Witness Name: ROBIN SWANN, MLA

Statement No: 1

Exhibits: RS/0300 to RS/0358 (59 exhibits)

Dated: 28 June 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF:

Robin Swann

Minister of Health (11 January 2020 – 27 October 2022 & 3 February 2024 – 28 May 2024)

Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY

MODULE 3 RULE 9 REQUEST – M03-RSW-001

DEPARTMENT OF HEALTH (NI)

Contents

WITNESS STATEMENT OF ROBIN SWANN

1. I, Robin Swann, former Minister of Health for Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 17 April 2024 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3.

SCOPE OF THIS STATEMENT

2. This statement is provided from the perspective of my former role as Minister of Health in relation to the Department of Health's decision-making by the government in Northern Ireland during the Covid-19 pandemic between early January 2020 until the Covid-19 restrictions were lifted in Northern Ireland in March 2022.

A. MY ROLE

1. Professional Background

3. I was first elected to the Northern Ireland Assembly at the 2011 election, representing North Antrim, and was re-elected in 2016, 2017 and 2022. From 6 April 2012, I served as the Ulster Unionist Chief Whip, which I retained until I was elected unopposed as the Ulster Unionist Party leader in April 2017. I resigned from that position in November 2019

4. I served as the Chairman of the Committee for Employment and Learning from 27 February 2013 until the Committee was dissolved on 30 April 2016 when the Department of Employment and Learning was closed, and its mandate transferred to other departments.[1] During the short 2016 Assembly mandate I was Chairperson of the Public Accounts Committee which commenced the Inquiry into the Renewable Heat Incentive scandal. From 11 January 2020 until 27 October 2022, I served as Minister of Health.

5. The table below sets out the entirety of my roles in office between 2011 and 2022.

Period	Position	Office/Committee
31/03/2020- 28/03/2022	Committee Member	Ad Hoc Committee on the COVID-19 Response
11/01/2020 - 27/10/2022	Minister of Health	Department of Health
31/05/2017 - 13/01/2020	Committee Member	Northern Ireland Assembly Commission

[1] This was as a result of the reduction in the overall number of Ministerial Departments in Northern Ireland.

31/05/2016 - 25/01/2017	Committee Member	Committee for Agriculture, Environment and Rural Affairs
25/05/2016 - 25/01/2017	Committee Chair	Public Accounts Committee
25/05/2016 - 25/01/2017	Committee Member	Chairpersons' Liaison Group
12/05/2016 - 25/01/2017	Committee Member	Business Committee
01/03/2016 - 30/03/2016	Committee Member	Concurrent Committee of the Committee for Enterprise, Trade and Investment and the Committee for Agriculture and Rural Development
30/06/2015 - 30/03/2016	Committee Member	Committee for Agriculture and Rural Development
09/02/2015 - 14/09/2015	Committee Member	Assembly and Executive Review Committee
10/09/2014 - 30/03/2016	Committee Member	Chairpersons' Liaison Group
02/09/2013 - 10/09/2014	Committee Chair	Chairpersons' Liaison Group
09/04/2013 - 05/11/2013	Committee Deputy Chair	Committee Review Group
27/02/2013 - 30/03/2016	Committee Chair	Committee for Employment and Learning
27/02/2013 - 01/09/2013	Committee Deputy Chair	Chairpersons' Liaison Group
25/02/2013 - 11/03/2013	Committee Member	Committee for the Office of the First Minister and deputy First Minister
11/02/2013 - 04/07/2014	Committee Member	Concurrent Committee of the Committee for Agriculture and Rural Development and the Committee for Health, Social Services and Public Safety
21/01/2013 - 04/07/2014	Committee Member	Committee for Agriculture and Rural Development
23/11/2012 - 03/02/2013	Committee Deputy Chair	Ad Hoc Committee on Conformity with Equality Requirements, Welfare Reform Bill
23/05/2011 - 04/03/2013	Committee Member	Committee for Culture, Arts and Leisure
23/05/2011 - 03/12/2012	Committee Member	Committee for Agriculture and Rural Development
12/05/2011 - 30/03/2016	Committee Member	Business Committee

Source: MLA Details: Mr Robin Swann (niassembly.gov.uk)

B. Ministerial Role and Working Relationships

1. Ministerial Role

6. In a ministerial role, a Minister will exercise the functions assigned to the ministerial office that they hold and have full executive authority within any broad programme agreed to by the Northern Ireland Executive and endorsed by the Northern Ireland Assembly. As a Minister I am expected to act in accordance with the Northern Ireland Executive Ministerial Code [RS/1 INQ000262764]. The functions of a department are at all times exercised subject to the minister's direction and control as per Article 4 of the Department's (Northern Ireland) Order 1999. Ministers are accountable to the Northern Ireland Assembly for the decisions and actions of their departments and agencies, including the stewardship of public funds and the extent to which key performance targets and objectives have been met.

7. As Minister of Health for Northern Ireland both health and social care are my responsibility. The Department of Health's operational decision-making remit, and therefore mine, covers policy and legislation relating to:

- Health and social care - this includes hospitals, family practitioner services, community health and personal social services;
- Public health - to promote and protect the health and wellbeing of the population of Northern Ireland, and
- Public safety - this covers fire and rescue services.

8. Alongside the role I had in managing the Covid-19 pandemic, I was responsible for a number of legislative changes and policy initiatives during my tenure. Upon taking up post in January 2020 the pressing issue was the industrial action by health service workers which was ultimately resolved.

9. In line with my ministerial role in implementing the vision set out in Health and Wellbeing 2026: Delivering Together (a 10-year approach to transforming health and social care in Northern Ireland) I progressed legislation to close the Health and Social Care Board. This involved my approval at all stages of the legislation's passage through the Northern Ireland Assembly from First and Second Stage in March 2021 with Committee Stage in September 2021. Consideration Stage and Further Consideration Stage followed in November 2021 with Final Stage in December 2021. Royal Assent was given on 2 February 2022, immediately prior to the Assembly's

collapse on 3 February 2022, resulting in the Health and Social Care Act (Northern Ireland) 2022.

10. Aligned with the work to close the Health and Social Care Board and the transfers of its functions in the main back to the Department, in October 2020 I approved a programme of work to develop a new planning model for the Health and Social Care system. This was based on an integrated approach in the line with the vision outlined in *Delivering Together.*

11. I promoted and progressed the mental health agenda, most notably by initiating work, on and subsequently approving, the:
    - Mental Health Action Plan (including Covid-19 recovery plan);
    - 10-year Mental Health strategy;
    - Mental Health Support Fund (£16m);
    - Establishment of the community Perinatal Mental Health Service, and
    - Appointment of a Mental Health Champion.

12. In September 2020 I announced that I would bring forward reform to adult safeguarding in Northern Ireland. Following a public consultation, I agreed the Final Policy Proposals to develop the draft Bill in July 2021 and officials continue to develop the draft Bill based on this mandate.

13. In September 2021, I introduced the Adoption and Children Bill, a substantial and complex piece of primary legislation which strengthens the statutory framework for adoption and children's social care in Northern Ireland, improving safeguards for vulnerable children and enhancing support for eligible children and young people, carers and families. Over the subsequent 7 months, I led on the plenary debates for each of the Bill's legislative stages in the NI Assembly, culminating in its Royal Assent in April 2022.

14. I also introduced 'Daithi's law', formally known as The Organ and Tissue Donation (Deemed Consent) legislation, to the Assembly in 2021 and it received Royal Assent on 8 February 2022. This law changed organ donation from an opt-in to an opt-out system for the way consent is granted and follows similar law changes in Wales, England and Scotland.

15. I also led through the Assembly, by means of the legislative consent procedure, the Medicines and Medical Devices Act 2021. This was needed to agree the Department of Health as the appropriate authority for the regulatory provision governing human medicines which are transferred matters to Northern Ireland, following the withdrawal of the United Kingdom from the European Union. United Kingdom-wide Primary legislation was needed to ensure that the United Kingdom could continue to update and amend regulations relating to human medicines. The Bill was first debated and agreed in the Northern Ireland Assembly in June 2020 and further amendments were debated and agreed in November 2020. The Medicines and Medical Devices Act 2021 received Royal Assent on 11 February 2021.

16. In respect of the United Kingdom exit from the European Union I also engaged regularly with United Kingdom Ministers and provided updates to the Executive on the implications of European Union Exit for the Department of Health. This included issues relating to the availability of and regulatory framework for medicines and risks of divergence between Northern Ireland and Great Britain in respect of the Northern Ireland Protocol.

17. I launched a number of consultations including the Reform of Adult Social Care Public Consultation in January 2022, the consultation on the potential introduction of Minimum Unit Pricing for Alcohol in February 2022 and the consultation on the regulation of pharmacy technicians in Northern Ireland in March 2022. Reform of Adult Social Care was a New Decade New Approach Agreement [RS/0101 INQ000391422] commitment which I continued to drive forward during the period of the pandemic.

18. I announced two statutory public inquiries into allegations of abuse at Muckamore Abbey Hospital and Urology Services at the Southern Trust, appointing chairs and agreeing terms of reference for each. I also upgraded the Independent Neurology Inquiry to a statutory public inquiry. In addition to announcing these two inquiries, I also made 6 written statements and gave oral evidence (in May 2021) to the Infected Blood Inquiry and reviewed the Northern Ireland Infected Blood Payment Scheme. I increased payments to align with other United Kingdom schemes, including the introduction of enhanced financial support for some Hepatitis C beneficiaries and new bereaved payments.

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

2. Decision Making

20. Section 48 of and Schedule 18 to the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health to make regulations in response to the Covid-19 pandemic. Under this primary legislation the Department was alone empowered to make and amend secondary legislation to bring into effect statutory Non-Pharmaceutical Interventions (NPIs). However, the responsibility for decisions to introduce statutory NPIs lay with the Executive, as these restrictive measures impacted across the wider society and economy of NI and therefore were significant, controversial and cut across the responsibilities of two or more Ministers.

21. Paragraph 2.4 of the Ministerial Code sets out when ministers are required to bring matters deemed to the Northern Ireland Executive:

> "Any matter which:-
>
> (i) cuts across the responsibilities of two or more Ministers;
>
> (ii) requires agreement on prioritisation;
>
> (iii) requires the adoption of a common position;
>
> (iv) has implications for the Programme for Government;
>
> (v) is significant or controversial and is clearly outside the scope of the agreed programme referred to in paragraph 20 of Strand One of the Agreement;
>
> (vi) is significant or controversial and which has been determined by the First Minister and deputy First Minister acting jointly to be a matter that should be considered by the Executive Committee; or
>
> (vii) relates to a proposal to make a determination, designation or scheme for the provision of financial assistance under the Financial Assistance Act (Northern Ireland) 2009 shall be brought to the attention of the Executive Committee by the responsible Minister to be considered by the Committee.
>
> Regarding (i), Ministers should, in particular, note that:-

- The responsibilities of the First Minister and deputy First Minister include standards in public life, machinery of government (including the Ministerial Code), public appointments policy, EU issues, economic policy, human rights, and equality. Matters under consideration by Northern Ireland Ministers may often cut across these responsibilities.
- Under Government Accounting Northern Ireland, no expenditure can be properly incurred without the approval of the Department of Finance and Personnel.

22. This meant that the Executive took decisions on the introduction of new restrictions or relaxations of existing ones throughout the pandemic response.

23. It is pertinent here to explain how ministers receive information and make decisions in Northern Ireland. Typically, submissions are sent from officials setting out the background to the issue and making recommendations. It is then for the Minister to consider that advice and decide. Submissions are generally cleared by a senior civil servant before a minister receives them; as such, they are not generally documents that can be produced, cleared and decided upon in minutes. During the Covid-19 pandemic there was not always the capacity and time to follow usual procedures and oral updates, either in person, by phone or teleconferencing, proved necessary. The result of this is that there is not always a record of how I was informed of changes or of the decision I took (other than the action implementing the decision) and this is evident in some of what I say below.

3. Working Relationships

i. Chief Medical Officer

24. Throughout the pandemic I had regular and, at times, nearly daily contact with the Chief Medical Officer (CMO), Professor Sir Michael McBride. His role is to provide me with independent professional advice and he regularly supported me in 4 Nation meetings and meetings with our Republic of Ireland counterparts. The CMO also regularly attended Executive meetings to answer questions and brief Executive colleagues. I consider that I had an excellent working relationship with my CMO and, as stated in my statement in Module 2C, I am thankful to have had him in post.

ii. Chief Nursing Officer

25. I had regular, as required, meetings with the Chief Nursing Officer (CNO). There were three CNOs during the relevant period: Ms Charlotte McArdle from the start of the pandemic until the 1 November 2021; Ms Linda Kelly from 1 November 2021 until 14 March 2022 when Ms Maria McIlgorm took up post. The role of the CNO is to provide me 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 United Kingdom level. I believe I had an excellent working relationship with each of the CNOs.

iii. Other Ministers of the Northern Ireland Assembly

26. At the start of 2020 there had been no functioning Assembly or Executive in place for over three years. Departments were without Ministers for the entirety of this period and the legal decision-making ability of the senior Northern Ireland Civil Service was very limited. Having been without an Executive for 3 years where there had been high levels of political disagreement and public display of those disagreements, it was going to be challenging to establish a 5-party mandatory coalition, who had been brought together on the back of the "New Decade, New Approach" document which was co-authored by the British and Irish Governments, rather than the five parties. However, I had regular contact with all of my ministerial colleagues, primarily through Executive meetings, the frequency of which increased during the pandemic from once per week to twice a week, and at short notice when required (these were conducted primarily via zoom), but also through ministerial colleagues approaching the Department of Health for advice, for example on how dog groomers could reopen safely.

27. The Northern Ireland Executive did face challenges because of the 5-party mandatory coalition where parties identify as Unionist/Nationalist/Other, right/left/centre of economic and social policy and pro or anti Brexit. A further challenge was that the government had only been formed in the weeks immediately preceding the pandemic taking hold, following a 3-year hiatus of there being no government. We were still learning how to work as a cohesive unit when we were faced with a global pandemic.

28. In the early stages of the pandemic, I did feel that there was support from other Executive colleagues, especially from the First and deputy First Minister, despite the deputy First Minister's initial criticism. As the pandemic progressed, however, there were other Ministers who publicly criticised the Executives response, by unfortunately

using me and the Department of Health as the proxy for that criticism. During the early stages the Junior Ministers took the Covid Regulation debates through the Assembly, which both took time pressure off me but also, I believe, demonstrated that the regulations being brought forward were Executive regulations and not solely those of the Department of Health.

29. Due to the different stakeholders each Department had there were times when Departmental Ministers would have disagreed with each other. Minister Dodds, for example, during her tenure at the Department of the Economy, was a strong advocate for those stakeholders she represented at the Executive, so while both her and I made representations and presentation that could be at odds, especially around Non-Pharmaceutical Interventions, I do not consider it to have been a significant impediment to our working relationship.

30. The leaking of documents was a continuing concern and difficulty for the Executive, but, unfortunately, around either the introduction of, or easing of, Non-Pharmaceutical Interventions it almost came to be expected. It did cause tension at times, especially when not just Executive papers were being leaked, but, on more than one occasion, it seemed that some in our media were being given a live update as to what was being discussed at Executive meetings. I feel that the leaking of papers prior to the Executive meetings was done in such a way as to try and exert public or stakeholder pressure on certain Ministers or Parties, prior to the meeting, to make certain decisions. They also created an air of mistrust and frustration among ministers as to where exactly the leak was.

31. Ministerial relationships became strained following alleged breaches of rules by senior political figures and senior civil servants. It has been well-documented elsewhere, but following the deputy First Minister's attendance at a funeral in June 2020, the First Minister and deputy First Minister would not do joint press briefings with the consequence that for a period they became solely Department of Health press briefings.

iv. Secretary of State for Health and Social Care and Ministers in Devolved Administrations

32. There was open and regular engagement between the health ministers of the 4 nations from the onset of the pandemic where there were regular, at least weekly, meetings. Due to the regularity of these meetings, at least initially, from a health

perspective the relationship between the health ministers of the 4 nations was built on trust and mutual respect: we were all facing the same challenges and were able to have open and frank discussions. Unfortunately, as the Secretary of State for Health of Her Majesty's Government changed, so too did the frequency and opportunity of the meetings. I continued to have a good relationship with Sajid Javid, following his appointment in June 2021, but was unable to secure meetings with either Thérèse Coffey or Steve Barclay following their respective appointments [RS/0300 INQ000485715; RS/0301 INQ000485716].

v. Republic of Ireland Minister for Health

33. The primary form of engagement with my counterpart in the Republic of Ireland was through quad meetings, North South Ministerial meetings and 1-2-1 meetings. From the outset of the pandemic, I had a good and open working relationship with Simon Harris TD but, following the change in Government in the Republic of Ireland after their election in February 2020, this unfortunately did not continue with Stephen Donnelly TD where engagements were more structured and intergovernmental with the formation of their coalition government in June 2020. At one point Minister Donnelly declined to meet me over cross border outbreaks for a number of weeks, stating that officials should meet instead [RS/0302 INQ000485717; RS/0303 INQ000485666; INQ000400882].

34. In addition to meeting with my ministerial counterpart, I sought, where possible, to use the strong working relationships already in place between the two Chief Medical Officers, the Public Health Agency and the Health Services Executive.

4. Ability of HSC to cope with Covid-19

35. The Public Health Agency (PHA), the Health and Social Care Board (HSCB and now Strategic Planning and Performance Group (SSPG)) and Business Services Organisation (BSO), collectively known as HSC Silver [INQ000102841 (DoH ref: 5018)], provided regional coordination of the HSC response to the pandemic. The Silver response was aligned with the strategic objectives set by Health Gold. HSC Silver forwarded, a daily Situation Report (Silver SitRep) to the Emergency Operations Centre Situation Cell, which provided validated key information and data on the situation. This daily Silver SitRep allowed the HSC to identify issues that should be escalated to the Department, whether to seek strategic advice or to require a strategic decision; and it provided the Department with an overview of the key issues in sufficient detail to keep Health Gold informed and to enable strategic

decisions to be made whenever necessary. The information was entered into reporting and decision logs [PM/54 INQ000130312 (DoH ref: PM0037)] which were maintained by the Emergency Operations Centre. I was informed of the detail in the Health Silver SitReps, and therefore the ability of the HSC to cope with the Covid-19 pandemic, through oral briefing sessions, submissions from my officials, and regular meetings with officials from Arm's Length Bodies and HSC Trusts.

36. In terms of how I was informed of the level of care of non-Covid conditions, as an example, in consultation with the HSCB, in mid- March 2020 the PHA produced proposals in relation to the population screening programmes, in the context of the emerging Covid-19 outbreak in NI [PM/159 INQ000120730 (DoH ref: PM0142)].The PHA proposals were to pause most screening programmes for a defined period (3 months initially) to release staff to undertake other duties related to the Covid-19 surge, but to complete screening investigations and ongoing surveillance monitoring for those who were under investigation for a potentially adverse screening result at that time. A paper on the risk assessment undertaken by the PHA for each screening programme was shared with HSC gold in mid-March 2020 [PM/158 INQ000346699 (DoH ref: PM0375)]. Proposals [PM/159 INQ000120730 (DoH ref: PM0142)] on the temporary cessation of population screening programmes were submitted to me for consideration and decision relating to the four broad categories of screening programmes: cancer screening; non-cancer screening; and antenatal and new-born screening programmes. I agreed to pause certain screening programmes while maintaining those that are time critical and/or focussed on high-risk occupations. It was subsequently announced on 7 April 2020 that routine screening programmes[2] had been temporarily paused to allow staff and resources to be reallocated to tackling Covid-19. The pause in screening was also intended to minimise risk to those people who attend screening programmes, in a higher-risk category from potentially contracting coronavirus, through maintaining social distancing.

37. A significant downturn in activity was experienced by all services within Health and Social Care and the impact of the pandemic remains a challenge in all service areas.

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

The impact of the pandemic across health and social care services, programmes and projects has been considerable, as resources were focused on the required emergency response. Following the formation of the Rebuilding Management Board in June 2020, chaired by the then Permanent Secretary, Richard Pengelly, I received updates on the restoration of screening services through this group through written submissions, verbal updates, emails and provision of the Trusts' rebuilding plans [PM/6034 INQ000130386; PM/6035 INQ000426978; PM/6036 INQ000346727; PM/6037 INQ000346734]. While I had requested a change to the Terms of Reference to allow me to attend meetings, I never exercised this right and was content to receive updates.

i. Frontline workers

38. I was also kept informed of the views of those working on the frontline and their own ability to respond to the pandemic and how they were coping with their role through regular meetings with Royal Colleges, Arms Length Bodies and Chairs of the Trusts. When concerns over the supply, quality and usage of PPE arose, I announced that the Department had established a new dedicated mailbox to allow concerned members of staff across the Health & Social Care workforce to raise issues. Details of the mailbox and how it would operate was published on the Department's website [PM/6383 INQ000477526]. A review report [PM/6384 INQ000438126; PM/6385 INQ000416360; PM/6386 INQ000416354; PM/6387 INQ000411115; PM/6388 INQ000411114] was produced and I received it on 5 February 2021, identifying those key themes and lessons learned from the content of the emails received.

39. From the start of my tenure on the 11 January 2020 I had frequent contact with Trade Unions due to the ongoing pay dispute and this continued throughout the pandemic. I distinctly remember our discussions included how those on the front line were coping with their roles during this period.

5. Consideration of Impact of Decisions on the Vulnerable

40. I was very aware of the impact my decisions would have on those groups with health-related concerns, particularly those who received 'shielding letters'. As a result, the letters offered advice on staying safe; how to access further information and support, including through the Northern Ireland Community Helpline; advice on indoor exercise and mental health tools and enabled those in receipt of a letter to access support schemes being offered to the most vulnerable by the Department for Communities [RS/40 INQ000130315]. The Department of Health worked with the

Department for Communities to put arrangements in place for priority access to online grocery shopping slots for those who were Clinically Extremely Vulnerable; this was in place from early May 2020 until shielding paused on 31 July 2020.

41. With my support, and that of the First and deputy First Ministers, the Chief Medical Officer emailed [RS/41 - INQ000346716] the Chief Executive of the Patient and Client Council on 27 May 2020 asking that the Council undertake research to "inform the relaxation of some of the current restrictions around outdoor exercise and possible subsequently meeting family outdoors in small numbers with appropriate safeguards and precautions."

42. The Patient and Client Council (PCC) was created on 1st April 2009 as part of the reform of Health and Social Care (HSC) in Northern Ireland. They act as an independent voice for patients, clients, carers and communities. The PCC has five main statutory functions and duties. They are:

- To represent the interests of the public by engaging with them to obtain their views on services and engaging with health and social care organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
- To promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- To provide assistance to individuals making or intending to make a complaint relating to health and social care;
- To promote the provision of advice and information to the public about the design, commissioning and delivery of health and social care services; and
- To undertake research and conduct investigations into the best methods and practices for consulting the public about, and involving them in, matters relating to health and social care; and provide advice regarding those methods and practices.

43. I published a statement on 10 June 2020 encouraging people who were Clinically Extremely Vulnerable, and those supporting them, to participate in the survey, the aim of which was stated to 'understand the impact shielding has had on individuals, to inform the steps and processes that must be considered now and in the future, and to ensure that the voice of those impacted by shielding was heard' [RS/42 INQ000348702].

44. The final Patient and Client Council survey report [RS/43 INQ000344088] was published in July 2020. The findings of the survey indicated that fear of Covid-19, and the risk it represented, was the dominant concern among those surveyed. In addition, shielding appeared to have had detrimental social and psychological effects on a significant group of respondents, although relatively very few of those surveyed mentioned a need for professional support or counselling. The survey found that those who were shielding prioritised being kept informed with clear advice and guidance, along with the scientific rationale for this advice. A considerable number of respondents felt that the shielding community was often 'forgotten' or 'ignored' as changes to guidance and restrictions for the wider population were announced. The need for the provision of updated advice and guidance to Clinically Extremely Vulnerable people was kept under continuous review and took account of the research undertaken by the Patient and Client Council including the mental health impact of shielding.

45. In April 2020, in partnership with the Education Minister, I outlined a package of measures, worth around £12 million, to support vulnerable children and the children of key workers [RS/71 INQ000400104]. They included:

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

46. On 23 April 2020 I launched, jointly funded with the Department of Communities, a remote interpreting service for sign language users [Exhibit RS/72 INQ000346720]. The service enabled British Sign Language and Irish Sign Language users to access NHS111 and health and social care services during the Covid-19 pandemic. The service was available 24 hours a day, 7 days a week.

47. On 29 April 2020, along with the Minister of Justice, I issued guidance on maintaining contact between parents and children during Covid-19, stating that the mandatory stay at home message does not apply to children moving between households.

48. Executive colleagues also had support packages for their stakeholders. The Infrastructure Minister, Nichola Mallon, and Agriculture, Environment and Rural Affairs Minister, Edwin Poots, put further community transport measures in place to ensure vulnerable people in rural areas isolated as a result of Covid-19 have access to vital services.

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

49. The Minister for Agriculture, Environment and Rural Affairs announced £200,000 had been allocated to the emergency 'Coronavirus Community Fund'. The Community Foundation NI considered applications for grants up to £10,000 to community organisations to deliver targeted practical support for the vulnerable and isolated, especially in rural areas and for those of all ages who were at increased risk due to poor mental health and wellbeing [RS/71 INQ000400104].

50. In addition to the above the Department also engaged at an early stage with AgeNI, the leading charity for older people in Northern Ireland, and the Commissioner for Older People. I also met with the Commissioner for Older People in July 2020.

6. Expert Advisory Groups

51. There were a wide range of Expert Advisory Groups and boards that officials in the Department of Health had involvement with during the pandemic. These included the following:

- Civil Contingencies Group NI;
- Health Emergency Planning Forum;
- Critical Threats Preparedness Steering Group;
- Joint Emergency Planning Board;
- New and Emerging Respiratory Virus Threats Advisory Group;
- Scientific Advisory Group for Emergencies;
- Joint Committee on Vaccination and Immunisation;
- Strategic Intelligence Group;
- Care Home Task and Finish Group;

- Expert Advisory Group on Testing;
- NI Modelling Group;
- Covid-19 Vaccination Programme Oversight Board;
- The Northern Ireland Systematic, Meaningful, Asymptomatic, Repeated Testing Programme Board;
- Test, Trace, Isolate, Protect Strategic Oversight Board; and
- Covid-19 Therapeutics Oversight Board.

52. While I did not attend any of these myself, I received relevant updates and advice from the officials who did attend by way of written submissions, verbal updates and information for Executive papers. At times, this advice would also have been presented to the Executive to aid in our decision making. The NI Modelling Group frequently provided information and advice on the 'R' number to the Executive; for example, at the Executive meeting on the 8 October 2020 I provided a paper which modelled the course of the pandemic [RS/82 INQ000276520; RS/83 INQ000259622; RS/84 INQ000196853]. I was extremely concerned about the situation, as reflected in my recommendation to the Executive that an intervention to reduce R to 0.7 was required as soon as possible in order to prevent the hospital system from being overwhelmed and to prevent deaths.

53. The Expert Advisory Group on Testing (EAG-T) was established by the Department to develop the NI approach to Covid-19 testing and to oversee and coordinate the implementation of testing. I received updates via submissions (see, for example [RS/0304 INQ000440008], emails and verbally. I presented its Covid-19 Testing Strategy [PM/98 INQ000103649 (DoH ref: PM0054)] to the Executive on 6 April 2020 and subsequently an updated version on 21 May 2020 [PM/99 INQ000103650 (DoH ref: PM0055)]. The updated Strategy set out how testing capacity had expanded and was being used on a prioritised basis. The Strategy was supported by an Interim Protocol for Testing for Covid-19 [PM/100 INQ000120705 (DoH ref: PM0056)], PM/101 INQ000103724 (DoH ref: PM0247)]. The Protocol was an operational tool which provided information on eligibility for testing and advice on how to access testing. The Interim Protocol was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity. I received updates on the work of the EAG-T by way of written submissions [RS/0305 INQ000485668; PM/98 INQ000103649 (DoH ref: PM0054)].

54. A NI Covid-19 Vaccination Programme Oversight Board was established in July 2020, chaired by the CMO [RS/0306 INQ000485669]. Its role was to set the direction for the Covid-19 vaccination programme, oversee the progress of the development and implementation of the vaccination programme, as well as manage the strategic interfaces between the expanded 2020/21 seasonal flu vaccination programme and the expected Covid-19 programme [INQ000276631 (DoH ref: PM2308)]. The Oversight Board was accountable directly to the me, and recommendations concerning strategic policy issues were submitted to me for decision via oral or written briefings, while operational decisions were taken by the CMO. The Oversight Board's membership included representation from across the Department including, Pharmacy, Nursing, Health Care Policy group, Health Protection, Emergency Planning, as well as the Public Health Agency, Health and Social Care Board and the Regional Pharmaceutical Procurement Service. Membership of the Oversight Board changed as necessary as the programme was implemented.

7. Decisions of the United Kingdom Government

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

56. JCVI had issued an interim vaccination prioritisation list on the 25 September 2020, which helped focus decisions on delivery plans. The ranking of priorities was a combination of clinical risk stratification and an age-based approach, aimed to optimise both targeting and deliverability. I was updated orally on developments and by submissions on 4 November and 16 November 2020 [INQ000276627 (DoH ref: PM2304); INQ000276633 (DoH ref: PM2310); INQ000276634 (DoH ref: PM2311)].

As such, the Department's Covid-19 vaccination strategy, including prioritisation, was based on advice provided by the UK Joint JCVI which I approved and which was supported by the NI Executive.

57. The Department for Business, Energy & Industrial Strategy led on the procurement of Covid-19 vaccines on behalf of the whole UK, and it was agreed each UK country would receive its Barnett[3] share of the total available approved vaccines. For NI this meant that it received 2.85% Barnett share of the available vaccines approved for use at that time. As this was based on a percentage of the overall UK population it seemed to me to be as fair a way as practicable to do this.

58. The decisions and advice of the UK government in these areas would appear to have had a positive impact on our healthcare system as the prioritisation for vaccines ensured the most vulnerable were vaccinated first, which in turn provided them with some protection from the virus meaning they were less likely to become seriously ill from it and require hospitalisation. It should be noted, however, that Northern Ireland did diverge slightly from the JCVI on care home residents as we were more proactive and were able to deploy in care homes as soon as a vaccination was available. The JCVI identified care home residents as a top priority but in Northern Ireland we took the decision to make them **the** top priority. I remain proud that the very first day of the Northern Ireland vaccination programme included the vaccination of the residents of a Care Home. I believe the Northern Ireland specific approach to testing and vaccination undoubtedly reduced the impact of COVID-19 on Care Home residents and staff throughout the course of this pandemic. By 8 January 2021 90% of care homes had been visited by vaccination teams in Northern Ireland, compared with 50% in Scotland and only 10% in England [RS/0307 INQ000485670]. By 26 February 2021 all care home residents in NI had been offered both vaccines [RS/0308 INQ000381472].

59. The 'Eat Out To Help Out' scheme was an initiative of the UK Government and I understand, from the Department's Module 2C statement and from the Chief Medical Officer and Chief Scientific Adviser, that views were not sought on it. While it is difficult to quantify the exact impact on the healthcare system that the scheme had,

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

the general advice of the Chief Medical Officer and Chief Scientific Adviser that any activity that increased interaction between people would ultimately increase the risk of transmission remained valid. With the benefit of hindsight, it would appear that the scheme did have an impact on the transmission of the virus, and therefore the healthcare system, but I cannot say definitively as there were other factors at play during that time, including the return of schools and increased interaction in general during the summer months.

8. Equality Impact Assessments

60. Due to the pace at which the pandemic evolved it was not possible to carry out equality impact assessments on all legislation enacted. This was particularly true of the regulations introduced to put NPIs on a statutory footing which were subject to regular reviews. Each review considered the public health implications, as is reflected in the relevant review of regulations papers subsequently submitted to the Executive and any potential emerging equality issues, which required amendments to the regulations would have been reflected in the reviews [INQ000276510 (paragraph 46 gives consideration to health impacts)]. In the circumstances, however, it was not possible to carry out an Equality Impact Assessment on those individuals or groups with protected characteristics.

61. Prior to the making of the Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) Regulations (Northern Ireland) 2020, departmental officials conducted equality impact screening, which I was informed of [RS/0309 INQ000485672; RS/0310 INQ000485673], in accordance with guidance produced by the Equality Commission for Northern Ireland and in keeping with section 75 of the Northern Ireland Act 1998. A further equality screening exercise was conducted before the extension of the operational period of the Regulations for a further six months. In both cases, it was concluded by the officials carrying out the assessment that a full Equality Impact Assessment was not required. Rural needs impact screening was also conducted prior to both the making and the extension of the Regulations and no adverse impacts were identified.

62. In order to ensure the Regulations would achieve their intended effect of enabling essential children's social care services to continue to be delivered during the pandemic in a safe manner to protect vulnerable children, their families/carers and social workers, departmental officials liaised at key points prior to, and following, the making of the Regulations with:

- The Northern Ireland Commissioner for Children and Young People;
- The Children's Law Centre;
- The Voice of Young People in Care;
- The Northern Ireland Human Rights Commission;
- Fostering Network (Northern Ireland), and
- The British Association of Social Workers (Northern Ireland).

63. Discussions also took place with representatives of the Health and Social Care Board, the Health and Social Care Trusts, voluntary adoption agencies and the Northern Ireland Courts and Tribunals Service. On the basis of those discussions, amendments were made to the draft Regulations, including the removal of a provision granting the Department the power to extend the modifications contained in the Regulations by a further 3 months after the expiry of an initial period of 6 months. This clearly limited the period for which the Regulations would have effect and meant that the Department would have to bring new Regulations to the Assembly if it wished to make provision beyond the 6-month expiry date.

64. Officials also took on board a range of suggestions relating to the draft guidance, including amending some of the timescales set out in the guidance relating to undertaking reviews and representations/complaints procedures, and strengthening key messages on how the flexibility provided by the Regulations should be exercised.

65. Before extending the operational period of the regulations, officials again consulted the NI Commissioner for Children and Young People and notified other key stakeholders, including the Northern Ireland Human Rights Commission and Children's Law Centre. In written evidence provided to the Health Committee, the Commissioner and the Northern Ireland Human Rights Commission indicated that, overall, they were content for the Regulations to be extended.

66. The Department also carried out equality screening on Covid-19 guidance for residential children's homes, foster care, supported accommodation for children aged 16+ and young adults, and adoption services. The screening exercises were completed between May 2020 and July 2020 and concluded that the guidance would have no impact, or minor positive impacts on looked after children and young people, including those children with a disability within the looked after child population. This conclusion was reached on the basis that a primary aim of the guidance was to

facilitate the continued provision of safe care, and to protect the health and wellbeing of children, young people, their parents and carers.

C. State of the Healthcare System in Northern Ireland Prior to the Start of the Pandemic

67. I believe it is important to consider the context of early 2020. There had been no functioning Assembly or Executive in place for over three years. Departments were without Ministers for the entirety of this period and the legal decision-making ability of the senior Northern Ireland Civil Service was very limited. Even before 2017, the political environment in Northern Ireland had often been unstable.

68. On the 14 May 2020 when I addressed the Northern Ireland Assembly's Ad Hoc Committee on Covid-19 [INQ000290375] I highlighted key areas where I believed collective past political/Governmental failings left health and social care vulnerable to the pandemic. I believed then, and still do, that over the previous decade Stormont had let the Northern Ireland Health Service down by not looking after health and social care as well as it could, and should, have done. It is my view that whilst Health was a devolved matter during this period, there was very limited local control over finances, vital services were underfunded, short term decisions were made instead of longer-term planning and difficult decisions were avoided. Social care was particularly neglected with a lack of proper pay and career structures, leaving our care homes exposed.

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

70. I remain of the opinion now that the lack of a recurrent budget had an adverse effect on the readiness of public services to prepare for a whole-system civil emergency. The Department of Health has been faced with single year budgets since 2015/16. With single year budgets the funding position is only known for 12 months which means the focus is on the short term. When single year budgets are coupled with

funding provided on a non-recurrent, or single year basis the position is exacerbated as you cannot make commitments over a number of years with no funding guaranteed. This had impeded long term financial planning and resulted in a focus on the short term. All recurrent funding received by the Department in recent years had been used to fund the costs associated with maintaining existing models of service and associated cost pressures. During this time, there has been limited budgetary cover to also fund service improvements. Single year injections of transformation funding, whilst successful in part, were not sufficient to embed the systemic change required due to their short-term nature. A recurrent multi-year funding commitment would have better supported the planning, delivery, and sustainability of our services. It would have also enabled us to develop plans to transform our services fully given that a multi-year budget guarantees funding over a number of years which enables long term planning and the ability to enter into commitments over a number of years as the funding has been assured.

71. In 2021 a judicial review was taken against the Department, and in his affidavit a Departmental official made a number of comments with which I agree, and which highlight the importance of a multi-year budget in order to make sustained progress and transformation [RS/0356 **INQ000492280**] Given that I concur with these comments, I repeat them below:

> "*The Department has been increasingly reliant on securing non-recurrent additional funding during in-year monitoring rounds to support the ongoing running costs to maintain existing services. This is far from ideal in terms of the planning and management of services. Non-recurrent funding cannot be used to invest in staff or services as there is no guarantee that it will be available in future years. As well as being faced with consecutive single-year budgets, the Department has needed to identify significant reductions in costs on an annual basis. The resultant impact is a focus on measures which can be taken to reduce costs, rather than on strategic measures which have been recommended for the transformation of service delivery models which could deliver increased capacity and efficiency in the longer term.*
>
> *The effect of these challenging financial circumstances is a very limited scope for in-year additional initiatives to counter rising hospital waiting times and growing pressures elsewhere in the system. Since 2015 the annual budget allocated to the Department has not been sufficient to keep waiting times to an acceptable level. There has been an acknowledgement that there is an*

imbalance between patient demand for many elective specialties in Northern Ireland and the available recurrently funded capacity. While doctors, nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow to a level where many believe that they are now out of control, will take years to stabilise and even longer to return to their pre-2015 levels.

Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround. A multi-year budget approach is needed to secure a recurrent funding source to increase the capacity of our elective care system, whether in-house or through increased use of the independent sector, and to enable us to invest in the staff and infrastructure required.

In January 2020 the Northern Ireland Executive committed, through the New Decade New Approach agreement, to tackle unacceptably long elective care waiting lists. This indicated the new Executive's support for the Department's existing ten-year transformation strategy: Health and Wellbeing 2026: Delivering Together. In order to achieve this, it was envisaged that spare capacity across the United Kingdom and the Republic of Ireland could be used; however, it was recognised that this would take sustained investment over a number of years. Aside from the challenges presented by Covid-19, the single year funding approach means that the Department cannot develop the long-term approach that is essential to taking this work forward.

What is needed at a minimum is a recurrent source of earmarked funding, agreed in advance, to close the capacity gap and address the patient backlog. Longer term surety of funding at a significant scale will enable innovations both in-house and with independent sector providers."

72. The political and Governmental limbo between 2017 and 2020 prevented progress towards a multi-year budget, which in turn inhibited the ability to take any long-term strategic decisions. In the Judicial Review mentioned above, the Departmental official's affidavit describes the impact the lack of an Executive had on elective care, in terms which I fully agree:

"*As part of the implementation of Delivering Together, the Department published an Elective Care Plan on 21 February 2017 [RS/20 INQ000400119]. The Plan set out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity.*

The collapse of the Northern Ireland Executive in 2017 was a significant contributory factor to the inability to implement the 2017 Elective Care Plan. While transformation funding was made available, this was only for a two-year period, which did not allow for long-term, or even medium-term planning.

Since then, the number of patients waiting has increased as the health service deficit has increased. Waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels. With the pressures of maintaining services in this period, allied to the impact of the pandemic, there is a real risk of burnout among staff. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround."

73. In addition, when I took office there was ongoing industrial action by healthcare workers which required my immediate attention to rebuild relationships and trust. I would contend that it is entirely possible that if there had been a functioning Executive during the period 2017 and 2020, that the industrial action would have been avoided. Issues relating to lack of reform, pay parity and patient safety meant a demoralised workforce, that felt undervalued, and sparked the industrial action. Without a functioning Executive, the restoration of pay parity sought by Health workers could not be delivered by Departmental Officials. The absence of a functioning Executive prolonged the industrial action, which is evident given the swift resolution of the issues, once government in Northern Ireland was restored. However, that loss of confidence from staff, the depletion of staff, as well as the inevitable disruption to the delivery of core health and social care services, inevitably had a negative effect on the resilience of the local health and social care system as it entered the pandemic phase. The proper financial recognition of our staff would have seen a stronger, more resilient workforce.

74. I took office with the initial challenge of resolving the industrial action; by that stage it took a lot of time and commitment from all sides to resolve. There were also

additional cultural challenges as to how any Department responded to having a Minister back in post and the additional mechanisms, and work, that came from having an Executive/Assembly/Health Committee back in place. By cultural challenges I mean officials had had three years when the usual machinery of government, and the administrative processes involved, had not been operating, for example answering oral and written questions, and ministerial briefings, meetings and visits. Department officials moved overnight from being led by Permanent Secretary to being led by an elected Minister who had responsibilities and duties connected to a reformed Executive. In addition, during the three-year hiatus, it had not been possible to take forward any legislation within Northern Ireland and those officials involved in the development of policy where legislation was anticipated as the end result may have been redeployed to other areas.

74.1 Given the mandatory coalition that operates when Northern Ireland has a government it is also entirely possible that when a new Assembly is elected that a different political party will take responsibility for a department. This has the potential effect of previously agreed policies being changed or discarded entirely as a new minister, from another political party will, in all likelihood, have different priorities and ideas. All of this means that departments and officials are not just adapting to having ministers again, but also potentially to changes in previously agreed policies and strategies.

74.2 The examples I have given of challenges apply across all departments. I do not consider that any of these challenges had a specific impact on how Department of Health officials and HSC staff responded to the pandemic. Departmental officials worked long hours, and at pace throughout the pandemic, against the backdrop of the cultural challenges mentioned above. At the early onset of the pandemic when the Assembly ceased to function there was a noticeable increase in the number of Assembly Questions for Written answer. This naturally had an impact on Departmental officials, who along with progressing urgent policy and legislation in relation to Covid-19, also had to answer an increasing number of questions. The Executive wrote to the speaker raising concerns about the number of questions and seeking a reduction in the number that members were encouraged to ask. I also wrote with similar concerns and seeking the same reduction, which was subsequently allowed, although it was voluntary.

75. If there had been political leadership during the 3 years, 2017-2020, I believe that at least some transformation would have taken place, in line with the recommendations of the Bengoa and Delivering Together Report, and that this would have placed the Health Service in a better position to continue with core work, both before and during the pandemic. It is, of course, impossible to quantify exactly how much of the transformation agenda would have been achieved in 2017-2020. Implementation of the recommendations would have meant that the Health Service would have been in a better position to continue with core work such as the further introduction of Multi-Disciplinary Teams in Primary Care and the further development of overnight elective care and day case units. I also consider that it would have permitted the development of green/non-covid sites more quickly than we were able to do so as the groundwork would have already been completed through transformation processes rather than a pressurised system.

76. While the medical staff we have in Northern Ireland are excellent, as evidenced by their work during the pandemic, it cannot be denied that the numbers and funding are inadequate. This is evident from the New Decade New Agreement which set out a key priority of providing a further 900 pre-registration nursing and midwifery training places over a 3-year period, commencing in 2020/21. It is also evident in the difficulties experienced by some Trusts in Northern Ireland retaining and recruiting staff as well as the current difficulties in respect of some General Practitioner Contracts [RS/21 INQ000400099].

D. Initial Response to the Pandemic including Planning and Modelling

77. By early March 2020, I was aware that extensive work had been undertaken to ensure all HSC Trusts had Covid-19 facilities in place to enable patients suspected of having Covid-19 to be assessed and treated away from routine hospital work. This is included reconfigurations such as: separated Covid and Non-Covid areas in Emergency Departments; one way systems in hospitals; introduction of social distancing/cordoned zones in seated areas; enhanced cleaning; and, preparations to cohort suspect-covid patients in separate wards. I confirmed that the Department continued to review the best use of testing and clinical pathways so that individuals would receive the appropriate care, whilst recognising that many patients would have a mild illness. I also outlined to Members of the Assembly the new structures that the Department had established to plan for the anticipated surge in hospital admissions [INQ000103639]. However, as this related to the operation of healthcare settings I

would not have had any particular role in the decisions made. These decisions were taken at Trust level and I was informed of the action.

78. I met with the Secretary of State for Health and Social Care, Matt Hancock, on the 13 March 2020. Also present at the meeting was the CMO, my SpAd and an official who took notes. During the meeting we discussed the actions being taken then on Covid-19 and those being planned. Unfortunately, I cannot locate the note of the meeting and can no longer recall specific details. I believe a note was taken by my private secretary and sent to my Special Adviser but no draft was kept and searches undertaken by my Special Adviser and Private Office have not found a record. I am aware that the following day I met senior government representatives from the Republic of Ireland [INQ000371538].

79. From a health perspective I believe there were only a couple of significant differences between the four nations of the UK; for example, I refused to adopt the policy from Public Health England that in certain cases PPE was reusable as I did not think the reasoning robust. [PM/6381 INQ000477524]. The Department also did not differentiate older people's Care Homes from other types of Care Homes. I recognised that residents of care homes were not simply older people, but also younger people who, for various health reasons, were unable to live independently. When Public Health England was abolished in March 2021, I did not contemplate a similar move in relation to the Public Health Agency in Northern Ireland as I considered it an essential part of the health care system structure. The PHA was central to our response and due to the small number of individuals working in public health it would have caused unnecessary upheaval without a clear benefit to Northern Ireland's response. The Department also did not have the capacity or resource to scope such a dramatic move. Furthermore, at that point the PHA had undergone a review and was being strengthened [INQ000102852]. The differences that did exist, for example in terms of NPIs and their imposition and relaxation, were Government and Executive decisions rather than specific health decisions. More often than not the differences in approach could be explained by where each nation was in terms of the spread of the virus rather than any particular disagreement in approach.

1. Surge Planning

80. The creation of the Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April was the result of work by several groups that had been

created across a number of disciplines to ensure coordination. From their creation to the publication of the plan on 19 March 2020 I would have been kept informed of the progress by means of oral updates and briefings and my agreement sought at appropriate points [RS/0311 INQ000485674]. In normal times such updates would be by written submission, and my comments and agreement in turn in writing, but due to the pace at which this work was required, officials were not always able to use this channel.

81. I have dealt with my understanding of the surge planning work in section F, below, on Capacity.

2. Modelling and Recording of Deaths

82. In the early stages of the pandemic, estimates of the likely impact on NI were based on assumptions and estimates generated by SAGE and its SPI-M-O subgroup. On 27 January 2020, SPI-M concluded that there was not sufficient evidence to estimate a reasonable worst case scenario for 20190bCoV and that it would be reasonable to use the Reasonable Worst Case for pandemic influenza [RS/0312 INQ000213151]. This suggested that up to 50% of the population would become ill, with infection attack rates up to 80-85% and a case fatality ratio of up to 2.5%. This advice was confirmed by SPI-M-O on 10 Feb and 17 Feb 2020 and was the scientific basis of the observations of the CMO at the Executive Committee on 2 March 2020 [INQ000065694].

83. On 6th March 2020 SAGE updated the COVID-19 Reasonable Worst Case Planning Assumptions to indicate an Infection attack rate of 80% and an Infection fatality rate of 1% of all infections, with a significantly higher infection fatality rate in older age groups [RS/0313 INQ000258365]. This was the basis of the overview contained in the Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020.

84. At the Executive meeting on 19 March 202 I am noted as saying that the "worst case scenario for Covid-19 in Northern Ireland was 32,000 new cases per day with 9,500 deaths; with intervention, that figure would be reduced to 10,000." [INQ000065737, page 8]. These are handwritten notes that I did not have sight of at the time, so my recollection is limited. I believe the figure of 32,000 new cases per day came from the attached exhibit [INQ000258050]. I regret I cannot recall where the information

on the potential number of deaths came from. I would clarify, as the note could be misconstrued, that the 10,000 figure relates to number of cases per day and not the number of deaths.

85. The DoH modelling group began to meet from around 23 March 2020 and produced its first NI specific reasonable worst case scenario on 1 April 2020 [INQ0000137369], which was subsequently updated in the first two weeks of April as additional data emerged. The actual progression of the pandemic during this period remained significantly below the figures proposed for planning purposes in the reasonable worst case scenario of 1 April 2020 and subsequent modelling, so the modelling did not underestimate the development of the pandemic in NI or its potential impact upon HSC.

86. The HSC response to the pandemic was mainly driven by community transmission of the virus, case numbers and HSC pressures, in addition to deaths data, and therefore the manner in which Covid-19 deaths were recorded did not have significant impact on the way that HSC responded to the pandemic. Furthermore, because of the lag period between Covid infection, hospital admission, ICU admission and deaths, deaths were a late indicator or progression of the pandemic, lagging significantly behind other lead indicators, and were therefore of less value for planning purposes.

87. I agreed to the CMO commissioning the PHA to provide relevant clinical data, including data on deaths, to contribute to the NI Covid-19 Dashboard. At the outset of the pandemic, the established system for monitoring and reporting on deaths in NI was through the General Register Office (GRO); data reporting was based on death certification and by necessity included a lag time in reporting as following each death, certification needs to be completed, the death reported to the GRO, and the data analysed and reported. This system continued to operate throughout the pandemic and remained the definitive source of reporting on deaths occurring in NI.

88. In a rapidly evolving context at the outset of the pandemic the PHA established an additional reporting system to capture information on deaths occurring in HSC settings (reporting based on deaths in individuals within 28 days of a positive test). This reporting and monitoring system was established by PHA in a timely manner and it mirrored similar reporting systems established in other UK countries. The

Department supported PHA as this data stream was established. The approach adopted by PHA was similar to that taken by the other public health bodies/agencies in the UK. Throughout all phases of the pandemic, the PHA continued to work closely with Departmental officials and colleagues across all UK nations to both capture and report public health information relating to progress of the pandemic.

89. Care homes are formally regulated in NI and deaths occurring in care home settings are reportable to the health and care systems regulator (the Regulation and Quality Improvement Authority), as 'notifiable events'. As the pandemic progressed, the Regulation and Quality Improvement Authority was able to provide a continuing data stream on deaths occurring in these settings.

90. As summarised above, there were a number of systems in place and developed at pace to capture and record information on deaths occurring during the pandemic – these included systems operated by the General Register Office, PHA, HSC Trusts and the Regulation and Quality Improvement Authority/Care Homes. Some of these systems were established and operating before the pandemic, others were established at pace in the early stages of the pandemic. In the context of data relating to deaths in NI: because there were a number of systems operating and being established, and each was based on different reporting requirements, there was potential for confusion in the early stages of the pandemic. It was the Department's experience that all parties worked together to address and resolve any particular areas in which there was a lack of clarity.

E. Primary Care and Use of Technology

1. Northern Ireland Ambulance Service

91. I approved significant additional funding over the period of the pandemic for the Northern Ireland Ambulance Service (NIAS). This was through a process of engagement across Health and Social Care organisations and with the Strategic Planning and Performance Group (SPPG – previously Health and Social Care Board – HSCB) and the Department of Health (DoH). Additional costs in relation to the pandemic were identified and shared with the region and a coordinated approach to additional funding agreed upon. This was throughout the duration of the pandemic and beyond. Requests for funding were provided in full over the period. Specific Covid allocations to NIAS over the last three financial years were as follows:

Financial Year	2020-21	2021-22	2022-23
Description	£m	£m	£m
Specific Covid Allocations	16.8	14.4	14.7

92. Additional costs in relation to the pandemic were identified through normal financial management arrangements, under the leadership of the NIAS Director of Finance, which identified additional costs being incurred. These were shared regionally by the NIAS Director of Finance and six key areas in respect of Covid funding were agreed with DoH and SPPG and Trusts - Workforce, Service Delivery, Infrastructure, Equipment and Supply, Digital and Communications and Corporate.

93. Covid funds were used by NIAS to maintain, enhance and protect ambulance service delivery, including 999 capacity for Northern Ireland. Given the reduction of NIAS staffing as a result of Covid-19 absence levels this additional funding allowed 999 capacity to be maintained safely across the region during the pandemic.

94. I have asked officials in the Department of Health as to whether there is information pertaining to the whether these funds resulted in the expansion of 999 capacity but I understand these figures are not held by the Department. NIAS may be able to assist with this query.

2. Primary Care

i. Quality and Outcomes Framework

95. In March 2020 I agreed to the proposal that the Quality and Outcomes Framework (QOF) activity and reporting be suspended with no financial detriment. The Quality and Outcomes Framework (QOF) is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004. At the same time, I also agreed to significantly downturn Enhanced Services activity, also with no financial detriment. Enhanced Services are part of the General Medical Services contract arrangements and are services that a GP practice may contract to provide that are beyond the normal scope of essential services or additional services which are designed around the needs of the local population. Enhanced services are delivered in accordance with specifications which require an enhanced level of service provision to that which a practice needs generally to provide in relation to that

service or element of service. Enhanced Services are not mandatory and GPs can contract to provide these if they wish [PM/6093 INQ000346777].

ii. Appointment Capacity

96. The management of Covid-19 in Primary Care resulted in many changes to General Practice across Northern Ireland. To allow for adequate social distancing, and to maintain effective infection prevention control measures, most practices took the decision, early in the pandemic, to reduce the number of people able to openly walk into General Practice premises. The 'telephone first' consultation process for General Practices enabled patients to continue to seek medical advice from their General Practitioner for both routine and urgent problems with General Practitioners determining the most appropriate approach to safely address the patient's needs which included the clinical decision on whether a face-to-face appointment was required. It should be noted that the move to 'telephone first' did not mean there were no face-to-face appointments. Instead, it was anticipated that this approach would prevent many patients attending their General Practice surgery if it was not necessary to do so and help prevent the spread of infection. General Practices also worked with community pharmacies to enable repeat prescriptions to be collected.

97. Without the 'telephone first' system it would not have been possible to maintain General Practice services during the pandemic. Despite the demands and capacity limits that Covid created, General Practitioners maintained most of their services.

98. It was recognised, however, that some patients were experiencing problems with contacting their General Practice which caused frustration. In 2020/21, I agreed non-recurrent funding of £1.7 million which was made available through a General Medical Services Telephony Grant Scheme[4] to enable appropriate telephony and technology to be in put place to support the change in operating model and to help improve demand management, capacity and access to General Practice. Practices could use funding towards purchasing new telephone systems and increasing the number of telephone lines into their surgery, with specific emphasis on making telephone lines available for staff in nursing homes, pharmacies and laboratory services in the local Health and Social Care Trust areas. In 2020/21, 277 Practices (out of 321) availed of the said scheme.

[4] This funding was from within the General Medical Services funding envelope and was repurposed towards telephony; it was not additional funding.

99. In October 2021, I allocated a £5.5 million investment package for General Practice. Of this, £3.8 million was committed to support additional patient care through facilitating additional clinical consultations over the winter and supporting the Out of Hours Service. Up to £1.7 million was made available through a Telephony Grant Scheme to further improve telephony infrastructure and improve accessibility to General Practice services using online systems for ordering repeat prescriptions, helping to free up telephone lines and staff time. This further funding for telephony was in addition to the £1.7 million of funding in 2020/21 [PM/6094 INQ000348853].

100. Primary Care's response to the Covid-19 pandemic accelerated the implementation of new and innovative ways of working, including making greater use of technology and telephony, which helped General Practices to react quickly and adapt flexibly to the demands and challenges of the pandemic.

101. General Medical Services (GMS) in Northern Ireland are provided by independent General Practitioner contractors under the terms of the Standard General Medical Services Contract (Northern Ireland) 2004. Paragraph 41 of this contract states "*Infection control -The Contractor shall ensure that it has effective arrangements for infection control and decontamination*" [PM/6179 INQ000417479].

102. Throughout the relevant period Strategic Planning and Performance Group signposted General Practitioner contractors to relevant nationally and regionally agreed Infection Prevention Control Guidance and policies as advised by the Regional Infection Prevention Control Cell chaired by the Public Health Agency [PM/6180 INQ000417480]. Any changes to these policies were communicated to all practices via email by the Health and Social Care Board. As independent contractors, each practice had autonomy in determining how best to act on this advice and this would have included how to continue to safely have face-to-face appointments with those patients who required it.

iii. Accessibility

103. As I have stated above at section B (8), it was not possible to carry out Equality Impact Assessments on the legislation enacted due to the pace at which the pandemic was evolving; this was true also, in large part, of policies and practices implemented during the pandemic.

104. In terms of the increased use technology within the health system this undoubtedly created access issues for some groups of patients. Efforts were made to mitigate

these; for example, to address the issue of access for the hearing impaired community, the Department of Health and Health and Social Care Board commissioned video relay services and remote video interpreter services for the British Sign Language/Irish Sign Language communities on 23 April 2020. [PM/6360 INQ000346720]. This enabled British Sign Language/Irish Sign Language callers, through an interpreter, to access any health service accessed via telephone. It also enabled remote British Sign Language/Irish Sign Language interpreter services to be available to the British Sign Language/Irish Sign Language communities, to assist communication in any necessary face to face clinical consultations.

105. I cannot recall any specific mitigations for older patients, disabled patients particularly those with sensory impairments, patients whose first language was not English, those with literacy issues, patients in areas with poor internet connectivity, patients who were homeless, patients from lower socioeconomic groups.

iv. Primary Covid-19 Centres

106. The establishment of Primary Care Covid-19 centres was a General Practice-led innovation, supported by the Health and Social Care Board and the Department, that was an urgent and immediate response to the challenges posed by the Covid-19 pandemic. The centres ensured that primary care services were able to be maintained by enabling patients with Covid-19 symptoms to be treated separately from those patients who had other conditions which required assessment or treatment in primary care.

107. General Practice leaders from across Northern Ireland played a key role in the design, implementation and ongoing management of the centres. Representatives from the Department of Health, the then Health and Social Care Board, the British Medical Association's Northern Ireland General Practitioners Committee and the Royal College of General Practitioners Northern Ireland took forward the planning for the Primary Care Covid-19 centres, working intensively from 18 March to 25 March 2020 to establish the network [PM/0138 INQ000120726]. The first Centre opened at Altnagelvin Area Hospital, Londonderry on 25 March 2020 with the network of Covid-19 centres fully up and running by Thursday 9 April 2020.

108. The Northern Ireland General Practitioners' Committee and the Royal College of General Practitioners' Northern Ireland were represented on the Project Board, chaired by the Head of General Medical Services within the then Health and Social

Care Board, that oversaw the running of the centres, with staffing of the centres managed locally by General Practice Federations in line with demand.

109. The centres provided services for patients symptomatic of Covid-19, and who were at higher risk of complications, or those described as having moderate or severe symptoms, and who required clinical assessment. The Covid-19 centres:

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

110. An arrangement was agreed that practices would engage in their share of Covid-19 centre rotas. This was as a result of negotiations with General Practice representatives that saw the standing down of elements of the General Medical Services Contract with no financial detriment to practices as noted above. I gave approval for these negotiations to commence and signed off on the final agreement. A small number of General Practices expressed concern about participation in the Covid-19 centres, noting the impact this might have on their own practice's resourcing and/or because they felt they were able to implement bespoke arrangements in their own practice to be able to separate 'Covid' and 'non-Covid' patients. The Department sought to reassure those practices that there was a need for General Practices to support the Covid centres to ensure that those patients who were Covid symptomatic could be quickly and safely assessed [PM/6095 INQ000477512; PM/6063 INQ000346743].

111. General Practices worked with their local General Practice Federation to ensure appropriate staffing cover for Covid centres was maintained in response to local

demand. As the rate of infection fell and vaccination rolled out, the requirement on General Practitioners' participation reduced.

112. With the ongoing Covid-19 vaccination programme and the easing of restrictions, General Medical Services for patients at risk from Covid-19 evolved towards being managed by General Practitioners and practice teams where this could be done safely. By March 2022, the need for Covid-19 centres had diminished substantially and the remaining 2 operating sites closed at the end of March 2022 [PM/6096 INQ000348855]. Between 6 April 2020 and 20 March 2022, Covid centres reported almost 68,000 patient contacts.

F. Capacity

113. As the decisions relating to critical care capacity were largely operational, clinical decisions taken at Trust and Health Silver level, my personal involvement in the process would have been limited to being briefed orally and in writing by officials. I have detailed below my understanding of how critical care capacity was increased, and why, and the roles of the Critical Care Network Northern Ireland and the Trusts.

114. It is my belief, however, that there was, and remains, insufficient critical care capacity in Northern Ireland and this was due to a lack of trained staff and the physical capacity of hospitals. While the medical staff we have in Northern Ireland are excellent, as evidenced by their work during the pandemic, it cannot be denied that the numbers are inadequate. This is evident from the New Decade New Agreement which set out a key priority of providing a further 900 pre-registration nursing and midwifery training places over a 3-year period, commencing in 2020/21.

115. I consider the only way in which this issue can be addressed is through the ongoing transformation programme, much of which had to be paused during the pandemic, see below at section G (5). Steps have been taken to start addressing this issue; for example, the roll out of Post Anaesthetic Care Units (PACU) [RS/0314 INQ000485677] and additional funding for nursing places [RS/0315 INQ000485678]. Unfortunately, there remain constraints to further addressing the issues in the form of the budget and the lack of recurrent funding, which I have explained at length in section C, above.

1. Increasing Critical Care Capacity

116. 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 in regional units. Table 1 below provides a summary of Northern Ireland's Commissioned Critical Care Beds by Health and Social Care Trust and Level of Care.

Table 1: Northern Ireland Commissioned Critical Care Beds

Critical Care Unit	Level 3 Beds	Level 2 Beds	Total Beds
Belfast Trust	27	15	**42**
Northern Trust	8	4	**12**
Southern Trust	6	4	**8**
South Eastern Trust	6	4	**10**
Western Trust	9	7	**16**
Sub-total	**56**	**34**	**88**
Regional Cardiac Intensive Care Unit[5]	10	8	18
Regional Paediatric Intensive Care Unit[2]	12	-	-
Total - ALL TRUSTS	**78**	**42**	**118**

117. Beds have four levels of classification as follows:

- Level 1 beds – general ward-based care where the patient does not require organ support (for example, they may need an intravenous drip, or oxygen by face mask); these are not included the Critical Care Table above as they are not considered critical care beds.
- Level 1.5 beds – enhanced beds such as post-anaesthetic care beds or respiratory non-invasive ventilation beds. These are not considered critical care beds and are also not included in the table above.
- Level 2 bed - High dependency unit. Patients needing single organ support (excluding mechanical ventilation) such as renal haemofiltration[6] or inotropes[7] and invasive blood pressure monitoring. They are staffed with one nurse to two patients.

[5] These are regional units located at the Royal Victoria Hospital, Belfast.
[6] A renal replacement therapy used in intensive care settings.
[7] Inotropes are drugs that make your heart muscles beat or contract with more power or less power, depending on whether it's a positive or negative inotrope.

- Level 3 bed - Intensive care. Patients requiring two or more organ support (or needing mechanical ventilation alone). Staffed with one nurse per patient and usually with a doctor present in the unit 24 hours per day.

118. As at 1 March 2020 70 of the general and specialist critical care beds were occupied with 44 Level 3 patients, 24 Level 2 patients (and 5 patients waiting for transfer to ward). These figures exclude the regional cardiac intensive care and paediatric intensive care beds as it was necessary to maintain those beds for cardiac and paediatric patients.

119. 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. On 10 February 2020 Health Silver wrote to Trusts regarding managing patient flow at both containment and surge phases of Covid-19 [PM/6390 INQ000376956; PM/6391 INQ000371524; PM/6092 INQ000259560; PM/6093 INQ000346777; PM/6094 INQ000348853]. 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.

120. Following a meeting with the senior leadership team of the Health and Social Care Board and the Public Health Agency on 11 February 2020 [PM/6095 INQ000477512], the Chief Medical Officer, on behalf of the Department, wrote to the Health and Social Care Board's Chief Executive on 17 February 2020 [PM0206 INQ000137326] requesting detailed worked up integrated surge plans from community and primary care through to acute care including those areas where it was anticipated that there would be particular demands such as critical care. The Health and Social Care Board's Chief Executive advised that surge planning was underway [PM0207 INQ000130371] and that the Health and Social Care Board and the Public Health Agency had established a regional operational Surge Planning Subgroup to ensure that there was an appropriate and proportionate level of health and social care preparedness across the Health and Social Care system in response to Covid-19.

121. Further work was commissioned to quality assure and address identified gaps in the initial surge plans, recognising that the lack of specificity at this time of the potential health and social care service pressures made surge planning problematic. It was

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, I asked the Deputy Secretary, Jackie Johnston, responsible for the Department's Healthcare Policy Group, and the Chief Nursing Officer, Charlotte McArdle, to assist the Chief Medical Officer with the coordination of the Department's policy input to surge planning for the health service.

122. A Covid-19 Regional Surge Planning Subgroup was chaired by the Health and Social Care Board's Director of Commissioning and was comprised of members from the Health and Social Care Board, Public Health Agency, Trusts, Northern Ireland Blood Transfusion Service, Northern Ireland Ambulance Service and the Department. There followed intensive engagement between the Department, the Health and Social Care Board, the Public Health Agency 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 [PM0300 INQ000103714]. The Plan summarised the key actions to be taken by the Health and Social Care system from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. It also outlined the planning assumptions available to the HSC in a reasonable worst-case scenario and of the actions taken across the HSC system to prepare for the impact of Covid-19. This was a dynamic plan, which was to be constantly refined in light of the emerging issues.

123. The Summary Covid-19 Plan was kept under constant review and a number of versions existed during this period i.e. 27 March 2020, 9 April 2020 & 1 May 2020. Work had commenced on a fourth draft but this was superseded by the Health and Social Care Regional Surge Planning process led by the Department [PM/6060 INQ000346740; PM0300 INQ000103714; PM/6062 INQ000346742]. I received regular updates on each iteration of the plan.

124. 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. In the first wave of the pandemic, the Department's modelling group updated modelling on a regular basis from early April 2020, including a range of estimates for inpatient and critical care numbers under different scenarios, and this information informed Trust specific planning in relation to

the surge which was led by the Health and Social Care Board. The modelling group considered information from a range of sources to inform its judgement on the potential course of the epidemic and the models were adapted over time as more data became available.

i. During the Pandemic

125. During the period 1 March 2020 – 28 June 2022 critical care beds fluctuated, largely in line with the Covid-19 waves. Surge Plans and De-escalation Plans were developed throughout the pandemic to enable the system to plan for surges of demand and to balance the need for critical care capacity required for Covid-19, urgent non-covid-19 and time critical surgery patients. On 26 March 2020 the Permanent Secretary for Health wrote to the Chief Executives of HSC Trusts [PM/160 INQ000325159 (DoH ref: PM0147)], on the issue of "COVID-19: Preparations for Surge". The letter, which I had sight of before it issued, summarised the extensive planning and investment underway across the HSC system designed to increase capacity.

126. That letter also included a range of actions that Trusts were asked to take to maximise surge capacity in hospitals and explained that the reason for the need to maximise capacity. This request was aligned with approaches which were being taken across other parts of the UK at that time, as all healthcare systems were activating surge plans in anticipation of potentially high Covid admissions during the first wave. This involved a range of measures to maximise capacity in hospitals, including through effective discharge arrangements.

127. On 1 April 2020 I was briefed on [PM/161 INQ000120709 (DoH ref: PM0063)] the key consensus estimates of the NI modelling group, based on outputs from several different models, which informed intensive hospital planning for the forthcoming surge in Covid-19 cases. The modelling outcome set out a reasonable worst-case scenario, based on a number of assumptions including social distancing measures producing a 66% reduction in contacts outside the home and workplace. In addition, it was anticipated that 70% of symptomatic cases would adhere to self-isolation. The modelling team's[8] best judgement was that this would lead to a peak number of 180

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

Covid-19 patients requiring ventilation and critical care beds during the first wave of the pandemic. The modelling assessed that the peak number of Covid-19 hospital admissions would be 500 per week. Under this reasonable worst-case scenario, the projected number of cumulative Covid-19 deaths in Northern Ireland over 20 weeks of the epidemic was calculated to be in or about 3,000. The modelling indicated that the peak of the first wave of the epidemic was expected to occur between 6-20 April 2020.

128. Informed by this reasonable worst case scenario modelling, I requested 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. The decision on the Nightingale Hospital facility is discussed below. 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.

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

130. The first Covid-19 related admission to critical care in Northern Ireland was on the 15 March 2020. I was aware that a Resource Modelling Group was established in April 2020 on the back of resource modelling developed in Southern Trust to help them plan and organise their resources to manage the impact of Covid-19, but, as this was a Trust-led initiative, I played no role. When the resource model was shared with all Trusts there was a request to take the model used by the Southern Trust and develop it for all Trusts to help them plan for Covid-19. The group was established by and chaired by the Trusts. The group did not take any decisions, but rather took the information developed by the Departmental modelling for use within each

respective organisation. Accountability was as per internal governance structures for each organisation which was represented.

131. A Terms of Reference was developed [PM/6064 INQ000276396] which set out the role/responsibility of the group as follows:

- To provide an interface between the five Health and Social Care Northern Ireland Hospital Trusts, the Health and Social Care Board, the Public Health Agency and any regional modelling activity;
- To provide an additional link between modelling activity and Directors of Planning to ensure that Trusts' operational needs from modelling activity are being effectively met by resource modelling outputs, and
- To provide guidance on the interpretation data purported to represent Trust-level activity.

132. Membership of the group was as follows:

- Clinical, operational, business intelligence and informatics staff from Trusts, currently open to any Trust-nominated representatives;
- Representatives of the Health and Social Care Board Performance Management & Service Improvement, Commissioning and Clinical Information departments;
- Representatives from the Public Health Agency;
- Members of any modelling projects engaged with the group;
- Any invited guests per meeting;
- Other members from other organisations following case-based approval, and
- No initial limit on numbers, but this was subject to review.

133. In its simplest terms, this group was established to provide guidance, support and an interface between the Trusts, the Public Health Agency and Health and Social Care Board on understanding the potential impact of Covid-19 on Trust services so that they could plan how to manage the pandemic.

134. The First Wave Surge Plan [PM/6065 INQ000346745] indicated a need for 140 covid and 35 non-covid critical care beds. The plan mapped the critical care bed need in Northern Ireland from 88 critical care beds at steady state through to 198 beds at high surge. This level of surge could be managed at local hospital level. However, when demand went over 198 beds it was determined that a Nightingale arrangement would be needed to manage up to 286 beds. I was updated on this on the 10 April

2020 and asked to agree that the surge team should provide a daily update on the position in critical care, which I did.

135. The Critical Care Surge Plan to meet these recommendations was agreed by the Department on 16 April 2020. The surge plan was set out in two papers - a 'Surge Plan on a Page' and a paper outlining the decision making of the 'The Surge Plan for Northern Ireland' [PM/6104 INQ000346787; PM/6105 INQ000103658; PM/6106 INQ000377154]. Health Gold level approval and ratification was provided for both plans. While the Surge Plan was published on 16 April 2020 it is clear that it was the product of 2 months' work and refinement, beginning on the 17 February when the CMO requested integrated surge plans. The plan, in all likelihood, was not created at a sufficiently early stage, but it was created as quickly as possible as new information emerged about the novel coronavirus.

136. On the 16 April 2020, the Regional Modelling Group produced an updated summary which considered modelling dated 7th April 2020. On the basis of this modelling, and assuming social distancing was still adhered to, it suggested that during the wave 1 peak (likely to occur between 6-20th April 2020) the following Reasonable Worst-Case Scenario (RWCS) was:

Description	Best Judgement
Peak number of Covid-19 patients requiring ventilation and **critical care beds** during the first wave of the epidemic	**140**
Peak number of Covid-19 patients requiring **oxygen** in the first wave of the epidemic	**400**
Peak number of Covid-19 **hospital admissions** during the first wave of the epidemic (per week)	**500**
Number of **cumulative** Covid-19 **deaths** in the **first 20 weeks** of the epidemic.	**1500**

137. The peak number of 140 was based on the more up to date modelling and related to the bed requirements for Covid-19 patients requiring critical care. This did not include the bed requirements for non-covid patients. An estimate of the need for 35 beds for non-covid patients was included within the revised surge plan:

Local Escalation of Trusts

- Pre-surge - 88 level 3 critical care beds at pre-surge level; Belfast City Hospital only to admit covid patients;
- Low surge - increase from 89 critical care beds to 112 critical care beds;

- Medium surge - increase from 113 critical care beds to 155 critical care beds; all but 3 cardiac critical care beds/ resources to be moved to Belfast City Hospital, and
- High surge - increase from 156 critical care beds to 198 critical care beds.

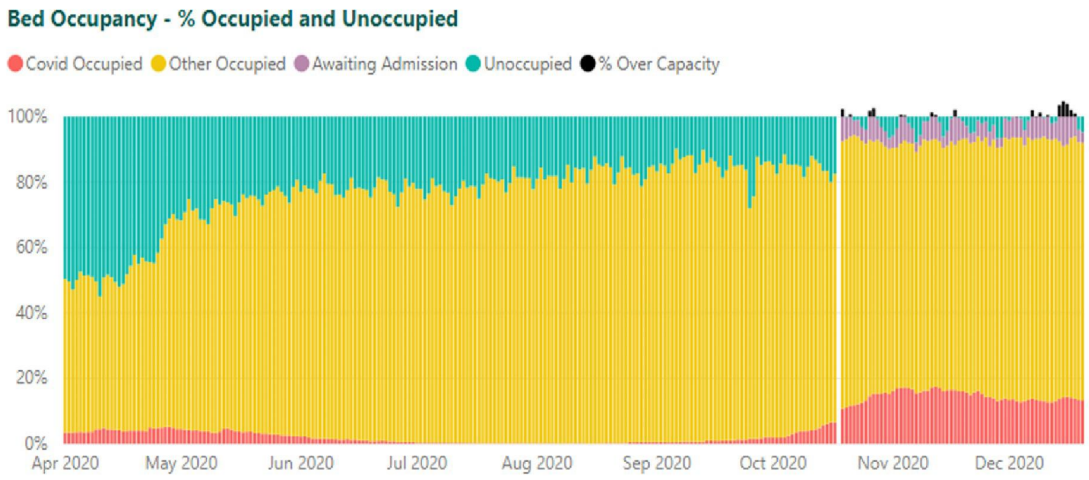
Regional Escalation

- Extreme surge - increase from 199 beds to 247 beds High Surge. At this stage 109 covid beds within Belfast City Hospital, and
- Beyond Extreme surge - increase from 248 beds to 286 beds High Surge. At this stage 109 covid beds within Belfast City Hospital.

138. Covid-19 related critical care occupancy peaked at 57 patients between the 6th and 11th of April 2020. On the 8 May 2020 Health Gold approved the start of planning for de-escalation for critical care across the network as numbers dropped.

139. In July 2020, the Critical Care Network Northern Ireland asked Health and Social Care Trusts to provide an updated local surge plan to realign capacity with demand in the event of a second surge of Covid-19. I understand that no evidence can be found as to who directed the Critical Care Network Northern Ireland to make this request. The Second Wave Surge Plan [PM/6066 INQ000377221], produced in October 2020, mapped the critical care bed need from 88 critical care beds at steady state through to 110 beds at medium surge, 134 beds at high surge and 158 beds at extreme surge. All surge plans were provided to Trusts and used to manage escalation steps.

140. On the 21 December 2020 I made a statement to the Assembly in which I said "[NICE] advises that there is an increased risk of adverse patient outcomes where hospital bed occupancy rates exceed 90%. In the period since 21 October, regional bed capacity has not dropped below 92%. There are only 5 days on which it has been lower than 95%. Some hospital sites have consistently been operating above 100% capacity for this period." [INQ000304964]. The Information Analysis Directorate processed the HSCB daily sitrep of bed occupancy levels and published it on the public facing COVID-19 Dashboard. Regional bed occupancy information included on the dashboard is detailed in the snapshot below, and includes data published for the period between 21 October 2020 and 20 December 2020. I received an updated summary document daily [RS/0316 INQ000485679].



141. I believe I became aware of an ongoing issue with occupancy rates exceeding 90% in or around mid-October 2020.

142. As stated above, the decisions relating to critical care capacity were largely operational, clinical decisions taken at Trust and Health Silver level and I would have received regular briefings and updates. However, between October and December 2020, and throughout the pandemic, I reiterated in my statements to the Assembly and in press releases the role that everyone could play in keeping themselves safe, which in turn would reduce numbers and cases requiring hospitalisation [INQ000381352; INQ000381358; INQ000381359; INQ000381370; INQ000381375; INQ000381382; INQ000381386; INQ000381391; INQ000381404].

143. Increasing critical care capacity would have had an impact on other services, and did have an impact, as I have explained above at section B (4) with the pausing of several screening services and the cancellation of elective surgery. This in turn meant that patients missed out on important screening appointments as well as surgery that they had most likely already been waiting on for a significant period of time.

144. I cannot recall the date on which regional critical care capacity fell below 90% for a period of 7 days in a row; however, I would imagine that this would not have been until late January 2021 because the of the increase in cases and hospitalisations we experienced following the Christmas period.

2. Role of the Critical Care Network Northern Ireland

145. My understanding of the role of the Critical Care Network Northern Ireland is that it provides direction and consistency in the development and delivery of the Critical Care Service within Northern Ireland. In line with its ToR [PM/6374 INQ000477517], it provides resolved advice on critical care activity to commissioners to inform critical care service commissioning. It is accountable to the Department through the Strategic Planning and Performance Group (SPPG) of the Department. I received updates on its work, including surge planning, through verbal briefings and written submissions [RS/0317 INQ000485680].

146. In relation to how it identified available critical care capacity and when additional critical care capacity was required, the Critical Care Network for Northern Ireland developed a daily situation report which was shared across Critical Care Network in Northern Ireland and across the wider Health and Social Care sector. This report informed the system of bed availability and demand by unit. This report's content was expanded in January 2021 to include additional information required for decision making. The new situation report provided decision making intelligence for Covid-19, non-Covid and suspected Covid patients for each unit in the region including bed availability, the types of management each patient required (whether the patient was ventilated, on non-invasive ventilation, high flow ventilation, extubated with no support), patients en route to beds from a resuscitation area, Emergency Department or theatres or from another Trust and the previous 24 hours admissions, discharges and deaths. The report also provided information on unit staffing and absences and enabled further modelling to take place aiding accurate escalation and de-escalation of units.

3. High Consequence Infectious Disease Beds

147. Northern Ireland does not have any high consequence infectious disease (HCID) beds. As HCID protocols were used at the start of the pandemic to prevent transmission the absence of any HCID beds did cause difficulties. Given the geographical location of Northern Ireland, the Health and Social Care sector requires the services of an air ambulance provider for the transfer of patients to and from specialist centres in Great Britain. The existing designated fixed wing air ambulance provider for Northern Ireland is Woodgate Aviation but, due to the layout of their aircraft, which had no separate cabin area, Woodgate were unable to provide Air Transfers for Covid-19 positive patients. Therefore, early in the pandemic, in April 2020, and in response to the need to transfer patients to Great Britain, by air, the

then Health and Social Care Board arranged for patient transfer by Royal Air Force assets (Military Aid to the Civil Authority) through the Department. These Military Aid to the Civil Authority (MACA) arrangements were made in line with the Military Aid to the Civil Authority UK protocol that was published on 4 August 2016 [PM0149 INQ000390021].

148. While the first patient transfer took place in April 2020, I made the first request for military aid in February 2020 when an individual who had returned from holiday had a presumptive positive test for Covid-19. The request was declined because, as I recall, the transfer was considered not necessary on clinical grounds as the individual was otherwise well.

G. Staffing and Redeployment of Staff

1. Workforce Appeal

149. On the 20 March 2020 I published an initiative to recruit former health professionals back into the health and social care workforce via the Health and Social Care Workforce Appeal [PM/0075 INQ000103668]. It was anticipated that this initiative had the potential to add over 5,000 temporary staff to the Health and Social Care workforce. The initiative was supported by the General Medical Council, the Health and Care Professions Council, the Northern Ireland Social Care Council and the Nursing and Midwifery Council.

150. Both the Chief Nursing Officer and Chief Social Work Officer made workforce appeals to help increase the numbers of available staff, while the Northern Ireland Social Care Council emailed all staff on the social care register and suspended collection of the annual £30 registration fee to ensure there were no barriers to engagement. Processes for recruiting staff were also streamlined by way of changes to the employment vetting policy. The changes permitted employers to recruit staff quickly to health and social care posts through more limited pre-employment checks in anticipation of staffing pressures [PM/0153 INQ000120734, PM/0116 INQ000130346, PM/0155 INQ000120735, PM/0157 INQ000130349, PM/0158 INQ000130350, PM/0159 INQ000130351, PM/0135 INQ000130347, PM/0160 INQ000120736, PM/0161 INQ000120737, PM/0162 INQ000120740, PM/0164 INQ000120745]. In support of the policy, the Department introduced the Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 in April 2020. In addition, AccessNI (an arm's length body run by the

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

151. The initial Workforce Appeal in March 2020 generated 19,100 formal applications which resulted in 1,702 doctors, nurses and other ancillary staff being successful in their application to work for the health service. In responding to the Covid-19 pandemic and in an effort to address the need for additional staff across Health and Social Care the Department continued the use of the Health and Social Care Workforce Appeal. The Appeal was in addition to the normal Health and Social Care recruitment; however, it was designed to deliver temporary recruitment through online campaigns with the ability to undertake administration processes at speed and volume. 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 Health and Social Care of which almost 2,800 were health and social care appointments in various disciplines; 78 doctors, 447 nurses, 1353 nursing support, 216 and some 900 appointments covering allied health, pharmacy, social work/care and psychology. The other appointments were non-medical and covered support services including portering, administration and clerical positions.

152. 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.

153. In response to the pandemic, the General Medical Council introduced temporary registration for all recently retired doctors who had relinquished their license to practice or registration. At the start of the pandemic, the then Health and Social Care Board wrote to retired General Practitioners who had come off the Northern Ireland Primary Medical Performers List (PMPL) within the past 3 years asking that they consider volunteering to support the Covid -19 response. The Health and Social Care Board also wrote to all organisations employing General Practitioners in a

non-clinical role to consider encouraging those General Practitioners to offer support to clinical care.

154. General Practitioners who returned to provide services were placed onto the Northern Ireland Primary Medical Performers List through a streamlined process for temporary inclusion as Emergency Response Practitioners (ERPs) and an expedited Access Northern Ireland checking process, to support their deployment as quickly as possible to help reduce pressures on primary care. Refresher training was offered by the Northern Ireland Medical and Dental Training Agency [PM/6173 INQ000417344]. In total, sixty returner doctors applied for inclusion on the Northern Ireland Performers List and underwent refresher training.

155. Alongside the workforce appeal, I approved a number of initiatives to help final year medical, nursing and midwifery, allied health professional and social work students to be deployed in the HSC earlier than anticipated. This provided up to an additional 250 doctors, 880 nurses and midwives, 120 allied health professionals and 240 social workers.

156. The preceding paragraphs describe workforce appeal carried out by the Department from March 2020. I approved this appeal and also agreed the award of a Direct Award Contract (DAC) [RS/0318 INQ000485681] to engage three private sector companies to assist with HSC staff and recruitment to deal with Covid-19 volunteer pressures. The DAC meant that we could bypass normal procurement processes which would have caused unnecessary delays and uncertainties, particularly as Business Services Organisation (BSO) and the Health Trusts had said they would not be able to cope [RS/0319 INQ000485662].

157. I also agreed to temporarily suspend the international nurse recruitment campaign [RS/0320 INQ000485663]. While it may seem counterintuitive to suspend a means by which additional nursing staff were coming to Northern Ireland when we were also running an additional recruitment drive, the reason for the suspension was due to the time spent training the international nurses. As described in the exhibit [RS/0320 INQ000485663 (as above)], there had been growing regional concern about HSC Trusts' ability to supervise international students given the current demand within services. In addition, the Clinical Education Centre (CEC) was facing extreme demand from across the HSC system for Covid-19 related training (for example, for the 880 third-year nursing and midwifery students and anticipated lapsed-registrants

and recent retirees) which it could not facilitate due to the number of staff currently delivering OSCE Training for International Students.

158. In order to further increase the number of available healthcare workers during the relevant period I also approved the approach to those nursing and midwifery students in their second year and first 6 months of their third year [RS/0322 INQ000485682]. Those students were invited to opt-in to an arrangement where they may spend 80% of time in clinical practice and 20% in academic study. As such they were not supernumerary and were effectively part of the workforce, remunerated at Band 3 for their clinical practice hours during the period. In addition, those students in their final 6 months of their degree were able to opt into paid placements. In total this increased the HSC workforce by nearly 1400 [INQ000373405]. No particular specialism or geographical area was targeted.

159. The workforce appeal had benefits and disadvantages. It generated a huge amount of interested but, unfortunately, out of 35,000 submitted applications only 6,000 appointments were made: a conversion/success rate of approximately 17%. There were a variety of reasons for this; first, it was common for candidates to only be able to commit to specific hours on specific days which did not match the demands of the positions being offered by the Health and Social Care Trusts. Candidates may also not have been successful in being offered a post or being appointed because they did not match the specific requirements of the roles being offered. Other candidates were seeking permanent employment but the workforce appeal was always designed with the aim of offering temporary employment in an effort to support the Health and Social Care Trusts through the pandemic. 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; this included deployment of candidates appointed from the workforce appeal to independent care homes where their skills were appropriate [INQ000371513].

160. While the final numbers appointed are relatively low in comparison to the number of applications, I am uncertain as to any changes that could have been made to the scheme that would have improved the number of applications and eventual appointments. It could have been that the scheme was too inflexible and not able to allow applicants to work hours that suited them or in areas local to them. I believe that the most successful schemes were those that were 'targeted' – for example, social workers, and this should perhaps be considered if the need arises in the

future. I believe these 'targeted' schemes were more successful because applicants would have known the type of post they were applying for and been placed in a post where the work was familiar to them. The more general workforce appeals meant that applicants could have been placed anywhere in the health and social care system.

2. Combat Medical Technicians

161. In January 2021 the Department requested Combat Medical Technicians to assist across the system. Combat Medical Technicians are trained to provide basic lifesaving skills and medical support and could be used to support existing nursing staff. This request was made against the background of the HSC under severe and sustained pressure arising primarily from rising demand due to Covid-19 hospital admissions. As of 13 January 2021, there were 809 Covid-19 inpatients in hospital across the system and there were 56 Covid-19 patients in ICU. Modelling suggested that this situation could deteriorate over the coming weeks. At the same time, there were 629 staff absent across the HSC Trusts due to Covid-19, with a further 826 HSC Trust staff recorded as absent due to self-isolation. In total, there were 494 nurses or midwifery staff absent either due to Covid-19 or self-isolation. These additional staff absences added to the normal absence rates and the significant vacancies across the system, particularly in nursing.

162. I approved the request for military assistance to be submitted on 15 January 2021. This was approved by the Ministry of Defence, through the UK Minister for the Armed Forces, on 20 January 2021 [INQ000276399 (DoH ref: PM2112), INQ000276400 (DoH ref: PM2113), INQ000185423 (DoH ref: PM2114)]. I did not face any issues regarding agreement to the MACA request. 110 Combat Medical Technicians were deployed from 25 January 2021 to 28 February 2021 as follows:

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

163. In March 2021, the Department requested military assistance for rolling-out NI's Covid-19 vaccination programme [INQ000276665 (DoH ref: PM2345)]. The establishment of a large mass vaccination centre at the SSE Arena, Belfast was only possible following a decision to activate the Military Aid to Civil Authority (MACA) requesting military assistance to Health and Social Care in NI [INQ000416453 (DoH ref: PM2346), INQ000276667 (DoH ref: PM/2347), INQ000276668 (DoH ref:

PM2348)]. This was approved by the Ministry of Defence and a total of 100 Combat Medical Technicians were stationed at the SSE Arena, from 22 March 2021 to 31 May 2021, to assist with the delivery of the vaccine.

164. Each time the Combat Medical Technicans were withdrawn from Northern Ireland it was for further deployment elsewhere. Their deployment in Northern Ireland each time was to meet a need which we could not cover from elsewhere within our system and that need had passed.

165. I am firmly of the belief that had we not been able to avail of Combat Medical Technicians that that an already overstretched staff would have been pushed to exhaustion and also that the moral boost that the HSC workforce received would not have occurred. Without those who were deployed in our mass vaccination centres we would not have achieved the level of vaccine delivery in the time frame we did.

3. NHS Immigration Health Surcharge

166. The Immigration Health Surcharge was a contribution towards healthcare costs for those who were applying for an immigration visa to enter the UK. Since July 2020, following a decision by the UK Government, the immigration health surcharge was abolished for all those eligible for a Health and Care Worker visa (or their dependents) being recruited to work across the UK. I can recall no personal involvement in the decision to remove the surcharge and would imagine that removal of it was a benefit to applicants as it removed a cost, which in turn would have meant international applications remained high.

4. Welfare of HSC Staff

i. Psychological Support

167. While the Department of Health did not formally monitor the mental health of health and social service staff during the pandemic, as is normal practice, line managers would have highlighted available health and well-being resources to all staff, including talking therapies, escalating concerns where appropriate. On 16 April 2020 the Department launched 'Covid-19 A Framework for Leaders and Managers' [PM/0078 INQ000120708] which was a document setting out a range of practical measures to protect the psychological health and wellbeing of Health and Social Care staff and volunteers during the pandemic. The Framework is based on evidence and best practice guidance and is informed by The British Psychological

Society Guidance Paper [PM/0080 INQ000390023]. I understand that a Staff Wellbeing Working Group was established to oversee service delivery and to review the implementation of the Framework but, as this was internal to Trusts, I had no role and do not recall receiving specific updates on it.

168. The workforce wellbeing framework provided a range of initiatives across Health and Social Care organisations to enhance psychological wellbeing of staff. These initiatives included access to Psychological Support Helplines manned by psychologists (care home and General Practitioner staff also had access to these helplines in each Health and Social Care Trust area), a broad range of online resources and drop-in services in critical facilities. The Covid-19 Framework is a Public Health Agency document and they should be able to provide any further information required.

169. Further, the Department was supportive of a proposal from the Public Health Agency to fund the creation of rainbow rooms [PM/0165 INQ000103710]. A Rainbow Room was a space for care home staff to go for solace when the pressures of dealing with coronavirus became too much. The proposal was to support the delivery of a Rainbow Room resource box to all 483 care homes in Northern Ireland from July 2020 and I attended the launch. The boxes were filled with information and advice on health and wellbeing issues to support staff as well as activity packs, toiletries, water bottles, tea, coffee and snacks [PM/6175 INQ000417346]. As this was a Public Health Agency proposal, they should be able to provide any further information required.

ii. Additional Support

170. As part of a range of initiatives to support Health and Social Care staff I approved Departmental funding to reimburse Health and Social Care workers for additional childcare fees incurred because of the pandemic. It was clear that many Health and Social Care workers struggled to cover the cost of childcare during the pandemic, either because they were required to work additional hours or informal sources of childcare (parents and grandparents in the main) ceased to be available. I have detailed above at section B(5) initiatives I funded and launched with the Education Minister. I also directed that the Health and Social Care Trusts receive additional funding for the provision of free canteen services to Health and Social Care staff and the provision of free car parking to Health and Social Care staff [INQ000103669]. Adjustment of work schedules would have been a matter for individual Trusts.

171. On 25 January 2021, I issued a direction to the Department [PM/2055 INQ000276338] approving the payment of a flat, one-off, special payment of £2,000 to qualifying students on specific nursing, midwifery, allied health professional, social work and physician associate pre-registration programmes commissioned by the Department over the period 1 October 2020 to 31 March 2021. This was provided in recognition of their contribution to the delivery of healthcare while on associated clinical placements during the unique and unprecedented operational challenges presented by the pandemic.

172. I also issued a direction for a one-off award of £15m to HSC Charitable trust funds. The HSC retains a number of separate and distinct charitable funds across the health estate covering a multitude of themes and locations. These funds have an important role in providing services, training and support that cannot be ordinarily funded using public funding and have made a very significant contribution to healthcare in Northern Ireland. They have contributed to the health sector for a number of years, relying on the general public's goodwill alone. In order to supplement the work of these and to support staff as we moved out of the pandemic, I recommended a disbursement to be split evenly between the five main Trusts, to be used to provide support to staff [RS/0323 INQ000485683].

173. I also announced the Special Recognition Payment of £500 to Health and Social Care staff in January 2021 [PM/2057 INQ000276341], subject to eligibility requirements including working during the defined qualifying period, to recognise the efforts of staff during the pandemic and to hopefully help maintain morale. For full-time staff, this amounted to £735 before tax and National Insurance deductions to ensure a net payment of £500 per person. Part-time staff received a proportionate payment.

iii. Clinically Extremely Vulnerable Staff

174. Arrangements for clinically vulnerable healthcare workers employed by Trusts are a matter for Trusts. I am aware that in the context of primary care services provided by independent contractors the then HSCB issued communication to contractors drawing attention to PHA resources [RS/0324 INQ000485684] indicating that where feasible and appropriate clinically vulnerable healthcare workers should be deployed to non-frontline roles particularly in the context of financial support schemes and furlough. I believe that this was the approach taken by HSCB but am unable to comment on how Trusts addressed the issue.

5. Impact of Pausing of DoH Core Business on the Population

175. The Department activated its Business Continuity Plan [PM/45 INQ000325157 (DoH ref: PM0031)], [PM/46 INQ000325162 (DoH ref: PM0356)] on 23 March 2020, which sets out the Department's core critical functions that will be prioritised in the event of a business continuity incident such as the pandemic. During the remainder of 2020 into the early months of 2021, due to the pressures on staffing, the Department paused much of its core business to manage the response to the pandemic. Difficulties in recruiting additional staff, or obtaining staff by redeployment from other NI departments, placed significant constraints on the Department during the pandemic. In the early stages of the pandemic staff were redeployed away from all but those priorities regarded as critical at that time. As the pandemic progressed priorities were continually reassessed.

176. Grade 7 officials and their teams recently recruited to manage health service transformation projects were immediately redeployed to the policy cells upon their arrival in the Department. The redeployment of these staff resulted in the Department's acute health services transformation programme being paused from April 2020 to the summer of 2021. This meant that transformation and reform did not progress as far as they could have over that time had there not been a pandemic.

177. The Transformation Programme is designed to bring stepped change to the HSC in NI. Each element of the programme, while working across the entire HSC and third sector, has its own milestones and deliverables; the pausing of the projects outlined below clearly had the impact of delaying the transformation agenda, delayed delivering improvements and efficiencies to HSCNI. This, in turn, would have had an adverse impact on Northern Ireland's population. It was, however, inevitable given the scale and longevity of the pandemic that the decisions to pause were taken, with finite resources available for tackling the pandemic. Specific examples include:

- The Neurology Review – Work on the Neurology Review was paused in March 2020. Work on the Review recommenced in June 2021. This has resulted in a delay in completing the Review and identifying recommendations to drive improvements in services. It is anticipated that a Final Report with Investment and Implementation plan will be completed late Spring 2024.
- Stroke Reform – Stroke reform was paused when the pandemic emerged but subsequently progressed with the publication of the Stroke Action Plan in June 2022. Work is now ongoing to progress the actions in that Plan, although delivery will be subject to budget availability. The high-level impact

is that stroke service reform, which is intended to improve patient outcomes, has been delayed.

- Urgent and Emergency Care Review – Work on the Review was paused in March 2020; however, the key emerging findings from the Review were picked up as part of the COVID-19 Urgent and Emergency Care Action Plan (No More Silos), which was published in October 2020. This Plan allowed progress to be made on the introduction of Urgent Care Services, Rapid Access Clinics and local Phone First services across all Trusts. The Review was ultimately published in March 2022, followed by a full public consultation, which saw broad support for the recommendations made. An Implementation Board was established in the Department in October 2022 to oversee delivery. While progress on implementation has suffered a degree of delay, this has not been as significant for the Urgent and Emergency Care Review as for some other service reviews.
- Pathology Modernisation – work to explore options for a revised regional management structure for HSC Pathology Services following the outcome of a public consultation in 2016 was delayed by the Assembly collapse between 2017-20 and subsequently by the onset of the pandemic. The impact was a further delay in developing a policy solution to growing capacity, workforce and modernisation challenges required to sustain vital pathology services. This work resumed following my policy statement on pathology modernisation in November 2021 [PM/6372 INQ000477515].
- Imaging Services – implementation of a new Strategic Framework for Imaging Services in Health and Social Care was further delayed (following publication in 2018 during the period of Assembly suspension) by the need to redeploy staff to the Covid response. This delayed implementation of the Framework's 19 key recommendations designed to stabilise and improve vital HSC imaging services. Work was resumed with the establishment of a Regional Medical Imaging Board in April 2021.
- Abortion Services – plans to develop a service specification to give effect to new Abortion Regulations, introduced by the UK Government from 31 March 2020, were paused due to redeployment of DoH staff from April 2020. The impact was a delay to the development of a service model for consideration by the NI Executive, whose approval was required at that time under the NI Act 1998 to commence the commissioning of these services (until further Regulations were introduced by the UK Government in May 2022 which provided the NI Secretary of State with the authority to instruct the

Department to commission these services). A revised project board was subsequently established in July 2021 to take forward plans.

H. Nightingale Hospitals

1. Belfast City Hospital

178. The Department's first Covid-19 Surge Plan, published on 19 March 2020 [PM/0300 INQ000103714], had outlined how 'normal' capacity of 88 routinely commissioned critical care beds across the Health and Social Care system (comprising a flexible complement of 56 Intensive Care Unit beds, and 32 high dependency or HDU beds) could be rapidly increased by a further 38 beds by taking the following steps:

- Utilising the facilities in cardiac surgery Intensive Care Unit at the Royal Victoria Hospital;
- Opening additional beds within the routine critical care locations, and
- By opening additional beds in recovery or theatre areas.

179. Following the publication of the initial Covid-19 Surge Plan on 19 March 2020, the Department, in conjunction with Critical Care Network Northern Ireland (CCaNNI), Health and Social Care Board (HSCB), Public Health Agency (PHA), and Trusts began to develop a specific critical care surge plan. This considered how critical care capacity could be further expanded, both locally and on a regional basis and consideration of the potential for a Nightingale hospital, delivering a specialist regional service for NI. The Critical Care Network NI was a key partner, as clinician expertise and knowledge was accessed through this.

180. Through regular engagement with clinicians from Critical Care Network Northern Ireland to surge planning leads within the Department and Health and Social Care Board, it was recognised that valuable staff resources were likely to be spread across multiple sites and that this would become impossible to sustain over an extreme surge period. Concentration of staff would allow expertise to be built up and shared rapidly, whilst working in a larger team would provide additional support and guidance to staff working in a pressured environment. This influenced the development of critical care capacity.

181. The output of this work was a draft Covid-19 Pandemic Critical Care Surge Plan, which I received as an urgent submission sent via email by the Director of Covid-19 Strategic Surge Planning on 1 April 2020 [PM/6086 INQ000346769 and PM/6107

INQ000439817]. The submission advised of a Reasonable Worst Case Scenario requiring 180 critical care beds at the peak of the first wave, that immediate action was therefore 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 relocating all other Intensive Care Units into the Belfast City Hospital as pressures on capacity and staffing ramped up.

182. The Department had initiated a rapid assessment of potential sites external to the existing Health and Social Care system to provide additional critical care beds if needed. This involved site visits by senior officials of the Healthcare Policy Group, and Strategic Surge Planning Directorate to the Titanic Exhibition Centre, Belfast Harbour Studios, and the Eikon Exhibition Centre at Balmoral Park, Maze, Co. Antrim, on 28 March 2020, supported by officials from Health Estates (at that point part of the Department of Finance, now integrated into the Department of Health), a nursing adviser and the Military.

183. The Belfast City Hospital tower block emerged as the preferred site for locating Northern Ireland's first Nightingale Hospital. The Department considered that, on balance, while the Eikon Exhibition Centre offered the optimum potential (in terms of capacity and accessibility) for a Nightingale Hospital facility on an external site, the Belfast City Hospital tower block could be more quickly adapted than the Eikon Centre. This factor swayed the decision in favour of the Belfast City Hospital tower block. Establishing this Nightingale facility would require significant temporary reconfiguration of existing critical care provision across the Health and Social Care hospital network. I agreed with this recommendation and [PM/6086 INQ000346769 and PM/6107 INQ000439817] designated Belfast City Hospital's tower block as Northern Ireland's first Nightingale Hospital, announcing the decision on 2 April 2020 [PM/0064 INQ000103653].

184. I would have agreed the surge plans through the Department's Gold Command structures and received assurances through these structures that plans were being implemented/operationalised in line with the prevailing pandemic conditions. However, other than being briefed on them, I would not involvement in any operational/clinical decisions, including staff recruitment and redeployment; reconfiguration; decisions on individual patients (e.g. decisions to transport from other Trusts, admit, provide treatment, etc) as this is always the responsibility of the treating Trust, supported through regional clinical collaboration facilitated by CCaNNI.

In the case of Belfast City Hospital the Belfast Health and Social Care Trust was responsible for its funding and fit out.

185. A challenge in the effective use of the Nightingale hospital was its staffing. During surge it was expected that staffing ratios should be of a similar level across all critical care units, including the Nightingale Hospital. In order to address this, critical care staffing was augmented by non-critical care staff, for example theatre staff, who would receive skills training. These nurses were supervised by critical care nurses.

2. Whiteabbey Hospital

186. I granted approval for work to begin on exploring the site and specification for a second regional Nightingale facility in April 2020, in advance of the anticipated second wave of Covid-19, because it was believed that it could coincide with winter pressures. This included approval for assessment of a number of potential sites and the identification of the most suitable clinical and technical requirements [PM/6330 INQ000276382]. There was concern at the time that the layout of the Belfast City Hospital Tower Block would not provide sufficient capacity for the anticipated winter wave and did not allow for the economies of scale similar Nightingale facilities enjoyed in other jurisdictions [PM/6330 INQ000276382 as above]. Our second regional Nightingale facility was also going to be a rehabilitation centre, rather than an intensive care unit, so its establishment was known to take some time, being cognisant of the evolving situation and knowing it would entail extensive work to reestablish a dormant site. This was also in recognition of providing a second regional facility to address either end of the treatment plan.

187. A Project Board was established [PM/6407 INQ000480751; PM/6408 INQ000426798; PM/6409 INQ000480753], chaired by the Chief Nursing Officer, which recommended that the new facility should focus on step-down provision. The Project Board instructed Construction & Procurement Directorate (CPD) to carry out a site analysis, with Construction & Procurement Directorate 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.

188. The Construction and Procurement Directorate 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 [PM/6331 INQ000426798]. This was endorsed by the Project Board at its meeting on 19 May

2020 and approval given of £126k to engage EY to provide external support and business case preparation and I ultimately gave approval on 1 September 2020 to move ahead with the proposal, [PM/6333 INQ000276384; PM/6334 INQ000276492] after seeking and receiving assurances around the legacy usage of the facility [PM/6335 INQ000276493; INQ000370938]. The decision was required in September because the capital build element was going to take up to three months to deliver, meaning a decision was needed by 1 September to have the facility ready for hand over on 1 December 2020. Any delays related to improving the business case would have had a knock-on effect on the critical path for the project, subsequently delaying opening of the facility.

189. As has already been recognised throughout this Inquiry, the situation was constantly evolving and it was only through greater knowledge of the virus, increased modelling information and capacity that it became apparent a second Nightingale hospital may be required to address the anticipated second surge and winter demands, alongside the increase in cases requiring rehabilitation.

190. I decided, on 1 September 2020, 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, concluding that the development of additional intermediate capacity would improve this flow and free up acute capacity. This position was strengthened by the belief that it was less likely for clinicians to be willing to transfer acute patients to a regional facility; therefore, the Whiteabbey Nightingale would provide additional capacity for intermediate care patients, rather than provide additional acute capacity, like that provided at the Belfast City Hospital Nightingale [PM/6333 INQ000276384; PM/6334 INQ000276492 as above]. I also decided, on 1 September 2020, 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. This decision was supported by analysis of Nightingale facilities in other United Kingdom nations [PM/6332 INQ000276383 as above]. Because of the decision to establish the Whiteabbey Nightingale as an intermediate care facility, there was no need to reconfigure existing critical care provision, as there was no need for additional critical care staff / facilities on the additional site.

191. The Whiteabbey Nightingale was largely a nursing and allied health professional led unit, with a workforce including nursing staff of varying seniority, pharmacists,

occupational therapists, physiotherapists, speech and language therapists, dietitians, psychologists and social workers. A workforce planning group was established as part of the Nightingale Project to oversee the recruitment of staff, leveraging where possible the Health and Social Care Workforce Appeal undertaken in March 2020, and supplementing this with staff redeployment, new recruits hired specifically for the unit and agency staff, although recruitment for opening additional wards became challenging and provided a significant limiting factor.

192. The Whiteabbey Nightingale was originally 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 [PM/6337 INQ000426806]. 23 beds were opened at the facility on 20 November 2020 [PM/6338 INQ000426807] and this number increased to 28 by mid-January 2021 [PM/6339 INQ000276499]. 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, with the unit, ultimately, never extending beyond the 28 beds opened by mid-January 2021 [PM/6338 INQ000426807; PM/6339 INQ000276499 as above]. By the end of January 2021, consideration began to be given to the legacy usage of the facility and, with occupancy down below 50% of the open beds by mid-February, efforts to recruit staff for the additional units were paused until the outcome of the legacy discussions were known [PM/6340 INQ000426809].

193. In February 2021, I agreed that 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 [PM/6340 INQ000426809 as above]. 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 [PM/6340 INQ000426809 as above]. This meant that the facility remained closely aligned to the clinical and staffing model required to manage Covid-19 patients. The facility also maintained its 14-day maximum average length of stay to ensure beds could be freed for Covid-19 patients if required. By March 2022, with the option having never

been activated, this requirement was relaxed to allow a broader legacy usage [PM/6340 INQ000426809].

194. The final capital costs for the Whiteabbey Nightingale unit were in the region of £4.2m [PM/6339 INQ000276499 as above], while the resource costs were in the region of £2.3m for the period of operation as a Covid-19-focused facility from November 2020 to early April 2021 [PM/6338 INQ000426807 as above]. While the costs appear high, they must be balanced against the number of patients who were treated in Whiteabbey thereby freeing up beds in more acute facilities and utilising staff more efficiently. The capital costs ultimately remain of benefit as the hospital still operates a number of services.

I. Discharge of Patients

1. Older People, Physical Disability & Sensory Impairment

195. The Covid-19 pandemic had a significant impact across the Health and Social Care system including patient flow and discharge. Hospital discharge delays continued during covid. The reasons for these delays were the same as for discharge delays that happened prior to the pandemic, for example social care related delays due to waiting for a package of domiciliary care to be available, or for the appropriate Care Home placement to be identified. While these reasons were prevalent pre and during the pandemic, the pandemic caused additional complexity within these areas and impacted upon patient flow and discharge due to, for example, reduced staffing availability, isolation within care homes, and Covid outbreaks. Internal delays within the acute sites also continued, for example the organisation of pharmacy/medication or equipment and transport delays. Additional conversations (and meetings where appropriate, for example with families) were also often necessary to provide reassurance to people in relation to the fear of infection and transmission rates in care home settings.

196. In response to the above, various steps were taken by the Department and the Health and Social Care Board, working in collaboration with other Health and Social Care organisations. Health Silver Command meetings oversaw the development of the '*Health and Social Care (NI) Summary Covid-19 Plan*' for the relevant period [PM/6399 INQ000477546]. As these were clinical decisions my involvement was not necessary and I was asked simply to note such actions. The importance of hospital discharge was recognised in the Mid-March to Mid-April plan 2020 [PM0300

INQ000103714] which noted that staff would be re-deployed to support hospital social work teams to facilitate safe discharges and maximise patient flow through the health and social care system. The following measures were put in place:

- Trusts activated their emergency discharge plans in line with their respective contingency/ emergency and/or major incident plans;
- Trusts expedited discharges when patients were deemed medically fit (the Plan did not include assessment criteria as this would have been a medical decision), through shortening assessment to home care package arrangements. In these circumstances it was acknowledged there would be increased reliance on families in order to facilitate discharges;
- Trusts worked to maximise and utilise all spare capacity in residential, nursing and domiciliary home care, and
- Trusts set aside the then choice protocols which allowed patients a choice of residential or nursing care homes.

197. It was also recognised that, as part of their contingency plans, Trusts may have needed to re-distribute domiciliary care hours; this would have included prioritising and targeting care hours to those clients who were [considered to be] at risk and those with the greatest clinical and/or care needs. For example, Trusts, as part of their contingency planning, prioritised service users who could not access any informal support from family during the pandemic.

198. Guidance that patients discharged from a hospital to a Care Home must be tested for Covid-19 48 hours in advance of discharge, was first set out in Version 3 of the Interim Protocol for Testing for Covid-19 dated 19 April 2020 [PM/0247 INQ000103724]. I was made aware of the contents of the Guidance. Version 3 of the Interim Protocol was communicated to Health and Social Care Trusts on 19 April 2020. A letter dated 25 April 2020 from the Permanent Secretary to Chief Executives (Health and Social Care Trusts, Public Health Agency, Health and Social Care Board, Northern Ireland Ambulance Service, and the Regulation and Quality Improvement Authority) about key changes to testing for Covid-19, also reiterated the requirement for patients discharged from hospital to a care home to be tested 48 hours in advance of discharge. The letter from the Permanent Secretary also advised that all new admissions to care homes from community settings, including from supported living accommodation, were to have their Covid-19 status checked 48 hours before admission to the care home. The same conditions applied to residents admitted to

care homes from community settings as applied to patients discharged from hospital to a care home [PM/0136 INQ000145670]. I was fully aware of the contents of the Permanent Secretary's letter.

199. Guidance published on the 27 April 2020 (Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland) [PM/245 INQ000087760 (DoH ref: PM0122)] included the updated approach to managing the discharge of patients from hospital to a Care Home. The guidance directed that all patients who were to be discharged from acute hospital care to a Care Home were to be tested 48 hours prior to discharge. In addition, this updated guidance explained that all patients/residents who were to be transferred into a Care Home from any setting, whether that be from hospital, supported living or directly from their own home, would be tested 48 hours prior to admission to the Care Home. This would help Care Home staff to understand each resident's status and to plan their care effectively. The updated guidance clarified that all patients who were discharged from hospitals into Care Homes – whether they had tested negative or not – should be subject to isolation for 14 days.

200. I would have been briefed on the guidance issuing but as discharge of patients is an operational and clinical decision my input into the formation of the guidance was limited. In terms of the guidance of the 27 April 2020 I received a submission on 23 April 2020 [PM/240 INQ000130366 (DoH ref: PM0176)] for approval to publish the revised guidance. I raised a number of queries on the submission and guidance [PM/241 INQ000130357 (DoH ref: PM0177)] relating to capacity, financial support and testing. The queries were responded to on 24 April 2020 [PM/242 INQ000130365 (DoH ref: PM0199)] and I approved the guidance on the same date [PM/243 INQ000130378 (DoH ref: PM0200)]. A letter from the Chief Social Work Officer and the revised guidance issued on 26 April 2020 to Health and Social Care Trusts and the Regulation and Quality Improvement Authority for issue to the sector. The revised guidance was published on the Department's website on 27 April 2020 [PM/245 INQ000087760 (DoH ref: PM0122)].

2. Enhanced Discharge

201. I am not aware of any discussions taking place in the Department on Enhanced Discharge and cannot locate any documentation relating to it.

J. Use of the Independent Sector

202. The Health and Social Care Board led on discussions with independent hospitals in the context of surge planning in order to support the pandemic response in Northern Ireland and the Department did not get directly involved in these discussions. Health Silver submitted a report to Health Gold setting out the plans for contracts, similar in context to the 'novel' contracts adopted by NHS England. While summarising some elements of the work, the focus of the report was to ask the Department to effectively act as insurer of last resort in relation to any uninsured clinical negligence and employer's liability claims. I agreed the indemnities, initially for the period to 30 June 2020 but subsequently extending them until end March 2022 [PM/6411 INQ000376914; PM/6412 NQ000396900; PM/6413 INQ000485222; PM/6414 INQ000396963].

203. The decision to contract with the Independent Sector Hospitals was taken in March 2020 by the HSCB [PM/6410 INQ000480754] and it was agreed to use the same arrangements made by NHS England i.e. to agree to a full cost recovery, not-for-profit arrangement with the three independent hospitals in Northern Ireland with oversight of income and expenditure through an independent third party. The legal drafting of the three Heads of Terms contracts which recorded these arrangements were finalised between Health and Social Care Board and the Independent Hospitals as follows: Kingsbridge Private Hospital on 14 April 2020; North West Independent Hospital on 21 April 2020 and Ulster Independent Clinic on 05 May 2020. The Independent Sector Providers specified and named premises to be made available for the exclusive use of the patients of the Trusts for the duration of the Heads of Terms contract, all Patients to be treated as public (HSC/NHS) patients for the duration of the Heads of Terms contract and any subsequent Formal Agreement.

204. These contracts, in effect between 1 April 2020 and 29 June 2020, were agreed on a not-for-profit full cost recovery basis and provided Health and Social Care Trusts with full access to the Independent Sector hospital facilities at certain specified premises. The Health and Social Care Board had the option to extend the arrangements monthly to 31 August 2020 but consideration of the value for money being delivered under the contracts led the Health and Social Care Board to serve notice that the contracts were not to be extended beyond the initial period. The rationale for this change was outlined in a paper to the Rebuilding Management Board dated 26 June 2020 [PM/6347 INQ000381740] and I received a submission on it asking for my

approval of the revised arrangements which I gave [INQ000373987]. Instead, the Health and Social Care Board moved from full cost recovery arrangements with these providers to per session prices (half days) for theatres, day procedure units and scope suites (including drugs, prosthetics, etc) with prices negotiated to achieve best value in the prevailing circumstances. While I was not a member of the Rebuilding Management Board I was regularly updated on issues by the Chair, Richard Pengelly.

205. The three hospitals sought full cost recovery of £3.5m per month in the period April to June 2020, with a further £325,000 estimated to be claimed by self-employed Consultant anaesthetists for this three-month period. With the move to the cost per sessional usage the Independent Sector was paid approximately £9,000 per session. These contracts had variable costs depending on the theatre session access that was made available. The contract activity and cost data for this period is on record and held by the Strategic Planning and Performance Group [PM/6348 INQ000426818; PM/6349 INQ000426819; PM6350 INQ000426820; PM6351 INQ000426821; PM/6352 INQ000426822; PM/6353 INQ000426823; PM/6354 INQ000426824 and PM/6355 INQ000426825].

206. The range of services to be provided by the independent hospitals to include: pre-assessment, operating theatres and acute bed capacity registered with' RQIA, facilities, diagnostics such as ultrasound and X-ray as required as part of the inpatient or day-case admission, staffing, independent consultants, management and full organisational facilities. The Health and Social Care Trust were to pay the Independent Hospital such sums as were equal to the actual costs incurred by the Independent Sector Provider in providing the Services during the Heads of Terms and during the term of any subsequent Formal Agreement (the Consideration). Five elements to the Consideration were identified: (1) Operating costs (2) Rent (3) Capex costs; (4) Finance costs; (5) De-commissioning costs.

207. The capacity was primarily used to support the continued delivery of urgent cancer diagnostics and treatment [PM/6357 INQ000426780 and PM/6358 INQ000376995], but Health and Social Care Trusts also accessed the Independent Sector hospitals to treat urgent non-Covid-19 patients across a number of elective specialities including breast surgery; maxillofacial surgery; urology procedures; general surgery, and ophthalmology. Prior to Covid-19 Trusts would have sent patients directly to the Independent Sector providers for assessment and/ or treatment. Trusts operated

and monitored these contracts and payment would have been made on a cost per case basis.

208. I believe that the use of Independent Sector hospitals provided valuable additional assessment, treatment and in particular surgical theatre capacity during the pandemic, at a time when Trust hospital theatres were operating at very reduced capacity. As explained above, the initial contract was on a not-for-profit basis full cost recovery basis and could have been extended beyond the original term, but, on consideration of the value for money, it was decided not to. Instead, the contract changed to a price per session with a negotiation on prices. I would, therefore, consider that due regard was had to value for money even in the prevailing circumstances at the time.

209. I am not aware whether the Trusts had any pre-existing contracts with independent sector providers; this may not have been possible due to the single year budgets in which we were, and still are, operating. I cannot recall receiving any information on communications between the Department of Health and the Department of Finance on either the cost of using independent hospitals or an analysis of value for money.

K. Medical Equipment

1. Ventilators

210. The process of ordering, distributing and monitoring demand for ventilator stock across Northern Ireland's critical care units was led by the Critical Care Network Northern Ireland (CCaNNI) in conjunction with the Procurement and Logistics Service (PaLS), which is a part of the Health and Social Care Business Services Organisation (BSO) and is the Centre of Procurement Expertise (CoPE) for the Health and Social Care system.

211. In March 2020 Trusts initially estimated that there was a need for 40 additional mechanical ventilators (30 adult units and 10 paediatric units) to bring the total available ventilators in Northern Ireland to 179 by the end of March. While Trusts had initially estimated their need as 40, further work was underway by the Trusts and CCaNNI, to scope the full extent of critical care equipment that may have been needed to be purchased to ensure that Northern Ireland could respond to the potential number of people who would need such specialised care. This fed into a costed proposal from Health Silver, received by the Department on 19 March 2020,

which was based on the advice of the clinical lead for CCaNNI), and proposed an additional 100 ventilators. I approved the spend for a further additional 100 ventilators and other equipment for critical care and respiratory services in preparation for the first wave of Covid. The costed proposal and approvals from DoH are referenced in an updated submission briefing me on the situation, dated 15 April 2020 [PM/6222 INQ000417498].

212. That same submission also advised advised that there was currently sufficient capacity, equipment and oxygen across the Health and Social Care system in Northern Ireland to provide critical care and respiratory services for those who currently needed it. As of the morning of 15 April 2020 there were 39 ventilated Covid patients (including 3 suspected cases) and 4 non-ventilated Covid patients occupying critical care beds across Northern Ireland.

213. At the time a new United Kingdom national allocation programme had been established for the allocation of critical care equipment, which was managed for the United Kingdom as a whole by the Department of Health and Social Care (DHSC) in England in conjunction with the Cabinet Office and the Department for Business, Energy and Industrial Strategy (BEIS). Under the first of the national programme's components (a central programme of procurement and United Kingdom-wide distribution of stock) I was advised [PM/6222 INQ000417498] that National Health Service England was in the process of procuring a large volume of ventilators, and other equipment, with the intention of allocating this as 'National Health Service loan stock' to devolved nations and crown dependencies on a population basis, i.e. Northern Ireland would be set to receive 2.8% of all stock when received.

214. Other than initial concerns in respect of ventilators I am not aware of substantial issues with the availability of ventilators. However, once a patient requires ventilation they require 1-1 nursing care from skilled critical care staff and it was recognised that, at peak surge, there may not be sufficient numbers of such staff. In these circumstances, additional training was provided to non-critical care staff redeployed and the staff would also be supervised by experienced staff.

2. Patient Safety

215. Several Serious Adverse Incidents (SAIs) were reported during the relevant time period which mention Covid. The SAIs identified are in relation to areas such as:

- Delay in treatment / diagnosis;

- Staff absences / shortages due to Covid;
- Covid outbreaks, and
- Healthcare associated infections.

216. On 7 September 2020, I informed the Northern Ireland Assembly that a Serious Adverse Incident (SAI) Level 3 learning review would be undertaken of Covid-19 cases and outbreaks which occurred in hospitals in the Southern Health and Social Care Trust [PM/3080 INQ000417466]. An Independent Panel was established by the Southern Health and Social Care Trust and the Public Health Agency to undertake this Serious Adverse Incident learning review. The panel comprised senior medical consultants in care of the elderly, haematology and microbiology, an independent senior nurse consultant with expertise in infection control, a consultant representative from the Public Health Agency and a lay representative.

217. On 16 September 2021, I announced that the Southern Health and Social Care Trust had received a copy of the Independent Panel's draft report related to the Covid-19 cases and outbreaks which tragically led to the deaths of 15 patients within the Southern Health and Social Care Trust's hospitals between August and October 2020 [PM/3081 INQ000383083]. I advised that this draft report was to be shared with the 32 families impacted by these outbreaks at that time, and with the former Health and Social Care Board (now the Strategic Planning and Performance Group in DoH). A draft copy of the Report was shared with SPPG on 23rd September 2021. SHSCT advised the draft report had also been shared with those families that had requested a copy and that SHSCT were continuing to collate patient feedback in order to inform the SAI panel.

218. On 28 September 2023, the Southern Health and Social Care Trust published the final report of the review of clusters of Covid-19 cases which occurred in 2020 in both Craigavon Area and Daisy Hill Hospitals [PM/3082 INQ000417468; PM/3139 INQ000088724; PM/3141 INQ000090419; PM/3143 INQ000408923; PM/3144 INQ000417474]. The final report contained important findings and recommendations regarding the prevention, control, and treatment of Covid-19 in the hospital settings. The Southern Health and Social Care Trust confirmed it would carefully consider the report and its recommendations, involving families in this process.

219. It is not normal practice to publish a SAI report, given the need to ensure anonymity, but it was done on this occasion because I had given a commitment to the findings

being published due to Assembly and public interest. While I acknowledge that the time taken to, firstly, produce a draft report and, secondly, publish the final report was lengthy, a level 3 SAI is highly complex. It was important that the process was thorough and transparent through the involvement of those families who wished to participate. However, I left office on 27 October 2022 after the draft report had been received and engagement with families was ongoing so cannot comment further on why the final report was not published until September 2023. I also understood, at the time of leaving office, that learnings from the draft report were being shared and implemented.

220. A concern in May 2020 related to the number of staff failing the fit-testing of PPE masks due to the range of products being supplied [PM/182 INQ000120710 (DoH ref: PM0081)]. An audit review of fit testing for respiratory masks was carried out, in early summer 2020, on a precautionary basis across the HSC system after it emerged that an independent contractor had inadvertently applied on some occasions a fit-testing setting not normally used in Northern Ireland. To ensure learning from this incident, the Public Health Agency was asked to undertake a Serious Adverse Incident review and implement the recommendations.

3. Medicine Shortage

221. The Covid-19 pandemic posed many new risks and challenges that the UK had never faced before and some medicines required for the management of patients with Covid-19, came under considerable pressure during the first wave as suppliers struggled to keep up with international demand. This was particularly true of certain medicines used in critical care settings to support mechanical ventilation, end of life care, and antibiotics. For example, I know that supplies of cisatracurium injection, a neuromuscular blocking agent used for intubation of patients undergoing mechanical ventilation in critical care, were temporarily unavailable in April 2020 due to increased demand across the UK but I cannot recall when I was informed of this. Supplies of alternative neuromuscular blocking agents atracurium and rocuronium were centrally managed by NHS England, working closely with pharmacy procurement leads in the devolved administrations, to allocate the limited supplies across the UK on an equitable basis. A proportion of the limited remaining stocks of atracurium and rocuronium injection in the supply chain was allocated to Northern Ireland on the basis of the Barnett formula, and the Regional Pharmaceutical Procurement Service made allocations to individual Trusts based on modelling data which took account of

current stockholding and ICU bed occupancy. This process ensured that HSC Trusts had sufficient stock of these critical medicines to meet immediate needs.

222. I am aware that Departmental officials participated and supported a range of measures which were taken at national level, led by the Department of Health and Social Care to maintain supplies of these medicines required for the management of Covid-19 patients during the peak of the pandemic, including:

- Banning parallel exports of these medicines;
- Setting up new National Health Service sourcing teams to source as much of these drugs as possible;
- Working to track down additional sources of supply around the world;
- Setting up new processes with wholesalers to manage distribution of key medicines;
- Setting up new processes of tightly controlled allocations to Trusts across the United Kingdom based on their actual daily needs;
- Publishing general guidance (developed with Royal Colleges) on alternative products and further clinical guidance on how to make supplies last longer, and
- Issuing a Supply Disruption Alert to the NHS on managing shortages of specific products.

223. This extensive range of actions ensured that while the availability of individual products used in critical care settings for the management of Covid-19 patients fluctuated, particularly during the first wave of the pandemic, the clinical needs of patients continued to be met by alternative products.

224. Despite this extensive range of action, additional measures were progressed following the first wave of the pandemic to provide me with additional assurance that sufficient supplies of critical medicines were available for the treatment of Covid-19 patients in the event of a further peak of the pandemic. The Department participated in United Kingdom-wide arrangements from July 2020, led by the Department of Health and Social Care, for the procurement and stockpiling of critical medicines to mitigate against the likelihood of medicine shortages should there be a further Covid-19 pandemic outbreak. These medicines included products used in end of life care, antibiotics, and supportive medicines used in critical care settings for sedation and maintenance of mechanical ventilation.

4. Oximeters

225. I was not aware in March 2020 that the accuracy of oximeter readings may vary depending on the skin tone of the patient nor was I aware of any assessments being undertaken to ascertain whether patients with darker skin might be disproportionately affected by the provision of oximeters that did not provide accurate readings. I was also not aware of the impact of any inaccurate readings on patients with darker skin.

226. Regretfully I cannot recall when this was brought to my attention.

L. Infection Prevention and Control

1. Non-Covid Conditions

227. Alongside the implementation of primary care covid centres and increased use of telephone appointments with GPs, which I have referenced above in section E(2), in July 2020, I announced the 'Policy Statement for Elective Care Day Procedures' [INQ000276347 (DoH ref: PM2063)]. The first surgical hub established was the Day Procedure Centre at Lagan Valley Hospital in July 2020. The overall aim of the Day Procedure Centre model was to deliver high volume, low complexity routine procedures. While the nature of the site meant that it is most suitable for day case surgery and procedures rather than more complex work, the complete separation of elective and unscheduled services at the site enabled services to continue be delivered throughout the pandemic on a 'covid-light' pathway.

228. The provision of services to patients receiving treatment in secondary care settings was in some cases subject to wider hospital restrictions and the delivery of these services. It was recognised that for some patients continued treatment was essential. The Infection Prevention and Control guidance is the fundamental source of guidance to Trusts, which governs how patients should be treated during the pandemic, while keeping them safe from potential nosocomial covid infection.

229. As part of efforts to rebuild services, the Rebuilding Management Board agreed on 17 February 2021 to five principles for critical care de-escalation and elective care rebuild. Principle 4 requested that all Trusts seek to develop green pathways, with 'green' in this context meaning that every effort would be made to keep the services entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services. Principle 5 requested that Belfast Nightingale de-escalation should focus on increasing regional complex surgery as quickly as

possible, focusing initially on the development of green pathways, with the aim for Belfast City Hospital ultimately to become a green site serving the region.

230. I approved these principles [PM2077 INQ000276361], on 17 February 2021, following which it was a matter for Trust Chief Executives, who sat on the Board, to ensure that the principles were communicated and implemented in each of their Trusts.

231. Subsequently I published the Elective Care Framework on 15 June 2021 [INQ000348868 (DoH ref: PM3114)] which committed Belfast City Hospital and Lagan Valley Hospital to remain as elective ('green') sites, which served the region. This was part of the Department's advice to make every effort to keep elective care services entirely separate from any exposure to Covid-19. In terms of the outworking of these policies, at the Department's request, the HSCB worked with Trusts via the Regional Prioritisation and Oversight Group to identify and build on the covid light/green sites and pathways; this included expanding provision at the day procedure centre facilities.

232. I would point out that these are examples of what transformation could have achieved prior to Covid-19 had there been budget and direction to do so.

2. Nosocomial Cell

233. Health and Social Care Trusts experienced particular challenges with the emergence of healthcare associated Covid-19 infections. Whilst there were measures in place to minimise the transmission of Covid-19 in healthcare settings, it was recognised that as we progressed through the winter months with hospitals under increased pressure with Covid-19 and non-Covi-19 admissions, those measures alone may not be sufficiently effective. It is within that context in December 2020 that the Chief Medical Officer established a regional Nosocomial Support Cell as part of the Department's approach to supporting the Health and Social Care Trusts to address the challenges arising from Covid-19 infections in healthcare settings [PM/3084 INQ000185385]. The key objective of the Nosocomial Support Cell was to provide multidisciplinary support to the region and Health and Social Care Trusts experiencing clusters or sustained complex outbreaks of healthcare associated Covid-19 infections in acute settings. The work programme for the Nosocomial Support Cell included:

- The development and introduction of a regional nosocomial dashboard, an important information management tool, utilised by all relevant Health and

Social Care organisations to support the oversight and operational management of Covid-19 incidents and outbreaks;

- The completion of a programme of learning visits to acute hospitals, by a team of experienced healthcare professionals, with a focus on identifying and sharing learning and supporting best practice to prevent and control transmission of Covid-19 infections in hospital settings, and
- The development of a region-wide approach to reviewing and learning from deaths associated with hospital-acquired Covid-19.

234. The Nosocomial Support Cell had a key role in enabling quick and effective sharing of lessons learned including that arising from risk assessment and management of significant clusters and outbreaks (as they arose), and the associated implementation of best practice to contain and prevent the spread of Covid-19 in hospital settings. The Nosocomial Support Cell was chaired by Dr Anne Marie Telford (a past Director of Public Health in Northern Ireland), supported by the Deputy Chief Medical Officer. Membership included the Department, the Public Health Agency, the former Health and Social Care Board and other healthcare Professionals as appropriate.

235. During the summer of 2021, having completed its planned programme of work, the support function initially provided through the Nosocomial Support Cell moved to the Public Health Agency, and the Nosocomial Support Cell transitioned into a Regional Health Care Associated Infection (HCAI) Working Group, also referred to as the 'HCAI, Regular Testing and Outbreak Group'. The regional nosocomial dashboard, developed by the Cell, was an important information management tool which continued to be utilised by all relevant Health and Social Care organisations to support the oversight and operational management of Covid-19 incidents and outbreaks. The dashboard facilitated prompt access to timely information on nosocomial Covid-19 infections within and across hospitals in Northern Ireland. Each Health and Social Care Trust received a summary report following the learning visits completed by the Cell's Visiting Sub-group, including the Southern Health and Social Care Trust [PM/6182 INQ000417482; PM/6183 INQ000417483; PM/6184 INQ000417484]. These reports were an important source of timely feedback to Health and Social Care Trusts on the approach and systems operating in their respective hospitals to address and mitigate the impact of Covid-19 as it emerged in the acute hospital sector.

M. Visiting

1. Guidelines and Protocols

236. The Department issued a statement on 12 March 2020 [PM/0068 INQ000103659] alerting the public that "[g]iven the particular risks from coronavirus, hospitals and other providers have to prioritise the safety and wellbeing of patients and staff. I had received briefing on this. People with underlying health problems are at particular risk, which is why hospital environments and care homes need to take particular care." Health and Social Care services were under growing pressure due to the increase in cases of Covid-19 and it was expected that normal business would not be possible as Health and Social Care moved into the next phase of the pandemic. Whilst a blanket ban on visits was not introduced, the statement, as published on the Department's website, set out guidelines for visitors to help ensure the safety and wellbeing of patients and staff. These recognised that the mixing from visiting increased the risk of transmission but that visits were also important and had significant benefits for patients.

237. In terms of restrictions to visiting, the Chief Nursing Officer issued the first iteration of visiting guidance for healthcare settings in Northern Ireland on 17 March 2020 [PM/0121 INQ000120717]. She recommended that this guidance should equally apply in nursing and residential Care Homes and other community settings. I recall being briefed on the contents of the guidance and being informed that it was issuing.

238. On 26 March 2020, with my agreement and approval, the Chief Nursing Officer wrote [PM/0069 INQ000103660, PM/0070 INQ000103663, PM/0071 INQ000103664, RS/0325 INQ000485685] to the Health and Social Care Trusts to inform them that with immediate effect, based on the clinical expertise of nursing colleagues from within CNO Group, Trusts and the Northern Ireland Practice and Education Council for Nursing and Midwifery, it had been decided that visits to hospitals should be stopped with immediate effect in the interests of protecting patients, their families and Health and Social Care staff. This reflected growing understanding of the impacts of the virus in terms of transmission rates, effectiveness of PPE, Aerosol Generating Procedures (AGP) and all the other evidence that emerged as the pandemic progressed. 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.

239. This approach to facilitating limited visiting was subject to ongoing review, and on 9 April 2020, updated guidance [PM/171 INQ000353609 (DoH ref: PM0438)] was issued by the CNO which stopped face-to-face visits in ICUs, recommending that where possible virtual visits be facilitated in those settings. I had been briefed on this.

240. As updated evidence, for example around transmission rates, relative effectiveness of PPE, AGP impacts and all the other evidence that emerged as the pandemic progressed was becoming available almost on a daily basis, updated guidance was issued by the CNO on 26 April 2020 [PM/245 INQ000087760 (DoH ref: PM0122)] which detailed further information for the care home sector. I approved the issue of this guidance [INQ000130372]. This included a section on necessary visiting restrictions developed by senior nurses within the CNO's team and particularly including advice around suitable arrangements for visiting at end of life. This stated that where end of life was imminent, the care home should facilitate one relative to visit. This should be for a short period of time (normally no more than one hour at most), with personal protective equipment worn, infection control protocols strictly followed, and a log kept of all visitors' names and contacts.

241. On 16 April 2020, I asked the Critical Care Network for Northern Ireland (CCaNNI) to undertake a rapid review of the situation with respect to visiting within Northern Ireland Intensive Care Units at the end of life as I was keen to facilitate visiting in such circumstances. The rapid review looked at emerging issues and risks associated with visiting patients in Intensive Care Units and considered the views of clinical staff and service users and the barriers that would have to be overcome to enable visiting to happen safely in selected cases. A report was produced at the end of the review which set out the key principles that Intensive Care Units should consider when facilitating end of life visiting in Intensive Care during pandemic Covid-19 [PM/6176 INQ000376875].

242. This review was considered when further modifications to the visiting arrangements were made on 11 May 2020 [PM/0132 INQ000120721] following advice from the CNO which I accepted [RS/0326 INQ000485686]. These modifications relaxed restrictions in certain circumstances, and allowed family, friends or loved ones to safely visit dying patients. The modifications applied equally to care home settings and other community settings as well as hospitals. Arrangements for end of life visiting were included in every iteration of the visiting guidance, known as the Regional Principles for Visiting in Care Settings in Northern Ireland, first published in June 2020, and amended periodically, as detailed above, from then until the May 2021 issue of setting specific guidance (detailed below).

243. Visitors to patients at end of life had to have capacity to provide informed consent of the risks involved. Visitors also had to comply with PPE requirements and agree to undertake the subsequent isolation and quarantine restrictions appropriate to the contact with their visits. IPC measures were not to be so restrictive as to prevent visitors from holding hands with the patient.

244. On 30 June 2020, [PM/0073 INQ000103666] I announced changes to restrictions on visiting across all care settings from Monday 6 July 2020. Following publication by the Executive on 12 May 2020 of the five-step approach to relaxing lockdown restrictions, it was considered timely to review the extent and application of restrictions on visiting across all care settings. As part of this review process, the Department's Strategic Clinical Advisory Cell undertook a review of the evidence relating to Covid-19 infection and the impact of hospital visitors on disease transmission. A summary of the evidence used is included in the resulting revised guidance [PM/0074 INQ000103667] prepared by the CNO's team, which recognised the right of people to visit their loved ones in hospitals and care homes, while balancing the ongoing risk from Covid-19.

245. This guidance - 'COVID-19 Regional Principles for Visiting in Care Settings in Northern Ireland' - provided advice in relation to 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. 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. The guidance referenced the particular restrictions which would apply in a range of settings based on the extant surge level,

which was defined in the guidance as high, medium, or low surge levels. There was a recognition that the pandemic would continue for an extended period of time. It was therefore possible to flex the restrictions in response to peaks and troughs in viral transmission.

246. I was advised of any changes to the level of applicable restrictions and my endorsement sought at every stage.

247. On 23 September 2020 I announced a further revision to this regional guidance. It reflected the need to protect patients, residents and staff from Covid-19, while recognising the importance of human contact to health and well-being and recommended that all health and social care facilities in Northern Ireland should move to facilitate one face-to-face visit per week by one person. There was continued provision to flex the restrictions in response to transmission levels. It also introduced the formalisation of the 'Care Partner' concept. This was a scheme which allowed the identification of an appropriate person to assist in maintaining each resident's physical and/or mental health.

248. On 12 November 2020 the Chief Nursing Officer and Chief Social Work Officer issued a guidance letter to Residential and Nursing Home Care Providers entitled 'Implementation of Care Partner in care homes in Northern Ireland' followed by a letter to HSC Trust Chief Executives and Directors of Older People Services on 13 November 2020. Both pieces of correspondence advised that, following engagement, a supplementary description around the care partner concept was being finalised in partnership with the care home sector and families to provide further clarity on how to operationalise the care partner concept. However, it was stressed that the issue of this supplementary information was not a reason to delay the implementation of the care partner concept.

249. On 16 December 2020, a joint letter to the care home sector was issued by the CNO, CSWO and CMO to advise that 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.

250. I was informed that compliance with the Care Partner scheme varied and a small number of care home providers required some intervention from the Department, Health and Social Care Trusts, Public Health Agency and Regulation and Quality Improvement Authority from time to time, to encourage ongoing compliance.

251. I approved a further update to this guidance - by way of the inclusion of an Appendix entitled: "Principles for visiting people (adults) with life limiting or progressive conditions, including visiting at the patient's time of death" which issued on 5 November 2020. While the guidance required permitted visitors to adhere to strict hand hygiene and infection control precautions on arriving and leaving, it also highlighted that infection prevention and control requirements should not be so rigid as to prevent family members/loved ones from saying goodbye in as humanely a way as possible, including the ability for them to hold hands and touch the dying person.

252. Guidance for Christmas visiting in care homes was issued by the Department on 9 December 2020. It reaffirmed that the regional visiting guidance should continue to apply during the Christmas period but, in recognition of the importance attached to seeing family and friends over the Christmas period, and the right to a family life for those living in care home settings, it stressed that homes should make particular efforts to facilitate visiting in line with this guidance over the Christmas period.

253. Given the introduction of additional restrictions announced by the Executive on 17 December 2020, and the identification of a new strain of the virus, I approved revised guidance for Christmas family visiting in care homes published on 23 December 2020. It introduced additional requirements to facilitate safe visiting to reduce the transmissibility of the virus.

254. Visiting guidance was reviewed following the recommendation by the four CMOs that the UK move into Alert level 5. The existing visiting guidance required that significantly more stringent restrictions be applied across all care settings in Northern Ireland. I approved the introduction of updated guidance entitled 'COVID-19 Regional Principles for Visiting' effective from 14 January 2021. It prohibited face to face visiting to general hospitals (including ICU). 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.

255. This remained in place until end February 2021 when, following the recommendation by the four CMOs that the UK should revert from level 5 to level 4, I endorsed an easing of the restrictions on visiting arrangements for all healthcare settings (including hospitals) from 26 February 2021.

256. In light of the completion of the care home vaccination programme and a downward trend in infection levels, the Public Health Agency was commissioned to reexamine the management of visiting in care homes with a view to developing an indicative journey back to business as usual for care home residents to include more normalised visiting and to enable residents to leave their care home for visits with friends and family. Following extensive engagement, revised guidance came into effect from 7 May 2021 as follows:

- A Pathway to Enhanced Visiting' applicable to hospices and hospitals, including maternity and other services; and
- 'Visiting With Care – A Pathway' [INQ000276334] applicable to care homes.

257. Both approaches to visiting 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.

258. Reviews relevant to hospice and hospital settings were undertaken by way of scheduled review meetings, attended by an established group comprising the Deputy CNO, policy officials from the Department's Chief Nursing Officer Group, the 5 Trust Executive Directors of Nursing and senior leaders from the Hospice sector.

259. Evidence relevant to the impact of visiting in care homes was collated and reviewed by the PHA. Progress meetings were co-chaired by a senior nurse from the PHA and a policy representative from the Department's CNO Group and a range of stakeholders.

260. Over the period from 21 May 2021 to 27 October 2022, following each review, I received a formal recommendation from the Chief Nursing Officer 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.

2. Care Homes

261. With effect from 20 October 2021, I approved a recommendation from the CNO that restrictions on visiting in care homes should move into the 'Gradual Easing' phase as set out in the 'Visiting With Care - A Pathway' document. This meant an increase in the frequency of visits permitted and in the number of people permitted to visit care homes at the same time.

262. On 17 February 2022, following the latest advice from the PHA, I announced a further easing of care home restrictions with a move from 'Gradual Easing' to 'Further Easing', and the expansion of the Care Partner Scheme to include hospitals and hospices. 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.

263. The final stage of the Pathway 'Preparing for the Future' was reached at the end of June 2022 and I endorsed a new guidance document "Visiting With Care – the New Normal" which was launched on 1 September 2022. It removed all Covid-19 related visiting restrictions in care homes not in outbreak, with clear instruction on effectively dealing with access during outbreaks.

3. Hospitals and Hospice Settings

264. To reflect local pressures that could apply in specific hospital settings (due to estate issues, local transmission spikes, etc.) I approved a protocol through which any of the HSC Trusts or Hospice providers could apply additional, risk-assessed proportionate but timebound restrictions, should local circumstances have required it. The protocol was shared with the HSC Trusts by the Department in July 2021, effective immediately [INQ000438159].

265. The final stage of the "Pathway to Enhanced Visiting" was reached in late June 2022. Following a review of visiting arrangements in hospital and hospice settings in Northern Ireland I approved updated guidance for these settings entitled 'Enabling Safer Visiting' which took effect from 31 October 2022. It broadly set out a return to the normal visiting arrangements that were in place prior to COVID-19, while allowing local ward managers to introduce temporary restrictions in some cases to protect the most vulnerable. It highlighted that any such restrictions would need to be risk-assessed, taking account not only of the risks of infection, but also the potentially detrimental impact of restrictions. It also reinforced the continued need to maintain

strict adherence to all necessary infection prevention and control measures, including enhanced cleaning, to help prevent the spread of infection.

N. Personal Protective Equipment

266. I decided to support the PPE needs of adult social care homes, domiciliary care providers, GPs, community pharmacists because I felt it was necessary to ensure that all sections of the health care family had access to PPE, particularly considering that their usual purchasing and supply lines had disappeared almost overnight. From the onset of the pandemic I recognised that nursing and residential Care Homes would be at the forefront of the battle against Covid-19 and therefore it was important to focus on both limiting infections and their impact in Care Homes as well as ensuring Care Homes could continue to function as an important part of the wider health and social care system. I was clear that ensuring that Care Homes had sufficient supplies of PPE was a priority.

267. The provision of personal protective equipment to the independent sector through nominated points of contact within Trusts where they were unable to source their own supplies [PM/6216 INQ000353600; PM/0121 INQ000120717] was also introduced in March 2020. A reporting mechanism was introduced from week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis [PM/6218 INQ000417493; PM/6219 INQ000417495]. Reporting and collation of this information concluded on 31 March 2023.

268. I do not believe that provision of PPE to these groups had an impact upon the ability of hospitals to secure a sufficient quantity of adequate PPE as, at no point, did the HSC Trusts report running out of PPE.

1. Adequate Supply of PPE

269. In order to ensure that there was a sufficient supply of adequate PPE for healthcare workers in Northern Ireland, I agreed to the establishment of a PPE Strategic Supply Cell with a remit of providing oversight and support for the Business Services Organisation who had responsibility for procuring PPE. This included monitoring of the stock position and supporting BSO in their exploration of potential avenues of supply; this involved engaging on a near daily basis with BSO and the Construction

and Procurement Delivery Division of the Department of Finance (responsible for leading on the procurement of PPE for the non-health sector) to ensure efforts were coordinated and that opportunities were explored to source PPE locally and internationally. The Supply Cell also oversaw the implementation of a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List (those items which were in high demand) and undertook a monitoring role with regards the distribution of PPE from Trusts to the Independent Sector. The Cell also supported the progression of actions across the HSC to strengthen the system's ability to respond effectively to meeting PPE needs within what was a new challenging operating environment.

270. The revised process for HSC Trusts to order PPE on the High Demand Management List commenced on 24 March 2020 and I was informed of it prior to it being communicated to the Trusts. The revision saw the introduction of measures for the handling of supplies from BSO PaLS to ensure that products were available for those HSC staff and patients who needed them in the response to Covid-19. The products involved were included in a Covid-19 High Demand Management List provided by BSO and meant that from the 24 March BSO PaLs would no longer process orders for products on the High Demand Management List at ward levels within Trusts. Instead, Trusts would work with BSO PaLS to establish a centralised system with nominated Trust contact points for managing the ordering and delivery of products, with the aim of ensuring a more even distribution of stock across all Health and Social Care sites. The process was introduced in recognition of the significant issues being experienced at that time globally in the procurement of personal protective equipment and was to ensure that available stock was evenly distributed across the region whilst also enabling Health and Social Care Trusts to continually review and prioritise the distribution of its available stock.

271. 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'[9] supply contracts across the United Kingdom. The Department's Emergency Planning Branch participated in calls on a United Kingdom four nations basis to discuss stock levels and planned procurement volumes and approvals. I also spoke to and wrote to the then Secretary of State for Health, Matt

[9] Just In Time Ordering and Procurement, also known as **JIT,** is a methodology of inventory control that aims to reduce waste by ordering supplies only when they are needed. This system operates on the idea that inventory is not an asset but rather a liability – it costs money to store and manage excess stock.

Hancock, requesting assistance with PPE stock [RS/0327 INQ000485687 and RS/0328 INQ000485688] when I was made aware of shortages in Northern Ireland. In [INQ000093318], I contacted the Secretary of State for an update on 13 April and to provide an updated position in respect of the shortages I had communicated on 30 March 2020. While I cannot now recall the detail from the text messages exchanged, I appear to be asking for an update and providing additional details of low stock based on new assumptions. I also asked whether he had issued a formal response to allow the Northern Ireland Executive to pursue PPE in China (see, further, below).

271.1 I was also pleased to be able to provide England with 25,000 gowns when they experienced a shortage in April 2020 and eye masks to Wales.

272. In addition to working at the UK level, I also agreed to explore opportunities for joint endeavours with the Republic of Ireland but these ultimately did not materialise. In mid-March/early April 2020 a joint order for personal protective equipment was taken forward by the Department of Finance and the Department of Health in Northern Ireland and the Department of Health in the Republic of Ireland, facilitated through the Republic of Ireland's Industrial Development Authority. However, given the changing market conditions at that time in China and the competing demands of other countries, this became increasingly difficult and consequently the Republic of Ireland's Industrial Development Authority confirmed that they had no further capacity to pursue the collaborative order.

273. The Department of Health, the Department of Finance and the Business Services Organisation also worked in collaboration with The Executive Office to successfully purchase significant stock direct from China through a company which was identified by the Northern Ireland Bureau and Invest NI in China and who had been approved by the Chinese government to export personal protective equipment. Successful procurement supported by a Due Diligence Report conducted by PWC resulted in an order which was worth approximately £61 million and consisted mainly of Type IIR surgical masks and examination gloves. Copies of the contractual documentation have been supplied as part of the M2C Annex C Document Disclosure [INQ000377346, INQ000377347, INQ000377348, INQ000377353, INQ000377354, INQ000377355, INQ000377356, INQ000377357, INQ000377358, INQ000377359, INQ000377360, INQ000377354].

2. Guidance

274. The Department of Health issued three HSS MD circulars from the Chief Medical Officer and Chief Nursing Officer on PPE in 2020. The first, dated 28 March 2020 [PM/6379 INQ000477522] provided updated guidance on the use of PPE in high risk procedures and in other settings. The second, dated 3 April [PM/6380 INQ000477523], issued a link to updated guidance agreed by four UK Chief Medical Officers, Chief Nursing Officers and Chief Dental Officers in the UK and endorsed by the Academy of Medical Royal Colleges and was applicable in all parts of the UK. It also provided a summary of that guidance. The final circular on 19 April 2020 [PM/6381 INQ000477524] referred to Public Health England's latest guidance on the re-use of PPE and highlighted that this had not been implemented in Northern Ireland.

275. As the circulars related to clinical issues I had no role in the content of the guidance, or to whom it applied, but would have been briefed on it.

3. Fit Testing

276. In terms of the general arrangements for PPE supply, quality and guidance for use, these are operational matters for HSC Trusts but I was kept abreast of any issues as they arose. However, given the extraordinary situation that the pandemic was presenting, the Chief Nursing Officer, a senior leader in the Department and the leader of the largest profession in the HSC, whilst not directly responsible, 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.

277. Concerns were also being raised around the number of staff failing the fit testing of masks due to the range of products being supplied [PM/0081 INQ000120710]. An audit review of fit testing for respiratory masks was carried out on a precautionary basis by Trusts across the health and social care system after it emerged that on some occasions an independent contractor had inadvertently applied a fit testing setting not normally used in Northern Ireland. I received briefing on the incident [RS/0329 INQ000485689]. No report was produced. I understand that the resulting Serious Adverse Incident report is still to be concluded by the PHA.

4. Risk Assessments

278. Risk assessments are the responsibility of the employer; therefore, in the context of PPE this would fall to the Trusts and health care providers. I played no role in this area.

5. PPE Mailbox

279. Following reports and concerns being raised by staff [RS/0330 INQ000485690] on how PPE was being managed and shared around those who needed it, I met with the CNO on 17 April 2020 to discuss how the Department could offer a solution, or at least a means by which any issues could be raised and addressed. Following that discussion, I announced that the Department had established a new dedicated mailbox to allow concerned members of staff across the Health & Social Care workforce to raise issues of concern over the supply, quality and usage of Personal Protective Equipment. Details of the mailbox and how it would operate was published on the Department's website [PM/6383 INQ000477526].

280. A team in the Nursing, Midwifery and Allied Health Professionals Directorate was charged with the management of this mailbox, and procedures established to address the issues raised. As of 31 December 2020 this mail box had received 95 queries, broadly segregated into four main themes:

i. Offers to supply personal protective equipment;
ii. Concerns regarding access to personal protective equipment supplies;
iii. Concerns regarding the correct use of personal protective equipment supplies;
iv. Concerns regarding the quality and decontamination of some items of personal protective equipment.

281. The Chief Nursing Officer's Group addressed each of the queries received, offering guidance and support or, where appropriate, referring correspondents on to another service:

- There were 27 offers to supply PPE. The offers were mainly of a commercial nature and ranged from local and national, to international manufacturers. All offers to supply PPE were forwarded to the Supply Cell at the Department for onward communication to the Business Services Organisation;
- There were 15 queries regarding access to supplies of PPE. These issues were raised by range of concerned individuals in Trusts, Nursing

and Care Homes, General Practice surgeries and some who did not declare their background. In all cases these queries were followed up by the team with the relevant Trust single point of contact, the Executive Directors of Nursing, and colleagues in the Department's supply cell. In all cases supplies were either found to be available or made available via the relevant Trust contact;

- The mailbox received a total of 27 queries seeking information on the correct type of PPE which should be worn. In each case advice was provided in line with current PPE Public Health England (PHE) guidance, and
- Quality issues and fitness for purpose were identified in 15 separate queries received in the mailbox. Advice was provided and information from the Chief Nursing Officer was sent to all Trust single points of contact. Issues with some masks were reviewed by the Infection Prevention and Control cell at the Public Health Agency who highlighted potential safety issues this to the Department, with the issue referred via the Northern Ireland Adverse Incident Centre (NIAIC) to the Medicines and Healthcare Regulatory Agency (MHRA) for further investigation. The masks involved were completely removed from service to remove risk to staff.

282. I received a review report [PM/6384 INQ000438126; PM/6385 INQ000416360; PM/6386 INQ000416354; PM/6387 INQ000411115; PM/6388 INQ000411114] on 5 February 2021, identifying those key themes and lessons learned from the content of the emails received.

283. In addition to the mailbox, Executive colleagues, my officials and I had regular contact with the Royal Colleges and Trade Unions where queries on PPE were raised and responded to [RS/0331 INQ000485691; RS/0332 INQ000485692].

6. Activation of Military Aid to Civil Authority

284. I made the decision to activate Military Aid to Civil Authority (MACA) in June 2020 because BSO's existing storage and distribution facilities had been operating at maximum capacity since the Covid-19 outbreak began and this had included continued use of NIFRS premises adjacent to the Boucher Crescent warehouse. In June 2020 plans were in place to significantly increase stock levels of PPE in preparation for a possible second Covid-19 surge and consequently BSO would,

between July 2020 and December 2020, take receipt of materials and supplies that would exceed normal business as usual assumptions.

285. At the end of April, the Department had approved a business case for funding for BSO to lease a warehouse unit for 9 months with a storage space of 23,735 square feet. On 27 May, BSO had indicated that even with this additional space, it would need an additional storage area of circa 100,000 square feet in order to securely hold stock due to arrive in the coming days and weeks.

286. The first deliveries of product procured directly from China was expected to begin to be delivered during June and this would have created an even greater pressure on available space. Therefore, BSO needed to access short-term storage until the end of September 2020 as a bridge between current storage space and securing business case approval for, and acquiring a lease, on larger premises to provide greater long-term stability in available storage.

287. In order to secure military assistance, BSO had to demonstrate that they had exhausted other alternatives and considered Trust storage facilities. However, Trust storage did not meet the inbound and outbound nature of BSO's logistical needs, in particular the scale and volume of deliveries and unloading turnaround times of Third Party transport companies. This storage also already contained significant volumes of PPE as part of Trust held stocks and many were already at capacity.

288. Early discussions with MoD indicated that this issue is something which the MoD believed it could assist with.

7. PPE and Inequality Issues

289. While the Department plays no role in the fit testing programme which is completed for HSC Trusts by a range of companies accredited under the Fit2Fit RPE Fit Test Providers Accreditation Scheme (a scheme designed to confirm the competency of any person performing face piece fit testing and operated in line with HSE INDG479 protocols), I was made aware of issues on the adequacy of fit testing. I regret, however, that I cannot recall being made aware of issues specifically in relation to age, race, disability or pregnancy and so I did not take any steps to address them.

290. Respiratory Protective Equipment cannot protect the wearer if it leaks. Fit testing compliance for female staff, for example, required a range of face mask type and

sizes to be available. HSC supplies were distributed with this in mind. A major cause of such leaks is poor fit since tight-fitting face pieces need to fit the wearer's face to be effective. As people come in all sorts of shapes and sizes it is unlikely that one particular type or size of Respiratory Protective Equipment face piece will fit everyone. Thus, it is a legal requirement that workers using such tight fitting respiratory protective equipment (face pieces/masks) must be fit tested by a competent person for all Aerosol Generating Procedures. This requirement is detailed in Control of Substances Hazardous to Health (COSHH) regulations and is intended to ensure that the equipment selected is suitable for the wearer.

291. I believe as well that in order to be properly fit tested it was not possible to have a beard.

8. PPE Review

292. On 15 April 2020 I commissioned [PM/0086 INQ000120712, PM/0269 INQ000120813, PM/0270 INQ000120814] a rapid review of personal protective equipment in order to assess the appropriate receipt, storage, distribution, and use of personal protective equipment across the health and social care system. The terms of reference [PM/0086 INQ000120712; PM/0270 INQ000120814] for the Rapid Review, which I agreed, included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the health and social care system. I received the final report on 14 May 2020 [PM/0087 INQ000130338, PM/0271 INQ000120815, PM/0272 INQ000120816, PM/0273 INQ000120817, PM/0274 INQ000120820, PM/0275 INQ000120821, PM/0276 INQ000120822] and agreed to the recommendation to set up an oversight board to oversee their implementation.

293. The Review made 19 recommendations for the short-term improvement of the personal protective equipment position, which was in preparation for a second wave of Covid-19. Seventeen associated actions were identified to implement the 19 recommendations. The actions were assessed as either Critical (to be completed within 2-4 weeks) or Essential (to be completed within 4-8 weeks). A lead official was identified as being responsible for their implementation [PM/0088 INQ000120714]. Progress on the actions was monitored by the Personal Protective Equipment Strategic Supply Cell and whilst some of the actions were completed in a relatively

timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions. Of the 17 actions 15 actions were considered closed by end of August 2020 prior to the commencement of the second wave, and all were considered closed by December 2020.

294. Twelve of the actions were deemed critical and, of these, none were completed within 2-4 weeks of my receiving the report on 14 May: three were closed by mid-July, five by the end of July, two by the start of August and one at the end of August. The remaining action was not closed until mid-December. Of the remaining 5 actions, considered essential, four were completed within 4-8 weeks of receipt of the report: three were closed by end of June, one mid-July and the other action was completed at the end of October.

295. I understand that the reasons for the delay in completing the actions related to needing to consult with stakeholders and waiting on sign off from appropriate areas. The two actions which took longer to close were in relation to the appropriateness of the reuse of personal protective equipment in a period of critical shortage in line with expert scientific advice (an essential action) and the development of systems to enable feedback from end users around the quality of personal protective equipment across all the health and social care system and independent sector which could be used to better inform procurement (a critical action). Both actions required the lead owner, the Public Health Agency, to engage with key stakeholders and develop supporting products which impacted on the overall timeline. The Department sought regular updates from the PHA lead on progress of the actions required to ensure implementation of the recommendation [INQ000130392].

296. I also approved a request [INQ000185387] in May 2020 from the Business Services Organisation to establish a Dynamic Purchasing System for personal protective equipment [INQ000377397]. This was in recognition of the significant increase in demand encountered in the first wave of Covid 19 and was considered an opportunity to mitigate supply chain issues such as the rapidly changing supply and demand position. A Dynamic Purchasing System is a procedure available for contracts for works, services and goods commonly available on the market and was set up under Regulation 34 of the Public Contract Regulations 2015. A Dynamic Purchasing System, unlike a traditional framework, allows an organisation (in this instance the Business Services Organisation) to work with suppliers with much more agility and speed as it was designed to allow the Health and Social Care system

access to a pool of checked and pre-qualified suppliers, thereby greatly reducing avoidable delay. The Department of Finance's Central Procurement Directorate concurred, given Business Service's Organisation's expertise regarding personal protective equipment products, that Business Services Organisation should establish and manage the Dynamic Purchasing System arrangements both for their own use and that of the wider Northern Ireland Public Sector.

297. Upon my approval a Departmental Direction issued [INQ000185391] which enabled the setting up and administration of a Dynamic Purchasing System for personal protective equipment which came into operation on 25 June 2020.

298. The Northern Ireland Audit Office also carried out a review on the "Supply and procurement of Personal Protective Equipment to local healthcare providers" which was published on 1 March 2022 [INQ000348882]. It highlighted the challenges faced by the health and social care sector in sourcing and securing adequate PPE in response to the Covid-19 pandemic. Among its lessons learned were:

- The need for improved contingency and emergency planning to avoid a repetition of any supply shortages;
- Less reliance on uncompetitive procurement processes;
- Better controls for managing potential conflicts of interest;
- More comprehensive documenting of decisions over high cost procurements; and,
- Greater clarity over longer-term procurement and funding arrangements for PPE provision to the independent care sector.

O. Testing

299. The Department of Health was early to put in place a protocol to guide the targeted and prioritised use of available Covid-19 testing resources. The first version of the Interim Protocol on Testing dated 19 March 2020 set out priority groups for testing and acknowledged a need for an approach which supported testing healthcare workers under certain conditions. Healthcare workers prioritised for Covid-19 testing included those who were providing frontline patient facing clinical care. [PM/100 INQ000120705 (DoH ref: PM0056)]. The Interim Protocol on Testing was kept under continuous review with priority groups for testing extended regularly – including greater testing of healthcare staff - in line with emerging scientific evidence and with expansions in testing capacity.

300. I presented the Executive with the Department's Covid-19 Testing Strategy [INQ000103650] on 6 April 2020. In it I highlight my decision to prioritise the testing of frontline workers alongside people in hospital with respiratory conditions. I considered it so imperative that health care staff were tested that, when we had a temporary surplus of tests over the Easter weekend, I agreed to procced with an offer of mutual aid in regard to testing to NHS colleagues [RS/0333 INQ000485693]. The email expresses my reluctance to do this because I wished to ensure that all efforts had been expended to use them in Northern Ireland and I asked officials to confirm this, which they did.

301. It was brought to my attention that there was not sufficient testing capacity, particularly at the start of the pandemic. To address this, in April 2020, I established an Expert Advisory Group (EAG) to lead on the expansion of testing for Covid-19 across all our laboratory services (within health and social care services/systems) and also to develop suitable approaches for the utilization of other testing facilities, including those within the research, academic and commercial sectors. Testing capacity increased significantly through the formation of new partnerships to deliver on this, both locally (through the Northern Ireland Covid-19 Testing Scientific Advisory Consortium established at the request of the Chief Medical Officer and which comprised both Universities in Northern Ireland, the Agri-Food Biosciences Institute and the ALMAC Group to boost local Northern Ireland based testing capacity - referred to as 'pillar 1'), and nationally (testing capacity increased significantly with the establishment of 'pillar 2' testing as part of the United Kingdom National Testing Programme).

302. I recall also issues in how long it was taking to receive results in some instances and also issues on the safety of some test kits produced where it was thought that they did not meet the required safety standards for coronavirus testing. The use of these test kits was therefore paused on a precautionary basis.

303. The availability of Covid-19 testing did have an effect on the availability of healthcare workers to work in face-to-face settings. In the earlier phases of the pandemic, when there was a limit on the information that was available about the Covid-19 virus to guide the public health response, a precautionary approach was taken to the management of self-isolation of cases, suspected cases and contacts who were healthcare staff. This was in keeping with established public health principles

underpinning the management and handling of cases and contacts but meant that there were staff with no symptoms of Covid-19 who, because they had been in close contact with someone who then tested positive, were unable to attend work because of the lack of testing capability. I cannot give specific examples of the precautionary approach in practice as that would require naming individuals who had to self-isolate because they were in contact with someone who tested positive. However, it is well-known that a key issue throughout the pandemic was the availability of health care staff and the impact absences had on service delivery [RS/0357 **INQ000490104** This approach was considered proportionate and commensurate given that healthcare staff were often working in inherently higher risk settings and caring for the most clinically vulnerable patients and service users.

303.1 As described above, the Department put in place a protocol to guide the targeted and prioritised use of available Covid-19 testing resources early in the pandemic and I endorsed this approach. I presented the Department's first Covid-19 Testing Strategy to the Executive on 6 April 2020; this was kept under regular review and I presented an updated Strategy to the Executive on 21 May 2020. A key change was the inclusion of testing for essential or key workers in sectors other than Health and Social Care. The May Strategy focused on rapid identification of cases and contacts, supported by testing and isolation. The approach was designed to:

- Break the chain of transmission of the virus by identifying people with Covid-19,
- Tracing people who may have become infected by being in close contact with them; and
- Supporting those people to self-isolate so that if they have the disease they are less likely to transmit it to others.

303.2 In addition to supporting the Department's Covid Testing Strategy, I provided funding packages to support various sectors throughout the pandemic. As part of the early response to the pandemic it was recognised that there could be a significant impact on the ability to deliver services to care home users normally. Indeed, a number of Care Homes saw a significant reduction in the number of residents and in their ability to fill beds, and care for residents (for instance, because of isolation requirements for residents and staff or because families were reluctant to place relatives in homes), during the pandemic. A number of measures were therefore put in place to try to ensure key organisations remained viable. Early in the response to the pandemic the Health and Social Care Board proposed an income guarantee was introduced for Care Homes, ensuring that where income fell 20% below the previous three-month

average then HSC Trusts should block purchase 80% of the vacant beds at the regional tariff. This was reflected at paragraph 4(f) of the 17 March 2020 guidance [PM/0121 INQ000120717]. The approach was later revised and amended to providing 96% of the pre Covid average payment in April 2021.

303.3 I announced further financial support packages of £11.7m on 2 June 2020 [RS0020, INQ000185429] and [(RS0046, INQ000185472 nd £27m in October 2020 [RS0021, INQ000185430] and [RS0047, INQ000371020]. This money funded a range of issues including enhanced sick pay to pay staff who received 80% of their salary when on sick leave for Covid-19 related reasons (ensuring sick staff did not feel financial pressure to attend work when they may be Covid-19 positive).

P. DNACPR Orders

304. I was aware, following articles in the media, that concerns had been raised over DNACPR orders being issued for patients with learning disabilities who had Covid-19. Cardiopulmonary resuscitation is a treatment that could be attempted on any individual in whom cardiac or respiratory function ceases. A Do Not Attempt Cardiopulmonary Resuscitation order is an explicit statement to prevent the inappropriate, potentially harmful or futile intervention of cardiopulmonary resuscitation on a person who is in the terminal phase of their illness or who is unlikely to survive such an intervention or if it is deemed that the risk of cardiopulmonary resuscitation would outweigh the benefit to an individual. A Do Not Attempt Cardiopulmonary Resuscitation order does not refer to any other clinical intervention.

305. 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 [PM/6324 INQ000331016].

306. In the early 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. The first meeting of the Covid-19 HSC Clinical Ethics Forum took place

on 15 April 2020. With the exception of the Covid-19 Guidance: Ethical Advice and Support Framework document [PM/6325 INQ000363462], the Forum did not issue any other directions, information, guidance or documents. The Covid-19 Guidance: Ethical Advice and Support Framework [PM/6325 INQ000363462] was published in June 2020 with further updates in September 2020. 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.

307. I received a number of written questions from my fellow MLAs asking about the application of DNACPRs. In my response I made it clear that orders based on age or disability were discriminatory and unethical [RS/0334 INQ000485694]. In terms of the policy in Northern Ireland, media reports were ill-founded.

308. A need for further work was identified that would develop a single integrated process for Advance Care Planning to support the Do Not Attempt Cardiopulmonary Resuscitation process. I agreed that this work should commence and approved it for publication in October 2022.

Q. Cancellation of Services and Reopening Services

1. Cancellation of Services

309. My involvement in the decision to cancel particular services within the HSC was limited because of the clinical nature of the decisions that had to be taken. At all times, however, I was kept fully informed of the decisions having to be taken, and why, and the options available and had the opportunity to ask questions and raise concerns. The redeployment of Health and Social Care elective care staff to increase critical care capacity for those admitted to hospital with Covid-19 resulted in the cancellation or postponement across all Trusts of non-urgent appointments, investigations and procedures across outpatients, day case, inpatient and diagnostic services.

310. It was decided on the basis of urgency what services would be cancelled or postponed. Efforts were made to minimise any disruption to treatment for cancer and other urgent procedures, but, unfortunately, there was some impact on their treatment. The 2019/20 Commissioning Plan Direction which set out the Ministerial targets was rolled forward for two years initially and then a further one year [RS/0358

INQ000490105], but there was an expectation that Trusts would continue to work to achieve the access targets. Cancer performance is measured across three domains:

- 100% of patients seen within 14 days of referral for Breast Cancer
- 98% - 31 days between decision to treat and first definitive treatment
- 95% - 62 days from date of decision to first definitive treatment

310.1 Therefore, the pre-pandemic performance standards for 14 day breast, 31 day and 62 day access continued remained in place throughout the relevant period. Red flag (suspect cancer) referrals were prioritised for triage and consultant appointments. Patients referred as a suspected cancer were assessed virtually/by telephone on the basis of clinical need, and the level of risk, (both patient and service).

311. Red flag (suspect cancer) referrals were also prioritised for diagnostics and consultant appointments. Diagnostics-imaging services continued across all Trusts, with priority being given to unscheduled care and cancer services as well as red flag and urgent examinations. Surgical and endoscopy diagnostics were significantly reduced as Trusts had to stand down all but urgent endoscopy provision due to infection risk, and surgery in general was significantly impacted. In the early stages of the pandemic patients were categorised for surgery according to clinical need. Later in the pandemic surgical patients were categorised based on Federation of Surgical Specialty Associations guidance on prioritisation. Surgical access was impacted on more severely at different surge stages of the pandemic.

312. However, some biopsy and endoscopic diagnostics services had been switched off for a period in adherence to national guidance due to infection control measures and this would have impacted on certain diagnostic procedures for suspect cancer referrals. This resulted in delays in diagnosis in certain pathways, hence introduction of FIT test to prioritise patients with suspect bowel cancer for endoscopy. Once a diagnosis of cancer was confirmed, treatment decisions were based on clinical need and the assessed risk/benefit of proceeding at that time. The risk of cancer not being treated optimally had to be balanced with the risk of the patient being immunosuppressed and becoming seriously ill from Covid-19 [PM/6346 INQ000226460].

313. These discussions were held between patients and their clinicians. Patients would have been offered treatment alternatives where possible (such as hormone treatment, Systemic Anti-Cancer Treatment or radiotherapy) where the normal

course of treatment could not take place due to infection control measures and reduced surgical access. Systemic Anti-Cancer Treatment (SACT) and radiotherapy (RT) procedures proceeded at a higher level than pre-pandemic as patients would have been offered Systemic Anti-Cancer Treatment and radiotherapy as alternatives to surgery.

314. As I have stated, the decision to cancel particular services was a clinical decision so I cannot be certain of the clinical detail of how it was decided what services were considered urgent or not, nor how the distinction was reached. I believe a service was classed as urgent if it was life-threatening or if a person's life would have been shortened without the procedure. This is not to say that those who had appointments and operations cancelled did not suffer as a result.

315. At the time the decision was made I knew that people would be adversely impacted by the cancellation of non-urgent appointments, investigations and procedures. Patients would have already been on waiting lists for an extended period of time, some would have received dates for operations, hip replacements for example, that were then cancelled at short notice, extending the time that they were living with pain and disability. I realised that not only the patients themselves be affected but also their families as they watched loved ones suffer longer. In some instances this would have been against the backdrop of fear that the person's condition may have been more serious than initially thought.

316. As detailed in Section J, above, the decision was taken in March 2020, following a meeting between the then HSCB and the representatives of the independent hospitals, to use independent sector hospital theatres and beds. However, the use of the independent sector was initially used to primarily ensure the delivery of urgent care alongside the HSC Trust hospitals. To help increase elective care capacity and mitigate the most severe impacts of this, in my opening Statement [PM/0301 INQ000130411] to the Assembly's Ad Hoc Committee meeting on 15 April 2020, I informed members that Health and Social Care Trusts were accessing Independent Sector hospitals to treat urgent, non-Covid 19 patients across a number of elective specialties [PM/6411 INQ000376914; PM/6412 INQ000396900; PM/6413 INQ000485222; PM/6414 INQ000396963]. It was expected that 120 to 135 procedures would be carried out per week across a range of red flag and urgent cases. This was a reduced number of procedures (mainly due to Infection control measures and access to surgery) but the best possible in the circumstances.

2. Reopening of Services

i. Lagan Valley Hospital

317. The 'Policy Statement for Elective Care Day Procedures' [INQ000276347] was published on 28 July 2020. It resulted from the work of the Rebuilding Management Board, chaired by the then Permanent Secretary Richard Pengelly, with the aim of reducing the numbers of patients waiting for elective care. I gave approval [RS/0336 INQ000485696 and RS/0337 INQ000485697] to the Day Procedure Centre at Lagan Valley Hospital to be used to support the region by treating high priority patients across a range of elective care specialities. The overall aim of the Day Procedure Centre model was to deliver high volume, low complexity routine procedures.

318. Day case Elective Care Centres are designed to provide a dedicated resource for less complex planned day surgery and procedures. Crucially, they operate separately from urgent and emergency hospital care – meaning they will not be competing for operating rooms, staff and other resources, leading to fewer cancellations of operations. They can be stand-alone centres or self-contained centres on a larger hospital site.

319. DECCs are a means to increase productivity, efficiency and reliability of the service. They are expected to have a significant impact on the number of patients treated. While concentrating services on a smaller number of locations means that some patients may have to travel a bit further for their day surgery, this will be offset by a significant reduction in the time spent waiting for that surgery. Prototype day case elective care centres had already been established in December 2018 for the treatment of cataracts and varicose veins in order to help address waiting times and to allow more patients to be treated and evaluation of the prototypes indicated that the concept of the DECCs was sound and they delivered real benefits for patients.

320. The proposed 'hub' site was Lagan Valley Hospital (LVH) in the South Eastern Trust. LVH had demonstrated its ability to successfully deliver a range of day case and endoscopy procedures. As one of the locations on which the varicose veins prototype was delivered, it proved popular with staff and with patients in terms of accessibility and patient experience.

321. Drive time statistics showed that almost 73% of the population are within a 60 minute drive time of LVH. Service Users were experiencing long delays in accessing day case elective care procedures so while some service users may have had to travel further, the trade-off was that they would be seen more quickly. The very nature of the policy decision to develop DECCs would inevitably have an impact on travel times for some people and such impacts would exist irrespective of where the Centre/s are sited in Northern Ireland. Selecting LVH as a regional hub provided the opportunity to ramp up day case activity in a clinically suitable location that was protected from the impact of unscheduled care pressures.

322. The services that would be prioritised were decided on the basis of work undertaken by several task and finish (T&F) groups across seven specialities. Each of these T&F groups had been led by doctors, nurses, Allied Health Professionals, service managers and other health professionals from across the Health and Social Care sector. The seven groups were also supported by a reference group of anaesthetists. Their work identified which procedures were most clinically suitable to move to a regional day procedure centre as part of a first phase approach, based on complexity, patient safety and ability to carry out the procedure in one day.

ii. Creation of Clinically Led Network

323. Alongside the approval of the Regional Day Procedure Centre at Lagan Valley Hospital, I also approved the creation of a clinically led Network to manage the planning and delivery of day procedure centres on a regional basis [RS/0337 INQ000485697]. Lagan Valley Hospital sits within the South Eastern Health and Social Care Trust (SHSCT) and I agreed that the SHSCT should take forward the establishment and management of the DECC model in the first instance. As part of this proposal a DECC Regional Network would also be established to ensure that the SHSCT involved all Trusts in the planning and delivery of the model. This regional network, hosted by the SHSCT, reported into the Management Board for Rebuilding HSC Services.

324. Initially, the regional DECC Network had the following tasks:

a. Clinical prioritisation of day case procedures to be delivered in Lagan Valley Hospital;
b. Set activity targets;
c. Develop regional booking systems;
d. Identify investment requirements and prepare a proportionate business case;
e. Agree the workforce model;

f. Assess PPE and testing capacity requirements.

325. As the work progressed the Regional DECC Network would then also consider the scope to expand the DECC model to other sites as identified and agreed.

iii. New Regional Approach to Orthopaedic Surgery

326. During the Covid-19 crisis, most elective orthopaedic procedures were deemed to be non-essential procedures and were therefore halted to ensure both the availability of resources and patient safety for those affected by Covid-19. While these measures will have had an immediate positive effect on the Covid-19 patients, they meant that other patients in the healthcare system became de-prioritised.

327. The Rebuilding Management Board approved a series of proposals for a phased regional rebuilding of elective orthopaedic services in Northern Ireland in June 2020, which were subsequently submitted to me for approval. This included proposals for the establishment of a separate regional network to oversee the commissioning of orthopaedic services; the development of regional waiting lists; and standardised practice so that patients could have timely access to the same quality of care, regardless of geographical location.

328. I agreed that a phased approach to rebuilding elective orthopaedics would be taken forward [RS/0338 INQ000485698]. As stated in the Blueprint document "Rebuilding, Transition and Transformation of Elective Orthopaedic Care (EOC) delivered by Health and Social Care in Northern Ireland, published on the 28 July 2020, the rationale for the work was:

- Provide a single system of Elective Orthopaedic Care (EOC) delivery for Northern Ireland;
- Create equity of access for all patients in Northern Ireland (Abolish 'Post Code Lottery');
- Develop standardised care pathways;
- Develop use of standardised implants;
- Encourage evidence based practice;
- Apply continuous improvement methods; and
- Explore cross specialty possibilities with Neuro and Plastic Surgeons.

329. At the time of my decision, in July 2020, we had moved into the 'recovery phase' of the pandemic, as evidenced by the establishment of the Rebuilding Management Board, and so work had started to focus on rebuilding the system.

iv. New Regional Approach to the Prioritisation of Surgery

330. The Regional Prioritisation Oversight Group (RPOG) was established in January 2021 to ensure that the relative clinical prioritisation of time critical/urgent cases across surgical specialties and Trust boundaries was consistent and transparent and to ensure the utilisation of all available capacity was fully maximised [PM/6309 INQ000373997 and PM/6310 INQ000381768]. It provided oversight on theatre allocation for priority cases requiring transfer to other Health and Social Care Trust or Independent Sector facilities.

331. An initial planning meeting was held with Health and Social Care Trusts' representation on 11 January 2021. FSSA guidelines sets out categories to help clinical and managerial teams to plan and prioritise the allocation of surgical resources: Priority categories 1- 4 with Priority 1 indicating emergency interventions. Priority 2 reflects time critical interventions and it was this cohort that was the immediate focus for RPOG. Given the scale of patients waiting for surgery categorised as Priority 2 (as per Federation of Surgical Specialty Association (FSSA) guidelines) in Northern Ireland, a sub categorisation framework [PM/6311 INQ000426952] was agreed for regional implementation as follows:

- 2a - Cancer with a limited treatment window (e.g. rectal cancer post neoadjuvant RT with 2 week treatment window);
- 2b - Proven cancer (biopsy proven or cancer in which the diagnosis is clinical / radiological and the surgery provides both treatment and pathological confirmation e.g. testes and ovarian cancer), and
- 2c - Suspected cancer (diagnostic procedure e.g. EUA + biopsy and 2d – Benign time critical).

3. Pausing of Routine Screening Services

i. Rationale for Pausing

332. In March 2020, the Public Health Agency, in consultation with the then HSCB, produced proposals in relation to the population screening programmes in Northern Ireland, in response to the current Covid-19 outbreak [PM/159 INQ000120730 (DoH ref: PM0142)]. The PHA proposed pausing most screening programmes for a defined period (3 month initially) to release staff to undertake other duties related to the Covid-19 surge, but to complete screening investigations and ongoing surveillance monitoring for those currently under investigation for a potentially adverse screening result.

333. PHA advised that these proposals had been made in the context of the following environment:

- Urgent need to release capacity in primary and secondary care to respond to the expected surge in demand;
- Anticipated significant levels of sickness absence among staff undertaking screening and all other professional and support services involved in the screening pathway;
- Uptake of screening services during the peak of the COVID-19 outbreak was likely to markedly reduce, services were already reporting an increase in patient cancellations;
- Attendance at screening appointments could potentially place screening participants at risk of exposure to coronavirus with particular concern in programmes aimed at those aged 60+ or with conditions such as diabetes who were a vulnerable population for infection and where social distancing was being recommended; and
- Without an agreed regional approach, local decision making on delivery of screening would be ad hoc and inequitable. Some Trusts were already stopping certain screening services due to operational constraints such as closure of council premises where screening facilities were located.

334. As an initial response to addressing these issues PHA proposed deferring all routine operational and quality assurance meetings, cancelling planned conferences and training, and deferring planning on new service and quality developments - including primary HPV in cervical screening and new service model for the Diabetic Eye Screening Programme. The PHA advised that whilst these actions will reduce some workload among Trust staff this would not be sufficient to address the above issues. Broader proposals on the temporary cessation of population screening programmes were therefore put forward for consideration and decision.

ii. Reasoning for Choice of Screening to be Paused

335. The PHA offered three options [PM0142; INQ000120730]:

> Option 1: Do nothing: continue all programmes and developments as per current services.
>
> This would have meant that a wide range of HSC staff would have continued to be engaged in screening and the necessary associated follow-up activity; consequently, they would not have been available for release to provide additional skilled resource for the Covid-19 surge response. A further

concern was that within particular screening programmes, screening is offered to those in older age groups and to those with underlying health conditions such as diabetes and cardiovascular disease, placing them in vulnerable groups for Covid-19 for whom attendance at clinics or hospital sites was not recommended at that time.

Option 2: Maintain only time-critical programmes,

This entailed maintaining newborn bloodspot and antenatal infection screening and pausing all other non-time critical screening programmes (including cancer programmes) for a defined period. Under this approach those who had already commenced a screening pathway and/or were under investigation for a potentially adverse screening result would be facilitated to complete that pathway.

Option 3: Maintain only time-critical programmes along with elements of other programmes

This option was the PHA's preferred and recommended approach and entailed maintaining the antenatal infection and newborn screening programmes along with higher risk breast screening and surveillance pathways in diabetic eye screening and AAA screening. It maximised the release of staff capacity within Trusts to support the Covid-19 response, and also maintained time critical and high risk screening pathways to minimise adverse patient outcomes.

Within this option it was also proposed that a small number of high priority areas of work continue to be progressed by the PHA as far as possible during the Covid-19 period. This included the development work on IT systems for the introduction of FIT in bowel screening and required minimal input from front line staff.

336. I ultimately approved the implementation of Option 3.

iii. Expected Impact of Pausing Screening

337. The expected impact of Option 3 was presented as follows, as contained in [PM/159 INQ000120730 (DoH ref: PM0142)]:

Programme	Recommendation	Programme specific risks/issues
Cervical screening	DEFER screening invitations for 3 months - Samples received by the labs should continue to be processed and reported. - Women identified as requiring colposcopy following an abnormal screening result should continue to be seen and managed as appropriate.	Delayed diagnosis of cancer. However, as CSP largely picks up pre-cancerous changes the impact is expected to be minimal. Restarting issues: - It is estimated that pausing activity for 3 months will take at least 6 months to be recovered. - Laboratory, Colposcopy and Primary Care services may experience increased activity during recovery.
Breast screening (routine)	DEFER routine screening invitations - Women who have been screened and recalled to assessment should still receive assessment appointments, as they are the equivalent of 'red flag' referrals and require urgent investigation.	**Trusts are making the decision to stop screening on an individual Trust basis. One Trust cannot screen at one site, because the council facility at which they are based has closed.** Not detecting or delay in detecting breast cancers in eligible women. Women will not be invited/ screened at the appropriate interval. A catch up exercise may take months to a year, with resulting persisting impact on screening coverage. Services will need to develop a recovery plan and adjust their screening round plan.
Higher risk breast screening	CONTINUE to screen with all women being screened within the NHSCT Higher Risk unit.	Women within this programme are identified as having 8 times the normal risk of breast cancer. These women are usually screened at an earlier age, and annually. This is small group numerically, only around 8000 women annually. The cancer detection rate for this population group is higher than that in the general population eligible for breast screening.

Programme	Recommendation	Programme specific risks/issues
Bowel cancer screening	DEFER invitations for 3 months - All test kits returned to the lab should continue to be tested and reported. - All participants with a positive screening result should continue to be followed up (ie pre-assessment, colonoscopy, CTC)	Delay in diagnosis of cancer. On restart, need to ensure the deferral does not exclude an individual from an invite if they are now outside the screening age range.
Abdominal Aortic Aneurysm screening	DEFER new invites and self-referrals - Participants on any referral pathway should complete that pathway CONTINUE surveillance programme for patients with known (large) AAA	Delayed diagnosis of abdominal aortic aneurysms Surveillance patients with a known AAA are at risk of rupture if ongoing monitoring is not maintained and acted on.
Diabetic eye screening	DEFER routine screening CONTINUE to screen newly diagnosed and surveillance patients -all reporting of images should be completed - all patients on a referral pathway should complete this.	This is happening already by default as GP practices will not facilitate screening sessions on their premises and patient cancellations are increasing. Those who are newly diagnosed or under increased surveillance are at higher risk of eye disease and should be prioritised.
Newborn bloodspot screening	CONTINUE	Critical time sensitive screening programme and must continue. Failure to deliver this programme could result in delayed diagnosis of rare but serious conditions that could result in loss of life or serious morbidity if not treated promptly. Under the PHA Corporate Business Continuity Plan the newborn blood spot screening programme is a priority 2 service (i.e. maximum acceptable outage 2-7 days).
Newborn hearing screening	CONTINUE	Maintain as a diagnostic delay is associated with poor development of communication

Programme	Recommendation	Programme specific risks/issues
		skills for children with sensorineural hearing loss. There is a known reduction in uptake when babies are not screened in hospital
Antenatal infections screening	CONTINUE	Critical time sensitive screening programme and must continue. Failure to deliver this programme could result in undiagnosed cases of Hep B, HIV etc in newborn babies.

338. In June 2020, the Public Health Agency established a 'Screening Restoration Group' to coordinate the process of restoring screening programmes and individual programme-specific plans were developed. The group sought a consistent and as far as possible an evidence-based approach, to ensure programmes were reintroduced in a planned and safe way. To this end, the restoration process was guided by the following principles, derived from Public Health England guidance:

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

- **Principle 2:** The benefits of screening should be greater than the clinical risks associated with Covid-19. This benefit/risk assessment varies between programmes and between groups of people eligible for screening.

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

339. Applying these three principles, cervical screening was restarted at the end of June 2020, early July 2020 for abdominal aortic aneurysm, mid-July 2020 for breast screening and August 2020 for diabetic eye screening and bowel screening [INQ000348873 (DoH ref: PM2037)]. The timing of restoration was individualised for each programme in terms of, for example, redeployment of staff, capacity, vulnerable

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

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

341. The Department should be able to advise as to whether there are any further updates to this information.

4. Maintaining Certain Screening, Procedures and Treatment

342. I have detailed above at Section Q(1) how red flag and cancer procedures, diagnostic screening, care and treatment for cancer were maintained throughout the pandemic.

343. In an urgent written statement on 25 September 2020 [RS/0339 INQ000485699] I informed the Assembly that the Executive had endorsed my Department's draft Policy Statement for Cancer, Oncology and Haematology services. The Statement set out short and medium term plans to rebuild and stabilise these services to address the serious detrimental impact of the Covid-19 pandemic on the HSC's delivery of these services across NI. The impact of Covid-19 had added a worrying new dimension to the HSC's underperformance in meeting waiting time targets for these services. In spite of endeavours to maintain red flag referrals and services, there was a significant fall in red flag referrals during the pandemic surge and it was anticipated that the service was likely to see a surge in referrals over the coming months, with the potential for an increase in late-stage presentations of patients experiencing symptoms. The immediate need was to rebuild services following the Covid-19 first wave and maintain service delivery for red-flag and urgent referrals for the year ahead. The Rebuilding Plan for Cancer Services therefore contained 17 actions to maximise available capacity across cancer services. The Oncology Stabilisation Plan included 5 key elements, including funding to support development of new consultant posts in Northern Ireland Cancer Care to address single handed / vulnerable practice and pressures. The Health and Social Care Board also developed a Stabilisation Plan for Haematology Services given its close association with Oncology services to address the capacity pressures also faced by this service. All HSC Trusts brought forward individual plans which provided enhanced capacity to meet the increase in demand for services whilst simultaneously providing a more resilient service through the development of more sustainable teams.

344. In an urgent oral statement to the Assembly on 6 October 2020 [PM/6312 INQ000276509] I announced my intention to publish, on 7 October 2020, a policy statement setting out important plans for rebuilding and stabilising cancer services as well as Oncology and Haematology [PM/6313 INQ000426954]. These plans aimed to take immediate action to increase capacity and ensure that the services were sustained over the weeks and months during the second wave of Covid-19. The estimated investment profile for the Cancer Services Rebuilding Plan was £2.5m revenue recurrent and £151K capital. The overall estimated cost of the Oncology and Haematology Stabilisation Plans was £13.43m revenue with an estimated spend over two years. This investment was initially supported through Covid funding. The Executive agreed that this investment would be rolled-out across 2 years through to March 2022 and be recurrently funded from 2022/23 and that it would help to build a

base for the long-term Cancer Strategy. By 2023/24 the Trusts will have been funded up to approximately 80% of the original costed stabilisation plan.

5. Rebuilding Cancer Services

345. The Cancer Reset Cell [PM/6294 INQ000426919] was established in mid-May with the aim of overseeing the resumption of screening, diagnosis and treatment of cancer patients in clinically safe environments as quickly as possible, and to protect these services as much as possible in the event of further potential surges of Covid-19 [PM/6295 INQ000426920; PM/6296 INQ000426930; PM/6297 INQ000426935; PM/6298 INQ000426936; PM/6299 INQ000426937 and PM/6300 INQ000426938]. Members are listed in the Terms of Reference [PM/6294 INQ000426919] and were primarily clinical, representing each of the Trusts and PHA, as well as non-clinical members from the Department and HSCB. The Cancer Reset Cell met weekly or fortnightly from June 2020 until August 2021 and monthly from September 2021 until August 2022.

346. The Cancer Reset Cell met weekly to monthly through the pandemic period and received reports from each Trust on delivery and impact of the pandemic on cancer services. Reports were also received from clinical leads of treatment modalities (Systemic Anti-Cancer Therapy, radiotherapy, surgery). The Reset Cell reported regularly to Gold Command. The Cancer Reset Cell also liaised with the Testing Cell and Infection Prevention and Control Cell throughout the period to raise issues for cancer staff and patients, such as staff and patient testing and infection prevention control issues. The Cancer Reset Cell agreed that services would be restarted on a regional basis, taking into account national guidance and Personal Protective Equipment, social distancing and decontamination constraints, equalisation of red flag/ urgent imaging waiting lists across the region, and to ensure appropriate safety netting processes were in place to ensure patient pathways restarted where they had been paused because of Covid-19.

347. To support cancer services, I used both transformation and Covid-19 funding to set up two grant schemes. The first used transformation funding of £600,000, which covered the period from December 2020 to 31st March 2021 and enabled charities to deliver a range of key services to support people living with cancer during the pandemic. I provided a Ministerial direction for the development of the second grants scheme on 29 March 2021 [INQ000276365 (DoH ref: PM2081), INQ000276366 (DoH ref: PM2082)] to Departmental officials to proceed with the establishment of a

fund to meet high level outcomes which would support cancer charities to undertake their valuable role in supporting HSC services, to the value of up to £10 million, plus the management fee. The grant scheme developed was the 'Cancer Charities Support Fund' and this was administered and managed by the Community Foundation NI [INQ000276368 (DoH ref: PM2083)].

348. I allocated this additional resource as I was aware it was needed to support those diagnosed with cancer, those going through treatment, those awaiting treatment, and those having completed treatment.

6. Recovery Plans

i. Cancer Care

349. In an oral statement on 13 April 2021 I [PM/6314 INQ000276438] informed the Assembly that the Department was finalising a Cancer Recovery Plan, 'Building Back - Rebuilding Better'. The reason for the plan was to redress the disruption to cancer services caused by the pandemic and it would also be fully aligned with the short-term recommendations in the proposed Cancer Strategy. The plan aimed to implement a range of actions to support and recover these services on a regional basis over a 3-year timeframe 2021- 2024. The recovery plan also addressed measures to support people while they wait, including the innovative new concept of prehabilitation. Prehabilitation enables people with cancer to prepare for treatment by promoting healthy behaviours and prescribing exercise, nutrition and psychological interventions where appropriate to a person's needs.

350. I published the Cancer Recovery Plan on 24 June 2021 'Building Back; Rebuilding Better' which was fully aligned with the short-term recommendations of the Cancer Strategy [PM/6315 INQ000426963]. The recommendations covered 11 key areas throughout the cancer journey to include screening, care and treatment of cancer patients and was based on two principles. Firstly, care would be delivered on the basis of clinical priority rather than order of waiting. For cancer surgery, clinical prioritisation would take place on the basis of Federation of Surgical Speciality Associations guidance. The Regional Prioritisation Oversight Group had been established in January 2021 to ensure that the available surgical resource is optimised. Additional surgical capacity would also be provided through the independent sector and via other UK and RoI providers to help address the patient backlog. This meant that some patients would have to travel for treatment. The

second principle was equality of waiting across Northern Ireland, ensuring each cancer patient has the same opportunity to receive the same high-level of diagnostic, treatment and care available, no matter where they may live.

351. The rationales behind each recommendation were to:

- Ensure all patients living with cancer felt supported across their pathway and had access to a Clinical Nurse Specialist, appropriate psychological support, information and signposting to other services;
- Increase screening capacity to address backlogs that had been created as a consequence of the impact of Covid-19 on screening and diagnostic and treatment services and to plan for the introduction of primary HPV testing into the NI Cervical Screening Programme in 2022/23;
- To address the pandemic impact on cancer referrals through the delivery of a formal public awareness campaign encouraging people to consult their GP with signs and symptoms of cancer;
- To invest in cancer services and enable new, more sustainable, models of care that will be resilient to potential future surges of Covid-19 and to the projected increase in cases of cancer. This included developing sustainable, high-quality services in the fields of imaging, pathology, colposcopy and endoscopy;
- To adopt a regional approach for Northern Ireland, where appropriate, to ensure patients received equitable access to diagnostics, care, treatment and support; and
- To create smoother and more efficient patient pathways from initial referral, through diagnosis and treatment that encompass the appropriate care and support during and after treatment with the aim of improving cancer waiting time and patient outcomes and patient experience.

ii. Elective Care

352. The Regional Prioritisation and Oversight Group [INQ000276351 (DoH ref: PM2067)], established in January 2021, continued throughout 2021 to ensure that the relative clinical prioritisation of time critical/ urgent cases across surgical specialities and HSC Trust boundaries was consistent, transparent and provided oversight on theatre allocation for priority cases requiring transfer to other HSC Trust or Independent Sector facilities.

353. On 15 June 2021, I launched a new Elective Care Framework for NI, the reason for it was to set out a detailed roadmap for tackling hospital waiting lists. At the time of

publication of the Framework, it was estimated that an additional £707.5m was required over the 5-year period [INQ000348868 (DoH ref: PM3114)]. It set out a twin track approach of targeted investment and reform and investment. The rationale behind targeted investment was to get many more people treated as quickly as possible, while the rationale behind reform and investment was to eradicate the gap between demand and capacity and ensure backlogs did not keep re-occurring. The Framework included implementation of "green pathways" to keep elective care services entirely separate from any exposure to Covid19. While there had been significant non-recurrent investment in 2021/22 and 2022/23, the improved outcomes described in the Framework will only be achieved with significant sustained recurrent investment to address the central issue of demand outstripping the current capacity, including expansion and strengthening of the workforce to build the sustainable capacity needed, alongside investment in infrastructure and equipment and reconfiguration of services across the HSC sector. The recurrent investment required to achieve the targets has not been made available.

354. The publication of the Elective Care Framework was followed by a statement from the Executive on 26 July 2021 stating that tackling the hospital waiting list crisis was a collective priority for the Executive [INQ000289197 (DoH ref: PM3115)]. The statement commented that: "the Covid pandemic has compounded pressure on the hospital system and sadly, this has resulted in even more people waiting longer for the care and treatment they need. This is not an acceptable situation to the Executive and all Ministers today reinforced their commitment to supporting the Health Minister and the wider Health and Social Care System in implementing a programme of investment and reform. It has been necessary that, as an Executive, our focus has been on managing the response to pandemic for the last 18 months, but now is the time to refocus on this crucial issue and take the action needed to reduce waiting times and ensure people get the treatment they need as quickly as possible".

iii. Urgent and Emergency Care

355. I published the Covid-19 Urgent and Emergency Care Action Plan (No More Silos) in October 2020. The reason for the plan was to allow progress to be made on the introduction of Urgent Care Services, Rapid Access Clinics and local Phone First services across all Trusts. No More Silos was a reference to the increased collaboration between primary and secondary care in managing urgent care demand, for example the introduction of Emergency Care Centres resourced by both GPs and Emergency Care doctors. This was required to address the rising numbers of

Covid-19 positive in-patients and significant numbers of HSC staff self-isolating. All HSC Trusts were experiencing pressures in Emergency Departments. Primary Care clinicians were also reporting rising numbers of patients presenting to general practice with urgent care needs. Prior to the pandemic, there was clear evidence that urgent and emergency care services were already under increasing pressure. However, the impact of Covid-19, and the accompanying focus on infection prevention and social distancing, had driven home the urgency needed to make these changes.

356. The plan focused on ten key actions that would be rapidly implemented in order to ensure that urgent and emergency care services across primary and secondary care could be maintained and improved in an environment that is safe for patients and for staff. The ten key actions set out in the Plan focused on structured collaboration between primary and secondary care; working towards a 'phone first' model to improve access to clinical advice and reduce unnecessary attendance at Emergency Departments; scheduling urgent care through appointments to reduce waiting room overcrowding and waits for treatment; avoiding unnecessary admission to hospital; and timely discharge from hospital. The underlying rationale of the Plan was to make sure patients could access the care they need, in the right setting, as quickly as possible, thereby helping to reduce backlogs of patients.

357. "The No More Silos Network' was established on 1 August 2020 [INQ000276388 (DoH ref: PM2103)] and the Network's inaugural meeting took place on 7 August 2020. The Network was co-chaired by a primary care clinician and an ED consultant, and brought together senior managers, clinicians and service users to manage implementation of the Plan.

358. On 16 November 2020 I announced that a new 'Phone First' service was being trialled across a number of hospital Emergency Departments [INQ000381365]. The 'Phone First' service would ensure patients could get direct access to the right care, avoid busy Emergency Departments, and further improve patient safety in terms of preventing overcrowding and reducing long waits in Emergency Departments, and so, help to reduce the risk of Covid-19 infection and transmission.

7. Maintenance of Treatment Pathways in the rest of the UK or the Republic of Ireland

359. The existing designated fixed wing air ambulance provider for Northern Ireland is Woodgate Aviation and, although Woodgate remained available during the period, there was a reduction in the number of transfers undertaken due to the reduced availability of services elsewhere in the UK because of Covid-19.

360. During the period 1 March 2020 to 28 June 2022, the following transfers took place to and from Northern Ireland:

- 735 air transfers for non-Covid-19 patients to and from Northern Ireland as part of the contractual arrangement with Woodgate Aviation. The range of conditions included patients travelling for transplant procedures (for example lung, heart, liver, bone marrow) and patients travelling for paediatric cardiac interventions as part of contracted arrangements with providers in England;
- 423 patients were transferred to and from Dublin as part of an All-Island Congenital Cardiac network arrangement for cardiac surgery or cardiac catheterisation, and
- A total of 5361 commercial flight and ferry transfers for non-Covid-19 patients to and from Northern Ireland were booked via the Health and Social Care Northern Ireland Travel Agent Provider.

R. Public Messaging

361. The Executive Information Service coordinated the Executive messaging, and the Executive received an update as to the feedback and engagement that certain messages and medium had received on a number of occasions. The Department of Health's press office also kept a similar update in respect of how Department of Health specific messages of PR's were received and disseminated [RS/147 INQ000400113; RS/149 INQ000400118].

362. As the pandemic progressed there was concern that people were avoiding seeking healthcare when it was actually appropriate to seek it. I issued statements [RS/0340 INQ000485700] which made it clear that the health service was still providing treatment and care and recommended that people should not delay seeking care and advice. General Practitioners wanted to ensure that anyone with a health concern was reassured that they would be able to get an appointment and see a General Practitioner, if necessary, and that if a person had symptoms, an unexplained illness or any reason to be concerned, they should in the first instance contact their General

Practitioner. In September 2020, General Practice leaders in the then Health and Social Care Board, the Royal College of General Practitioners (RCGP) and the British Medical Association's (BMA) Northern Ireland General Practitioners Committee issued a joint statement reassuring patients that General Practice surgeries remained open but that patients may be being seen in a different way, including via phone or video, but that those who needed to be seen in person would be. They also wrote to Northern Ireland's Members of Parliament, Members of the Legislative Assembly and District Councillors with a similar message – the letter to Members of the Legislative Assembly is provided [PM/6091 INQ000374200].

363. This was a message that the Department sought to reinforce. On 1 December 2020, the Department published a 'General Practice Mythbuster' [PM6092 INQ000259560]. The statement noted that despite the challenges of infection control and social distancing measures, General Practices have maintained vital primary care services, adapting to meet the demands of delivering these during a pandemic, including video consultations and enhanced telephony capacity to make it easier for many patients to get in touch with their General Practitioner quickly with General Practices remaining committed to providing face-to-face care where this is needed.

364. There was a specific policy to redirect people with Covid-19 symptoms to seek alternative sources of help, rather than attending at the General Practitioner's or Accident and Emergency department. Following the first presumptive positive result for Covid-19 on the 27 February 2020, members of the public, who had symptoms and were concerned that they had Covid-19, were asked not to attend their General Practitioner or hospital Emergency Departments, but rather they were advised to make contact by telephone with their General Practitioner or with the out of hours General Practice service. This 'ask' was by way of public statements carried in the media [RS/0341 INQ000485701]. A helpline was also established to provide advice, and this was further enhanced on 28 February 2020 when a dedicated Northern Ireland helpline was created with NHS 111 [RS/4 INQ000371524].

365. I cannot recall any specific patient safety concerns being raised, more that there was a general concern that people would delay seeking treatment because it was not Covid-related.

S. Shielding

1. UK wide approach

366. My role in shaping a UK wide approach to shielding was limited as shielding was a clinical matter and led by the 4 United Kingdom CMOs. 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 and therefore the policy in Northern Ireland, that I agreed, was fully aligned with that elsewhere in the United Kingdom. However, it remained the case that each of the administrations could diverge if it so wished. Under the UK wide criteria General Practitioners also had a degree of flexibility to include patients they judged to be at high risk. It was this ability to diverge that benefited Northern Ireland as it meant that we were able to include people with Motor Neurone Disease in the definition of Clinically Extremely Vulnerable. A largely umbrella definition across the UK of Clinically Extremely Vulnerable also meant that there was a degree of clarity for people if they heard guidance from England, for example.

2. Pausing Shielding

i. Decision to pause and PCC Survey

367. I received a submission [PM/6129 INQ000346714] dated 16 June 2020 from the Director of Primary Care advising of plans in England to pause shielding from 31 July 2020. The submission recommended that Northern Ireland should follow suit. The submission incorporated evidence about the concerns of the shielded population identified in Patient and Client Council research and the advice of the Chief Medical Officer which was that "the rate of community transmission is such that it would be appropriate to pause the shielding advice here for all adults and children on 31 July." The decision to pause shielding required Executive approval and the submission included a draft Executive paper to this end. The paper [PM/6130 INQ000207253] was submitted to the Executive meeting held on 18 June 2020. The paper highlighted a need for some continued support beyond 31 July 2020 with helpline services continuing for the foreseeable future. It advised that Health and Social Care Trust support services would also continue and the Department would again confirm the package of mental health support resources which had been made available online. General Practitioner and hospital specialist consultations would also remain available to everyone who had continuing concerns about their health.

368. The minutes from the Executive meeting of 18 June 2020 [PM/6131 INQ000348692] record that the Executive agreed to pause shielding from 31 July 2020. By 27 July 2020 there had been no recorded Covid-19 related deaths in Northern Ireland for 14 days and, considering the small number of cases and absence of deaths, it was decided that advice on shielding was no longer proportionate to the risks. Shielding was therefore paused from 31 July 2020 with the situation to be kept under review. A statement from the Chief Medical Officer published on the Department's website to coincide with the pause of shielding reiterated the importance of continuing to exercise caution and follow public health advice [PM/6132 INQ000373404].

ii. Practical impact of pausing shielding

369. The practical impact of pausing shielding was considered. A letter issued to those shielding on 6 July 2020 advising of the support and help that was available up until the 31 July and that available after 31 July. The provision of food boxes would stop after the 31 July but the letter set out helplines that could be contacted for further help and advice, both community and government. It highlighted that medicine deliveries would continue after 31 July but that those who had been shielding would no longer be entitled to Statutory Sick Pay, although this was not a decision of the Department of Health. People were advised to speak to their employer if they could not return to work because either their travel or their place of employment would not allow for social distancing. Links to advice on Covid-19 and working were provided, along with advice if childcare was required.

iii. Reasons for Pausing Shielding

370. I believe the reasons for pausing shielding were clear to those who had been shielding. Transmission rates had dropped and, on the 27 July 2020, there had been no recorded Covid-19 related deaths for 14 days. The results of the PCC's survey were also considered, and these indicated that shielding appeared to be having a detrimental social and psychological effect on a significant group of respondents, although relatively very few of those surveyed mentioned a need for professional support or counselling.

371. The need for shielding was kept under continuous review. A dedicated Clinically Extremely Vulnerable cell, chaired at Deputy Chief Medical Officer level, was established in mid-October 2020 to facilitate this and to formulate policy and guidance relating to the Clinically Extremely Vulnerable population. In reviewing the advice, the Clinically Extremely Vulnerable cell took account of the latest evidence from the epidemiology of Covid-19; the status of the wider restrictions in place for the

general population and also took account of the advice for Clinically Extremely Vulnerable people that was in place elsewhere in the UK.

372. On 6 October 2020 the CMO issued a guidance circular (HSS(MD)70/202) [PM/6133 INQ000348694] to the Health and Social Care system endorsing Covid-19 - 'Shielding Guidance for Children and Young People' developed by the Royal College of Paediatrics and Child Health (RCPCH) and requiring that Trusts, the Health and Social Care Board and General Practitioners take actions to ensure they fully implement the guidance.

373. In an urgent written Statement dated 23 October 2020 [PM/6134 INQ000305015], I informed the Assembly that the Chief Medical Officer had looked at the position again in light of the increased numbers of cases of Covid-19 in Northern Ireland. A search for the CMO's written advice could not locate the document. Since shielding was first advised, a number of important changes had taken place in the Department's approach to managing Covid-19 and reducing its transmission. This included a greater awareness of the importance of social distancing, the requirement to use face coverings, Covid-19 secure workplaces and greater adherence to respiratory and hand hygiene. After careful consideration, the Chief Medical Officer had advised me that shielding should remain paused. A statement published on the Department's website on the 23 October 2020 noted the Chief Medical Officer's assessment and that the position would be kept under review [PM/6135 INQ000373472].

374. Over Christmas 2020, the Clinically Extremely Vulnerable were advised to consider carefully any plans for a Christmas Bubble over the festive period with the safest options to not form a Christmas bubble and avoid attending shops, pharmacies and hospitality settings unless absolutely necessary. From 26 December 2020, Clinically Extremely Vulnerable people who were working and unable to do so from home were advised not to attend the workplace. This advice would be in place for 6 weeks initially, with a review after 4 weeks in line with the review of restrictions more generally. A letter was issued to people who were Clinically Extremely Vulnerable setting out this advice and it could be provided to employers by employees as evidence that they were considered clinically extremely vulnerable in relation to Covid-19 and had been advised not to attend the workplace [PM/6137 INQ000276299].

375. On 6 January 2021, in Prime Minister's statement to the House of Commons, CEV in England advised to shield again. However, this was not replicated in Northern Ireland and on 7 January the advice not to attend the workplace was reiterated in a further statement published on 7 January 2021 [PM/6138 INQ000381421]. It was stated clearly that "The Department of Health has today reiterated the advice regarding "shielding". While not a return to the shielding advice in place in the early part of the pandemic, the updated NI advice does mirror the latest advice in England [on how to stay safe]." The risk of confusing people with not reinstating shielding in Northern Ireland had to be weighed against the psychological effects of shielding, as highlighted in the PCC survey and report. While this may have caused some confusion to people initially, I do not believe it would have been onerous. In the easing and imposition of restrictions Northern Ireland had always taken action in accordance with the trajectory and transmission of the disease and not what was happening elsewhere in the United Kingdom. There is no doubt that the differing news available to people in Northern, both from the rest of the United Kingdom and the Republic of Ireland could, and did, cause some confusion, but I consider the updates issued by the Department and the letters they would have received mitigated any confusion.

376. In a statement on 24 March 2021, the Department announced that in recognition of the improving picture in terms of the activity of the virus in the community, a graduated easing of the advice for Clinically Extremely Vulnerable people was planned, to commence on 12 April 2021. The first step would involve the easing of the advice around going to the workplace from that date. The statement advised that future steps would see the gradual easing of other elements of advice for Clinically Extremely Vulnerable people and would be linked to easing of restrictions more generally [PM/6139 INQ000382899].

377. From 30 April 2021, there was further easing of restrictions for people who were Clinically Extremely Vulnerable across a range of settings including socialising in gardens, overnight stays in self-contained accommodation, retail, gyms and indoor facilities and hospitality. The advice given to Clinically Extremely Vulnerable people was that they may participate in the gradual re-opening of society, however it was vitally important that they continued to exercise great care, for example visiting public places at quieter times, wearing face coverings and maintaining social distancing.

3. Engagement with the Clinically Extremely Vulnerable

378. I issued statements in May and June explaining that shielding was being actively reviewed and would be updated before the end of the initial 12-week period people had been asked to shield for [INQ000348685; INQ000348702]. The CMO wrote to those who were Clinically Extremely Vulnerable in early June 2020 [PM/6125 INQ000348686]. The letter advised those who were shielding that, whilst Covid-19 still posed a high risk to those who are most vulnerable, as infection levels were falling, so the risk of exposure was significantly less. Accordingly, the guidance for Northern Ireland was updated so that from 8 June 2020, those who were shielding could spend time outside with people from their own household or one person from another household whilst ensuring social distancing was observed. This updated shielding guidance was in place until 30 June 2020.

379. On 18 June 2020 I announced plans to pause the shielding advice from 31 July 2020, subject to the rate of community transmission continuing to be low [PM/6126 INQ000348687]. This would mean that those shielding would no longer need to do so and could instead follow the advice provided to those considered generally clinically vulnerable and they were advised to take particular care when out and to maintain strict social distancing. On 22 June 2020, I announced fresh easements to the shielding advice from 6 July 2020, subject to the rate of community transmission remaining low, people who were shielding would be able to meet up to six people outside the home, as long as social distancing was strictly observed. In addition, people who were shielding and living alone would be able to form a support bubble from 6 July 2020 with one other household [PM/6127 INQ000348688].

380. Following on from my statement, a letter from the Chief Medical Officer was issued to those who were shielding setting out the easements to shielding advice from 6 July 2020. The letter also advised that, if the risk continued to remain low, from 31 July 2020, those who were shielding would no longer need to follow the current shielding advice and shielding would be paused. The letter set out details about what would happen after 31 July 2020 for those who were Clinically Extremely Vulnerable and the importance of continuing to stringently follow public health advice. It also provided information and advice about support that was available to those who were Clinically Extremely Vulnerable, including information on medicines delivery, access to priority online shopping slots until 31 July 2020, advice on returning to the workplace, information on access to benefits and support for mental health and well-being [PM/6128 INQ000348689].

T. Long Covid

381. In summer 2020 I asked the CMO to establish a Clinical Working Group to review the needs of those recovering from Covid-19, specifically following a hospital admission. A series of meetings took place with a range of health professionals to review how the needs of post Covid-19 patients were being met at that point and to consider any improvements. These discussions identified that while there were good working models in Northern Ireland which were offering post-Covid-19 follow-up, there was also evidence of services operating in silos which was making it difficult to connect with other service areas. The report recommended that, so far as possible, disciplines working on post-Covid recovery should be incorporated into a follow-up 'one-stop' clinic, similar to that in operation in the Belfast Health and Social Care Trust. Where a discipline cannot contribute to a 'one stop clinic', there should be regionally uniform signposting adopted. The Working Group also recognised the importance of self-help resources which should be made available. It was also suggested that self-help resources should be made available and a recommendation made for specialist clinics in Northern Ireland. The findings of this report are summarised at Annex A of [RS/0342 INQ000485702].

382. On 5 October 2020 the National Institute for Care and Health Excellence (NICE) announced that it would be developing a rapid guideline by the end of the year on long Covid [RS/0343 INQ000320249]. The aim of the work was to provide a formal definition of the disease, advise on how to identify on-going symptoms and provide a definition of best practice investigation and treatment options. On 26 November 2020, NICE circulated a draft version of the rapid guideline for review by stakeholders including the Department of Health with a response date of 1 December 2020 and the guidelines were then published on 18 December [INQ000238545].

383. In December 2020 I agreed the HSCB should be asked to develop plans for a multidisciplinary clinic as part of the management of the long-term effects of Covid-19 [RS/0344 INQ000485704 and RS/0345 INQ000485705]. The initial proposal from HSCB, received in February 2021 [RS/0342 INQ000485702 (as above)], proposed that a multi-disciplinary team be established to provide assessment clinics with the team comprising of a range of disciplines including physiotherapy, occupational therapy, psychology and dietetics. Following the submission of the initial proposals, HSCB officials continued to consult with the various professional bodies and

organisations, as well as further investigation into the approach being adopted in the rest of the UK. The HSCB subsequently submitted a proposal on 7 May [RS/0346 INQ000485706] to the Department for a package of Post Covid services. This proposal built on the initial February 2021 submission and took into account a range of national guidance. The proposal was updated to reflect further discussion with DoH as well as additional information regarding the approach that was being taken forward in Wales. The final proposal [RS/0347 INQ000485707 and RS/0348 INQ000377254] encompassed 5 separate strands:

- Post Covid-19 Syndrome patients referred by primary or secondary care to a one-stop-shop Multi-Disciplinary Team assessment service;
- Bespoke pulmonary rehabilitation / dysfunctional breathing service for patients with significant respiratory symptoms post Covid-19;
- Patients discharged from critical care (both Covid-19 and non-Covid-19);
- Strengthening psychology support to all Trusts; and,
- Signposting and access to self-management resources.

384. The proposal also provided an indicative timeframe that reflected key actions required to progress to implementation:

Action	**Indicative Timescales for Completion**
Further engagement with Trusts with regards to finalising and agreeing investment proposal templates to support the delivery of the proposed service models and pathways. This will include agreement on data collection with regards to patients treated and outcomes.	By the end of June 2021
Engagement with primary care / e-health with regards to electronic referral, the criteria for referral from primary and secondary care and arrangements for e-triage.	May / June 2021
Engagement with service users and carers and other key stakeholders.	Ongoing
Engagement with the Mental Health and Emotional Wellbeing Surge Cell with regards to the range of	May / June 2021

psychological and mental health needs emerging (to include psychiatry, psychology and social work) from a clinical perspective.	
Investment proposals approved and funding allocated.	End of August 2021
Services in place and first patients seen.	End of October 2021

385. In line with NICE Guidance, post-Covid-19 services were designed for people aged 16 years and over.

386. On 9 June 2021, I approved the proposals and that the HSCB should be directed to commission the service. On 14 June, I announced the new services for the treatment and assessment of post Covid-19 syndrome [PM3070 INQ000348831]. The services were launched on the 1 November [INQ000348832].

U. Oversight by RQIA

1. Reduction of Statutory Inspection Activity and Suspension of Non-Statutory Activity

387. A letter from the Chief Medical Officer, on 20 March 2020 [PM/275 - INQ000103688], gave direction to the Regulation and Quality Improvement Authority to reduce the frequency of its statutory inspection activity as set out in the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005 and cease its non-statutory inspection activity and review programme with immediate effect until otherwise directed. I agreed to this as it was to enable the Regulation and Quality Improvement Authority to prioritise inspections on an evidence, intelligence led and risk-assessed basis to focus their activity where it was most needed in a flexible and proportionate manner. This direction prevented footfall in care homes and therefore reduced infection risk. It also allowed the RQIA to redeploy RQIA staff to establish a Service Support Team [INQ000137313, INQ000137315, and INQ000137316] which I announced on 14 April 2020 [INQ000137317]. The Service Support Team was to act as the point of contact for providers of adult residential and nursing homes, domiciliary care and supported living services who had questions and issues arising from the pandemic [INQ000137410 (DoH ref: PM0236)].

388. The main objective of this exercise was to ensure that providers had a single point of contact to raise issues and receive the most up to date advice, guidance and support from the Regulation and Quality Improvement Authority's expert teams of inspectors who, for those supporting this function, were all registered nurses, social workers or Allied Health Professionals. The Regulation and Quality Improvement Authority had key points of contact identified in each Trust in order to ensure the information being passed on was the most current and also in order to refer specific queries if they were unable to resolve the matter. In addition, the Regulation and Quality Improvement Authority were afforded broad flexibility to work with providers to find bespoke solutions to specific issues beyond the remit of generic standards or regulations, to provide safe, pragmatic remedies on a case-by-case basis. While care home, domiciliary care and supported living providers will be able to reflect their experience, I believe that this support was well received.

389. Following a review of the direction of 20 March 2020, given a reduction in community transmission and in light of the recovery process and rebuilding of HSC services, I agreed to rescind the direction to the Regulation and Quality Improvement Authority to reduce and suspend its activity [PM/277 - INQ000346700 (DoH ref: PM0379)] on 22 June 2020. The direction to the RQIA to reduce the frequency of inspections lasted 13 weeks.

2. Benefit to Maintaining Inspections

390. Concerns were raised as to the direction contained in the letter of 20 March 2020 that has been widely reported as suspending the RQIA's inspection function. This was not the case. As I explained in response to a letter from the Commissioner for Older People and the Northern Ireland Human Rights Commission [RS/0349 INQ000485709]:

- The RQIA's statutory inspections were not suspended;
- The RQIA had carried out a number of inspections and issued enforcement action;
- The RQIA were developing new approaches on how inspections would be carried out to gain assurance about the safety and quality of services (both unaffected by COVID 19 and where there was an outbreak);
- The RQIA focussed its activity where it was most needed; and
- The HSC Trust safeguarding teams continued to operate.

391. The direction given to the RQIA also brought Northern Ireland into line with regulatory practice in the rest of the United Kingdom and the Republic of Ireland rather than created a difference:

- 12 March: Health Information and Quality Authority (HIQA) in the Republic of Ireland - "all routine inspections of designated centres have been cancelled until further notice" [RS/0350 INQ000485710];
- 13 March: Care Inspectorate (Scotland) - "we have taken the decision to cease our inspections of care services .... at this time" [RS/0351 INQ000485713];
- 16 March: Care Inspectorate Wales - "we have decided to pause all routine inspections from 5pm today" [RS/0352 INQ000485712]; and,
- 16 March: Care Quality Commission (England) – "we will be stopping all routine inspections from today" [RS/0353 INQ000485711].

392. While consideration had been given to continuing inspections by the RQIA this had to be weighed up against the infection risk posed by people entering care homes; particularly people who would then potentially have been in a number of different homes. Given that all inspection bodies had paused their routine inspections, I do not consider that the RQIA could have continued them irrespective of any benefits there may have been.

3. Independent Review into the RQIA

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

394. On 23 June 2020 I announced I had commissioned an independent Review of the circumstances that gave rise to the resignation of the RQIA Board members. I commissioned this because I wanted to establish the reason for the resignations and to ensure that a similar situation would not arise in another ALB of the Department.

395. The independent Review was published by the Department on 19 July 2021 [RS/0354 INQ000260638] alongside an action plan [RS/0355 INQ000485714] detailing the Department's response and lessons learned. Due to the pause in governance work during the pandemic, implementation of the recommendations in the independent review was initially delayed. Guidance issued to Executive Board Members on the process for Ministerial/Departmental Directions on 10 August 2021. Revised Codes of Conduct and Accountability for HSC and Northern Ireland Fire and Rescue Service Board Members issued on 12 October 2022. Updated ALBs ground-clearing meetings and Accountability Meetings guidance issued on 30 December 2022. A revised DoH ALBs Sponsorship Handbook issued on 22 December 2023.

396. Development and implementation of Partnership Agreements is due to be completed for all ALBs during 2024 and the next review of the Department's ALBs is scheduled for 2024.

V. Lessons Learned

397. In answering a similar question in my statement for Module 2C of this Inquiry I stated that "Given the staffing pressures experienced within the Department of Health I would also consider that the Northern Ireland Civil Service needs to develop procedures to allow the quick redeployment of staff between all Departments. This would ensure that the staffing pressures experie4nced by the Department of Health would not occur again during a pandemic." I believe there is merit in reiterating here that the Northern Ireland Civil Service must be more agile in redeploying its staff to areas under pressure. It should also pay more regard to the expertise and skills of its employees and ensuring sufficient sharing of knowledge and experience.

398. While I greatly benefited from the Chief Medical Officer having a policy role in addition to his advisory role during the pandemic, it also served to highlight the heavy workload of, and reliance on, the role. The Department of Health has reacted to this and the CMO no longer has a policy remit.

STATEMENT OF TRUTH

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

Signed: **Personal Data**

Date: 28 June 2024