Witness Name: PETER MAY

Statement No:

Dated: 07 June 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF:

PETER MAY

Permanent Secretary (4 April 2022 – present)

Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY

MODULE 3 RULE 9 REQUEST – M3/DOHNI/01

DEPARTMENT OF HEALTH (NI)

Contents

WITNESS STATEMENT OF PETER MAY

I, Peter May, Permanent Secretary of the Department of Health, Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry, dated 10 March 2023 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

I, Peter May, will say as follows: -

On 4 April 2022, I took up post as Permanent Secretary for the Department of Health and Chief Executive of Health and Social Care. I previously held Permanent Secretary positions in the Department of Justice, Department for Infrastructure and the Department of Culture, Arts and Leisure. My predecessor in the Department of Health was Richard Pengelly who was in post from 2014. Given the timing of my appointment, I have limited first-hand knowledge of the events and issues set out. In preparing this statement, I have relied on my staff who have carried out a thorough review of the documentary evidence held by the Department.

H. NIGHTINGALE AND INDEPENDENT HOSPITALS

1. Nightingale Hospitals

a. Rationale behind a Nightingale Hospital

1. 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.

2. However, the Chief Medical Officer and Chief Scientific Officer, sometime in the period from 19 March to 1 April 2020, indicated that an increase in critical care capacity to this level was unlikely to be sufficient to cope with the potential level of critical care admissions. Further, it was recognised that critical care capacity across the HSCNI network needed to be considered in the context of reasonable worst case

scenario modelling. They concluded this based on emerging UK modelling data from SAGE and other sources at that time. From this the Department's Covid-19 modelling group (chaired by the CSA) set out a range of scenarios, including a reasonable worst-case scenario that suggested the peak number of Covid-19 patients requiring ventilation and critical care beds during the first wave should be 180 for planning purposes [INQ000137356]. While an exact date cannot be ascertained, these figures informed the draft Covid-19 Pandemic Critical Care Surge Plan of 1 April 2020 and were shared with the HSC by CMO on 1 April 2020 to assist their planning. In addition, they used a range of other sources of evidence, including from the World Health Organisation, European Centre for Disease Prevention and Control, the US Food and Drug Administration and the wider scientific and grey literature.

3. Following this revised RWCS, 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 considered 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.

4. 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.

5. The output of this work was a draft Covid-19 Pandemic Critical Care Surge Plan, which the Health Minister was asked to approve through 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.

6. DoH received advice from clinicians for the purposes of surge planning in the form of regular/daily contact between CCaNNI leads, HSCB, PHA and DoH officials to develop feasible escalation plans, trigger points, staffing requirements, transportation etc based on their local knowledge (e.g. the ability to configure theatre recovery space into additional critical care beds in a particular location), in order to respond to anticipated additional demand surges while adhering to appropriate patient safety requirements.

b. Decision on a Site

7. When it was realised that a regional centre for critical care would potentially be required, the Department, in late March 2020, 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.

8. While no formal assessment report was prepared, the knowledge gained from the site visits fed into the development of proposals, which – along with the work being undertaken by Trusts and the Health and Social Care Board for reconfiguring Health and Social Care hospital sites to increase critical care capacity - were submitted to the Minister and are set out below.

9. It was following assessment of these strands of work, as well as discussions between senior officials of the Healthcare Policy Group and Strategic Surge Planning Directorate, the clinical lead of the Critical Care Network and the Chief Executive of the Belfast Trust, that 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. The Chief Medical Officer supported the Director of Covid-19 Surge Planning and the Chief Nursing Officer with this work. Through continued dialogue, the Department therefore obtained the agreement of the Chief Executives of the Health and Social Care Board, Public Health Agency and Health and Social Care Trusts for the approach being recommended to the Minister.

10. The Minister agreed [PM/6086 INQ000346769 and PM/6107 INQ000439817] with the Department's recommendation to designate Belfast City Hospital's tower block as Northern Ireland's first Nightingale Hospital for the anticipated surge of Covid-19 patients requiring intensive care in the weeks ahead. This decision was announced on 2 April 2020 [PM/0064 INQ000103653].

11. In relation to both the BCH and Whiteabbey Nightingale facilities, it should be noted that the DoH would not have had any involvement in any operational/clinical decisions. This would include staff recruitment and redeployment; 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. The Department's role was to set policy i.e. by approving surge plans through Gold Command structures and Minister, and to receive assurances through these structures that plans were being implemented/operationalised in line with the prevailing pandemic conditions.

12. Funding for the fit out of BCH Nightingale and its operational resourcing would have been led by Belfast Trust, with the Health and Social Care Board, adopting the financing processes introduced in relation to managing the response to the pandemic. This is explained in section A (6) of the Department's M3 Part 1 statement.

13. The BCH facility required development to provide the anticipated 230 bed regional facility which was to be staffed by a team drawn from across Northern Ireland.

14. The Belfast Trust developed the facility, ensuring that equipment and resources were in place. The BCH managed a significant proportion of COVID-19 patients from both the Belfast Trust catchment area and from across Northern Ireland, as part of the Trust's proportion of the regional surge plan. Fortunately, due the impact of social

distancing, individual Trusts were able to manage critical care demand without the need for regional escalation. However, the Nightingale Facility was ready to flex up capacity if/when this was required.

15. During the period January 2021 - 26 Feb 2021, the Belfast City Hospital (BCH) moved to a fully functioning Nightingale when surge volumes were such that Nightingale beds needed to be opened and staffed by nursing staff from across Northern Ireland. The number of patients admitted to, and treated by, the Nightingale Hospital during the relevant period was 50 into the BCH Nightingale in January and 16 in February 2021.

16. The Belfast Trust had three critical care units – BCH, Mater, Royal Victoria Hospital (RVH). During Covid the Trust amalgamated the staff from Mater into BCH and RVH, consolidating critical care in these two locations. Most Covid admissions in the Belfast Trust catchment that required critical care were admitted to BCH. The Belfast Trust has most of Northern Ireland's tertiary and regional services and the RVH is the regional intensive care unit for Northern Ireland. Tertiary and regional specialties are high users of critical care and the demand in tertiary services did not significantly reduce during Covid. Therefore, the RVH Covid admissions to critical care tended to be for tertiary or regional patients or when BCH was at capacity.

17. The "Nightingale" was in the same facility as the BCH Critical Care unit but had additional beds split into pods:
Pod 1 – 4 beds, Pod 2 – 12 beds, Pod 3 – 12 beds, Pod 4 – 12 beds = 40 additional beds
These Nightingale beds were to be staffed by mutual aid from across 5 Trusts – i.e. each trust had to provide a share of nursing, medical, pharmacy and AHP staff to open the Nightingale.

18. Prior to the establishment of the Critical Care and Respiratory Operational Hub (Hub), all Trusts had agreed to redeploy staff to BCH Nightingale from surge level 4 [PM/6010 INQ000276393] (need for more than 133 beds) and beyond. However, although plans were in place for the redeployment of all types of staff (medical, Allied Health Professionals, nursing), in practice the only staff required for redeployment in this wave were nursing staff. The Permanent Secretary wrote to Trust Chief Executives on 5 January [PM/6010 INQ000276393], following a decision at Gold Command, and advised that the Hub was now charged with requesting and determining the movement of deployed Trust critical care team into the BCH Nightingale as part of the agreed CCaNNI surge plan. Trusts were asked to put

arrangements in place to have staff ready to be deployed to BCH Nightingale within a 48-hour window.

19. The Hub, in identifying and managing pressures across the critical care system, supported Trusts in triggering the redeployment staff into the BCH Nightingale, linking with operational Directors, lead nurses and Directors of Nursing as required. Meetings also took place with staff side representatives and Trust Human Resource Directors. A total of 14.87 whole time equivalent (WTE) nursing staff were redeployed from four Trusts to support BCH Nightingale. Belfast Trust redeployed an additional 34.41 nurses, mobilising both POD1 and POD 2 of the Nightingale. Belfast Trust was the only Trust to mobilise POD 2 staff.

20. Alongside supporting the BCH Nightingale, each Trust redeployed their own staff into critical care units to support the local escalation of bed capacity. The scale of this movement of staff was significant, with, for example, on the week commencing the 18 January 2021 over 282 wte nursing staff redeployed into critical care, facilitating over 70 extra level 3 equivalent critical care beds, doubling the commissioned bed capacity. Although staff came from all services within hospitals to critical care, the majority of nurses came from theatres and surgical services, with less staff from medical and respiratory specialties where they were needed for increases in admissions.

21. The support and induction provided by BCH Nightingale was considered excellent and reassured many redeployed staff [PM/6427 **INQ000440936** This included support in the provision of accommodation and the use of welcome and orientation booklets and resource packs. Some Trusts identified staff early, secured training and enabling induction and visits to BCH Nightingale before staff were required to transfer in. The Critical Care and Respiratory Hub carried out a Reflection and Learning Report in March 2021 which included collecting the views of staff who had been redeployed to BCH Nightingale [PM/6427 **INQ000440936** as above].

22. Trusts generally asked for volunteers for redeployment, with some limiting the recruitment pool to the acute sectors while others encouraged volunteers from the entire Trust. As Critical Care is a specialist type of nursing role, it is not a role that a nurse can easily move into without training. It was an operational decision for each Trust as to how they managed redeployment locally and/or regionally. Staff confidence working in this specialist unit grew the longer they worked in it. It is

understood that some staff asked to stay in ICU after COVID, as they enjoyed this type of intense nurse to patient nursing. However, other Trusts considered it unfair to ask staff to move for long durations to ICU but preferred to train a higher number of staff to work in ICU and then they had a wider pool of staff to place on rotas. As an operational decision, this was for the individual Trusts to manage.

23. The different types of treatment available in the Nightingale Hospital were:

- Ventilation of patients (Level 3 patients – intensive care)
- CPAP/ NIA/ Airvo patients (Level 2 patients – high dependency)
- Extubated – no respiratory support (Level 2 patients – high dependency for other reasons)

24. As the Belfast City Hospital is a designated Critical Care Unit it therefore has the capability to provide care for all types of critical care patients; however, during Covid it was designated as a Covid facility until the 4th Wave de-escalation of surge began. It should be noted that BCH is also the regional cancer unit in NI and, as such, the critical care unit carries out care for patients receiving complex cancer surgery and requiring critical care. This is why it was important to de-escalate the BCH Nightingale first as these patients could not have been treated in a Covid facility. In order to increase the number of patients getting cancer surgery it was decided by Gold command that the BCH Nightingale would be the first unit to be de-escalated. This would ensure that patients waiting on complex surgery, that could only be carried out in BCH, would have their surgery.

25. Belfast Trust has 42 Critical Care beds (BCH including Mater and RVH) excluding PICU and Cardiac Intensive Care beds:

CRITICAL CARE UNIT	L3 Commissioned beds *	L2 Commissioned beds **	Total Beds commissioned	L3 Equivalent Beds
BCH	5	4	9	7
Mater	3	3	6	4.5
Royal Victoria	19	8	27	23
Belfast Total	**27**	**15**	**42**	**34.5**

* 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.

** Level 2 bed - High dependency unit. Patients needing single organ support (excluding mechanical ventilation) such as renal haemofiltration[1] or inotropes[2] and invasive blood pressure monitoring. They are staffed with one nurse to two patients.

26. Belfast Trust managed its beds during Covid, where possible, to care for Covid patients on the BCH site, keeping the Regional Intensive Care Unit in RVH as a regional and tertiary unit. This is because many of the regional conditions continued to need to be treated throughout Covid (brain tumours, vascular bleeds, trauma etc). These patients can only be cared for in the Royal Victoria Hospital.

27. It should also be noted that all Trusts managed Covid patients throughout the pandemic and facilities were split as Covid, suspected Covid and non-Covid zones.

28. Patients were admitted to the Nightingale Hospital through a Standard Operating Procedure [PM/6189 INQ000417352] which was developed by the Critical Care and Respiratory Operational Hub to support the optimal use of critical care beds in Northern Ireland during the pandemic response. It also ensured maximum benefit for the population by enabling appropriate transfer of patients while reducing unnecessary delays and administrative burdens on clinical teams. This operated in conjunction with the Northern Ireland Specialist Transport and Retrieval service (NISTAR), a member of the Critical Care and Respiratory Operational Hub. The procedure was agreed by the Chief Medical Officer.

29. NISTAR is the combined critical care transfer service for Northern Ireland. It incorporates the neonatal, paediatric and adult retrieval services. NISTAR provides advanced resuscitation, stabilisation and inter-hospital transfer of critically ill infants, children and adults. Patients are managed by specialised clinical teams experienced in transport and retrieval. The service operates 24 hours a day, seven days a week. Approximately 1200 patients are transferred by NISTAR annually. NISTAR also provides advice, support, education and training to hospitals on the safe transfer of critically ill patients. It is hosted by the BHSCT in partnership with the Northern Ireland Ambulance Service (NIAS). BHSCT provide the medical and nursing staff and NIAS the dedicated critical care ambulances and crew.

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[1] A renal replacement therapy used in intensive care settings.

[2] **Inotropes** are **drugs that make your heart muscles to beat or contract with more power or less power, depending on** whether it's **a positive** or **negative inotrope.**

30. There were 50 transfers to BCH Nightingale in January and 16 transfers in February.

31. There were a number of challenges faced in making effective use of the Nightingale Hospital:

- Redeploying of staff to BCH Nightingale was more of a challenge than anticipated. Many staff wanted to be nearer their family and work locally. All Trusts would have faced a significant challenge had POD 2 staff been required for BCH Nightingale.
- As staff were redeployed within their own Trust as well as to the Nightingale, the preparation training was not consistent across Trusts. The failure to utilise the CCaNNI recommended programme, was out with the Military Assessment Team recommendation, which indicated that a consistent approach to training would support the movement of redeployed staff.
- Some redeployed staff reported that they felt pulled between supporting critical care and providing a service to their core patients and teams back at base.

c. Second Nightingale Hospital

32. In April 2020, the Minister granted approval for work to begin on exploring the site and specification for a second regional Nightingale facility in advance of the anticipated second wave of Covid-19, which it was believed could coincide with winter pressures. This included assessment of a number of potential sites and the identification of the most suitable clinical and technical requirements [PM/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].

33. A Project Board was established [PM/6407 INQ000000; PM/6408 INQ000000; PM/6409 INQ000000], 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. 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 [PM/6332 INQ000276383], with the Minister ultimately deciding on 1 September 2020 to move ahead with the proposal, [PM/6333 INQ000276384; PM/6334 INQ000276492] following assurances around the legacy usage of the facility [PM/6335 INQ000276493; **INQ000370938**

34. Work on the new facility began immediately, with the Northern Health and Social Care Trust (NHSCT) Board granting approval for the necessary capital works [PM/6336 INQ000276495]. The Northern Health and Social Care Trust was responsible for the operation of the facility and will be able to provide information on the number of patients admitted and treated at the Whiteabbey Nightingale.

35. It was recommended by the Project Board and agreed by the Minister 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, with the Project Board concluding that the development of additional intermediate capacity would improve this flow and free up acute capacity. The Project Board also agreed that it was less likely for clinicians to be willing to transfer acute patients to a regional facility, again strengthening the case for developing an intermediate facility; 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].

36. The Project Board also agreed 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 UK nations [PM/6332 INQ000276383 as above]. As a result 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.

d. Whiteabbey Hospital

37. 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].

38. The Minister determined, 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]. The Minister 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].

39. From 20 November 2020 until 2 April 2021, the period during which the Whiteabbey Nightingale was focused on treating Covid-19 patients, the unit treated 146 patients. These patients were past the acute stage of the illness but had a range of intermediate care / step down needs, which were best treated by the enhanced rehabilitation model delivered at the site. These patients had an average length of stay of just under 13 days and their ability to receive treatment at Whiteabbey saved the system an estimated 1,662 acute beds days over the period [PM/6333 INQ000276384]. The Department does not hold data relating to daily occupancy

figures; this information should be requested from the Northern Health and Social Care Trust.

e. Legacy Arrangements

40. In February 2021, the Minister 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].

f. Operational Issues

41. Following the Ministerial decision to open a step-down Nightingale facility on the Whiteabbey site, ownership of the Second Nightingale Project passed from the Departmental policy team to the Northern Health and Social Care Trust, who would oversee the delivery of the operational requirements. However, the Department remained closely engaged with the Trust on the delivery of the project throughout, with senior Departmental officials holding seats on the Project Board and the Departmental policy lead joining weekly project team meetings. Following the move from policy to operational delivery, regular updates were provided to the Minster on all aspects of the Project, including monitoring usage of the facility, ongoing costs and staffing issues.

42. 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.

43. Patients were admitted to the unit following a regional daily call between nurses at Whiteabbey and single points of contact within each of the five Trusts. Patients were assessed against strict entry criteria, to ensure that they were suitable for the intensive rehabilitation offered at the facility and that they would be suitable for discharge within the 14-day average length of stay. The Northern Ireland Ambulance Service was included as part of the operating structure for the Whiteabbey Nightingale, to ensure emergency and non-emergency transport was available to transfer patents to and from local hospital settings.

44. 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].

45. As the Northern Health and Social Care Trust was responsible for the leadership of the project and the operation of the facility, that Trust will be best placed to provide more accurate and final information on: staff recruitment; deployment and redeployment; the different types of treatment available; and capacity to provide care for patients with Covid-19 or other conditions. The Northern Health and Social Care Trust will also hold the most accurate and detailed information on how patients were admitted and transported to the Whiteabbey Nightingale and on the costs associated with setting up, operating and decommissioning the Whiteabbey Nightingale [PM/6343 INQ000426812 and PM/6344 INQ000426813].

46. The Strategic Planning and Performance Group was involved in the development of a Covid Response Business Case with the Northern Trust. This included the pathway into the service, expected beddays to be achieved, occupancy rates, length of stay and associated activity. A post project evaluation was carried out on the Nightingale Model of Care in Northern Trust and submitted to the Strategic Planning and Performance Group on 5 October 2023 [PM/6345 INQ000426815].

47. The post project evaluation showed that the service was able to maintain high occupancy levels to save the maximum number of beddays, continued to provide a nurse and Allied Health Professional led rehabilitation model, delivered intensive rehabilitation and strong patient outcomes to return patients home within an average length of stay and preserved the capability to treat covid-19 patients as bed capacity was maintained at 28 beds.

2. Independent Sector Hospitals

48. On 19th March 2020 a meeting was held between the Health and Social Care Board (HSCB) Director of Commissioning, Miriam McCarthy, senior managers and representatives of the Independent Sector (IS) hospitals to discuss surge planning in the emerging Covid-19 situation. No minutes or readout could be located. The meeting discussed the potential for Health and Social Care to contract for access to Independent Sector hospital facilities, to engage their clinical staff and to utilise other resources for the pandemic effort. The alternative was discussed i.e., closing valuable Independent Sector hospital facilities and having the skilled clinical staff on furlough. This meeting was the starting point for Health and Social Care developing contracts to utilise all available Independent Sector hospital theatres and bed capacity for the pandemic response. Following the meeting a letter issued to the Independent Sector confirming this [PM/6410 INQ000000].

49. The decision to contract with the Independent Sector Hospitals was taken in March 2020 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.

50. 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.

51. The redeployment of Health and Social Care elective care staff to increase critical care capacity resulted in the cancellation or postponement across all Trusts of non-urgent appointments, investigations and procedures across outpatients, day case, inpatient and diagnostic services. Efforts were made to minimise any disruption to treatment for cancer and other urgent procedures, but there was some impact. 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).

52. Red flag (suspect Cancer) referrals were also prioritised for diagnostics and consultant appointments. However, some biopsy and endoscopic diagnostics services had been switched off for a period of time 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 qFIT test to prioritise patients with suspect bowel cancer for endoscopy.

53. 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].

54. 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.

55. To help increase elective care capacity and mitigate the most severe impacts of this, the Health Minister, in his opening Statement [PM/0301 INQ000130411] to the Assembly's Ad Hoc Committee meeting on 15 April 2020, 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 INQ000000 PM/6412 INQ000000; PM/6413 INQ000000; PM/6414 INQ000000]. 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. The Health and Social Care Board led on discussions with independent hospitals in order to support the pandemic response in Northern Ireland, in the context of surge planning. The Department's input was not required with making the contract arrangements with IHs as a range of expert advisors i.e. from RQIA, DLS, PHA, BSO ITS and Trusts were available and directly engaged with this. 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. The Department subsequently provided these indemnities, initially for the period to 30 June 2020 but subsequently extending them until end March 2022 More detail on the contractual agreement is set out in the section below.

56. 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 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.

57. 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.

a. Contractual Agreement

58. The Health and Social Care Board, on behalf of itself and five Health and Social Care, Trusts entered into contracts with the Ulster Independent Clinic, the North West Independent Clinic and Kingsbridge Private Hospital between 1 April 2020 and 29 June 2020. These contracts 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 dated 26 June 2020 [PM/6347 INQ000381740]. 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.

59. 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; PM/6355 INQ000426825 .

b. Treatment and Capacity

60. 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.

61. 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. Thousands of urgent patients with life-threatening or time-critical conditions were scheduled for treatment in these "green site" hospitals who would otherwise have had reduced access to surgeons and theatre teams and would not have received treatment as quickly as they did. Green sites', or 'Covid light' sites, were designated elective sites which ensured that Trusts were able to continue to undertake planned surgery safely during the pandemic. These green sites and pathways were established to mitigate the risks of Covid-19 in elective surgical patients. Before being admitted for surgery, all patients would have been tested for Covid. These green sites were initially identified in the Belfast City Hospital and Lagan Valley Hospital. In addition, all Trusts continued to develop green pathways on other sites where elective work could be facilitated subject to the available workforce and adequate IPC safeguards.

62. During the period from April 2020 to December 2021, a total of 84,000 patients were admitted electively (either as Inpatients or Day Cases) through the Independent Sector and the 3 'Green sites' of BCH, Musgrave Park and Lagan Valley. During the period from January 2022 – December 2022, a total of 65,000 patients were admitted electively through these routes. Trust service managers had responsibility for coordinating and scheduling these urgent patients through the three hospitals.

63. No Intensive Care Unit bed capacity was registered with the Regulation and Quality Improvement Authority (RQIA) in any of these hospitals. The three independent hospitals provided a combined total of 112 inpatient beds, recovery areas, day case bed space and outpatient space. The original contracts with these hospitals defined the bed capacity as that registered with Regulation and Quality Improvement Authority i.e., to record that the Health and Social Care had access to all the registered bed capacity in exchange for full cost recovery.

64. The capacity provided by the Independent Sector hospitals supplemented the capacity of the Health and Social Care and allowed more time critical patients to be treated. Thousands of patients were assessed and treated in the independent hospitals over the period with a focus on oncology patients but also in a number of other specialties listed above.

I. HEALTHCARE PROVISION AND TREATMENT

1. General

65. The redeployment of Health and Social Care elective care staff to increase critical care capacity resulted in the cancellation or postponement across all Trusts of many non-urgent appointments, investigations and procedures across outpatients, day case, inpatient and diagnostic services. Theatre nurses were mainly used in critical care units. Non-theatre staff were used in other areas of hospitals to manage covid pressures. Efforts to rebuild services following the first wave of the pandemic under the Rebuilding Health and Social Care Services Strategic Framework [INQ000137430], published by the Health Minister in June 2020, continued to be subject to capacity constraints due to the prevailing pandemic conditions, including subsequent waves of infection and further high surges in admissions. These conditions placed continuous pressure on the entire Health and Social Care system throughout 2020 and 2021.

66. In Primary Care, General Practices continued to provide treatment, care and support to patients throughout the pandemic. A telephone first approach allowed General Practices to provide both face-to-face appointments and alternative consultation options and to maintain the majority of General Practice services. Further information about the provision of General Practice is provided in Section D – Capacity.

2. Non-Covid-19 Conditions and Treatment

67. To help maintain a level of elective care in the context of drastically reduced capacity the Minister, in his opening Statement to the Assembly's Ad Hoc Committee meeting on 15 April 2020, informed members that Health and Social Care Trusts were accessing the independent sector hospitals to treat urgent, non-Covid-19 patients across a number of elective specialities for red flag and urgent cases [PM/6229 INQ000426831]. The Health and Social Care Board, on behalf of itself and five Trusts, entered into contracts with three independent hospital providers, namely the Ulster Independent Clinic, the North West Independent Clinic and Kingsbridge Private Hospital between 1 April 2020 and 29 June 2020. The Independent Sector contracts were utilised to assist in addressing elective capacity for both assessment and treatment. During the pandemic response, the limited available capacity was targeted at cancer services and time-critical planned care, with routine and urgent patients therefore having to wait. The Regional Prioritisation Oversight Group was established to equalise access to theatres on the basis of clinical urgency. Further

details on these contracts and how the facilities were used is in Section H – Nightingale and Independent Hospitals.

68. 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. The impact of the pandemic across health and social care services, programmes and projects has been considerable, as resources were rightly focused on the required emergency response. The Covid-19 pandemic has presented unprecedented challenges for the planning and delivery of health and social care services in Northern Ireland.

69. The Rebuilding Health and Social Care Services Strategic Framework, which was published in June 2020 [PM/3047 INQ000348808], provided an analysis of the adverse impact of Covid-19 at that time on individual health and social care services. It also sets out the approach to restoring services as quickly as possible, taking into account examples of innovative approaches to service delivery, developed in response to the pandemic.

70. The implementation of the Strategic Framework resulted in the development, by Health and Social Care Trusts, of incremental service plans, which detailed how capacity could be increased in the context of Covid-19. The aim was to maximise service activity within the context of managing the ongoing Covid-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future. Further detail regarding the implementation of the Strategic Framework through Trust Rebuilding and Delivery Plans is provided under section 4 below.

71. On the 28 July 2020, the Minister also announced key decisions concerning the way forward for two important services: day procedure centres and orthopaedic surgery. The Minister published a Policy Statement for Elective Care Day Procedures [PM/6230 INQ000426832] and a Blueprint for Orthopaedic Care [PM/6231 INQ000426834]. The Blueprint for Orthopaedic Care is explained in detail below. The Minister informed the Assembly that he believed that it was in the public interest to move forward with the implementation of these service changes as quickly as possible to address the adverse impact of the Covid-19 pandemic on elective care waiting times and to enable the Health and Social Care system to have dedicated treatment centres in place, ahead of potential further waves of the pandemic. This

would allow the Health and Social Care system to maintain robust infection control preventative measures at dedicated sites to enable procedures to continue during any future outbreaks of Covid-19.

72. The overall aim of the Day Procedure Centre model was to deliver high volume, low complexity routine procedures. However, given the pressures across the Health and Social Care system during the surge periods of the pandemic and the subsequent downturn in elective activity, the Minister approved an initiative whereby the Day Procedure Centre at Lagan Valley Hospital, Lisburn would be used to support the region by treating high priority patients across a range of elective care specialities. This regional support has continued as elective capacity is restored incrementally on the other hospital acute services sites.

73. In a written statement on 8 January 2021 [PM/6232 **INQ000305006**] the Minister informed the Assembly that he had approved the establishment of a new regional approach to ensure that any available theatre capacity across Northern Ireland was "allocated for those patients most in need of surgery both during surge and as we come out of this [third] surge." This included seeking to fully maximise all available inhouse Health and Social Care and Independent Sector capacity. Inter-Trust transfers for the highest clinical priority cases were also to be facilitated.

74. On 6 January 2021 a submission [PM/6233 INQ000426836] was made to the Minister seeking approval to the planned approach for the allocation of the available in-house and Independent Sector capacity. This was because of expected downturn in elective capacity associated with staff absence and the modelling of Intensive Care Unit requirements. Ministerial approval was subsequently given on 8 January 2021 [PM/6234 INQ000373992]. An updated paper was provided to the Health and Social Care Rebuilding Management Board on 19 May 2021 [PM/6235 INQ000276350]. This provided an update on the proposed actions to streamline and enhance the prioritisation process and utilisation of elective theatre capacity by the Health and Social Care system. The paper set out the process for the Regional Prioritisation Oversight Group and outlined the actions undertaken by each Trust to address pressures across the region.

75. The following sub sections a) – e) cover a number of non-covid services impacted by the pandemic and what work was undertaken to support rebuilding the services for

the benefit of patients. These are all set within the departmental rebuilding Health and Social Care Services, Strategic Framework.

a. Children's and Maternity Services

76. Plans were put in place early in the pandemic to protect children's and maternity services. Concerns were also brought to the Department's attention over this period by patient representatives in relation to both renal transplant surgery and access to fertility services. Further detail about the measures taken by the Department to maintain and protect these services is set out below.

77. On 3 April 2020 the Department published details of a regional plan which had been developed with the five Health and Social Care Trusts to protect access to children's and maternity services through temporary reconfiguration, while escalating the critical care surge plan using the newly established Nightingale facility at Belfast City Hospital. The plan contained a number of steps that could be triggered, depending on the pressures on services, including an expectation that around 50 Covid beds for adults could be made available by implementing Step One during the anticipated surge over the subsequent days [PM/6236 INQ000426842].

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

79. The plan ensured that maternity services continued to be safely provided in Daisy Hill Hospital (Newry), South West Acute Hospital (Enniskillen), Craigavon Area Hospital (Craigavon), Altnagelvin Hospital (Derry), Antrim Area Hospital (Antrim), the Ulster Hospital (Dundonald) and the Royal Jubilee Maternity Hospital (Belfast) during the pandemic response. After careful consideration, it was agreed, from 9 April 2020, to temporarily close Causeway Hospital to Paediatric admissions and Inpatient Maternity Services [PM/6237 INQ000426843]. It was agreed that antenatal services would continue at Causeway Hospital (Coleraine), but it was decided that it would not

be possible to safely deliver babies in the Causeway Hospital during this surge period, due to the lack of sufficient numbers of skilled paediatricians who would be needed to ensure provision of emergency care to a baby born in distress throughout the 24-hour period. Women who were booked to deliver babies in Causeway Hospital were contacted to arrange to have their delivery transferred to either Antrim Area Hospital or Altnagelvin Hospital from the 9 April 2020 until 24 August 2020. From 25 August 2020 the Causeway Hospital resumed its inpatient Maternity Services.

b. Fertility Services

80. In June 2020, as focus moved from managing the first wave pandemic response into the process of rebuilding services, the Health Minister sought to prioritise the resumption of fertility services at the Regional Fertility Centre which had been paused since March 2020. This was in light of increasing interest from patient representatives, the media and elected representatives.

81. In pausing treatment initially, the Belfast Trust, which operates the Regional Fertility Centre for all of Northern Ireland, was responding to patient safety concerns and a request from the regulator of fertility treatment in the United Kingdom, the Human Fertilisation and Embryology Authority, as well as recognising the need to concentrate its staff and other resources on the pandemic response.

82. To mitigate the impact of the downturn, the Regional Fertility Centre continued to carry out egg vitrification (freezing) for cancer patients throughout the Covid-19 period, and all the usual storage services (for sperm, eggs and embryos) remained in place for those awaiting fertility treatment. It was also agreed that the eligibility for anyone currently on the waiting list would be extended by 1 year, as a means of reducing the pressure for women who would otherwise breach the upper age limit of 42 years and 364 days before receiving treatment. This measure also allowed women on the waiting list to be treated in chronological order upon resumption of the service, in line with extant policy, rather than prioritising those approaching the upper age limit.

83. A Ministerial submission [PM/6238 INQ000426844] of 16 June 2020 outlined a proposed path to resuming fertility services as part of ongoing rebuilding/recovery planning across Health and Social Care Trusts in the wake of the first pandemic wave. It advised that fertility treatment, including In Vitro Fertilisation, fell into the

category of routine elective care. It advised that difficult decisions had to be taken about the order and prioritisation with which all services should be restarted, and that the Trusts had to bear restarting fertility treatment in mind when developing their respective first 3-month rebuild plans. In addition, the Minister was advised that the Regional Fertility Centre faced significant capacity constraints at that time in terms of both workforce (with staff still redeployed to the Covid response) and limited physical capacity within the Regional Fertility Centre (which had been exacerbated by social distancing requirements). In light of this, an initial resumption date for fertility services of September 2020 was envisaged; in the event, as explained below, a phased resumption of services commenced on 10 August 2020.

84. The submission noted that the Human Fertilisation and Embryology Authority began accepting applications from fertility clinics to recommence some fertility treatments from 11 May 2020. Due to staffing constraints, the Regional Fertility Centre application was submitted to the Human Fertilisation and Embryology Authority on Friday 5 June 2020 and approval to recommence was subsequently granted by the Human Fertilisation and Embryology Authority on 11 June 2020.

85. On 23 June 2020, in response to the submission, the Minister sought further clarity about the reasons for delaying the resumption of fertility services given the Human Fertilisation and Embryology Authority's position [PM/6239 INQ000426846 and PM/6240 INQ000426850]. A revised submission, which provided further details about the Trust's position and the current status of redeployed staff, was submitted to the Minister's Private Office on 2 July 2020 [PM/6241 INQ000426851]. In response to the revised submission, the Minister asked how quickly the Regional Fertility Centre could resume its services as he was keen to prioritise doing so in light of the Executive's "New Decade, New Approach" commitment of providing up to 3 funded In Vitro Fertilisation cycles to women [PM/6242 INQ000426852]. In a further response to the submission, the Minister's Special Advisor noted that early September 2020 was not ambitious enough and asked officials whether a resumption of services, even at a reduced level, from 29 July 2020 would be attainable (note that the original email contained a typographical error which said 20 July rather than 29 July) [PM/6243 INQ000426854]. Officials responded on 2 July 2020 advising that a paper would be provided to the Rebuilding Management Board meeting on 22 July 2020 and that it would contain options including the immediate recommencement of services from 29 July 2020 [PM/6244 INQ000426856].

86. On 3 August 2020 the Chief Executive of the Belfast Trust wrote to the Department's Acting Director of Secondary Care to explain that a range of IT and estates issues were in the process of being resolved with regard to the Regional Fertility Centre. Remedial works had been planned in respect of these matters prior to the pandemic, but were unable to be resolved since then, due to other pressing infrastructure works across the Trust. The letter advised that the return of staff to the Regional Fertility Centre would enable elements of fertility services to be introduced from 10 August 2020 [PM/6245 INQ000426857 and PM/6246 INQ000426858].

87. The Health Minister issued a press release on 10 August 2020 [PM/6247 **INQ000373411** welcoming the return of services at the Regional Fertility Centre from that date, on a phased basis. He stated that re-starting fertility services was a priority for him and advised that the Regional Fertility Centre would be opening for extended hours to help mitigate some of the delay by providing appointments to as many patients as safely as possible.

c. Renal Transplant Services

88. Organ donation and transplantation are managed on a United Kingdom-wide basis by National Health Service Blood and Transplant, who work closely with Northern Ireland commissioners and Health and Social Care Trusts to coordinate all organ retrieval and transplantation services. The only solid organ transplants carried out in Northern Ireland are kidney transplants at Belfast City Hospital within Belfast Health and Social Care Trust. In addition to donation after death, it is possible to transplant kidneys from a live donor. Belfast City Hospital is a world leader in deceased and living donor kidney transplant services.

89. While the renal transplant team in Belfast Health and Social Care Trust had successfully utilised downturned theatre capacity at the Royal Victoria Hospital, Belfast during the first wave to carry out a record number of kidney transplants (101) in 101 days between April-July 2020, this was not possible after the first wave as all available theatre capacity was now being used to address the growing backlog in high priority surgery work, including cancer surgery. Together with the rest of the United Kingdom, the Health and Social Care system in Northern Ireland was guided in its prioritisation of limited theatre capacity across all surgical specialties by the latest revision of a Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic [PM/6248 INQ000426860], which was published by the Federation of Specialty Surgical Associations on 24 July 2020.

90. The Department worked closely with the commissioners in the Health and Social Care Board, public health leads within the Public Health Agency, and Health and Social Care Trust renal clinicians, as well as National Health Service Blood and Transplant, to seek ways to mitigate the impact of constrained surgical capacity on patients awaiting both renal access or renal transplant surgery. A detailed account of the steps taken to maintain and restore access to these services is outlined below, including the consideration of options to temporarily relocate the renal transplant service to another Trust site, for which the support of National Health Service Blood and Transplant's Kidney Advisory Group was secured. The Department also met regularly with patient representatives, for example Kidney Care United Kingdom, during this period to understand the impact that limited theatre capacity was having on kidney patients across Northern Ireland.

i. Deceased Donor Transplants

91. Under the Rebuilding Health and Social Care Services Strategic Framework, Belfast Health and Social Care Trust's first rebuilding plan for June 2020 noted that deceased donor transplants would continue and that the transplant team had access to theatres in Belfast City Hospital between the hours of 5pm-8am from Monday to Friday and 24 hours at weekends [PM/6249 INQ000426861]. Belfast Trust confirmed that, whilst there were no imminent plans to resume living donor transplants for adults, as these were not included in any of the four priority levels outlined in the Federation of Specialty Surgical Associations guidance, living donor transplants would be considered in cases where the recipient met the Federation of Specialty Surgical Associations Priority Level 2 (P2) criteria. Belfast Trust also advised the Department on 27 May 2020 [PM/6250 INQ000426862] that it would prioritise living donor transplants for children as Priority 2 and to resume same on 2 June 2020.

92. In response to some NHS Trusts across the United Kingdom citing Federation of Specialty Surgical Associations guidance as rationale for not resuming transplant surgery in the context of limited theatre capacity after the first wave, the National Health Service Blood and Transplant worked with the Presidents of the four United Kingdom surgical colleges to develop a joint statement which was issued to Medical Directors and Chief Executives of all Trusts providing organ transplant services. The statement [PM/6251 INQ000426863 and PM/6252 INQ000426865] confirmed that solid organ transplantation had not been included in Federation of Specialty Surgical Association's surgical priority guidance as it does not lend itself to the categorisation approach used for other surgical specialties. It concluded that, as there was a

backlog of patients requiring assessment, the Colleges strongly supported the restoration of solid organ transplants, with a progression from deceased donation to living donation, with appropriate priority, commensurate with the time-sensitive nature of the surgeries. National Health Service Blood and Transplant asked all United Kingdom transplant centres to submit a Restoration Action Plan (RAP) by 24 July 2020.

93. The Department's Acting Director of Secondary Care wrote to the Belfast Trust on 13 August 2020, enclosing the statement from the Surgical Colleges and asking for a timetable for the phased resumption of transplant surgery [PM/6252 INQ000426865 (as above) and PM/6253 INQ000426866]. A response from Belfast Trust on 8 September 2020 advised that a timetable would be submitted following a planned meeting with Health and Social Care Board and Public Health Agency colleagues in September 2020 [PM/6254 INQ000426868]. It was also confirmed that all clinically appropriate patients who met the Priority 2 category continued to receive surgery and that kidney patients who had previously been matched with unrelated donors through the United Kingdom Living Kidney Sharing Scheme were scheduled to proceed in September 2020.

ii. Proposed Relocation of Renal Transplant Services

94. During a meeting on 18 September 2020 between Health and Social Care Board, Public Health Agency and the Belfast Trust, renal clinicians raised concerns that the living donor service had effectively stopped and advised that they had held constructive discussions with staff in the South West Acute Hospital in Enniskillen, within the Western Health and Social Care Trust, about potentially relocating aspects of the living donor transplant service to there. A summary of the discussion was provided via email on 22 September 2020 by the Health and Social Care Board to the Department's Acting Director of Secondary Care, who issued a reply that day setting out a proposed approach for requesting formal proposals to be developed for consideration by the Department's Rebuilding Management Board [PM/6255 INQ000426869].

95. The Department's Acting Director of Secondary Care subsequently wrote formally to the Acting Director of Commissioning in Health and Social Care Board on 28 October 2020 to ask the Health and Social Care Board to work with the Belfast and Western Trusts to develop a workable proposal for consideration by the Department's Rebuilding Management Board to enable the restoration and/or relocation of the service as soon as possible [PM/6256 **INQ000377014**]. The Health and Social Care

Board developed a draft paper (dated 27 October 2020), for discussion the following week, by the Health and Social Care Board's senior management team on the potential relocation of renal surgery to South West Acute Hospital. The paper noted the need to explore the concerns which had been raised recently by Trust senior management on the appropriateness of moving transplant surgery outside the Belfast Trust [PM/6257 **INQ000377013**].

96. The Acting Director of Commissioning, Health and Social Care Board, subsequently wrote to the Director of Planning, Performance and Informatics in the Belfast Trust, on 13 November 2020, to request an urgent meeting to progress this matter [PM/6258 **INQ000377015**]. The Belfast Trust replied to the Health and Social Care Board on 18 November 2020 [PM/6259 INQ000426874] to advise that:

- There were five pairs and five altruistic donors identified as suitable for the United Kingdom Living Kidney Sharing Scheme from Northern Ireland since 18 December 2019;
- The renal team remained committed to progressing transplant surgery for those matched in the United Kingdom Living Kidney Sharing Scheme (these were to take place by December 2020), including actively seeking transfer of Northern Ireland patients to other United Kingdom transplant centres if surgery could not be carried out in Belfast;
- Renal transplant surgery would be recommenced as soon as possible;
- In the meantime, the Trust remained committed to carrying out priority transplants for highly sensitised kidney patients (these are patients for whom finding a compatible donor is extremely rare and where a suitable match has been found);
- Patients awaiting transplant are prioritised alongside other patients of the same priority rating, and
- The governance risks would not enable transplant surgery to transfer to another Northern Ireland hospital due to the lack of the necessary specialist support services that may be needed in an emergency.

97. On 27 October 2020 the Department's Acting Director of Secondary Care emailed the Medical Director in National Health Service Blood and Transport; firstly, to confirm that Northern Ireland was committed to participation in the forthcoming United Kingdom Living Kidney Sharing Scheme 'run', with a view to transplants between matched pairs taking place in Belfast by December 2020 and, secondly, to seek National Health Service Blood and Transplant's view about the proposal to relocate

the service [PM/6260 INQ000426876]. The enquiry was forwarded within National Health Service Blood and Transplant to its expert Kidney Advisory Group, with a request for the Kidney Advisory Group's clinical opinion regarding the safety of proceeding with kidney transplants during a period of high community transmission of Covid-19, and any risks there may be to immunocompromised patient's post-transplant.

98. On 1 November 2020, the Kidney Advisory Group Chair, replied to the Department advising, on the basis of published clinical evidence, that transplant centres should remain open and continue to perform both deceased and living transplants through the second and third pandemic waves [PM/6261 INQ000426879]. The Kidney Advisory Group acknowledged that, based on hospital pressures (beds, workforce redeployment etc.) or community prevalence, centres may choose to clinically prioritise which patients would remain active on the list, and that the elective nature of living donor kidney transplants meant that these procedures are more susceptible to cancellation when competing bed pressures arise. The Kidney Advisory Group advised that there was unequivocal support that the pandemic should not be a reason to stop children/young people receiving transplants. The Kidney Advisory Group also advised that moving living donor transplant activity to an alternative/new site required planning, careful stakeholder engagement (including with the Human Tissue Authority to ensure any new premises were licensed for such activity) but that this has been successfully done in multiple sites in London (moving from National Health Service to private hospital sites). As such, it could be replicated in any other geographical area as the learning from such moves is easily transferable.

99. On 28 October 2020, Prof John Forsythe, the National Health Service Blood and Transplant's Medical Director for Organ and Tissue Donation and Transplantation, wrote to all United Kingdom Trust Medical Directors that had a transplant centre (including Belfast Trust) to advise of National Health Service Blood and Transplant's plans for a second surge and to advise of the backing of the Royal College of Surgeons to keep transplant centres open [PM/6262 INQ000426880]. However, on 15 November 2020, Belfast Trust announced a further pause in renal transplant surgery, due to unprecedented critical care pressures which led to a significant reduction in theatre staffing [PM/6263 INQ000426881].

100. Theatre staff share many of the clinical competencies required to deliver critical care particularly in management of ventilated patients. At times of pressure, theatre staff

were often redeployed to critical care to support the unit in accommodating increased admissions. This then impacted on the ability of the Trust to maintain theatre activity as planned.

101. The Trust, however, were able to continue to provide assurance that deceased donor kidney transplants would continue to be facilitated for highly sensitised patients, for whom it is extremely difficult to find a suitable match.

102. On 27 November 2020, the Health and Social Care Board and Public Health Agency met with the Belfast Health and Social Care Trust [PM/6415 INQ000000; PM/6416 INQ000000], but no clear plan was agreed for resuming transplant surgery, either in Belfast or the South West Acute Hospital. At that time, Belfast Trust advised that it had a total of 1400 surgical cases meeting the Federation of Specialty Surgical Association's Priority 2 criteria across a wide range of clinical specialties, in addition to renal transplant cases. The Belfast Health and Social Care Trust also ruled out relocating to South West Acute Hospital for renal transplant surgery on safety grounds. The Department's Acting Director of Secondary Care advised senior colleagues via email on 29 November 2020 that there was no prospect of kidney transplants being provided in the foreseeable future. The Permanent Secretary agreed to a discussion on the issue at the Department's Top Management Group meeting on Monday 30 November 2020 [PM/6264 INQ000426882].

103. Following the Top Management Group discussion, it was agreed that National Health Service Blood and Transplant would be approached to carry out a rapid assessment of options to resume transplant surgery in Northern Ireland [PM/6265 INQ000426883]. On 30 November 2020, the Health and Social Care Board approached the Medical Director at National Health Service Blood and Transplant, who agreed to progress discussions on the matter [PM/6266 INQ000426884]. The Health and Social Care Board also wrote to the Belfast Trust to advise of the approach to National Health Service Blood and Transplant, and to advise that the Public Health Agency would liaise with the Belfast Trust to make a formal submission to National Health Service Blood and Transplant as to how a level of capacity could be delivered in Northern Ireland but outside the Belfast Trust. This would then be shared with Kidney Advisory Group to secure further clinical advice regarding any specific proposals [PM/6267 **INQ000377016**].

104. On 11 December 2020, the Health and Social Care Board Director of Commissioning wrote to the Chair of National Health Service Blood and Transplant Kidney Advisory Group seeking advice on proposals to move transplant surgery to the South West Acute Hospital [PM/6268 **INQ000377017**]. The Chair responded to the Health and Social Care Board on 16 December 2020 to advise that the proposals had the unanimous support of the Kidney Advisory Group to move living donor transplants to the South West Acute Hospital [PM/6269 INQ000426887].

105. On 18 December 2020 the Health and Social Care Board wrote to both the Belfast [PM/6270 INQ000426888] and Western Trusts [PM/6271 INQ000426889] to relay the Kidney Advisory Group advice and ask both Trusts to work together to establish a framework for delivery of live-donor activity by mid-January 2021, to include proposals to relocate living donor transplant surgery to the South West Acute Hospital. The Department's Acting Director of Secondary Care also updated senior officials via email about these developments on 18 December 2020 [PM/6272 INQ000426890].

106. On 22 December 2020, the Belfast Trust Medical Director replied to the Health and Social Care Board reiterating the Belfast Trust's view that transplant surgery should not move to the South West Acute Hospital due to patient safety concerns [PM/6273 INQ000426891]. The Health and Social Care Board responded on 28 January 2021 advising that governance arrangements for the South West Acute Hospital would lie with the Western Trust, and requesting that plans for the relocation / resumption of the transplant service should now be submitted by 8 February 2021 [PM/6274 INQ000426892]. Belfast Trust responded on 31 January 2021 advising that it remained concerned on the basis of patient safety about moving the transplant service, clarifying the interpretation of Federation of Specialty Surgical Associations prioritisation guidance in respect of living donor transplants, and advising that it would be of greater assistance to the Belfast Trust's current elective pressures to move some of its other Priority 2 patient cohorts – now numbered at 2100 surgical cases – to the South West Area Hospital instead [PM/6275 INQ000426893 and PM/6276 INQ000426895]. The requested plans for the relocation of the transplant service were ultimately not brought forward by the Belfast Trust but the following weeks saw some resumption of services in Belfast.

107. On 1 March 2021 the Health and Social Care Board provided an update paper [PM/6277 INQ000426896] to the Department via email advising that further to the

involvement of National Health Service Blood and Transplant, revised Federation of Specialty Surgical Associations guidance was issued on 26 February 2021 which included deceased donor transplants in the top priority group (P1) along with deteriorating live donor transplants. Live donor transplants were in the second category (P2) and stable live donor transplants were in the third (P3). It was hoped that these revisions, together with general easing of covid pressures, would allow for an increase in the number of deceased donor transplants and a phased increase in scheduled theatre capacity to recommence the live donor programme in Belfast Trust. The paper anticipated an increase in transplantation on a phased basis from the end of March 2021, subject to continued reduction in Covid-led demand. The paper also advised that discussions were planned with the Belfast and Western Trusts to explore the potential for selected transplants to be carried out at South West Acute Hospital.

108. An update was provided to the Health Minister and senior Departmental colleagues via email on 11 March 2021 [PM/6278 INQ000426897] advising that theatre lists had been confirmed for living donor transplants to resume in Belfast on 22 March 2021, and that dates were secured to transplant those Northern Ireland patients who had been matched with unrelated donors in the United Kingdom Living Kidney Sharing Scheme during the October 2020 matching run. The Belfast Trust also confirmed its commitment to the next planned matching run in April 2021, with resultant transplants expected to be carried out in Belfast during May and June 2021. The update was noted by the Minister on 15 March 2021 [PM/6278 INQ000426897 and PM/6279 INQ000426899].

iii. Resumption of living donor transplants and Renal Surgery Recovery Plan

109. An update on activity from the Health and Social Care Board on 30 March 2021 confirmed that a small number of living donor transplants had taken place on 22 and 29 March and dates were proposed in April and May 2021 for United Kingdom Living Kidney Sharing Scheme surgery [PM/6280 INQ000426900]. On 16 April 2021 the Belfast Health and Social Care Trust issued a statement in response to a media enquiry from the Irish News announcing the recommencement of its renal transplant programme. The statement confirmed that this would include participation and ongoing commitment to the United Kingdom Living Kidney Sharing Scheme, the living donor transplant programme and the deceased donor programme, in line with the Belfast Health and Social Care Trust's service rebuild plans for April – June 2021 [PM/6281 INQ000276353 and PM/6282 INQ000426902].

110. On 14 May 2021 the Belfast Trust's Renal Surgery Recovery Plan was submitted to the Health and Social Care Board [PM/6283 INQ000426903]. This covered the initial period between April – June 2021 and outlined an incremental increase in living donor transplants as follows:

- Week commencing 3 May 2021 - two fixed all-day theatre lists;
- Week commencing 10 May 2021 – two fixed all-day theatre lists plus an additional day to complete United Kingdom Living Kidney Sharing Scheme surgery from the October 2020 matching run;
- Week commencing 17 & 24 May 2021 – allocation of two fixed all-day theatre lists plus an additional flexible day;
- Week commencing 31 May 2021 (bank holiday week) - two and a half all-day theatre lists, and
- Week commencing 7 June 2021 and beyond – four all-day theatre lists.

111. The plan anticipated that the backlog of patients waiting for surgery would be cleared by August 2021. In addition, it was planned that those transplants identified in the United Kingdom Living Kidney Sharing Scheme April 2021 matching run would undergo their transplants within four months.

112. The living donor pre-assessment service was restored to pre-pandemic activity levels on 31 March 2021, and it was anticipated that those patients would undergo their surgery from August 2021 onwards. The plan also confirmed that deceased donor transplants would need to be accommodated out of normal working hours to ensure that no patients scheduled for time-critical surgery were cancelled.

113. On 12 August 2021 an update provided to the Department of Health by the Health and Social Care Board confirmed that theatre access for elective renal surgery, including transplants, was at 30% of pre-covid capacity [PM/6284 INQ000426904], which was in line with other elective surgeries. Contingency plans were also being developed by the Health and Social Care Board to transfer planned living donor transplant surgeries to providers in Great Britain in the event that the Belfast Health and Social Care Trust would be unable to deliver this as planned (due to further unscheduled pressures) for those identified in the United Kingdom Living Kidney Sharing Scheme [PM/6285 INQ000426906].

114. On 31 August 2021 a further update from the Health and Social Care Board confirmed that, with the improving Covid-19 position, renal surgery had further increased to 4 sessions a week, i.e., 50% of pre-covid capacity [PM/6286 INQ000426909]. On 10 September 2021 a further update from the Health and Social Care Board confirmed that the deceased donor transplant programme had fully resumed and was now open to all offers of organs [PM/6287 INQ000426912]. On 17 September 2021 a further update from the Health and Social Care Board to the Department of Health confirmed that all patients awaiting kidney transplant had been cleared, with the exception of two, who were clinically unsuitable [PM/6288 INQ000426913].

115. The service remained susceptible to unscheduled pressures, and the deceased donor service experienced a further downturn between 10-12 November 2021. This was due to the latest surge in Covid-19 Intensive Care Unit admissions requiring the Belfast Health and Social Care Trust to open another two Intensive Care Unit beds which required nursing staff to be deployed to the Intensive Care Unit from emergency theatres (where transplants take place) [PM/6289 INQ000426914]. An update from the Belfast Health and Social Care Trust on 12 November 2021 confirmed that, following an easement of Intensive Care Unit pressures, the deceased donor programme had now fully resumed [PM/6290 INQ000426915].

d. Orthopaedic Treatment

116. The Department of Health commissioned a blueprint document [PM/6231 INQ000426834] to provide a programme of work to quickly rebuild Orthopaedic Care, provided by the Health and Social Care Trusts, to address the aftermath of the first wave of the Covid-19 pandemic. The new service delivery model outlined in the blueprint provided the basis for protecting orthopaedic care, in the event of further waves of Covid-19, by ring-fencing this service in dedicated delivery centers. The new model also provided the basis for transforming the delivery of orthopaedic care over the medium to long-term.

117. Further to the blueprint document, in February 2022 as part of Health and Social Care Rebuilding, the Department commissioned consultants from the Royal National Orthopedic Hospital and 'Getting it Right First Time' (GIRFT) Projects Directorate to undertake a rapid review of the Northern Ireland Orthopedic Service. The key aim of the review was to identify actions to increase activity in the short term with the overall of aim of building a sustainable service for the future. A report was presented to the

Department of Health in June 2022 detailing 21 recommendations, all of which were accepted, and work is underway to implement same [PM/6292 INQ000348866].

118. Since the publication of the GIRFT review and the Department's acceptance of its recommendations, significant progress has been made on implementation across many areas within the orthopaedic service in a relatively short period of time. Notable achievements include the establishment of an Orthopaedic Surgery Recovery Board, which meets on a regular basis, and which has the full engagement between key stakeholders from across all Health and Social Care Trusts. There is also the successful recovery of services at Musgrave Park Hospital, and fully embedded situation reporting from Trusts to the Department to support effective performance monitoring and management.

119. Focus will continue on taking forward remaining operational GIRFT actions, but also on moving beyond rebuilding objectives to focus on other and new ways to improve performance and service delivery in orthopaedics.

e. Cancer Services

i. Response

120. The Regional Cancer Covid Response Group first met on 30 March 2020 to draw up a response on Maintaining Cancer Care during Covid-19, acknowledging the risk and benefits of proceeding with planned treatment for cancer patients as cancer treatment added to the risk of significant adverse effects from Covid-19 infection. This group produced a paper to the Department of Health in April 2020 which outlined the key measures to support essential cancer diagnostics and treatment during the pandemic [PM/6293 INQ000376995]. This paper covered regional tumour site guidelines, continuation of multidisciplinary meetings, use of independent sector for diagnostics and treatment, safety netting to ensure patients whose treatment has been delayed resumed on the appropriate pathway once safe to do so, changes to cancer information systems and communication with patients.

121. The Northern Ireland Cancer Network worked with the Trust cancer specialists and cancer service managers across Northern Ireland to develop a regional approach to ensure a robust and equitable delivery of cancer services during the pandemic. Northern Ireland Cancer Network produced regional guidelines for 17 tumour sites to encompass all diagnostic and treatment modalities and to provide guidance on the

continuance of multidisciplinary meetings (MDMs). In addition to this the Northern Ireland Cancer Network Systemic Anticancer Therapy Clinical Reference Group agreed the Northern Ireland systematic anti-cancer therapies Response, and the Northern Ireland Cancer Network Radiotherapy group also agreed a Regional Radiotherapy Response plan.

122. Steps were taken immediately to reduce face to face visits, waiting times on site, and assessment and management of cancer patients with suspected Covid-19 in line with National Institute for Health and Care Excellence guidance. Staff also followed extant public health guidance in relation to suspected infection and self-isolation. Cancer specialists actively discussed additional risks posed by Covid-19 infection with their patients to help them decide on the best course of action such as whether to proceed with standard therapy, switch to alternative treatment or to stop or delay treatment.

123. The Regional Cancer Covid Response Group met daily in the first month of the pandemic with reducing frequency until mid-May 2020 when this group was stood down and replaced by the Cancer Reset Cell [PM/6294 INQ000426919]. The aim of this new group was to to oversee 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]. The Cancer Reset Cell met weekly or fortnightly from June 2020 until August 2021 and monthly from September 2021 until August 2022.

124. 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.

ii. Diagnostic Screening

125. The Public Health Agency had suspended cancer screening programmes in mid-March 2020 (including routine breast screening, bowel cancer screening and cervical screening) due to competing pressures as a result of the pandemic [INQ000120730]. Phased restoration of the paused screening programmes commenced as follows:

- Routine breast screening restarted from mid-July 2020;
- Bowel cancer screening invites recommenced from mid-August 2020, and
- Cervical screening invitations recommenced from end June 2020.

126. While the above programmes were paused due to Covid-19, screening continued to be offered to people who required higher risk breast screening - all eligible women continued to be screened at the higher risk screening unit in Antrim Area Hospital.

127. Diagnostic Imaging Services were fundamental to the Covid-19 response and all modalities provided access to key imaging investigations throughout the pandemic period and into rebuild and recovery. Modalities, such as computer tomography scanning (CT), had only minimal reduction in activity during the pandemic period.

128. The initial imaging response was an evaluation of extant reporting arrangements within individual Trusts and in-house reorganisation of resources to maintain in and out of hours cover. Secondly, a regional Radiology Reporting Contingency Plan was developed in April 2020 which outlined the arrangements that would be triggered in the event that any individual or number of Health and Social Care Trusts were unable to maintain on-call reporting due to staff absence for Covid-19. The actions included increased support for home reporting, "buddying up" with a neighbouring Trust to cross-cover reporting and, if required, a move to single reporting lists for the region if multiple Trusts were impacted. Weekly monitoring was undertaken by Health and Social Care Board until it was agreed to step down to exception reporting. The Contingency Plan did not need to be activated.

129. Northern Ireland Cancer Network supported the production of the Cancer Imaging Prioritisation Guidance [PM/6301 INQ000377002] in April 2020 to ensure access to imaging for red flag investigations, notably securing funds to appoint additional radiographers in all Trusts to assist with continuation of scanning services at times of

staff absence; securing and allocating a range of imaging equipment from the National Health Service England supply for Covid-19 contingency; supporting Trust bids for additional imaging equipment and additional computer tomography sessions. All of this was underpinned by creation of a weekly imaging waiting list dashboard which enabled monitoring of waiting times by clinical priority.

130. As per national guidance, all endoscopy procedures, with the exception of emergency procedures, ceased in March 2020 due to the pandemic. In response to this, the Northern Ireland Cancer Network introduced guidance on the use of the quantitative faecal immunochemical test (qFIT) in secondary care in May 2020 to risk stratify red flag (suspect bowel cancer) and urgent patients were referred to Trusts who were waiting a scope or outpatient appointment. This enabled the identification and investigation of patients who had the greatest predicted chance of bowel cancer. The quantitative faecal immunochemical test was also introduced to primary care in the summer of 2021.

131. All cancer patients were prioritised in all Trusts for rapid Covid-19 (and later flu and Covid-19) screening to allow faster admission into oncology/haematology wards, including Polymerase Chain Reaction (PCR) testing in Emergency Departments for admission into high-risk units with immune-compromised patients.

iii. Surgical treatment

132. The Health and Social Care Board developed proposals for redistribution of cancer surgery across Trusts to maximise treatment capacity and equalise waiting lists (based on clinical priority) where possible. A regional prioritisation group was set up and implemented by the Federation of Surgical Specialty Association 'Clinical Guide to Surgical Prioritisation in the recovery from the Coronavirus Pandemic'. More detail and any relevant exhibits on elective diagnostics and surgery provision throughout the pandemic is provided elsewhere in this statement. Where necessary and feasible, patients were offered alternative treatment plans as an alternative to surgery including systematic anti-cancer therapies and radiotherapy treatments.

iv. Systematic anti-cancer therapies (SACT) (includes chemotherapy, targeted therapy and immunotherapies).

133. Systems were introduced in March 2020 to reduce footfall at clinics and to protect staff and patients. These included telephone consultations; moving patients to oral systematic anti-cancer therapies, where possible; extended prescription supplies of systematic anti-cancer therapies and supportive medications; and implementation of

a medicine delivery service. Northern Ireland Cancer Network agreed the Northern Ireland Systematic anti-cancer therapies response to Covid-19 in April 2020 which included a systematic anti-cancer therapies contingency prioritisation plan for treatment prioritisation in the event of serious service disruption for both oncology and haematology patients in line with National Institute for Health and Care Excellence guidance.

134. The paper [PM/6302 INQ000376999] was written by Belfast Health and Social Care Trust and was endorsed by the Northern Ireland Cancer Network Systemic Anti-Cancer Therapy Clinical Reference Group (CRG). The paper outlined staffing principles; patient prioritisation; risk benefit of cancer treatment; case by case assessment and specific measures for haematology systematic anti-cancer therapies capacity. Treatment prioritisation was in accordance with National Institute for Health and Care Excellence and the National Health Service England patient categorisation based on absolute benefit from treatment.

135. The Northern Ireland Cancer Network agreed consistent approaches to testing and implementation of Infection Prevention and Control (IPC) guidelines for systematic anti-cancer therapies units. Oncology and haematology patients were provided with updated guidance on shielding, testing and vaccination throughout the period [PM/6303 INQ000377058 and PM/6304 INQ000426942].

136. The Network developed protocols for lymphoma, myeloma and Myeloproliferative neoplasm (MPN) patients and switched these patients to oral systematic anti-cancer therapies or subcutaneous systematic anti-cancer therapies, where possible [PM/6305 INQ000426943; PM/6306 INQ000426944 and PM/6307 INQ000426945]. Decisions with regard to haematopoietic stem cell transplant (HSCT) were taken in line with national guidance. During the initial stages of the pandemic, haematopoietic stem cell transplants were paused although no patients were affected, and the service resumed in early May 2020 with risk assessment and adaptions to approach in place to allow transplants as defined by National Institute for Health and Care Excellence.

v. Radiotherapy

137. As part of the Department of Health Covid-19 response paper (April 2020), both radiotherapy departments developed a Radiotherapy Covid-19 Response plan [PM/6308 INQ000377000] which sought to stratify an appropriate adjustment of the clinical services, dependent upon staffing levels. This covered treatment principles,

staffing principles, general measures to protect patients and staff, and response in event of staff shortages for all patients on treatment and those patients who had not yet started treatment. Prioritisation of all patients was based on National Institute for Health and Care Excellence guidelines.

138. To reduce footfall at clinics and minimise risk to patients and staff, in the early period of the pandemic, patients due to commence radical radiotherapy for prostate cancer and having neo-adjuvant hormone therapy were required to have their treatment deferred. The disease biology of this group of patients allowed for a delay in radiotherapy treatment if hormone treatment was ongoing. Prostate radiotherapy was reinstated in June 2020. A Covid-19 Radiotherapy Guidelines Clinical Protocol was developed by Belfast Health and Social Care Trust in response to the pandemic to provide guidance on dose, fractionation and imaging. The protocol allowed the Radiotherapy Team to reduce patient time in the department, limit the chance of treatment delays and manage potential reduced capacity.

vi. Prioritisation of Cases

139. The expected increase in hospital demand combined with increased staff absence levels meant that Trusts were facing major challenges in being able to provide medical and nursing staff to care for Covid patients. Pressures varied across and within Trusts and there was an acknowledgement that limited scheduling and cancellations were already taking place at a local level. At a regional Silver Command meeting on 31 December 2020, Trust Chief Executives sought approval to significantly downturn elective activity to release clinical and administrative staff to be redeployed to the front line. Gold considered the request and subsequently sought confirmation of regional agreement for time critical services/exemptions. Given the very challenging operational context and the significant additional pressures anticipated it was proposed that with immediate effect a regional prioritisation mechanism was established for the allocation of the limited available in-house and Independent Sector capacity based on clinical priority irrespective of postcode.

140. The Regional Prioritisation Oversight Group 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.

141. An initial planning meeting was held with Health and Social Care Trusts' representation on 11 January 2021. 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). This sub-categorisation was included within the Regional Prioritisation Oversight Group Terms of Reference.

142. Health and Social Care Trusts submitted weekly prioritisation data by close of play each Friday, and an analysis by specialty and HSC Trust was undertaken in advance of the weekly Regional Prioritisation Oversight Group meeting. This data helped identify emerging pressures and allowed for early interventions including inter-Trust transfers or increased access to theatre capacity both inhouse and in the Independent Sector. Examples of co-operation included the provision of all day theatre lists in the South West Acute Hospital, Enniskillen in the Western Health and Social Care Trust; provision of regional urology lists in Craigavon Area Hospital in the Southern Trust, and inter-Trust transfers of colorectal, laparoscopic nephrectomies and breast patients.

vii. Rebuilding Cancer Services

143. In an urgent oral statement to the Assembly on 6 October 2020 [PM/6312 INQ000276509] the Minister announced his intention to publish, on 7 October 2020, a policy statement setting out important plans for rebuilding and stabilising cancer services, including oncology and systemic adjuvant chemotherapy (SACT) services, as well as haematology services [PM/6313 INQ000426954]. These plans were intended to take immediate action to increase capacity and ensure that the services were sustained over the weeks and months during the potential 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.

144. In an oral statement on 13 April 2021 the Minister [PM/6314 INQ000276438] informed the Assembly that his Department was finalising a Cancer Recovery Plan, 'Building Back - Rebuilding Better'. This plan would make recommendations to redress the disruption to cancer services caused by the pandemic. The Plan would also be fully aligned with the short-term recommendations in the Cancer Strategy.

145. Minister Swann 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. As set out in the Cancer Recovery Plan, an additional investment of £108 million was required.

146. The Information and Analysis Directorate received elective cancellations data for suspected and confirmed cancer patients from the Health and Social Care Board and the Information and Analysis Directorate reported on the total cancellations which was shared internally within the Department. Trusts began to submit data to the Health and Social Care Board on a daily basis from 14 March 2020, detailing the number of elective cancellations of patients booked for Inpatient or Day Case Admission and who were either Suspect or Confirmed (Red Flag) Cancer cases. This data was recorded based on PAS Covid Technical Guidance distributed to all Trusts.

147. From 14 March 2020 to 31 December 2021, the data collated detailed that Trusts cancelled 581 Inpatient Admissions and 5,861 Day Case Admissions of patients who were either Suspect or Confirmed (Red Flag) Cancer cases. During this time period from 14 March 2020 to 31 December 2021, there was a total of 72,000 Elective Admissions of patients coded as either Suspect or Confirmed Cancer cases (Inpatients = 9,000 /Daycases = 63,000). During the pandemic Trusts developed green pathways in other sites and across a range of specialties which allowed further activity to be delivered.

e. Children and Adolescent Mental Health

148. At the outset of the pandemic, the Public Health Agency and the Health and Social Care Board developed a recovery plan for Child and Adolescent Mental Health Services with an overarching aim to deliver a regionally consistent health and social care response to the delivery of children's mental health services through the pandemic and shared this with the Department in July 2020 [PM/6316 INQ000426966]. The recovery plan was developed in recognition that there was likely to be an increase in both the acuity and number of referrals to Mental Health Services due to stressors arising from the impact of Covid-19 and the measures taken to reduce the risk of spread and infection. The key objectives of the plan were prevention, mitigation and reset and recovery. As a result, Children and Adolescent Mental Health Services adjusted their models of delivery to address immediate priorities and to maintain a level of continuity, ensuring children and young people were reached and provided with the help they needed.

149. The use of electronic platforms in appointments and communications with young people was promoted to help provide quicker access to services. For example, Trusts carried out appointments by telephone and video conferencing (e.g. Zoom), where clinically appropriate to do so, to ensure mental health treatment and intervention did not cease during the pandemic. Trusts also came up with innovative ways to continue to deliver services while taking account of the restrictions such as offering extended hours of service, including evening and weekend working.

150. The Department of Health published the Covid-19 Mental Health Response Plan as part of the wider Mental Health Action Plan [PM/6317 **INQ000325176**]. This Plan included a dedicated CAMHS workstream and other actions to provide support to young people, including:

- The development of an online apps library to help and support self-help, and
- Production of key resources for children and young people and their mental health and wellbeing, specifically in relation to managing the impact of Covid-19.

151. The ORCHA Apps Library was developed by the Health and Social Care Board, together with support from the Department of Health, provided a one stop shop for the public to access safe, evidence-based, secure, and effective apps to assist them with their wellbeing during the Covid-19 pandemic. The Apps Library was designed

to provide additional support to people to help them stay well at home by supporting their psychological wellbeing and good mental health when face to face meetings were not possible [PM/6318 INQ000426968].

152. During 2020/21, an additional investment of £1.35m was made to Children and Adolescent Mental Health Services to address inescapable pressures such as recruitment and uplift. This additional investment was used to maintain existing services and strengthen clinical and support staff across Step 2 and Step 3 Child and Adolescent Mental Health Services, assisting the service to deal with the increase in demand across the region. A further recurrent allocation of £910k to address these pressures was made in in 2021/22.

153. An additional investment of £186k was made to the Belfast Health and Social Care Trust to support the establishment of a Managed Care Network for acute services in 2020/21. This investment was to enable clinical expertise, specifically in relation to young people in crisis, to be shared across the region.

154. The demand for inpatient services at the Beechcroft inpatient unit remained high during 2021/22. These pressures were largely caused by a higher number of young people presenting to the service with higher levels of acuity in relation to eating disorders. An additional investment of £500k was made to the Health and Social Care Board for Children and Adolescent Mental Health Services to assist with alleviating pressures within the community. The funding was increased to a total of £1m in 2022/23.

155. In addition, £455k for in year pressures was provided to Trusts as part of Covid response. The initiatives implemented included the piloting of an intensive day treatment programme for children with mild to moderate presentations of eating disorders or eating difficulties within the Belfast and South Eastern Health and Social Care Trusts. This pilot provided an intensive programme as an alternative to inpatient treatment and aimed to reduce bed pressures within the regional inpatient facility at Beechcroft.

156. Additionally in 2021/22, £1.7m (£1.5m from the Department of Health and £200k from the Department of Education) funding was agreed for the next 3 years to support the implementation of Emotional Wellbeing in Schools Teams. This is a joint initiative with the Department of Education and forms a key element of the Emotional Health

and Wellbeing in Education Framework. The Emotional Wellbeing in Schools Team service aims to promote the emotional wellbeing of children, build individual and collective resilience and most critically, provide intervention at the earliest opportunity.

157. In February 2021, work was undertaken to review the Still Waiting Action Plan to ensure it reflected new priorities post Covid-19 and recommendations outlined in Northern Ireland Commissioner for Children and Young people's monitoring report as well as other strategic developments, such as the new Mental Health Strategy [PM/6319 INQ000426969 and PM/6320 INQ000426970].

158. More broadly, the Mental Health Strategy 2021-2031, launched on 29 June 2021, set out a number of key strategic actions to further improve the emotional wellbeing and mental health of our children and young people over the next decade [PM/6321 **INQ000348775**]. From a Children and Adolescent Mental Health Service perspective, strategic priorities include:

- Promoting positive social and emotional development throughout childhood;
- Providing enhanced and accessible mental health services for those who need specialist support, including children and young people with disabilities, their parents and families;
- Increasing funding for CAMHS to 10% of overall mental health budget, and
- Creating clear and consistent urgent, emergency and crisis services to children and young people.

159. The Mental Health Strategy also includes other priority actions, which will directly benefit children and young people in need of mental health support and assist with improving overall Children and Adolescent Mental Health Service's performance. Most notable among these is the commitment to establish a new regional crisis service, which will seek to provide a regional approach to mental health crisis interventions as well as the completion of a comprehensive workforce review designed to consider the existing workforce need and training, as well as the development of a new workforce.

160. Implementation of the Mental Health Strategy is being facilitated by way of annual delivery plans and full implementation is subject to securing significant additional investment.

161. It should be noted that referrals to Children and Adolescent Mental Health Services decreased during the pandemic and this may have been as a result of young people delaying seeking care/unable to access appointments with General Practitioners due to the national lockdown. In 2020/21 the number of accepted referrals to Child and Adolescent Mental Health Services was 8,719 which was a decrease of 2,606 referrals (23%) on the previous year. The number of young people waiting for an initial appointment with Child and Adolescent Mental Health Services also decreased during the pandemic. For example, as at 31 December 2019 there were 1,810 children and young people waiting for an initial appointment with Child and Adolescent Mental Health Services in comparison to 1,310 waiting as at 31 December 2020, representing a decrease of almost 28% [PM/6322 INQ000426972]. This was largely considered to be as a result of the more flexible appointments and the use of electronic platforms.

162. In terms of other areas where the public may have delayed seeking treatment, assessment was also carried out and figures have been analysed for the following services for the years 2018/19, 2019/20 and 2020/21:

- Referrals to Consultant-led Outpatient Services
- Red Flag Referrals for Suspect Breast Cancer
- Red Flag Referrals for 31/62 Cancer Pathways
- Referrals to Adult Mental Health and Psychological Therapy Services
- Attendances at Emergency Departments

These are outlined in the [PM/6323 INQ000426973].

163. Analysis shows a reduction in the level of Referrals/ED Attendances in the 2020/2021 year when compared to 2018/2019 for all the services reviewed as follows:

- 28% reduction in Referrals to Consultant-led Outpatient Services
- 2% reduction in Red Flag Referrals for Suspect Breast Cancer
- 8% reduction in Red Flag Referrals for 31/62 Cancer Pathways
- 33% reduction in Referrals to Adult Mental Health and Psychological Therapy Services
- 24% reduction in Attendances at Emergency Departments

3. Do Not Attempt Cardio-Pulmonary Resuscitation Orders

164. 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]. 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.

165. The responsibility for making a Do Not Attempt Cardiopulmonary Resuscitation order rests with the senior clinician who has clinical responsibility for the patient during that episode of care. A Do Not Attempt Cardiopulmonary Resuscitation decision should be made in conjunction with other members of the multidisciplinary team including the patient's General Practitioner.

166. Prior to March 2020 two Health and Social Care Trusts had Clinical Ethics Committees in place with representation from senior clinical and social care staff as well as lay representation. Cases could be referred to the Trust Clinical Ethics Committees for advice and guidance by the clinical team. Many such referrals related to best interest decisions[3] where patients lacked capacity. Some decisions may also be referred for legal opinion.

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[3]When a person lacks the mental capacity to make a specific decision about their treatment at that time and does not have a valid and applicable Advance Decision to Refuse Treatment (a set of instructions detailing specific circumstances in which the person would not want certain treatments or would want a particular treatment to be stopped. They are legally binding in Northern Ireland under common law providing the health and social professional is aware of it.), the clinician treating the person will make a 'best interests' decision(s). The clinician who is treating the person would base their best interest decision(s) on the principles provided for under section 7 of the Mental Capacity Act (NI) 2016 and on their experience and understanding of the person's circumstances and be informed by the person's prior anticipatory care planning conversations. Decisions cannot be made on the basis of assumptions based solely on factors such as the person's age, disability, or on a professional's subjective view of a person's quality of life.

167. 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.

168. All Health and Social Care Trusts established Clinical Ethics Committees linked to the regional Forum and participated in the development of regional guidance. 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.

169. The Department considered reissuing a Do Not Attempt Cardiopulmonary Resuscitation form for use during the pandemic but on the advice of the Regional Clinical Ethics Forum identified the need for further work to develop a single integrated process for Advance Care Planning to support the Do Not Attempt Cardiopulmonary Resuscitation process. It should be noted that the Department did not *seek* advice from the Covid-19 HSC Clinical Ethics Forum on the reissuing of the Do Not Attempt Cardiopulmonary Resuscitation form for use during the pandemic; instead, the Chair of the Forum became aware that the Department was considering reissuing the form through the clinicians in the Forum who were concerned by timing of any reissue. The Chair, along with a number of Forum members, subsequently met with departmental officials to raise their concerns. The work was subsequently commissioned by the Chief Medical Officer, co-produced through extensive consultation and approved by Minister for publication in October 2022. In the interim period the Covid-19 Guidance: Ethical Advice and Support Framework supported DNACPR decision making for clinical teams.

170. Early in the pandemic, an issue was raised to Health Gold Command from Health Silver about the non-transferability of DNACPR between acute and community settings. Silver sought clarity in relation to a transferable form that had previously been developed but had not been verified by the Department and whether that might

be made available to practitioners. In practice, this could mean that wishes not to be resuscitated expressed in an acute setting may not be given effect in a community setting [PM/6417 INQ000000 and PM/6418 INQ000000].

171. The Department considered the potential to implement the regional form with supporting operational guidance for clinicians for its use. This included engaging with colleagues in the then Health and Social Care Board, during which a number of issues were identified around the practicalities that would be required to be put in place to support this. The Department also had engagement with the newly established Covid-19 Ethics Forum after the issue was discussed at the Ethics Forum, where clinicians had expressed concern about the need to have appropriate guidance and training in place to support a regional form.

172. It was also recognised that discussions and decisions relating to cardiopulmonary resuscitation should be part of a wider holistic approach to Advance Care Planning. As a result of these considerations, it was agreed that the issue of transferability should be referred back to be progressed by Health Silver, to include development of an implementation plan to ensure that operational guidance on Advance Care Planning and guidance to support the implementation of a regional DNACPR form be progressed and finalised [PM/6419 INQ000000; PM/6420 INQ000000].

173. Coming out of this, an Advance Care Planning lead was identified to progress this area of work. It was proposed that a regional Advance Care Planning policy for adults should be developed which would include within it wishes and preferences for future care. The policy would also include DNACPR and the standardisation of the recording and transferability of DNACPR decisions, underpinned by training for staff and public awareness. In September 2020, the development of the Advance Care Planning policy for adults was commissioned by the Chief Medical Officer [PM/6421 INQ000000; PM INQ000480763 and approved by the Minister [PM/6423 INQ000000; PM/6424 INQ000000].

174. The Clinical Ethics Forum was a Reference Group for the development of the Advance Care Planning policy and the Forum Chair was also a member of the policy Steering Group. The policy was developed on a co-production approach which involved extensive engagement and consultation. It was approved by Minister for publication in October 2022. In the interim period the Covid-19 Guidance: Ethical

Advice and Support Framework supported DNACPR decision making for clinical teams [PM/6325 INQ000363462].

175. The Department was aware of the Care Quality Commission report published in March 2021. A number of correspondence cases and Assembly Questions were raised following its publication. In terms of DNACPR in Northern Ireland, established clinical and professional guidance was in place to support clinicians in decision-making and providing quality treatment and care for people towards the end of life. This included the General Medical Council's '*Treatment and care towards the end of life: good practice in decision making'* and The British Medical Association, Resuscitation Council and the Royal College of Nursing guidance '*Decisions relating to Cardiopulmonary Resuscitation*'.

176. The Regional Covid-19 Guidance Ethical Advice and Support Framework for Northern Ireland, published in June 2020 and updated in September 2020, was also already in place to assist and support clinical decision making during the COVID-19 pandemic [PM/6325 INQ000363462]. The Framework set out a series of ethical principles in a rights-based approach and applied at all levels of health and social care. It also emphasised that all clinical staff are required to act in accordance with professional guidance and with their legal obligations.

177. The Framework was developed by the regional HSC Clinical Ethics Forum, with membership drawn from a wide range of clinicians from health and social care, representatives from HSC Trust Clinical Ethics Committees, representatives from the Critical Care Network, Palliative Care in Partnership and the Frailty Network, as well as a range of lay members including hospital chaplains. The Forum also engaged with a number of interested parties (such as the Patient and Client Council and NI Ambulance Service) and reference groups (such as Disability Action and the Alzheimer's Society) at different points in the development of the Framework.

178. The Resuscitation Council has recommended integrating resuscitation decisions with other treatment decisions, such as invasive mechanical ventilation, in overarching advance emergency care treatment plans through the use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process which would increase clarity of treatment goals and prevent inadvertent deprivation of other indicated treatments. In Northern Ireland it is proposed that the ReSPECT process

will be introduced as part of the implementation of the Advance Care Planning programme. Planning for this is ongoing.

4. Rebuilding Health and Social Care Services following Wave 1

179. In addition to the specific actions detailed above, a new temporary Department of Health Management Board for Rebuilding Health and Social Care Services was established in June 2020 and reported directly to the Minister through the then Permanent Secretary, Richard Pengelly, (as Chair). It was given the responsibility for providing oversight and direction to the Health and Social Care Board, the Public Health Agency, the Health and Social Care Trusts and the Business Services Organisation on the implementation of the Department's 'Rebuilding Health and Social Care Services Strategic Framework' [PM/6326 INQ000348873].

180. Under the Strategic Framework, the Health and Social Care Board, Public Health Agency, Health and Social Care Trusts and the Business Services Organisation from June 2020 were asked to prioritise their service planning, delivery, and deployment of resources to stabilise and restore service delivery as quickly as possible by achieving the right balance between delivering Covid-19 and non-Covid-19 activity. In this context the Health and Social Care Care Trusts published their first set of Rebuild Plans covering the month of June 2020, and thereafter developed Rebuilding Plans in three-month phases from July - September 2020 (Phase 2) until January – March 2022 (Phase 8). However, it should be noted that due to further surges in COVID-19 it was agreed that service rebuilding plans would not be developed for the periods October – December 2020 (Phase 3) and January – March 2021 (Phase 4) [PM/6327 INQ000130386]. The term 'Rebuilding Plan' was replaced by 'Service Delivery Plan' from July 2021 (Phases 6 – 8).

181. Individual Health and Social Care Trust Rebuilding/Service Delivery Plans for 2020/21 and 2021/22 [PM/6327 INQ000130386 (as above) and PM/6328 INQ000426978] prioritised activity designed to stabilise and restore service delivery as quickly as possible at the Trust level of local commissioning and through regional collaboration with other Trusts guided by the Department's 'Rebuilding Health and Social Care Services Strategic Framework'. The performance targets set out in the Commissioning Plan Direction, Service and Budget Agreements, and Trust Delivery Plans for the financial year 2019/20 would be reviewed by the Department to determine the optimum method for assessing the performance of Health and Social

Care Trusts in the delivery of services during the period of the Covid-19 emergency in the years 2020/21 and 2021/22.

182. Accordingly during the second and third waves of the pandemic (late August 2020 to April 2021 and late July 2021 to May 2022), the Health and Social Care Board working with the Public Health Agency reviewed the Health and Social Care Trusts' Rebuilding/Service Delivery Plans and related activity information to assess whether they provided a satisfactory level of detail on the progress of each Trust in rebuilding and delivering services in response to pandemic-related pressures. The Health and Social Care Board's assessments were submitted to the Department of Health Rebuilding Management Board for Health and Social Care services to consider and sign-off before Trust plans were published for each phase. Papers covering the assessment of the plans were submitted to the Rebuilding Management Board on 24 June 2020, 26 August 2020, 23 September 2020, 30 September 2020, 13 January 2021, 10 March 2021, 31 March 2021, 19 May 2021 and 26 May 2021.

183. On 9 July 2021, in a letter to the Health and Social Care Board, the Department of Health set out a number of short and medium term actions required to address the challenges faced by the Health and Social Care system [PM/6329 INQ000348889].

184. As part of the medium-term action, the Health and Social Care Board was requested to start the process for local and regional resilience planning for winter 2021/22. This request was in response to discussions in relation to planning for the forthcoming winter and further Covid-19 surges. The Department of Health advised that the context for winter 2021/22 was different in that Covid-19 surge planning were to be incorporated into health and social care plans.

185. In line with the Departmental direction, a revised planning approach for Phase 7 (Oct-Dec 21) and Phase 8 (Jan-Mar 22) was put in place.

186. The Health and Social Care Board provided Trusts with key planning assumptions on issues such as Covid-19 modelling scenarios, detailed bed modelling, flu, Respiratory Syncytial Virus and the regional approaches to management of critical care, respiratory services, unscheduled care and elective care. This enabled Trusts to adapt their delivery plans and set out their approach to winter / surge planning.

187. In addition to a number of key regional areas identified by the Health and Social Care Board, the regional guidance provided to Trusts sought to ensure the following Departmental priorities were addressed:

- Scenario planning/modelling assumptions for bed occupancy levels, including approaches to ensure that the staff were available within Trusts to respond to surges in demand. This would include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period;
- The management of elective care, particularly in relation to prioritising red flag and urgent patients, including regional approaches and the delivery of any associated actions in the Elective Care Framework for the period to March 2022;
- Preparation for flu activity to respond to any potential surge in demand, particularly if this were to occur over the extended holiday period and with the associated seasonal staff sickness absence;
- Preparation for a likely spike in Respiratory Syncytial Virus infections and the impact on paediatric services;
- Care planning for frail and elderly patients, both in the community and residential care, and those with long term conditions particularly in advance of the Christmas/New Year holiday period;
- Arrangements for Multi-Disciplinary Team discharge planning/community capacity so that this would be available over weekends and holidays;
- Resilience plans for the General Practitioner Out of Hours Service, access to General Practitioner services and Community Pharmacy over the Christmas / New Year holiday period, including related public communications about using Emergency Department services wisely;
- The main potential risks and proposed mitigating action, particularly in relation to the most vulnerable Emergency Department sites, including any regional management unscheduled pressures;
- Regional management of Intensive Care Units and respiratory pressures;
- resilience planning undertaken by Northern Ireland Ambulance Service, and
- Communications planning (internal and external).

5. Public Health Messaging

188. As the response to the pandemic became extended beyond the first wave there were growing concerns from health professionals and professional organisations that people were avoiding seeking health care when it was in fact appropriate and

necessary to seek health care. The Health Minister and the Department issued public statements to make clear that the health service was still providing treatment and care and recommended that people should not delay seeking care and advice. While both elective throughput and Emergency Department attendances did reduce throughout the pandemic, this reduction was likely due to several factors. These factors included the need for social distancing within health and social care facilities for IPC reasons, the fact that a number of people who would otherwise be using services were shielding and the impact of general advice to control infection with Covid-19 on both staff and patients. The following statistics are illustrative of the basis of the general concerns:

- Emergency Departments attendances decreased by 26.2% (219,719) from 839,706 in 2019/20 to 619,987 in 2020/21 during the period of the Covid pandemic. Data published by Information Analysis Directorate (IAD) in the Department in August 2021 [INQ000408138];
- The routine monitoring by the HSCB of hospital referral activity showed a 28% decrease in GP referrals to Consultant-led Outpatient services between 2019/20 and 2020/21 from 395,372 to 282,094; and interim evidence collated by IAD in December 2020 and published [INQ000408139] related the impact of the pandemic, with increases in Elective waits.

189. Furthermore, additional information was available from the (Northern Ireland Statistics and Research Agency (NISRA) Coronavirus (Covid-19) Opinion Survey which ran from April 2020 through to March 2022 and was designed to measure how the Coronavirus (Covid-19) pandemic was affecting peoples' lives and behaviour in Northern Ireland. The NISRA Coronavirus (Covid-19) Opinion Survey questionnaire was based on a similar survey that was being conducted by the Office for National Statistics (ONS) in Great Britain. Various phases of the survey were carried out and covered different topics relating to the pandemic. In phase 6 of the survey, a module was asked on "Access to Medical Care" which covered questions including whether people were able to receive the same level of medical care for any long-term mental or physical health condition, problem or illness that they had been receiving before the outbreak of the pandemic. It also included questions relating to the perceptions of people at that time using different healthcare services. Results from phases 1 to 6 of the survey which include the Access to Medical Care section can be found at NISRA Coronavirus (Covid-19) Opinion Survey Key Findings – Phases 1 to 6 [INQ000272476].

190. It was undoubtedly the case that health seeking behaviour changed significantly during the pandemic because of people not wishing to overly burden the health service given the pressures of the pandemic, possible fear of infection, and also restricted access to services. 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**].

191. 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.

J. Clinically Extremely Vulnerable

192. Throughout the pandemic there was a focus on protecting the most vulnerable in our society as reflected in the introduction of "shielding" for those who were at significant increased risk of contracting Covid-19, including those who were later defined and described as being in the cohort of the Clinically Extremely Vulnerable. This also included specific additional advice, included in letters issued from the Chief Medical Officer to the Clinically Extremely Vulnerable and people caring for them. The advice to the Clinically Extremely Vulnerable was accompanied by, for example, support with food and medicine deliveries.

193. The Department of Health played a significant role in providing public information and communications on the risks to public health, the rationale for non-pharmaceutical interventions and the benefits of these to the community. The Department's response to the pandemic in those areas contributed to its approach to providing targeted advice and guidance to those of all ages at very high risk in the community, defined as Clinically Extremely Vulnerable, as to how they might shield themselves so as to avoid contracting the virus.

1. Designation of Clinically Extremely Vulnerable

194. Work across the four United Kingdom jurisdictions to develop guidance and specific supports for the Clinically Extremely Vulnerable proceeded at a rapid pace during March 2020. The Chief Medical Officer for England circulated a short briefing note on shielding for the Prime Minister to the other United Kingdom Chief Medical Officers on 15th March 2020 [PM/6108 INQ000346718]. There were also direct communications between TEO and the Cabinet Office on the policy intent of having a UK wide approach to the shielding policy [PM/6109 INQ000346719].

195. Work in this area was led by Advisers from within the Chief Medical Officer's group, with support from the Primary Care Directorate. The Advisers led on definitional issues whilst the Primary Care Directorate team led on operational issues such as the issuing of advice letters (in partnership with the then Health and Social Care Board and Health and Social Care Trusts) and the establishment of supports for the Clinically Extremely Vulnerable population in partnership with other stakeholders including the Department for Communities.

196. The designation of the Clinically Extremely Vulnerable categories of medical conditions was informed by the information and advice provided via the Department's

participation in the United Kingdom National Clinically Extremely Vulnerable Group. Public Health England and Scientific Advisory Group for Emergencies guidance in relation to the risk of high mortality among the clinically extremely vulnerable because of Covid-19 infection also informed the development of the Department's policy in this area.

197. The overall policy intent, including the definition of Clinically Extremely Vulnerable initially used by all four jurisdictions in March 2020, was agreed by the four United Kingdom Chief Medical Officers and therefore the policy in Northern Ireland, as agreed by the Minister, 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, as Northern Ireland did in relation to people with Motor Neurone Disease. This is discussed in more detail below. Under the UK wide criteria General Practitioners also had a degree of flexibility to include patients they judged to be at high risk.

a. Initial Designations

198. The list of diseases or conditions considered to be very high risk and listed in the first shielding letter issued from 27 March 2020 [PM/058 INQ000130313; PM/059 INQ000120706] were:

- Solid organ transplant recipients;
- People with specific cancers, as follows:
    - People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer;
    - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment;
    - People having immunotherapy or other continuing antibody treatments for cancer;
    - People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors[4], and
    - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs, people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe Chronic Obstructive Pulmonary Disease.

[4] PARP inhibitors are a group of pharmacological inhibitors of the enzyme poly ADP ribose polymerase.

- People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as Severe Combined Immunodeficiency and homozygous sickle cell);
- People on immunosuppression therapies sufficient to significantly increase risk of infection, and
- People who are pregnant with significant heart disease, congenital or acquired.

199. People living with other underlying health conditions were identified at a United Kingdom-wide level as part of a wider clinically vulnerable group. These individuals were not included in the shielding group but it was agreed they should follow strict social distancing measures instead. This group included those who were:
    - Aged 70 or older (regardless of medical conditions)
    - Under 70 with an underlying health condition listed below (i.e. for adults this usually anyone instructed to get a flu jab as an adult each year on medical grounds):
        - Chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease, emphysema or bronchitis;
        - Chronic heart disease, such as heart failure;
        - Chronic kidney disease;
        - Chronic liver disease, such as hepatitis;
        - Chronic neurological conditions, such as Parkinson's disease, multiple sclerosis, a learning disability or cerebral palsy;
        - Diabetes;
        - Problems with their spleen – for example, sickle cell disease or those who had their spleen removed;
        - A weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy;
        - Being seriously overweight (a BMI of 40 or above), and
        - Those who are pregnant.

200. By 25 March 2020 letters were being issued to the Clinically Extremely Vulnerable population by a combination of General Practitioners and Health and Social Care Trusts. In practical terms it required a number of weeks for all of these letters to be issued. This was because guidance issued [PM0059 INQ000120706] to GP practices on 25 March 2020 by the Health and Social Care Board on caring for

people at highest risk of Covid-19. PM0059 INQ000120706 asked practices to prioritise the issue of a shielding letter to all their patients who were considered to be at highest risk of severe illness that would require hospitalisation from Covid-19. In order to issue the letters to patients, GP practices first had to identify those patients who were at highest risk. The guidance to practices provided information about computer system searches as a tool to help identify those patients who should be included in the high risk list and receive a letter. The guidance issued to practices, also advised that if additional individuals were identified as clinically at highest risk of severe outcomes, they should also be contacted regarding that recommendation.

201. Given the urgency of the requirement to identify this cohort, clinicians in primary and secondary care and their teams worked to identify these individuals as soon as possible. It was recognised that this was a complex task. As GPs were central to the care of their patients, it was the responsibility of practices to identify those at highest risk and who should receive shielding letters. People could contact their GP or hospital care team, if they had not received a letter (or been contacted directly by their GP/clinician) and they thought they fell into one of the categories of people considered to be at highest clinical risk, or if they were concerned that their underlying condition placed them at risk of severe illness should they contract Covid-19.

202. The Clinically Extremely Vulnerable 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 [PM/6110 INQ000130315].

b. Changes to the Designation of Clinically Extremely Vulnerable

203. There were several changes to the designation of Clinically Extremely Vulnerable over the course of the pandemic. The Chief Medical Officer in Northern Ireland made the decision to include people with Motor Neurone Disease on the list of those people who were Clinically Extremely Vulnerable and advised to shield; this group of people were added on 2 April 2020. Regulations[5] made on 28th March 2020 prohibited "*anyone from leaving the place where they are living without reasonable excuse. Examples of a reasonable excuse include the need to provide care or assistance to a*

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

vulnerable person, to travel for the purposes of work and to access critical public services." The inclusion of Motor Neurone Disease in the definition of Clinically Extremely Vulnerable within the Regulations, in Schedule 1, meant that it was a reasonable excuse for someone to leave home and travel to provide assistance to someone with Motor Neurone Disease.

204. The inclusion of people with Motor Neurone Disease in the definition of Clinically Extremely Vulnerable was the only area where Northern Ireland diverged from the rest of the United Kingdom. The recommendation and the decision were made by the Chief Medical Officer on clinical grounds. The Minister, who had been receiving communications on the issue from political representatives, would have been advised of this decision. The Department has not been able to locate a record of the Minister being advised of the decision, nor any documents setting out the CMO's recommendation and decision, and it is believed to have been a verbal communication. The vulnerability and risk in patients with Motor Neurone Disease primarily relates to reduced respiratory capacity and difficulty clearing secretions. Many patients with Motor Neurone Disease will require respiratory support in the course of their illness and therefore would likely have been identified by General Practitioners for inclusion on the Clinically Extremely Vulnerable list on the basis of clinicians' discretion to do so. The inclusion of Motor Neurone Disease in the Northern Ireland definition of Clinically Extremely Vulnerable was intended to offer additional reassurance to this population of approximately 140 people in Northern Ireland at any one time [PM/6111 INQ000348674].

205. For the rest of the United Kingdom, the issue of including Motor Neurone Disease in the definition of Clinically Extremely Vulnerable was discussed at a meeting of the United Kingdom Clinical Panel for Shielding Patients on 28 April 2020 [PM/6112 INQ000348675]. At the conclusion of the meeting the minutes recorded:
"Recommendation:

- Patients should be continued to be identified by General Practitioners/Specialists for shielding on a case-by-case basis to reflect the varying degrees of severity of Motor Neurone Disease.
- To ask the Motor Neurone Disease Association to collect/submit further data on outcomes for consideration by New and Emerging Respiratory Virus Threats Advisory Group / Scientific Advisory Group for Emergencies.

- To work with the Royal College of General Practitioners and Royal College of Physicians to develop the e-learning resources to include awareness of Motor Neurone Disease with regard to the shielded patient list."

206. It is the Department's understanding that other jurisdictions did not subsequently add the Motor Neurone Disease population as a category in their Clinically Extremely Vulnerable lists, although those suffering from Motor Neurone Disease are likely to have been so designated through General Practitioner discretion as outlined in advice in the associated professional letter or by the interpretation of 'rare diseases'.

207. People undergoing renal dialysis [PM/6113 INQ000348676; PM/6114 INQ000348677; PM/6115 **INQ000130315** were added to the designation list of Clinically Extremely Vulnerable after 24 April 2020 on advice from the United Kingdom Clinical Panel for Shielded Patients to United Kingdom Chief Medical Officers, whilst people who had a splenectomy [PM/6117 INQ000348679] were added to the said list on 15 May 2020, again on advice from United Kingdom Clinical Panel for Shielded Patients to United Kingdom Chief Medical Officers.

208. On 26 November 2020, the Department announced that adults with Down's Syndrome [PM/6118 INQ000385683; PM/6119 INQ000348681; PM/6120 INQ000381377] had been added to the Clinically Extremely Vulnerable list and the Chief Medical Officer wrote to adults with Down's Syndrome to advise them that they had been included on the list and what this would mean for them [PM/6121 INQ000276298]. An easy read version was also available [PM/6122 INQ000348684].

209. Adult patients with kidney impairment (Stage 5 Chronic Kidney Disease) were also added to the Clinically Extremely Vulnerable list on the 26 November 2020 [PM/6118 INQ000385683 and PM/6119 INQ000348681].

210. People were added to the Clinically Extremely Vulnerable list on a case-by-case basis where their attending clinician (General Practitioner or hospital consultant) assessed them as being at a higher risk based on their clinical judgement.

211. The Chief Medical Officer and Deputy Chief Medical Officers were fully engaged in the United Kingdom's expert panel and Chief Medical Officers' ongoing and continuous review of the emerging evidence and further discussions to identify those most at risk. This work also considered approaches to protect the most vulnerable

people in society including the ongoing review of the appropriateness and proportionality of these measures given the significant impact in terms of loneliness, isolation and mental health. In concert with other United Kingdom nations, the Chief Medical Officer for Northern Ireland advised on the recommendations in relation to "shielding and the Clinically Extremely Vulnerable cohort". The Department's approach was informed in due course by its participation in the United Kingdom's National Clinically Extremely Vulnerable Group and consideration of the Scientific Advisory Group for Emergencies' guidance.

c. Communication with the Clinically Extremely Vulnerable

212. In the absence of specific vaccines or medical treatments, shielding advice was introduced by the Department on 25 March 2020. At the start of the pandemic shielding letters were issued by General Practitioners [PM/0058 INQ000130313, PM/0059 INQ000120706] to patients within their practice who had specific clinical conditions which meant that they were most at risk of severe illness or hospitalisation if they were to contract Covid-19; i.e. those who were Clinically Extremely Vulnerable [PM/6110 INQ000130315]. In addition, Health and Social Care Trusts were also asked to contact specific patient groups who were known to them as being Clinically Extremely Vulnerable to ensure that all specific patient groups and individual patients were identified.

213. Throughout the course of the pandemic, information and advice on shielding for those who were Clinically Extremely Vulnerable continued to be provided through statements published on the Department of Health website and through further letters from the Chief Medical Officer and issued by General Practitioners and Trusts to those who had been identified as Clinically Extremely Vulnerable, as outlined below.

214. In addition, the Northern Ireland Direct website, which is the official Government website for Northern Ireland, provided updated information, advice and guidance via dedicated web pages for those who were Clinically Extremely Vulnerable.

d. Guidance from the Department of Health

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

shielding was, people were assured that it would last no longer than deemed clinically necessary [PM/6124 INQ000348685].

216. The Chief Medical Officer 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.

217. In a statement on 18 June 2020, the Minister 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. A further statement issued by the Minister on 22 June 2020, 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].

218. Following on from the Health Minister's 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].

e. Pausing of Shielding

219. In a submission [PM/6129 INQ000346714] to the Minister dated 16 June 2020 the Director of Primary Care advised 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. 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.

220. 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].

221. Over the following period, the Department continued to monitor the situation and the need for any further advice for those who were Clinically Extremely Vulnerable 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.

222. 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 fully implement the guidance.

223. In an urgent written Statement dated 23 October 2020 [PM/6134 INQ000305015], the Minister 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. No written document of the CMO's advice could be located. 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 advised the Health Minister 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**].

f. Christmas 2020 and early 2021

224. On 23 December 2020, the Department announced that it had updated the advice to Clinically Extremely Vulnerable people to help them keep safe through the Christmas period and beyond [PM/6136 **INQ000381407**]. Clinically Extremely Vulnerable people were reminded to consider very 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. The advice in relation to Clinically Extremely Vulnerable people attending the workplace was also changed. From 26 December 2020, Clinically Extremely Vulnerable people who were working and unable to do so from home were advised not to attend the workplace. This advice 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]. This advice was reiterated in a further statement published on 7 January 2021 [PM/6138 **INQ000381421**].

225. 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**].

226. 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.

2. Assessment of the Impact of Shielding

227. On 27 May 2020 the Chief Medical Officer emailed [PM/6140 INQ000346716] the Chief Executive of the Patient and Client Council asking that the Council undertake research to "inform the relaxation of some of the current restrictions around outdoor exercise and possible subsequently meeting family outdoors in small numbers with appropriate safeguards and precautions." The email indicates that the proposed research was supported by the Minister and by the First Minister and deputy First Minister of Northern Ireland.

228. The Minister published a statement 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' [PM/6141 INQ000348702].

229. The Chief Medical Officer's letter, which issued in early June 2020 [PM/6125 INQ000348686] to advise of a change in shielding advice, also advised recipients that the Chief Medical Officer was leading a programme of rapid engagement with people who were shielding so that, in considering the future of shielding, there would be a clear understanding of the issues those who were shielding faced. The letter provided details on how to participate in the Patient and Client Council survey online, by post and by telephone. The final Patient and Client Council survey report [PM/0060 INQ000344088] was published in July 2020.

230. 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.

231. Membership of the Department's Clinically Extremely Vulnerable cell included representation from the Patient and Client Council to ensure that the patient voice was heard in decisions around advice for this group of people. The Patient and Client Council played a pivotal role in the development of a Distance Awareness Scheme which was launched by the Minister on 24 February 2021 [PM/6143 INQ000348703]. The scheme was modelled on a scheme which had been developed in Wales and was delivered by the Patient and Client Council in partnership with community pharmacies, General Practices, Health and Social Care Trusts, and in the voluntary and community sector through the Northern Ireland Council for Voluntary Action. As part of the launch the Minister stated "The badge can be worn by anyone to signify that they wish to maintain social distancing and it is not meant to be an identifier of someone who has been shielding or may have any specific health condition. This is an opportunity for members of the public to become more involved in promoting the social distancing message and to help our efforts to halt the spread

of Covid. There is a very simple message behind the scheme – show your concern and respect for other people by maintaining social distancing".

3. Support for the Clinically Extremely Vulnerable

232. Throughout the pandemic, all letters that issued to people identified as Clinically Extremely Vulnerable provided a range of information and signposting to sources of advice to support those who were shielding, including access to medicines and food deliveries, support for mental health and well-being, financial assistance and support when returning to the workplace.

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

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

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

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

K. TECHNOLOGY

1. Appointments and Meetings

237. The Department of Health's Digital Co-Ordination Cell (DCC), headed by the Department Chief Digital Information Officer, co-ordinated the deployment of digital solutions across the Northern Ireland Health & Social Care landscape to provide a consistent response to the needs of citizens. They sought to identify emerging requirements and begin consideration of potential regional solutions; remove barriers to the rapid deployment of technology to support front-line services and the delivery of equipment to priority areas; and provide a reporting mechanism for the regional technical work undertaken to support the clinical response to the pandemic.

238. An example of this work was the rapid approval of the procurement of required regional technical services such as regional Zoom video conferencing "Enterprise licences" (that enable central configuration of Cyber Security settings) to support virtual meetings. In this case permission was given for various workstreams to operate in parallel rather than the more usual serial manner required by audit processes, removing several weeks from the procurement and deployment timetable. Individual HSC organisations continued to manage the operational delivery of local ICT services required to meet their particular business requirements. A representative of those organisational IT managers was invited to participate in the DCC.

239. The DCC did not produce any advice to primary, secondary, or tertiary healthcare to allow appointments, meetings (including multi-disciplinary and team) and document/diagnostic review to take place remotely.

240. There was a clear imperative at the start of the pandemic to reduce face to face contact in health service delivery in an effort reduce viral transmission. Many health and social care services in Northern Ireland that could accommodate telephone and video access (to reduce face to face encounters wherever possible) transitioned to telephone and video access. While significant information was made available online through NI Direct, the Public Health Agency and the Department of Heath websites and via the COVIDCare NI app launched on 27 March 2020 [PM/6359 INQ000371470] (first established on 28 February 2020 as a dedicated NI helpline with NHS 111) created to provide advice to the public presented access issues for some communities [RS/0127 INQ000371524]. One such group was the hearing impaired who used British Sign Language (BSL) / Irish Sign Language (ISL). In order

to address the issue of access, 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.

241. Further information on the increased use of technology in the provision of healthcare or how patients would be able to access healthcare remotely is provided in Section D (6)(iii).

2. Imaging

242. In regard to imaging, at the time of the pandemic, Northern Ireland had regional imaging systems in place that could be accessed remotely, with Northern Ireland having the highest percentage of home workstations in the United Kingdom. The NI Health and Social Care Trusts have provided the detail below to evidence the ability to move to home working for remote reporting for Radiologists.

REMOTE REPORTING CAPABILITY FOR RADIOLOGISTS		
	Percentage @ April 2020	**Notes and details of upgrade**
WHSCT	88%	Additional 4 radiologists provided with capability.
BHSCT	All radiologists had viewing capability only and no reporting capability	Belfast Trust secured finance during the pandemic to develop a home reporting solution capable of supporting 60 home reporting workstations to support the vast majority of BHSCT consultants. – It moved from a viewing solution to full availability to workforce with the caveat that some sub specialist procedures such as PET and Breast were not compatible with the solution at the time. Full roll out occurred in early 2021
SHSCT	100%	2 Breast Radiologists were changed from DX workstations to MX workstations which allowed capability of breast reporting

		from home. In September 2020 Sep 2020 the Reporting Radiographers also gained home workstations
NHSCT	73%	Additional 6 radiologists provided with capability
SEHSCT	100%	All SET radiologists had a diagnostic home reporting system without speech dictation

243. The Digital Co-ordination Cell co-ordinated the rapid approval and deployment of upgraded secure remote access capability to enable additional remote working capability for appropriate staff. This involved the enhancement of the bandwidth (to 10GB) of the central HSC connection to the Internet, to facilitate remote access from outside the HSC network [PM/6425 INQ000000]. A radiology reporting contingency plan was in place and available on escalation to ensure that reporting of imaging activity was preserved in the event that on-call radiology was negatively impacted as a result of the Covid-19 pandemic [PM/6361 INQ000436913]. As such, imaging services, especially CT, continued to support unscheduled, cancer and elective activity during the pandemic and were among the first services to achieve pre-Covid levels of activity as part of the rebuilding of HSC Services.

3. Impact of use of Technology

244. Northern Ireland is subject to equality duties over and above those in other UK regions by virtue of Section 75 of the Northern Ireland Act 1998. This requires public authorities to pay regard to the need to promote equality of opportunity—

(a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;

(b) between men and women generally;

(c) between persons with a disability and persons without, and

(d) between persons with dependants and persons without.

245. There are also duties under the,

- Rural Needs Act (Northern Ireland) 2016 that requires public authorities to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services, and
- UK GRPR when conducting any type of processing, including certain specified types of processing that are likely to result in a high risk to the rights and freedoms of individuals.

246. The history of the development and deployment of the Covid Certification Service [PM/3046 INQ000348807] illustrates how the Department and the Northern Ireland Health and Social Care organisations discharged their obligations when considering increased use of technology within the healthcare system:

- The Digital Health and Care Northern Ireland partnership, Northern Ireland Civil Service, NI Direct and key suppliers worked jointly on the development and delivery of a multi-channel COVID Certification Service (CCS) that would, by virtue of vaccination or Covid-19 testing, facilitate international travel (meeting European Union and World Health Organisation requirements).
- The work on the COVID Certification Service covered both digital and non-digital, (telephone accessed, paper-based) solutions for people to obtain trusted, and internationally accepted, Covid status certification. This was initially for use in international travel settings, and later for "domestic use" in Northern Ireland, to meet the requirement that emerged in Autumn 2021. As part of the COVID Certification Service, the COVIDCert NI and COVIDCert Check NI apps were developed, and a Helpdesk established, to assist those having difficulty in passing automated checks, and for those unable to use digital channels. The need for such measures was identified during the creation of the Equality Impact Assessment in line with Departmental guidance [PM/6362 INQ000436919].
- Both the Data Protection Impact Assessment (DPIA) [PM/6363 INQ000436920] and the Equality Impact Assessment (EQIA) [PM/6364 INQ000436921] were completed and published on the Internet.
- The Department produced a Human Rights Impact Assessment [PM/6365 INQ000390955].
- The Department commissioned a Web Accessibility review of the public facing website supporting the CCS [PM/6366 INQ000436923].

247. The Department's DCC was concerned with the strategic co-ordination of specific technical solutions designed to support regional programmes of work in response to the pandemic. The different HSC organisations retained responsibility for the commissioning of technology solutions to support their particular organisational, business or service needs. The NI HSC Trusts may be able to provide more detail of how they used technology to supplement existing services.

248. The Covid Certification Scheme required a regional approach (managed by the Department), drawing as it did on,

- A regional digital identity solution,
- The regional Vaccination Management System (holding records of vaccination given),
- UK and International agreements on how travellers might satisfy requirements for international travel (these were managed by the Foreign, Commonwealth & Development Office), and
- Centralised support for those who used the solution.

249. Examples of considerations around more service specific delivery were given in Section D (6) (iii) in the information on Telephone First and the Telephony Grant schemes.

L. Lessons Learned and Reviews

250. The Department carried out a number of lessons learned and review exercises of various areas throughout the pandemic. These are detailed below in chronological order.

1. Review of the social care HSC Trust Covid-19 surge planning for the Independent Care Home Sector

251. On receipt of the Health and Social Care Board's and Public Health Agency's initial surge plans in February 2020, the Chief Medical Officer commissioned further work to quality assure and address identified gaps in the initial surge plans, recognising that the lack of specificity at this time of the potential health and social care service pressures made surge planning problematic. The quality assurance was to address gaps and to work with those involved in preparing the plans to support improvements in planning and monitoring. It was carried out by a team of assessors tasked by the Department's Chief Professional Officers to undertake a review of the social care HSC Trust Covid-19 surge planning for the Independent Care Home Sector (nursing and residential care homes) and for HSC Trusts' directly managed inpatient and residential mental health and learning disabilities services (including supported living), critical care and secondary care sectors.

252. As a result of the review a report was produced and in that report the gaps identified in each of the surge plans were as follows:

- Social Care - regional surge planning for the social care sector was predicated on a model of staff absence being the most significant risk factor for the continuation of services. A revised regional escalation plan set out 'a plan on a page', for care homes, mental health and learning disability sectors, with explicit expectations in respect of prevention, mitigation of risk, management of symptomatic patients and support for service continuity;
- Critical Care – the focus of this surge plan was based on a Nightingale hospital. However, there were inconsistencies in the local escalation stages before stepping up to a regional Nightingale setting which were identified and addressed in the revised escalation plan;
- Secondary Care – each HSC Trust had a plan at local level, however, testing of these identified how all HSC Trusts' plans needed to connect at a regional level to bring consistency across the region. Secondary care plans also had to connect the total system of health and social care, from critical care, community and Covid hubs, protected non-Covid services and to ensure that

pathways were in place to transfer individuals across the levels of care as required.

253. Given that the initial surge plan for the social care sector was predicated on a model of staff absence being the most significant risk factor for the continuation of services, a revised regional escalation plan was developed by the PHA with support from HSCB. This revised regional escalation plan set out 'a plan on a page', for care homes, mental health and learning disability sectors, with explicit expectations in respect of prevention, mitigation of risk, management of symptomatic patients and support for service continuity.

254. Lessons learned in relation to need for the revised regional escalation plan informed the approach to future waves during the Covid-19 response and for planning to deal with other pandemics that may occur in the future.

2. Rapid Review of Personal Protective Equipment

255. This review, and its recommendations, is described in detail in Part 1 of the Department's Module 3 Corporate Statement at Section C(4)(i). Whilst the rapid review recommendations were to enable the short-term improvement of the PPE position, they also resulted in the development of a dynamic purchasing system to support a more agile system of procurement of PPE. The benefits of a Dynamic Purchasing System include:

- Supporting the creation of markets to secure provision of critical supplies during a period of pandemic;
- Increasing market capacity during a time of unprecedented demand;
- Working responsively to support SME sectors and enhance business development and employment opportunities;
- Increasing supply chain resilience to accommodate ability to respond sustainably to further 'waves'; and
- Exploring capacity to build innovative and sustainable supply chains to protect front-line services. The review also saw the development of a supply chain strategy by BSO centred on the building and maintaining of a 'Just In Case' stock level based on usage for a 12 week period as a necessary mitigation against the risk of potential further surges in demand and unstable supply chains.

3. Review of existing research relating to the impact of the pandemic on the mental health and emotional wellbeing of the general population and those with additional needs

256. This work took place over a number of weeks from April 2020 and included the establishment of a Research/Impact sub-cell which was chaired by the Health and Social Care Board's psychiatry lead/chair of the Trauma Network. The sub-cell produced a Rapid Review, the purpose of which was to consolidate the research, knowledge and evidence on the impact of Covid-19 on key areas of mental health and emotional wellbeing and the likelihood of new inceptions of mental illness. It included recommendations for ameliorating these, including prevention, early intervention and recovery, as well as priorities for further research.

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

258. The review mainly drew conclusions and made recommendations regarding the research implications of the mental health impact of the pandemic. The aim was to identify, analyse and present evidence to inform the response to mental health needs arising and/or being exacerbated by the pandemic. In relation to the impact on Primary Care services the report suggested measures which could be taken to support GP services to cope with an increased demand. It also stated that many of the measures suggested have been included in the Mental Health Action Plan which was published in May 2020. The findings from the rapid review also helped to inform action within the Mental Health Strategy 2021-2031, published in June 2021.

259. The Rapid Review, which was published in July 2020, recognised that it was difficult to approximate the increased mental health risk associated with isolation, loneliness, alcohol misuse, domestic violence, the economic recession and corresponding risk of unemployment for the NI population given the knowledge that was available at the time. The Rapid Review Report made estimates and acknowledged that, as the knowledge on the impact of the pandemic increases, these estimates may be subject to change.

260. It is recognised that, due to the timing of the review, the evidence in relation to the impact of Covid-19 on mental health which was available to the review authors at the time was limited. However, the Rapid Review Report noted the importance of

ensuring that any response to mental health needs arising from and/or being exacerbated by the pandemic is evidence-based. Recognising this need for an emphasis on mental health research and innovation, Action 35 of the Mental Health Strategy, published in June 2021, commits to the creation of a centre of excellence for mental health research.

4. Project to assess the impact of Covid-19 on HSC services delivery to inform the production of a 'Rebuilding HSC Services Strategic Framework'

261. In May 2020 a project was established to assess the impact of Covid-19 on HSC services delivery. It showed that the main impact on services was a downturn in activity resulting in increased waiting times to access services. The lowest increase in waiting times to access inpatient services was 2.0 weeks and the highest 8.9 weeks. The lowest increase in waiting times to access outpatient services was -0.6% weeks and the highest increase 4.8 weeks [PM/6426 INQ000000]. The project aimed to prioritise the services, projects and programmes that should be resumed as Covid-19 patient numbers began to stabilise. The project also recommended changes to the HSC governance arrangements to make these as efficient as possible within the challenging situation for service delivery arising from the pandemic. The changes to the governance arrangements were also informed by the findings of an 'in-flight' assessment of the Health & Social Care service coordination in response to the pandemic [PM/426 INQ000188799 (DoH ref: PM0228)], which reviewed the Department's emergency management structures.

262. The Rebuilding Management Board was established in June 2020 with the dual role to oversee rebuilding of services and the system response to future Covid-19 waves. This Board was stood down in June 2022 and replaced by the HSC Performance and Transformation Executive Board (see below).

5. Audit Review of Fit Testing

263. In early summer 2020, an audit review of fit testing for respiratory masks was carried out on a precautionary basis across the HSC system after it emerged that an independent contractor had inadvertently applied on some occasions a fit testing setting not normally used in Northern Ireland. To ensure learning from this incident, the Public Health Agency was asked by the Department of Health to undertake a Serious Adverse Incident review and implement the recommendations.

264. The final report from the Public Health Agency is still being finalised. The Department expects to receive it within the next few weeks.

6. 'In-Flight' Assessments

265. The Chief Medical Officer commissioned an 'in-flight' assessment of the Health and Social Care service coordination in response to the pandemic in March 2020 to review the Department's emergency management structures [INQ000188799]. The Top Management Group recognised that these emergency structures, which had been designed to cope with short-term emergencies, were not appropriate to sustain the effective management of the Health and Social Care organisations over the period of a long pandemic. A new business model was required to both manage the long-term emergency response to the pandemic, and to progressively reinstate Health and Social Care routine service delivery as the demand for Covid-19 treatment fluctuated across the pandemic waves. This assessment assisted with informing changes to Health and Social Care governance arrangements to make these as efficient as possible within the challenging situation for service delivery arising from the pandemic.

266. A new integrated Gold Command Group was created, which was chaired by the Permanent Secretary. This had as its membership officials from both the Department, the Public Health Agency and the Health and Social Care Board. The integrated nature of this Gold Command Group meant that issues arising could be assessed, discussed and actioned quickly. The Gold Command Group meetings were supported by regular Sitreps and modelling outputs produced by the Modelling Group. The frequency of Gold Command Group meetings and associated Sitreps was kept under regular review and fluctuated with the pandemic.

7. Independent Review of the Resignation of the Regulation Quality and Improvement Authority Board members

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

268. 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.

269. 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.

8. Health Silver Debrief

270. In July 2020, the Health and Social Care Board organised and facilitated a debrief of Health Silver for Surge 1 of the Covid-19 Pandemic [PM/61 INQ000188798]. This debrief was facilitated to inform the overarching Departmental debrief and was shared with the Department in September 2020. The debrief took place over two sessions: session one being the 'contain' phase which had been led by Public Health Agency, and session two was the 'delay' phase which had been led by Health and Social Care Board. Attendees from the three organisations that make up Health Silver attended both sessions. At the time of writing, we have been unable to locate any record of the Department having received the Public Health Agency's report on session one, the 'Contain' phase, and therefore the information below relates to the report of the Health and Social Care Board on session two, 'Delay' phase.

271. The report of the Health Silver debrief session two [PM/61 INQ000188798 (DoH ref: PM5064)] included a series of recommendations. At the time the report was shared, in September 2020, the Department, the Health and Social Care Board, Public Health Agency and Business Services Organisation remained heavily involved in managing the ongoing pandemic response with ongoing capacity issues. There was therefore no opportunity for the organisations to meet to reflect on the findings from the Health Silver sessions, to review the report, make corrections, develop a shared understanding, or to specifically discuss the points raised and how to address them. However, the Department had in many cases identified similar issues, informed by the 'In flight' review and took account of these in developing the approach to the next wave of the pandemic. For example, the temporary "Management Board for Rebuilding HSC Services" (established in June 2020) and the integrated Covid-19 Gold Command structures (established in autumn of 2020) to manage the second

wave of the pandemic recognised the point made in the Health Silver debrief session two report that Covid-19 was no longer an 'emergency' but rather it needed to be incorporated into a new way of doing business. The structures that replaced Health Gold took a more integrated approach than had been taken during the initial emergency response phase, with subject specific cell membership drawn, not only from the Department, but also from counterparts in the Health and Social Care Board, Public Health Agency and Business Services Organisation.

272. Many of the recommendations of the Health Silver Debrief were around early engagement with key partners on situational awareness as the emergency evolved and establishing good internal and external communications, specifically in establishing effective reporting rhythms and developing accurate, timely and relevant Situational Reports from Health and Social Care and Departmental Arm's Length Bodies. These issues have been addressed through the review of the Department of Health's Emergency Response Plan.

273. The Emergency Response Plan, which sets out the operations of Health Gold, is reviewed at least every three years. It must be reviewed every time it is activated in response to an emergency or any significant training exercise that requires activation of Health Gold. It will also be reviewed if any significant revisions are made to the relevant sections of Northern Ireland Civil Contingencies Risk Register.

9. Review of the Emergency Operations Centre

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

are being incorporated into the next iteration of the Departmental Emergency Response Plan, currently in progress.

275. In total, 6 of the recommendations were completed prior to the redrafting of the Department's Emergency Response Plan (ERP).

276. 12 of the recommendations have been adopted into the new version of the ERP, which was endorsed by the Senior Leadership Team on 11 March 2024. Many of these recommendations related to the need for early engagement with key partners on situational awareness, as the emergency evolved, and the importance of establishing good internal and external communications, specifically in establishing effective reporting rhythms and developing accurate, timely and relevant Situational Reports from HSC and Departmental ALBs.

277. Of the 20 recommendations, a remaining 2 recommendations are on-going. These are: a review of the Military Aid to Civil Authority procedures which Emergency Planning Branch is taking forward; and liaison with NI Direct about the process for setting up a Helpline, in respect of which the Emergency Planning Branch will engage with the Chief Digital Information Officer.

278. This particular review was specific to the operation of the Emergency Operations Centre and so did not have specific relevance to the wider response of healthcare systems within the UK to the Covid-19 pandemic, or what changes should be made to relevant systems and processes in the future.

279. This review has contributed to the future plans of the Department in respect of the Emergency Response Plan. The Emergency Response Plan sets out the stand-up and operating procedures for Health Gold and is reviewed at least every three years. The Emergency Response Plan must be reviewed every time it is activated in response to an emergency or any significant training exercise that requires activation of Health Gold. The Emergency Response Plan will also be reviewed if any significant revisions are made to the relevant sections of NI Civil Contingencies Risk Register.

10. Rapid Review of changes in HSC Pharmacy services

280. The review, commissioned by the Department's Chief Pharmaceutical Officer in September 2020, was led and coordinated by the Medicines Optimisation Innovation

Centre, with input from pharmacy teams in all sectors. The review described the wide range of interventions by pharmacy teams that were necessary to ensure that patients and the public had access to medicines and pharmaceutical care throughout the initial stages of the emergency.

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

282. The recommendations in the review informed the development of a Pharmacy Services Surge & Rebuild Plan which was presented to the HSC Rebuilding Management Board on 4 November 2020 [INQ000276484 (DoH ref: PM2026)]. This plan outlined the contribution of pharmacy services in general practice, community pharmacy and HSC Trusts to the rebuilding of the HSC after the first wave and actions undertaken to prepare for subsequent surges.

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

284. Since the publication of the 2020 review, pharmacy in NI continues to play an integral role in the Covid-19 pandemic response in subsequent waves, including the rollout of Covid-19 vaccination and novel therapeutic agents. In April 2023 the Department commissioned the Medicines Optimisation Innovation Centre (MOIC) to undertake a follow-up review aimed at measuring progress against the recommendations made in the 2020 review and identifying areas for future development of HSC pharmacy services. This report was completed in August 2023 and contained recommendations for further actions required to support the rebuilding of HSC services and future pandemic preparedness. An action plan has now been developed to progress implementation of these recommendations, overseen by the

Pharmacy Leaders Forum. MOIC are also completing reviews of the pharmacy contribution to the rollout of Covid-19 vaccination and therapeutics aimed at identifying what went well and areas for future improvement, and these are anticipated to be completed by April 2024.

285. The 2020 review was an endorsement of the commitment and professionalism shown by pharmacists and pharmacy teams working in hospitals, general practices, community pharmacies and support services. It was also a positive reflection of the support provided to the frontline pharmacy workforce by the Health and Social Care Board and the Department and stressed the benefits of partnership working with pharmacy professional and representative bodies and the community and voluntary sector. The 2023 follow up review found that some of the initial recommendations had been fully implemented, while others were less relevant due to changes in professional practice in the intervening period. Recommendations for actions required to implement outstanding points in the 2020 review were made in the 2023 follow-up review, and these have informed the development of an action plan for service improvement and implementation will be overseen by the Pharmacy Leaders Forum. The Forum has representation from the most senior pharmacy leaders in HSC Trusts and the Department of Health and is chaired by the Chief Pharmaceutical Officer.

286. An action plan has now been developed to progress implementation of the recommendations outlined in the 2020 review and the 2023 follow-up review relating to HSC service rebuilding and pandemic preparedness, with progress overseen by the Pharmacy Leaders Forum which is chaired by the Chief Pharmaceutical Officer.

11. Rapid Learning Initiative on Care Home Pandemic Experiences

287. In September a Rapid Learning Initiative was established which brought together a wide range of stakeholders through both its Steering Group and four Subgroups who undertook the work of the Initiative. The Subgroups examined four key areas in Care Homes and identified 24 recommendations within six themes to be used to focus learning from the transmission of Covid-19 into Care Homes during the first surge to mitigate the impact on residents and staff of a potential second surge.

288. The Public Health Agency (PHA) was charged to work with Trusts, the independent sector, and other relevant stakeholders to co-ordinate the implementation of the recommendations. The Minister of Health subsequently announced plans to produce

a new Framework for further enhancing clinical care for people living in care homes – the Enhancing Clinical Care Framework (ECCF) project. The ECCF project represented one of the ten Key Actions under the No More Silos action plan which aimed to ensure that urgent and emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and staff. The ECCF was published in August 2023 and the Department is currently undertaking a review of the current Care Home Standards to assist with full implementation of the ECCF.

289. This Rapid Learning Initiative focused on the response to the first surge. Its recommendations were categorised under the following six themes: Technology; Information; Medical support; Health and Wellbeing; Safe and Effective Care; Partnership. A key topic was the "information" theme, which recommended the management of information and guidance to and from care homes more efficiently and effectively, and this was taken forward by colleagues in RQIA, who acted as a single point of contact for information transfer. The findings and recommendations of the subsequent ECCF project are in line with those that have been seen in other UK jurisdictions.

290. The Enhancing Clinical Care Framework, which was commissioned following the Rapid Learning Initiative, aims to ensure those living in care homes have access to the clinical and wellbeing support they want and need, to live healthy, fulfilling lives and to meet the daily challenges many will face. While it is not specific to future pandemics, the Framework will ensure a more integrated approach to meeting the clinical needs of care home residents.

12. Rapid Review of Contact Tracing Services

291. The Rapid Review of Contact Tracing Services reported on 12 October 2020 and was underpinned by a key assumption that there would be a significant escalation in Covid-19 infections over the weeks and months ahead (from Autumn 2020) and that in order for the service to be effective, positive cases had to be contacted within 24 hours and their close contacts within 48 hours of notification to the contact tracing system. The main purpose of the Rapid Review was to support the ongoing and future delivery of the contact tracing function by looking at the elements of the Contact Tracing Service that had worked well, and to consider what measures were required to effect improvements in the service with a focus on more efficient and

effective contact tracing processes, supported by appropriate technology and the provision of high quality management information to support oversight of the service.

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

13. Public Health Agency Reshape and Refresh Programme

293. In Autumn 2020, as the pandemic progressed, Dr Ruth Hussey, former Chief Medical Officer (CMO) for Wales, was jointly commissioned by the Department and the Public Health Agency (PHA) to carry out a rapid, focused external review of the PHA's requirements to respond to the Covid-19 pandemic over the subsequent 18-24 months. This rapid review was conducted between mid-November and mid-December 2020 and the final report (the Hussey Review) was delivered to the PHA and the Department in December 2020. The report contained four main, high-level recommendations, which through their implementation would constitute a major change programme for the PHA, leading to a new model for operational delivery of the core public and population health function in Northern Ireland. The recommendations were to:

- Strengthen the public health system in Northern Ireland;
- Strengthen health protection capability within the PHA;
- Develop science and intelligence capability [in the PHA]; and
- Build a modern, effective and accountable organisation [viz., the PHA].

294. The PHA and Department accepted the findings of the Hussey Review, and established a Programme to Reshape and Refresh the PHA to ensure that it could not only effectively deal with the current pandemic, but would be better equipped to deal with future pandemic challenges as they arise. The Programme would also ensure that the PHA was well placed to maximise the additional strategic and operational benefits from new UK-wide arrangements being taken forward by the UK Health Security Agency (UKHSA) including: pandemic preparedness and capabilities as they developed; and, to ensure alignment and complementarity with our own

public health capacity and capability requirements in Northern Ireland. It would further ensure that the PHA could effectively interact with the reformed Health and Social Care system, in the context of the planned closure of the former Health and Social Care Board (HSCB) and the new integrated care model for services also planned to come into operation.

295. The refresh and reshape Programme commenced in March 2022 and is now at an advanced stage of implementation across the PHA. The programme has been developed using a phased approach, with Phase one completing with an "As-is" assessment in September 2022. Phase 2a involved the development of a target operating model which completed in May 2023 with Phase 2b/c (full implementation) commencing immediately thereafter. The programme comprises three workstreams: the Transformation Management Office, People & Organisation, and Change & Communications. A further workstream relating to Data and Digital commenced in Autumn 2023.

296. Following agreement on the new Target Operating Model, which included a high-level organisation structure, in January 2024, responsibility for implementation has passed fully to PHA and work is fully underway to refine a structure which is based on functional areas and multi-disciplinary teams, which include ensuring that there is capacity and capability in relation to pandemic preparedness. This work will be monitored by the Department through its governance and accountability arrangements.

14. The Rapid Learning Review of Domiciliary Care in Northern Ireland

297. On 17 November 2020 the Department carried out a review of Domiciliary Care in Northern Ireland. This review engaged with a wide range of stakeholders including service users, carers, providers and commissioners to help shape plans moving forward. The final report made nine recommendations which would inform surge plans and longer terms plans for the sector. The recommendations covered 9 areas:

- Improving recognition and profile of the domiciliary care workforce – it was suggested that a member of domiciliary care staff should feature at a Ministerial briefing as with other staff, that domiciliary care providers consider sending thank you cards/letters to domiciliary care staff, and that the Department should promote positive media stories about domiciliary care.

- Improving recognition and support for family carers – it was recommended that Trusts should be more proactive in offering direct payments to family carers and flexible in the permitted uses of carers' grants to relieve stress for informal carers. Trusts should include the prioritisation of carers' assessments and re-assessments in their rebuilding plans to mitigate against fatigue and adverse impact on wellbeing. Co-production with service users and family carers should be promoted in pandemic planning and strategic planning for domiciliary care. Attempts should also be made to identify new carers as a result of the pandemic.
- Workforce support – it was suggested that domiciliary care providers should use the framework of the Covid Staff Wellbeing Framework to provide support to their staff and increase awareness of availability of psychological support for their staff, including online NISCC resource on staff wellbeing. Providers should also focus on increased communication with their staff and ensure opportunities for peer support are also available. Work should also continue on developing a proposal for the Minister of Health's consideration, to seek improvement in the lowest pay for social care staff employed by the independent sector, and on developing proposals for the Minister of Health's consideration for standardised improvements to the training, development and career pathways of the social care workforce across the system.
- Infection prevention and control – current IPC advice and PPE guidance relevant to domiciliary care should be reviewed and consolidated to ensure regional consistency, version control and a consistent, clear interpretation of IPC advice across Trusts and all domiciliary care providers.
- Meeting needs of service users and family carers – Trusts should proactively contact those service users whose care packages were stood down from the start of the pandemic and consider their current needs; this should include a full consideration of the sustainability of the current arrangements, with particular regard to the physical, mental and social support needs of any informal or family carers. Trusts should also engage with anyone on their caseloads who was not previously getting a care package, but where it is likely that the pandemic may have created a need for additional support.
- Financial support for providers – offers of financial support for providers should be set out in one document, which should be accompanied by clear, regionally consistent pathways for claiming financial supports.

- Communication with providers - All guidance/ policy/ procedure/ information for domiciliary care should be electronically available and hosted in one place and on one platform. Any revisions made to guidance should highlight the revisions and changes required.
- Data - A core data set for domiciliary care during the pandemic should be agreed across Trusts and regional agencies that takes into account the time and effort involved in producing data and the quality of the current data systems. Expectations for providers to provide this core data set should be made clear. Requests for data outside this core data set should be made in exceptional circumstance only.
- Systemic issues and future planning for domiciliary care – these were addressed to the Department of Health's Reform of Social Adult Care team and highlighted the need to improve the pay, terms and conditions of the domiciliary care workforce as well as the role of the community and voluntary sector in providing supports to people. It was also stressed that there was a need to consider the future model of social care provision, including the respective roles of the statutory, private and voluntary sectors and the importance of assessing the benefits and costs of informal care in future service planning and as part of the costing of the social care economy.

298. The recommendations of the rapid learning review were accepted by the Adult Social Care Surge Planning Working Group chaired by the Chief Social Worker. There followed an implementation plan and monitoring and review of same which also reported into the Adult Social Care Surge Planning Working Group. Apart from a small number of recommendations which were outdated by developments in the pandemic since the report had been written, all other recommendations were implemented.

299. It is also relevant that in this review many of the longer term and more strategic recommendations related to the provision of social care as a whole and were not restricted to merely the issue of social care during the pandemic. Much of the learning was incorporated into the Department of Health's proposals on the reform of adult social care which went out for public consultation in January 2022. Since then, the Department has established an adult social care collaborative forum which is taking forward the reform process.

300. Workstreams have been set up to look at the following: Maximising Capacity, Workforce Development, Enhancing Care in Care Homes, Data, Research and Evidence, Communications, Commissioning and Contracting, Carers, and Supported Living. Lessons from the Rapid learning Review are incorporated as described above in the Reform of Adult Social Care process. These lessons are also built into pandemic surge plans.

15. Northern Ireland Audit Office Review of PPE Distribution and Procurement

301. The Northern Ireland Audit Office Report on 'The COVID-19 pandemic: Supply and procurement of Personal Protective Equipment to local healthcare providers' (the NIAO Report) was published on 1 March 2022, concluding a review started in March 2021. The NIAO Report identified six areas of learning and these have all been considered by the Department and its relevant Arms' Length Bodies. The Department and its Arms' Length Bodies had all taken action in relation to the learning points in the final report, most of which were already addressed by the time the final report was published.

16. Post Covid-19 Staff Wellbeing

302. In August 2021 a focused review of staff experiences during the pandemic was carried out [INQ000383326]. The reviewer undertook Department wide engagement in order to:

- Improve communication and staff engagement;
- Engage directly with staff about their well-being; and,
- Provide a platform for staff to deal with any residual issues remaining after lock-down.

303. The report provided a small number of conclusions and recommendations, with a focus on wellbeing and support for those working in distressing areas.

304. The report was accepted by the then Top Management Group (TMG); now Senior Management Team (SLT). The findings of the report directly influenced the production of the new people strategy. In addition, the DoH has also made provision for specialist support for those people working in areas with the potential to deal with distressing issues.

17. Internal Review of Rebuilding HSC Services Management Board

305. Following an internal review in spring 2022, the Management Board for Rebuilding HSC Services was stood down and was replaced by the HSC Performance and Transformation Executive Board (PTEB) which was established in June 2022 as part of the new governance arrangements for the Transformation of Health and Social Care services. The internal review highlighted a need for a forum that engaged system leaders in advising on, advocating and leading HSC reform, improvement and prioritisation. Given the publication of key strategies in mental health, urgent and emergency care, cancer and elective care, together with enabling strategies relating to workforce development and digital innovation, there was a need for a strategic executive forum that could drive forward and implement regional and system wide operational improvements [INQ000348835 (DoH ref: PM3074)], [INQ000348836 (DoH ref: PM3075)], [INQ000348837 (DoH ref: PM3076)], [INQ000348838 (DoH ref: PM3077)], [INQ000348839 (DoH ref: PM3078)], [INQ000348840 (DoH ref: PM3079)].

306. The Management Board for Rebuilding HSC Services (RMB) was created via a Memorandum to the HSC Framework Document for a period of two years with the intention to review after this point. Following the internal review, RMB was stood down at the end of the two-year operating period as originally envisaged. PTEB was established as part of the recommendations following the internal review.

18. Independent external review of the regional orthopaedic service in NI to identify proposals for the immediate recovery of the service

307. The Review, which was undertaken by the Getting It Right First Time (GIRFT) team from the Royal National Orthopaedic Hospital (RNOH), commenced in April 2022 and a report was presented to the Department in June 2022 [INQ000348866 (DoH ref: PM3112)]. The report detailed 21 recommendations designed: firstly, to increase activity in the short term, with the overall aim of building a sustainable service for the future; and secondly, to further develop and maintain a sustainable and efficient service. The report included, for example, recommendations to ring fence staff and beds for elective orthopaedics, and to create an Orthopaedic Elective Surgery Recovery Board to provide oversight to Trusts throughout the rebuild process.

308. All 21 recommendations were fully accepted by the Department, and work is underway to implement all recommendations. In overall terms, 10 of the 21 recommendations are deemed to be either complete or on track for completion. It is

anticipated that implementation of remaining recommendations will be complete by June 2024, however this will be dependent on availability of resources as well as other influencing factors, such as the status of the operating environment within which Trusts are working.

19. Review of the experiences of staff during the pandemic from EY management consultants

309. In June 2022 the Department commissioned EY to conduct a review of the organisational and personal impacts of the pandemic response. A wide range of staff who worked in the Department during the pandemic told their story and shared views about the successes and the learnings from the response. The Review included:
    1. Areas of innovation and good practice emerging from the response which should be mainstreamed;
    2. Learning from the response should be incorporated into future arrangements in the Department;
    3. A forward-looking organizational approach which takes into account the response to the pandemic and the current priorities and challenges.

310. Although the report [INQ000348736] does not make any specific recommendations, it does highlight a number of findings for the Department. These findings were grouped thematically: Leadership and Direction; Policy Development and Implementation; Collaboration and Support; External Communications; Staff Management and Wellbeing; and Use of Innovative Technology and Development.

311. The report was accepted by the then Top Management Group (TMG); now Senior Management Team (SLT). There was agreement that the Department would seek to integrate the findings of this report into their business areas as appropriate. Although it has informed a number of aspects of engagement at the senior management level, a key product following this review was the production of a new People Strategy for the Department.

STATEMENT OF TRUTH

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

Signed: Personal Data

Dated: 07 June 2024