UK COVID-19 PUBLIC INQUIRY
MODULE 3 - IMPACT OF THE COVID-19 PANDEMIC ON HEALTHCARE SYSTEMS
RULE 9 – DATA

Contents

Witness Name: Eugene Mooney & Lisa McWilliams
Statement No.
Exhibits: 15
Dated: 5 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Eugene Mooney and Lisa McWilliams,
Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY
MODULE 3 - IMPACT OF THE COVID-19 PANDEMIC ON HEALTHCARE SYSTEMS

We, Dr Eugene Mooney, Director of Information and Analysis of the Department of Health Northern Ireland, ('the Department') and Lisa McWilliams, Director of Strategic Performance, Safety & Service Improvement of the Strategic Planning and Performance Group of the Department make this statement in response to the request from the UK Covid-19 Public Inquiry, dated 23 May 2024 under Rule 9 of the Inquiry Rules 2006 (M3/DOHNI/02), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3.

SCOPE OF THIS STATEMENT

We will say as follows: -

1. On 13 of October 2009, I, Eugene Mooney, took up post as Director of Information and Analysis for the Department on long-term loan from the Department of Finance and Personnel for Northern Ireland. I am a Board member of the Northern Ireland Statistics and Research Agency. I previously held senior statistician positions in the Department of Finance and Personnel for Northern Ireland and Department of Agriculture for Northern Ireland. My Directorate were responsible for publishing the Department's Covid19 daily dashboard.

2. On 4 May 2021, I, Lisa McWilliams, took up post as Director of Strategic Performance, Safety and Service Improvement within the Strategic Planning and Performance Group of the Department. I previously held the role of Interim Director of Planning and performance in the former Health and Social Care Board (now SPPG) from 2018 and continued in this role until my appointment within the newly established SPPG. I had overall responsibility for the reporting of HSC performance during the relevant period. This involved the monitoring of service management information for internal purposes – components of which were used by the Information and Analysis Directorate of the Department of Health on the public-facing Covid Dashboard as the official record of statistics during the Pandemic. This also covered the extraction and collation of specified service data to facilitate the pandemic modelling and surge planning processes, during the relevant period, by relevant Health and Social Care Board (HSCB) and Public Health Agency teams.

Data relating to hospital capacity

3. The Department of Health in Northern Ireland ('the Department') does not, nor has ever held data in respect of the number of hospitals in Northern Ireland which closed their emergency departments to new admissions; and/or where incoming patients (for other departments) were transferred or diverted to other hospitals due to a hospital outbreak of Covid-19. However, the Department does not believe that any emergency department was closed during the Covid-19 pandemic for patients seeking emergency care including those subsequently deemed as requiring admittance. It is understood that the five Northern Ireland Health and Social Care (HSC) Trusts should hold information in respect of patient transfers and the Northern Ireland Ambulance Service (NIAS) should hold information on instances of diversion. These organisations would be better placed to assist in this regard.

4. Further, in respect of data relating to hospital capacity, specifically regarding the number of patients who were transferred or diverted from one hospital to another due to capacity issues, the Department does not hold or have access to records which detail the number of patients that were transferred or diverted to other hospitals due during the relevant period. The reason for this is again due to fact that the Department does not, nor has ever held this genre of data, and specifically the data in respect of the number of patients transferred due to a lack of capacity in critical care; a lack of capacity in an acute respiratory ward; capacity issues in general acute care or problems with oxygen supply

or other medical equipment. We would suggest as we have set out in paragraph 3 that HSC Trusts and NIAS should hold this information and would be better placed to assist in this regard.

5. Data on the occupancy of Intensive Care Unit (ICU) beds was collated by the Department and published on the Covid-19 Dashboard. Data was only collected by the Department between 20 March 2020 and 20 May 2022, with some date exclusions detailed in paragraph 7. Occupancy rate data held by the Department cannot be desegregated by the critical care level of ICU beds because although the Department does hold information in respect of the number of beds occupied by level 1, 2 or 3, it does not hold the number of available beds by critical care level but simply the total.

6. Between 20 March 2020 and 20 May 2022, there were 651 dates when, in at least one hospital in Northern Ireland, all ICU (level 1, 2 and 3) beds were occupied. This information was published daily on the Covid-19 Dashboard. As part of disclosure for Module 2C, the Department provided the Inquiry with a sample of 35 Covid-19 Dashboard reports [1]which include details of some of these instances. Further information by way of submission of a further sample of dashboard reports can be provided if required. Further, if the Inquiry wish to be advised of the date and location of each of the 651 instances of maximum capacity being reached, this information could be extracted from the Covid-19 Dashboard records held on file and presented as a singular report, with the Inquiry's permission.

7. It should be noted that from 27 April 2021 onwards, occupancy figures were no longer collected by the Department for paediatric ICU and cardiac ICU beds. This was with the exception of 4 cardiac ICU beds which were included within Royal Victoria ICU occupancy figures. Also, from this date onwards, all ICU beds previously in the Mater Hospital were redistributed to Belfast City and Royal Victoria, the occupancy of these beds were then reported against the respective hospital. Occupancy data was not collected by the Department on 29 March 2020, weekends between 4 July 2020 and 27 September 2020, as well as 25 December 2020, 27 December 2020 and 1 January 2021.The requirement for 7-day reporting by the Department was reduced between 4

[1] Dashboard reports can be found at: [INQ000355562], [INQ000355567], [INQ000355605], [INQ000355610], [INQ000355617], [INQ000355622], [INQ000355627], [INQ000355633], [INQ000355638], [INQ000355643], [INQ000355649], [INQ000355654], [INQ000355662], [INQ000355672], [INQ000355677], [INQ000355682], [INQ000355687], [INQ000355692], [INQ000355697], [INQ000355702], [INQ000355707], [INQ000355712], [INQ000355717], [INQ000355722], [INQ000355727], [INQ000355732], [INQ000355739], [INQ000355745], [INQ000355747], [INQ000355752], [INQ000355754] **INQ000355571** **INQ000355578** **INQ000355589** **INQ000355665**

July and 27 September 2020, and the 2020 Christmas period (25 and 27 December 2020 and 1 January 2021), resulting in occupancy figures not being reported at weekends or public holidays. Any proposed changes to content and coverage was communicated to Minister Swann and senior staff to ensure that the proposed revisions would meet their needs. Changes were agreed and approved by Minster Swann. Changes in reporting were at a time when there were fewer cases and on one occasion for a few days over the Christmas holiday to allow staff some respite from reporting 7 days per week. It was clearly agreed with Minister Swann that should there be a surge or for any reason the Department felt that reporting should be stepped up then this could be actioned immediately.

8. The Department never collected data in respect of beds designated for patients with or suspected of having Covid-19 (red or hot zones) and beds designated for patients not infected with Covid-19 (green or cold zones), this information has never been collected by the Department. We would suggest that this information may be available from HSC Trusts.

Healthcare workers

9. Information on monthly absence rates of HSC workforce due to sickness over the relevant period and the proportion of absence due to Covid-19-related illness or isolation the period April 2020 and June 2022 are displayed in table 1 below. It should be noted that data is not available prior to this date as monitoring sickness and self-isolation due to Covid-19 did not begin until April 2020. The standardised metric used for HSC sickness absence rates is the percentage of working hours lost and is calculated from absence hours divided by hours available. The Inquiry should further note that the information displayed below was sourced from a regional Sharepoint file in which HSC organisations have entered their monthly sickness absence data. Although the Department has access to this information, it is reliant on inputs from HSC organisations and therefore the accuracy of the information cannot be guaranteed by the Department. HSC Organisations would be better placed to provide information based on their individual records.

Correspondence was issued to Trusts on 12 May 2020 from the Chief Medical Officer [INQ000490088], which set out the Minister's request for all HSC Trusts to advise the

Department on a daily basis of the number of health and social care workers who had died with or from COVID-19. Such notification was to be sent to HSC Silver for inclusion in the daily SITREP to Gold. Whilst such information was included in numerous relevant Sit Reps, the Department does not hold collated, extrapolated and verified data confirming the totality of numbers of HSC workers who died of Covid-19 and is therefore of the view that individual HSC Trusts would be best placed to provide specific data relating to the totality of such deaths to the Inquiry.

Table 1 - Regional HSC Monthly % Sickness Absence Comparators - percentage of working hours lost

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
BHSCT	**Absent due to Sick Leave (excluding COVID-19)**	8.53%	8.37%	7.76%	6.77%	7.09%	7.34%	7.73%	7.49%	7.45%	7.49%	7.26%	6.75%	6.89%	7.26%	7.83%	8.25%	8.67%	8.73%	9.13%	9.12%	8.54%	8.52%	8.56%	9.35%	7.37%	7.52%	7.97%
	Absent due to COVID-19	1.39%	0.80%	0.49%	0.29%	0.12%	0.22%	0.23%	0.90%	0.66%	1.01%	0.56%	0.33%	0.26%	0.22%	0.17%	0.43%	0.72%	0.74%	0.80%	0.87%	1.18%	2.52%	2.56%	2.35%	1.44%	1.04%	1.43%
	Absent due to Self-Isolation	3.61%	3.10%	2.64%	1.93%	0.42%	0.80%	0.67%	1.56%	0.93%	1.58%	1.22%	0.82%	0.36%	0.22%	0.23%	0.78%	0.85%	0.63%	0.68%	0.71%	1.04%	1.11%	1.04%	0.98%	0.48%	0.27%	0.28%
NHSCT	**Absent due to Sick Leave (excluding COVID-19)**	7.94%	7.57%	7.01%	6.50%	6.58%	6.78%	6.52%	6.30%	6.25%	6.23%	5.99%	5.58%	5.57%	5.90%	6.58%	7.25%	7.50%	7.50%	7.61%	7.52%	7.49%	7.02%	7.59%	6.57%	6.65%	6.98%	6.90%
	Absent due to COVID-19	1.22%	1.01%	0.48%	0.24%	0.17%	0.30%	0.64%	0.82%	1.28%	2.50%	1.44%	0.90%	0.68%	0.59%	0.52%	0.66%	1.09%	1.24%	1.29%	1.33%	1.55%	2.85%	3.60%	3.41%	2.25%	1.55%	2.40%
	Absent due to Self-Isolation	4.64%	3.99%	3.34%	2.39%	0.64%	1.00%	2.18%	1.47%	1.42%	2.40%	1.50%	1.14%	0.54%	0.32%	0.30%	0.98%	1.20%	0.90%	0.88%	1.18%	1.23%	1.30%	1.55%	0.93%	0.49%	0.30%	0.37%
SEHSCT	**Absent due to Sick Leave (excluding COVID-19)**	7.29%	6.63%	6.54%	6.34%	6.42%	6.79%	6.95%	7.12%	6.61%	6.56%	6.57%	6.09%	5.99%	6.28%	6.92%	7.55%	7.53%	7.57%	7.71%	7.84%	7.67%	7.17%	7.32%	7.57%	6.49%	6.42%	7.12%
	Absent due to COVID-19	0.72%	0.86%	0.59%	0.19%	0.15%	0.22%	0.55%	0.73%	0.72%	0.87%	0.71%	0.44%	0.35%	0.21%	0.22%	0.52%	0.81%	0.96%	0.89%	0.74%	1.26%	2.92%	3.49%	3.49%	0.52%	1.15%	1.85%
	Absent due to Self-Isolation	3.83%	3.65%	3.18%	2.20%	0.45%	0.88%	2.33%	2.22%	1.32%	1.81%	1.49%	0.99%	0.10%	0.25%	0.32%	1.15%	1.09%	1.01%	0.96%	0.91%	1.10%	1.28%	1.28%	0.99%	1.77%	0.32%	0.48%
SHSCT	**Absent due to Sick Leave (excluding COVID-19)**	6.73%	6.30%	5.85%	5.16%	5.21%	5.77%	5.71%	5.89%	6.10%	6.06%	5.73%	5.02%	4.87%	6.28%	5.65%	5.90%	6.27%	6.54%	6.74%	6.66%	6.55%	6.01%	5.66%	5.21%	5.31%	5.37%	5.87%
	Absent due to COVID-19	1.23%	0.73%	0.27%	0.18%	0.22%	0.87%	1.08%	1.20%	1.27%	2.42%	1.69%	0.94%	0.64%	0.54%	0.47%	0.62%	1.08%	1.25%	1.13%	1.24%	1.64%	3.50%	3.21%	2.49%	1.52%	0.94%	1.57%
	Absent due to Self-Isolation	4.00%	3.55%	3.10%	2.32%	0.62%	1.53%	1.77%	1.33%	1.19%	2.19%	1.44%	0.93%	0.54%	0.42%	0.50%	1.03%	1.30%	0.88%	0.89%	0.97%	1.24%	1.09%	0.94%	0.67%	0.44%	0.28%	0.32%
WHSCT	**Absent due to Sick Leave (excluding COVID-19)**	8.25%	8.03%	7.19%	6.44%	6.69%	6.99%	6.76%	6.71%	6.89%	6.64%	6.09%	5.65%	6.10%	6.36%	6.99%	7.36%	7.56%	7.65%	7.83%	7.77%	7.62%	6.97%	7.13%	7.91%	6.46%	6.88%	7.12%
	Absent due to COVID-19	0.77%	0.42%	0.21%	0.16%	0.13%	0.28%	1.13%	1.01%	1.00%	1.53%	0.88%	0.57%	0.59%	0.52%	0.55%	0.83%	1.37%	1.39%	1.26%	1.23%	1.78%	3.78%	3.18%	4.04%	1.73%	1.01%	1.61%
	Absent due to Self-Isolation	4.55%	3.23%	2.51%	1.92%	0.41%	0.98%	3.00%	1.43%	1.20%	1.54%	1.03%	0.72%	0.51%	0.49%	0.56%	1.09%	1.58%	0.92%	0.70%	0.87%	1.30%	0.97%	0.60%	0.69%	0.34%	0.25%	0.25%
NIAS	**Absent due to Sick Leave (excluding COVID-**	6.84%	6.89%	7.87%	8.18%	9.23%	8.92%	8.89%	8.24%	10.16 %	7.70%	6.97%	5.81%	6.56%	7.41%	10.33 %	12.77 %	13.20 %	12.48 %	11.28 %	11.39 %	10.93 %	9.86%	21.31 %	11.71 %	10.62 %	10.67 %	11.34 %

	19)																												
	Absent due to COVID-19													1.12%	0.91%	0.98%	1.29%	1.39%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.27%	2.13%	2.44%
	Absent due to Self-Isolation													0.46%	0.38%	0.60%	1.97%	2.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.24%	0.24%	1.04%
BSO	Absent due to Sick Leave (excluding COVID-19)	3.39%	3.33%	3.33%	2.93%	2.79%	2.96%	3.12%	3.53%	3.00%	3.40%	2.83%	3.01%													3.36%	3.36%	3.35%
	Absent due to COVID-19	0.41%	0.04%	0.01%	0.02%	0.01%	0.07%	0.89%	0.82%	0.70%	0.91%	0.27%	0.14%													0.97%	0.43%	0.55%
	Absent due to Self-Isolation	1.95%	0.77%	0.74%	0.52%	0.02%	0.15%	0.56%	0.33%	0.13%	0.18%	0.09%	0.04%													0.06%	0.01%	0.04%
HSCB	Absent due to Sick Leave (excluding COVID-19)	1.74%	1.65%	2.17%	2.63%	2.78%	2.32%	3.24%	2.97%	3.66%	4.23%	3.44%	3.15%													3.07%	3.00%	2.78%
	Absent due to COVID-19	0.08%	0.00%	0.00%	0.00%	0.00%	0.10%	0.25%	0.29%	0.28%	0.46%	0.26%	0.00%													0.78%	0.70%	0.37%
	Absent due to Self-Isolation	0.01%	0.00%	0.00%	0.00%	0.01%	0.07%	0.00%	0.05%	0.26%	0.24%	0.10%	0.00%													0.01%	0.00%	0.00%
PHA	Absent due to Sick Leave (excluding COVID-19)	2.60%	2.82%	2.54%	2.27%	2.08%	2.00%	2.22%	1.48%	1.41%	1.48%	1.40%	1.29%													3.42%	2.52%	3.59%
	Absent due to COVID-19	0.17%	0.17%	0.00%	0.00%	0.00%	0.00%	0.08%	0.00%	0.00%	0.33%	0.29%	0.23%													1.61%	1.22%	1.62%
	Absent due to Self-Isolation	0.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.00%	0.00%	0.00%													0.00%	0.00%	0.06%[2]

[2] Where cells are blank, no data was provided.

The standardised metric for HSC sickness absence rates is percentage of working hours lost, calculated from absence hours divided by hours available.

Each HSC organisation's data was sourced from the Human Resource, Payroll, Travel & Subsistence system (HRPTS).

Figures exclude those staff who are on bank contracts and domiciliary care workers. This is due to the variable nature of the hours worked during their employment.

The regional spreadsheet did not begin to monitor covid sickness and self-isolation (due to Covid-19) until April 2020.

Ante-natal care, maternity services, postpartum and neonatal care

10. Plans were put in place early in the pandemic to protect children's and maternity services. The Department issued a statement on 12 March 2020 [INQ000103659] alerting the public that HSC services were under growing pressure due to the increase in cases of coronavirus. That statement confirmed the expectation that normal business would not be possible as the HSC moved into the next phase of the pandemic.

11. On 26 March 2020 the Department's Chief Nursing Officer wrote to the HSC Trusts [INQ000438142] to inform them that with immediate effect, based on clinical advice, all visits to hospitals were to be stopped in the interests of protecting patients, their families and HSC staff. There were limited exceptions to this, including the allowance that while visiting was not permitted in either ante-natal or post-natal ward areas, women in established labour could be accompanied by one birthing partner through the birthing process. Another exception was that children admitted to Paediatrics settings, including Neonatology / Paediatric ICU could be accompanied throughout by a parent.

12. Guidance on visiting arrangements continued to be developed and enhanced as the evidence to support this emerged. Comprehensive Regional guidance was announced by Minister Swann and published on 30 June 2020 [INQ000103667] and this detailed the changes to restrictions on visiting, which applied across all care settings from Monday 6 July 2020. This guidance was posted on the Department's website, as well as being widely circulated across the sector.

13. The guidance provided clear advice around the restrictions that should apply across a range of settings, including Maternity Services, while remaining careful to recognise the right of the patient's next of kin, partners, children, parents, and carers to visit their loved ones, and also recognising the need to minimise the risk of transmission of the virus.

14. With the increased level of transmission of Covid-19 during August and September 2020, the Department announced revised visiting guidance for hospitals and care homes on 23 September 2020 [INQ000256450]. This revised guidance was again predicated on a phased approach to visiting, with the Regional Alert Level [INQ000270105] as assessed by the 4 UK CMOs, at any given point in time dictating the level of restrictions

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

15. For maternity settings, this meant that arrangements were as follows, depending on the applicable Alert Level at any given time:

Table 2 - Regional Alert Level Arrangements

Alert Level 5	Alert Level 4	Alert Level 3
A material risk of healthcare services being overwhelmed - extremely strict social distancing	**A high or rising level of transmission - enforced social distancing**	**The virus is in general circulation - social distancing relaxed**
Birth partner will be facilitated to accompany the pregnant woman to labour ward for active labour (to be determined by midwife) and birth only.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, early pregnancy clinic, anomaly scan, Foetal Medicine Department, when admitted to individual room for active labour (to be determined by midwife) and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.	Birth partner will be facilitated to accompany the pregnant woman to dating scan, early pregnancy clinic, anomaly scan, and Fetal Medicine Department, for induction of labour, duration of labour and birth and, to visit in antenatal and postnatal wards for up to one hour once a week.

16. Following the recommendation by the four CMOs that the UK should move into Alert level 5, an urgent review of the existing visiting guidance was completed, which added some additional text to provide clarity for patients, residents, care providers and the public, and the new guidance took effect from 8 January 2021 [INQ000276331]. This meant that no face to face visiting to general hospitals (including ICU) would be permitted, and that end-of-life visiting would be considered following a risk assessment and ensuring a Covid-19-secure environment. Visiting to hospices and care homes was still allowed during that time.

17. This guidance continued in force until late February 2021, when following the recommendation by the four CMOs that the UK should revert from level 5 to level 4, the

Department confirmed that Minister had approved an easing of the restrictions on visiting arrangements for all healthcare settings (including hospitals) from 26 February 2021 [INQ000276332]. The revised position was subject to local risk assessment and kept under review.

18. As the Department began to navigate the "road back to normal", revised guidance to facilitate increased visiting in health and social care settings in NI came into effect from 7 May 2021. The revised guidance was set out in two documents, with bespoke advice provided, which varied, dependent on the category of care setting involved. *'A Pathway to Enhanced Visiting'* [INQ000276333] set out a new approach to visiting in hospices and hospitals, including maternity and other services, which incorporated a scheduled periodic review process which allowed public health officials to consider progress. Changes to *'A Pathway to Enhanced Visiting'* were made, in line with available data and experiential evidence, to decide whether progress along the Pathway would be appropriate (see [INQ000348956] for full list of meetings and decisions). Following each review, a formal recommendation was made to the Minister on whether progress along the 'Pathways' was appropriate, based on the available scientific data as assessed by public health professionals from the PHA, and the expertise of those responsible for its delivery.

19. Following successful progress to the final stage of that Pathway, which was achieved in late June 2022, a 'new normal' document for these settings *'Enabling Safer Visiting'* [INQ000276337] was developed by the Department. The Public Health Agency and the HSC Trusts provided input into that document. Following Ministerial approval on 27 October 2022 the document was launched to take effect from 31 October 2022.

20. During the relevant period, a Maternity Collaborative Covid-19 Cross Trust Task and Finish group was established for Paediatric, Maternity and Neonatal Care in order to address any impact of the Covid-19 pandemic on the delivery of ante-natal and maternity care. The Task and Finish group managed demand and capacity concerns and escalation triggers during periods of surge. The Task and Finish group also developed options for patients from presentation to discharge. The Department has been unable to locate a terms of reference for this group. It should be noted that the Department became involved in this group after its establishment, and to this end, we are unaware if a terms of reference for the group was developed prior to our involvement. In order to

demonstrate the workings of the group, a copy of the action notes from the first meeting attended by Departmental staff, on 21 May 2020, can be found at [INQ000490089]. It would be our belief that the South Eastern HSC Trust may be better placed to advise in respect of any terms of reference for this group, given their role in providing a chairperson.

21. On 3 April 2020, the Department had published details of a regional surge plan [INQ000346740] which had been developed with the five Health and Social Care Trusts to protect access to children's and maternity services through temporary reconfiguration. This surge plan ensured continued access to urgent and emergency care from suitably qualified and experienced staff, when required. The surge plan also 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.

22. From 9 April 2020, following a report from HSC Silver (which was approved by HSC Gold) it was agreed to temporarily close Causeway Hospital to Paediatric admissions and Inpatient Maternity Services. 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.

23. 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.

24. On 6 April 2020 an HSC Silver paper approved the immediate launch of the Diabetes Care Helpline which aimed to provide advice to all patients living with diabetes, including gestational diabetes [INQ000377153] The service officially launched on 7 April 2020 and ran seven days a week. The helpline complemented existing Trust services, which were operational from Monday to Friday and operated as a stand-alone service on Saturdays and Sundays.

25. On 7 May 2020, a paper was submitted to HSC Silver [INQ000490091] which outlined a proposal to introduce blood pressure monitoring for selected pregnant women during Covid 19. Pathways for the proposed service were developed, in conjunction with Trusts, based on guidance provided by the Royal College of Obstetricians and Gynaecologists (RCOG) for self-monitoring of BP and urine in pregnancy. Subsequently, funding was allocated to HSC Trusts for the purchase of blood pressure monitors and urinalysis kits. Final versions of pathway were circulated on 7 September 2020. [INQ000490092] [INQ000490093]

26. There were a number of pieces of key guidance and guidelines published by and/or with the involvement of the Department for ante-natal and obstetrics during the relevant period. These are set out below and are referenced as exhibits.

- On 28 April 2020, a letter was issued from the Director of Commissioning, Health and Social Care Board (HSCB) to HSC Trusts, the Regulation and Quality Improvement Authority (RQIA) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) Chief Executives to provide advice to HSC staff on the provision of placental histology and hospital post mortem services if mother or baby is suspected or confirmed Covid-19 positive. [INQ000490094], [INQ000490095], [INQ000490096], [INQ000490097]

- On 1 May 2020, guidance was published on 'Fertility and Termination Of Pregnancy'; in which it was stated that the commissioning of services would be directed by the Department and also explained that health care professionals could continue to practice in line with the limits of the legislation. [INQ000490098]

27. There were a number of instances during the relevant period when key guidance or advice for pregnant women published by the Department. These are summarised below:

- 03 April 2020 - Plans in Place to Protect Children's and Maternity Services [INQ000130412]

- 07 April 2020 - Temporary pause of routine screening programmes [INQ000371486]

- 30 June 2020 - Covid-19: regional principles for visiting in care settings in Northern Ireland. [INQ000103667].

- 22 September 2020 - COVID-19 - Regional Principles for Visiting Care Settings in Northern Ireland [INQ000256450].

- 08 December 2020 - A Guide to Covid-19 vaccination - All women of childbearing age, those currently pregnant, planning a pregnancy or breastfeeding. [INQ000490101]

- 07 May 2021: '*A Pathway to Enhanced Visiting*' [INQ000276333] set out a new approach to visiting in hospices and hospitals, including maternity and other services.

- 31 October 2022 '*Enabling Safer Visiting*' [INQ000276337] - a 'new normal' document for all hospital/hospice care settings.

- 17 December 2021: 'JCVI advice that pregnant women of any age should be considered as a clinical risk group for Covid-19'. [INQ000390061]

Hip replacement surgery/elective orthopaedic surgery

28. The Department does not, nor has ever held data in respect of the annual number of patients waiting for hip replacement surgery. The Department believes that this information should be available from HSC Trusts.

29. Figures are available on the number of patients waiting for an inpatient or day case procedure under the Trauma and Orthopaedics Surgery specialty and these are displayed in table 3 below. These figures only record the position as at the end of each quarter and these are presented for the quarter ending June 2017 to the quarter ending March 2023 in order to include the relevant period and to display the three years prior to the Covid 19 pandemic. This information has been taken from the Department's Inpatient Waiting Times Dataset. This information contained within this dataset is sourced from HSC Trusts Patient Administration Systems. The dataset also contains information on other specialities over a large number of years and as such, due to its size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

Table 3 - Number of Patients Waiting for Inpatient and Day Case Procedure Under the Trauma and Orthopaedics Specialty

Quarter Ending	Total Waiting	Quarter Ending	Total Waiting

30 June 2017	13,631	30 June 2020	18,783
30 September 2017	14,196	30 September 2020	19,309
31 December 2017	15,202	31 December 2020	20,535
31 March 2018	15,261	31 March 2021	21,556
30 June 2018	15,944	30 June 2021	22,148
30 September 2018	16,408	30 September 2021	22,975
31 December 2018	16,846	31 December 2021	24,700
31 March 2019	16,667	31 March 2022	25,742
30 June 2019	16,916	30 June 2022	26,415
30 September 2019	16,986	30 September 2022	25,951
31 December 2019	17,283	31 December 2022	25,623
31 March 2020	18,050	31 March 2023	25,075

30. The Department does not hold figures for the annual number of patients who are waiting for an inpatient or day case procedure. At 31 March 2020, there were 18,050 patients waiting for an inpatient or day case procedure under the Trauma and Orthopaedics Surgery specialty, compared with 26,415 on 30 June 2022. Three years prior to the relevant period, there were 13,631 patients waiting as at 30 June 2017.

31. Data held by the Department provides the annual number of hip replacement procedures rather than the number of patients. A patient may receive more than one procedure within the time period. During the relevant period, the annual number of hip replacement procedures carried out in Northern Ireland in the health service was 726 in 2020/21; 1,105 in 2021/22; and 1,402 in 2022/23. During the three years prior to this, there were 2,234 in 2017/18; 2,390 in 2018/19; and 2,174 in 2019/20. These figures are set out in table 4 below. This information has been taken from the Department's Hospital Inpatient System. The information contained within this dataset is sourced from HSC Trusts Patient Administration Systems. The dataset also contains information on other specialities over a large number of years and as such, due to its size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

Table 4 - Number of Hip Replacement Procedures in the 2017/18 to 2022/23 Financial Years[3]

Financial year	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Hip replacement procedures	2,234	2,390	2,174	726	1,105	1,402

[3] Admissions to the mental health and learning disability programmes of care are not included. Hip replacement procedures were identified using a number of OPCS codes in any of the operation fields of the Hospital Inpatient System. Codes can be provided if required.

32. The Department does not have specific targets for the length of wait for assessment for hip replacement/orthopaedic surgery or the length of wait between assessment and surgery. However, the pre-pandemic and current ministerial waiting time targets [INQ000490103] state that 50% of patients should wait no longer than nine weeks for a first outpatient appointment; with no patient waiting longer than 52 weeks. The guidance also provides that 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment; with no patient waiting longer than 52 weeks.

33. The Department is not in a position to provide the number and percentage of patients who were dealt with within the target timeframes for hip replacement/orthopaedic surgery. Waiting time data produced by the Department does not indicate completed waiting times nor expected future waiting times, but instead records ongoing waits. We understand that HSC Trusts should hold more specific information and may be better placed to assist in this regard.

34. The Department does have information on ongoing waits which have exceeded the ministerial targets as detailed in paragraph 33. Also, as indicated in paragraph 29, the Department does not hold waiting time data specifically for hip replacement surgery. However, figures for patients whose ongoing waits have exceeded the ministerial targets for a first outpatient appointment or an inpatient/day case procedure under the Trauma and Orthopaedics Surgery speciality that includes hip replacement. These are presented in tables 5 and 6 below, respectively, for the quarter ending June 2017 to the quarter ending March 2023 in order to include the relevant period and to display the three years prior to the Covid 19 pandemic. This information has been taken from the Department's Outpatient Waiting Times dataset and Inpatient Waiting Times dataset respectively. The information contained within both these datasets is sourced from HSC Trusts Patient Administration System. The datasets also contain information on other specialities over a large number of years and as such, due to their size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

35. It should be noted that the statistics presented in table 5 refer to the number of patients waiting for a first outpatient appointment and the length of time they had been waiting as at the end of each quarter between the 2017/18 and 2022/23 financial years. They do not indicate completed waiting times nor expected future waiting times. Waiting time begins from the date the HSC Trust receives a referral to a consultant-led service.

It should be further noted that the statistics presented in table 6 refer to the number of patients waiting for inpatient or day case admission and the length of time they had been waiting as at the end of each quarter between the 2017/18 and 2022/23 financial years. They do not indicate completed waiting times nor expected future waiting times. Waiting time begins from the date the clinician decided to admit the patient.

Table 5 - Number and Percentage of Patients Waiting for a First Outpatient Appointment Under the Trauma and Orthopaedics Specialty Breaching the Target Timeframes

Quarter Ending	0-9 Weeks	9-52 Weeks	Over 52 Weeks	Total Waiting	Percentage Breaching 9 Week Target	Percentage Breaching 52 Week Target
30 June 2017	5,882	11,014	15,570	32,466	81.9%	48.0%
30 September 2017	5,222	11,219	15,054	31,495	83.4%	47.8%
31 December 2017	5,322	10,630	15,602	31,554	83.1%	49.4%
31 March 2018	5,232	9,616	15,462	30,310	82.7%	51.0%
30 June 2018	5,710	9,068	15,431	30,209	81.1%	51.1%
30 September 2018	5,382	9,317	15,296	29,995	82.1%	51.0%
31 December 2018	4,704	8,937	13,330	26,971	82.6%	49.4%
31 March 2019	4,936	8,134	12,489	25,559	80.7%	48.9%
30 June 2019	5,334	7,710	12,123	25,167	78.8%	48.2%
30 September 2019	5,136	8,136	11,924	25,196	79.6%	47.3%
31 December 2019	5,047	8,229	10,948	24,224	79.2%	45.2%
31 March 2020	4,128	8,273	10,017	22,418	81.6%	44.7%
30 June 2020	2,765	9,669	11,269	23,703	88.3%	47.5%
30 September 2020	4,071	9,136	12,426	25,633	84.1%	48.5%
31 December 2020	3,391	8,521	12,205	24,117	85.9%	50.6%
31 March 2021	3,342	7,745	13,997	25,084	86.7%	55.8%
30 June 2021	4,451	8,034	13,815	26,300	83.1%	52.5%
30 September 2021	3,761	8,804	14,173	26,738	85.9%	53.0%
31 December 2021	3,540	8,294	11,942	23,776	85.1%	50.2%
31 March 2022	4,092	7,726	10,758	22,576	81.9%	47.7%
30 June 2022	4,449	7,260	10,104	21,813	79.6%	46.3%
30 September 2022	4,278	7,760	10,045	22,083	80.6%	45.5%
31 December 2022	4,484	7,948	9,218	21,650	79.3%	42.6%
31 March 2023	4,841	7,917	8,661	21,419	77.4%	40.4%

Table 6 - Number and Percentage of Patients Waiting for an Inpatient or Day Case Procedure Under the Trauma and Orthopaedics Specialty Breaching the Target Timeframes

Quarter Ending	0-13 Weeks	13-52 Weeks	Over 52 Weeks	Total Waiting	Percentage Breaching 13 Week Target	Percentage Breaching 52 Week Target
30 June 2017	2,780	6,891	3,960	13,631	79.6%	29.1%
30 September 2017	2,255	7,273	4,668	14,196	84.1%	32.9%
31 December 2017	2,915	7,025	5,262	15,202	80.8%	34.6%
31 March 2018	2,755	7,226	5,280	15,261	81.9%	34.6%
30 June 2018	2,827	7,346	5,771	15,944	82.3%	36.2%
30 September 2018	2,225	8,001	6,182	16,408	86.4%	37.7%
31 December 2018	2,815	7,552	6,479	16,846	83.3%	38.5%
31 March 2019	2,912	7,116	6,639	16,667	82.5%	39.8%
30 June 2019	2,696	7,324	6,896	16,916	84.1%	40.8%
30 September 2019	2,287	7,587	7,112	16,986	86.5%	41.9%
31 December 2019	2,712	7,398	7,173	17,283	84.3%	41.5%
31 March 2020	2,615	7,360	8,075	18,050	85.5%	44.7%
30 June 2020	789	8,106	9,888	18,783	95.8%	52.6%
30 September 2020	1,458	6,146	11,705	19,309	92.4%	60.6%
31 December 2020	2,058	4,837	13,640	20,535	90.0%	66.4%
31 March 2021	1,796	4,120	15,640	21,556	91.7%	72.6%
30 June 2021	2,294	4,568	15,286	22,148	89.6%	69.0%
30 September 2021	1,960	5,289	15,726	22,975	91.5%	68.4%
31 December 2021	2,927	5,415	16,358	24,700	88.1%	66.2%
31 March 2022	2,735	6,428	16,579	25,742	89.4%	64.4%
30 June 2022	2,902	6,586	16,927	26,415	89.0%	64.1%
30 September 2022	2,412	7,226	16,313	25,951	90.7%	62.9%
31 December 2022	2,943	6,596	16,084	25,623	88.5%	62.8%
31 March 2023	2,872	6,698	15,505	25,075	88.5%	61.8%

36. The data held by the Department suggests that in the Independent Sector there were 4,899 hip replacement procedures carried out during the relevant period. This information is presented in table 7 and is broken down by those carried out during elective and non-elective surgery. The total percentage of all hip replacement procedures carried out in the Independent Sector within the relevant period was 10% and is also set out in table 7. Due to data quality issues with the recording of Independent Sector Activity by Trusts, it has not been possible to calculate the percentage of these procedures that were within the target timeframes.

37. The information included in table 7 has been sourced from operational data which has been downloaded from HSC Trusts Patient Administration Systems. This dataset is

classified as management information, is downloaded directly from Trust IT Systems on a frequent basis and is designed to provide very timely indicators of HSC Service activity and performance. It is not subject to the same rigorous validation and submission by Trusts for statistics which are submitted to the Department and put into the public domain. The dataset also contains information on other specialities over a large number of years and as such, due to its size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

Table 7 - number and percentage of HSC patients who received hip replacement surgery orthopaedic surgery in or from private healthcare providers during the relevant period and the percentage of these patients who received treatment within the target timeframes

	Elective	Non Elective	Total
Total activity (HSC Trusts and Independent Sector)	1755	3144	**4899**
Independent Sector activity only	510	0	**510**
% Independent Sector activity	29%	0%	**10%**

Heart disease and heart attacks

38. The Department does not have specific waiting time targets for cardiology. However, the pre-pandemic and current ministerial waiting time targets state that 50% of patients should wait no longer than nine weeks for a first outpatient appointment; with no patient waiting longer than 52 weeks. Ministerial targets also state that 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment; with no patient waiting longer than 52 weeks.

39. The Department does not hold, nor has it ever held the data required to provide the number and percentage of patients who were dealt with within the target timeframes for cardiology. This is because waiting time data produced by the Department does not indicate completed waiting times nor expected future waiting times, but instead records ongoing waits. The Department understands that HSC Trusts should hold more specific information and may be better placed to assist in this regard.

40. The Department calculates ongoing waits that have exceeded the ministerial targets as detailed in paragraph 40. The Department does not hold waiting time data specifically for a diagnosis of, or to begin treatment for, heart disease. However, figures for patients

whose ongoing waits have exceeded the ministerial targets for a first outpatient appointment or an inpatient/day case procedure under the Cardiology speciality, which will not be confined to heart disease and will include other cardiology treatments are available. These are presented in tables 8 and 9 below, respectively, for the quarter ending June 2017 to the quarter ending March 2023 in order to include the relevant period and to display the three years prior to the Covid 19 pandemic. This information has been taken from the Department's Outpatient Waiting Times Dataset and Inpatient Waiting Times Dataset, respectively. The information contained within both these datasets is sourced from HSC Trusts Patient Administration System. The datasets also contain information on other specialities over a large number of years and as such, due to their size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

41. It should be noted that the statistics presented in table 8 refer to the number of patients waiting for a first outpatient appointment and the length of time they had been waiting as at the end of each quarter between the 2017/18 and 2022/23 financial years. They do not indicate completed waiting times nor expected future waiting times. Waiting time begins from the date the HSC Trust receives a referral to a consultant-led service.

It should be further noted that the statistics presented in table 9 refer to the number of patients waiting for inpatient or day case admission and the length of time they had been waiting as at the end of each quarter between the 2017/18 and 2022/23 financial years. They do not indicate completed waiting times nor expected future waiting times. Waiting time begins from the date the clinician decided to admit the patient.

Table 8 - Number and Percentage of Patients Waiting for a First Outpatient Appointment Under the Cardiology Specialty Breaching the Target Timeframes

Quarter Ending	0-9 Weeks	9-52 Weeks	Over 52 Weeks	Total Waiting	Percentage Breaching 9 Week Target	Percentage Breaching 52 Week Target
30 June 2017	4,022	3,787	710	8,519	52.8%	15.8%
30 September 2017	3,767	3,689	938	8,394	55.1%	20.3%
31 December 2017	3,632	3,992	1,146	8,770	58.6%	22.3%
31 March 2018	4,291	3,249	232	7,772	44.8%	6.7%
30 June 2018	4,684	3,335	221	8,240	43.2%	6.2%
30 September 2018	4,604	4,181	319	9,104	49.4%	7.1%
31 December 2018	4,759	4,745	263	9,767	51.3%	5.3%
31 March 2019	5,061	4,892	351	10,304	50.9%	6.7%
30 June 2019	4,876	5,004	651	10,531	53.7%	11.5%
30 September 2019	4,684	5,314	834	10,832	56.8%	13.6%
31 December 2019	3,856	5,597	962	10,415	63.0%	14.7%
31 March 2020	3,610	5,494	1,192	10,296	64.9%	17.8%
30 June 2020	1,750	6,641	1,655	10,046	82.6%	19.9%
30 September 2020	2,239	5,531	2,302	10,072	77.8%	29.4%
31 December 2020	2,254	4,682	2,921	9,857	77.1%	38.4%
31 March 2021	2,720	3,793	3,396	9,909	72.6%	47.2%
30 June 2021	2,906	4,197	3,207	10,310	71.8%	43.3%
30 September 2021	2,665	4,522	3,414	10,601	74.9%	43.0%
31 December 2021	2,572	4,485	3,466	10,523	75.6%	43.6%
31 March 2022	3,069	4,276	3,520	10,865	71.8%	45.2%
30 June 2022	3,185	4,173	3,794	11,152	71.4%	47.6%
30 September 2022	3,339	4,315	4,060	11,714	71.5%	48.5%
31 December 2022	3,354	4,476	4,225	12,055	72.2%	48.6%
31 March 2023	4,083	4,453	4,374	12,910	68.4%	49.6%

Table 9 - Number and Percentage of Patients Waiting for an Inpatient or Day Case Procedure Under the Cardiology Specialty Breaching the Target Timeframes

Quarter Ending	0-13 Weeks	13-52 Weeks	Over 52 Weeks	Total Waiting	Percentage Breaching 13 Week Target	Percentage Breaching 52 Week Target
30 June 2017	1,168	1,302	130	2,600	55.1%	5.0%
30 September 2017	1,177	1,172	243	2,592	54.6%	9.4%
31 December 2017	1,226	1,012	349	2,587	52.6%	13.5%
31 March 2018	1,271	985	237	2,493	49.0%	9.5%
30 June 2018	1,264	931	90	2,285	44.7%	3.9%
30 September 2018	1,156	1,116	82	2,354	50.9%	3.5%
31 December 2018	1,298	825	73	2,196	40.9%	3.3%
31 March 2019	1,264	784	74	2,122	40.4%	3.5%
30 June 2019	1,259	816	124	2,199	42.7%	5.6%
30 September 2019	1,201	848	70	2,119	43.3%	3.3%
31 December 2019	1,102	1,010	91	2,203	50.0%	4.1%
31 March 2020	977	1,138	87	2,202	55.6%	4.0%
30 June 2020	628	1,456	245	2,329	73.0%	10.5%
30 September 2020	698	1,034	461	2,193	68.2%	21.0%
31 December 2020	889	792	604	2,285	61.1%	26.4%
31 March 2021	943	716	731	2,390	60.5%	30.6%
30 June 2021	975	820	674	2,469	60.5%	27.3%
30 September 2021	896	918	684	2,498	64.1%	27.4%
31 December 2021	919	928	701	2,548	63.9%	27.5%
31 March 2022	982	1,022	893	2,897	66.1%	30.8%
30 June 2022	1,015	1,057	706	2,778	63.5%	25.4%
30 September 2022	1,123	1,045	742	2,910	61.4%	25.5%
31 December 2022	1,097	1,081	833	3,011	63.6%	27.7%
31 March 2023	1,052	1,017	771	2,840	63.0%	27.1%

42. The Department does not, nor has it ever held data in respect of referral to treatment time for patients requiring cardiology surgery. NI does not have a Ministerial Target for Referral To Treatment (RTT) and therefore waiting times are not captured on this basis – there are specific targets for assessment, diagnostics and treatment but these are not cumulative targets i.e. they are reported individually.

43. The Department does not, nor has ever held data in respect of the number and percentage of cancelled cardiac surgeries during the relevant period. The Department is therefore unable to advise on the number and percentage of treatments cancelled by the hospital or the number and percentage cancelled by the patient. We understand that HSC Trusts should hold this information and would be better placed to assist in this regard.

Child and Adolescent Mental Health Services

44. Child and Adolescent Mental Health Service (CAMHS) provision is commissioned by the Department of Health's Strategic Planning and Performance Group (SPPG). The CAMHS Commissioner is a member of the Community Care Directorate and has responsibility for commissioning services in line with the 5 stepped care model, as outlined within the regionally agreed Integrated Care Pathway for CAMHS. With the exception of Belfast Trust, who also provide CAMHS on behalf of South Eastern Trust, each Trust is responsible for providing services to children and young people within its boundary.

45. There are also a number of specialist services which are provided on a regional basis by individual trusts i.e. Community Gender Identity Service, Community Forensic CAMHS, Community Deaf CAMHS, Beechcroft General Adolescent Inpatient Unit and inpatient provision via the Iveagh Centre for young people with intellectual disability

46. The CAMHS stepped care model pathway, launched in 2018, is for everyone involved with and receiving emotional and well-being services across Northern Ireland. The Pathway describes the services available within CAMHS for all children and young people up to the age of 18. The 5 stepped care model describes the range of services available under each step broken down as follows;

- Step 1: Universal/Prevention
- Step 2: Early Intervention
- Step 3: Specialist Intervention
- Step 4: Intensive Intervention
- Step 5: Intensive Interventions (Inpatient and regional specialist)

47. The Pathway provides assessment, treatment and consultation to children, young people, families and the wider professional network. The Pathway covers the range of services provided as part of CAMHS service provision. CAMHS is made up of multi-disciplinary teams with a wide range of knowledge, skill and expertise and come from

different disciplines like nursing, psychiatry, psychology, occupational therapy, social work. The work they do is supported by many sources of information; for example National Institute for Clinical Excellence (NICE) Guidance which sets out the best known treatment options for different types of conditions.

48. A referral to CAMHS is appropriate regardless of whether Step 2 (Primary Mental Health) or 3 (Core CAMHS) is the appropriate level for intervention. Both of the following two conditions must be met:

- Condition 1 - Basic threshold - A child/ young person has or is suspected to have a mental ill health or other condition that results in persistent symptoms of psychological stress
- Condition 2 (complexity and severity threshold) (at least one of the following exists)
    - An associated serious and persistent impairment of their day to day functioning
    - An associated risk that the child/young person may cause serious harm to themselves or others

49. In respect of regional inpatient services, Beechcroft provides capacity for 25 beds across 2 wards, a 15 bedded admission ward and a ward with 10 beds for treatment. The service also provides access to 4 Psychiatric Intensive Care Unit (PICU) beds. These PICU beds will be available to manage short-term behavioural disturbance which cannot be contained in general adolescent unit.

50. The service is based and managed by the Belfast Trust and accepts referrals meeting the following criteria:

- Primary diagnosis of mental illness including young people with neurodevelopmental disorders including mild learning disability and autism, drug and alcohol problems, physical disabilities
- Severe and complex needs that cannot be safely managed within Step 3 & 4 CAMHS

- Aged 13 years until 18th birthday (there may be rare cases of 12 year olds being appropriately admitted dependent upon risk and need)

- May require detention under the Mental Health Order (MHO) although not a pre-requisite.

- Young people who need Step 5 CAMHS Low Secure and where PICU can meet their needs in the short term until an appropriate placement is secured through Extra Contractual Referral (ECR) process

51. Iveagh is a 6 bedded hospital in-patient centre that provides specialist inpatient multidisciplinary assessment and treatment services for young people with a learning disability who are resident in all Trust areas of Northern Ireland. Services are provided for children and young people aged 12 to 17 inclusive who have a learning disability, additional mental health difficulties and who may display associated behaviours of concern. Children under the age of 12 may be considered for assessment and treatment as a day patient if it is clinically appropriate.

52. The services provided are based on sound principles of collaborative, evidence based practice that are child centred. A systemic approach to understanding and working with young people is a core tenet of service delivery. The centre encourages the involvement of families/carers in all aspects of the young person's assessment, treatment and care which is always delivered in a respectful and sensitive manner.

53. All referrals for inpatient mental health services for Children and Young people in Northern Ireland are accepted from Consultant Psychiatrists or where detention under the Mental Health Order is required by an Approved Social Worker and GP. During the relevant period, the Department did not routinely collect data in relation to the number of young people referred for inpatient mental health services. To this end, individual HSC Trusts would be best placed to provide the number of referrals for inpatient treatment during the relevant period. Subsequently, the Department has overseen the introduction of the CAMHS Acute Managed Care Network (MCN) which became operational in February 2022. Work is currently being taken forward by the MCN which will, when complete, enable the Department to undertake routine monitoring of the number of inpatient CAMHS referrals for Northern Ireland.

54. The Department does however collect data on the number of referrals to CAMHS community outpatient services and this is displayed in table 10. It should be noted that the data included within table 10 is not routinely collected in the categories stipulated in the rule 9, however, details on the referral source have been included which are broadly in line with the Inquiry's request for information.

55. It should be further noted that the data contained within table 10 has been collected using monthly aggregate data from HSC Trusts, therefore the data presented is up to and including 30th June 2022.

The information included in table 10 relating to new referrals to CAMHS Inpatient Services is sourced from the Monthly CAMHS Minimum Dataset Return which is submitted to the Department by Trusts. This return is designed to provide timely management information on service activity and performance indicators for internal HSC consumption and are not classified as official statistics for publication.

Table 10 - The number of new referrals to CAMHS inpatient services in Northern Ireland monthly throughout the relevant period and during the 12 months prior to 1 March 2020[4]

Source of Referral	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
General Practitioner (GP) **(primary)**	795	660	633	471	324	336	562	734	640	467	685	615	462	139	257	351	440	396	775	548	674	524	395	459	569	667	699	578	316	367	634	573	651	467	673	585	668	505	567	460
Paediatrics/Child Health/Inpatient Service **(secondary)**	126	105	93	106	102	79	101	79	83	70	92	88	69	54	54	84	75	56	65	77	109	84	73	87	86	103	92	96	107	68	95	89	84	86	81	85	75	71	77	73
Emergency Department	21	29	68	15	25	20	21	24	86	66	61	77	75	30	70	57	61	53	42	69	77	75	66	57	72	25	96	80	65	60	87	95	94	70	91	114	104	45	66	42
General Hospital	72	46	13	53	32	43	58	53	58	10	28	14	23	10	21	15	29	26	74	14	17	9	0	13	22	102	11	15	19	12	36	16	28	14	21	9	9	60	60	49
AMH **(adults)**	4	10	14	10	13	11	6	5	12	5	26	18	17	9	5	18	15	17	37	26	27	40	13	24	25	34	23	42	16	23	36	39	29	33	30	42	32	30	47	19
Card Before You Leave (CBYL)	20	15	17	15	22	19	20	38	7	2	36	2	5	9	6	31	14	17	6	27	36	5	2	26	41	5	1	3	3	20	0	0	4	1	0	6	4	1	4	2
AHP	8	14	19	19	12	7	8	16	20	4	6	11	8	8	5	7	5	7	19	9	6	6	5	11	10	4	6	6	13	10	15	18	16	8	5	9	14	9	5	15
ASD Services/Professional	11	11	7	15	7	10	11	4	8	3	3	3	0	8	5	2	5	8	2	7	1	6	4	7	9	10	17	5	3	3	4	5	7	11	1	6	9	5	2	4
GP Out of Hours	0	2	2	3	5	0	0	0	0	1	1	0	1	0	0	1	1	1	0	0	2	0	2	1	0	1	1	1	1	0	11	0	2	2	0	0	4	1	1	0
Child Health	12	18	12	1	0	0	0	1	1	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	3	1	0	1	4	0	0	0
Autism Spectrum Disorder (ASD) Services/Professional	0	0	0	1	0	0	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0
Addictions Service	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Family/Self **(Family/self)**	2	1	0	3	0	0	2	1	1	2	0	2	2	0	2	0	2	0	0	2	0	0	2	0	0	1	0	1	1	0	0	1	0	0	0	0	3	0	0	0
Self-referrals	0								3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Family	0													1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Education (other to include Youth justice and Education)	29	23	30	25	14	7	40	17	19	16	9	35	17	27	5	17	5	2	23	14	14	13	7	8	72	18	19	26	21	11	23	19	14	12	9	9	13	12	12	25
Social Services - CP/FS/Disability **(Community)**	13	8	11	8	18	12	14	9	7	7	12	14	14	9	15	9	18	9	11	19	15	12	12	7	19	12	18	12	11	10	10	13	8	7	9	8	18	15	13	17
Voluntary/Community Sector **(3rd sector)**	7	7	3	3	2	0	4	5	2	7	5	3	7	4	5	9	8	5	12	10	12	9	4	0	7	0	8	6	2	1	10	4	7	6	4	2	14	6	23	15
Social Services	6	9	1	4	4	3	5	4	7	8	14	3	8	12	3	0	2	6	2	8	3	1	10	9	5	7	6	3	1	6	0	12	8	12	16	10	3	3	0	0
Health Visiting/School Nurse	8	4	8	11	1	3	4	4	8	3	5	5	4	2	3	5	5	3	7	4	4	2	2	2	8	6	0	4	5	5	2	4	5	6	5	5	10	5	6	6
Social Services - Child Protection/Family Services/Disabilty	4	4	5	1	2	1	2	6	2	4	3	2	2	2	3	2	2	5	6	4	5	3	6	8	4	1	3	1	5	1	2	1	3	1	1	3	0	5	5	0
Other	3	3		2	4	2	1	4	1	5	1	4	0	0	2	1	4	0	12	3	0	0	4	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Services - LAC	5	4	2	1	4	3	0	4	2	2	2	1	0	1	1	1	0	1	1	0	0	1	0	1	0	0	0	2	1	0	0	1	1	1	2	4	1	2	3	1
Community & Voluntary Service	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	4	1	0	0	2	4	0	0	3	1	0	9	8	0
Social Services - Looked After Children (LAC)	0	1	2	1	0	0	0	2	2	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	1	0	1	2	2	3	2	0	0	0
Youth Justice	0	0	0	1	0	0	0	1	0	3	1	1	0	0	1	1	0	1	3	1	0	0	0	0	0	0	1	0	2	0	1	0	0	0	1	2	0	1	0	1
3rd Sector	1	1	1	2	0	1	0	1	0	0	0	2	4	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0
Total	**1147**	**975**	**942**	**771**	**591**	**557**	**862**	**1012**	**969**	**686**	**991**	**901**	**719**	**325**	**464**	**611**	**692**	**614**	**1098**	**842**	**1004**	**790**	**607**	**720**	**952**	**1007**	**1006**	**883**	**594**	**597**	**969**	**896**	**966**	**740**	**954**	**905**	**987**	**785**	**899**	**729**

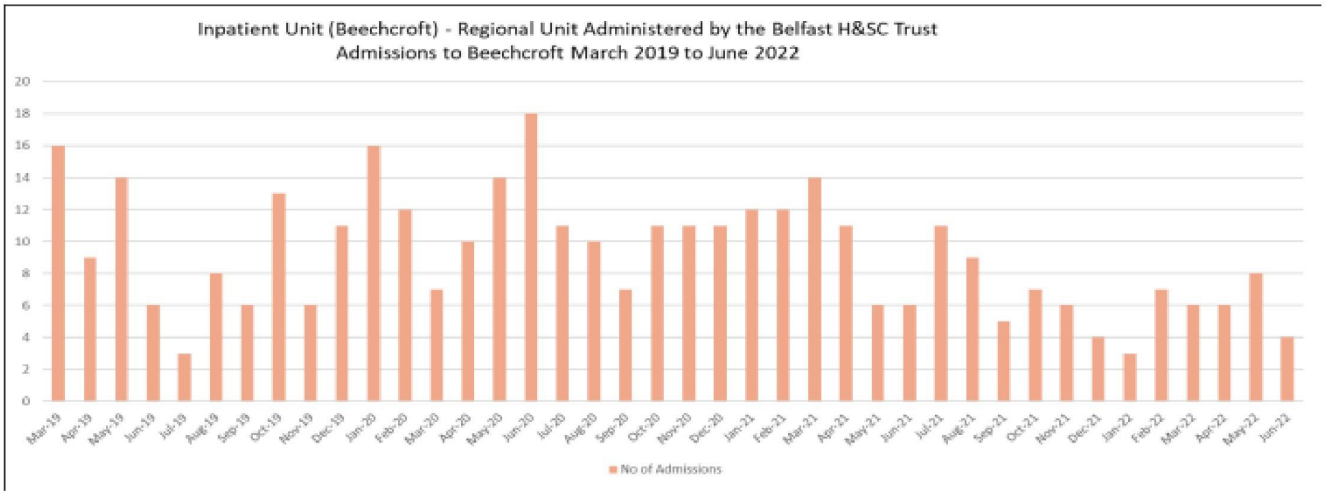
[4] The data included above on 'Referrals Accepted' covers all with the exception of KOI (Knowing Our Identity; Gender Identity Service). The KOI service only accepts internal referrals. A small proportion of internal referrals (= 215) are included in the above data during 2019/20 due to difficulties in identifying these by source of referral.

56. Separately, the Department also collects data on the number of admissions to the Regional Inpatient Unit (Beechcroft) which has been provided as supplementary information. This has been presented in table 11 and figure 1 below.

Table 11 - Inpatient Unit (Beechcroft) Information - Admissions - Regional Unit Administered by the Belfast H&SC Trust

Month Ending	Number of admissions	Month Ending	Number of admissions
Mar-19	16	**Nov-20**	11
Apr-19	9	**Dec-20**	11
May-19	14	**Jan-21**	12
Jun-19	6	**Feb-21**	12
Jul-19	3	**Mar-21**	14
Aug-19	8	**Apr-21**	11
Sep-19	6	**May-21**	6
Oct-19	13	**Jun-21**	6
Nov-19	6	**Jul-21**	11
Dec-19	11	**Aug-21**	9
Jan-20	16	**Sep-21**	5
Feb-20	12	**Oct-21**	7
Mar-20	7	**Nov-21**	6
Apr-20	10	**Dec-21**	4
May-20	14	**Jan-22**	3
Jun-20	18	**Feb-22**	7
Jul-20	11	**Mar-22**	6
Aug-20	10	**Apr-22**	6
Sep-20	7	**May-22**	8
Oct-20	11	**Jun-22**	4

Figure 1 - Admissions to Beechcroft March 2019 to June 2022



57. The information included in table 11 and figure 1 relating to Admissions to the Regional Inpatient Unit at Beechcroft is sourced from the Monthly CAMHS Minimum Dataset Return which is submitted to DoH by HSC Trusts. This return is designed to provide timely management information on service activity and performance indicators for internal HSC consumption and are not classified as official statistics for publication.

58. The Department does not, nor has it ever collected data relating to new referrals to CAMHS Inpatient Services. The Department cannot therefore advise as to the length of the average wait for children and young people referred to CAMHS between referral and CAMHS mental state assessment or risk assessment, or the length between the first contact with outpatient or community support and inpatient admission as a voluntary patient during the relevant period.

59. The Department does however collect the number of patients still waiting at month end. This information is presented below in table12 and figure2 and is broken down by the number of days waiting and the single longest waiting time between referral and first contact with Outpatient community CAMHS. Again, it should be noted that the data contained within table 12 and figure 2has been collected using monthly aggregate data from HSC Trusts therefore the data presented is up to and including 30th June 2022.

60. The Information relating to Waiting Times for CAMHS in Table 12 and Figure 2 is sourced from the Mental Health Outpatient Waiting Times Return which is submitted to DoH by HSC Trusts. This return is designed to provide timely management information on service performance against the 9 week waiting time standard for CAMHS set by the Department

61. In respect of compulsorily admissions of children and young people to psychiatric inpatient care under the provisions of the Mental Health (Northern Ireland) Order 1986 for assessment or treatment, the Department collates these figures on a quarterly basis. As such, during the relevant period, figures are only available quarterly and not monthly. These are presented in table 13 below. It should be noted that these figures are based on admissions rather than patients. A patient may be compulsorily admitted more than once within the time period. During the quarter ending March 2020, there were 7

compulsorily admissions of individuals aged under 18 to psychiatric inpatient care under the provisions of the Mental Health (Northern Ireland) Order 1986, compared to 9 admissions during the quarter ending June 2022.

62. The information included in table 13 has been taken from the Department's Compulsory Admissions Dataset. The information contained within this dataset is sourced from the mental health and learning disability statutory quarterly returns provided by the HSC Trusts. The dataset also contains information on other specialities over a large number of years and as such, due to its size and the inclusion of information not relevant to the scope of this rule 9, has not been exhibited to this statement.

63. The Department is not in a position to say whether any children 'sectioned' under the Mental Health (Northern Ireland) Order 1986 were admitted to general paediatric wards during the relevant period, and whether such admissions took place prior to the relevant period. The reason for this is that the Department does not, nor has it ever held data on this. The Department understands that HSC Trusts should be better placed to assist in this regard.

Table 12 - Regional Waiting Times by Time Band and Longest Wait (in days) for CAMHS at Month End, March 2020 to 2022[5]

Month End	Waiting 0-9 weeks	Waiting > 9 weeks	Total Waits	Longest Wait (in days)
Mar-20	1,122	707	1,829	365
Apr-20	655	914	1,569	395
May-20	378	881	1,259	426
Jun-20	512	620	1,132	1013*
Jul-20	643	512	1,155	393
Aug-20	689	454	1,143	370
Sep-20	850	288	1,138	380
Oct-20	983	174	1,157	303
Nov-20	1,081	175	1,256	427
Dec-20	1,068	242	1,310	282
Jan-21	842	372	1,214	313
Feb-21	787	444	1,231	297
Mar-21	951	338	1,289	328
Apr-21	1,071	389	1,460	336
May-21	1,216	451	1,667	308
Jun-21	1,192	556	1,748	328
Jul-21	915	854	1,769	359
Aug-21	712	933	1,645	390
Sep-21	871	928	1,799	420
Oct-21	1,061	894	1,955	451
Nov-21	1,074	948	2,022	481
Dec-21	1,106	948	2,054	512
Jan-22	1,056	1,018	2,074	543
Feb-22	1,141	996	2,137	571
Mar-22	1,177	929	2,106	549
Apr-22	1,065	1,079	2,144	557
May-22	1,023	1,170	2,193	559

[5] Figures presented are 'active' waiting times as reported to SPPG Information by HSC Trusts. These figures are based on a snap shot at each month end. Longest Wait for CAMHS Step 3 at June 2020 month end have increased from May 2020 month end due to a client having been overlooked and then put on waiting list in June from Original referral dates.

Figure 2 - regional CAMHS active total waits at month end

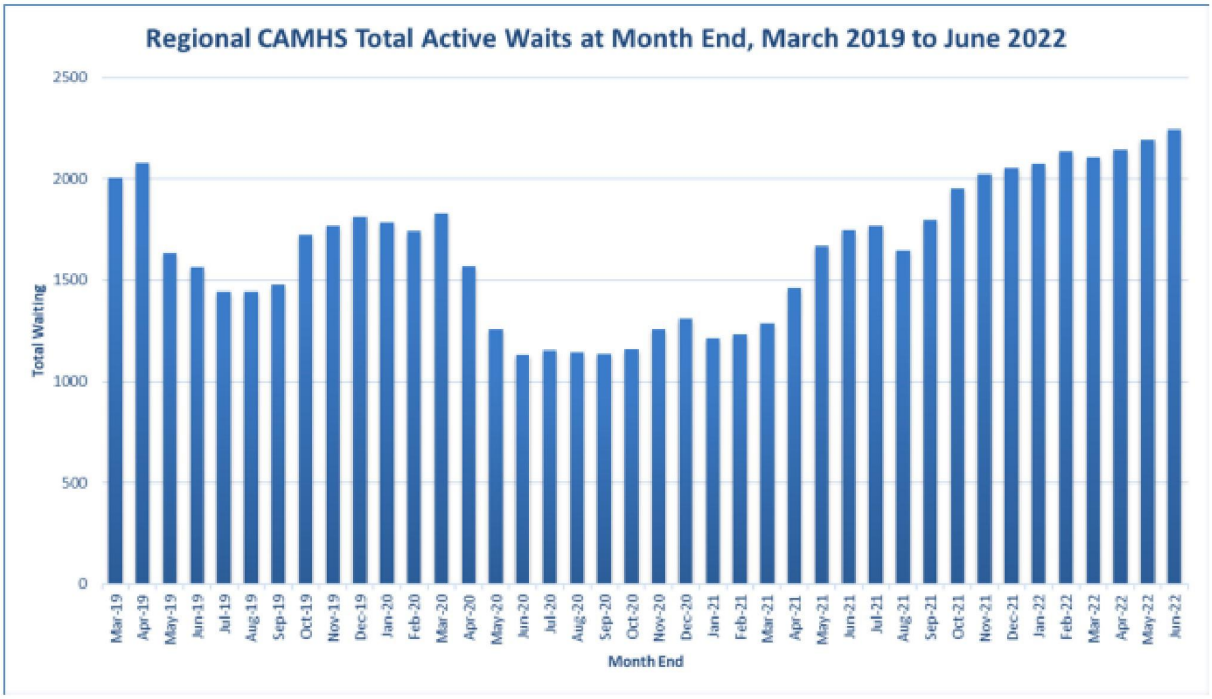


Table 13 - Number of compulsorily admissions of individuals aged under 18 under the Mental Health (NI) Order 1986

Quarter Ending	Number of Compulsory Admissions of Individuals Aged Under 18
31 March 2020	7
30 June 2020	8
30 September 2020	25
31 December 2020	12
31 March 2021	10
30 June 2021	8
30 September 2021	14
31 December 2021	12
31 March 2022	14
30 June 2022	9
30 September 2022	6
31 December 2022	6
31 March 2023	12

STATEMENT OF TRUTH

We believe that the facts stated in this witness statement are true. We 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: 5 July 2024

Exhibit Schedule to Statement
Department of Health Northern Ireland - M3/DOHNI/02

Exhibit Reference	INQ
EMLM/001	INQ000355562
EMLM/002	INQ000355567
EMLM/003	INQ000355605
EMLM/004	INQ000355608
EMLM/005	INQ000355614
EMLM/006	INQ000355622
EMLM/007	INQ000355627
EMLM/008	INQ000355633
EMLM/009	INQ000355636
EMLM/010	INQ000355643
EMLM/011	INQ000355649
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EMLM/013	INQ000355662
EMLM/014	INQ000355672
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EMLM/016	INQ000355682
EMLM/017	INQ000355687
EMLM/018	INQ000355692
EMLM/019	INQ000355697
EMLM/020	INQ000355702
EMLM/021	INQ000355707
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EMLM/025	INQ000355727
EMLM/026	INQ000355732
EMLM/027	INQ000355739
EMLM/028	INQ000355745
EMLM/029	INQ000355752
EMLM/030	INQ000355754
EMLM/031	INQ000355571
EMLM/032	INQ000355578
EMLM/033	INQ000355589
EMLM/034	INQ000355665
EMLM/035	INQ000490088
EMLM/036	INQ000103659
EMLM/037	INQ000438142

Exhibit Reference	INQ
EMLM/038	INQ000103667
EMLM/039	INQ000256450
EMLM/040	INQ000270105
EMLM/041	INQ000276331
EMLM/042	INQ000276332
EMLM/043	INQ000276333
EMLM/044	INQ000348956
EMLM/045	INQ000276337
EMLM/046	INQ000490089
EMLM/047	INQ000346740
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