in the degree of upset and disagreement going forward.

310. Engagement with the wide range of stakeholders involved in developing and seeing through the visiting arrangements for those living in care homes, including those transferring from hospitals for respite or step-down care, while at times challenging, in my opinion proved the most effective way to facilitate the development of visiting arrangements. While there was a heavy focus on the evidence and how that evidence was then used to increase protection of public safety, there is a need to also focus on the experience and impact of the restrictions on the public. This is a challenging balance and the strength of feeling and experience were enough to tip the balance to a creative way of meeting both needs. While the introduction of the care partner scheme was an attempt to do this, however, this was not implemented until 8 months into the pandemic period following an intense period of evidence review. Those with loved ones living in care homes were best placed to advocate for arrangements somewhere

close to what was previously deemed "normal," while also cognisant of the risks of virus transmission to that particularly vulnerable cohort of the population.

311. Linked to this, I fully supported and engaged with the carrying out of the "Pulse" survey of user experience by colleagues in the PCC launched in June 2021, demonstrating our ongoing approach to listening to experience. This facilitated PCC colleagues to provide updates through visiting stakeholder groups, such as the reception of service users and carers to the care partner scheme, and the volume of queries PCC was receiving around moving to the next stage of the guidance. This feedback was a valuable additional layer of information, contributed to the ongoing process of reviewing visiting guidance and was a key factor in driving our thinking around the impact of the restrictions we were recommending in addition to the relevant scientific data.

312. We now have significant experience of the best practice approach to considering how to best protect vulnerable people in health and social care settings while allowing them to have valid social interaction with friends and family and are confident that in any future comparable situation, this experience will inform the approach to setting the parameters of visiting guidance which should include this co-production approach. Involving and engaging service users and advocates alongside healthcare professionals, at the earliest possible stage will deliver a more rounded effective policy, which can be effectively communicated to those directly impacted by it, and the wider public.

Maternity and Children's services

313. As a registered nurse on part 1 of the NMC register these are not areas of my professional expertise and from the outset of the pandemic, I, Charlotte McArdle, was assisted by my Midwifery Officer in liaising with Heads of Midwifery and Directors of Nursing regarding Midwifery practice and the Trusts' development of plans to protect maternity services and ensure as far as possible the continuance of the safest, most appropriate care for mothers and babies. HSC Trusts are operationally independent, and any changes to their services because of the impact of the pandemic would have been brought to my attention through the normal governance arrangements. I am not specifically aware of issues where staff shortages adversely impacted on the experience of women other than the impact upon the availability of the home birth option as set out below.

314. At the CNO Business meeting on 25 January 2021 a full and frank discussion took place regarding midwifery practice, maternity safety, and the decision to temporarily suspend Home Births in one trust (INQ000437992). The decision by the Trust was taken in the interests of

safety as Northern Ireland Ambulance Service were concerned that they may not be able to respond to an emergency with current service pressures caused by the pandemic. Midwives expressed concern regarding home births for high-risk women potentially leaving mother, baby, and midwife in a compromised position. I provided clear professional advice regarding the management of risk recognising the women's legal right to choose place of birth and women's anxiety about going to hospital. I advised that decisions regarding home births needed to be made on a case-by-case basis and involve the women in this decision. Engagement took place with RCM who provided further advice on guidance to midwives. It was agreed to review the decision on standing down home births on a weekly basis and that this would be reinstated as soon as possible.

315. I am not aware of any issues in respect of free births, pain relief, access to elective caesarean sections, the requirement for masking during labour, access to translation services, inequality issues and other neonatal services. I was however aware of some reluctance amongst pregnant women to attend healthcare appointments, particularly due to the restrictions on accompaniment, but this is set out in greater detail below.

316. As set out above, I directed the preparation and circulation of the "visiting" restrictions, which were intended to offer protection for mothers, babies, partners, family members, staff, and the public. Pregnant women were no more or less likely to contract SARS-CoV-2 infection, however at the outset of the pandemic there was concern, as with other viral illnesses, including influenza and varicella, that the risk of developing severe disease is increased in pregnant women compared with non-pregnant women, particularly if they contract the infection in the third trimester of pregnancy. This was subsequently confirmed.

317. There was a recognition that partners accompanying mothers to the full range of appointments is not and should not be classed as "visiting," since it affected access to care facilities (in this case hospitals / maternity units), the restrictions were included in the visiting guidance applicable at any given time. Dependent on the assessed level of risk at any given time, this meant that a mother's ability to be accompanied to various antenatal appointments, through labour and childbirth and into the postnatal wards could be significantly curtailed.

318. In short, while at all times birth partners were facilitated to accompany the pregnant woman to labour ward for active labour and birth, dependent on the status of the Regional Alert level, this access could be extended to allow the birth partner to accompany the pregnant woman to dating scan, early pregnancy clinic, anomaly scan, and Fetal Medicine Department, for

induction of labour, duration of labour and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.

319. I fully recognise that this unpredictable variance of access for birth partners to support pregnant women did cause distress and confusion, and the restrictions on allowing mothers to be fully supported by their chosen partner at all stages throughout their interaction with maternity services meant that many did not have the maternity experience that I would wish them to have had. However, at every stage of the restrictions, regardless of Alert Level or other considerations, the policy requirement was that women should at least be able to be accompanied during their established labour and through childbirth, as to do otherwise would have been intolerable.

320. The impact of the range of applicable restrictions on this group of women generated a large amount of correspondence to the Minister, with significant numbers of Assembly Questions, letters from other MPs / MLAs and from those mothers and their families affected by the restrictions. Maternity services, along with Care Homes arrangements were the most challenging and fraught element of the visiting restrictions. At every stage of review, consideration was given to the expressed impact of the restrictions while considering whether they could or should be eased, and this was a challenging element of the process for all concerned.

321. At the outset of the pandemic, my Midwifery Officer was involved with the Department's engagement with the Royal College of Obstetricians and Gynaecologists (RCOG) in the development of their "*Occupational health advice for employers and pregnant women during the COVID-19 pandemic*" (INQ000437947). This guidance was used to inform the development of our visiting guidance, and colleagues in the CMO's team used it to inform the guidance they developed around isolation and infection control in maternity settings. Plans were put in place early in the pandemic to protect children's and maternity services. Concerns were also brought to the Department's attention over this period by patient representatives in relation to access to fertility services. Further detail about the measures taken by the Department to maintain and protect these services is set out below.

322. On 3 April 2020, the Department published details of a regional plan (INQ000437948) which had been developed with the five Health and Social Care Trusts to protect access to children's and maternity services through temporary reconfiguration, while escalating the critical care surge plan using the newly established Nightingale facility at Belfast City Hospital. The plan contained several steps that could be triggered, depending on the pressures on services,

including an expectation that around 50 Covid beds for adults could be made available by implementing Step One during the anticipated surge over the subsequent days.

323. The plan was developed in conjunction with paediatric and maternity units from across Northern Ireland with the aim of ensuring continued access to urgent and emergency care from suitably qualified and experienced paediatric staff for babies and children who needed it. While the plan included a temporary reduction in inpatient paediatric services it ensured that every acute hospital continued to have senior consultant pediatricians located in these facilities to assess and treat acutely unwell children. The temporary measures were also designed to ensure that highly specialised paediatric services, including paediatric intensive care, could continue to be provided even during periods of high staff absence.

324. The plan ensured that maternity services continued to be safely provided in Daisy Hill Hospital (Newry), South West Acute Hospital (Enniskillen), Craigavon Area Hospital (Craigavon), Altnagelvin Hospital (Derry), Antrim Area Hospital (Antrim), the Ulster Hospital (Dundonald) and the Royal Jubilee Maternity Hospital (Belfast) during the pandemic response. After careful consideration, it was agreed that antenatal services would continue at Causeway Hospital (Coleraine) but that it would not be possible to safely deliver babies in the Causeway Hospital during this surge period due to the lack of sufficient numbers of skilled paediatricians who would be needed to ensure provision of essential emergency care to a baby born throughout the 24-hour period. Women who were booked to have their babies in Causeway Hospital were contacted to arrange to have their delivery transferred to either Antrim Area Hospital or Altnagelvin Hospital.

325. To deliver the plan midwives were not redeployed in the same way nurses were and changes were made to the undergraduate midwifery programme by the NMC for them to opt to undertake their final six months of their programme as a clinical placement. This clinical placement supported the provision of maternity services, reflecting the pressures maternity services were under.

326. As CNO I did not have a role in monitoring or addressing concerns about Trusts implementing guidance issued by RCOG stating that a minimum of 6 face-to-face antenatal consultations and 3 post-natal contacts should continue. Neither was I made aware of any such concerns. In relation to the use of technology my view is that there is and was a role for remote access to clinics. It can be helpful to assess the woman's progress, answer questions, provide advice and alleviate any concerns. This approach should be blended and used in conjunction with professional judgement and access to face-to-face clinics when required.

327. My Midwifery Officer and her counterpart in the PHA established a maternity COVID-19 website which was a helpful resource to women, their partners, and families with relevant up to date information and advice. It included advice on antenatal care, child health services, antenatal classes, post-natal care, planning for birth and further information regarding COVID 19 and pregnancy. Following discussion between the Department and PHA The Solihull approach ante natal programme was made available on the PHA website. This was widely used at the time by pregnant women, but the website is no longer available, although details of the programme are now available on the Safeguarding Board for Northern Ireland's website (INQ000437949).

Enhancing Clinical Care Framework (ECCF)

328. Para 34 above details that I carry responsibility for nursing policies across both the health and social care sectors. Issues faced within the independent care home sector had been recognised for some time. Published in 2016, Health and Wellbeing 2026: Delivering Together, the then Minister of Health's ten-year vision for health and social care made a commitment to reform adult social care and support with the aim of bringing long-term stability and sustainability to that sector.

329. The existing challenges were brought sharply into focus during the COVID-19 pandemic. Upon consideration of these challenges with the Minister of Health, in June 2020, I, Charlotte McArdle, proposed and with his agreement established a Rapid Learning Initiative (RLI) (INQ000276404) to identify and apply the learning from the changes implemented within the HSC system and care homes in Northern Ireland in management of the first surge of the pandemic, to inform recommendations for policy and practice and prevent/mitigate the impact of further transmission of COVID-19 into and within care homes. The recommendations as set out in the report were categorised under six themes, as follows:

- Technologyc
- Information
- Medical support
- health & Wellbeing
- Safe & Effective Care
- Partnership.

330. A key theme was the "information" theme which recommended the management of information and guidance to and from care homes more efficiently and effectively, and this was taken forward by colleagues in RQIA who acted as a single point of contact for information transfer.

331. The RLI, which was project managed by my DCNO, adopted a collaborative approach between: the Department of Health, the Health and Social Care Trusts, the Public Health Agency, the Health and Social Care Board, the Patient and Client Council, the Regulation and Quality Improvement Authority, the Royal College of Nursing, the CNMAC representative from the Independent Healthcare Sector, the CEO of the Independent Healthcare Providers on behalf of their members, UNISON and representatives from the Independent Healthcare Sector.

332. Care home residents, their loved ones and care home staff were critical partners in this work, providing insight and knowledge over a defined 3-month period to identify recommendations for action.

333. In recognition of the powerful impact of the lived experience of residents, their loved ones, and staff, with support from the PHA Experience Team, a separate supplementary report was issued using 10,000 More Voices methodology. (INQ000416806) The narrative of residents, relatives and staff was collected over the period 24th June 2020 to 31st August 2020. In total, 744 stories were collected in relation to experiences within Care Homes. This report informed many of the key recommendations outlined in the RLI report and was utilized to influence change and improvement moving to the next stage of the pandemic.

334. The stories of the residents, their loved ones, and staff, highlighted the deep and lasting impact the first wave of pandemic had on the Care Home staff, residents and loved ones. In the early days of the pandemic many reported that they carried the burden of protecting and caring for residents in the absence of clear guidance and support. I therefore recognised how crucial it was to acknowledge and learn from the key messages to support and maintain the health and wellbeing of staff, families and residents as the pandemic progressed in Northern Ireland.

335. The resulting report was published on 2nd September 2020 (INQ000276404), and the Public Health Agency (PHA) was charged to work with Trusts, the independent sector, and other relevant stakeholders to co-ordinate the implementation of the recommendations.

336. The Minister of Health then asked me to work in partnership with the care home sector to co-produce a new Framework for further enhancing clinical care for people living in care homes – the Enhancing Clinical Care Framework (ECCF) project. This project represented one of the ten Key Actions under the No More Silos action plan which aimed to ensure that urgent and

emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and staff.

337. The central aim of the ECCF project was to ensure that those living in adult care homes could continue to have equitable and easy access to the clinical and wellbeing support they want, and need, to live healthy, fulfilling lives. Having engaged with residents, their families, staff, and those organisations providing a range of support to the care home sector, it was identified that, in common with other jurisdictions, people living in adult care homes do not always have the equitable access to the clinical care they need, when they need it, to maintain their health and wellbeing. This could be due to practical considerations around residents' physical ability, or cognitive impairment impacting their ability to access to the necessary care which could not be provided within the home setting.

338. This co-produced Framework, whilst already in part use, was formally launched in August 2023 (INQ000362018), and describes best practice in care provision, with the ultimate ambition of ensuring that people living in care homes can equitably access the same range of responsive and preventative healthcare available to those living outside care homes, as part of an overarching, holistic approach to their health and wellbeing. It sets out four key areas within which this approach should be focused:

- prevention
- an anticipatory approach, self-management, and early intervention
- urgent and emergency care
- palliative and end of life care.

339. The Framework also sets out the system enablers required to ensure those working in a care home environment feel empowered, and have the suitable skills, training, and access to career development opportunities.

340. Work has commenced to take forward ECCF Phase 2 (Implementation) under the auspices of Workstream 3 of the Adult Social Care Collaborative Forum. This will provide the structures and linkages to other strategic and policy work within the Department required to advance ECCF. It will also provide the appropriate governance arrangements. The Workstream is accountable through the Chairs to the Collaborative Forum, which is accountable to the HSC Performance and Transformation Executive Board (PTEB).

Clinical Frailty Scale

341. The Clinical Frailty Scale (CFS), also known as the Rockwood Scale, was developed in 2005 and is now used in more than 20 countries. The CFS is derived from the Canadian Study of Health and Aging Frailty Index. It is employed both in routine clinical care and in research. The scale is an evidence-based measurement to assess how frail an individual is. It is on a scale of 0 to 9 with 0 being classified as being very fit and 9 classified as most frail. It is designed to consider how active a person is and how much help they may need with the normal activities of daily living including mobility, energy, physical activity, and function. It is not profession specific and therefore any member of the healthcare team may use the tool to assess frailty. In relation to nursing care the nurse can use the assessment to inform the individual persons nursing care plan and to assess progress or deterioration. The CFS requires a degree of interpretation and application of professional judgement in its use.

342. On 26 April 2020, the Assistant Director of Nursing (Adult Services) in the PHA contacted the Department (INQ000437952) to seek clarity around the Department's position on the guidelines published on 29 March 2020 by NICE around using the Clinical Frailty Scale (Rockwood) as a tool to support clinical decision making. In response it was confirmed that this had been subject to consideration by the Clinical Ethics Forum on 22 April 2020 (also INQ000437952), and that while as CNO I was not made aware of the rationale for their decision, it had been decided that the NICE guidance was not to be issued in Northern Ireland at that time, though it would be considered as part of the wider anticipatory care pathway.

343. The CFS was incorporated into the approach to developing a new Framework for further enhancing clinical care for people living in care homes – the Enhancing Clinical Care Framework (ECCF) project (outlined above). While this project was commissioned during the summer of 2020, it only reached fruition in terms of the launch of the report in August 2023. The CFS plays an integral role in the policy, and I am not aware of concerns being raised about its suitability for use at any point.

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

Charlotte McArdle **Linda Kelly** **Maria McIlgorm**

Dated: 1 May 2024