Witness Name: PETER MAY

Statement No:

Exhibits:

Dated: 7 May 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF:

Peter May

Permanent Secretary

Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY

MODULE 3 RULE 9 REQUEST – REFERENCE 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.

A. DEPARTMENT OF HEALTH AND HEALTH AND SOCIAL CARE SECTOR

1. Background to the Health and Social Care system in Northern Ireland

1. The National Health Service is the shared name of three of the four publicly funded health care systems in the United Kingdom. Only the English National Health Service is officially called the National Health Service. There are separate entities entitled National Health Service Scotland and National Health Service Wales. The integrated system in Northern Ireland is unique and is generally called "Health and Social Care" rather than the National Health Service.

2. The Department of Health is responsible for health and social care legislation and policy in Northern Ireland. The Department of Health, until April 2022, had 17 Arm's Length Bodies, which aid in achieving the Department's objectives through functions delegated to them by the Department. On 31 March 2022, one of those Arm's Length Bodies – the Health and Social Care Board – was dissolved and its functions were transferred back into the Department of Health. Those functions now reside within the Strategic Planning and Performance Group in the Department. The functions of the Department of Health and its Arm's Length Bodies are often referred to by the umbrella term "Health and Social Care and to the Arm's Length Bodies as "Health and Social Care bodies". These are colloquialisms and "Health and Social Care" is used as

shorthand for the health system as a whole in Northern Ireland. There does not exist, and never has existed, an organisation called "Health and Social Care Northern Ireland".

3. The structures in Northern Ireland, as established by the Health and Social Care (Reform) Act (Northern Ireland) 2009, retained commissioning like England (with a central commissioning body – the Health and Social Care Board), but also place specific emphasis on public health. The normal governance arrangements for Health and Social Care in Northern Ireland are set out in the Health and Social Care Framework Document [PM/6370 **INQ000188742** published by the Department in September 2011, to meet the statutory requirements placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the Department, its Health and Social Care Arm's Length Bodies and the systems that govern their relationships with each other and the Department. The Health and Social Care Act (NI) 2022 saw the closure of the Health and Social Care Board on 31 March 2022 and the formation of the Strategic Planning and Performance Group within the Department as part of the process of reform currently underway.

4. The system here is believed to be too small to support a fully-fledged "market" and the emphasis has been on commissioning as a means of developing and promoting reform and modernisation. The private sector in healthcare is tiny compared to England and, to date, there has been no demand or expectation that it should grow.

i. The Integrated Care System

5. Health and social care services in Northern Ireland were integrated in 1973. Since then, there have been numerous restructuring exercises which follow broad patterns established across the United Kingdom. The Health and Social Care (Reform) Act (Northern Ireland) 2009 reinforced in statute the Department's responsibility to promote an integrated system of health and social care in Northern Ireland. It also provided for a single Health and Social Care Board, working in conjunction with a Public Health Agency, which commissioned services to meet assessed need and promote general health and wellbeing. A full range of health and social care services are provided by five Health and Social Care Trusts, with a sixth Trust providing ambulance services for the region. These structures are unique to Northern Ireland because in England, Scotland and Wales provision of social services remain the responsibility of Local Authorities.

6. In addition to supporting the commissioning process, the Public Health Agency is also charged with promoting health protection; service improvement; and improvements in the general health and wellbeing of the people of Northern Ireland. The Public Health Agency works closely with other public services such as health, education and local government in a local community planning process.

7. Integration provides the opportunity for comprehensive assessment of both health and social care needs and allows the Department to plan services based on Programmes of Care. A single budget has also promoted the coherent development of objectives within a unified strategic planning process, which spans acute and community-based care.

8. On 4 November 2015 the then Minister of Health announced his intention to close the Health and Social Care Board with the aim of reducing bureaucracy and complexity within the system and enhancing the Department's strategic leadership and control of the system. The decision was re-affirmed following public consultation in March 2016, and further confirmed with the launch of *Health & Wellbeing 2026: Delivering Together* in October 2016. Minister Swann further reaffirmed the decision to close the Health and Social Care Board in early 2020.

9. Work was undertaken to give operational effect to this decision, and legislation progressed leading to the Health and Social Care Act (Northern Ireland) 2022. The 2022 Act provisions took effect on 1 April 2022 and provided for the following:

    - The closure of the Health and Social Care Board and the transfer of its legislative functions to the Department except for Social Care and Children's functions. Responsibility for these was placed directly upon Health and Social Care trusts. The Health and Social Care Act (Northern Ireland) 2022 inserted a new Article 10A of the Health and Personal Social Services (Northern Ireland) Order 1991 which provides a definition of Social Care and Children's functions;
    - Responsibility for the exercise of prescribed Social Care and Children functions are now placed directly upon Health and Social Care Trusts, and the Department has responsibility for the oversight of the exercise of these functions;
    - Local Commissioning Groups which were Committees of the Health and Social Care Board, remain in place beyond the closure of the Health and Social Care Board. They remain in place until such times as the Department makes

regulations via the draft affirmative process to establish local area bodies (Area Integrated Partnership Boards) as part of the development of an Integrated Care System for Northern Ireland.

10. Since 1 April 2022 the newly established Strategic Planning and Performance Group in the Department has undertaken the former functions of the Health and Social Care Board, as prescribed in the Health and Social Care Act (Northern Ireland) 2022. The former Health and Social Care Board staff continue to carry out their previous roles within the Department's Strategic Planning and Performance Group although they are employed by the Business Services Organisation under a hosting arrangement, retaining their status as public servants with the same terms and conditions as before.

11. The closure of the Health and Social Care Board has provided the system with an opportunity to transform how the Department plans, manages and delivers services in line with the vision set out in *Health and Wellbeing 2026: Delivering Together.* It articulates the need to empower local providers and communities to plan integrated continuous care based on the needs of their population, with specialised and regional services planned, managed and delivered regionally.

12. In line with this vision, Minister Swann approved a programme of work in October 2020 on the development of an Integrated Care System model in Northern Ireland. To support the model, a Draft Framework has been developed which provides a blueprint for the future of planning and managing health and social care services in Northern Ireland. The model will promote and enable improved integration, partnership working and collaboration both within and outside traditional Health and Social Care boundaries [PM/0002 INQ000114846]. This will allow the Department to tackle wider determinants of health and wellbeing and will deliver care on a population health-based needs approach, which places the individual at the centre of the model.

ii. Department of Health, Northern Ireland

13. The Northern Ireland Executive is comprised of nine departments, each with a ministerial lead. The Department of Health is one of those nine. The Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 are to promote an integrated system of health and social care designed to secure improvement in:

- The physical and mental health of people in Northern Ireland;
- The prevention, diagnosis and treatment of illness, and

- The social wellbeing of people in Northern Ireland.

14. The Department discharges these responsibilities, both by direct Departmental action and through its Arm's Length Bodies[1], by developing appropriate policies; determining priorities; securing and allocating resources; setting standards and guidelines; securing the commissioning of relevant programmes and initiatives; monitoring and holding to account its Arm's Length Bodies; and promoting a whole system approach. The Arm's Length Bodies are: the Health and Social Care Board (dissolved April 2022) the Northern Ireland Blood Transfusion Service; the Northern Ireland Medical and Dental Training Agency; the Northern Ireland Guardian ad Litem Agency; the Northern Ireland Social Care Council; the Northern Ireland Fire and Rescue Service (NIFRS); the Northern Ireland Practice and Education Council; the Public Health Agency (PHA); the Business Services Organisation (BSO); the Patient and Client Council (PCC); the Northern Ireland Ambulance Service (NIAS); the Western Health and Social Care Trust (WHSCT); the South Eastern Health and Social Care Trust (SEHSCT); the Belfast Health and Social Care Trust (BHSCT); the Southern Health and Social Care Trust (SHSCT); the Northern Health and Social Care Trust (NHSCT), and the Regulation and Quality Improvement Authority (RQIA).

15. Prior to April 2022 the Department's principal service delivery objectives for Health and Social Care commissioners and Trusts were set out in detail in the annual Health and Social Care Commissioning Plan Direction. The annual Health and Social Care Commissioning Plan Direction was issued by the Department to the Health and Social Care Board, which was the Arm's Length Body jointly responsible with the Public Health Agency for the commissioning of health and social care services in Northern Ireland. Following the dissolution of the Health and Social Care Board in March 2022, its functions were, in the main, transferred to the Department except for Social Care and Children's functions, as described above, and its staff were transferred to the Health and Social Care Business Services Organisation. This dissolution meant that there was no longer any requirement for the Department to issue an annual Health and Social Care Commissioning Plan Direction.

a. Roles and Responsibilities

16. In his/her ministerial role, a minister will exercise the functions assigned to the ministerial office that they hold and have full executive authority within any broad

[1] There were 17 Arm's Length Bodies during the pandemic, reduced to 16 following the dissolution of the Health and Social Care Board in March 2022.

programme agreed to by the Northern Ireland Executive and endorsed by the Northern Ireland Assembly, and they are expected to act in accordance with the Northern Ireland Executive Ministerial Code [INQ000262764]. The functions of a department are at all times exercised subject to the minister's direction and control as per Article 4 of the Department's (Northern Ireland) Order 1999. Ministers are accountable to the Northern Ireland Assembly for the decisions and actions of their departments and agencies, including the stewardship of public funds and the extent to which key performance targets and objectives have been met. Under paragraph 2.4 of the Ministerial Code, ministers are required to bring matters deemed to be crosscutting, significant or controversial to the Northern Ireland Executive.

17. The Minister of Health, along with all ministers, is supported by a Special Adviser. According to the Code of Conduct for Special Advisers [PM/6001 INQ000400121] Special Advisers are an additional resource for the Minister, who can provide advice from a more political viewpoint than a civil servant. While Special Advisers work closely with civil servants, they are not civil servants. Special Advisers can act on behalf of their Minister; they can convey their Minister's views, instructions and priorities to officials including on issues of presentation. In doing so they must take account of any priorities that their Minister has set. For example, Special Advisers can request officials to prepare and provide information and data for Ministers, including internal analyses and papers and they can review and comment on – but not change, suppress or supplant – advice submitted to Ministers by civil servants.

b. Structure and Organisation

18. The diagram provided at [PM/0240 INQ000137413] sets out the Department's organisational structure at policy group level, its senior leaders, and their respective group areas of responsibility as at 1 January 2020. The senior officials and professional officers identified in the diagram comprise the Department's Top Management Group and the Departmental Board. The Top Management Group and the Departmental Board have responsibility for the overall corporate governance of the Department and ensuring that the Minister's policies and priorities are implemented in compliance with all statutory, regulatory and financial management requirements to which Northern Ireland Executive departments adhere. Both the Top Management Group and the Departmental Board are chaired by the Department's Permanent Secretary who is the Department's Accounting Officer. The Permanent Secretary is also the Accounting Officer for the statutory-based health and social care bodies in Northern Ireland reporting to the Minister. The Top Management Group's respective

roles and responsibilities both before and during the pandemic are set out in the document exhibited at [PM/0241 INQ000137414].

19. The Top Management Group (now known as the Senior Leadership Team) has regular weekly meetings. The Departmental Board, which also has two Non-Executive Directors among its membership, meets every two months. The Top Management Group is the main vehicle for managing the Department on a day-to-day basis whereas the Departmental Board has oversight for monitoring the effective discharge of corporate governance. Whilst not formally stood down during the pandemic, the frequency of Departmental Board meetings was reduced. This meant that only two meetings were held in 2020 and three meetings were held in 2021. This reduction in meetings was to permit the Department to focus on the additional workload arising from the pandemic. The Top Management Group weekly meetings were also paused from 19 March 2020 to 18 May 2020 as the Department's senior team was fully engaged in leading the emergency response.

20. A Transformation Implementation Group was established in November 2016 and chaired by the Department's Permanent Secretary. The purpose of the Transformation Implementation Group was to provide the strategic leadership to oversee and make decisions on the design, development and implementation of the Delivering Together Transformation Programme published by the Department on 25 October 2016 [PM/0352 INQ000353594]. The membership of the Transformation Implementation Group encompassed the Department's Top Management Group and the Health and Social Care Executive and clinical leaders drawn from the Department's Arm's Length Bodies. The work of the Group was temporarily suspended at the start of the pandemic as the Department's main objectives were to manage the Health and Social Care response to the emergency, and, in summer 2020, to commence the process of rebuilding service delivery. The Health and Social Care Rebuilding Management Board replaced the Transformation Implementation Group from summer 2020 and is discussed further below.

21. The Transformation Advisory Board was established in December 2016 to oversee the direction of reform in health and social care. The Transformation Advisory Board was chaired by the Minister, and its membership was drawn from the field of independent healthcare experts, trade unions, service users and community and voluntary sector representatives. The work of the Board was temporarily suspended at the start of the pandemic as the Department's main objectives were to manage the Health and Social

Care response to the emergency and in summer 2020 to commence the process of rebuilding service delivery. The Transformation Advisory Board was re-established in December 2020, although it did not have a role in relation to the Department's response to the pandemic.

22. The following paragraphs provide details of the posts and personnel with key responsibilities and oversight within the Department, with particular focus on the role of those in the Chief Medical Officer's Group as well as the Permanent Secretary and Chief Nursing Officer. Exhibits [PM/0240 INQ000137413 and PM/0241 INQ000137414] provide detail on senior officials in other Departmental groups.

Permanent Secretary - Richard Pengelly (Jan 2020 to 31 March 2022); Peter May (1 April 2022 to date)

23. The Permanent Secretary acts as the senior adviser to the Minister of Health, and to the Northern Ireland Executive via the Northern Ireland Civil Service Board, on the working of Department of Health on a daily and weekly basis, including developing and delivering on policy, leading and managing people and business, delivering outcomes and innovation and driving better public services.

24. As Principal Accounting officer for the Department, the Permanent Secretary is accountable to the Northern Ireland Assembly (through the Public Accounts Committee) for the sound management of risk and public funds. In addition to this, the Permanent Secretary is responsible for the direction and oversight of Health and Social Care organisations which plan and deliver health and social care services for Northern Ireland's population.

Chief Medical Officer – Professor Sir Michael McBride (September 2006 – present)

25. The Chief Medical Officer is a member of the Department's Top Management Group and is responsible for a wide range of roles which cut across professional, executive and leadership responsibilities within the Department.

26. The Chief Medical Officer is accountable to the Minister of Health and the Permanent Secretary in the Department. The Chief Medical Officer's role is to provide professional advice to the Minister of Health, independent of political consideration or influence. The Chief Medical Officer is responsible for the Chief Medical Officer Group which has had responsibility (prior to, during and after the pandemic) for all domains of public health policy including health protection and health improvement. Population Health

Directorate, within the Chief Medical Officer Group, sponsors the Public Health Agency, an Arm's Length Body of the Department, which has a pivotal role to play in its response to incidents and outbreaks.

27. The Chief Medical Officer also has policy responsibility for a range of healthcare quality, safety and improvement areas, including the Health and Social Care Complaints Process, Serious Adverse Incidents Reporting and Investigation, Adverse Incidents involving Medical Devices, 'Never' Events, the relationship between the Department and the National Institute for Health and Care Excellence which issued Covid-19 related advice and guidance throughout the pandemic, Certification of Deaths including the completion of Medical Certificates on the Cause of Death, Openness and Candour in Health and Social Care, and the Regulation and Inspection of Health and Social Care services. The Quality Safety and Improvement Directorate within the Chief Medical Officer Group sponsors the Regulation and Quality Improvement Authority, which is an Arm's Length Body of the Department providing regulation and assurance of Health and Social Care services. Separately from these responsibilities, the Chief Medical Officer has policy responsibility for Health and Social Care Research policy working closely with the Chief Scientific Advisor.

28. The Chief Medical Officer works closely with other Chief Medical Officers in the United Kingdom and the Republic of Ireland. In their respective jurisdictions, each Chief Medical Officer provides independent advice to their Ministers; however, as was the case during the pandemic, the Chief Medical Officers work closely, and collectively, on public health policy, generating evidence and independently advising their respective Ministers as decision makers.

29. As the principal healthcare professional advisor to the Minister of Health and to other policy groups within the Department, the Chief Medical Officer leads a small team of doctors who provide professional medical advice. This group includes two Deputy Chief Medical Officers, Dr Lourda Geoghegan and Dr Naresh Chada, together with several medical advisors. Both Deputy Chief Medical Officers have specific policy responsibilities within the Chief Medical Officer Group alongside their role as professional advisors.

30. The Chief Medical Officer has an important role in communicating with the public on key public health issues and actions that are important to protect and improve public health and wellbeing. This communication role was a crucial element of his

responsibilities during the pandemic and took a variety of forms. For example, throughout the response to the pandemic there was a need to provide advice, information and data on a range of issues including what was known about the virus, the risk of severe disease, hospitalisation and death and what the public could do to protect themselves.

31. The role of the Chief Medical Officer in response to any emergency (including a pandemic) is described in detail in the Department's Emergency Response Plan [INQ000184662] which describes the roles and responsibilities of Senior Officers and business areas within the Department, as well as the roles of various organisations which are expected to play a role in a response to an emergency.

32. From January 2020 onwards, the Chief Medical Officer's role and responsibilities changed significantly to meet the challenges of the pandemic as these evolved and much of his wider policy and professional responsibilities were, by necessity, paused. In addition to supporting the Minister of Health in Four Nation meetings and meeting with his Republic of Ireland counterparts, the Chief Medical Officer regularly attended Executive meetings, along with the Chief Scientific Adviser, to answer Executive Ministers' questions and provide them with additional information as required. The Chief Medical Officer also attended pre-Executive meeting briefings, alongside the Minister and Chief Scientific Adviser, with the First Minister and deputy First Minister. The frequency of these meeting briefings began on an *ad hoc* basis in the first few months of the pandemic, but progressed to a more regular basis when these became more routine later in 2020. All policy decisions were made formally at Executive level. The Chief Medical Officer, along with the Chief Scientific Adviser, provided professional, public health and scientific advice in the development and communication of public health advice, guidance and campaigns. Alongside this, the Chief Medical Officer remained responsible for providing and updating relevant professional guidance.

33. During the 'Emergency' phase of the pandemic, once Health Gold Command was operational on 9 March 2020, the Chief Medical Officer chaired the Emergency Response Plan's Strategic Cell. The Chief Medical Officer's role involved founding, overseeing and seeking assurance on various programmes of work, including testing and contact tracing, and working with cell leads to ensure any matters escalated to the Strategic Cell were resolved. As Chair, the Chief Medical Officer's role was also to ensure strategic alignment and coordination of the totality of the

response across the cells, so that the necessary elements of the initial response were in place and functioning effectively.

Chief Scientific Adviser – Professor Ian Young (November 2015 – present)

34. The Chief Scientific Adviser provided key leadership and support during the pandemic. His role has three main aspects:

    a) Chief Scientific Advisor – this involves providing scientific advice as required in the Department, and it was in this capacity that he was mainly acting during Covid-19;

    b) Director of Research and Development for Health and Social Care with overall responsibility for issues related to Research (including funding) in the Health and Social Care system; and

    c) Head of Profession with leadership responsibility for the Healthcare Science workforce in the Health and Social Care system, a role similar to that of other Heads of Profession (Chief Medical Officer, Chief Nursing Officer, Chief Pharmaceutical Officer, Chief Social Work Officer, Chief Allied Health Professional Officers).

35. The Chief Scientific Adviser chaired both the Department's Strategic Intelligence Group and Modelling group and liaised with officials in other Government Departments, The Executive Office, and other parts of the Health and Social Care system as required. He provided advice to the Department's Minister and attended Northern Ireland Executive meetings and meetings with individual Ministers as required to provide scientific advice. The Chief Scientific Adviser also attended meetings with officials from the Republic of Ireland, and represented Northern Ireland at the Scientific Advisory Group for Emergencies, relevant subgroups and other United Kingdom wide groups.

Chief Nursing Officer – Charlotte McArdle (April 2013 to October 2021), Linda Kelly (interim) (2021 to 2022), Maria McIlgorm (2022 to present)

36. The Chief Nursing Officer is a member of the Department's Top Management Group, and by extension, also a member of Health Gold Command and the Strategic Cell. The Chief Nursing Officer provided nursing leadership and advice, working alongside the Chief Medical Officer, Deputy Secretary (Healthcare Policy Group) and the Covid-19 Strategic Surge Planning Director as a leadership group, within the Strategic Cell, to coordinate the Department's policy input to surge planning for the health service. This leadership group worked closely with the Health and Social Care Board Director

of Commissioning to ensure that the development of the Department's policy was responsive to the evolving situation within Health and Social Care Trusts and fully informed by expert medical advice provided by The Health and Social Care Board and Public Health Agency.

37. Charlotte McArdle was the Senior Responsible Officer for the planning and implementation of the Nightingale Hospitals at the outset of the pandemic response. The escalation in capacity involved significant staff redeployment and reconfiguration of clinical space in hospitals. The Chief Nursing Officer led the nursing care response and worked closely with the Directors of Nursing and the Critical Care Network Northern Ireland within the various Health and Social Care Trusts to agree staff training, redeployment, skill mix and patient care ratios.

38. Charlotte McArdle was also responsible for developing the Department's policy guidance, which was subsequently issued and distributed to all healthcare settings to allow safe and compassionate visiting arrangements to be put in place for patients, residents and others. This guidance was developed to apply equally in nursing and residential Care Homes and other community settings.

c. Funding

39. The general means of funding provided to the Department is through the Department of Finance in Northern Ireland. The Department is provided with an opening budget and any easements are declared or additional funding requirements are bid for through "Monitoring Rounds" in-year (June, October and January). Transfers of funding both between other Northern Ireland departments and from other United Kingdom departments (via His Majesty's Treasury) are also processed through the Department of Finance at a Monitoring Round.

40. The pandemic covered a number of financial years, and the impact of the pandemic is still ongoing. Covid-19 commenced in the 2019/20 financial year, and the main impact of Covid-19 was within the 2020/21 and 2021/22 financial years. There were still significant Covid related costs being incurred in 2022/23, although no specific additional funding was made available in 2022/23.

d. Shared Responsibilities with other Departments and the Northern Ireland Executive

41. The Department also works in partnership with other Northern Ireland Executive departments to develop and implement cross-cutting policy which is designed to improve the health and wellbeing of the population and in areas such as suicide

prevention, tackling homelessness and the safeguarding of vulnerable adults and children. If an issue is considered to be cross-cutting, significant or controversial, Departmental Ministers are required to bring the said issue to the Executive under paragraph 2.4 of the Northern Ireland Ministerial Code [PM/0006 INQ000262764].

42. Having regard to this requirement, the Department, through the Chief Medical Officer and Chief Scientific Advisor, provided public health and scientific advice to inform the Executive Committee's decisions on a wide range of policy issues, including:

- The timing of the introduction of non-pharmaceutical interventions;
- The relaxation of non-pharmaceutical interventions based on the weekly estimates of R (where R is the number of people that one infected person will pass on a virus to, on average); and,
- Regular reviews of Northern Ireland specific modelling.

43. This advice informed Executive decisions on non-pharmaceutical intervention countermeasures and included information on the trajectory of the pandemic in Northern Ireland and approaches to contain and mitigate the impact, including relative and cumulative impact based on evidence from the Scientific Advisory Group for Emergencies.

2. Departmental Membership of Emergency and Preparedness Groups

44. There are a number of groups and fora in which Departmental representatives participate along with representatives from other government departments and Arm's Length Bodies, sharing information and advice.

i. Civil Contingencies Group Northern Ireland

45. The Civil Contingencies Group Northern Ireland is the principal strategic civil contingencies preparedness body for the public sector. At the time of Covid-19, Civil Contingencies Group was chaired by the Head of Civil Service and membership comprised of representation from all Northern Ireland government Departments, as well as local government, the Food Standards Agency, emergency services and the Met Office. The Civil Contingencies Group is responsible for providing strategic leadership to civil contingencies preparedness by agreeing policy and strategy on cross cutting issues. It exercises a corporate governance function for civil contingencies preparedness at regional level and oversees delivery of an agreed work programme to enhance resilience in Northern Ireland. The Civil Contingencies Group has oversight and responsibility for pandemic planning in non-health areas in Northern Ireland including sector resilience.

46. The Group is a key information sharing body that participates in the effective delivery of the Central Crisis Management Arrangements in Northern Ireland as necessary during an emergency. Until January 2023 the Department's representative was the Director of Population Health and/or the Deputy Chief Medical Officer for Public Health. Since January 2023 the Department's representative has been the Director of the newly created Emergency Preparedness, Resilience and Response Directorate.

ii. Health Emergency Planning Forum

47. The Health Emergency Planning Forum was established in 2008 to act as a two-way channel of communication between the Department and Health and Social Care organisations in Northern Ireland, including the former Health and Social Care Board, the Public Health Agency, Business Services Organisation, Trusts, the Northern Ireland Fire and Rescue Service, the Northern Ireland Blood Transfusion Service and, from the third sector, the British Red Cross. Prior to the emergence of the Covid-19 pandemic, the group met quarterly and was jointly chaired by the Department and Public Health Agency. The Health Emergency Planning Forum facilitates information-sharing on all aspects of emergency planning, including incident updates, best practice and lessons learned through training and exercising. Meetings were paused between September 2019 and September 2020 as members were diverted to managing the first wave of the Covid-19 pandemic response from early 2020. The Forum also had a role in providing feedback on emergency preparedness strategies and policies (including Controls Assurance Standards/Core Standards) and in facilitating discussion on training needs and best practice.

iii. Critical Threats Preparedness Steering Group

48. The Critical Threats Preparedness Steering Group sits under the auspices of Civil Contingencies Group Northern Ireland. It is chaired by the Department of Justice and has members from government departments, agencies and key stakeholder groups, who have a key role in preparing for, and managing, a multi-agency response to critical threats. The role of the Critical Threats Preparedness Steering Group is to understand the critical threats picture for Northern Ireland (taking account of the National Security Risk Assessment and other pertinent national and local information and data) and to set the strategic direction for, and provide oversight of, an effective co-ordinated multi-agency preparedness and response capability in respect of critical threats in Northern Ireland. The term "critical threat" refers to a Chemical, Biological, Radiological, Nuclear incident, Hazardous Material incident or a Marauding Terrorist Attack. This group is supported by the Critical Threats Preparedness Tactical Working Group, who are

responsible for tactical planning. The Department was represented at the Steering Group by the Deputy Chief Medical Officer of Public Health, Director of Population Health and/or a representative from Emergency Planning Branch and at the tactical Group by a representative from the Emergency Planning Branch.

iv. Joint Emergency Planning Board

49. The Joint Emergency Planning Board was established in 2014/15 and was co-chaired by the Health and Social Care Board and the Public Health Agency and supported by the Emergency Planning leads in the Health and Social Care Board, Public Health Agency and Business Services Organisation. The Department and each of the Health and Social Care Board and Public Health Agency directorates were represented on the Board, and meetings were held on a quarterly basis. The purpose of the Joint Emergency Planning Board was to seek assurance on Health and Social Care preparedness to manage a response to emergency incidents (in adherence to the Department Policy Circular (2010) and within the context of the Northern Ireland Civil Contingency Framework [PM/0003 INQ000086932], and to ensure an appropriate and proportional level of Health and Social Care preparedness across the three organisations to enable an effective Health and Social Care response to emergencies which have a significant impact on the local community.

v. New and Emerging Respiratory Virus Threats Advisory Group

50. The New and Emerging Respiratory Virus Threats Advisory Group is an expert committee of the Department of Health and Social Care, which advises their Chief Medical Officer and, through the Chief Medical Officer, ministers, Department of Health and Social Care and other government departments. It provides scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management. The scope of the group includes new and emerging respiratory virus threats to human health including strains of influenza virus (regardless of origin), and other respiratory viruses with potential to cause epidemic or pandemic illness, or severe illness in a smaller number of cases. The group draws on the expertise of scientists and health care professionals, including clinicians, microbiologists and public health practitioners, and colleagues in related disciplines and is scientifically independent.

51. The New and Emerging Respiratory Virus Threats Advisory Group communicates its advice to United Kingdom health departments through the published minutes of Committee and Sub-committee meetings and statements produced by the Committee. Ministers or Chief Scientific Advisers or Medical Advisors may request advice from the

Committee directly. The Department attends meetings as an observer and was represented during the Covid-19 pandemic by Professor Stuart Elborn, Queen's University of Belfast.

vi. Scientific Advisory Group for Emergencies

52. The Scientific Advisory Group for Emergencies is a UK group, which provides independent scientific advice to support decision-making in the Cabinet Office Briefing Room in the event of an emergency. It provides timely scientific and/or technical advice to decision makers to support UK cross-government decisions. It is also responsible for coordinating and peer reviewing scientific and technical advice to inform decision-making and can only be activated by the Cabinet Office Briefing Room; however, any of the Devolved Administrations can request assistance from the United Kingdom Government for securing or sourcing scientific and technical advice to help inform decision-making on issues within their statutory competence. The Group is usually chaired by the United Kingdom Government's Chief Scientific Advisor.

53. Given its relatively small size, Northern Ireland does not have its own Scientific Advisory Group for Emergencies group but relies on the independent scientific advice provided by the United Kingdom group. Northern Ireland's representation at the Scientific Advisory Group for Emergencies, either with observer or with participant status, is dependent on the nature of the emergency. For most of the Covid-19 pandemic, the Chief Scientific Adviser or deputy Chief Scientific Adviser attended the meetings as a participant. In the absence of Northern Ireland involvement, summaries of the views and discussions, in the form of minutes, were received by the Chief Medical Officer.

54. The Chief Medical Officer agreed to a proposal by the Chief Scientific Adviser to establish a Northern Ireland Group specifically to focus on scientific evidence. This group was established in April 2020 and titled the Strategic Intelligence Group which is described further below.

vii. Joint Committee on Vaccination and Immunisation

55. The Joint Committee on Vaccination and Immunisation is an independent statutory Advisory Committee established under the National Health Service (Standing Advisory Committees) Order 1981 (SI 1981/597). Its terms of reference, agreed by the United Kingdom Health Departments, are:

- to advise United Kingdom health departments on immunisations for the prevention of infections and/or disease following due consideration of the

evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies.

- to consider and identify factors for the successful and effective implementation of immunisation strategies.
- to identify important knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered.

56. The Committee provides advice to all 4 United Kingdom health Ministers/Departments on vaccination and immunisation matters. It has a statutory role in England and Wales, while health departments in Scotland and Northern Ireland may choose to accept its advice. Draft recommendations and minutes of meetings are shared with relevant officials.

3. Department of Health's Emergency Response Role

57. In April 2010, in line with Cabinet Office best practice guidance, the Department defined its Lead Government Department role [PM/0152 INQ000145671] for responding to the health consequences of emergencies arising from chemical, biological, radiological and nuclear incidents; disruptions to the medical supply chain; human infectious diseases; and mass casualties.

58. The Civil Contingencies Framework for Northern Ireland (2011) [PM/0003 INQ000086932], published by the Executive Office, also required the Department to maintain, review and update its Emergency Response Plan [INQ000184662] and to test and exercise the plan response arrangements. This was to ensure the Department's ability to deliver an effective response to minimise the health and wider impacts of the emergency on society, given that it had been designated lead Government department. The Department will also provide strategic health and social care policy advice and/or direction in support of the efforts of others, including its associated agencies and Arm's Length Bodies in response to emergencies for which it had been designated lead. In such circumstances, the Minister of Health is required to lead, direct and co-ordinate the response for Northern Ireland, reporting as necessary to the Northern Ireland Executive under the Northern Ireland Central Crisis Management Arrangements Protocol [PM/0005 INQ000103601] when an emergency has been categorised as Serious or Catastrophic and requires a cross-departmental or cross-governmental response.

i. Emergency Response Plan

59. The severity and complexity of an emergency will dictate the level of involvement of the Department in the health response to it and whether activation of Health Gold Command is required. The structures, systems and processes involved in responding to an emergency are defined within the Emergency Response Plan 2019. A review of the Emergency Response Plan, in consultation with stakeholders, is carried out after live exercises or when incidents have led to the activation of all or part of the plan. The 2019 Plan is currently under review to take account of lessons learned from Covid-19.

60. It was this response plan that was activated in January 2020 in response to the emergence of the SARS-CoV-2 virus which is responsible for the disease that became known as Covid-19. Emergency Planning Branch in the Department's Population Health Directorate (until January 2023) is responsible for maintaining, reviewing and updating the plan.

61. The Emergency Response Plan is designed to be modular in structure and therefore flexible and scalable, capable of escalation and de-escalation. It sets out how the Department will effectively carry out the responsibilities and functions associated with its role as Lead Government Department. It describes the key processes and disciplines necessary in planning for and responding to health crises. The design of the plan is based on the principle of preparation, response and recovery to enable an effective joint response to, and recovery from, any emergency. It provides assurance in the ability of the Department to deal with a range of Health and Social Care emergencies in Northern Ireland, from short term emergencies which are sudden, unexpected and relatively brief, to longer term 'rising tide events', such as pandemic influenza.

62. Within the Emergency Response Plan, the oversight of managing an emergency falls to Health Gold Command which consists of two key elements: the Strategic Cell and the Emergency Operations Centre. The Strategic Cell provides strategic health and social care policy advice to the Minister. It also provides health, social care and public safety advice, direction and leadership to Health and Social Care organisations and to other departments and organisations. The second element, the Emergency Operations Centre, is responsible for management of the flow of information into and out of the Strategic Cell between the Department and Health and Social Care sector, and the wider Northern Ireland Executive departments and United Kingdom Government. Activation of the Emergency Operations Centre is not reliant on the full activation of

both key elements of the Health Gold Command structure and can operate without activation of the Strategic Cell in lower-level emergencies requiring a degree of central co-ordination. However, the Strategic Cell requires the support of the Emergency Operations Centre to function.

63. Tiers of emergency response command within the health system are generally referred to as Health Gold, Health Silver and Health Bronze, and refer respectively to the strategic, tactical and operational response to an emergency. The Gold/Silver/Bronze structure adheres to the four nationally accepted tiers, or categories, of emergency: Local (requiring Health Bronze activation); Significant (requiring Health Silver activation in conjunction with Health Bronze); Serious or Catastrophic, (both requiring Health Gold Command in conjunction with Health Silver and Health Bronze). These structures exist for routine preparedness, resilience and emergency assessment and can be escalated or deescalated depending on the nature of the emergency.

64. When the Department's Emergency Response Plan is activated, it is supported by Health Silver. This comprises the collective tripartite of the Public Health Agency, the Strategic Planning and Performance Group (formerly the Health and Social Care Board), and Business Services Organisation, any one of which may lead a tactical level response, depending on the nature of the incident. Where Health Silver is activated, it will jointly lead the tactical coordination of a Health and Social Care response when an incident or emergency involves more than one Health and Social Care Trust, i.e., when an emergency is categorised as 'significant' but does not require involvement by central Government. In line with the principle of subsidiarity, i.e. the idea that an issue should be dealt with by the most local level possible, Health Silver may be stood up without Health Gold. Health Bronze refers to the operational or Trust level response. Both are described further below.

65. Within the Department during the period 2009 until the emergence of the pandemic in 2020, responsibility for providing health protection policy advice to the Minister of Health sat with the Chief Medical Officer, supported by the Deputy Chief Medical Officer for Public Health and the Director of Population Health. Within Population Heath Directorate the Health Protection Branch and Emergency Planning Branch undertook work to formulate policy advice in the areas referred to above. Since the end of October 2022, the arrangements have changed, while the policy lead remains with Chief Medical Officer, the support for High Consequence Infectious Diseases and endemic infectious disease now falls to the remit of the newly created post of Director

of Health Protection, Heather Stevens. As of 1 January 2023, the support for emergency preparedness, including pandemic planning, falls to the remit of the separate newly created post of Director of Emergency Preparedness, Resilience and Response.

ii. Activation of Health Gold Command

66. An extraordinary meeting of the Top Management Group was held on 4 March 2020. A note of that meeting [PM/0033 INQ000103631] which confirmed the Top Management Group's agreement to full activation of the Health Gold Command was circulated the following day, advising that the Strategic Cell had been convened and would have its first meeting on 9 March 2020.

67. On 9 March 2020 the Department activated Health Gold Command in line with the guidance set out in its Emergency Response Plan 2019 [INQ000184662] regarding the levels and approvals necessary to stand up.

a. Strategic Cell

68. The Strategic Cell met formally for the first time on 9 March 2020 [PM/0034 INQ000103632] in response to the growing threat to Northern Ireland from the virus. It had regular meetings and operated for the first four months of the pandemic during the initial emergency response phase of the pandemic, holding its last meeting on 16 June 2020. The Strategic Cell was chaired by the Chief Medical Officer or a deputy from the Department's Top Management Group. The meetings were conducted based on a set agenda. The membership of the Strategic Cell included Top Management Group senior officials and the Department's professional officers from the medical, nursing and social care disciplines.

69. Alongside the meetings of the Strategic Cell, the Department's Permanent Secretary chaired a regular early-evening teleconference meeting. This meeting involved the Top Management Group senior officials, the Department's professional officers, chief executives from the Health and Social Care Trusts, Health and Social Care Board, the Public Health Agency and Business Services Organisation. The purpose of this meeting was to supplement the Strategic Cell meetings by providing the chief executives from the Health and Social Care organisations with the ability to directly input into information sharing and reflect on the progress of urgent regional operational issues requiring resolution.

70. The diagram provided at [PM/0035 INQ000103633] provides the overall organisational structure for Health Gold Command[2] which was comprised of the Strategic Cell and of 13 subject-specific policy cells. The remit and staffing for each of these policy cells is provided in the document at [PM/0036 INQ000103634]. These policy cells were mainly chaired by lead officials from the Department's business areas who were also members of the Strategic Cell. Additional Grade 7 officials and their teams (which had been recently recruited to manage health service transformation projects) were immediately redeployed to the policy cells upon their arrival in the Department. The redeployment of these staff resulted in the Department's acute health services transformation programme being paused from April 2020 to the summer of 2021.

71. Each policy cell was responsible for monitoring the impact of the pandemic in specified service delivery/policy areas, responding to issues escalated to Health Gold by Silver. As the impact of the pandemic began to take hold and became pervasive across the Health and Social Care system, the cells also developed new policies or responses designed to mitigate or address the new and complex issues faced by Health and Social Care. Policy recommendations and advice prepared by the policy cells for the Minister to approve were cleared by the Strategic Cell. The clearance of policy recommendations was given either verbally at Strategic Cell meetings or via email, which often included a draft Ministerial submission, circulated amongst the Cell's membership in between meetings. The Strategic Cell worked at pace logging its decisions and actions [PM/0037 INQ000130312].

b. Emergency Operations Cell

72. The Department received the first Situation Report (SitRep) regarding Covid-19 from the Department of Health and Social Care on 21 January 2020 and began to monitor the situation closely. The Department's Emergency Operations Centre was activated on 27 January 2020 in response to the emerging threat of Covid-19. Information boards were quickly established in the Emergency Operations Centre to aid decision-makers and to assist in managing the flow of information into and out of the Emergency Operations Centre. These information boards were continuously monitored and maintained throughout the duration of the emergency response phase. In preparation for the United Kingdom's departure from the European Union, a cohort of staff volunteers had undergone emergency response training and familiarisation sessions

[2] This was the structure between March 2020 and June 2020 when the Rebuilding Management Board was established. This is discussed further below.

within the Emergency Operations Centre during 2019. These officials were redeployed from routine business areas to work in the Emergency Operations Centre.

73. The main responsibility of the Emergency Operations Centre was to coordinate information, in collaboration with policy leads and the wider Health and Social Care Arm's Length Bodies, and to provide SitReps on health and social care related matters. This involved receiving and reviewing the daily "Health and Social Care Silver SitReps" and, beginning on 20 March 2020, escalating issues to the Northern Ireland Hub, which is part of Civil Contingencies Group Northern Ireland, to inform the "Northern Ireland SitRep".

74. During the initial response to the pandemic, the Emergency Operations Centre established and maintained a reporting rhythm, which included regular meetings to support Health Gold. In addition, the Chief Medical Officer and Deputy Chief Medical Officer, along with the Chief Nursing Officer and other professional officers within the Department, attended *ad hoc* meetings with Health and Social Care organisations as necessary.

75. The days and hours of operation changed throughout the period of the Emergency Operations Centre stand-up; at peak times it operated 7 days a week and late into the evenings. As the emergency became less acute, hours were reduced, and eventually the Centre did not operate on weekends until it was finally stood down on 11 August 2020.

iii. Other Departmental Committees/Groups

76. In addition to activating Health Gold Command there were a number of other groups and boards that sat at various points.

a. Rebuilding Management Board

77. During the period April to May 2020 the Department's Top Management Group had recognised that a new temporary governance model would be needed to oversee the Health and Social Care system during the period of the ongoing pandemic. This required striking a balance between the emergency governance arrangements introduced to mitigate the impact of Covid-19 on the Health and Social Care system, allowing these to be escalated and de-escalated in line with the projected trajectory of the pandemic; and modifying the normal governance arrangements for the oversight of Health and Social Care routine service delivery.

78. The new business model required amending the Health and Social Care Framework Document to establish new temporary governance arrangements and a new temporary Management Board. Both measures were required to facilitate and provide direction for the rebuilding of Health and Social Care services and to oversee planning of service capacity for any potential further waves of the pandemic and/or local outbreaks. The Department had carried out an assessment [PM/637 **INQ000477514** on the impact of Covid-19 covering the six weeks period from 9 March to 17 April 2020 across screening, primary care, community services, secondary care, and a wide range of programmes and projects which indicated that the impact of the pandemic across HSC services, programmes and projects had been devastating. Following this, a Memorandum [PM/0231 INQ000103722] to the Framework Document[3] was published setting out the temporary changes to the governance arrangements, constituted by the establishment of the Management Board for Rebuilding HSC Services, for a period of two years with effect from June 2020 and to be kept under review. It was proposed that the two years period would be followed by a consultation on substantive and longer-term changes to the Framework Document, reflecting both learning from this period, and the dissolution of the Health and Social Care Board which was expected within this timescale.

79. The Rebuilding Management Board [PM/0232 INQ000137398] was established in June 2020, at the same time as the Emergency Operations Centre was being stood down and ensured a sustainable and inclusive approach to decision-making during this difficult, protracted and unprecedented period. The Rebuilding Management Board reported directly to the Minister, and was chaired by the then Permanent Secretary, Richard Pengelly. It had responsibility for providing oversight and direction to the Health and Social Care Board, Public Health Agency, the Health and Social Care Trusts and the Business Services Organisation on the implementation of the Department's Strategic Framework for Rebuilding Health and Social Care Services [PM/6012 INQ000137342]. The Management Board would not exercise any other authority in relation to the statutory duties, roles, and responsibilities, as specified in the Framework Document, which the Department has delegated to the Health and Social Care Board, the Public Health Agency and a number of other Health and Social Care bodies.

[3] The draft Memorandum – amendments to the HSC Framework [INQ000103722] references a comprehensive assessment of the impact of covid 19 on HSCNI. The reports on this assessment were published as three Appendices to the Strategic Framework for Rebuilding services [INQ000137430]. For completeness the three published appendices are included in this exhibit as they were inadvertently omitted from Exhibit INQ000137430.

b. Strategic Intelligence Group

80. The Strategic Intelligence Group was chaired by the Chief Scientific Adviser and attended by the Chief Medical Officer. It considered a wide range of scientific papers throughout the course of the pandemic, including those developed by Scientific Advisory Group for Emergencies and the group provided advice to the Chief Scientific Adviser and Chief Medical Officer. The specific role of the group was to consider the scientific and technical concepts and processes that are key to understanding the evolving Covid-19 situation, the potential impacts in Northern Ireland, and the approaches to mitigating these. The Strategic Intelligence Group's role was to consider the advice coming to the four nations from the Scientific Advisory Group for Emergencies and other appropriate sources of evidence and information, including from the Republic of Ireland, and use it to inform the Chief Medical Officer and the Health Minister to aid with decision making in Northern Ireland during the pandemic.

c. Care Home Task and Finish Group

81. This was established in May 2020 and was chaired by the Deputy Chief Medical Officer - Dr Lourda Geoghegan. Its aim was to provide direction and guidance to support the development and implementation of Covid-19 testing arrangements within care homes. The Group included active participation from Departmental social care and nursing colleagues, the Public Health Agency and the Regulation and Quality Improvement Authority.

d. Expert Advisory Group on Testing (EAG-T)

82. This was a Departmental Group led, at the Chief Medical Officer's request, by an Associate Director within the Public Health Agency, Dr Brid Farrell. The group was established in March 2020. A key function of this group was to advise on implementation of Covid-19 testing in Northern Ireland and to provide expert advice which was then considered by policy leads to inform advice to the Chief Medical Officer and the Minister. The group also played a significant role in advising on and in delivering the expansion of testing capacity in hospital and community services as quickly as possible.

e. The NI Modelling Group

83. This was chaired by the Chief Scientific Adviser and was attended by the Chief Medical Officer. The role of the group was to undertake modelling work and to estimate the value of 'R' in Northern Ireland. The group considered information and modelling generated from across the United Kingdom and within Northern Ireland to inform their work and this was submitted to the Executive and published on the Department's

website. This group also oversaw the Health and Social Care Board bed modelling in Waves 2 and 3 of the pandemic.

f. The Northern Ireland Systematic, Meaningful, Asymptomatic, Repeated Testing Programme Board

84. This was established in March 2021, chaired by the Chief Medical Officer, and was designed to rapidly expand asymptomatic testing for Covid-19 in Northern Ireland using Lateral Flow Devices. The Board initially focused on making asymptomatic testing available through workplace schemes. It also oversaw the introduction of testing in the wider community using Lateral Flow Device tests by making these available to the general public in Northern Ireland through the Home Channel managed by the United Kingdom Health Security Agency[4], Pharmacy Collect and a range of local collect sites.

g. Test, Trace, Isolate, Protect Strategic Oversight Board

85. This was established and chaired by the Chief Medical Officer in May 2020. Its role was to provide oversight of both the contact tracing and testing programmes. This included the sharing of intelligence on clusters and outbreaks and providing advice in terms of policy implementation and its effectiveness. In April 2022 the Board's Terms of Reference were updated to oversee implementation of the Covid-19 Test, Trace and Protect Transition Plan.

h. Covid-19 Vaccination Programme Oversight Board

86. The Covid-19 Vaccination Programme Oversight Board was established and chaired by the Chief Medical Officer in July 2020 to oversee the end-to-end deployment of the Covid-19 vaccine including storage, distribution, and administration.

i. Covid-19 Therapeutics Oversight Board

87. This was established by the Chief Medical Officer in December 2021 and co-chaired with the Chief Pharmaceutical Officer to set the overall strategic direction for deployment of novel Covid-19 therapeutics in Northern Ireland and oversee the development and implementation of a coordinated system-wide approach to deployment. The operational delivery of the treatment of non-hospitalised eligible people was provided by the five Health and Social Care Trusts with regional coordination by the Health and Social Care Board (now Strategic Planning and Performance Group) and who chaired the Covid-19 Therapeutics Operational Group.

[4] The Home Channel was the name for the system by which people could order tests through Gov.uk or by ringing '119'. This service was managed centrally by UKHSA on behalf of all the Devolved Administrations. Primarily in Northern Ireland it was used by members of the public who required Lateral Flow Tests or Polymerase Chain Reaction (PCR) tests, although it was also used by a number of small businesses and some Health and Social Care staff.

iv. Health and Social Care Response

88. The requirements on Health and Social Care organisations in Northern Ireland regarding emergency preparedness were defined in a Policy Circular that was issued by the Department of Health in 2010 titled '*1/2010 – Emergency Preparedness for Health and Social Care Organisations*' [INQ000188755].

89. This 2010 Policy Circular stressed that the purpose of planning for emergencies in the Health and Social Care sector was to ensure preparedness for an effective response to any major incident or emergency. All Health and Social Care organisations, other contracted health and social care providers, local authorities and other local organisations were instructed to give a high priority to putting in place and testing plans and arrangements that would deliver an effective response to threats and hazards.

a. Joint Response Emergency Plan

90. The Joint Response Emergency Plan **INQ000102841** was developed in 2010 as the Health Silver Emergency Response Plan of the Public Health Agency, Health and Social Care Board and Business Services Organisation. The plan describes the processes and arrangements for a joint response in an emergency, thereby ensuring that the response of the three regional HSC organisations is co-ordinated and effectively managed. It is intended to be used as a guideline to aid an effective response to an incident, irrespective of its cause, and it complies with the requirements of the Northern Ireland Civil Contingencies Framework.

91. The Joint Response Emergency Plan clarifies the roles and responsibilities of each organisation and the resources that may be utilised, as well as providing a clear authority structure. It provides detailed arrangements for responding to incidents and emergencies – including the periods before, during and immediately following a major incident in order to meet statutory requirements and the Joint Emergency Services Interoperability Programme principles. The plan advises of the range and nature of incidents and the levels of response.

92. The Strategic Planning and Performance Group (formerly Health and Social Care Board), the Public Health Agency and Business Services Organisation jointly lead the co-ordination of the Health and Social Care response when an incident or emergency involves more than one Trust, but does not require cross-department or cross-government co-ordination, i.e. when an emergency is categorised as significant or serious. The composition of the team between Public Health Agency/Strategic Planning and Performance Group and who will be the Chair from either Strategic

Planning and Performance Group/Public Health Agency will depend on the nature of the incident.

93. The Joint Response Emergency Plan is, as far as possible, and when not activated, tested and reviewed jointly on an annual basis by the Strategic Planning and Performance Group, Public Health Agency and Business Services Organisation. Lessons learnt from incidents and activations are included within revisions to the document. The plan (dated April 2018) was activated in January 2020, following the outbreak of Covid-19, and was reviewed and updated to take cognisance of the learning from Covid as well as the migration of the Health and Social Care Board to the Strategic Planning and Performance Group in April 2022 [INQ000188754].

b. Activation of Health Silver

94. Health and Social Care Silver (Tactical Command) Structures, as outlined in their Joint Response Emergency Plan **INQ000102841** and as implemented by the Public Health Agency, Health and Social Care Board and Business Services Organisation, were formally stood up on 22 January 2020. Health and Social Care Silver provided regional coordination of the Health and Social Care response to the pandemic. The Silver response was aligned with the strategic objectives set by Health Gold. Silver forwarded a daily Silver Situation Report (SitRep) to the Emergency Operations Centre Situation Cell, which provided validated key information and data on the situation. This daily Silver SitRep allowed the Health and Social Care sector to identify issues that should be escalated to the Department, whether to seek strategic advice or to require a strategic decision; and it provided the Department with an overview of the key issues in sufficient detail to keep Health Gold informed, and to permit strategic decisions to be made whenever necessary. The information was entered into reporting and decision logs [PM/0037 INQ000130312] which were maintained by the Emergency Operations Centre.

95. Health Silver arrangements were also activated by the Public Health Agency and the Health and Social Care Board to coordinate the preparation and response to the developing situation across the health and social care sector. The decision to activate Health Silver was made by the Public Health Agency in conjunction with the Health and Social Care Board. On the 22 January the Public Health Agency wrote to the Chief Medical Officer [MMcB/0106 INQ000425510] to advise that they had established Health Silver to coordinate the response to what was then known as the Wuhan coronavirus. In response to the evolving situation, Public Health England had established an enhanced 4 nations incident response daily tele-conference and the

Public Health Agency health protection team were represented on the call. Cases were no longer, at this time, restricted to Wuhan and the activation of Health Silver was to support the co-ordination of a consistent approach across Northern Ireland to enable the HSC to plan and respond to across a number of areas including but not limited to, identification of potential Coronavirus cases, testing, sharing of information across HSC and partner organisations, Infection Prevention and Control and Personal Protective Equipment.

96. During the initial response to the pandemic there was also a regular meeting of the Health Gold/ Silver by way of teleconference (also referred to as Gold-Silver calls). This meeting dealt with issues for resolution, and associated decision-making, and was chaired either by the Deputy Chief Medical Officer for Public Health or by the Director of Population Health, who was also an Emergency Operations Centre Lead. This meeting facilitated the sharing of information between Health Gold, Silver and Health and Social Care organisations, and enabled key issues to be discussed and actions agreed. If an issue could not be resolved, or required strategic advice/decision, it was escalated to the Strategic Cell with Silver or policy cell leads providing supporting papers as required. The structures, reporting mechanisms and meetings referenced above ensured that the appropriate health and social care Arm's Length Bodies were involved in the core decisions made in response to the pandemic in the early weeks and months of the emergency.

97. The Health and Social Care Board took over the lead of Health Silver from the Public Health Agency in mid-March 2020. There is an established principle in the Joint Response Emergency Plan that Health Silver lead will fall to the organisation that has the greater responsibility. In the 'contain' phase which related to the early detection of cases, follow up of close contacts and prevention of the disease taking hold in the country the response was led by Public Health Agency. In the 'delay' phase (which related to response in slowing the spread of the disease and lowering the peak impact) Health Silver was led by the Health and Social Care Board. As part of this transition, the Health and Social Care Board amended and updated the SitRep issued to Health and Social Care Trusts, the Regulation and Quality Improvement Authority, and the Northern Ireland Blood Transfusion Service (all of which comprised Health 'Bronze') for submission of information to Health Silver on a daily basis. The purpose of the SitRep was to obtain qualitative information on key issues identified by Health and Social Care Trusts, Northern Ireland Ambulance Service and relevant Health and Social Care organisations relating to Covid-19.

98. In addition, the revised SitRep captured daily information from the various groups/planning teams established within the Health Silver organisations, i.e. Surge, Personal Protective Equipment, Supply Chain, Social and Community Care, Infection/Prevention Control, Human Resources, Integrated Care and Finance and updates from Communications teams in the Public Health Agency and Health and Social Care Board and Health Protection. The SitRep also captured business continuity/staffing issues across the Health Silver organisations.

99. This information was received via a dedicated Covid-19 inbox, which had been established by the Health and Social Care Board for the purpose of receiving information for consideration by Health Silver and potential escalation to Health Gold, which at the height of the pandemic operated on a seven-day basis and Out of Hours.

100. The 'battle rhythm' of SitRep reporting changed during the course of the response. It quickly moved to a seven-day reporting requirement during April 2020, before being amended to twice weekly and ultimately weekly reporting from the end of June 2020 until stand down on 9 July 2020. The Covid-19 inbox remained fully operational, de-escalated to a 9-5, five day per week from the 9 July 2020 but with the Health and Social Care Trusts aware of the ability to raise issues through the inbox or via the Health and Social Care Board Director on call.

101. The arrangements for managing the Department's response to the surges in demand for Health and Social Care services from Covid-19 patients, which were initially managed through Gold Command during the first wave, were revised during autumn 2020 in anticipation of the further surges expected over the winter months of 2020/21. This involved taking a business continuity approach to managing the response to the second wave, instead of the emergency management approach adopted during the first wave. The revised arrangements were set out in a memo issued by the then Permanent Secretary on 22 October 2020 [PM/2008 INQ000276292]. The primary purpose of these arrangements was to effectively manage future Covid-19 waves, including the second wave, by avoiding duplication of effort, simplifying the decision-making process and ensuring sustainable working arrangements. The new arrangements involved the establishment of an integrated Covid-19 Gold Command Group, consisting of senior Departmental officials, alongside senior Health and Social Care Board and Public Health Agency officials. This Covid-19 Gold Command Group was chaired by the Permanent Secretary.

102. The letter of 22 October 2020 referred to establishing a Departmental Covid-19 Taskforce to support the Covid-19 Gold Command Group. However, while the proposed Taskforce was not established as a formal entity, five existing Departmental Directorates (Covid-19 Response Directorate, Surge Directorate, Rebuilding Directorate, Secondary Care Directorate and General Healthcare Policy Directorate), along with Health and Social Care Board staff involved in processing and managing daily Health and Social Care Trust SitReps, operated on an integrated basis directed by the Covid-19 Gold Command Group.

103. In response to rapidly increasing numbers of Covid-19 positive patients in hospitals having a significant impact on Trust services, the SitRep reporting process was stood up again in mid-October 2020, having been stood down on 9 July 2020 as noted above. When stood up again, a further revised SitRep was developed by Health and Social Care Board working with Department policy leads, to provide a risk assessment of delivery confidence across acute and community services in the five Health and Social Care Trusts and in the Northern Ireland Ambulance Service. The amended SitRep also included detail of impact on services, including cancellation of Red Flag inpatients and day cases and elective/routine inpatient and day cases. The SitRep also sought information of any potential European Union Exit implications or impacts, including information about the supply of medicines, medical devices and clinical consumables.

104. Further, an amended structure was established for consideration of the (initial) twice weekly SitReps, reducing to weekly, as time progressed, reporting key issues from the Health and Social Care Trusts to Silver and consideration, if appropriate, by the newly established integrated Department policy led Cells, and weekly reporting to the Health Gold Command Group. This process remained in place until the Health Gold Command Group was formally stood down on 23 May 2022, at which time Health and Social Care Trusts were advised that they no longer had to provide a weekly SitRep.

v. Consideration of the Effect of Advice and Guidance

105. The Department was aware that epidemics and pandemics highlight and exacerbate existing health inequalities and disparities such as those associated with socioeconomic deprivation, ethnicity, sex, age and sexuality. There were many individuals and communities disproportionately affected by the Covid-19 pandemic both directly and indirectly. This was an important consideration throughout the pandemic response. Such disparities arise either because of a difference in infection

risk, risk of more severe disease and mortality or the wider consequences of the public health measures taken to control the pandemic. Many across society were more 'at risk' or 'clinically vulnerable' throughout the Covid-19 pandemic either because of a greater risk of exposure to infection, a greater risk of more severe disease or because the NPIs and restrictions introduced had a disproportionate impact on their personal and family circumstances, education, livelihood or health and well-being. For example, the closure of hospitality and leisure had significantly greater economic impact on individuals employed in these sectors, and a greater proportion of those who were affected are women and of younger age. With Covid-19 those at increased risk of infection included those at greater occupational risk in public facing roles; those who were unable to work from home; those from lower socioeconomic groups living in crowded or multiple-occupancy housing, who often, in addition, found it difficult to work from home or self-isolate for financial reasons.

106. As evidence emerged, some disparities observed in the Covid-19 pandemic arose from the airborne transmission of the pathogen with increased spread in crowded households or for individuals working in poorly ventilated environments, often compounding factors for already vulnerable individuals and populations. As result of the virus reaching increasing numbers early evidence emerged about poorer outcomes for older patients and men. Additional data highlighted the risks for those with certain underlying conditions and immunosuppression.

107. In terms of data and analysis with respect to inequalities, in NI we were able to review the impact of the pandemic in relation to age, gender, and social deprivation. Ethnic minorities form a much smaller proportion of the population than in many other regions of the UK, and ethnicity is not well coded in NI health care records. Consequently, analysis regarding ethnic minorities was not available due to the poor coding of ethnicity in health care records and it was not possible to look at trends in those from different ethnic backgrounds nor to analyse differential impacts of the pandemic according to ethnicity in our general population. In contrast, we were able to look at the influence of social deprivation on the various impacts of the pandemic. In addition, data collection relating to co-existing morbidities and underlying health conditions was also not also routinely reported and so also could not be analysed in real time.

108. Certain guidance issued by the Department focussed on the protection of the most vulnerable in society; for example, the purpose of the Department's visiting guidance was the protection of those in hospital inpatient settings and those in care homes. The

visiting guidance therefore would be relevant to those who were disabled, people who were clinically vulnerable, clinically extremely vulnerable and severely immunocompromised, and those who were from poor socio-economic backgrounds and/or groups with existing health inequalities who were in the settings of hospitals or care homes. Given the smaller proportion of individuals from ethnic backgrounds of those from ethnic backgrounds in NI, there was no specific consideration of the impact on them as a distinct cohort in hospitals or care homes. While formal equality impact assessments were not completed on the development of those visiting guidelines, at every stage the impact of restrictions on anyone affected by them was considered.

109. The policy on shielding included regular reviews to ensure that it remained proportionate to its aim of protecting the most vulnerable and effective in that aim. This is further explained in Section J of this statement. The regulations introduced to put NPIs on a statutory footing were subject to regular reviews by the Executive. Each review considered the public health implications, as is reflected in the relevant review of regulations papers subsequently submitted to the Executive. Any potential emerging equality issues, which required amendments to the regulations were reflected in the reviews which the CMO approved. In the circumstances it was, however, not possible to carry out an Equality Impact Assessment on those individuals or groups with protected characteristics. The Health Intelligence Unit in the PHA developed an evidence overview on inequalities at the start of the pandemic which was shared across the Department and used to inform policy and as appropriate.

110. From the second Review of the Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 [MMcB/6065 INQ000346705 (DoH ref PM0399)] and thereafter throughout Wave 1 of the pandemic [MMcB/6066 INQ000346706 (DoH ref PM0400), MMcB/6067 INQ000346707 (DoH ref PM0401), and MMcB/6068 INQ000346708 (DoH ref PM0402)] and subsequent waves, the Executive papers considered, not only the impact of the Coronavirus pandemic itself, but also the measures put in place to control the spread of infection. The wider health, societal and economic impacts of the regulations were integral to the Executive weighing up the continuing necessity and proportionality of the restrictions and were also part of the consideration of each individual new measure proposed. Although the Department clearly did not advise on the economic or societal impacts of (*inter alia*) the closure of hospitality and leisure industry, it was aware that its guidance and advice would have an impact on, and affect, certain individuals disproportionately.

111. The Department of Health published Coronavirus Related Health Inequalities Reports [MM/43a INQ000137375, MM/43b INQ000137376 and MM/43c **INQ000183436** in both June and December 2020. These reports present an analysis of Covid-19 related health inequalities by assessing differences between the most and least deprived areas of NI (by super output area) and within Local Government District (LGD) areas for Covid-19 infection and admission rates. The Institute of Public Health Ireland (IPHI) also completed a review of the potential impact of the pandemic on the indicators in the Executive's Public Health Framework, "Making Life Better". In addition, the PHA also undertook work in relation to the impact of face-coverings and the consequences particularly in respect of existing health inequalities. The PHA also carried out some analysis on the detrimental impact of the self-isolation guidance. This demonstrated that children from lower socio-economic groups were disproportionately impacted.

vi. Departmental Core Business

112. There were aspects of the Department of Health's core business which were paused in late 2020 to early 2021 due to the pressures on staffing within the Department. The Transformation Programme is designed to bring stepped change to the HSC in NI. Each element of the programme, while working across the entire HSC and third sector, has its own milestones and deliverables; the pausing of the projects outlined below clearly had the impact of delaying the transformation agenda, delayed delivering improvements and efficiencies to HSCNI. It was, however, inevitable given the scale and longevity of the pandemic that the decisions to pause were taken, with finite resources available for tackling the pandemic. Specific examples include:

- The Neurology Review – Work on the Neurology Review was paused in March 2020. Work on the Review recommenced in June 2021. This has resulted in a delay in completing the Review and identifying recommendations to drive improvements in services. It is anticipated that a Final Report with Investment and Implementation plan will be completed late Spring 2024.
- Stroke Reform – Stroke reform was paused when the pandemic emerged but subsequently progressed with the publication of the Stroke Action Plan in June 2022. Work is now ongoing to progress the actions in that Plan, although delivery will be subject to budget availability. The high-level impact is that stroke service reform, which is intended to improve patient outcomes, has been delayed.
- Urgent and Emergency Care Review – Work on the Review was paused in March 2020; however, the key emerging findings from the Review were picked

up as part of the COVID-19 Urgent and Emergency Care Action Plan (No More Silos), which was published in October 2020. This Plan allowed progress to be made on the introduction of Urgent Care Services, Rapid Access Clinics and local Phone First services across all Trusts. The Review was ultimately published in March 2022, followed by a full public consultation, which saw broad support for the recommendations made. An Implementation Board was established in the Department in October 2022 to oversee delivery. While progress on implementation has suffered a degree of delay, this has not been as significant for the Urgent and Emergency Care Review as for some other service reviews.

- Pathology Modernisation – work to explore options for a revised regional management structure for HSC Pathology Services following the outcome of a public consultation in 2016 was delayed by the Assembly collapse between 2017-20 and subsequently by the onset of the pandemic. The impact was a further delay in developing a policy solution to growing capacity, workforce and modernisation challenges required to sustain vital pathology services. This work resumed following the Health Minister's policy statement on pathology modernisation in November 2021 [PM/6372 **INQ000477515**
- Imaging Services – implementation of a new Strategic Framework for Imaging Services in Health and Social Care was further delayed (following publication in 2018 during the period of Assembly suspension) by the need to redeploy staff to the Covid response. This delayed implementation of the Framework's 19 key recommendations designed to stabilise and improve vital HSC imaging services. Work was resumed with the establishment of a Regional Medical Imaging Board in April 2021.
- Abortion Services – plans to develop a service specification to give effect to new Abortion Regulations, introduced by the UK Government from 31 March 2020, were paused due to redeployment of DoH staff from April 2020. The impact was a delay to the development of a service model for consideration by the NI Executive, whose approval was required at that time under the NI Act 1998 to commence the commissioning of these services (until further Regulations were introduced by the UK Government in May 2022 which provided the NI Secretary of State with the authority to instruct the Department to commission these services). A revised project board was subsequently established in July 2021 to take forward plans.

4. Communication

113. The Public Health Agency published a daily bulletin between 24 March and 19 April 2020 which provided a summary of the information to date including the number of new cases, the number of tests reported and, eventually, the number of deaths. It was replaced by the Department of Health's Dashboard on 19 April 2020.

i. Department of Health Dashboard

114. The Department of Health was responsible for the development and management of the Covid-19 Dashboard which was the primary vehicle for the collation and dissemination of all official pandemic-related data and analysis. In line with the Northern Ireland Civil Service policy and practice, it was designed to the requirements of the pillars of the Code of Practice for Statistics [PM/0292 INQ000092790] in terms of trustworthiness, quality and value. Although the Dashboard was based on similar information published by other United Kingdom jurisdictions, the information for Northern Ireland also included useful health service data about capacity and availability.

115. In order to collect relevant and standardised data from Health and Social Care Trusts, the Health and Social Care Board and the Public Health Agency, the Department established a Data Coordinating Group on 18 March 2020. Membership of that group consisted of Information leads in the relevant organisations and it was chaired by the Principal Statistician of the Hospital Information Branch in the Information & Analysis Directorate in the Department. This information was primarily used to create analyses and statistics for publication on the Department's COVID-19 Daily Dashboard of Statistics. A summary of the data items collected is set out in [PM/6002 INQ000400122].

116. Several systems and processes were developed and utilised by the Department to collate the relevant data for this Dashboard. The then Health and Social Care Board was tasked with developing a process specifically to collate Hospital Bed Occupancy data for Covid-confirmed and non-confirmed patients to help assess pressure on hospital services and this information was forwarded to the Department for publication on the Covid-19 Dashboard.

ii. Early Alert System

117. The Early Alert System was introduced in June 2010 as a means by which Health and Social Care Chief Executives, and their Directors, can inform the Department of events which have occurred in the services provided or commissioned by their organisations,

and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department. An updated circular was issued on 12 November in respect of Covid-19 incidents [PM/6013 INQ000400130; PM/6014 INQ000400131]. The Health and Social Care organisations used the Early Alert System extensively throughout the pandemic to notify the Department of matters related to Covid-19 individual incidences such as Health and Social Care site infections and staff shortages. Between 1 March 2020 and 28 June 2022, the Department received 299 Early Alerts in relation to Covid-19. The Department does not hold a breakdown by reference to the Early Alert criteria 1-7 as referenced in the Early Alert Proforma [PM/6013 INQ000400130].

iii. Internal communication within the Health and Social Care Trusts

118. In addition to the information collated for the Covid-19 Dashboard, the then Health and Social Care Board developed an internal daily management information report from June 2020, which collated data from Health and Social Care Trusts and analysed trends in a range of supporting indicators to help assess pressures on the Health and Social Care organisations. These indicators included the:

- Number of Attendances at Emergency Departments;
- Number of Hospital Admissions;
- Number of Cancellations of Elective Admissions;
- Number of Patients receiving Non-Intensive Care Unit Respiratory Support – Continuous Positive Airways Pressure, High Flow Nasal Oxygen or Non-invasive Ventilation (Monitoring of this last indicator commenced from October 2020), and
- Bulk Oxygen Levels – Flow vs System Capacity (sourced from Safety and Strategy Unit in the Department – monitoring effective from January 2021).

119. The then Health and Social Care Board also co-ordinated a range of fora and groups to support regional communication among frontline staff dealing with the challenges of the pandemic. Notably, several groups focused on critical care, including:

- Regular discussion led by the Critical Care Network for Northern Ireland Clinical Lead with critical care consultants across Northern Ireland, including discussion on treatment methods and emerging evidence on Covid-19;
- Discussion led by the Critical Care Network for Northern Ireland Nurse Lead and Hub Nurse Coordinator on nursing issues, including supporting critical care nurses and those nurses redeployed to critical care;

- On 23 November 2021, the Department and HSCB held a workshop to discuss ethical issues in the care of critically ill patients, dealing with emergency care pressures and non-Covid patients whose care had been delayed due to the pandemic response, including cancer patients [PM/6046 INQ000381325; PM/6047 INQ000400162 agenda and PM/6048 INQ000400163]. The workshop had been agreed at Gold Command following a request from the Critical Care and Respiratory Care Operational Hub. The event was co-facilitated by the Chair of the DoH Ethics Committee and the HSCB Director of Planning and Commissioning and involved lead clinicians from across HSC as well as representatives from DoH, HSCB and PHA, and
- Regular (weekly to monthly depending on the phase of the pandemic response) exchange on cancer service challenges (Cancer Cell, later renamed Cancer Recovery Cell), including delivery of chemotherapy and radiotherapy during the periods when surgery was curtailed.

120. At the request of the Chief Medical Officer, in April/May 2020, the Covid-19 HSC Clinical Ethics Forum task and finish group was established to develop the Covid-19 Guidance: Ethical Advice and Support Framework document. This Forum was a sub-group of the Strategic Clinical Advisory Cell (SCAC). Membership of the Forum included a range of individuals with experience in clinical ethics, largely drawn from existing HSC Trust Clinical Ethics Committees, such as clinicians, lay representatives, faith representatives and members of the regional Critical Care, Palliative Care and Frailty Networks. A full list of members can be found at Appendix 1(ii) of the Framework document [PM/6046 INQ000381325].

121. The Framework document was initially published on 10 June 2020 [PM/6373 **INQ000396822** and a revised version in September 2020, and circulated to health and social care services, including primary care and hospices. During the months between the establishment of this forum and production of the framework document consultation with key stakeholders, as above, was taking place, along with drafting of the document. In consultation with Disability Action, an easy read version and plain English version of the document was published for service users, carers and families and those who advocate on their behalf. Briefings on the Framework document were offered to the NI Commissioner for Children and Young People, Equality Commission, NI Human Rights Commissioner and the Commissioner for Older People in NI and these organisations were also given the opportunity to consult on the document.

122. The Covid-19 HSC Clinical Ethics Forum task and finish group was concluded in June 2020 and replaced with the HSC Regional Clinical Ethics Forum. There is no record of either the Covid-19 HSC Clinical Ethics Forum task and finish group or the HSC Regional Clinical Ethics Forum providing any other direct ethical guidance or advice to HSC staff during the specified period. However, as the members of the Covid-19 HSC Clinical Ethics Forum task group included the chairs or senior members of every HSC Trust Clinical Ethics Committee, support for staff decision making and advice was provided at local level in the line with the regional Guidance as published in June 2020 and during its period of development.

iv. Critical Care Reporting

123. The role of the Critical Care Network Northern Ireland (CCaNNI) is to provide direction and consistency in the development and delivery of the Critical Care Service within Northern Ireland. In line with its ToR [PM/637 **INQ000477517**, it provides resolved advice on critical care activity to commissioners to inform critical care service commissioning. It is accountable to the Department through the Strategic Planning and Performance Group (SPPG) of the Department.

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

125. As well as the main critical care SitRep, two nursing reports were also developed. One report looked at the distribution of critical care nurses and registered nurses to the numbers and acuity levels of patients in respective units each day, taking account of each shift. This report was aimed at supporting lead nurses to equitably capture and relay the distribution of critical care nurses and registered nurses to the numbers and acuity levels of patients in respective units and identifying nursing pressures within the

system. This aided the redeployment of staff in units and across the network. A second nursing report was provided weekly and was aimed at enabling the Critical Care and Respiratory Operational Hub to make informed decisions regarding equity and mutual aid of nurse distribution, across the system, and providing surveillance of staff absenteeism, particularly in relation to individual units being affected directly by Covid-19 or other anomalies. This report also helped develop and inform a workforce nursing initiative.

126. To further advise the system of critical care bed availability and to control the pressure within beds across Northern Ireland, a sequencing list of which hospital would admit next, when an admission was required out of unit, was produced throughout the day and night and shared via email to all relevant stakeholders. Daily transfer reports were also produced on the transfer of critical care patients between units, which provided intelligence on pressures at particular times of the day.

127. Daily reports were provided on the non-critical respiratory care support. These reports were split into the types of non-respiratory support and included a daily non- Intensive Care Unit respiratory Support Report and an Oxygen Flow versus System Support Report. This enabled decision making to occur on respiratory admissions and oxygen usage by unit, and thereby supported transfer decisions. This information, along with daily Emergency Department attendance by site, admissions by site, admissions due to Covid-19 by site, and bed occupancy by site, enabled daily decisions to be taken in respect of mutual aid between Trusts, and modelling to inform escalation and de-escalation plans to be carried out.

v. Regional Prioritisation Oversight Group Data Reporting

128. The Regional Prioritisation and Oversight Group (RPOG)[5] was established in January 2021 to minimise the significant and prolonged negative impact of Covid-19 on those high priority/time critical patients who required surgery. It was agreed that the relative clinical prioritisation of time critical/urgent cases across surgical specialties had to be consistent and transparent, taking account of available facilities and local Covid conditions. The Federation of Surgical Specialty Associations (FSSA) guide to surgical prioritisation during Covid had been designed to help clinical and managerial teams plan and prioritise the allocation of surgical resources to sustain the delivery of surgery in a timely fashion. It was agreed that all available theatre capacity, including capacity

[5] The work of the Regional Prioritisation Oversight Group is detailed later in the section on Health Care Provision and Treatment.

procured from the Independent Sector should be allocated on a priority basis and that system-wide transparency was required to ensure that all available capacity was fully and appropriately utilised.

129. This regional approach, whilst remaining agile, helped minimise post code lottery and ensured the allocation of capacity on a clinical prioritisation basis. To support the work of the Regional Prioritisation Oversight Group, Trusts were required to submit weekly prioritisation data by close of play each Friday, and an analysis by specialty. 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.

5. Collaboration with the Republic of Ireland

130. The Republic of Ireland and Northern Ireland are separate jurisdictions, each with an elected Government and respective Ministers accountable for policy decisions in their own jurisdiction. The Government in the Republic of Ireland has its own separate advisory structures and committees in addition to European expert advisory structures such as the European Centre for Disease Control.

i. Pre-pandemic

131. Prior to the pandemic there was close collaboration and cooperation between Public Health in Northern Ireland and the Republic of Ireland operationally and on health issues ranging from public health policy to health service policy, including arrangements for the sharing of information on infectious diseases. In 1998 the Institute of Public Health in the Republic of Ireland and Northern Ireland was established. The Institute is jointly funded by the Departments of Health in both the Republic of Ireland and Northern Ireland and is directly accountable to both Chief Medical Officers. It has researchers and policy specialists from a range of disciplines based in offices in Dublin and Belfast.

ii. Memorandums of Understanding

132. The Chief Medical Officers in Northern Ireland and the Republic of Ireland jointly contributed to the development of a Memorandum of Understanding 'Covid-19 Response – Public Health Cooperation on an All-Ireland Basis', [PM/0171 INQ000130355]. This Memorandum was recommended to their respective departments and Ministers and was agreed on 7 April 2020 by the Departments of Health, and their respective agencies, from Northern Ireland and the Republic of

Ireland. The Memorandum, focussed primarily on the following key areas: modelling, public health and non-pharmaceutical intervention measures; common public messages; behavioural change; research; and ethics.

133. The Chief Medical Officer liaised with the Chief Medical Officer in the Republic of Ireland regularly throughout the pandemic to share information and modelling data, and to support joint work between the Irish Health Services Executive, the Public Health Agency and both Departments. As two jurisdictions with respective governments, the Chief Medical Officers in Northern Ireland and the Republic of Ireland provided advice separately to their respective Ministers.

134. Subject to the consideration and agreement of Ministers in Northern Ireland and the Republic of Ireland, the Chief Medical Officers explored options for coordinating respective responses, including joint statements and an integrated approach to addressing higher levels of transmission that were experienced in some border counties, supported by an agreement that both the Public Health Agency and the Health Services Executive would formally meet regularly and share data and intelligence. The joint Northern Ireland and the Republic of Ireland collaboration in relation to border issues was exemplified by the actions taken in response to a high level of infection in the border area of Donegal and Strabane and Derry City Council area, in effect taking a common epidemiological approach. At the request of both Chief Medical Officers, respective public health agencies worked with local councils, the business community and wider civic society to ensure coordinated action to reduce community transmission. This included joint public messaging on media outlets.

135. There was routine sharing of information between Northern Ireland and the Republic of Ireland, including:

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

136. The two health departments also liaised regularly with each other and with their respective national regulators of healthcare professionals, to ensure that there would be no regulatory impediment to the delivery of healthcare across the border throughout the duration of the emergency associated with the Pandemic.

137. There were regular Ministerial meetings on a Northern Ireland/ Republic of Ireland basis frequently involving the First Minister and the deputy First Minister. These meetings were in addition to the North South Ministerial Council meetings. There were also detailed engagements around travel within the Common Travel Area and international travel, given the challenges arising around data sharing in respect of international travel, and at times the differences in risk assessment at an individual country level.

138. There were also detailed engagements around travel within the Common Travel Area and international travel given the challenges arising around data sharing in respect of international travel and, at times, the differences in risk assessment at an individual country level. It took some time to progress the technical solution and the legal framework for the sharing of passenger details of those returning on international flights into the Republic of Ireland and then travelling on to Northern Ireland. In the interim, joint approaches were established to address the issue of Northern Irish residents arriving into the Republic of Ireland before travelling on to Northern Ireland. This included for example the development of a Short Message Servicing (SMS) system by officials in Northern Ireland and the Republic of Ireland that notified those travelling across the border of the requirement to complete both jurisdictions' passenger locator forms.

139. A further Memorandum of Understanding was signed in July 2020 on the sharing of anonymous 'diagnosis keys' generated by each jurisdiction's Covid-19 Proximity Apps agreed between Departments of Health, North and South [PM/6015 INQ000400132]. The apps developed in both jurisdictions were interoperable on an all-island basis.

140. A further Memorandum of Understanding, entitled 'Covid-19 Response – Cooperation on an All-Island Basis in Regard to Provision of Critical Care' [PM/6011 INQ000400128], between the Department of Health, Ireland (and its agencies) and the Department of Health, Northern Ireland (and its agencies)', was signed by both Departments on 9 November 2020. This Memorandum of Understanding recognised existing constraints on critical care surge capacity in both jurisdictions and set out the

criteria that could trigger emergency assistance or critical aid, and also agreed that patient transfer and escalation protocols would be developed to enable clinicians and provider organisations to provide emergency assistance or mutual aid in the event of a high surge in demand on the critical care infrastructure in either jurisdiction.

141. A protocol [PM/6011 INQ000400128] was subsequently developed and agreed between clinical and commissioning leads in both jurisdictions; however, despite further surges in critical care occupancy it was not necessary for this to be triggered at any time, i.e., critical care patients were not transferred from one jurisdiction to another due to Covid critical care occupancy being at or above capacity at any time.

6. Funding during the Pandemic.

142. During the pandemic period, additional funding exercises were commissioned by the Department of Finance to determine requirements and redistribute ring fenced Covid-19 funding in addition to and/or alongside Monitoring Rounds. These are listed in the table below.[6] This is the only funding that came to the Department as budget and the Department cannot be sure that no other cash funding was provided to Health and Social Care trusts outside of the budget process. The Department does not hold any additional information and the Inquiry should request any further information directly from the Health and Social Care trusts.

Date of Exercise	**Title**	**Exhibit**
Additional Exercises commissioned by the Department of Finance		
15/03/2020	Letter from Sue Gray asked for details of issues requiring a response and estimates costs/ timescales if possible for 20/21 and anything in 19/20 which is unaffordable in existing budget. SCORR-0119-2020	[PM/6016; INQ000400133]

[6] Due to the *ad hoc* nature of the requests and the variety of ways in which they were commissioned it is not possible to confirm that this is a complete list of all the exercises. There were announcements of funding by Minister Murphy in early 2021 that may have been commissioned separately or could just be a continuation of proposals coming forward from his letter of 21 January 2021 We have not, as yet, located any further requests than the ones listed.

30/03/2020	Letter from Joanne McBurney re response to Covid-19. This request was in response to the Sue Gray letter dates 15/03/2020 (see above)	[PM/6017 INQ000400134]
18/05/2020	Letter from Sue Gray Covid-19 Re-Prioritisation Exercise. To review existing pressures and provide the most up to date position and re-prioritise budgets to help address the Covid-19 pressures that departments have identified this financial year.	[PM/6018 INQ000393375]
10/07/2020	Letter from the Department of Finance – Covid-19 Allocation of Additional Funding - July 2020. Following the Chancellor's Summer Economic update the Executive now has additional funds at its disposal to help address Covid-19 issues	[PM/6019 INQ000400136]
11/11/2020	Letter from Minister of Finance – Additional £400 million funding to be allocated on top of October Monitoring position. Department of Finance seeking urgent proposals.	[PM/6020 INQ000400137]
21/01/2021	Letter from Minister of Finance to Executive colleagues seeking further spending proposals	[PM/6021 INQ000392606]
30/04/2021	Letter from the Department of Finance to Finance Directors 2021-22 Public Expenditure: Covid-19 Exercise. The Department of Finance commissioned an exercise to allocate the Covid-19 funding available.	[PM/6022 INQ000400139]
Monitoring Rounds		
26/5/2020	2020-21 June Monitoring Round	[PM/6023 INQ000400140]
08/09/2020	2020-21 October Monitoring Round	[PM/6024 INQ000400141]
18/11/2020	2020-21 January Monitoring Round	[PM/6025 INQ000400142]
24/05/2021	2021-22 June Monitoring Round	[PM/6026 INQ000400143]

31/08/2021	2021-22 October Monitoring Round	[PM/6027 INQ000400144]
16/11/2021	2021-22 January Monitoring Round	[PM/6028 INQ000400145]

143. The Department also received a Budget Cover Transfer from the Department of Health and Social Care in England for Covid-19 Testing during the pandemic. This Budget Cover Transfer supplemented the general funding arrangements underpinning the National Testing Programme across the four United Kingdom nations whereby, in summary, Northern Ireland and the other Devolved Administrations received a Barnett (population-based) share of National Testing Programme capacity in lieu of the consequential funding they would otherwise have received from health spending in England. Outputs funded under the National Testing Programme, managed centrally by Department of Health and Social Care, included, for example, delivery of the public facing Covid-19 polymerase chain reaction (PCR) testing sites and the supporting laboratory processing capacity, and procurement of new Covid-19 test technologies (for example Lateral Flow Devices).

144. There were limited stipulations on what the funding had to be used for, other than the overarching description of Covid-19. In 2020/21 these included the following [PM/6029 INQ000400146]:

"2.9 Budget 2020-21 was set at the start of the coronavirus crisis. Only limited funding for the COVID 19 response was able to be incorporated into the Budget position. The majority of COVID 19 response measures were handled outside the Budget process. COVID 19 allocations, while being announced on an ongoing basis as they were agreed, will be formalised at the next financial exercise through the in-year process.

2.10 COVID 19 allocations will be processed on the public expenditure database by PSD at the first opportunity. PSD will contact departments about setting up the necessary ring-fenced Units of Business and record lines for this new funding as part of that process.

2.11 As with all allocations, those related to COVID 19 response measures are ring-fenced for a specific purpose and should be treated as ceilings, with departments managing activities within those ceilings. If this funding is not

required for the specific purpose intended it should be notified as an easement at the earliest opportunity and a reduced requirement keyed to the next monitoring round."

145. In 2021/22 they included [PM/6030 INQ000400147]:

2.7 Covid-19 allocations were incorporated into the Budget position. Should any COVID 19 allocations be announced outside of the formal monitoring rounds, these will be processed on the public expenditure database by PSD at the first opportunity. PSD will contact departments about the necessary ring-fenced Units of Business and record lines for this funding as part of that process.

2.8 Allocations related to COVID 19 are ring-fenced for a specific purpose and should be treated as ceilings, with departments managing activities within those ceilings. If this funding is not required for the specific purpose intended it should be notified as an easement at the earliest opportunity and a reduced requirement keyed to the next monitoring round."

146. In 2021/22 this was broadened in agreement with the Department of Finance to include activity related to the recovery of health services from the pandemic. In practice the conditions in relation to Health spending were broad in nature and enabled funding to be spent on the complete range of measures required to address the challenges of the pandemic both directly and to assist with early recovery of the service in 2021/22.

147. While the Covid-19 pandemic began in 2019/20 and some Covid-19 related costs arose in that year, these costs were contained within existing budgets. In 2020/21 the Department received £989 million of additional resource Covid-19 Funding. However, final spending on Covid-19 exceeded this budget by £11.1 million, with the overspend being authorised by the Department of Finance. In 2021/22 the Department received £610 million of additional resource Covid-19 Funding, including a Budget Cover Transfer of £49 million in relation to Covid-19 Testing, and the underspend against this was £3.3 million. Resource spending included:

- Support for the health and social care workforce, including a one-off acknowledgement payment for service during the pandemic;
- Support for additional service delivery, including testing and contact tracing;
- Support for independent providers of health and social care;
- Purchase and consumption of Personal Protective Equipment;

- Revenue costs associated with capital works; and.
- Additional support costs including increased cleaning.

148. Capital funding of £70 million was provided in 2020/21, with an underspend of £2.43 million declared at year end. This underspend related to £1.65 million being held as unallocated Covid capital funds at end year with a further underspend of some £782,000 reported by Health organisations in their final end year spend returns. The underspend related primarily to equipment, IT and capital works.

149. In 2021/22 the Department received an additional £15.7 million of capital in relation to Covid-19, reporting an underspend of £1.5 million at year end. This underspend, relating to capital works schemes and IT related schemes, was some £370,000 being held as unallocated funds at year end with a further £1.1 million reported by Health organisations in their final year spend returns. Capital spending included purchase of medical equipment including oxygen generators, capital works to provide necessary adaptations to facilities, ICT to support homeworking and other IT infrastructure developed as part of the Covid-19 response, such as the Track, Trace & Protect Contact Management System. No resource funding requests made by the Department during the pandemic were refused, but a bid for Capital funding was rejected by the Department of Finance in September 2020 [PM/6031 INQ000394319; PM/6032 INQ000400149]. The Department of Finance referenced the Department's capital underspend in the previous year, and advised the capital bids would be considered pending an assessment of the Department's capital spending plans against the capital budget allocation for that year. A paper was provided to the Department of Finance and the funding was subsequently allocated in the October 2020 Monitoring Round.

150. Funding for individual initiatives was considered in line with the guidance issued by the command-and-control structures and later the Covid-19 Finance Process and Approvals Guidance issued by the Department [PM/0296 INQ000130406]. Early in the pandemic the Department of Health was given assurances, both written [PM/6033 INQ000370677] and oral, by the Department of Finance that its Covid-19 funding needs would be met.

151. This assurance was passed on to Health and Social Care organisations and in 2020/21 funding was then provided in accordance with applications made via Covid-19 funding templates. In 2021/22 the process returned to the normal allocation process whereby appropriate funding needs for the Health and Social Care Trusts were assessed by the

Health and Social Care Board and notified to the Department. Also in line with normal processes, the needs of other Arm's Length Bodies (which were comparatively minimal) were advised directly to the Department. In both years all funding needs were met in full. In the 2022/23 financial year no additional funding was provided to the Department specifically for Covid-19. However, Health and Social Care organisations were again assured that their Covid-19 funding needs would be prioritised and all requirements (again assessed via the former Health and Social Care Board in the case of the Health and Social Care Trusts) were fully met in the period covered by this statement (Q1 of 2022/23).

7. Review of Pandemic Planning

152. While many of the reviews of emergency planning are still underway, a number of lessons learned and updates have been identified and implemented which are discussed below.

i. 'In-flight' assessments

153. 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 [INQ000188799] to review the Department's emergency management structures. 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 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.

ii. Health Silver

154. 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 [INQ000188798]. This debrief was facilitated in order 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.

155. The structure of the event was a series of questions posed and discussed with attendees, facilitated by the Emergency Planning leads of the Public Health Agency and the Health and Social Care Board:

- Overall Management of the Incident;
- What went well and what could be changed/improved;
- Whether roles and responsibilities were clearly understood;
- Adequacy of staffing and resources;
- Communication with the Health and Social Care sector (Silver/Department of Health);
- Reporting (Battle Rhythm)/Meetings structure and frequency;
- Data availability/Situation Reports;
- Decision Making – Silver/Gold (to include timeliness);
- Governance- Leadership and Accountability; and,
- Key challenges moving forward.

156. The report of session two [PM/5064 INQ000188798] recognised that many of the areas that gave rise to concern early in the pandemic (staffing, SitReps, reporting/battle rhythm) were rectified as the response to the pandemic evolved. For example, staffing was highlighted as inadequate at the beginning with over-reliance on a select few members of staff, but this improved from March 2020 following the establishment of a core team which ensured a seamless flow of information on a daily basis. Sitrep formats were also revised and developed to take account of the developing situation and changing demands for information. In a similar vein, the reporting/battle rhythm developed over time, with the timing of daily meetings adjusted to ensure key issues could be escalated on the same day to Health Gold.

157. The report identified a number of areas where changes and improvements could be made, for example to ensure lines of communication were clearer and to reduce parallel working. Issues identified with procurement and distribution of Personal Protective Equipment are discussed more fully in Section C.

158. The report of the Health Silver debrief session two 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.

159. However, the Department had in many cases identified similar issues, informed also by the review of the Emergency Operations Centre and the 'In flight' review discussed also in this section, and took account of these in developing the approach to the next wave of the pandemic [INQ000188797]. 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.

iii. Emergency Operation Cell

160. The Department's Emergency Operation Cell was activated on 27 January 2020 in response to the emerging threat of what came to be known as the Covid-19 pandemic. The Emergency Operation Cell formally stood down on 12 August 2020. Following its stand down, the Emergency Planning Branch established a review team to engage with key stakeholders to examine its effectiveness internally as well as how it interfaced with the Northern Ireland Hub and Health and Social Care Silver. Two separate questionnaires were developed: one online survey for all staff who had completed a shift in the Emergency Operation Cell [PM/0425 INQ000353603] and one questionnaire which was sent to key staff who had interacted with the Cell including Departmental policy leads and senior staff as well as the Northern Ireland Hub[7] and Health and Social Care sector [PM/0426 INQ000353604]. There was also a debrief

[7] The Northern Ireland Hub is the enhanced information fusion centre run by The Executive Office. Its aim is to centrally coordinate information during an emergency response, across all Northern Ireland Departments and key partners, providing situational awareness to enhance decision making at all levels, primarily the Civil Contingencies Group.

session for core Cell staff including press office and senior medics. The overall themes explored were:

- Incident response;
- Strategic and policy/subject-specific cells;
- Communication;
- Governance, and
- People and skills.

161. The scope of the findings in the Lessons Learnt Report range from 27 January to 30 July 2020. A total of 20 lessons and recommendations were identified during the review period [INQ000188797]. 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 used. These lessons and recommendations have all been considered by the Department's Emergency Planning Branch and have been incorporated into the next iteration of the Departmental Emergency Response Plan, currently in progress.

iv. HSC Trust Reviews

162. During the relevant period, Health and Social Care Trusts were required to produce Resilience Plans/Surge Plans/Winter Plans setting out how they would manage all services. The Department developed a Surge Planning Strategic Framework, the *Regional Covid-19 Pandemic Surge Planning Strategic Framework (1 September 2020)* [PM/6006 INQ000276502], which provided the overall structure and parameters within which Health and Social Care Trusts were asked to develop plans for managing the response to Covid-19 in the event of further waves. The Framework sought to:

- Highlight important learning from the first wave;
- Set out the approach to surveillance and modelling;
- Review actions to minimise Covid-19 transmission and impact;
- Summarise key regional initiatives to organise health and social care services to facilitate effective service delivery;
- Highlight actions around the key issues of workforce, medicines and testing; and

- Confirm a number of principles for Health and Social Care Trusts to adopt when developing their individual surge plans.

163. Trusts were asked to base their plans on the following Department system principles in preparing this surge plan and asked to ensure that:

- Patient safety remained the overriding priority.
- Safe staffing remained a key priority and Trusts engaged with Trade Union side on safe staffing matters in relation to relevant surge plans.
- Trusts adopted a flexible approach to ensure that 'business as usual' services could be maintained as far as possible, in line with the Rebuilding Health and Social Care services Strategic Framework. This allowed Trusts to adapt swiftly to the prevailing Covid-19 context.
- It was recognised that there would be a fine balance between maintaining elective care services and managing service demand arising from Covid-19 and winter pressures. Addressing Covid-19 and winter pressures took priority over elective care services, although the regional approaches announced, such as day case elective care centres and orthopaedic hubs, supported continuation of elective activity in the event of further Covid-19 surges.
- The Health and Social Care system considered thresholds of hospital Covid-19 care, which might require downturn of elective care services.
- Trust's Surge Plans, whilst focusing on potential further Covid-19 surges, took account of likely winter pressures.
- Trusts planned for further Covid-19 surges within the context of the regional initiatives outlined in Section 8 of the document.
- Trusts should as far as possible manage Covid-19 pressures within their own capacity first. Should this not be possible, Trusts were required to make use of the regional Emergency Care facility at Belfast City Hospital or the regional 'step down' facility provided at Whiteabbey hospital, as appropriate. Trusts to also consider collectively how they will contribute staff resources to support Nightingale hospitals when necessary.
- The Department, Health and Social Care Board, Public Health Agency and the Trusts closely monitored Covid-19 infections, hospital admissions and Intensive Care Unit admissions to ensure a planned regional response to further Covid-19 surges. This supported continued service delivery.

- The Department, if Covid-19 infection rates and other indicators gave cause for action, recommended further tightening of social distancing measures to the Executive.

164. Within this context, the Director of Commissioning, Health and Social Care Board, requested Trust resilience plans to address Winter Pressures and any subsequent waves of Covid-19 Pandemic 2020/2021. Trusts developed individual plans which were approved by their Trust boards before submission to the Health and Social Care Board for consideration. Following a positive assessment by the Health and Social Care Board and Public Health Agency service leads, the plans were forwarded to the Rebuilding Management Board and the Minister for approval. The plans were approved by the Rebuilding Management Board on 20 September 2020, subject to a number of minor revisions within the financial sections. The final drafts were published on the Department of Health's website following approval by the Minister.

165. Health and Social Care Trusts and the Ambulance Service were required to set out their challenges and the plans in place to continue to provide services factoring in winter pressures and Covid-19 surges. These plans[8] were submitted every quarter to the then Health and Social Care Board Director of Commissioning and are all held by the Strategic Planning and Performance Group [PM/6034 INQ000130386; PM/6035 INQ000426978; PM/6036 INQ000346727; PM/6037 INQ000346734]. Trusts were required to plan for increases in demand of 5%, 10%, 15% and 20% rise in activity for Adult Emergency Department Attendances and admissions (Covid-19 and non-Covid-19).

166. To help deal with any expected rise in demand, the Trusts were required to provide detail on plans to provide alternatives to Emergency Departments, including increasing ambulatory and surgical assessment, to include:

- Specialty areas (including surgical assessment);
- Hours/days of operation (including plans to increase);
- Capacity daily/weekly Including plans to increase), and
- Entry route – direct access General Practice, Direct Access Northern Ireland Ambulance Service, via Urgent Care Centre or Emergency Department (if so

[8] These plans are available on the Department's website at COVID-19 - Surge Planning Strategic Framework | Department of Health (health-ni.gov.uk). We have exhibited two, one from the start of the period and one from the end as well as an action log and checklist. If more are required, they can be provided.

is this direct from triage) including plans to open up access if not in place for the above.

167. In order to improve hospital flows and deal with the expected increase in admissions (Covid-19 and non-Covid-19), the Trusts were also required to provide details of Discharge Planning in place and plans to improve/increase this.

a. Unscheduled Care

168. Throughout the pandemic period, severe pressures in Emergency Departments were evident. Partly, these reflected challenges in the years before the pandemic, often characterised as winter pressures, although evident across most of the year. Physical space in Emergency Departments was of concern and efforts to prevent overcrowding which increased risk of infection were a daily challenge. Inpatient bed stock had to be curtailed for Infection and Prevention Control reasons, although the counterbalance was that planned care was reduced, particularly in the first wave of the pandemic. Emergency admissions have been challenging for some years due to bed availability, and this continued through the pandemic period.

169. The Health and Social Care Board met weekly to fortnightly during the pandemic with Trust Directors of Acute Services in the main to discuss unscheduled care pressures. From time to time, the Health and Social Care Board would facilitate regional discussions with Trusts and the Northern Ireland Ambulance Service to consider actions to alleviate pressure on particular hospital sites under severe pressure, which may have included redirecting ambulances arrivals for a period of time.

170. Emergency Departments acted to introduce Covid-19 testing of patients coming to Emergency Departments once tests became available. Before this, there was telephone triaging and support from General Practice-led Covid-19 Centres to identify patients with symptoms which could indicate Covid-19 infection. Efforts to separate patients suspected of infection were made and emergency admissions were identified as Covid or non-Covid in an effort to separate wherever possible. This was more challenging in the early days of the pandemic before testing was available. Separation of (suspected and confirmed) Covid and non-Covid patients went some way to maintaining unscheduled care services for all patients. Efforts to re-establish elective care and maintain substantial levels in the later stage of the pandemic response however placed yet more pressure on a system which maintained high demand for unscheduled care.

171. Some hospital sites were particularly challenged for adequate Emergency Department space and appropriate ward configuration. Craigavon Hospital, in particular, was of significant concern, partly due to ongoing unscheduled care demand pressures and also due to challenges presented by an old building with configuration limitations. The Emergency Departments at the Ulster Hospital, Dundonald and Altnagelvin Hospital, Derry presented similar space restrictions.

172. Despite efforts to reconfigure hospital wards to limit infection among patients, unfortunately outbreaks happened. In these instances, and as per Infection and Protection Control guidelines, beds and bed areas were closed to new admissions and it was often several days before these could be reopened following deep cleaning. Appropriate and timely discharge of patients in order to release beds for new admissions was a constant focus of the Health and Social Care Board and Trusts.

173. It should also be emphasised that Trusts were also coping with staff absence due to Covid-19 infection which impacted on medical, nursing and other rotas. At various points, Trusts, including the Ambulance Service, made appeals to staff not working or on leave to come in due to staff shortages. In many cases, staff rose to the challenge, working long hours and at considerable personal expense.

v. Military Assessment Team (MAT)

174. In advance of the anticipated surge in Covid-19 cases post-Christmas 2020, the Department commissioned an exercise to test the Health and Social Care critical care plans to assess their continued ability and effectiveness for dealing with the reasonable worst-case scenario. The Department invited a Military Assessment Team, comprising regular and reservist personnel with local Health and Social Care Trust knowledge, to carry out this assessment to determine how robust the plans were in the face of various covid modelling scenarios, modelled by the Chief Scientific Adviser's team. The focus of the exercise was on Intensive Care Unit capabilities, drawing on similar work undertaken in Great Britain to inform this exercise.

175. The Military Assessment Team carried out its assessment of the critical care plans in Northern Ireland from 9 to 11 December 2020 [PM/6007 INQ000400124], with a report delivered to the Department on 14 December 2020. The report made 13 recommendations covering areas such as, *inter alia*, staffing, logistics and planning. All recommendations were accepted by the Department. [PM/6008 INQ000276389].

176. Following the completion of this exercise, the Critical Care Network for Northern Ireland met on 14 December 2020 to review the plans in the light of the recommendations of the Military Assessment Team. It explored all options to maximise the number of Intensive Care beds available and to revise their surge plan in light of the recommendations made [PM/6008 INQ000276389]. As with many Covid-19 related issues, staffing was identified as the key limiting factor in the ability to flex capacity, particularly the number of available Intensive Care Consultants. The Critical Care Network produced a revised surge plan [PM/6054 INQ000346734] new SPPG exhibit], which involved drawing upon all available resources locally, while also staffing the regional Nightingale facility at the Belfast City Hospital Tower at the extreme levels of surge. All Trust Chief Executives signed up to this plan, which involved up to seven levels of surge, with the maximum number of beds potentially stretched to 177 in the most extreme circumstances; however, the Critical Care Network was clear that this could only have been maintained for a very limited period of time [PM/6009 INQ000276392].

177. A key Military Assessment Team recommendation [PM/6008 INQ000276389] involved the introduction of a clinically led, regional command and control Hub with the authority to manage the surge plan and direct individual Trusts and hospitals on critical care bed placement and patient transfers. This regional Hub was seen as necessary to ensure equitable treatment for ICU patients across the region, meaning any burden on staffing ratios would be shared and that transfer decisions would be made centrally and at pace. On 4 January 2021, the Department's Gold Command agreed that the regional command and control Hub should be led by a clinical Director from Belfast Health and Social Care Trust [PM/6010 INQ000276393]. The Hub worked to ensure that patients across Northern Ireland received a critical care bed when they required a bed, that the Nightingale in Belfast City Hospital had the required staff to open beds and that staff were supported to look after critical care patients.

178. Work continues in considering and implementing measures to improve planning, preparedness and readiness for future pandemics.

B. INFECTION PREVENTION AND CONTROL

179. This section details the infection prevention and control measures developed and put in place throughout the pandemic including the work of the Infection and Prevention Control (IPC) Cell and the guidance on visiting. It does not cover infection and prevention measures taken in respect of discharge from hospital which is covered in Section E 'Admission to and Discharge from Hospital'.

1. Infection Prevention and Control Cell

180. The Department established an Infection Prevention and Control (IPC) Cell within its integrated Gold business continuity arrangements. The Cell was was established in March 2020, with its first meeting on 20 March 2020, and was chaired by the Public Health Agency's Executive Director of Nursing, Midwifery & Allied Health Professions [PM/0167 INQ000145672]. The core membership of the Infection and Prevention Control Cell was comprised of:

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

181. Representatives from other internal and external organisations were invited to attend the Infection and Prevention Control Cell meetings to discuss any specific issues relating to them. The Cell reported through silver command into the Department's integrated Gold Strategic Cell. The chair of the Infection and Prevention Control was provided with professional support and guidance as needed through the Department's Chief Nursing Officer.

182. The Infection and Prevention Control Cell provided a forum to discuss, develop and provide input to Infection and Prevention Control guidance, arrangements, and policies across the region, providing an opportunity to share learning and innovative ideas used in Health and Social Care Trusts to minimise the risk of transmission. It provided expert Infection and Prevention Control advice to:

- Health & Social Care Trusts: this was complementary to the expertise that Health and Social Care Trusts already had within their infrastructure in terms

of expert Infection and Prevention Control nurses and practitioners. All Trusts across Northern Ireland were already required to adhere to the regional Infection and Prevention Control Manual. This was a PHA online tool available at https://www.niinfectioncontrolmanual.net/ [PM/6375 **INQ000477518** which provided detailed guidance for implementation and standardisation across Trusts and was amended/updated as new evidence emerged. The PHA would be best placed to advise on amendments/updates to this manual;

- Primary and Community Care: most primary or community care settings and services in Northern Ireland do not have Infection and Prevention Control nurses/practitioners within their structures. Covid-19 presented particular challenges in terms of requirements for infection control, so the IPC cell developed its guidance centrally and provided to primary care settings (and other sectors) during the pandemic – the PHA would be able to advise on this.
- In the context of General Medical Practice, under the General Medical Services Contract (2004), the contractor is required to ensure that he has appropriate arrangements for infection control and decontamination. The then Health and Social Care Board signposted General Practitioner contractors to relevant nationally and regionally agreed Infection Prevention Control Guidance and policies as advised by the Regional Infection Prevention Control Cell chaired by the Public Health Agency. Any changes to these policies were communicated to all practices via email by the Health and Social Care Board. It was then up to each independent General Medical Services contractor to determine how to respond to this advice; and, finally,
- Voluntary and Independent Sector care providers: similarly, many such care providers in Northern Ireland do not have Infection and Prevention Control nurses/practitioners within their structures, which could cover one facility or a group of facilities. The PHA would be able to advise on any guidance developed for these providers.

183. The Gold Infection and Prevention Control Cell's linked into the United Kingdom 4-Nations Infection and Prevention Control Cell and this allowed Northern Ireland to have an input in the shaping and influencing of expert advice and guidance. A senior Infection and Prevention Control practitioner (Registered Nurse) from the Gold Infection and Prevention Control Cell acted as the Northern Ireland representative member in the United Kingdom 4-Nations Infection and Prevention Control Cell, which generally met daily from January/February 2020, moving to twice weekly in April/May

2020, and then weekly from August/September 2020 through to 2022. Resolved expert advice was provided by the United Kingdom 4-Nations Infection and Prevention Control Cell to each of the nations who then would assess the guidance with a view to adopting and/or advising in respect of its implementation in their respective jurisdictions.

2. Health and Social Care Settings

i. Preparation

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

185. A Regional Covid-19 Surge Planning Workshop was convened on 5 March 2020 to support Trusts in planning for the establishment of Covid-19 facilities. The workshop was informed by plans that had been developed since February 2020 in respect of primary care, acute hospital services and hospital discharge / community care which would support Trusts to free up capacity. [PM6058 INQ000346738; PM6059 INQ000325164 (agenda and read out from this workshop)]. Consideration was given to key areas for immediate action in the coming days which included the establishment of separate pathways for Covid and non-Covid patients, including the designation of ward space and critical care capacity.

186. Key areas for further action in coming weeks were also considered, such as identification of equipment needs and the redeployment of staff to the additional ward space. Consideration was also given to putting in place appropriate restrictions for visitors in order to minimise the spread of hospital infection. Plans were further developed and implemented in the following weeks. Trusts were able to put in place

arrangements to respond to Covid-19 patients requiring hospital admission during the second half of March and into early April with specific Covid-19 facilities identified:

- Belfast Trust – Ward 7a, RVH and Ward B, Mater;
- Northern Trust – Ward C5 and A5, Antrim Area Hospital;
- Southern Trust – Isolation, acute medical and surgical wards, Craigavon Area Hospital;
- South Eastern Trust – Wards 3a, 4a and 5a, Ulster Hospital plus additional wards in Lagan Valley Hospital and Downe Hospital; and,
- Western Trust – Ward 31, Altnagelvin Hospital and Wards 1 and 4, South West Acute Hospital.

In addition, 10 GP Covid Centres went into operation on 9 April 2020.

ii. Non-Covid Treatment

187. The Department advised that surgical hubs and green pathways should be developed by the HSC to prevent patients receiving treatment for non-Covid conditions in secondary care settings from contracting Covid-19. Surgical hubs and green pathways were separate from unscheduled care and as such allowed stricter controls around testing and infection control and a reduced risk of Covid-19. The Department's advice in relation to elective care was articulated in the 'Policy Statement for Elective Care Day Procedures' [INQ000276347 (DoH ref: PM2063)]. On foot of this advice, the first surgical hub established was the Day Procedure Centre at Lagan Valley Hospital in July 2020. The overall aim of the Day Procedure Centre model was to deliver high volume, low complexity routine procedures. While the nature of the site meant that it is most suitable for daycase surgery and procedures rather than more complex work, the complete separation of elective and unscheduled services at the site enabled services to continue be delivered throughout the pandemic on a 'covid-light' pathway.

188. The provision of services to patients receiving treatment in secondary care settings was in some cases subject to wider hospital restrictions and the delivery of these services. The Department, along with its health sector partners recognized that for some patients continued treatment was essential. The Infection Prevention and Control guidance is the fundamental source of guidance to Trusts, which governs how patients should be treated during the pandemic, while keeping them safe from potential nosocomial covid infection; this is described further below.

189. As part of efforts to rebuild services, the Rebuilding Management Board agreed on 17 February 2021 to five principles for critical care de-escalation and elective care

rebuild. Principle 4 requested that all Trusts seek to develop green pathways, with 'green' in this context meaning that every effort would be made to keep the services entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services. Principle 5 requested that Belfast Nightingale de-escalation should focus on increasing regional complex surgery as quickly as possible, focusing initially on the development of green pathways, with the aim for Belfast City Hospital ultimately to become a green site serving the region.

190. With these principles endorsed by Rebuilding Management Board, and approved by the Minister [PM2077 INQ000276361], on 17 February 2021, it was a matter for Trust Chief Executives, who sat on the Board, to ensure that the principles were communicated and implemented in each of their Trusts.

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

3. Guidance on Visiting Health and Social Care Settings

i. March 2020 – August 2020

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

the mixing from visiting increased the risk of transmission but that visits were also important and had significant benefits for patients.

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

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

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

195. As updated evidence, for example around transmission rates, relative effectiveness of PPE, AGP impacts and all the other evidence that emerged as the pandemic progressed was becoming available almost on a daily basis, updated guidance was issued by the CNO on 26 April 2020 [PM/0122 INQ000087760] which detailed further information for the care home sector. This included a section on necessary visiting restrictions developed by senior nurses within the CNO's team and particularly including advice around suitable arrangements for visiting at end of life. This stated that where end of life was imminent, the care home should facilitate one relative to visit. This should be for a short period of time (normally no more than one hour at most), with personal protective equipment worn, infection control protocols strictly followed and a log kept of all visitors' names and contacts.

196. Further modifications to the visiting arrangements were made on 11 May 2020 [PM/0132 INQ000120721] following advice from the CNO which was accepted by Minister Swann. These modifications relaxed restrictions in certain circumstances, and allowed family, friends or loved ones to safely visit dying patients. The modifications applied equally to care home settings and other community settings as well as hospitals.

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

ii. September 2020 – December 2020

198. With the increased level of transmission of the virus during August and September 2020, the Department announced on 23 September 2020 revised visiting guidance for hospitals and care homes, [PM/2042 INQ000256450, PM/2043 INQ000276327]. This revised guidance was driven by the Executive's decision to re-establish a number of restrictions based on the potential for a secondary spike in COVID-19 transmission (Executive papers that informed this decision may be available from The Executive Office). The CNO's team reviewed the visiting guidance to provide greater clarity in the rules that should apply in line with the UK Government's surge planning scale. The level of restrictions were predicated on a phased approach to visiting, linked to the Regional Alert Level, as assessed by the 4 United Kingdom Chief Medical Officers at any given point in time.

199. The United Kingdom Health Security Agency (UKHSA) provided advice to the UK Chief Medical Officers who in turn advised ministers on the UK coronavirus alert level. The alert levels were originally defined in the United Kingdom government's Covid-19

recovery strategy 'Our Plan to Rebuild' in May 2020 (most recently revised in August 2022) and communicate the current risk at a United Kingdom-wide level.

200. The alert levels were, and remain:

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

201. The guidance for appropriate visiting arrangements across a range of care settings was summarised in a grid format in Appendix 1 of the revised visiting guidance which took effect from 23 September 2020, illustrating the impact of the United Kingdom's Regional Alert Level on the extent of visiting to be allowed.

202. All health and social care facilities in Northern Ireland were advised, in the revised visiting guidance from 23 September 2020, to move to facilitate one face-to-face visit per week by one person to protect patients, residents and staff from Covid-19 while recognising the importance of human contact to health and well-being. Additional advice on compassionate visits was also included in the guidance.

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

204. Listening and reflecting on the feedback and experience of residents, patients, their loved ones, the public, our staff, and political representatives, the Chief Nursing Officer and her team recognised that the lived experience of those residents living in care homes was being massively impacted by the restrictions applied to visiting. The Minister also had received a significant amount of correspondence from relatives of residents who felt that the impact of restrictions to visiting was causing untold damage to their loved ones. Reflecting on this, the Chief Nursing Officer felt that in the specific case of care home residents, long-term separation from loved ones, particularly those who would have been regular, supportive visitors prior to the pandemic, a more nuanced approach was appropriate, so the Care Partner scheme was developed. While initially launched in the 23 September guidance, a lead in period of around 6 weeks was allowed for care homes to consider how to put in place the necessary procedures to facilitate the Care Partner scheme.

205. The Department engaged with representatives of families and other statutory organisations involved with the independent care home sector to seek to address concerns regarding the implementation of Care Partner arrangements in a small number of care homes. Department staff then engaged with the Independent Care Home Providers involved, and relevant Health and Social Care Trust staff involved in commissioning care in those settings, to provide focussed support to individual care homes around the introduction of the Care Partner concept. While the Care Partner arrangements were introduced under the auspices of the Regional Guidance Principles, and not mandatory or underpinned in legislation, there was a clear expectation that the scheme would be fully implemented in all care homes and for all residents who desired it. To that end, the Minister announced additional funding on 22 October 2020 [PM/2115 INQ000276403] to be allocated to providers to ensure the necessary infrastructure and other necessary arrangements could be established. The expectation was that the steps necessary to introduce the Care Partner scheme should be completed by early November 2020, but a small number of care home providers continued to require some intervention from the Department, Health and Social Care Trusts, Public Health Agency and Regulation and Quality Improvement Authority from time to time, after the initial implementation period, to encourage ongoing compliance. In most cases this required nothing more than telephone contact to fully explain the detail of the scheme to staff in the care homes involved and encourage them to facilitate the identification of Care Partners for those residents who wished to have one. This contact would have been triggered by residents or their families contacting either the Department or the Public Health Agency to complain that their request to be

facilitated to act as Care Partners was not being facilitated. The Public Health Agency Duty Room did receive regular, mainly daily, updates from all care homes confirming the number of care partners in place in each. However, it was not appropriate to base interventions on such statistics, as some settings may not have had requests to identify and facilitate any Care Partners due to the nature of their facility, or the type of residents living there, so in the main contact was driven by exception – that is complaints raised.

206. Minister Swann was consistent in stating that officials would keep the visiting guidance under constant review and make changes or additions as necessary. Over the period since the launch of the Regional Principles in June, the Department received several enquiries from care settings and from families seeking clarity on the restrictions which should apply in the sad circumstance of a patient / loved one requiring palliative or end of life care. To reduce the stress for families and care providers dealing with those circumstances in the absence of clear guidance, the CNO's team consulted with colleagues across the Heath & Social Care sector to develop clearer guidelines to apply in such circumstances, which were derived from the relevant NICE guidelines then applicable. As a result of this consultation, Minister Swann approved the "Principles for visiting people (adults) with life limiting or progressive conditions, including visiting at the patient's time of death", which was added as an appendix to the regional guidance. This update was included at 'Appendix 7' of the full guidance (a short version was also available) which was issued by CNO, with Minister's approval, as a minor update [PM/2044 INQ000276328] to the Regional Visiting Guidance (merely incorporating the above Appendix 7), on 5 November 2020. In addition, on 12 November 2020 the Department's Chief Nursing Officer (CNO) and Chief Social Work Officer (CSWO) issued a guidance letter to Residential and Nursing Home Care Providers entitled 'Implementation of Care Partner in care homes in Northern Ireland' [PM/2178 INQ000256455]. This was followed by a letter to Health and Social Care Trust Chief Executives and Directors of Older People Services on 13 November 2020 [PM/2179 INQ000256374].

207. On 16 December 2020, a joint letter to the care home sector was issued by the Chief Nursing Officer, Chief Social Work Officer and Chief Medical Officer [PM/2186 INQ000256371]. The letter informed the sector that the care home regulator, the Regulation and Quality Improvement Authority, would assess the approach being taken to visiting when it was undertaking inspections of residential and nursing homes, and considering compliance with the relevant care standards, as part of their normal

inspections. The letter advised that the visiting policy and appropriate implementation of the policy into practice would therefore be a material consideration in the inspection and regulation of each care home. The letter also indicated that the current income guarantee funding support measure was likely to be linked in future to the implementation of appropriate visiting arrangements. The income guarantee support was introduced at an early stage, in March 2020, in the Covid-19 pandemic to provide a guaranteed level of funding for Care Homes, regardless of occupancy levels. As an additional assurance, the letter advised that Covid-19 testing would be made available to one visitor or care partner per care home resident per week over the Christmas 2020 period and up to 8 January 2021, and that the testing would be bookable at existing testing facilities, using the established Polymerase Chain Reaction (PCR) tests. The letter emphasised that safe visiting could already be accommodated as set out in regional guidance documents and should not stop after 8 January 2021.

iii. Christmas Guidance

208. Guidance for Christmas visiting in care homes ("Christmas Visiting Guidance") was issued by the Department on 9 December 2020 [PM/2045 INQ000276329]. This advised that the regional visiting guidance continued to apply during the Christmas period. It also stressed that care homes should recognise the importance many people attach to seeing family and friends over the Christmas period, and the right to a family life for those in care homes.

209. However, on 17 December 2020, the Executive announced new public health measures, which were effective from 26 December 2020. The Minister issued a press release [PM2237 INQ000276557] detailing the restrictions coming into effect[9]. Given the introduction of these additional restrictions and the identification of a new strain of the virus, the Christmas Visiting Guidance was revised and additional requirements to

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

facilitate safe visiting to reduce the transmissibility of the virus introduced [PM/2046 INQ000276330].

210. The phased approach to setting the visiting restrictions applicable at any time was predicated on the 4 UK CMO's assessment of the Regional Alert Level. Following the recommendation by the 4 United Kingdom Chief Medical Officers that the United Kingdom should move into Alert level 5, and, with effect from 8 January 2021 Minister Swann approved a recommendation from the CNO that the applicable restrictions should be moved to the High/Extreme Surge (Level 5) stage of the alert grid. This meant that no face to face visiting to general hospitals (including Intensive Care Units) would be permitted, and that end of life visiting would be considered following a risk assessment and ensuring a Covid-secure environment. Some limited visiting to hospices and care homes, in cases where patients / residents were approaching end of life, was still allowed. At this time an urgent review of the existing visiting guidance was completed by the CNO's team to ensure the appropriateness of some of the restrictions, as it had dealt with significant correspondence around the issue of visiting. This took account of the available evidence around infection transmission in Care Homes, and guidance from other UK nations and the Republic of Ireland was considered. The resulting updated guidance added in some additional text to provide clarity for patients, residents, care providers and the public, and this took effect alongside the resulting new guidance when launched [PM/2047 INQ000276331].

iv. End of Life

211. On 26 March 2020 the Permanent Secretary and Health and Social Care Chief Executive wrote to the health service in relation to preparations for the Covid-19 surge [PM/0069 INQ000103660, PM/0070 INQ000103663, PM/0071 INQ000103664]. It was noted here that "all general hospital visiting across Northern Ireland has stopped". Exceptions were detailed, which included Critical Care areas, where one visitor was permitted to visit with the duration and timing to be agreed in advance with the Ward Sister or Charge Nurse.

212. On April 9 2020, following consultation with clinical leaders, CNO approved the publication of a Covid-19 Visiting Update for Health and Social Care (no documented underpinning evidence can be located [PM0438 INQ000353609]. This update stated that: "with immediate effect all intensive care and general hospital visiting across Northern Ireland has now stopped." Although palliative (end of life) care outside of Intensive Care was listed as an exception, there was no exception for those patients receiving end of life care within Intensive Care Units. Whilst there was no visiting

permitted to Intensive Care Units in Northern Ireland virtual visiting (via smart phone/ iPads) was to be supported by staff when it was possible to do so.

213. On 16 April 2020, due to the expert opinion that allowing significant numbers of visits to Intensive Care Units presented too significant a risk given the serious risks of infection, the Critical Care Network for Northern Ireland (CCaNNI) was asked by Minister Swann to undertake a rapid review of the situation with respect to visiting within Northern Ireland Intensive Care Units at the end of life. The rapid review looked at emerging issues and risks associated with visiting patients in Intensive Care Units and considered the views of clinical staff and service users and the barriers that would have to be overcome to enable visiting to happen safely in selected cases. A report was produced at the end of the review which set out the key principles that Intensive Care Units should consider when facilitating end of life visiting in Intensive Care during pandemic Covid-19 [PM/6176 INQ000376875].

214. Subsequently the Chief Nursing Officer, having consulted with a wide group of staff (and sought advice from the Critical Care Network Northern Ireland specifically relating to Intensive Care Units) issued revised arrangements for visiting patients who were approaching their end of life on 11 May 2020 [PM/6177 INQ000120721]. The correspondence indicated that whilst virtual visiting was to be promoted and used it was important that, wherever possible and safe to do so, units supported families and loved ones to say goodbye to Covid-19 positive patients receiving end of life care; such visits are important both for the patient and their loved ones. Arrangements for end of life visiting were included in every iteration of the visiting guidance, known as the Regional Principles for Visiting in Care Settings in Northern Ireland, first published in June 2020, and amended periodically, as detailed above, from then until the May 2021 issue of setting specific guidance.

215. Recognising the need to show some distinctions between the circumstances applying in Care Homes, and those applying in other care settings, the CNO commissioned a group of professionals from Trusts, the Hospice sector and the PHA to review arrangements for visiting in all other healthcare settings, primarily hospitals and hospices, using the available evidence and recommendations from other parts of the UK, and identifying the key points of concern raised in correspondence over the preceding year around such access arrangements. As a result of the work of this group, in May 2021, Minister Swann accepted the CNO's recommendations for an updated approach to visiting and the Department formally launched its new approach

to visiting in Hospital and Hospice settings, 'A Pathway to Enhanced Visiting' [PM/2049 INQ000276333]. This enabled contact through visiting arrangements which were progressively relaxed to be as close as possible to those in place prior to the pandemic, supported by appropriate regional and localised mitigations as necessary.

216. Engagement with Critical Care colleagues took place at various stages of the pandemic in relation to visiting guidance. In advance of the issuing of the pathway to enhanced visiting guidance, there had been ongoing discussion with senior leaders from Trusts and the Hospice sector – those involved were expected to represent the views of critical care colleagues and others impacted by the potential relaxation of restrictions. On 10 May 2021 a meeting was arranged by the Critical Care Network for Northern Ireland to collectively consider and discuss the implementation of the new visiting guidance so that all units, where possible, were operating similarly and any collective issues could be raised.

217. Later, the identification of Care Partners for specific individuals allowed the introduction of individualised and tailored arrangements to assist in meeting the needs of the patient. Following a review, with effect from June 2022, it was agreed to progress to the final stage of the pathway, "Further Easing". This heralded the most relaxed set of arrangements to apply across all healthcare settings since the imposition of restrictions in March 2020. While this progress was welcomed, the responsibility to remain vigilant due to risks of new variants or significant increases in transmission rates that may necessitate the reintroduction of some visiting restrictions in future, remained.

v. Easing of Restrictions

218. Following the recommendation by the 4 United Kingdom Chief Medical Officers that the United Kingdom should move back from level 5 to level 4, the Department confirmed an easing of the restrictions on visiting arrangements for all care settings from 26 February 2021 [PM/2048 INQ000276332]. The revised position was subject to local risk assessment, i.e. care home managers and ward managers, and kept under review.

219. Recognising the distinctions between the circumstances applying in Care Homes, compared to other care settings, on 15 March 2021, the Department commissioned the Public Health Agency to re-examine the guidance covering visiting in care homes, with a view to developing an indicative "journey back to business as usual" for care home residents [PM/6178 INQ000381490]. The Public Health Agency was asked to collaborate with all relevant stakeholders when providing the required public health

and clinical advice to inform an agreed plan for the care home sector to move to a more normalised situation with regards to visiting, services into the care home and care home residents being able to leave the care home.

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

221. The resulting revised guidance to facilitate increased visiting in health and social care settings in Northern Ireland came into effect from 7 May 2021. The revised guidance was set out in two documents, with bespoke advice provided dependent on the category of care setting involved. 'A Pathway to Enhanced Visiting' set out a new approach to visiting in hospices and hospitals, including maternity and other services; and 'Visiting With Care – A Pathway' [PM/2050 INQ000276334] was developed as described above in partnership with the Public Health Agency, using a co-production approach with input from representatives from the statutory sector, representatives from various relatives' groups and independent healthcare providers. It set out a phased "Pathway" approach by which safe and proportionate visiting arrangements in care homes could be gradually relaxed in line with the relevant guidance. This included updated arrangements for the safe management of care home residents receiving visitors, as well as residents being able to visit other households, community facilities and take part in excursions.

222. Both these updated approaches to visiting, effective from 7 May 2021, incorporated a scheduled periodic review process to allow public health officials to consider progress, and in line with available data and experiential evidence, to decide whether progress along the Pathways would be appropriate. Progress meetings to update the stakeholder group were chaired by the Public Health Agency and the Department and involved a standing working group of stakeholders broadly in line with the group that had co-produced the "Visiting with Care" Pathway document. These meetings were held at the end of each review cycle, that is approximately on a 4-weekly basis in respect of care homes, and allowed stakeholders to be apprised of the reasons for the recommendations being submitted to Minister for decision. Following each review, the Chief Nursing Officer made a formal recommendation to the Minister on whether progress along the pathways was appropriate, based on the available scientific data

as assessed by public health professionals from the Public Health Agency, and the expertise of those responsible for its delivery.

223. As a result, progress was made along the Pathway culminating in reaching the final stage of restrictions in summer 2022. Based on that progress, the Public Health Agency reconvened its review group and developed a new guidance document "Visiting With Care – the New Normal" [PM/2052 INQ000276336] which in effect removed all Covid-19 related visiting restrictions in care homes not in outbreak, with clear instruction on effectively dealing with access during outbreaks. This was launched on 1 September 2022.

224. Similarly, as required under the terms of the Pathway guidance document, arrangements in hospitals and hospices were kept under regular scheduled review by means of (approximately) 4-weekly meetings which commenced after the launch of the Pathway guidance on 7 May 2021. These review meetings were attended by an established group comprising the Deputy Chief Nursing Officer and policy officials from the Department's Chief Nursing Officer's Group, the five Health and Social Care Trusts Executive Directors of Nursing and senior leaders from the Hospice sector. Consideration was given to the evidence around transmission rates and the potential impact on those of any potential move along the visiting Pathway. Visiting arrangements in Hospital settings in Northern Ireland were driven by the Chief Nursing Officer's engagement with the Directors of Nursing and other senior leaders in Trusts across the region, with localised exemptions also applied where risks were identified, including related to localised outbreaks in specific settings, or regional spikes in transmission affecting particular locations. Examples of the application of such short-term local restrictions included:

- Temporary restrictions applied in the Craigavon Area Hospital Emergency Department when a spike in local transmission, allied to the challenges presented by the older nature of the hospital estate, required a reduction in footfall, facilitated by restricting the ability of patients to be accompanied by a friend/loved one (unless they had special requirements for such accompaniment)
- Localised Covid-19 outbreaks led to the temporary suspension of visiting in a number of wards and settings across all Trusts, for example in the Royal Victoria Hospital, in Altnagelvin Hospital, and in the Ulster Hospital at various times as the situation required.

225. The application of these temporary arrangements was informed by those senior leaders' knowledge of their local clinical settings, clinical environments which differ from facility to facility and staff availability to logistically manage an increase in footfall on wards and departments with a clear focus on preventing nosocomial infection. To reflect the local pressures that could apply in specific hospital settings (due to estate issues, local transmission spikes, etc) the Minister authorised the use of a protocol [PM/6376 **INQ000438159** through which any of the all five Health and Social Care Trusts could apply additional, risk-assessed, proportionate but timebound restrictions should local circumstances have required it, but the expectation was that compliance with the applicable stage of the guidance pathway was the default position. Given the ongoing level of public interest in how visiting arrangements continued to be applied in healthcare settings, the Chief Nursing Officer Group sought weekly updates from the Trusts in which they confirmed their compliance with the extant pathway guidance position, or a full detailing of any applicable variance alongside a rationale for that variance. These were shared with the Minister through his Special Advisor on a weekly basis for the remainder of the pandemic period while any restrictions were applicable.

226. Progress to the final stage of that pathway was also achieved in summer 2022. The "new normal" document for these settings "Enabling Safer Visiting" [PM/2053 INQ000276337] was developed by the Department with input from the Public Health Agency and in consultation with the Health and Social Care Trusts. Following Ministerial approval on 27 October 2022 the document was launched to take effect from 31 October 2022.

4. Role of the Executive

227. While the Executive were responsible for decisions which imposed or lifted restrictions, on an operational level, it did not take any decisions on care homes; this includes decisions on testing, the supply of Personal Protective Equipment, support from the health and social care sector to independent care home providers, staffing or financial supports. It is likely that they viewed responsibility for these decisions as operational matters that fell entirely within the remit of the Department of Health. Individual ministers did raise personal and constituency issues around specific care homes, or providers, which were then addressed by the Department of Health. In general, the Executive's focus appeared to be on the overall general supply of Personal Protective Equipment rather than the specific supply to care homes.

228. Decisions taken by the Executive to tighten or relax restrictions were reflected by the Department in guidance it issued, as detailed in section B(3).

5. General Medical Services

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

230. Throughout the relevant period Strategic Planning and Performance Group signposted General Practitioner contractors to relevant nationally and regionally agreed Infection Prevention Control Guidance and policies as advised by the Regional Infection Prevention Control Cell chaired by the Public Health Agency [PM/6180 INQ000417480]. Any changes to these policies were communicated to all practices via email by the Health and Social Care Board. As independent contractors, each practice had responsibility for determining how best to act on this advice.

231. More broadly, the establishment of Primary Care Covid-19 centres at the outset of the pandemic was a General Practice-led innovation that was an urgent and immediate response to the challenges posed by the Covid-19 pandemic. The centres provided services for patients symptomatic of Covid-19, and who were at higher risk of complications, or those described as having moderate or severe symptoms, and who required clinical assessment. The centres enabled patients with Covid-19 symptoms to be treated separately from those patients who had other conditions which required assessment or treatment in primary care, reducing the risks of cross contamination and infection. In setting up the Primary Care Covid-19 centres, relevant nationally and regionally agreed Infection Prevention Control Guidance and policies were also followed.

6. Clusters and Outbreaks

232. Infections acquired within a health and social care setting were a major cause for concern. An Early Alert regarding a covid outbreak on a Haematology ward within the Southern Health and Social Care Trust was notified to the Department of Health and copied to the Health and Social Care Board on 24th August 2020 via the HSCB early

alert inbox. It is therefore the first notification recorded on the DATIX (an online system for any member of staff to record an incident) record.

233. On 25 August 2020 HSCB's Safety Team assigned the Early Alert to Denise Boulter, PHA as Lead Officer and copied to Directors and Senior Professionals / Officers within SPPG / PHA. It was confirmed on 2nd September by PHA colleagues that PHA Health Protection personnel had embarked on a process of engagement with Trusts to support infection control and patient safety. The Serious Adverse Incident Notification was received on 10th September and the Early Alert subsequently closed as per Early Alert protocol at that time [PM/6377 **INQ000477520**

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

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

236. The Designated Review Officer and HSCB Governance team continued to link with SHSCT in relation to submission of the final report. The final report was reviewed by the Acute SAI Professional Group and shared with the Healthcare Acquired Infection Group, Dr Brid Farrel and Judith Ewing and also with the Infection, Prevention and

Control Cell members. On 30th June 2022 an action plan was submitted to SPPG, however it was not accepted as the responsible officer was not named and timelines for completion of actions were not detailed. An updated action plan was then received on 5th September 2022. The action plan was shared with the Department (Director of Secondary Care, Ryan Wilson and the deputy Chief Medical Officer, Lourda Geoghan), Infection Prevention and Control and Healthcare Associated Infection colleagues. SPPG/PHA colleagues confirmed that the final report is robust, no immediate action was required as a number of the recommendations had been taken forward or in process.

237. On 27th June 2023, Ryan Wilson, Director of Secondary Care in the Department of Health, advised Denise Boulter, DRO that SHSCT colleagues planned to submit the final report to Trust Board for sign off in September 2023, and then publish as a Board paper. The Director of Secondary Care advised that the Trust had planned on publishing the report in May 2023 but decided not to proceed as DHH issues were to the fore. Denise Boulter, DRO advised she was content with approach.

238. On 28 September 2023, the Southern Health and Social Care Trust published the final report of the review of clusters of Covid-19 cases which occurred in 2020 in both Craigavon Area and Daisy Hill Hospitals [PM/3082 INQ000417468; PM/3139 INQ000088724; PM/3141 INQ000090419; PM/3143 INQ000408923; PM/3144 INQ000417474]. The final report contained important findings and recommendations regarding the prevention, control, and treatment of Covid-19 in the hospital settings. The Southern Health and Social Care Trust confirmed it would carefully consider the report and its recommendations, involving families in this process. The Department welcomed the publication of the final report which contained recommendations for strengthening infection, prevention and control measures in the hospitals, as well as the systems for overseeing and assuring best practice across Health and Social Care in Northern Ireland [PM/3083 INQ000417469].

239. The time lapse is due to a period of engagement with each of 30+ families before finalising the report, and then a period for consideration and sign off by the Trust Board. While it is not normal practice to publish a SAI report, given the need to ensure anonymity, it was done on this occasion because the Minister had given a commitment to the findings being published due to Assembly and public interest. Importantly, however, the learning from the SAI was being shared as it was emerging through

existing SAI processes across the HSC system, and (ii) the families concerned were engaged throughout the whole process.

240. Whilst there may be appear to be a delay in the publication of the report, the Department was assured there was a comprehensive review being undertaken whilst effectively engaging with all involved and any learning was shared across the HSC as it emerged.

i. Inspections

241. On behalf of the Department, the Chief Medical Officer engaged with the Interim Chief Executive of the Regulation and Quality Improvement Authority about plans to introduce a series of Infection Prevention and Control focussed inspections of health and social care Acute and Independent Hospitals across Northern Ireland. Between September and December 2020, the Regulation and Quality Improvement Authority inspected a total of 13 hospitals (11 Acute hospitals across the five Health and Social Care Trusts and 2 hospitals within the Independent Sector), producing individual inspection reports for each hospital inspected. Using an inspection framework drawing from a range of best practice sources in the management of Covid-19, the Regulation and Quality Improvement Authority inspected both clinical and non-clinical areas of the hospital sites visited. The Regulation and Quality Improvement Authority also spoke with staff at all levels and engaged with patients and visitors to obtain an understanding of their experiences when using the services. During the inspection process, any issues of note or concern identified by the Regulation and Quality Improvement Authority were raised in real time with the relevant organisation and also referenced in the individual hospital inspection reports. To support the sharing of learning across the wider healthcare sector the Regulation and Quality Improvement Authority also published an overall report "COVID-19 HSC and Independent Hospital Inspections - Emerging Learning" on 18 December 2020, setting out the key thematic findings and opportunities for improvement identified during the series of hospital inspections [PM/6181 INQ000398911].

242. During their inspections RQIA sought assurances across the following key criteria to determine if each hospital's approach to infection prevention and control was effective in achieving and maintaining a Covid-19 safe environment:

a) Governance & Collaborative Working
b) Risk Assessment
c) Audits of Staff Practices
d) Staff Training

e) Information Sharing
f) Innovative Practice
g) Environment and Cleaning Practices
h) Observations of Staff Practice
i) Supporting Patients and Visitors
j) Support for Staff.

243. While overall it concluded that Trusts and Independent Hospital providers had responded effectively to minimise the risks of Covid-19 infection and to keep people safe while in hospital, it offered 6 opportunities for improvement:

1. All Trusts and Independent Hospital providers should ensure that a COVID-19 environmental risk assessment is fully completed for clinical and non-clinical areas. An important element of this process is to ensure that the capacity of all rooms is identified to support safe social distancing measures.
2. All Trusts and Independent Hospital providers should reintroduce audits of environmental cleanliness, hand hygiene and PPE for routine completion in all their clinical areas.
3. Where staff do not have ready access to email and internet services organisations must ensure they are updated on the latest COVID-19 guidance by other means.
4. All Trusts and Independent Hospital providers must maintain good practice and where gaps are identified, improve mechanisms to support visitor's compliance with face coverings, social distancing and one way systems.
5. All Trusts should explore potential ways to expand the current capacity of IPC teams to enable them to respond to the needs of services.
6. At this critical stage of the pandemic [December 2020] it is important that all Trusts and Independent Hospital providers continue to focus on the health and wellbeing of staff.

244. The CMO regularly engaged with the RQIA and in view of his concerns about the number of healthcare associated outbreaks of Covid-19 in healthcare settings, the CMO spoke directly with the RQIA Interim Chief Executive about plans for the Infection Prevention and Control (IPC) focussed inspections of health and social care Acute and Independent Hospitals [PM/6378 **INQ000477521** Separately, the RQIA had also received information from members of the public who had raised concerns about IPC practices when visiting hospitals.

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

- The development and introduction of a regional nosocomial dashboard, an important information management tool, utilised by all relevant Health and Social Care organisations to support the oversight and operational management of Covid-19 incidents and outbreaks;
- The completion of a programme of learning visits to acute hospitals, by a team of experienced healthcare professionals, with a focus on identifying and sharing learning and supporting best practice to prevent and control transmission of Covid-19 infections in hospital settings, and
- The development of a region-wide approach to reviewing and learning from deaths associated with hospital-acquired Covid-19.

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

247. During the summer of 2021, having completed its planned programme of work, the support function initially provided through the Nosocomial Support Cell moved to the Public Health Agency, and the Nosocomial Support Cell transitioned into a Regional

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

C. PPE

248. As Module 5 will examine government procurement across the United Kingdom, the information in this section focuses primarily on the operational side of the provision of Personal Protective Equipment in line with the questions posed in the Rule 9 request.

1. Early response to Personal Protective Equipment demand

249. The Regional Critical Care Network Northern Ireland Escalation Plan[10] [PM/6212 INQ000417485] requires that during escalation caused by infectious outbreak or contaminated casualties (chemical biochemical, nuclear and radiological), the provision of appropriate Personal Protection Equipment (PPE) is a crucial factor in health, safety and confidence of front-line staff. Full personal protective equipment is required for all staff performing invasive procedures such as intubation and bronchoscopy. As such Health and Social Care Trusts have responsibility for an ongoing "Fit Testing" Programme and have been required to do so since the inception of the Escalation Plans in 2006. The Department plays no role in the fit testing programme which is completed for HSC Trusts by a range of companies accredited under the Fit2Fit RPE Fit Test Providers Accreditation Scheme (a scheme designed to confirm the competency of any person performing face piece fit testing and operated in line with HSE INDG479 protocols.

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

[10] Escalation Plans have been in place for Critical Care from the development of the Critical Care Network in April 2006. The Critical Care Network Northern Ireland (CCaNNI) Escalation Plan identifies the regional response in the event of an excess number of patients that could reasonably be managed within the scope of the current available critical care resources. This plan is intended to augment HSC Trusts (HSCT) emergency planning frameworks and is intended to be used when the number of patients requiring admission to critical care outweighs the capacity of any individual HSC Trust to accommodate.

251. The Clinical Lead for the Critical Care Network Northern Ireland inputted to a United Kingdom document 'Covid-19 Pandemic Personal Protective Equipment (PPE): Guidance for Intensive Care' [PM/6213 INQ000376884]. The guidance was developed and endorsed by all the critical care national medical and nursing professional organisations to provide critical care units across the United Kingdom with the best evidence available on personal protective equipment at that time. While the guidance was for individual organisations to determine how best to implement it in order to protect their staff and patients, it offered support for those decisions.

252. There was a significant and intensified demand for Personal Protective Equipment (PPE) across all health and social care settings at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a significant decline in the export of personal protective equipment by China, a leading global provider.

253. During the initial response to the pandemic, Public Health England coordinated the management of the Pandemic Influenza Preparedness Plan stockpile items and letting of 'Just in Time'[11] supply contracts across the United Kingdom. The Department's Emergency Planning Branch participated in calls on a United Kingdom four nations basis to discuss stock levels and planned procurement volumes and approvals. However, the Department does not have information relating to the stock levels in Northern Ireland at 1 March 2020, but the Business Services Organisation may be able to provide this information. Pandemic Influenza Preparedness Plan stock levels were then managed by Emergency Planning Branch and all other stock by the Business Services Organisation.

i. Personal Protective Equipment Supply Cell

254. Given the critical need for personal protective equipment, a decision was taken on 23 March 2020, by Health Gold Command [PM/6214 INQ000417487], to establish a distinct Personal Protective Equipment Strategic Supply Cell. The focus of the Supply Cell was to provide oversight and support for the Business Services Organisation who had responsibility for procuring PPE. This included monitoring of the stock position and supporting BSO in their exploration of potential avenues of supply; this involved engaging on a near daily basis with BSO and the Construction and Procurement Delivery Division of the Department of Finance (responsible for leading on the

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

procurement of PPE for the non-health sector) to ensure efforts were coordinated and that opportunities were explored to source PPE locally and internationally.

255. At a UK level, the Supply Cell engaged with the other jurisdictions through a range of fora and worked with them on the UK-wide PPE Action Plan which was published on 10 April 2020 [PM/183 **INQ000050008** (DoH ref: PM0082)]. The plan was set around three strands; guidance, distribution and future supply, which was aimed at ensuring that everyone got the PPE they needed. This engagement allowed for a collaborative working arrangement which included the application of mutual aid, whilst enabling each nation to continue with its own procurement plans. At this time through engagement with the other UK CNOs the CNO was able to gain agreement under mutual aid to supply 25,000 gowns to colleagues in England who were experiencing extreme shortages and at a time when we had better availability in the NI stockpile. The gowns were supplied on 18 April 2020.

256. In relation to distribution, the Supply Cell oversaw the implementation of the revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List and undertook a monitoring role with regards the distribution of PPE from Trusts to the Independent Sector. The Cell also supported the progression of actions across the HSC to strengthen the system's ability to respond effectively to meeting PPE needs within what was a new challenging operating environment. This included oversight of the implementation of the recommendations of the Rapid Review Report of PPE (see below) including bringing forward proposals that required both Departmental and Ministerial approval, such as the BSO's development of a Dynamic Purchasing System. It should be noted that the Department's PPE Supply Cell had no remit over the provision of guidance on the use or standards of PPE.

257. In the context of the PPE Supply Cell's remit of supporting BSO in its procurement of PPE, the main challenge faced by the PPE Supply Cell was the fact that it was operating in an environment of unprecedented supply issues. This was also against a backdrop of large volumes of "offers of help" being received which required an assessment of their viability. The following paragraphs set out the action taken to deal with these challenges.

ii. Procurement Strategy

258. Whilst the Health and Social Care procurement lead, the Business Services Organisation, had ultimate responsibility for procuring personal protective equipment, their efforts were strongly supported by the Personal Protective Equipment Strategic Supply Cell and the Construction and Procurement Delivery Division of the Department of Finance (responsible for leading on the procurement of personal protective equipment for the non-health sector). The three parties engaged on a near daily basis during this period to ensure efforts were co-ordinated and that opportunities were explored to source personal protective equipment locally and internationally.

259. From late March 2020 an approach was taken to address the issues raised, particularly around supply, was to explore every viable channel both locally and internationally to procure personal protective equipment. A focus was also placed on maximising the opportunities to strengthen the local supply position and the repurposing of local manufacturing which was investigated with Invest Northern Ireland (the investment and trade arm of the Department for the Economy), and which supported engagement with businesses in this area.

260. Given the significant volume of approaches to government by potential manufacturers to supply personal protective equipment, a process was put in place in early April 2020 where all offers of help were channelled through the Department of Finance, which undertook a first level triage before directing suitable offers to the Business Services Organisation or elsewhere as appropriate.

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

262. Business Services Organisation also sought approval from the Department in May 2020 to proceed with the establishment of a Dynamic Purchasing System for personal protective equipment [INQ000377397]. This was in recognition of the significant increase in demand encountered in the first wave of Covid 19 and was considered an opportunity to mitigate supply chain issues such as the rapidly changing supply and demand position. A Dynamic Purchasing System is a procedure available for contracts for works, services and goods commonly available on the market and was set up under Regulation 34 of the Public Contract Regulations 2015. A Dynamic Purchasing System, unlike a traditional framework, allows an organisation (in this instance the Business Services Organisation) to work with suppliers with much more agility and speed as it was designed to allow the Health and Social Care system access to a pool of checked and pre-qualified suppliers, thereby greatly reducing avoidable delay. The Department of Finance's Central Procurement Directorate concurred, given Business Service's Organisation's expertise regarding personal protective equipment products, that Business Services Organisation should establish and manage the Dynamic Purchasing System arrangements both for their own use and that of the wider Northern Ireland Public Sector.

263. The Minister subsequently approved the proposal [INQ000185387] and a Departmental Direction issued [INQ000185391] which enabled the setting up and administration of a Dynamic Purchasing System for personal protective equipment which came into operation on 25 June 2020.

264. At a United Kingdom level, there was engagement with the other jurisdictions through a range of fora. The Department worked closely with them on all aspects of the United Kingdom-wide Personal Protective Equipment Action Plan which was published on 10 April 2020 [PM/0082 INQ000050008]. The plan was set around three strands: guidance, distribution and future supply which was aimed at ensuring that personal protective equipment got to where it was needed. This engagement allowed for a collaborative working arrangement which included the application of mutual aid, whilst enabling each nation to continue with its own procurement plans.

265. In addition, opportunities for joint endeavours with the Republic of Ireland were also explored but ultimately did not materialise. In mid-March/early April 2020 a joint order for personal protective equipment was taken forward by the Department of Finance and the Department of Health in Northern Ireland and the Department of Health in the Republic of Ireland, facilitated through the Republic of Ireland's Industrial Development

Authority. However, given the changing market conditions at that time in China and the competing demands of other countries, this became increasingly difficult and consequently the Republic of Ireland's Industrial Development Authority confirmed that they had no further capacity to pursue the collaborative order.

iii. Confidence in Supply

266. In addition to pursuing all potential supply avenues, efforts were focussed on putting in place the processes which would, *inter alia,* identify issues pertaining to confidence in supply at an early stage; support the management of demand in Health and Social Care Trusts to ensure a more even distribution of stock across all Health and Social Care sites; enable provision of personal protective equipment to the independent sector by their local Health and Social Care Trust; and assess the level of immediate and forecasted demand.

267. The decision to introduce a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List, i.e. those items which were in high demand, was taken by Cathy Harrison, lead of the Supplies Cell which pre-dated the PPE Cell. The Supplies Cell reported to the Strategic Cell who were advised of the issue and the decision took effect from 24 March 2020. The Minister would have been informed of the decision prior to it being communicated to the Trusts. The revision saw the introduction of measures for the handling of supplies from BSO PaLS to ensure that products were available for those HSC staff and patients who needed them in the response to Covid-19. The products involved were included in a Covid-19 High Demand Management List provided by BSO and meant that from the 24 March BSO PaLs would no longer process orders for products on the High Demand Management List at ward levels within Trusts. Instead, Trusts would work with BSO PaLS to establish a centralised system with nominated Trust contact points for managing the ordering and delivery of products, with the aim of ensuring a more even distribution of stock across all Health and Social Care sites. The process was introduced in recognition of the significant issues being experienced at that time globally in the procurement of personal protective equipment and was to ensure that available stock was evenly distributed across the region whilst also enabling Health and Social Care Trusts to continually review and prioritise the distribution of its available stock.

268. During March 2020 provision of personal protective equipment to the independent sector through nominated points of contact within Trusts where they were unable to source their own supplies [PM/6215 INQ000120717; PM/6216 INQ000353600;

PM/6217 **INQ000120717** was also introduced. A reporting mechanism was introduced from week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis [PM/6218 INQ000417493; PM/6219 INQ000417495]. Reporting and collation of this information concluded on 31 March 2023.

269. From 14 April 2020 to 30 June 2020 the Department's Personal Protective Equipment Supply Cell reported daily to the Department of Health and Social Care England on Health and Social Care Northern Ireland personal protective equipment demand and supply data based on information provided by Business Services Organisation [PM/6220 INQ000417496]. This assisted the monitoring of stock levels across the four nations to help inform procurement and distribution plans.

iv. Personal Protective Equipment Liaison Role

270. The Business Service Organisation's procurement role was supported by the Personal Protective Equipment Supply Cell with the aim of prioritising the supply and distribution of personal protective equipment and improving the robustness of the decision-making at the appropriate level. Once the supply position was largely stabilised and the processes and supporting tools in place to enable Business Services Organisation to undertake their responsibilities in the new operating environment, as described above, the Personal Protective Equipment Supply Cell was formally stood down on 20 September 2020 and a new role of Personal Protective Equipment Liaison was created within the Department. The Personal Protective Equipment Liaison role was established to provide continued support to Business Services Organisation and specifically a mechanism for managing Assembly business in relation to personal protective equipment supply and seeking approvals at a Departmental/Ministerial level where appropriate.

v. Issues with Personal Protective Equipment

271. At the time the Personal Protective Equipment Cell was established at the end of March 2020, issues were being escalated to the Department around the supply and availability of personal protective equipment within Health and Social Care Trusts and within parts of the health and social care system which would normally not use personal protective equipment daily, for example, Community Pharmacies or those who would normally source their own supplies, such as General Practices and dentists and the Independent Sector (Care Homes). At no point did the HSC run out of PPE; the main concerns were the level of demand and being able to meet that in the supply

environment we were operating in. Paragraphs 254-270 of the Module 3 Section C statement the actions the Department took to address the issue.

272. In terms of the general arrangements for PPE supply, quality and guidance for use, these are operational matters for HSC Trusts. However, given the extraordinary situation that the pandemic was presenting, the Chief Nursing Officer, a senior leader in the Department and the leader of the largest profession in the HSC, whilst not directly responsible, was involved in discussions around respiratory protection equipment and the number of concerns which were being raised around failures in the fit testing of masks.

273. Concerns were also being raised around the number of staff failing the fit testing of masks due to the range of products being supplied [PM/0081 INQ000120710]. An audit review of fit testing for respiratory masks was carried out on a precautionary basis by Trusts across the health and social care system after it emerged that on some occasions an independent contractor had inadvertently applied a fit testing setting not normally used in Northern Ireland. No report was produced. As described below the resulting SAI review is still to be completed by the PHA.

274. Respiratory Protective Equipment cannot protect the wearer if it leaks. Fit testing compliance for female staff, for example, required a range of face mask type and sizes to be available. HSC supplies were distributed with this in mind. A major cause of such leaks is poor fit since tight-fitting face pieces need to fit the wearer's face to be effective. As people come in all sorts of shapes and sizes it is unlikely that one particular type or size of Respiratory Protective Equipment face piece will fit everyone. Thus, it is a legal requirement that workers using such tight fitting respiratory protective equipment (face pieces/masks) must be fit tested by a competent person for all Aerosol Generating Procedures. This requirement is detailed in Control of Substances Hazardous to Health (COSHH) regulations and is intended to ensure that the equipment selected is suitable for the wearer.

275. During the early stages of the pandemic, the fit testing providers used by Health and Social Care Trusts in Northern Ireland were:

- Amon Electronics
- G&L Consultancy Ltd
- Healthcare Essentials

- FITTEST.IE
- Task NI.

276. All those companies had been accredited under the Fit2Fit RPE Fit Test Providers Accreditation Scheme (a scheme designed to confirm the competency of any person performing face piece fit testing and operated in line with HSE INDG479 protocols). Additionally, Amon Electronics provided accredited fit test training programmes to all five Health and Social Care Trusts and NIAS Trust which would allow those Trusts to carry out in-house fit testing.

277. All these fit testing companies procured by Health and Social Care Trusts across Northern Ireland were trained to the required standards and operated in line with HSE INDG479 protocols which state that the Fit Test Protocol must include a minimum of seven test exercises performed for at least one minute each. The wearer must achieve an individual pass result in each of the seven test exercises within one single testing period i.e., if an individual fails one of the exercises, then the test must be repeated. The minimum fit factor pass level which must be achieved depends on the type of face piece being tested.

278. Fit Testing Provision was and continues to be subject to regular audit in all health and social care settings across Northern Ireland. In the early part of summer 2020 it emerged that one independent contractor, which conducted Fit Testing of masks during the pandemic, had on some occasions inadvertently applied a fit testing setting not normally used in Northern Ireland. This should have been readjusted to the United Kingdom Fit Testing requirements. On review, over 2,800 staff across the five Health and Social and the Northern Ireland Ambulance Service were identified as having incorrectly 'passed' their fit test. All Health and Social Care Trusts immediately implemented a retesting programme. A small number of staff (23 as at 26 June 2020, according to according to a PHA Regional Fit-testing Situation Incident Report [PM/6382 **INQ000477525** identified as having received an incorrect fit testing result subsequently tested positive for Covid-19, but it should be noted there is no way to assess causality. While clinical advice suggested that any risk to staff arising from this error was likely to be low, to ensure proper compliance and safety for staff, all fit testing Certificates in place at that time were reviewed regardless of provider, meaning over 37,000 fit-testing certificates were ultimately reviewed.

279. Of these, over 2,800 staff, across all 5 HSCTs and NIAS were identified as needing a re-test. Health and Social Care Trusts urgently implemented a retesting programme that the independent contractor completed at no additional cost to the HSC System.

280. A Serious Adverse Incident (SAI) was notified on 1 July 2020 and the Public Health Agency initiated a Serious Adverse Incident review. The Public Health Agency acknowledged that this incident was a serious breach of protocol and as such presented a safety risk, hence the reason for the commissioning of a Level Two Serious Adverse Incident review. We still await the outcome of that Serious Adverse Incident but, at the time of writing, the Public Health Agency has confirmed that the report has been received by the external panel and is under consideration in the Public Health Agency prior to submission to the Department.

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

282. Through the chair of the IPC Cell, the PHA established a product review team designed to support the testing of PPE in a clinical environment. This helped ensure the maintenance of PPE standards. Timely updates on the emerging best evidence and advice in regard to IPC and use of PPE were shared on the CNO communication platform when endorsed and available. Examples of information shared included the development of IPC learning videos on donning and doffing and media campaigns to inform the public and staff in relation to health care professionals coming into a home. It should be noted that the Department's PPE Supply Cell had no remit over the provision of guidance on the use or standards of PPE. PPE guidance was issued by the IPC Cell in the PHA.

a. PPE Mailbox

283. Through initial reports and concerns being raised by staff the Department was aware that whilst there were no shortages of PPE, there were concerns around how PPE was being managed and shared around those who needed it. The CNO relayed concerns between operational leadership and the PPE Supply Cell, supporting the PHA Director of Nursing in his role as a member of the cell, and ensuring the identified needs of nurses and midwives were highlighted. Reacting to this widespread concern, on Friday

17 April 2020, the CNO met with Minister Swann to discuss how the Department could offer a solution, or at least a means by which issues could be raised and addressed. Following that discussion, Minister Swann announced that the Department had established a new dedicated mailbox to allow concerned members of staff across the Health & Social Care workforce to raise issues of concern over the supply, quality and usage of Personal Protective Equipment. Details of the mailbox and how it would operate was published on the Department's website [PM/6383 **INQ000477526**

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

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

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

- There were 27 offers to supply PPE. The offers were mainly of a commercial nature and ranged from local and national, to international manufacturers. All offers to supply PPE were forwarded to the Supply Cell at the Department for onward communication to the Business Services Organisation;
- There were 15 queries regarding access to supplies of PPE. These issues were raised by range of concerned individuals in Trusts, Nursing and Care Homes, General Practice surgeries and some who did not declare their background. In all cases these queries were followed up by the team with the relevant Trust single point of contact, the Executive Directors of Nursing, and colleagues in the Department's supply cell. In all cases supplies were either found to be available or made available via the relevant Trust contact;
- The mailbox received a total of 27 queries seeking information on the correct type of PPE which should be worn. In each case advice was provided in line with current PPE Public Health England (PHE) guidance, and

- Quality issues and fitness for purpose were identified in 15 separate queries received in the mailbox. Advice was provided and information from the Chief Nursing Officer was sent to all Trust single points of contact. Issues with "Tiger" masks were reviewed by the Infection Prevention and Control cell at the Public Health Agency who highlighted potential safety issues this to the Department, with the issue referred via the Northern Ireland Adverse Incident Centre (NIAIC) to the Medicines and Healthcare Regulatory Agency (MHRA) for further investigation. The masks involved were completely removed from service to remove risk to staff.

286. A review report [PM/6384 **INQ000438126** PM/6385 **INQ000416360** PM/6386 **INQ000416354** PM/6387 **INQ000411115** PM/6388 **INQ000411114** was produced, and submitted to the Minister on 5 February 2021, identifying those key themes and lessons learned from the content of the emails received.

vi. Adequacy of PPE

287. In March 2020, the Medicines Optimisation Innovation Centre (MOIC)[12], in partnership with BSO PaLS and regional IPC leads, utilised pharmacist skills to undertake a technical assessment of a wide range of products including PPE items which were offered to the Department/HSC to procure – this assessment was to inform the procurement decisions of BSO, who were the procurement lead for the Health Service [PM/6389 **INQ000477538** Following due diligence checks undertaken by BSO PaLS, MOIC reviewed and validated all technical documentation associated with each PPE product to ensure that items procured were genuine, fit for purpose, and compliant with relevant legislation e.g. EU Regulation 2016/425, and guidance e.g. PHE guidance on types of PPE for use in clinical settings. The physical design of the product was desktop assessed by regional IPC leads to confirm user acceptability and product performance. This process identified that many items offered for purchase were identified as sub-standard e.g. due to documentation deficiencies or misleading labelling, and that procurement of only safe and effective products was progressed to ensure the safety of HSC staff and patients. MOIC had no role in the testing of adequacy of PPE subsequently procured and provided to the HSC.

[12] The Medicines Optimization Innovation Centre (MOIC) is a regional centre in Northern Ireland dedicated to delivering medicines optimisation to the people of Northern Ireland. It is uniquely positioned to work alongside the health sector and the private sector to improve medicines use and patient care. It is the only dedicated medicines optimisation centre in Europe. It provides research, project management and offers professional expertise on projects that will improve patient care on medicines use. MOIC engages with partners across Europe and throughout the world to learn and engage with professionals on best practice and bring this learning back to Northern Ireland.

2. Health and Social Care Board Modelling

288. To inform the demand for personal protective equipment, initial modelling was undertaken by the Health and Social Care Board, in conjunction with the Public Health Agency's Director of Nursing, in late March 2020. The modelling looked at personal protective equipment demand across hospital, community and primary care settings at extreme surge / worst case scenario [PM/0084 INQ000130316, PM/0248 INQ000120794, PM/0249 INQ000120795, PM/0250 INQ000120796]. The Public Health Agency, in partnership with Business Services Organisation, continued to develop and refine the modelling via the IPC cell.

289. The Business Services Organisation used this information, in conjunction with revised guidance on personal protective equipment published in April 2020, to develop demand planning based on envisaged usage. It was recognised, however, that there was need for a more dynamic approach. Whilst the Business Services Organisation utilised this information, in conjunction with revised guidance on personal protective equipment requirements published in April 2020, to develop demand planning based on envisaged usage, there was a recognised need for a more dynamic approach. Led by the Public Health Agency, work was progressed on the development of a Health Resource Demand Model, which was aimed at predicting and managing key resources, including the production of regional personal protective equipment demand estimates which were then used to inform Business Services Organisation's procurement strategy. The accompanying exhibits document the approval process, activity data and model assumptions supporting the methodology and development of the regional resource model [PM/0085 INQ000130319, PM/0251 INQ000130320, PM/0252 INQ000120798, PM/0253 INQ000130322, PM/0254 INQ000120799, PM/0255 INQ000120800, PM/0256 INQ000120801, PM/0257 INQ000120802, PM/0258 INQ000120803, PM/0260 INQ000120804, PM/0261 INQ000120805, PM/0262 INQ000120806, PM/0263 INQ000120807, PM/0264 INQ000120808, PM/0265 INQ000120809, PM/0266 INQ000120810, PM/0267 INQ000120811, PM/0268 INQ000120812].

i. Confidence in Supply

290. In addition to pursuing all potential supply avenues, efforts were focussed on putting in place the processes which would, *inter alia,* identify issues pertaining to confidence in supply at an early stage; support the management of demand in Health and Social Care Trusts to ensure a more even distribution of stock across all Health and Social Care sites; enable provision of personal protective equipment to the independent

sector by their local Health and Social Care Trust; and assess the level of immediate and forecasted demand.

291. The decision to introduce a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List, i.e. those items which were in high demand, was taken by Cathy Harrison, lead of the Supplies Cell which pre-dated the PPE Cell. The Supplies Cell reported to the Strategic Cell who were advised of the issue and the decision took effect from 24 March 2020. The Minister would have been informed of the decision prior to it being communicated to the Trusts. The revision saw the introduction of measures for the handling of supplies from BSO PaLS to ensure that products were available for those HSC staff and patients who needed them in the response to Covid-19. The products involved were included in a Covid-19 High Demand Management List provided by BSO and meant that from the 24 March BSO PaLs would no longer process orders for products on the High Demand Management List at ward levels within Trusts. Instead, Trusts would work with BSO PaLS to establish a centralised system with nominated Trust contact points for managing the ordering and delivery of products, with the aim of ensuring a more even distribution of stock across all Health and Social Care sites. The process was introduced in recognition of the significant issues being experienced at that time globally in the procurement of personal protective equipment and was to ensure that available stock was evenly distributed across the region whilst also enabling Health and Social Care Trusts to continually review and prioritise the distribution of its available stock.

292. During March 2020 provision of personal protective equipment to the independent sector through nominated points of contact within Trusts where they were unable to source their own supplies [PM/6215 INQ000120717; PM/6216 INQ000353600; PM/6217 **INQ000120717** was also introduced. A reporting mechanism was introduced from week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of personal protective equipment they provided to the independent sector – Care Homes and Domiciliary Care on a weekly basis [PM/6218 INQ000417493; PM/6219 INQ000417495]. Reporting and collation of this information concluded on 31 March 2023.

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supply data based on information provided by Business Services Organisation [PM/6220 INQ000417496]. This assisted the monitoring of stock levels across the four nations to help inform procurement and distribution plans.

3. Care Homes and the Independent Sector

294. A Care Home sector representative (a Director of the Independent Health Care Providers) was included on the Business Services Organisation's structures overseeing work on the provision of personal protective equipment in the very early stages of the pandemic. However, following engagement with the Business Services Organisation and the sector, interim guidance on 12 March 2020 [PM0120 INQ000103696] provided further detail in relation to personal protective equipment. The guidance stated that in the event independent providers were unable to source the appropriate items Health and Social Care Trusts should work closely with independent providers to ensure they have appropriate equipment available. The decision to provide PPE free of charge to the independent sector was taken by the Director of Mental Health, Disability and Older People within the Department who had policy responsibility for social care. The decision was taken in the early stages of the pandemic and was reflected in the guidance issued by the Department on 12 March 2020. From the onset of the pandemic the Department recognised that nursing and residential Care Homes would be at the forefront of the battle against Covid-19. The Department was focused on both limiting infections and their impact in Care Homes as well as ensuring Care Homes could continue to function as an important part of the wider health and social care system. The Minister was clear that ensuring that Care Homes had sufficient supplies of PPE was a priority. This requirement was expanded on and detailed in later versions [PM0120 INQ000103696, PM0121 INQ000120717, PM0122 INQ000087760, PM0259 INQ000137415] of the guidance, addressing feedback from the sector. The procurement and supply of for care homes was therefore partially centralised through the Business Services Organisation.

295. The Department can locate no evidence to show that this had any impact on PPE stock on HSC premises.

296. A Departmental news release [PM0115 INQ000137317] issued on 14 April 2020 announced that:

> *"in the past week 1.7 million items of PPE have been distributed by Trusts to the Independent sector which includes Care Homes and domiciliary care*

settings. This includes 637,000 gloves, 413,000 plastic aprons and 400,000 liquid repellent surgical masks".

297. In his statement of 27 April 2020 [PM0118 INQ000371513], the Minister stated: "ensuring that Care Homes have sufficient supplies of PPE is an absolute priority, and Trusts will work with Care Homes in their areas to ensure that each home has a buffer of PPE stock".

298. In addition, Construction and Procurement Delivery in the Department of Finance were circulating details of providers of personal protective equipment to the wider public sector. The Department engaged with the Regulation and Quality Improvement Authority at the time and then asked the Department of Finance to include it on the distribution list for providers of personal protective equipment so that details of personal protective equipment providers could be circulated to independent providers such as care homes, helping them to access personal protective equipment.

4. Personal Protective Equipment Review

i. Internal Review

299. On 15 April 2020 the Minister commissioned [PM/0086 INQ000120712, PM/0269 INQ000120813, PM/0270 INQ000120814] a rapid review of personal protective equipment to focus on the appropriate receipt, storage, distribution, and use of personal protective equipment across the health and social care system. The terms of reference for the Rapid Review included an assessment of readiness for continuing response during the pandemic wave at that time and by way of preparation for a second wave of Covid-19.

300. A Review Panel led by the Department's Internal Audit carried out the Rapid Review with input from across the health and social care system. The final report was submitted to the Minister on 14 May 2020 [PM/0087 INQ000130338, PM/0271 INQ000120815, PM/0272 INQ000120816, PM/0273 INQ000120817, PM/0274 INQ000120820, PM/0275 INQ000120821, PM/0276 INQ000120822]. The accompanying exhibits detail the final report and supporting documentation such as a submission with the background information, Ministerial comments and approval and action plan for the recommendations. [MMcB024a INQ000137351]

301. The Review made 19 recommendations for the short-term improvement of the personal protective equipment position, which was in preparation for a second wave of Covid-19. Seventeen associated actions were identified to implement the 19 recommendations. The actions were assessed as either Critical (to be completed within 2-4 weeks) or Essential (to be completed within 4-8 weeks). A lead official was identified as being responsible for their implementation [PM/0088 INQ000120714]. Progress on the actions was monitored by the Personal Protective Equipment Strategic Supply Cell and whilst some of the actions were completed in a relatively timely manner, the initial timeframe for completion proved challenging given the nature of some of the actions. Of the 17 actions 15 actions were considered closed by end of August 2020 prior to the commencement of the second wave, and all were considered closed by December 2020.

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

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

ii. Northern Ireland Audit Office Review

304. In October 2020, the Northern Ireland Audit Office wrote to the Department of Health to advise of its intention to undertake a Review of the supply and procurement of personal protective equipment for the local healthcare providers. This included a proposed scope for this Review [PM/6221 INQ000417497]. This review was in line

with similar reviews undertaken by other audit agencies in the other United Kingdom jurisdictions.

305. The timing of this request was such that it coincided with preparations for routine Winter pressures on the Health Service in Northern Ireland and a further anticipated Covid-19 pandemic surge. The Department advised the Northern Ireland Audit Office of these pressures and requested the review commence early in 2021 which was agreed to [INQ000348880; INQ000348881].

306. Officials from the Northern Ireland Audit Office met with Department of Health policy officials on 25 March 2021 to formally commence the Review. The Northern Ireland Audit Office advised the Department of Health that the review was not a formal audit from which recommendations would be made, rather the report would highlight learning points for the Department and the wider Health Service to consider.

307. While a significant proportion of the work involved engagement with Business Service Organisation Procurement and Logistics Service, Department of Health officials were the main point of contact for the Northern Ireland Audit Office and coordinated appropriate input from across the Department and Arm's Length Bodies to support the Northern Ireland Audit Office in its Review.

308. The 'NIAO Report on '*The COVID-19 pandemic: Supply and procurement of Personal Protective Equipment to local healthcare providers'* (the Report) was published on 1 March 2022 [PM/3128 INQ000348882]. It identified six areas of learning and these have all been considered by the Department and its relevant Arm's Length Bodies. The Department and its Arm's 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.

309. These 6 key areas are:

- It is important to see how longer-term planning can be further enhanced to avoid a situation arising again where there is not sufficient personal protective equipment available at the outset of such an incident;
- Local procurement providers need to consider how supply chain resilience can be strengthened and enhanced, in order to avoid the unnecessary use of awarding contracts without competition;

- Recognising the innovative approach adopted early in the pandemic, with the involvement of Business Services Organisation, to ensure products procured were of appropriate standard for clinical settings, this process should be maintained and where possible enhanced;
- Consideration should be given to how emergency and contingency arrangements can be enhanced, along with more effective demand modelling;
- Longer term supply arrangements for the independent sector need to be clarified; and,
- There should be assessment of supply chain readiness for future waves of the pandemic and future pandemics.

310. During 2022-23 officials within teams in the Department and those arm's length bodies that contributed to the review considered all learning points within the report and how best to progress these through ongoing work, including longer term planning and as appropriate responding to the pandemic. A report has been prepared recording progress to date on these [PM/6221 INQ000417497].

5. Changes to the supply of PPE

311. The following changes were made to the process of supplying personal protective equipment during the relevant period:

- The introduction of a revised process for Health and Social Care Trusts to order personal protective equipment on the High Demand Management List with effect from 24 March 2020. The revision saw the introduction of a centralised system with nominated contact points for managing the ordering and delivery of products, a move away from authorisation at ward level, with the aim of ensuring a more even distribution of stock across all health and social care sites.

- In normal circumstances domiciliary care and independent sector Nursing and Residential Care Home providers are responsible for sourcing (and paying for) their own personal protective equipment. However, in recognition of the difficulties experienced by independent sector providers in sourcing this personal protective equipment during the Covid-19 pandemic, the Department directed the Health and Social Care Trusts to support providers from an early stage (end of March 2020 with formal reporting on volumes supplied introduced from 6 April) – where they were unable to secure their own supplies – and provide them with the personal protective equipment needed to protect both their patients and their staff, to ensure continuity of service provision.

312. Regional co-ordination of the health and social care response to the pandemic (Health Silver) was via the Department's emergency operations Health Gold structure and issues were raised through daily Health Silver situation reports which included those pertaining to personal protection equipment supply issues.

D. CAPACITY

1. Overview of Capacity

313. On the 1 April 2020 the number of inpatient beds in Northern Ireland was as follows:[13]

Table 1: Breakdown of no. of beds in Northern Ireland

HSC Trust	No. of Available Beds	No. of Occupied Beds	No. of Spare Beds
Belfast	1,567	725	842
Northern	631	303	328
South Eastern	606	381	225
Southern	659	309	350
Western	564	313	251
Total	4,027	2,031	1,996

2. Critical Care Capacity

314. On 1 March 2020 there were 88 critical care beds in Northern Ireland. There are a further 18 cardiac intensive care beds and 12 paediatric intensive care beds in regional units. Table 2 below provides a summary of Northern Ireland's Commissioned Critical Care Beds by Health and Social Care Trust and Level of Care.

Table 2: Northern Ireland Commissioned Critical Care Beds

Critical Care Unit	Level 3 Beds	Level 2 Beds	Total Beds
Belfast Trust	27	15	**42**
Northern Trust	8	4	**12**
Southern Trust	6	4	**8**
South Eastern Trust	6	4	**10**
Western Trust	9	7	**16**

[13] This was the position at 11am on 1 April 2020. Occupancy excludes patients with a Decision to Admit as was the requirement on 1 April 2020. From 18 October 2020 onwards, the methodology for calculating bed occupancy changed. Previously, the General Beds data displayed a static picture of beds which were physically occupied at a given point in time. This did not, however, take into account the dynamic nature of bed modelling and the flow of patients in and out of hospital over the course of a day. The revised methodology from 18 October included patients where a 'Decision to Admit' has been made, e.g. from an Emergency Department, thereby projecting more accurate occupancy levels across hospital sites. Trusts were also asked to provide additional Admissions data as at 9am on the morning of reporting to help assess operational pressures which are impacting upon bed occupancy. Hospitals were Belfast City, Mater, Musgrave Park, Royal Victoria, Antrim, Causeway, Mid-Ulster, Whiteabbey, Ards, Downe, Lagan Valley, Ulster, Craigavon, Daisy Hill, Lurgan, South Tyrone, Altnagelvin, Omagh & Primary Care, and South West Acute.

Sub-total	**56**	**34**	**88**
Regional Cardiac Intensive Care Unit[14]	10	8	18
Regional Paediatric Intensive Care Unit[2]	12	-	-
Total - ALL TRUSTS	**78**	**42**	**118**

315. Beds have four levels of classification as follows:

- Level 1 beds – general ward-based care where the patient does not require organ support (for example, they may need an intravenous drip, or oxygen by face mask); these are not included the Critical Care Table above as they are not considered critical care beds.
- Level 1.5 beds – enhanced beds such as post-anaesthetic care beds or respiratory non-invasive ventilation beds. These are not considered critical care beds and are also not included in the table above.
- Level 2 bed - High dependency unit. Patients needing single organ support (excluding mechanical ventilation) such as renal haemofiltration[15] or inotropes[16] and invasive blood pressure monitoring. They are staffed with one nurse to two patients.
- 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.

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

3. Increased Capacity

i. Planning

317. Between late-January and April 2020 the Health Service faced a rapidly evolving and uncertain environment as the outbreak of Covid-19 spread rapidly to become a pandemic. On 10 February 2020 Health Silver wrote to Trusts regarding managing patient flow at both containment and surge phases of Covid-19 [PM/6390 **INQ000477539**

[14] These are regional units located at the Royal Victoria Hospital, Belfast.
[15] A renal replacement therapy used in intensive care settings.
[16] **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.**

PM/6391 INQ000477540 PM/6392 INQ000477541 PM/6393 INQ000477542 PM/6394 INQ00047754 This correspondence requested nominees from Trusts for each of the Continuity / Surge Planning Support Groups which were being convened, by Health Silver, to support a coordinated approach to strengthen the capability of Health and Social Care to respond to the impact on health and social care of any surge associated with Covid-19.

318. Several task and finish groups (a task and finish group is a time-limited group drawn together from relevant disciplines to consider specific issues and bring forward a consolidated approach to dealing with relevant matters) were established including:

- Secondary Care (acute & community interfacing) escalation and capacity concerns during any surge – developing options from presentation to discharge;
- Critical Care (adult & paediatric) escalation and capacity concerns during any surge – developing options from presentation to discharge, and
- Paediatric, Maternity and Neonatal Care escalation and capacity concerns during any surge – developing options from presentation to discharge.

319. Following a meeting with the senior leadership team of the Health and Social Care Board and the Public Health Agency on 11 February 2020 [PM/63 INQ000477544 , the Chief Medical Officer, on behalf of the Department, wrote to the Health and Social Care Board's Chief Executive on 17 February 2020 [PM0206 INQ000137326] requesting detailed worked up integrated surge plans from community and primary care through to acute care including those areas where it was anticipated that there would be particular demands such as critical care. The Health and Social Care Board's Chief Executive replied to the Chief Medical Officer on 20 February 2020 [PM0207 INQ000130371] and advised that surge planning was underway and that the Health and Social Care Board and the Public Health Agency had established a regional operational Surge Planning Subgroup to ensure that there was an appropriate and proportionate level of health and social care preparedness across the Health and Social Care system in response to Covid-19.

320. On receipt of the Health and Social Care Board and the Public Health Agency's initial surge plans 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 Chief Medical Officer also anticipated that it was likely that Health Gold would be leading the strategic policy response to the surge and giving

direction to the regional coordination of the response to the surge. Therefore, to facilitate the enhanced strategic management of the surge, the Chief Medical Officer asked the Deputy Secretary, responsible for the Department's Healthcare Policy Group, and the Chief Nursing Officer to assist him with the coordination of the Department's policy input to surge planning for the health service.

321. The Deputy Secretary of the Healthcare Policy Group, Jackie Johnston, immediately established a Covid-19 Strategic Surge Planning Directorate to provide leadership to the Surge Policy Cell of the Emergency Operations Centre and report into the Strategic Cell. The terms of reference for the Covid-19 Strategic Surge Planning Directorate are provided in [PM0244 INQ000325160]. The new Directorate was headed by a dedicated Director at Senior Civil Service Grade 5 level.

322. On 3 March 2020 the Deputy Secretary of the Healthcare Policy Group, Jackie Johnston, sent an email to the Health and Social Care Board's Director of Commissioning to inform her that the Chief Medical Officer had asked him to oversee the Department's policy input and coordination to Health and Social Care surge planning covering workforce, primary and secondary care. The Deputy Secretary proposed that, as the Health and Social Care Board's Director of Commissioning was leading on surge planning at silver level, it would be useful to have an early meeting to scope out and agree the lines of communication and arrangements for engagement.

323. From this point the Chief Medical Officer, Chief Nursing Officer, Deputy Secretary of the Healthcare Policy Group and the Covid-19 Strategic Surge Planning Director worked together as a leadership group, within the Strategic Cell, to coordinate the Department's policy input to surge planning for the health service. This leadership group worked closely with the Health and Social Care Board's Director of Commissioning to ensure that the development of the Department's policy was responsive to the evolving situation within the Trusts and fully informed by expert medical advice provided by the Health and Social Care Board and Public Health Agency.

324. Minutes were not taken at the surge planning groups; instead, daily action logs were completed. The number of these documents totals in the hundreds. A sample of these has been provided [PM/6053 INQ000346727]. Surge planning groups covered a diverse range of areas of work. Each Group sought to keep apprised of emerging national guidance, assess application in NI and ensure implementation as necessary

through established channels, including Gold Command. The Groups also responded to issues emerging in service and sought to provide advice and direction where appropriate. This included an assessment of the impact of a surge on primary, secondary and community care. In addition, it liaised with other groups that had been established by HSC Silver to address human resource, PPE/equipment, and social care issues.

325. Issues emerging in service, included the following:

- Planning for containment phase eg need to identify respiratory isolation rooms on acute hospital sites to isolate patients who either self-present or are referred where case definition has been me and require testing. Arrangements needed to include arrangements for patients presenting at emergency departments
- Planning for surge phase eg:
    - ensuring that there is was a coordinated approached to strengthening HSC capability to response to the impact on health and social care of any surge in COVID-19
    - Service configuration would need to change significantly to increase capacity and resilience in critical care, hospital services and community care
    - Staffing levels will be significantly impacted by absence
    - Key secondary and tertiary services will need to be maintained throughout
- Critical care (adult and paediatric) / paediatric, maternity and neonatal care – need to consider options to support escalation and capacity from presentation to discharge.

ii. Covid-19 Regional Surge Planning Sub-Group

326. A Covid-19 Regional Surge Planning Subgroup was chaired by the Health and Social Care Board's Director of Commissioning and was comprised of members from the Health and Social Care Board, Public Health Agency, Trusts, Northern Ireland Blood Transfusion Service, Northern Ireland Ambulance Service and the Department. Trust Surge Plans and Self-assessment Checklists [PM/6054 INQ000346734; PM/6055 INQ000346735; PM/6056 INQ000346736; PM/6057 INQ000346737; PM/6080 INQ000346763; PM/6099 INQ000346782; PM/6100 INQ000346783; PM/6101 INQ000346784; PM/6102 INQ000346785; PM/6103 INQ000346786] informed the Group's work and, in order to consider these documents, the Subgroup facilitated a

regional workshop, on 5 March 2020 [PM/6058 INQ000346738; PM/6059 INQ000325164].

327. There followed intensive engagement between the Department, the Health and Social Care Board, the Public Health Agency and the Trusts resulting in the publication, on 19 March 2020, of the Health and Social Care (NI) Summary Covid-19 Plan for the period mid-March to mid-April 2020 [PM0300 INQ000103714]. The Plan summarised the key actions to be taken by the Health and Social Care system from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. It also outlined the planning assumptions available to the HSC in a reasonable worst-case scenario and of the actions taken across the HSC system to prepare for the impact of Covid-19. This was a dynamic plan, which was to be constantly refined in light of the emerging issues.

328. While the Surge Plan was kept under constant review, a number of versions existed during this period i.e. 27 March 2020, 9 April 2020 & 1 May 2020. Work had commenced on a fourth draft but this was superseded by the Health and Social Care Regional Surge Planning process led by the Department [PM/6060 INQ000346740; PM/6061 INQ000103714; PM/6062 INQ000346742].

329. The Regional Surge Plan used information provided by the Department's Covid-19 modelling group. This modelling group was chaired by the Chief Scientific Advisor and reported to the Chief Medical Officer. In the first wave of the pandemic, the Department's modelling group updated modelling on a regular basis from early April 2020, including a range of estimates for inpatient and critical care numbers under different scenarios, and this information informed Trust specific planning in relation to the surge which was led by the Health and Social Care Board. The modelling group considered information from a range of sources to inform its judgement on the potential course of the epidemic and the models were adapted over time as more data became available.

iii. During the Pandemic

330. During the period 1 March 2020 – 28 June 2022 critical care beds fluctuated, largely in line with the Covid-19 waves as referred below. Surge Plans and De-escalation Plans were developed throughout the pandemic to enable the system to plan for surges of demand and to balance the need for critical care capacity required for Covid-19, urgent non-covid-19 and time critical surgery patients.

331. On 26 March the Permanent Secretary for Health wrote to the Chief Executives of HSC Trusts [PM/160 INQ000325159 (DoH ref: PM0147)], on the issue of "COVID-19: Preparations for Surge". The letter summarised the extensive planning and investment underway across the HSC system designed to increase capacity. The Permanent Secretary gave encouragement to his colleagues stating, "ensuring that we can meet these pressures as best we can, will require a collaborative approach, streamlining processes and decision making to put the interests of our patients and staff first. Together we must look after each other's wellbeing to ensure that no-one is left behind or feels neglected during the turbulent times which we are now living through".

332. The correspondence of 26 March 2020 also included a range of actions that Trusts were asked to take to maximise surge capacity in hospitals and explained that the reason for the need to maximise capacity in the following terms "it will be more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they are well enough to leave hospital in order to release beds for newly admitted patients. Trusts should also work to maximise and utilise all spare capacity in residential, nursing, and domiciliary care." This request was aligned with approaches which were being taken across other parts of the UK at that time, as all healthcare systems were activating surge plans in anticipation of potentially high Covid admissions during the first wave. This involved a range of measures to maximise capacity in hospitals, including through effective discharge arrangements.

333. Effective discharge of patients in line with their healthcare needs was an important part of NI surge plans from the early stages of the pandemic response. The use of spare capacity in nursing homes represented one of a range of possible discharge arrangements, which also included discharge to the patient's own home or to residential or domiciliary care facilities.

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

isolation. The modelling team's[17] best judgement was that this would lead to a peak number of 180 Covid-19 patients requiring ventilation and critical care beds during the first wave of the pandemic. The modelling assessed that the peak number of Covid-19 hospital admissions would be 500 per week. Under this reasonable worst-case scenario, the projected number of cumulative Covid-19 deaths in Northern Ireland over 20 weeks of the epidemic was calculated to be in or about 3,000. The modelling indicated that the peak of the first wave of the epidemic was expected to occur between 6-20 April 2020.

335. Informed by this reasonable worst case scenario modelling, the Department initiated a rapid assessment of potential sites, external to the HSC, on which to locate a Nightingale Hospital facility to provide additional critical care beds if needed. The decision on the Nightingale Hospital facility is discussed in detail in Section H – Nightingale and Independent Hospitals. In parallel to the assessment of these external sites for a Nightingale Hospital facility, assessments of options for reconfiguring HSC hospital sites to increase critical care capacity were also underway.

336. Inpatient capacity was increased in designated wards that could treat up to 280 adult inpatients with Covid-19; however, increasing capacity for treating patients with Covid-19 had an impact on other services, as detailed below at section 3(iv). All HSC Trusts assessed the steps required to convert additional wards currently used by medical and surgical specialties into areas to treat patients diagnosed with Covid-19. If required, it was anticipated that the normal capacity of 88 critical care beds across the HSC could be increased by a further 38 beds. Mechanical ventilators had been ordered to increase the then current stock of 139 to 179 by end-March 2020. The Department worked closely with NHS partners on a four nations basis to ensure adequate supply of ventilators as required.

337. The first Covid-19 related admission to critical care in Northern Ireland was on the 15 March 2020. The Resource Modelling Group was established in April 2020 on the

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

back of resource modelling developed in Southern Trust to help them plan and organise their resources to manage the impact of Covid-19. When the resource model was shared with all Trusts there was a request to take the model used by the Southern Trust and develop it for all Trusts to help them plan for Covid-19. The group was established by and chaired by the Trusts. The group did not take any decisions, but rather took the information developed by the Departmental modelling for use within each respective organisation. Accountability was as per internal governance structures for each organisation which was represented.

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

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

339. Membership of the group was as follows:

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

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

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

342. The Critical Care Surge Plan to meet these recommendations was agreed by the Department on 16 April 2020. The surge plan was set out in two papers - a 'Surge Plan on a Page' and a paper outlining the decision making of the 'The Surge Plan for Northern Ireland' [PM/6104 INQ000346787; PM/6105 INQ000103658; PM/6106 INQ000377154]. Health Gold level approval and ratification was provided for both plans.

343. The Belfast City Hospital Tower Block was designated Northern Ireland's Nightingale Hospital for the first wave. The decision was announced on the 2 April 2020 [PM0064 INQ000103653] when the Covid-19 Strategic Surge Directorate in the Department wrote to the Health Silver and advised that, in order to meet the critical care bed demand expected, a surge plan would need to be developed which would require some units down-turning critical care beds in order to create additional capacity on a large regional covid site, based at the Belfast City Hospital Tower Block.

344. To support planning for the Nightingale Hospital, Health Silver was asked to provide an understanding of what critical care capacity needed to remain in existing critical care base units (medical and nursing cover to deal with any emergency situations) in order to meet any residual, non-covid requirements. During surge it was expected that staffing ratios should be of a similar level across all critical care units, including the Nightingale Hospital and that critical care staffing would be augmented by non-critical care staffing, who would receive skills training. These nurses were supervised by critical care nurses. Work also took place to clarify the impact of PPE on nurse staffing, and is described in the following paragraphs, and additional nursing required to support critical care nurses to help with dressing, undressing and toilet breaks of nurses needing to come in and out of units during shifts.

345. The Intensive Care Nurse, whose patient is dependent on mechanical ventilation, must ensure that the patient is 'observed at all times by personnel competent to anticipate,

detect, and respond immediately to the failure of adequate ventilation.'[18] HSC sought to maintain this standard throughout the pandemic, given that critical care patients with Covid 19 often required mechanical ventilation. In order to do this, it was necessary to bring nurses from other specialisms, most notably theatre nurses with transferable skills to critical care.

346. Throughout the pandemic, critical care staffing levels were monitored daily and bed numbers adjusted accordingly to ensure that they were within the safe levels agreed. It was the ward sister responsibility to make a daily assessment on whether they had adequate nursing to open the beds requested. If they did not, CCaNNI, and subsequently the Critical Care and Respiratory Care Operational Hub, was notified and beds were adjusted accordingly. Critical care admissions were managed at a regional level, taking account of both bed availability and staffing, throughout the pandemic.

347. Furthermore, in preparing for a second Covid-19 Surge, in light of learning, experience and evidence from the first surge, the Critical Care Network of Northern Ireland (CCaNNI) was asked to carry out a scoping exercise to determine the 'Frequency' and 'Length of Time' required for a nurse to relieve other nurses for breaks, and consequently equated this to 0.6 WTE equivalent nurse being required for a COVID-19 supplement to relieve a nurse for break times, for a Level 3 patient.

348. Trusts were then asked to provide a non-recurrent business case for their units to:

- Ensure that nursing staff had adequate break relief which is not reduced due to the length of time it takes to 'don and doff' PPE;
- Ensure appropriate environmental cleaning and waste disposal was carried out as per IPC guidance;
- Ensure adequate support and guidance is given to support family/carer visiting as deemed appropriate;
- Ensure senior lead nurses have appropriate nursing capacity for manual handling to support the turning and proning of patients, who are completely immobile; and

[18] Guidance for nurse staffing in critical care (baccn.org), page 4.

- Provide and maintain a supplementary cross skilled workforce, who can be rotated into critical care to retain critical care competencies to give an assurance that increases in surge activity demand can be met.

349. A meeting was arranged by the Health and Social Care Board's Director of Commissioning on Saturday 4 April 2020 with all stakeholders. The purpose of this meeting was to provide clarity around the Nightingale arrangement. An expert group led by the Chief Nursing Officer developed the regional surge plan which was split into three phases:

- Phase 1 - 88 critical care beds at pre surge level, to 132 critical care beds (which was the current surge level at that time);
- Phase 2 - Main hub (Belfast City Hospital – 230 critical care beds) and smaller hubs (Altnagelvin) centralisation of critical care staff and resources and protection of Non-Covid Royal Victoria Hospital Critical Care & Cardiac Intensive Care Unit (all non-Covid-19 to the Regional Intensive Care Unit at the Royal Victoria Hospital), and
- Phase 3 - 3 Hub model Belfast City Hospital, Altnagelvin and Ulster Hospital. This was to accommodate Belfast City Hospital and Altnagelvin running out of capacity.

350. Written instructions were in the process of being developed which defined the trigger points to move between the three phases. These instructions included a daily update meeting between the Chief Nursing Officer's Team and the Clinical Lead of the Critical Care Network NI (CCaNNI), which would provide information on admissions into critical care in the previous 24 hours to inform triggers. However, this surge plan was superseded before the written instructions were complete because on the 16 April 2020, the Regional Modelling Group produced an updated summary which considered modelling dated 7th April 2020. On the basis of this modelling, and assuming social distancing was still adhered to, it suggested that during the wave 1 peak (likely to occur between 6-20th April 2020) the following Reasonable Worst-Case Scenario (RWCS) was:

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

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

Local Escalation of Trusts

- Pre-surge - 88 level 3 critical care beds at pre-surge level; Belfast City Hospital only to admit covid patients;
- Low surge - increase from 89 critical care beds to 112 critical care beds;
- Medium surge - increase from 113 critical care beds to 155 critical care beds; all but 3 cardiac critical care beds/ resources to be moved to Belfast City Hospital, and
- High surge - increase from 156 critical care beds to 198 critical care beds.

Regional Escalation

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

352. Covid-19 related critical care occupancy peaked at 57 patients between the 6th and 11th of April 2020. On the 8 May 2020 Health Gold approved the start of planning for de-escalation for critical care across the network. De-escalation was network wide; however, the de-escalation plans always started with the Nightingale hospital. On 13 May 2020 the Department announced that it had reduced the escalation level for critical care to 'Low Surge' and that the Nightingale hospital would therefore be temporarily stood down as it had not been required to deliver its full capacity during the first wave due to the commitment of HSC staff across the network and the positive

impact of social distancing. De-escalation plans commenced in with Nightingale Hospitals, due to two reasons:

- Reducing the beds in the nightingale released nurses from outside Belfast Trust back to their own hospital unit, this allowed a reduction in pressure in these units and allow nurses to return to home Trust.
- The Nightingale Hospital is also Northern Ireland Cancer Centre and provides a significant proportion of the complex cancer work. It was agreed across NI that it was a priority for any theatre nurses to be returned to theatre and enable these surgeries to start again.

353. In July 2020, the Critical Care Network Northern Ireland asked Health and Social Care Trusts to provide an updated local surge plan to realign capacity with demand in the event of a second surge of Covid-19. The former HSCB, now SPPG, believe this was requested by the Department but can locate no evidence of the request; the Department also has no record of the request. The Second Wave Surge Plan [PM/6066 INQ000377221], produced in October 2020, mapped the critical care bed need from 88 critical care beds at steady state through to 110 beds at medium surge, 134 beds at high surge and 158 beds at extreme surge. All surge plans were provided to Trusts and used to manage escalation steps.

354. On 5 January 2021 the Permanent Secretary of Health wrote to the Health and Social Care Chief Executives across Northern Ireland and advised that, at the Health Gold Command Group meeting on 4 January 2021, it had been agreed that a new command and control structure needed to be put in place to implement a revised Third Wave Critical Care Surge Plan [PM/6010 INQ000276393]. This would help ensure that collectively Northern Ireland could deliver the level of critical care likely required during the third wave of Covid-19. His correspondence set out the structure of the Critical Care and Respiratory Operation Hub and provided authority for it to strategically manage critical care and respiratory admissions and transfers on a regional basis.

355. The Third Wave Surge Plan [PM/6067 INQ000346747] produced in January 2021 mapped critical care beds between 88 baseline beds and 177 critical care beds through 7 steps incorporating critcon levels 0-4. This was subsequently revised on 10 January 2021 [PM/6068 INQ000346748]. Occupancy levels within Critical Care started to fall in February 2021 and de-escalation plans were put in place to reduce beds. These plans were the reverse of the surge plan [PM/6069 INQ000346749; PM/6070 INQ000276394; PM/6071 INQ000346751; PM/6072 INQ000346752; PM/6073

INQ000377241; PM/6074 INQ000346754; PM/6075 INQ000377246; PM/6076 INQ000346756]. The de-escalation plan got Northern Ireland to its commissioned bed numbers by mid-March 2021. The Critical Care and Respiratory Operational Hub was stood down formally by the Permanent Secretary at the end of February 2021 but continued to meet until 8 March 2021 to finalise de-escalation. A small core team continued to monitor critical care capacity and take forward pieces of work.

356. On 21 June 2021 an email was sent from the Chair of the Critical Care Network Northern Ireland [PM/6077 INQ000346757; PM/6078 INQ000346759] to start the planning cycle for the Fourth Wave Surge Plan. A finalised Fourth Wave Surge Plan was agreed in October 2021 [PM/6079 INQ000346762]. This plan considered that demand for critical care capacity emanates from three patient groups:

- Those with Covid-19;
- Unscheduled care including respiratory, trauma and other emergencies, and
- Time sensitive elective surgery.

357. Throughout Covid-19 the surge plans were monitored and reviewed to understand demand and capacity and to allow the bed and staffing to flex when required. The careful management of the Surge Plan enabled beds to fluctuate over time.

358. Inpatient and Intensive Care Unit bed occupancy statistics were published daily on the Department's Covid-19 Dashboard during the relevant period. These statistics are all available online[19] but because of the number of documents only the last day's data has been provided as an exhibit [PM/6052 INQ000346726].

359. In summary the critical care escalation plans worked effectively to ensure that bed capacity was managed to meet the demand for critical care beds for both Covid-19 and non-Covid patients over time. This was due to the frequent reporting and careful management of the surge plan as outlined above. The Critical Care and Respiratory Operational Hub was stood down formally in February 2022.

360. The above has detailed plans and actions to increase overall capacity; should information be required on how individual Trusts increased their capacity the Inquiry should approach the Trusts and their legal advisers, the Directorate of Legal Services, directly.

[19] https://www.health-ni.gov.uk/articles/covid-19-dashboard-updates

iv. Effect of Increasing Capacity

361. A consequence of increasing critical care capacity for the care of Covid-19 patients was that elective activity largely stood down for routine and urgent treatments. During the pre-covid year 2019/20, there were 40,960 elective inpatient acute admissions compared to 21,550 in 2020/21 and 26,890 in 2021/22. While Section I – Healthcare Provision and Treatment - describes the effect of this on the specific areas of Children's and Maternity Services, Fertility Services, Renal Transplant Services, Orthopaedic Treatment, Cancer Services and Children's and Adolescent Mental Health, and the work done in order to alleviate this, the following paragraphs provide a broad summary of the overall impact.

362. The redeployment of Health and Social Care elective care staff to increase critical care capacity for those admitted to hospital with Covid-19 resulted in the cancellation or postponement across all Trusts of non-urgent appointments, investigations and procedures across outpatients, day case, inpatient and diagnostic services. Efforts were made to minimise any disruption to treatment for cancer and other urgent procedures, but there was some impact on their treatment. 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).

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

364. However, some biopsy and endoscopic diagnostics services had been switched off for a period in adherence to national guidance due to infection control measures and this would have impacted on certain diagnostic procedures for suspect cancer referrals. This resulted in delays in diagnosis in certain pathways, hence introduction of FIT test to prioritise patients with suspect bowel cancer for endoscopy. Once a diagnosis of

cancer was confirmed, treatment decisions were based on clinical need and the assessed risk/benefit of proceeding at that time. The risk of cancer not being treated optimally had to be balanced with the risk of the patient being immunosuppressed and becoming seriously ill from Covid-19 [PM/6346 INQ000226460].

365. These discussions were held between patients and their clinicians. Patients would have been offered treatment alternatives where possible (such as hormone treatment, Systemic Anti-Cancer Treatment or radiotherapy) where the normal course of treatment could not take place due to infection control measures and reduced surgical access. Systemic Anti-Cancer Treatment (SACT) and radiotherapy (RT) procedures proceeded at a higher level than pre-pandemic as patients would have been offered Systemic Anti-Cancer Treatment and radiotherapy as alternatives to surgery.

366. The requirement to increase inpatient capacity for Covid-19 had no impact on Mental Health or Learning Disability in patient bed stock, as staff from these areas were not deployed to Covid Wards. Accordingly, the pandemic did not result in a downturn in Mental Health and Learning Disability inpatient availability. There were incidents of Covid outbreaks on Mental Health and Learning Disability Wards which had an impact on the ward's ability to receive admissions at times.

367. 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. 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.

v. Issues

368. In general, the HSC system effectively managed bed pressures due to surges in covid cases and pressures from unscheduled care while also seeking to balance the need to provide an optimal level of beds to support elective surgery. HSCB, through Silver arrangements and ongoing commissioning activities, was in close contact with Trusts in relation to hospital pressures and worked closely with the NI Ambulance Service to smooth unscheduled care demand across the system and deal with any concern regarding covid infection within hospitals due to infection control challenges.

369. In advance of the anticipated surge in Covid-19 cases post-Christmas 2020, the Department commissioned an exercise to test the HSC critical care plans to assess their continued ability and effectiveness for dealing with the reasonable worst-case scenario. The Department invited a Military Assessment Team, comprising regular and reservist personnel with local HSC Trust knowledge, to carry out this assessment to determine how robust the plans were in the face of various Covid-19 modelling scenarios. The focus of the exercise was on ICU capabilities, drawing on similar work undertaken in GB to inform this exercise. Following the completion of this exercise, the HSC Critical Care Network NI met on 14 December 2020 to review the plans in the light of the recommendations of the Military Assessment Team. This exercise has been described in Section A (7)(v).

370. Intensive Care Unit information was sent daily to the Department of Health from the Critical Care Network NI (CCaNNI) on ICU occupancy by hospital which was included in the daily Covid-19 dashboard. This data return allowed ICU occupancy data to be broken down by hospital, Covid-19 status and ventilation status. Data for ICU was reported based on the date that the CCaNNI network collated the information.

371. CCaNNI provided the data to the Department as an excel spreadsheet, providing the ICU and ventilation position for each Intensive Care Unit as of the morning of reporting. The ICU capacity presented included additional surge capacity available on the day of reporting. The spreadsheet included for each Unit:

- The number of available ICU beds;
- The number of beds occupied by COVID-19 confirmed patients;
- The number of beds occupied by COVID-19 suspected patients; and
- The total number of beds occupied.

372. From 27 April 2021, the method of recording occupancy levels in Intensive Care Units changed. From this date, these data excluded Paediatric ICU patients and included just 4 of the commissioned level 2 Cardiac ICU beds in the region. These 4 Cardiac ICU beds were included within the Royal Victoria (RICU) site breakdown. Belfast Trust managed bed stock dynamically across their sites in line with best practice infection control, taking available resource and demand into account. Beds collapsed in the Mater Hospital were redistributed between the Belfast City (BCH) and Royal Victoria (RICU) sites. The number of ICU beds occupied included patients on route to the ICU site from this date.

373. Given that the information was collated from teams in each Trust responsible for the management of ICU beds, it was believed to be an accurate reflection of ICU capacity on any given day. However, it presented a static picture at a point in time and was not revised retrospectively unless an error was discovered in the data or a change to the methodology used to produce the information was required. Information provided by the CCaNNI network enabled the Department to report on the number of patients occupying ICU beds each day, how many patients were ventilated, how many of these patients had suspected or confirmed Covid-19 and how many beds were still available across the region. Charts were presented to show the daily occupancy levels as well as 5 day rolling averages which helped to smooth the variations in daily data. From 25th June 2020 onwards, all ICU beds data displayed on the dashboard referred to confirmed Covid-19 patients only. Prior to 13th April 2020, ventilator data presented included both suspected and confirmed Covid-19 patients. From 13th April 2020 onwards, ventilator data included confirmed Covid-19 patients only.

374. There was one occasion when a Trust escalated bed capacity issues. This related to an incident on 9 – 10 of February 2021 in Antrim Hospital. On the 9 February 2021 in response to this issue, the Critical Care and Respiratory Operational Hub (Hub) co-ordinated the transfer of 8 respiratory patients to the Belfast Trust, via a Northern Ireland Ambulance Service divert. This was to reduce demand within the Emergency Department and respiratory services in Antrim Hospital. The Hub also arranged for the transfer of 2 critical care patients via the Northern Ireland Specialist Transport and Retrieval service (NISTAR – the NI joint paediatric and neonatal transfer service), in order to reduce pressure in the Antrim Critical Care Unit. Capacity in Antrim was reviewed on the morning of the 10 February 2021 and 4 further transfers were arranged in a planned way to avoid any further escalation.

4. Transfer of Patients to England

i. Patients with Covid-19

375. Given the geographical location of Northern Ireland, the Health and Social Care sector requires the services of an air ambulance provider for the transfer of patients to and from specialist centres in Great Britain. The existing designated fixed wing air ambulance provider for Northern Ireland is Woodgate Aviation but, due to the layout of their aircraft, which had no separate cabin area, Woodgate were unable to provide Air Transfers for Covid-19 positive patients. Therefore, early in the pandemic, in April

2020, and in response to the need to transfer patients to Great Britain, by air, the then Health and Social Care Board arranged for patient transfer by Royal Air Force assets (Military Aid to the Civil Authority) through the Department. These Military Aid to the Civil Authority arrangements were made in line with the Military Aid to the Civil Authority UK protocol that was published on 4 August 2016 [PM0149 INQ000390021].

376. This arrangement was intended for specific cases that were not eligible for transfer by other commercial arrangements, including patients being transferred to specialist centres in England for Extracorporeal Membrane Oxygenation treatment that is not available in Northern Ireland. The Northern Ireland population is too small to safely, and sustainably, provide Extracorporeal Membrane Oxygenation treatment, which is a highly specialist service provided from a small number of designated centres in Great Britain. The arrangements were also available for use when patients with Covid-19 with other specialist needs required transfer to a specialist centre in Great Britain.

377. In total nine Covid-19 patients were transferred to specialist hospitals in Great Britain from 27 April 2020 to 8 December 2021, as follows:

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

378. The process for the referral of patients, by the Health and Social Care Trusts, requiring Extracorporeal Membrane Oxygenation was via the National Health Service's national referral portal.

379. Subsequently, in November 2020, as a first line of response, and following on from arrangements put in place by the Scottish Ambulance Service (who have responsibility for air transfers in Scotland), the Health and Social Care Board put in place arrangements to access air ambulance services for the transfer of Covid-19 patients from Logan Air [PM/6081 INQ000377024; PM/6082 INQ000377025]. This

arrangement involved the use of a modified passenger plane with a separate cabin for flight crew. This allowed the capability to transfer Covid-19 positive patients.

380. In August 2021 the then Health and Social Care Board put in place a further arrangement with Her Majesty's Coastguard Search and Rescue, via their UK Search and Rescue inter facility transfer procedure [PM/6083 INQ000346766], to provide a further tier of support for air transfer, where Logan Air was unable to provide transport for Covid positive patients. In December 2021 Logan Air advised that it was no longer able to provide air ambulance transfer services for Covid positive patients, and, in January 2022, the Coastguard Search and Rescue became the first line of support to Woodgate Aviation.

381. There has been no decision to stand down the existing arrangements for transfer of Covid-19 patients requiring access to specialist centres, and, whilst no Covid-19 patient has been transferred since December 2021, this is still possible if required.

ii. Non-Covid-19 Patients

a. General

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

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

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

384. No information is held by the Department on whether any general transfer requests were rejected.

b. Mental Health Patients

385. Patients detained under Northern Ireland's mental health legislation (the Mental Health (Northern Ireland) Order 1986) occasionally need to be transferred between hospitals in Northern Ireland and Great Britain. Generally, patients detained under the Mental Health (Northern Ireland) Order 1986 requiring transfer to hospitals in Great Britain will either:

- Require treatment in conditions of high security not available in Northern Ireland, or
- Require specific specialist inpatient services, which are not available in Northern Ireland.

386. The Department's guidance on the Transfer of Patients Detained under Mental Health Legislation between Hospitals in Northern Ireland and Great Britain was updated in June 2017, with a further addendum issued to Trusts in January 2019 clarifying some details of the processes to be followed [PM/6084 INQ000346767; PM/6085 INQ000346768]. This guidance sets out the procedures to be followed by Health and Social Care Trusts when a patient detained under the Mental Health (Northern Ireland) Order needs to be transferred either to or from Great Britain.

387. There were no special arrangements put in place by the Department for the transfer of detained patients under the Order because of the pandemic – the existing transfer guidelines continued to apply. There may have been some arrangements at an operational level within Trusts, for example in relation to requirements for Covid testing, however Trusts within Northern Ireland or the receiving hospital in Great Britain would have put any such requirements in place.

388. Departmental records show there were a total of 11 patient transfers of patients detained under the Mental Health (Northern Ireland) Order 1986 to/from Northern Ireland between 1 April 2020 until 31 March 2021. Of these, 5 were transfers to England and 2 were transfers to Scotland. The remaining 4 transfers were back to Northern Ireland, 2 each from England and Scotland. During this period no requests for patient transfers under the Mental Health (Northern Ireland) Order were refused.

5. Oxygen Supplies

389. The Chief Pharmaceutical Officer led the medical supplies/medicines cell at Gold command reporting to the Strategic Cell. The scope of this work included oxygen

supply availability, oxygen system delivery capacities and related consumables. Modelling undertaken in March 2020 to inform the first Covid-19 surge plan [PM/6086 INQ000346769] indicated that large numbers of patients would require high intensity treatments including oxygen therapy. In addition, it was anticipated that levels of cylinder and concentrator oxygen use in domiciliary settings would also increase. Reliable information was needed to assist planning to ensure the continuity of oxygen supplies, and this presented a number of challenges including:

- Calculating the likely patient demand in acute hospital settings, including an assessment of the available ventilator devices and type;
- Calculating maximal deliverable oxygen capacity across all hospital sites in the region;
- Assessing availability of oxygen therapy consumables including ventilator specific items;
- Assessing the number of oxygen concentrator devices and oxygen cylinder availability in community settings, and, and
- Reviewing the logistics of supply in community settings, including the prescribing and dispensing processes.

390. To meet these challenges a number of interlinked work-streams were progressed, and two regional groups were established to consider the likely acute hospital and community clinical demands. Coupled with this, mathematical modelling was used to establish the oxygen system capacity across Northern Ireland. The following actions were implemented:

- The Department working with the Health and Social Care Trusts and the regional oxygen supplier, BOC, coordinated and authorised a prioritised work plan to enhance Trust's infrastructure and capacity for oxygen supplies;
- The Department authorised additional investment in oxygen equipment and ventilator devices;
- A weekly report was produced in relation to oxygen concentrator installations and removals in community settings;
- Practice changes were implemented providing respiratory specialists the authority to sign the Hospital Oxygen Order Form and on 10th April 2020 the commissioning of BOC to install concentrators into nursing homes on a named patient basis, and
- At Trust level the medical gas committees, which included relevant pharmacy, clinical and estates staff, provided information to the regional Acute Oxygen Supply Working Group, ensured that oxygen safety alerts were considered,

and appropriate action taken. Trusts were asked to ensure that clinicians and managers had clear communication channels with their estates teams in regard to oxygen systems and their capacity and that Trusts designate a member of staff with an appropriate level of authority to ensure clear decision making and close collaboration across the teams. Ongoing monitoring systems for oxygen usage in each Trust site matched to the actual and planned ventilator demand were established. This permitted a Red Amber Green rating of oxygen use at Trust level to be established and the reporting of Red Amber Green status of a Trust oxygen management as part of the Health Silver Command Delivery Confidence section of the daily Situation Report to the Department of Health Gold command for a regional Red Amber Green assurance. The criteria for Red Amber Green rating of the oxygen use and management was set by individual Trusts depending on their oxygen systems and management procedures. A Red rating did not mean that the system was operating outside of system limits only that the oxygen use required careful management in line with a Trust's agreed procedures to prevent the oxygen system delivery capacity being exceeded. This careful management of oxygen delivery capacity and bed capacity at the Southern Trust highlighted that further patients would not be able to be treated and initiated an ambulance divert during the peak period response. The daily Gold sit-rep report also included a YES/NO assessment of whether HSC organisations had sufficient oxygen supply available to meet their needs in the next 24 and 72 hours. The organisations included all Trusts, Northern Ireland Ambulance Service, Primary care and Community Services. The Department has no record of assurances not being provided regarding oxygen supply. In the event of an issue arising the organisations involved would have been required to provide a report with recommendations detailing the mitigating actions required for Gold Command to either note or approve.

391. The Department issued 3 safety letters related to oxygen safety during the period April 2020 to December 2020 reflecting national advice and actions required. These included:

- SSU20/02, Impact of the Use of High Flow Oxygen Therapy Devices including wall CPAP and high Flow Face Mask or Nasal Oxygen on Hospital Medical oxygen System [PM/6087 INQ000346771];
- SSU 20/04 Monitoring of Oxygen Systems [PM/6088 INQ000376962], and

- SSU20/31 Oxygen Supply and Fire Safety [PM/6089 INQ000346773]; [PM/6090 INQ000376956].

392. The Department also received regular updates about oxygen issues through the Situation Report process. These related to the management of oxygen supplies and capacity but there were no specific issues related to an individual's access to or use of oxygen or patient safety reported – an example is provided in exhibit [PM/6098 **INQ000362345**

6. General Practice

i. Consultation Numbers

393. General Medical Services consultation numbers and type data was not a core requirement of the General Medical Services contract and therefore, as at March 2020, no such data was collected by the Health and Social Care Board. Data collection in relation to General Medical Services consultation numbers (General Practitioners and Practices Nurse) commenced in October 2020 but this data was not split by profession. It is therefore not possible to provide the number of General Practitioner appointments (including a breakdown of the number of in-person surgery appointments, in-person home visits and remote consultations) and the levels of utilisation available across Health and Social Care as at 1 March 2020.

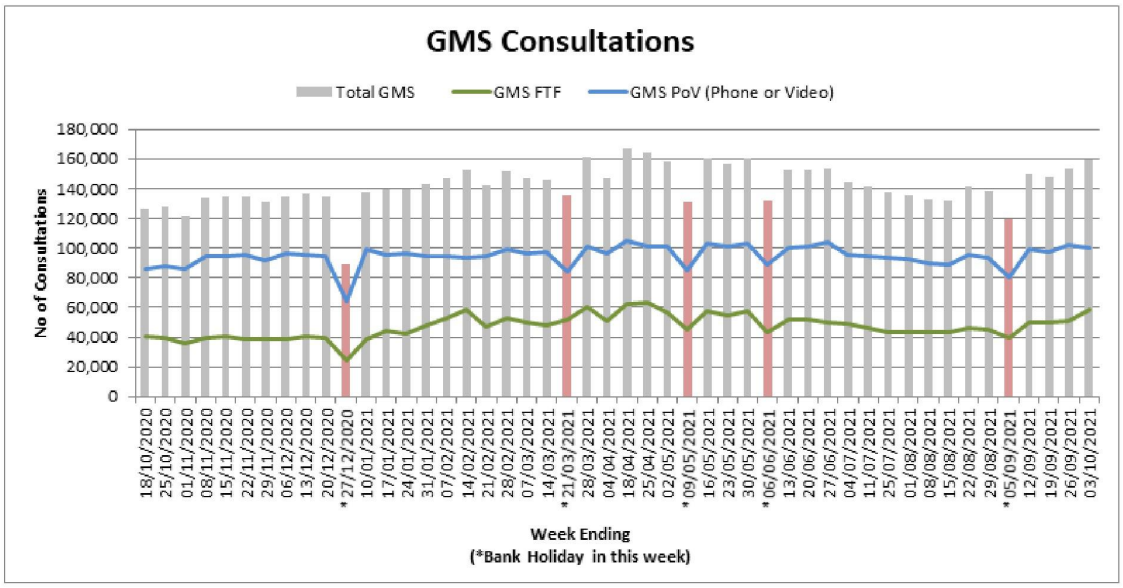
394. In October 2020, the then Health and Social Care Board commissioned the Northern Ireland Local Enhanced Service Managing Winter Pressures (October 2020 – March 2021); this required contracting Practices to collect two sets of practice workload data during November 2020 and January 2021. The weekly data collected from October 2020 onwards was to help with service planning and to help identify trends as the Health and Social Care Board / General Practice transitioned through the pandemic. The data collected is a proxy of overall numbers across all Practices.

395. The graphs below present the activity trend information collected in each time period as follows:

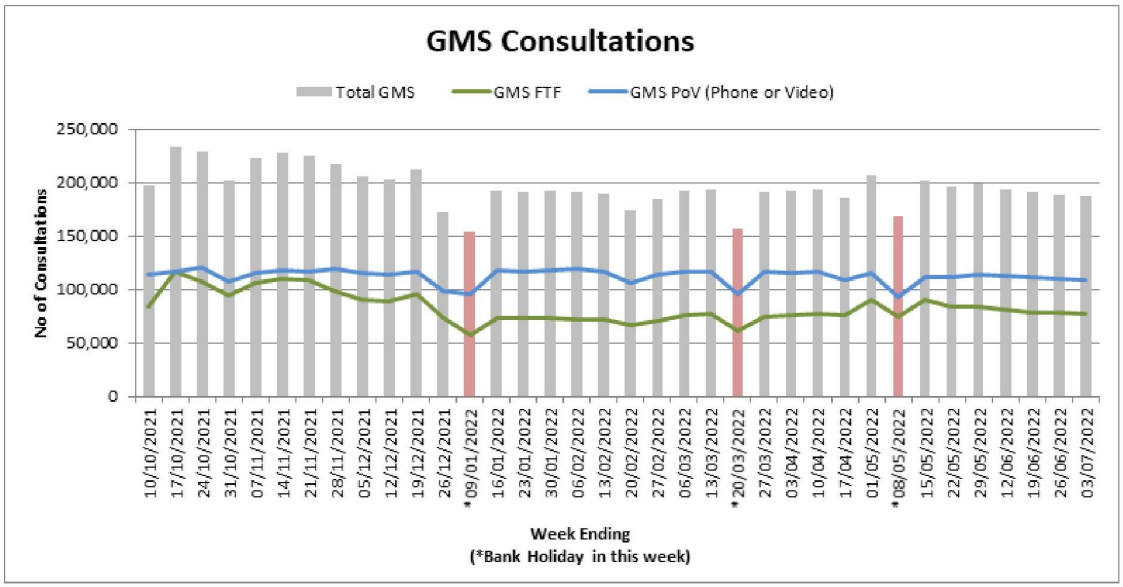
- Graph 1 - General Practitioners and Practice Nurses consultations from w/c 18 October 2020 to w/c 3 October 2021.
- Graph 2 – Figures encompass the whole Practice Team consultations from w/c 10 October 2021 to end June 2022.

396. The differences in total consultation numbers between the two time periods is higher in the latter time period shown in graph 2 due to the data collection encompassing the whole Practice Team rather than just GPs and Practice Nurses. Roles included in the whole practice team include GPs, Practice Nurses, Healthcare Assistants, General Practice Pharmacists and where appropriate Advance Nurse Practitioners, Nurse Practitioners and paramedics as well as Multi-disciplinary Team first contact physiotherapists, mental health practitioners and social workers.

Graph 1 (GMS Consultation Activity Data - General Practitioners and Practice Nurses)



Graph 2 (GMS Consultation Activity Data – Whole General Practice Team)



397. The two sets of practice workload data (in a one-week period) collected during November 2020 and January 2021 enabled General Practitioner Practices to review their current activity and workload data to help them identify areas of improvement to manage workload. The data collected does not provide a breakdown of General Practitioner appointments in respect of the number of in-person surgery appointments, in-person home visits and remote consultations. With no baseline data available, it is not possible to provide data on whether and how the number of General Practitioner appointments changed over the relevant period (including a breakdown of the number of face-to-face surgery appointments, home visits and remote consultations) and the levels of utilisation available across Health and Social Care in Northern Ireland.

ii. Consultation Types

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

399. An essential element of the health service preparation was to ensure the continued access to emergency and essential services, including general practice, dental services, maternity and children's services, cancer services and screening services for high-risk conditions. This involved, for example the development and implementation of alternative service models such as Covid-19 Centres, virtual general practice and hospital consultations, the establishment of urgent dental care centres, including treatment pathways for those with cancer, given their increased risk from Covid-19. All these pathways and new service arrangements progressed and were coordinated by Health Gold Command Strategic Cell. Despite the considerable efforts by the HSC, there was regrettably a significant impact on non-urgent elective activity and a range of other planned services, including routine screening programmes and support services. Extensive efforts were made to provide as many of these services by alternative means as possible, while minimising the risk of infection.

400. General Practices across Northern Ireland remained open and continued to provide treatment, care and support to patients throughout the pandemic through both face-to-face appointments and alternative consultation options, such as telephone and video consultations, signposting or directing to other relevant services as appropriate.

401. Under the General Medical Services (GMS) Contract (2004), the GMS contractor is required to ensure that appropriate arrangements are in place for infection control and decontamination. As outlined in Section B (Infection Prevention and Control), throughout the relevant period, the then Health and Social Care Board signposted General Practitioner contractors to relevant nationally and regionally agreed Infection Prevention Control Guidance and policies as advised by the Regional Infection Prevention Control Cell chaired by the Public Health Agency. It was then up to each practice to determine how to respond to this advice. Advice on social distancing, in what would often be crowded conditions in GP practice waiting areas, meant that practices, based on an individual risk assessment, managed patient contact through controlled entry to their premises. A 'telephone first' consultation approach allowed General Practices to provide services in line with infection control guidance and maintain the majority of General Practice services (for further information on this see section 6(iii) below).

402. 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 and the British Medical Association's 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 [PM/6396 **INQ000477545** 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**

403. This was a message that the Department sought to reinforce. On 1 December 2020, the Department published a 'General Practice Mythbuster' [PM/6092 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.

iii. Expanding Capacity

404. The management of Covid-19 in Primary Care resulted in many changes to General Practice across Northern Ireland. In March 2020, routine General Practice work was adjusted or suspended with some elements of the General Medical Services contract stood down. The Minister approved that the Quality and Outcomes Framework (QOF)[20] activity and reporting be suspended. Enhanced Services[21] activity was also significantly downturned, with no financial detriment to practices, to help ease the burden on General Practice and free up capacity to help manage the potential significantly increased demand [PM/6093 INQ000346777].

[20] The Quality and Outcomes Framework (QOF) is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the equality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

[21] Enhanced Services are part of the General Medical Services contract arrangements. They are services that a GP practice may contract to provide that are beyond the normal scope of essential services or additional services which are designed around the needs of the local population. Enhanced services are delivered in accordance with specifications which require an enhanced level of service provision to that which a practice needs generally to provide in relation to that service or element of service. Enhanced Services are not mandatory and GPs can contract to provide these if they wish.

405. To allow for adequate social distancing, and to maintain effective infection prevention control measures, most practices took the decision, early in the pandemic, to reduce the number of people able to openly walk into General Practice premises. The 'telephone first' consultation process for General Practices enabled patients to continue to seek medical advice from their General Practitioner for both routine and urgent problems with General Practitioners determining the most appropriate approach to safely address the patient's needs. It was anticipated that this approach would prevent many patients attending their General Practice surgery if it was not necessary to do so and help prevent the spread of infection. General Practices also worked with community pharmacies to enable repeat prescriptions to be collected.

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

407. It was recognised, however, that some patients were experiencing problems with contacting their General Practice which caused frustration. In 2020/21, non-recurrent funding of £1.7 million was made available through a General Medical Services Telephony Grant Scheme[22] to enable appropriate telephony and technology to be in put place to support the change in operating model and to help improve demand management, capacity and access to General Practice. Practices could use funding towards purchasing new telephone systems and increasing the number of telephone lines into their surgery, with specific emphasis on making telephone lines available for staff in nursing homes, pharmacies and laboratory services in the local Health and Social Care Trust areas. In 2020/21, 277 Practices (out of 321) availed of the said scheme.

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

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

was in addition to the £1.7 million of funding in 2020/21. Announcing the additional investment, the Minister for Health noted that work was underway on several fronts to help improve access to primary care services for patients, including how telephony could be better used to support services [PM/6094 INQ000348853].

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

410. As well as General Practices, other members of practice staff, such as General Practice Pharmacists and practice nurses, were also a key part of the response of Primary Care to the pandemic. In General Practice Federation areas where there were Primary Care Multi-disciplinary teams, those staff also played an important role in providing patient care and support.

411. The establishment of Primary Care Covid-19 centres also helped to safeguard primary care capacity and preserve essential General Practice services. By creating separate primary care-based provision for 'Covid' and 'non Covid' patients, this aimed to help General Practice to respond to patients' needs and reduce the risks of cross contamination and infection.

iv. Primary Care Covid-19 Centres

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

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

Altnagelvin Area Hospital, Londonderry on 25 March 2020 with the network of Covid-19 centres fully up and running by Thursday 9 April 2020.

414. The Northern Ireland General Practitioners' Committee and the Royal College of General Practitioners' Northern Ireland were represented on the Project Board, chaired by the Head of General Medical Services within the then Health and Social Care Board, that oversaw the running of the centres, with staffing of the centres managed locally by General Practice Federations in line with demand.

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

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

416. An arrangement was agreed that practices would engage in their share of Covid-19 centre rotas. This was as a result of negotiations with General Practice representatives that saw the standing down of elements of the General Medical Services Contract with no financial detriment to practices as noted above. A small number of General Practices expressed concern about participation in the Covid-19 centres, noting the impact this might have on their own practice's resourcing and/or because they felt they were able to implement bespoke arrangements in their own practice to be able to separate 'Covid' and 'non-Covid' patients. The Department sought to reassure those practices that there was a need for General Practices to support the Covid centres to

ensure that those patients who were Covid symptomatic could be quickly and safely assessed [PM/6095 **INQ000477512** PM/6063 INQ000346743].

417. General Practices worked with their local General Practice Federation to ensure appropriate staffing cover for Covid centres was maintained in response to local demand. As the rate of infection fell and vaccination rolled out, the requirement on General Practitioners' participation reduced.

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

v. GP Referrals

419. In terms of diagnoses, General Practitioners were still expected to clinically assess for risk of serious illness and refer as clinically appropriate for diagnostic tests, to specialist services such as an Outpatient clinic, and through red flag referrals to Secondary Care for suspected cancers, as they had always done.

420. The information below indicates the number of General Practitioner referrals for a first outpatient appointment with a consultant led service each year from 2018 to 2022. It should be noted that this data is not validated with Health and Social Care Trusts. The Department does not hold any information on the reasons for changes in the number of referrals.

General Practitioner referrals to first outpatient appointment (Consultant led)

Year	Number of Referrals
2018	414,831
2019	408,153
2020	291,466
2021	350,492
2022	374,800

vi. 'COVIDCare NI' Self-Diagnosis Tool

421. The 'COVIDCare NI' solution was a self-diagnosis tool, providing Covid advice on self-care or when to seek a clinical consultation. There was a website with an online

symptom checker and an app, with a 'chatbot' solution that answered general queries about Covid. The app was designed and delivered in just 14 days. The diagnosis algorithm was developed and deployed on call scripts for the NI 111 Pandemic Helpline. It was the first symptom checker launched in the UK and was launched second in the world, by four days, on the 27th of March 2020 (four days behind the US CDC app – developed by Apple).

422. Prior to the app's introduction, the Pandemic Helpline was managing over 6000 calls daily. After the app was introduced on 27th of March 2020, that level of calls dropped to below 1000 calls per day. The app managed 6000 daily citizen journeys during the peak of the pandemic, demonstrating a clear digital shift. Only 13% of those checking Covid symptoms were recommended to seek clinical assessment (87% being advised to self-manage). That was a significant contribution to alleviating pressure on frontline services.

7. Northern Ireland Ambulance Services

i. Changes to 999 capacity

423. The Department does not hold information on the number of emergency ambulances; the number of 999 calls made, nor the expansion and changes to 999 capacity.

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

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

425. Additional costs in relation to the pandemic were identified through normal financial management arrangements, under the leadership of the NIAS Director of Finance, which identified additional costs being incurred. These were shared regionally by the

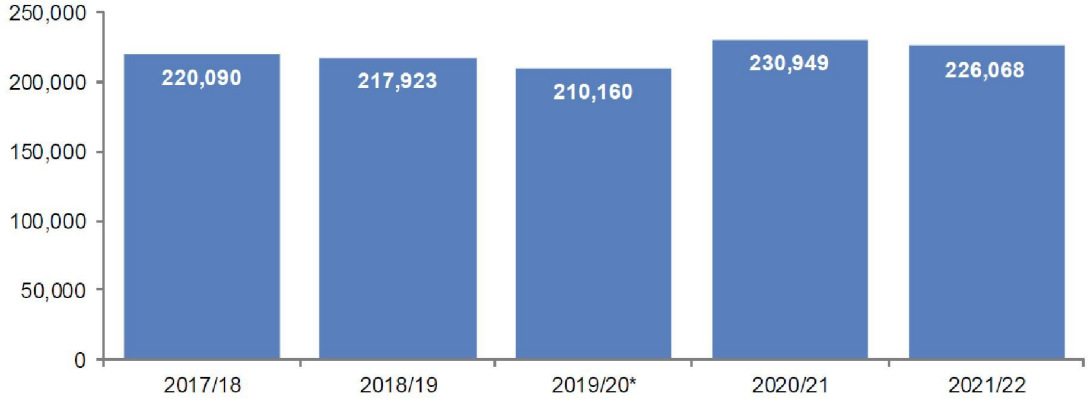
NIAS Director of Finance and six key areas in respect of Covid funding were agreed with DoH and SPPG and Trusts - Workforce, Service Delivery, Infrastructure, Equipment and Supply, Digital and Communications and Corporate.

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

ii. Changes in the number of 999 calls

427. Due to the introduction of a revised clinical response model by the Northern Ireland Ambulance Service on 12 November 2019, it is not possible to provide comparative information on 999 calls made to the Northern Ireland Ambulance Service. We can, however, provide information on the number of calls (urgent and non-urgent) received by the Northern Ireland Ambulance Service for each of the last five years (chart below), which indicates that it received a slightly higher number of calls in both 2020/21 and 2021/22 than in previous years. It should be noted, however, that information reported for 2019/20 is not directly comparable as it excludes activity for November 2019, during which time the Northern Ireland Ambulance Service was reconfiguring its service.

Number of Calls (Urgent / Non-Urgent) Received by the Northern Ireland Ambulance Service (2017/18 – 2021/22)



428. Following the introduction of a revised clinical response model in November 2019, the way in which calls received by the Northern Ireland Ambulance Service were categorised changed, as did the target times for each category of call. Further information on these changes, including the number of calls received and response times for each category of call by month from April 2020 to March 2022 is detailed from

pages 30 to 41 of the Hospital Statistics: Emergency Care Activity publication for 2021/22[23] [PM/6097 INQ000346780].

429. In general, there was an increase in the number of Category 1 (Immediately life threatening for a response to arrive at the scene), Category 1T (immediately life threatening requiring a vehicle to transport a patient to arrive at the scene) and Category 2 (Emergency calls which are potentially serious) calls during each month of 2021/22 when compared with 2020/21.

430. Between April 2020 and March 2022, the mean and 95th percentile targets for Category 1 and Category 2 calls were not met during any month. However, during this period the mean and 95th percentile targets for Category 1T calls were achieved during each month.

8. Medicine Shortage

431. In global medicines supply chains, problems can and do arise for a variety of reasons including manufacturing issues, access to raw ingredients, batch failures and regulatory intervention. This can sometimes lead to supply problems with medicines that require United Kingdom-wide management, as well as local collaboration across health and social care to help mitigate the risk affecting patients. These issues can occur for reasons aside from the Covid-19 pandemic.

432. The Department of Health and Social Care Medicines Supply Team has overall responsibility for maintaining the continuity of medicines supply to the United Kingdom and leads on the identification and management of medicines shortages issues, working in partnership with officials in the Department of Health in Northern Ireland and the other United Kingdom administrations to ensure co-ordinated management of medicines supply issues across all parts of the United Kingdom.

433. Under Part 6 of the Health Service Products (Provision and Disclosure of Information) Regulations 2018, medicines manufacturers are legally required to provide information to the DHSC Medicines Supply Team about availability of UK licensed medicines and about discontinuation or anticipated supply shortages. These requirements ensure that the DHSC Medicines Supply Team have relevant information from manufacturers

[23] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-emergency-care-21-22.pdf

at the earliest point to help manage supply shortages and mitigate any potential impacts on patients. These requirements were in place both before and during the COVID-19 pandemic, and supported mitigation of medicine shortages that arose during the pandemic, including shortages occurring due to increased demand arising from the pandemic as well as shortages occurring for reasons unrelated to the pandemic.

434. As was the case prior to the pandemic, medicines shortages arose throughout the pandemic. The Department of Health and Social Care typically actively manage upwards of 100 medicine supply issues at any one time, with issues arising due to a wide range of factors including manufacturing or regulatory issues, and with varying impact on the healthcare system depending on the product affected, duration of the shortage and availability of alternative products. Full details of the specific reasons for all medicines shortages and why efforts to maintain supply failed are not routinely shared with the Department and the other devolved administrations, however DHSC may share information about high impact shortages with the devolved administrations where necessary to facilitate a UK-wide approach to management.

i. European Union Exit

435. In August 2018 Department of Health and Social Care established a Medicines Supply Contingency Planning Programme to work with the pharmaceutical industry to mitigate against risks to the continuity of medicines supply arising from the United Kingdom's exit from the European Union. Medicines supply chains are United Kingdom wide and so engagement was based on securing supplies for the whole of the United Kingdom. From August 2018, Departmental officials worked collaboratively with Department of Health and Social Care officials to represent Northern Ireland's interests in the Medicines Supply Contingency Planning Programme, including sharing information relating to Health and Social Care medicines usage and engagement in regular information sharing update meetings led by Department of Health and Social Care officials.

436. Working closely with the pharmaceutical industry, a multi-layered approach to continuity of supply was implemented at United Kingdom level including stockpiling approximately 6 weeks' worth of medicines and medical supplies, supporting trader readiness for new border checks, rerouting shipments away from the English Channel short strait crossings, securing additional freight capacity, and developing enhanced United Kingdom-wide arrangements for managing medicines shortages.

437. The Department of Health and Social Care Medicines Supply Team is supported by a clinically led United Kingdom Medicines Shortage Response Group which was established in January 2019 as part of enhanced national arrangements established to monitor the medicines supply chain, identify issues and manage shortages that arise. The Medicines Shortage Response Group was established in January 2019 and has met fortnightly since then, and additional ad hoc meetings are called, if urgently required. It leads on the management and escalation of high impact shortages and provides guidance on communications to the health service across the United Kingdom with actions to mitigate the impact on patients. Northern Ireland's interests are represented on this group by the Chief Pharmaceutical Officer's team and the Northern Ireland Medicines Shortages Team based at the Regional Pharmaceutical Procurement Service in Northern Health and Social Care Trust.

438. As part of enhanced shortage management arrangements established as part of the European Union exit preparedness, a Northern Ireland Medicines Shortages Advisory Group, which includes Departmental officials and Health and Social Care pharmacy leads, was also established by the Department in September 2019 to ensure that Health and Social Care in Northern Ireland is positioned to influence and act on local, regional and national shortages and to communicate any associated actions in a timely fashion to ensure implementation at pace. The Northern Ireland Medicines Shortages Advisory Group has met on a fortnightly basis aligned with meetings of the United Kingdom Medicines Shortage Response Group.

ii. Covid-19 measures

439. The Covid-19 pandemic posed many new risks and challenges that the UK had never faced before and some medicines required for the management of patients with Covid-19, came under considerable pressure during the first wave as suppliers struggled to keep up with international demand. This was particularly true of certain medicines used in critical care settings to support mechanical ventilation, end of life care, and antibiotics.

440. The Department actively participated and supported a range of measures were taken at national level, led by the Department of Health and Social Care to maintain supplies of these medicines required for the management of Covid-19 patients during the peak of the pandemic, including:

- Banning parallel exports of these medicines;

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

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

442. For example, supplies of cisatracurium injection, a neuromuscular blocking agent used for intubation of patients undergoing mechanical ventilation in critical care, were temporarily unavailable in April 2020 due to increased demand across the UK. Supplies of alternative neuromuscular blocking agents atracurium and rocuronium were centrally managed by NHS England, working closely with pharmacy procurement leads in the devolved administrations, to allocate the limited supplies across the UK on an equitable basis. A proportion of the limited remaining stocks of atracurium and rocuronium injection in the supply chain was allocated to Northern Ireland on the basis of the Barnett formula, and the Regional Pharmaceutical Procurement Service made allocations to individual Trusts based on modelling data which took account of current stockholding and ICU bed occupancy. This process ensured that HSC Trusts had sufficient stock of these critical medicines to meet immediate needs.

Despite this extensive range of action, additional measures were progressed following the first wave of the pandemic to provide additional assurance to the Minister and Health Service that sufficient supplies of critical medicines were available for the treatment of Covid-19 patients in the event of a further peak of the pandemic. The Department participated in United Kingdom-wide arrangements from July 2020, led by the Department of Health and Social Care, for the procurement and stockpiling of critical medicines to mitigate against the likelihood of medicine shortages should there

be a further Covid-19 pandemic outbreak. These medicines included products used in end of life care, antibiotics, and supportive medicines used in critical care settings for sedation and maintenance of mechanical ventilation.

9. Patient Safety

443. Several Serious Adverse Incidents (SAIs) were reported during the relevant time period, where Covid is referred to within the SAI. The SAIs identified are in relation to areas such as:

- Delay in treatment / diagnosis;
- Staff absences / shortages due to Covid;
- Covid outbreaks, and
- Healthcare associated infections

444. A high-level review of the relevant SAI Notifications received during the relevant time period has not identified any SAIs where patient safety concerns, which related to the implementation of the policy to redirect people with Covid-19 symptoms to seek alternative sources of help rather than attending at the Accident and Emergency department or their general practitioner, were raised. It is, however, important to note that further information may be contained within the SAI final review reports which are produced by HSC Trusts and submitted to the Department (SPPG) at the end of the SAI review process. Assessment of these reports would require an extensive manual review of records which has not been completed.

445. In terms of complaints, the Department (SPPG) as per requirements of the HSC Complaints Procedure received information on closed complaints from Family Practitioner Services (FPS) Practices and Trusts. These FPS complaints have been reviewed. Approximately 95% of these relate to General (Medical) Practice rather than any of the other FPS Services. In the main the complaints were regarding the difficulties and concerns raised by service users in terms of access to services, i.e. trying to get through to their GP Practice – calls not being answered, frustrations with the triage service, having to provide detail they may not otherwise have wished to share with reception staff; and being unable to present to their Practice with worrying symptoms and associated anxieties of not being assessed for a diagnosis during this period. There is the possibility that within these complaints issues of 'patient safety' could have been present. Additional funding to support the purchase of improved telephony services was provided to seek to mitigate these concerns, as described above.

446. In terms of complaints to Trusts, the Department is aware from discussions with the Trusts at the time about the nature of complaints during the Covid-19 pandemic, and the information we received from them, that at the start of the pandemic the complaints mainly were about access to services, impact on planned treatment/diagnostic tests, moving to impact of not being able to visit or be with loved ones when they were dying as the pandemic progressed. Trusts were responsible for addressing any immediate patient safety issues through their governance mechanisms.

E. ADMISSIONS TO AND DISCHARGE FROM HOSPITAL

1. Admissions to Hospital

i. Elective Care

447. The 'Policy Statement for Elective Care Day Procedures' [INQ000276347 (DoH ref: PM2063)] was published on 28 July 2020. Day Procedure Centres are designed to provide a dedicated resource for less complex planned day surgery and procedures. In the summer of 2020, the HSC Rebuilding Management Board started work with the intention of making inroads into reducing the numbers of patients waiting for elective care (building on the prototypes established pre-pandemic). The Elective Care Framework was published by the Department on 15 June 2021 [INQ000348868 (DoH ref: PM3114)] and it committed that Belfast City Hospital and Lagan Valley Hospital would remain as elective ('green') sites, serving the region, with every effort being made to keep elective care services entirely separate from any exposure to Covid-19. While the Department had overall policy lead for the Framework, the HSCB continued to work with Trusts to assess the potential to build on the covid light/green sites and pathways including expanding provision at the current day procedure facilities.

This extensive programme of work was undertaken by Trusts in September 2021 to identify Covid-19 light [PM/6185 INQ000374081], or 'green sites', where designated elective sites would continue to undertake planned surgery safely during the pandemic. These green sites were initially identified in the Belfast City Hospital and Lagan Valley Hospital. In addition, all Health and Social Care Trusts continued to develop 'green pathways' on other sites where elective work could be facilitated (subject to the available workforce and adequate Infection Prevention Control safeguards). Further detail on the provisions made to restore elective treatment is contained in Section I – Healthcare Provision and Treatment.

ii. Critical Care

448. Critical care capacity across the health and social care system was managed throughout the pandemic to ensure that patients could access appropriate levels of critical care in accordance with their clinical needs. This was initially managed by clinicians within the Critical Care Network for Northern Ireland and later by the Critical Care and Respiratory Care Hub (from 5 January 2021) [PM/6186 INQ000276393]. The role of the CCaNNI is described in Section A 4(iv). The approach allowed patients to be managed locally when a bed was available, and a process was put in place to provide a sequence of available beds in order of admission when no bed was available locally, i.e. the next patient requiring critical care would go to the hospital with an

available critical care bed at the top of the agreed list which was updated throughout the day as beds filled or became available.

449. The Sequence of Admissions Process was part of the role of the Core team of the Critical Care and Respiratory Operational Hub. A number of tools were put into place to gather information to inform and aid the Critical Care and Respiratory Hub's collective decision making and proactively manage the transfer of patients from one critical care provider to another [PM/6187 INQ000417350].

450. This sequence of admission process was supported by:

- The available critical care beds on the surge plan which designated beds as covid and non-covid;
- The frequent critical care situation reports completed throughout the day and evening. These reports informed the system of which beds were available and occupied in each unit, and the type of bed occupied ie, covid, non-covid and suspected covid;
- The situation reports also showed which patients /(covid or non-covid) were "en-route" to each hospital and therefore would require a bed;
- The Core Team of the Critical Care and Respiratory Operation Network supported by the Clinical Lead on-call in Belfast City Hospital or the Clinical Lead of the Critical Care Network for Northern Ireland helped maintain the Sequence of Admission List [PM/6188 INQ000417351], and
- A transport Standard Operating Procedure agreed by the Chief Medical Officer and each unit set the principles for patients transferring [PM/6189 INQ000417352].

451. A list which documented the sequence of admission of critical care patients was agreed at the Critical Care and Respiratory Operational Hub meeting each day. This list was updated throughout the next 24 hours as and when further beds were required. The process was managed as close to a "live system" as possible [PM/6190 INQ000377239].

452. To ensure appropriate prioritisation of patients, the Critical Care and Operational Hub Team had access to the on-call consultant in the Belfast Trust (Belfast City Hospital) and the Clinical Lead of Critical Care of the Critical Care Network for Northern Ireland and Hub who worked with them to agree a new sequence as required. This clinical input was also available to provide advice if there were any clinical questions regarding

the transfer or if any further clinical discussion was required. The Critical Care and Operational Hub Team would have received frequent updates throughout the day and night on the admissions and discharges of patient (split by covid and non-covid presentation) within units, and other patient movement, to help inform decisions.

453. It should be noted that each patient on the list was added on the basis of "clinical status permitting". This meant that clinical discussion and agreement was required for each individual before transfer between units. If transfer to the lead unit was not possible (perhaps because they admitted a patient locally and the bed was no longer available) the next unit was approached for transfer. This process started from the commencement of the Critical Care and Respiratory Operational Hub.

454. Importantly, the sequence differentiated between Covid-19 and non-Covid-19 patients reflecting how critical care units had created segregated areas for Covid-19/non-Covid-19 treatment. Patients admitted to hospital were tested at point of entry into a hospital and then moved into a covid, non-covid or suspected covid pathway. This pathway continued into critical care beds.

455. Guidance relevant to GPs was issued by the Department, including CMO letters. Other guidance, such as Infection Prevention and Control (ICP) guidance and vaccination guidance was issued to General Practice by the Public Health Agency. Operational decisions taken on foot of these Departmental guidelines are a matter for the relevant HSC bodies, such as NIAS.

2. Discharge from Hospital

i. Older People, Physical Disability & Sensory Impairment

456. The Covid-19 pandemic had a significant impact across the Health and Social Care system including patient flow and discharge. Hospital discharge delays continued during covid. The reasons for these delays were the same as for discharge delays that happened prior to the pandemic, for example social care related delays due to waiting for a package of domiciliary care to be available, or for the appropriate Care Home placement to be identified. While these reasons were prevalent pre and during the pandemic, the pandemic caused additional complexity within these areas and impacted upon patient flow and discharge due to, for example, reduced staffing availability, isolation within care homes, and Covid outbreaks. Internal delays within the acute sites also continued, for example the organisation of pharmacy/medication

or equipment and transport delays. Additional conversations (and meetings where appropriate, for example with families) were also often necessary to provide reassurance to people in relation to the fear of infection and transmission rates in care home settings.

457. In response to the above various steps were taken by the Department and the Health and Social Care Board, working in collaboration with other Health and Social Care organisations. Health Silver Command meetings oversaw the development of the '*Health and Social Care (NI) Summary Covid-19 Plan*' for the relevant period [PM/6399 **INQ000477546** The importance of hospital discharge was recognised in the Mid-March to Mid-April plan 2020 [PM/6191 INQ000103714] which noted that staff would be re-deployed to support hospital social work teams to facilitate safe discharges and maximise patient flow through the health and social care system. The following measures were put in place:

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

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

459. Guidance that patients discharged from a hospital to a Care Home must be tested for Covid-19 48 hours in advance of discharge, was first set out in Version 3 of the Interim

Protocol for Testing for Covid-19 dated 19 April 2020 [PM/0247 INQ000103724]. Version 3 of the Interim Protocol was communicated to Health and Social Care Trusts on 19 April 2020. A letter dated 25 April 2020 from the Permanent Secretary to Chief Executives (Health and Social Care Trusts, Public Health Agency, Health and Social Care Board, Northern Ireland Ambulance Service, and the Regulation and Quality Improvement Authority) about key changes to testing for Covid-19, also reiterated the requirement for patients discharged from hospital to a care home to be tested 48 hours in advance of discharge. The letter from the Permanent Secretary also advised that all new admissions to care homes from community settings, including from supported living accommodation, were to have their Covid-19 status checked 48 hours before admission to the care home. The same conditions applied to residents admitted to care homes from community settings as applied to patients discharged from hospital to a care home [PM/0136 INQ000145670].

460. Guidance published on the 27 April 2020 (Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland) [PM/0122 INQ000087760] included the updated approach to managing the discharge of patients from hospital to a Care Home. The guidance directed that all patients who were to be discharged from acute hospital care to a Care Home were to be tested 48 hours prior to discharge. In addition, this updated guidance explained that all patients/residents who were to be transferred into a Care Home from any setting, whether that be from hospital, supported living or directly from their own home, would be tested 48 hours prior to admission to the Care Home. This would help Care Home staff to understand each resident's status and to plan their care effectively. The updated guidance clarified that all patients who were discharged from hospitals into Care Homes – whether they had tested negative or not – should be subject to isolation for 14 days.

461. Prior to Covid-19, for a patient to be discharged to a Care Home, the patient/ their family had to consent to admission; be assessed as appropriate and then referred by a hospital social worker to a Care Home. The Care Home then had to assess and be assured that they could meet the needs of the patient in line with their registration requirements from the Regulation and Quality Improvement Authority. This could cause delayed discharges due to working through these processes, and time taken for the identification, and availability, of an appropriate Care Home placement.

462. The 14-day isolation did have an impact on discharge and patient flow from hospitals to Care Homes; however, the Department does not hold specific information regarding

acute discharge delays into care home settings where the delay was due to the requirement to facilitate the 14 day isolation period. Patients and their families were conscious of the requirement to isolate for 14 days after admission, and this impacted their decision-making because of concern that if loved ones went into a care home, family could not have any contact for 14 days. There was also an impact on care home bed availability due to the need for single rooms for isolating residents, or for double rooms to be utilised by one person only, reducing overall capacity. Care Homes also had to take into account additional staffing requirements when they had to care for isolating patients. This combination of factors negatively impacted on discharge/patient flow. A number of Care Homes saw a significant reduction in the number of residents and in their ability to fill beds (for instance, because of isolation requirements or because families were reluctant to place relatives in homes) during the pandemic. A number of measures were therefore put in place to try to ensure key organisations remained viable. Early in the response to the pandemic an income guarantee was put in place for Care Homes, ensuring that where income fell 20% below the previous three month average then HSC Trusts should block purchase 80% of the vacant beds at the regional tariff. The approach was later revised and amended to providing 96% of the pre Covid average payment in April 2021. This approach helped to mitigate the risks associated with a reduction in the number of admissions to a care home following discharges from hospital. The Department engaged on an ongoing basis with the key stakeholders and representatives of the Care Home sector, to seek feedback on service delivery and the challenges faced by the sector. This engagement also tested or gave early warning of new approaches, policies, initiatives, and guidance that the Department was proposing or implementing to respond to, in relation to the impact of the virus on adult social care services.

463. There is no longer a requirement for any resident to isolate on admission but, if they are suspected of having Covid-19, or have been a close contact with someone who has, the care home manager can do a dynamic risk assessment to inform decision making on whether there is a need for the resident to isolate. It is preferred that residents do not isolate rather the home remain vigilant for signs and symptoms and respond appropriately.

ii. Mental Health and Learning Disability Patients

a. Mental Health Patients

464. The Regional Bed Management Protocol for Acute Psychiatric Beds provides the policy context for the transfer of patients between mental health and learning disability hospitals, including detained patients. [PM/6192 INQ000417355] In March 2020, Trusts noted that there was a risk that a Covid positive patient may be transferred (prior to knowing he or she is positive), therefore spreading Covid between hospitals. The Trusts therefore wanted to suspend the protocol, with the result that each Trust would have to provide beds for their own patients [PM/6193 INQ000417356].

465. The Department considered the request on 2 April 2020 and declined the suspension of the protocol [PM/6193 INQ000417356 (as above)]. Psychiatric in-patient bed pressure was very significant at the time, meaning some sites could not provide safe space for their own patients. At the same time, some Trusts only offered a very small number of psychiatric beds, due to bed occupancy rates consistently exceeding 100% meaning fluctuations were difficult to control within the Trust. This could have led to patients who needed to be detained not receiving in-patient care, thus creating a risk of harm, including death, to self or others.

466. However, it was agreed that uncontrolled transfers of psychiatric patients may create undue risks to such patients who were at higher clinical risk of serious consequences of Covid-19. Alternative pathways and mitigating actions were therefore agreed in an amended bed management protocol [PM/6194 INQ000417357].

467. The impact on mental health services did not follow the same pattern as Covid-19 infection rates as peaks in demand for mental health services typically occurred following the surge in infection rates and new cases of Covid-19. As a result, mental health in-patient bed pressures were increasing as the wave 1 Covid infection peak was reducing. In response to this increase in pressures, in July 2020 the Department commissioned a short-term task and finish group to consider immediate actions to mitigate the pressures in Adult acute in-patient services [PM/2102 INQ000276501]. This included creation of a regional bed management system to allow a more agile response to in-patient pressures. On 22 September 2020, Minister Swann approved the establishment of a Regional Mental Health Bed Network. The Department wrote to the Chief Executives of the Health and Social Care Board and Trusts on 8 October 2020 asking for their support and coordination for the implementation of the network

which would be led by the Health and Social Care Board, with the expectation that the network would be up and running by November. The purpose of the network was to provide help and support to the Trusts in improving patient flow and bed management. The proposed structure of the network was a regional manager, 5 Trust coordinators and administration support. Bed pressures continued to be discussed at the Covid-19 Mental Health Reset and Service Recovery Sub- group chaired by the HSCB [See exhibit references PM/6195 INQ000417358; PM/6196 INQ000276431 & PM/6197 INQ000417360].

b. Learning Disabilities

468. In terms of learning disability, the pandemic may have impacted timeframes for individual discharge arrangements from inpatient care as this was dependent on capacity in residential care and supported living. It is difficult to be more precise as there are a number of factors that influence discharge of long-stay patients from inpatient services, including the availability of suitable environments, staffing, transition planning, which all would be impacted by the pandemic and HSC response. It is also important to note long discharge of people with learning disabilities from inpatient care tends to be via individualised accommodation units, rather than congregated settings such as care homes, each placement requires significant planning, adaptation and funding.

469. Throughout the pandemic, the Department provided additional funding to the independent sector [PM/0108 INQ000103686; PM0118 INQ000371513; PM/6198 INQ000371020] to the independent sector (inclusive of residential care, domiciliary care and supported living) to meet the increased costs associated with infection control, to ensure workforce stability, and improve overall resilience of the independent sector thereby enabling the providers to have a continued role in expediting discharge. Financial packages were developed according to service type, i.e. care homes, domiciliary care, supported living, all of which cut across multiple programmes of care; see, further, Section A, Department of Health and Health and Social Care Sector. The purpose of these packages was to address the significant increase in costs faced by the independent sector to continue safe delivery of services. The absence of this funding would have reduced the overall capacity of the sector to provide accommodation based and floating support services, therefore delaying discharges from inpatient services.

iii. Development of Further Guidance

a. Care Home and Domiciliary Sector

470. The Health and Social Care Board developed the 'Northern Ireland Covid-19 Regional Surge Plan for the Domiciliary Care Sector' [PM/6199 INQ000120717] and was also involved in the drafting of regional guidance 'Northern Ireland COVID-19 Regional Surge Plan for the Care Home Sector' [PM/6200 INQ000417363]. This was led by the Public Health Agency and commenced in September 2020. It advised that; '*Care Home residents should not remain in secondary care or hospital care if not clinically appropriate and should return to their home as soon as possible or be in "home-based" care similar to their usual place of residence.*' In addition, the Surge Plan outlined the need for Trusts to; '*Provide guidance on the transfer of residents to and between hospital and from the community into Care Homes to reduce transmission of Covid-19.*'

471. The Health and Social Care Board was represented in the regional Infection Prevention and Control Cell which commenced on 20 March 2020. It was chaired by Executive Director of Nursing, Midwifery and Allied Health Professions, Public Health Agency. It was attended by Infection Prevention and Control Leads in Trusts, the Northern Ireland Ambulance Service, the Regulation Quality and Improvement Authority, the Health and Social Care Board and the Public Health Agency. Meetings were held daily at the beginning of the pandemic reducing to weekly at the end of July 2020. The Infection Prevention and Control Cell was the regional vehicle for providing direction on infection prevention and control such as the Personal Protective Equipment required in the hospital and community setting. Regional policy documents such as those outlined below were shared with the Infection Prevention and Control Cell for expert input. Further information on the Infection Prevention and Control role is contained in Section B – Infection Prevention and Control.

472. The Health and Social Care Board reviewed several regional guidance documents related to hospital discharge and patient flow as follows:

- Covid-19: Guidance for the Domiciliary Care Providers in Northern Ireland - the initial guidance document (Version 1) issued on 10 April 2020 was led by Department Policy teams [PM0172 INQ000120749]. It referenced hospital discharge and advised; '*Trusts should ensure that where individuals who are discharged from hospital have tested positive for Covid-19 or are symptomatic and are in receipt of domiciliary care, that the domiciliary care provider is made*

aware of this, in line with any legislative requirements and guidance about sharing of data and personal information.'

- Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland - the development of this guidance was led by the Department and was updated to include the requirement of a 14-day period of isolation following discharge from hospital, as discussed above;
- Use of Emergency Direct Payments to Assist with Hospital Discharge – this was developed in August 2020 led by the Department [PM/6201 INQ000417364]. The Chief Social Work Officer's letter of 22 December 2020 encouraged Trusts to consider the use of Emergency Direct Payments (EDP) to facilitate the discharge of patients with complex care during the Covid-19 period [PM/6202 INQ000276418]. Direct payments are cash payments made in lieu of social service provision, to individuals who have been assessed as needing services. They increase choice and promotion and provide a more flexible response to meeting the needs of the service user. The use of Emergency Direct Payments during the Covid-19 pandemic to assist with hospital discharge allowed for an initial emergency one-off payment to be made with potential for further payment within an overall total of 12 weeks if necessary. This meant those with complex needs did not need to remain in hospital longer than necessary and any reduction in unnecessary delays would have benefitted acute staff by easing capacity pressures. It also provided those with complex care needs a means for obtaining care and support provision that suited them and their needs, rather than having to wait for a Trust arranged domiciliary care package that may be more restrictive in terms of times and capacity to carry out certain tasks. The use of Direct payments provided an option for non-care staff to care for an individual (relative, friend etc) and receive a payment from the client to do so. This had the potential to avoid the use of domiciliary care provision and could reduce footfall between houses.
- Supported Living Covid-19 Guidance – The development of this guidance was led by the Department. The initial guidance document (Version 1) dated December 2020 [PM/6203 INQ000417366], advises that; '*Trusts must ensure that all individuals discharged from hospital into shared supported living setting are tested for Covid-19. Supported living providers should ensure that support plans are in place to maintain a supportive and planned transfer informed by discussion with the person being discharged, and where appropriate their family and care providers.*'

- Covid-19: Advice for Informal (unpaid) Carers and Young Carers during Covid-19 pandemic - Version 1 dated 9 April 2020 sought to support carers and provide advice in the event of a hospital admission [PM/6204 INQ000417367]. There was also a link within to the Department of Health Visiting Hospitals Guidance of the time which advised; '*To meet the needs of the individual this may necessitate 1 carer/family member for a period per day supporting the patient whilst in hospital.*' This support when available would have contributed to patient flow and communication surrounding discharge as carers/family members supporting the patient when in hospital allowed nursing staff to perform other duties, increased their understanding of the best way to support the patient and assisted in communication around discharge planning thus improving patient flow.

473. The Regional Discharge Group, which focused on hospital discharge, was reconvened in September 2020, having been previously stood down in the initial phase of Covid-19. The Regional Discharge Group (RDG) was set up pre the pandemic as a forum to optimize hospital discharge. It was stood down in the early stages of the pandemic due to the multiple alternative fora that were established, such as surge meetings and daily SITREP meetings to respond to the pandemic. Co-Chaired by the Health and Social Care Board's Director of Social Care and Children's Directorate and the Public Health Agency's Executive Director of Nursing, Midwifery and Allied Health Professions it was attended by Health and Social Care Trusts, the Public Health Agency, Department of Health and the Health and Social Care Board. Due to the Covid-19 issues that were affecting discharge; i.e. patient flow and delayed discharges, as described above at section E 2(i), a decision was made by the Regional Discharge Group in September 2020 to extend the regional Delayed Transfer of Care coding to take account of issues impeding patient flow. Within acute hospital sites there is coding for patients who are medically fit and delayed in their discharge. The codes identify the reason for delay. Coding options were extended to take account of the impact of Covid-19 on discharge. Additional codes were added in or around November 2020 which included testing within the acute setting; Covid-19 outbreaks and patient/family resistance to the discharge option for a Covid-19 specific reason, for example the isolation period in a care home [PM/6205 INQ000417371]. This allowed a regional understanding of the impact of Covid-19 on discharge from acute sites [PM/6400 **INQ000417371** PM/6401 **INQ000477548** PM/640 **INQ000477549** and PM/6403 **INQ000477550**

474. The revised PAS Delayed Transfer of Care Definitions and Guidance document was implemented in NI, in general acute sites, from Monday 2 March 2020, whilst Covid specific codes were implemented across sites from Monday 2 November 2020. A breakdown of the Covid-related Delay codes is attached [PM/6400 **INQ000417371** These codes were then reviewed at a regional workshop held on 2 February 2021. Letters dated 21 September 2020 and 29 December 2020 were issued jointly by the PHA and HSCB under the auspices of the Regional Discharge Group, and which outlined the proposed process for implementing these Delayed Discharge codes, are attached [PM/640 **INQ000477548** and PM/6402 **INQ000477549** Data presenting the use of these Care Homes/Covid-related Delayed Discharge codes in Acute hospitals was then circulated via e-mail in a weekly report from January 2021 to June 2022 to senior management in the PHA and HSCB for assessment and action as appropriate. A copy of this report is attached [PM/6403 **INQ000477550**

475. The Acute Hospital Social Forum was established in September 2018, chaired by Health and Social Care Board and attended by Health and Social Care Trusts. It is the vehicle for sharing good practice and relevant regional guidance. It considers patient flow and discharge issues and intelligence gathered is shared with line management.

476. Communications issued relating to discharge were issued in the early stages of the pandemic from the Health and Social Care Board's Director of Social Care and Children's Services:

- Communication dated 27 March 2020 to Chief Executives of Health and Social Care Trusts [PM/6206 INQ000370972] regarding the allocation of dementia patients to nursing and residential home beds which were currently registered for other purposes. The Department was made aware of difficulties with finding registered dementia beds in nursing homes which could impact significantly on discharge. Given the likely pressure that acute services would be under as the Covid-19 peak approached, it was suggested that rules should be relaxed to allow the placement of dementia/delirium patients into other registered nursing home beds. Given changing the designation of beds in nursing homes would require a variation to their registration, the Department was content for commissioning organisations to place dementia patients into beds currently registered for other purposes provided there was an appropriate analysis of risk and that individuals should be placed only for the duration of the Covid-19 surge; consideration should be given to moving individuals as soon as a registered bed for dementia becomes available; moves between placements

should be limited to an absolute minimum; efforts to find a registered dementia bed should continue once a placement is made and be ongoing until a bed is found; that there was ongoing and active case management; that the care in the setting the individual was placed in was appropriate to need; and that the care provider was involved in the decision making and content with the approach to managing risk. Mitigating factors were outlined as was the remit for the flexibility to apply only to the Covid-19 surge; and

- Communication dated April 2020 to Care Home Registered Providers regarding Hospital Discharge Protocols [PM/6207 INQ000370973]. Within this there is reference to isolation periods and the support of the Regulation and Quality Improvement Authority it is noted; '*There is no expectation that patients are tested for Covid-19 before discharge from hospital to a care home*.'

b. Mental Health and Learning Disabilities

477. Many of the processes and guidance relating to older people also guided services and the Covid-19 response for the Mental Health and Learning Disability services. An existing adult Mental Health sub-group with membership from the Health and Social Care Board, Public Health Agency, Health and Social Care Trusts and Department of Health policy/professional groups was utilised to lead discussions on necessary and proposed changes to service provision, use of Personal Protective Equipment, social distancing, and visiting to Mental Health and Learning Disability wards. These meetings ran from 19 March 20 to 2 July 20 and overlapped / were complemented by other groups such as Mental Health Reset and Service Recovery Sub-Group (19 May 2020 to 23 February 2021, with a total of 22 meetings) and the Covid-19 Regional Mental Health Assistant Director Level Group (1 February 2022 to 8 March 2022, with a total of 5 meetings).

478. The Health and Social Care Board contributed to the production of a number of relevant materials led by the Department which were related to patient flow and discharge such as:

- Final - Addendum Regional Bed Protocol for Acute Psychiatric Beds; [PM/6208 INQ000417374]

- Admission and Care of Residents to care homes during the Covid-19 emergency period paper;

- Protocol for Transfer of Adult Mental Health Patients between Trusts Addendum 20 April 2020; [PM/6209 INQ000417375]

- Children and Adolescent Mental Health Services – Adult Mental Health Service Transitions Addendum April 2020 and

- Health and Social Care Circular Mental Health Capacity Unit 420 Mental Health Order [PM/6210 INQ000417347].

479. The Health and Social Care Board also developed the Northern Ireland Covid-19 Regional Surge Plan for Mental Health and Learning Disability services. This commenced March 2020 and was followed by subsequent Reset and Recovery/Re-build plans with trusts with respect to mental health and learning disability areas respectively [PM/6211 INQ000417376].

F. STAFFING

480. Covid-19 had a direct impact on the availability of Health and Social Care staff, from both contracting Covid-19 and self-isolating due to having been in close contact to others with Covid-19. Aside from this Health and Social Care staff were also absent from work because of routine sickness absence that was compounded by work related stress and exhaustion due to Covid-19. In the management of all types of absence, staff welfare and support always remained fundamental.

481. The peak of the combined Health and Social Care staff absence due to sickness, covid sickness and covid-related self-isolation during the first wave of the pandemic was in the April-June 2020 quarter when the percentage of hours lost was 11.33%. During the second wave, the percentage of hours lost rose to a peak of 9.36% in the October to December 2020 quarter and was 8.61% hours lost in the January to March 2021 quarter[24].

482. In order to support mutual aid and equity of patient care during Covid-19 surges, consideration was given to the parity of nursing within each of the Critical Care Units across the system. This led to the development of a daily nursing sitrep [PM/6170 INQ000417340; PM/6171 INQ000417341; PM/6172 INQ000417343].

483. The nursing sitrep included information on the number of available Critical Care Nurses (CCN) and Registered Nurses (RN) per bed in each unit. The nursing sitrep further provided information on staff absence due to clinical vulnerability, illness or self-isolation. The sitrep provided information which helped to inform decision making relating to, for example, the availability of beds and pressures being experienced by individual units across Northern Ireland.

484. In addition, medical manpower was monitored by the Clinical Lead of the Critical Care Network Northern Ireland and the Critical Care and Respiratory Operational Hub and changes to medical manpower were notified at a daily meeting. Further, the Critical Care and Respiratory Operational Hub and relevant leads received updates from each Trust on staffing availability within respiratory units.

[24] This data is sourced from the Human Resource, Payroll, Travel & Subsistence system (HRPTS).

485. The consideration of the totality of this information enabled oversight of the availability of mutual support and this proved effective when co-ordinating consultant or nurse cover across units, as and when this was required.

1. Workforce Appeals

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

487. Both the Chief Nursing Officer and Chief Social Work Officer made workforce appeals to help increase the numbers of available staff, while the Northern Ireland Social Care Council emailed all staff on the social care register and suspended collection of the annual £30 registration fee to ensure there were no barriers to engagement. Processes for recruiting staff were also streamlined by way of changes to the employment vetting policy. The changes permitted employers to recruit staff quickly to health and social care posts through more limited pre-employment checks in anticipation of staffing pressures [PM/0153 INQ000120734, PM/0154 INQ000120734, PM/0116 INQ000130346, PM/0155 INQ000120735, PM/0157 INQ000130349, PM/0158 INQ000130350, PM/0159 INQ000130351, PM/0135 INQ000130347, PM/0160 INQ000120736, PM/0161 INQ000120737, PM/0162 INQ000120740, PM/0164 INQ000120745]. In support of the policy, the Department introduced the Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 in April 2020. In addition, AccessNI (an arm's length body run by the Department of Justice) put in place an emergency Barred List Check mechanism, which facilitated the safe recruitment of staff more quickly. The temporary policy was stood down when pressures eased in September 2020 and AccessNI closed the Barred List Check scheme around the same time. The Department revoked the Establishment and Agencies (Fitness of Workers) Regulations (Northern Ireland) 2020 in July 2021.

488. The initial Workforce Appeal in March 2020 generated 19,100 formal applications which resulted in 1,702 doctors, nurses and other ancillary staff being successful in their application to work for the health service. In responding to the Covid-19 pandemic and in an effort to address the need for additional staff across Health and Social Care

the Department continued the use of the Health and Social Care Workforce Appeal. The Appeal was in addition to the normal Health and Social Care recruitment; however, it was designed to deliver temporary recruitment through online campaigns with the ability to undertake administration processes at speed and volume. From April 2020, and throughout the second wave, the Workforce Appeal handled almost 60,000 Expressions of Interest, and generated over 35,000 formal applications. This level of interest delivered a total of 5,949 new temporary appointments across the Health and Social Care of which almost 2,800 were health and social care appointments in various disciplines; 78 doctors, 447 nurses, 1353 nursing support, 216 and some 900 appointments covering allied health, pharmacy, social work/care and psychology. The other appointments were non-medical and covered support services including portering, administration and clerical positions.

489. The level of appointments made by the Health and Social Care Trusts were based on demand alongside the specific requirements for the roles which needed to be filled against the available applicants. Candidates may not have been successful in being offered a post or being appointed for a variety of reasons such as the suitability and availability of the candidates may not have always matched the specific requirements of the roles being offered. It was common for candidates only being able to commit to specific hours on specific days which unfortunately did not match the demands of the positions being offered by the Health and Social Care Trusts. Other candidates were seeking permanent employment; however, the Workforce Appeal was always designed with the aim of securing temporary employment in an effort to support the Health and Social Care Trusts through the pandemic. An estimated 20% of applicants either withdrew, declined an appointment, ceased to communicate or were rejected from the Appeal which may have been for one, or a combination of, the reasons set out above. Of the remaining 35,000 applications submitted 5,949 appointments were made, a conversion / success rate of approximately 17%. However, all of the appointments made through the Workforce Appeal played a vital role in assisting the health and social care service to cope with the additional demands placed upon it during the pandemic.

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

2. General Medical Services

i. Retired General Practitioners

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

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

493. In total, sixty returner doctors applied for inclusion on the Northern Ireland Performers List and underwent refresher training.

ii. Indemnity

494. In Northern Ireland, a state-backed indemnity scheme for General Practice is not in place. In response to the pandemic, clinical negligence indemnity arrangements were agreed for General Practice that would cover both existing General Practitioners and General Practitioners who returned to support the response to the pandemic.

495. To ensure that clinical indemnity was not a barrier to anyone assisting with the response to Covid-19, arrangements were put in place to allow for the Department to provide clinical indemnity coverage for activities connected to the care, treatment or diagnostic services provided in response to the Covid-19 pandemic. The indemnity arrangements reflected the principles set out in the Coronavirus Act 2020. For existing General Practitioners, where the individual's existing indemnity arrangement would not cover their additional Covid-related work, or where indemnity would only be available at an additional cost, the Department of Health undertook to provide clinical negligence indemnity to cover this work. The Department provided clinical negligence indemnity

cover for General Practitioners who returned to provide support in response to the Covid-19 emergency [PM/6174 INQ000417345].

496. In addition, early in the pandemic, appraisal and revalidation was suspended for all General Practitioners with arrangements put in place that General Practitioners employed as appraisers would work in clinical sessions at times when they would have been completing appraisals. This suspension continued until 31 December 2020 when General Practitioner appraisal was restarted on a phased basis depending on the individual circumstances of the General Practitioner.

3. Additional Support to Health and Social Care Workers

i. Psychological Support

497. While the Department of Health did not formally monitor the mental health of health and social service staff during the pandemic, as is normal practice, line managers would have highlighted available health and well-being resources to all staff, including talking therapies, escalating concerns where appropriate. On 16 April 2020 the Department launched 'Covid-19 A Framework for Leaders and Managers' [PM/0078 INQ000120708, P, which was a document setting out a range of practical measures to protect the psychological health and wellbeing of Health and Social Care staff and volunteers during the pandemic. The Framework is based on evidence and best practice guidance and is informed by The British Psychological Society Guidance Paper [PM/0080 INQ000390023]. A Staff Wellbeing Working Group was established to oversee service delivery and to review the implementation of the Framework.

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

ii. Financial Support

499. As part of a range of initiatives to support Health and Social Care staff the Department provided funding to reimburse Health and Social Care workers for additional childcare fees incurred because of the pandemic. It was clear that many Health and Social Care workers struggled to cover the cost of childcare during the pandemic, either because

they were required to work additional hours or informal sources of childcare (parents and grandparents in the main) ceased to be available. Other initiatives included the Department providing Health and Social Care Trusts with additional funding for the provision of free canteen services to Health and Social Care staff and the provision of free car parking to Health and Social Care staff.

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

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

iii. Change to terms

502. The Minister also approved a temporary variation of Agenda for Change Terms and Conditions, allowing Health and Social Care Trusts' Band 8a employees (senior managers) to claim overtime from September 2020 to April 2021 [PM/2056 INQ000276339]. This enabled senior management oversight to ensure service delivery over weekends, public holidays etc in the face of ongoing pressure experienced by Health and Social Care Trusts during the second wave.

iv. Immigration Health Surcharge

503. The Immigration Health Surcharge was a contribution towards healthcare costs for those who were applying for an immigration visa to enter the UK. Since July 2020, following a decision by the UK Government, the immigration health surcharge was abolished for all those eligible for a Health and Care Worker visa (or their dependents) being recruited to work across the UK. The Department had little or no involvement in the decision to remove the surcharge and did not see any issue or impact on recruitment across Health and Social Care because of the surcharge being removed.

This was because there was always demand internationally to work within Health and Social Care and, whilst the removal of the surcharge would have had a positive impact as it removed a cost to the applicants, in practical terms, demand from international applicants remained high and in line with pre-pandemic levels.

4. Care Homes

504. Early in the pandemic, Care Home providers identified staffing pressures as an issue. While data from the social care regulator, Northern Ireland Social Care Council, identified that the number of registered social care workers had increased, increased demands across the sector and requirements for self-isolation meant significant challenges remained. The Department therefore took several steps to help address this challenge, including asking Health and Social Care Trusts to step in and provide staff to Care Homes where there were no other options.

505. To help address some of the challenges Health and Social Care Board's Director of Social Services wrote to all Health and Social Care Trusts on 15 April 2020 [PM/0150 INQ000120733], activating a 4 Stage Mutual Aid and Resilience Planning process that ranges from activation of a Home's contingency plans to direct recruitment of volunteers.

506. The Department monitored the position by asking Health and Social Care Trusts for information on the number of shifts they were being asked to help fill by Care Homes [PM/0151 INQ000103708]. The Department established a regular data feed from Care Homes through the submission of the Regulation and Quality Improvement Authority's data returns, which asked Health and Social Care Trusts to RAG (i.e. Red / Amber / Green risk) rate their staffing position. The Department was aware that the position in a single home could change very quickly if there was a significant outbreak. As part of the above information gathering exercise no Trusts raised issues with the Department related to the impact upon hospitals and/or primary care of asking Trusts to provide staff to Care Homes.

507. On 27 April 2020 the Minister announced [PM/0118 INQ000371513] that Health and Social Care Trusts would continue to work in partnership with care home providers to help deal with staff shortages. The Minister confirmed that where people had responded to the Department's Workforce Appeal, those with the right skills would be prioritised for deployment to independent care home providers. He also confirmed that Trust staff had already been redeployed to Care Homes and would continue to be. The

Minister's statement noted that the provision of nursing care was essential, and that those registered nurses who had transferable skills, expert knowledge and experience of caring for older people in a range of other settings should feel encouraged to come forward and play their part in keeping vulnerable people out of hospital and in their own home.

508. Health and Social Care Trusts also stepped in to provide thousands of hours of free staffing time to homes that needed it. By 7 May 2020 one Health and Social Care Trust alone had provided 1,700 hours of staff time. This support included:

- Additional nursing staff to assess and treat residents who had increased health care needs;
- Ward rounds with primary care which involved medical practitioners assessing and recommending treatment and management plans for individual nurses;
- Infection prevention control nurses to support management within the units;
- Social workers supporting family liaison work to maintain good communication between the resident and family members;
- Hospital diversion staff who assessed and treated residents with high complex needs;
- Palliative care staff who supported the treatment and management of resident with end of life care;
- Dementia homes support staff who provided guidance and direct care to residents with complex needs associated with their dementia, and
- Provision of deep cleaning services

509. As a core element of the overall strategy to mitigate infection in care homes Health and Social Care Trusts were also asked to ensure staff did not move between homes, given the risks of transferring infection.

510. The Department also re-prioritised professional staff from arms lengths bodies to provide direct support to or in Care Homes[25]. This was additional to the support already provided by Health and Social Care Trust staff to Care Homes in their areas on infection prevention and control. In addition, the Department worked with regulators such as the Northern Ireland Social Care Council and with the universities to help

[25] The Regulation and Quality Improvement Authority set up a Services Support Team to provide advice, guidance and an accessible avenue for any queries / concerns during Covid-19.

social work students, nursing students and medical students to qualify early, allowing them to enter the workforce early and boost staffing numbers [INQ000103640].

511. The Department also recognised that staff retention and wellbeing was an important issue and ensured independent sector social care staff had access to Trust wellbeing helplines and other support services. Further, the Department was supportive of a proposal from the Public Health Agency to fund the creation of rainbow rooms [PM/0165 INQ000103710]. A Rainbow Room was a space for care home staff to go for solace when the pressures of dealing with coronavirus became too much. The proposal was to support the delivery of a Rainbow Room resource box to all 483 care homes in Northern Ireland from July 2020. The boxes were filled with information and advice on health and wellbeing issues to support staff as well as activity packs, toiletries, water bottles, tea, coffee and snacks [PM/6175 INQ000417346]. The Public Health Agency should be able to provide any further information required.

512. In an urgent written statement on 30 October 2020 [PM/2054 INQ000371365], the Minister reported to the Assembly that the Health and Social Care system and its dedicated staff remained under intense and unprecedented pressure. The welfare of patients, both Covid and non-Covid, and of staff continued to be the overriding priority. Many staff were physically and mentally exhausted and the welfare of staff was at the forefront of the Minister's mind as next steps for Non-Pharmaceutical Interventions after 13 November 2020 were considered by the Executive.

5. Testing for Healthcare Workers

513. In the Department's view the level to which the availability of Covid-19 testing impacted on the availability of healthcare workers to work in face-to-face settings is not clear. Indeed, the Department has interrogated relevant sources and there is no record which relates to the impact that the availability of testing had on the availability of healthcare workers to work in face-to-face settings. While testing capacity more generally was constrained early in the pandemic, available testing capacity was prioritised early on to protect the sickest and most vulnerable and those healthcare workers caring for them.

514. The approach to the management of self-isolation of cases, suspected cases and contacts who were healthcare staff was by necessity precautionary and was a contributing factor impacting the availability of staff.

i. Testing Capacity

515. Whilst Covid-19 tests were developed rapidly, the time taken to scale up testing capacity early in the pandemic in particular was at times significant, largely impacted by global supply chain challenges in relation to the availability of reagents and other consumables.

516. The impact of this meant that, early on in the pandemic, testing was primarily targeted at protecting the sickest individuals requiring inpatient care and those caring for them. This was reflected in the Department's Covid-19 Testing Strategy [PM/0055 INQ000103650] and the earliest versions of the Department's Interim Protocol on Testing [PM/0056 INQ000120705] and PM/0247 INQ000103724]. The Department of Health was early to put in place a protocol to guide the targeted and prioritised use of available Covid-19 testing resources. The first version of the Interim Protocol on Testing dated 19 March 2020 set out priority groups for testing and acknowledged a need for an approach which supported testing healthcare workers under certain conditions. Healthcare workers prioritised for Covid-19 testing included those who were providing frontline patient facing clinical care. [PM/0056 INQ000120705]. The Interim Protocol on Testing was kept under continuous review with priority groups for testing extended regularly – including greater testing of healthcare staff - in line with emerging scientific evidence and with expansions in testing capacity.

517. The Department worked hard to rapidly build testing capacity. We increased our testing capacity significantly through the formation of new partnerships to deliver on this, both locally (through the Northern Ireland Covid-19 Testing Scientific Advisory Consortium established at the request of the Chief Medical Officer and which comprised both Universities in Northern Ireland, the Agri-Food Biosciences Institute and the ALMAC Group to boost local Northern Ireland based testing capacity - referred to as 'pillar 1'), and nationally (testing capacity increased significantly with the establishment of 'pillar 2' testing as part of the United Kingdom National Testing Programme).

ii. Management of Self-Isolation of Healthcare Staff

518. In the earlier phases of the pandemic, when there was a limit on the information that was available about the Covid-19 virus to guide the public health response, a precautionary approach was taken to the management of self-isolation of cases, suspected cases and contacts who were healthcare staff. This was in keeping with

established public health principles underpinning the management and handling of cases and contacts.

519. This approach was considered proportionate and commensurate given that healthcare staff were often working in inherently higher risk settings and caring for the most clinically vulnerable patients and service users.

520. The approach to the management of self-isolation of healthcare staff was kept under review and was refreshed a number of times throughout the pandemic as more became known about the virus, in response to changing epidemiology, and as the wider public health risk posed by the virus evolved and lessened with the implementation of the Covid-19 vaccination programme and the availability of new Covid-19 treatments.

521. Advice for healthcare workers that they could leave isolation after testing negative ('Test to release') came much later as the science of the virus was better understood. This happened in line with evolving national scientific understanding and evidence base and, in broad terms, in line with the other UK nations.

522. In respect of the four primary care services (general practice, community pharmacy, dentistry and optometry), the providers employ their own staff and the former Health and Social Care Board, now SPPG in the Department, does not keep staff records. Therefore, the Department cannot advise whether the availability of healthcare workers in HSC was reduced during the pandemic. In terms of General Practice, as the staff are employed by the Practice, the former Health and Social Care Board, now SPPG in the Department, does not keep absence records. Each Practice is required to have a business continuity plan which they would have implemented in the case of staffing being significantly affected by the impact of Covid-19.

523. As the Department is unsighted on the reduced levels of availability of healthcare workers it is not possible to accurately assess the impact that this reduction may have had on care or capacity to provide care. Given that the former Health and Social Care Board, now SPPG in the Department, does not keep records of staff shortages, it is also not possible to assess whether there were areas of the HSC, whether by geographical location, specialism or otherwise, that suffered any significantly greater reduction in the availability of healthcare workers.

G. MEDICAL EQUIPMENT

1. Ventilators

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

525. In March 2020 Trusts initially estimated that there was a need for 40 additional mechanical ventilators (30 adult units and 10 paediatric units) to bring the total available ventilators in Northern Ireland to 179 by the end of March. While Trusts had initially estimated their need as 40, further work was underway by the Trusts and CCaNNI, to scope the full extent of critical care equipment that may have been needed to be purchased to ensure that Northern Ireland could respond to the potential number of people who would need such specialised care. This fed into a costed proposal from Health Silver, received by the Department on 19 March 2020, which was based on the advice of the clinical lead for CCaNNI), and proposed an additional 100 ventilators. The Department approved the spend for a further additional 100 ventilators and other equipment for critical care and respiratory services in preparation for the first wave of Covid. The costed proposal and approvals from DoH are referenced in an update submission to the Minister dated 15 April 2020 [PM/6222 INQ000417498].

i. Stock

526. This submission [PM/6222 INQ000417498] also provided advice to the Health Minister on ventilators and other respiratory equipment in stock, and on order, across the Northern Ireland Health and Social Care system, through either Health and Social Care supply chains or a new United Kingdom national allocation programme. At that time the Minister was advised that there were 188 adult mechanical ventilators across 10 hospital sites and a further 9 portable ventilators for use during patient transfers between critical care units. Based on the advice of the Northern Ireland Critical Care Network (CCaNNI), the Health Minister was advised that there was currently sufficient capacity, equipment and oxygen across the Health and Social Care system in Northern Ireland to provide critical care and respiratory services for those who currently needed it. As of the morning of 15 April 2020 there were 39 ventilated Covid patients (including 3 suspected cases) and 4 non-ventilated Covid patients occupying critical care beds across Northern Ireland.

527. Annex A to the submission provided the Health Minister with explanatory advice regarding the terminology and types of respiratory equipment used to provide care for Covid-19 patients (in addition to mechanical ventilators), how and when these are deployed, including the benefits and disadvantages of each These included forms of non-invasive ventilation such as continuous positive airways pressure (CPAP), as well as the use of High Flow Nasal Oxygen (HFNO) and anaesthetic machines.

528. The submission noted that the current stock of 188 ventilators included 33 mechanical ventilators which had been ordered by Health and Social Care Trusts prior to surge planning and subsequently received (this was part of routine equipment replacement), as well as 21 reconditioned mechanical ventilators which had been provided to Belfast City Hospital during April 2020 by a local supplier based in Northern Ireland. The submission noted that a further two reconditioned units were expected to be delivered to Altnagelvin Hospital during that week. The submission also noted that a further 7 paediatric ventilators had been ordered and subsequently received, however these were not included in the 188 figure which referred to adult ventilators only.

ii. Increasing Capacity

529. With regard to increasing the Health and Social Care system's capacity for mechanical ventilation and other forms of oxygen support, the submission advised that the latest pandemic modelling as at 14 April 2020 indicated a Reasonable Worst Case Scenario (RWCS) of 90 Covid-19 ventilated critical care beds being required at the peak of the first wave. This was in addition to an estimated ongoing requirement of 35 non-Covid ventilated critical care beds, i.e., a total of 125 mechanically ventilated patients at the peak. The Reasonable Worst Case Scenario suggested that a further 400 Covid-19 patients would simultaneously require oxygen at the peak.

530. Surge plans at that point had been based on the previous modelling estimates from one week prior (7 April 2020) which indicated a more severe Reasonable Worst Case Scenario of 140 Covid plus 35 non-Covid critical care beds, totalling 175. These estimates were uplifted for planning purposes by a margin of 20% to give a target of 210 ventilated critical care beds.

531. The submission noted that further orders were in place with various suppliers which would bring the total to over 400 mechanical ventilators and that these were being actively progressed through Health and Social Care supply chains and a central United Kingdom Government allocation programme. The submission included (at Annex B)

a copy of a costed proposal from Health Silver Command dated 19 March 2020 for ventilators and other respiratory equipment with estimated costs in the region of £12million and noted that the Department's Health Gold Command had confirmed approval to proceed to procurement later that day. It was noted that, in addition to the initial Health Silver proposal, further leads for procuring ventilators had also been pursued where there was reasonable confidence of fulfilling requirements sooner. This included an order placed by PaLS on 30 March 2020 for 200 x Puritan Bennett (PB980) mechanical ventilators through a Republic of Ireland supplier, at a total cost of £5,655,000 – the supplier had indicated that, in light of growing demand, the manufacturer had increased production to a 24/7 operation and intended to release the Northern Ireland order in weekly batches of 50 units.

532. Annex C to the submission provided an update on the current status of orders for ventilators which had been placed with various suppliers and the associated estimated lead times.

533. The submission advised that, despite the revised modelling data indicating a potentially lower demand at the peak, it would be prudent for CCaNNI and PaLS to continually review requirements and to either revise or continue procurement of equipment currently on order, given the potential for further modelling revisions, further waves of transmission, and the lack of certainty from suppliers regarding lead times due to unprecedented global demand.

534. The submission also noted that, whilst there was a need to seek further assurance with regard to the lead times for ventilators and other equipment on order, there were a number of other rate-limiting obstacles to expanding critical care and respiratory care capacity in the event of an extreme surge. These included the current hospital footprint across the Health and Social Care estate, the sustainability of the oxygen infrastructure and supply, and, in particular, the availability of sufficient numbers of medical and nursing staff. The number of staff/workers required per mechanically ventilated patient was not specified in the submission, however it was generally well understood across surge planning discussions that increasing critical care/ventilation capacity would require a commensurate increase in medical and nursing staff as well as additional training particularly for those being redeployed from other parts of the service.

535. The submission advised the Health Minister regarding a national programme for the allocation of critical care equipment, advising that the scheme was managed for the

United Kingdom as a whole by the Department of Health and Social Care (DHSC) in England in conjunction with the Cabinet Office and the Department for Business, Energy and Industrial Strategy (BEIS) in two components: firstly, a central programme of procurement and United Kingdom-wide distribution of stock on an 'on-loan' basis from National Health Service England; and, secondly, a Rapidly Managed Ventilator System (RMVS) challenge to United Kingdom industry.

536. With regard to ensuring sufficient critical care capacity and the awareness of global supply issues for ventilators, the submission noted that Northern Ireland's Chief Medical Officer had highlighted the particular challenges faced in Northern Ireland in discussions with his GB counterparts. In a conference call on 30 March 2020, the four Chief Medical Officers recognised that the ability to transfer Northern Ireland patients to ventilators elsewhere in United Kingdom would be constrained in the event of reaching critical care capacity within the Health and Social Care system. Whilst fully supporting the principle that ventilator capacity should be aligned with patient need and disease activity across the United Kingdom, the Chief Medical Officers agreed that the particular logistical challenges and lead time for deployment to Northern Ireland should be recognised in the operation of the programme.

iii. National Programme

537. Under the first of the national programme's components (a central programme of procurement and United Kingdom-wide distribution of stock) the submission advised that National Health Service England was in the process of procuring a large volume of ventilators, and other equipment, with the intention of allocating this as 'National Health Service loan stock' to devolved nations and crown dependencies on a population basis, i.e. Northern Ireland would be set to receive 2.8% of all stock when received. This was to be shipped in phased consignments through to late May 2020, however distribution would also be prioritised to areas of peak Covid-19 need at the time that goods become available and may be withdrawn or stored in stockpiles when no longer in use. A standard operating procedure had been developed by National Health Service England and shared with Health and Social Care Northern Ireland to help manage and track the stock.

538. Department of Health officials had not been involved from the outset of this programme in decisions around the allocation criteria/process. However, procurement leads from PaLS participated in an initial national telecall on 26 March 2020, along with representatives from National Health Service England, Scotland and Wales, and

reported that Northern Ireland could expect to receive the following equipment based on capitation at 2.8%:

- 196 mechanical ventilators (total 7000);
- 224 NIV (total 8000);
- 154 Oxygen concentrators (total 5500), and
- 644 Monitoring Equipment (23,000).

539. Under the second component of the national programme (a Rapidly Managed Ventilator System (RMVS)) the Health Minister was advised that this was a large scale initiative announced by Health Secretary Matt Hancock on 20 March 2020 which involved 13 different work streams. It was progressing rapidly, with an expectation at that time that in the coming weeks tens of thousands of ventilators and other respiratory equipment would be allocated around the United Kingdom, also as 'National Health Service loan stock'.

iv. Oxygen Supplies

540. An Oxygen Supply Working Group was established on 25 March 2020 within the Health and Social Care Board to oversee and coordinate work in Health and Social Care Trusts to increase oxygen supply capacity in acute hospital sites and community settings (including nursing/residential homes) and ensure it was both sustainable and adequate at times of peak demand. This group met regularly until May 2021. The work of the group was informed by a detailed Department of Health led Covid-19 site assessment of anticipated oxygen supply and demand [PM/6404 **INQ000376949** PM/6405 **INQ000477551** nd PM/6406 **INQ000477552** he assumptions of the Department of Health led Covid-19 surge modelling cell, the Critical Care Draft Surge Plan and data documenting extensive work between Health and Social Care Board, Public Health Agency and Health and Social Care Trusts with suppliers of ventilation equipment to ensure that additional and compatible equipment for mechanical and non-invasive ventilation was ordered and available if and when needed [PM/6223 INQ000417499].

541. In addition to procuring additional respiratory equipment, the submission of 15 April 2020 advised of ongoing work to assess the existing oxygen infrastructure of the major acute facilities to ensure that necessary oxygen capacity is available in each facility to meet the projected increase in demand. Upgrade works had been undertaken in conjunction with BOC, the regional contactor for bulk oxygen supply, at two sites – the Mater and Belfast City Hospitals – to augment their existing systems to meet planned demand. It was recognised, however, that the oxygen capacity at each facility is a

finite resource and that Health and Social Care Trusts would need to carefully manage oxygen use during the Covid-19 surge. The submission therefore outlined a number of mitigating actions which Trusts had been asked to implement. These included:

- Clear communication channels between Trust clinicians, managers and estates teams in regard to oxygen systems and capacity. This included a designated member of staff with an appropriate level of authority to ensure clear decision making and close collaboration across teams;
- Ongoing monitoring systems for oxygen usage in each Trust site matched to the actual and planned ventilator demand;
- Maintaining a full inventory of all types of ventilators held at each Trust site to allow total ventilator flow rates to be matched with system capacity, and
- Reporting the RAG status of Trust oxygen management as part of the Health Silver Command Delivery Confidence section of the daily SitRep to Department of Health Gold Command.

542. The Health and Social Care Board made arrangements to purchase outsize oxygen cylinders which could be used in case of an oxygen outage in a ward environment where patients were dependent on oxygen. The business case was developed by the respiratory commissioner at the Health and Social Care Board and the clinical lead from the Medicines Optimisation Innovation Centre (MOIC), with advice from the Chief Pharmacist at the Department. The cylinders themselves were kept on a short order arrangement by BOC and trollies and regulators purchased and made available to all Trust sites in case of usage. This equipment was available from June 2020.

543. Further information on the Chief Pharmaceutical Officer's role in ensuring suitable oxygen supply to all sites providing critical care is contained in section D – Capacity.

v. Offers of Assistance

544. The submission also advised the Minister how high volumes of offers of assistance received by the Department since the start of the pandemic were being handled in relation to ventilators and other medical equipment. Where offers were received from existing manufacturers/suppliers they were being considered by CCaNNI and PaLS and pursued where appropriate. Where offers had come from local companies or consortia aiming to pivot their production lines to assist in this area, they had been directed to Invest NI which had agreed to coordinate input from Northern Ireland to the Rapidly Managed Ventilator System challenge.

545. On 30 April 2020 a further Ministerial submission, [PM/6224 INQ000417500], provided the Health Minister with an update on the latest position in relation to the supply of ventilators and respiratory equipment. It confirmed that the total number of mechanical ventilators across Trusts stood at 214, an increase of 17 from the previous reported total of 197 (which included 9 portable devices for patient transportation). Of these 17 additional units, 15 had been allocated by National Health Service England as the Northern Ireland share of national loan stock from the National Ventilator Allocation Programme (NVAP), of which eight had been nationally procured, and seven had come through the Rapidly Managed Ventilator System challenge. The submission noted that other equipment had also been allocated to Northern Ireland through the National Ventilator Allocation Programme including Continuous Positive Airways Pressure machines, patient monitors, video laryngoscopes, O2 concentrators and syringe drivers.

546. The submission reported that the other two additional mechanical ventilators had been received through Health and Social Care supply chains in recent weeks, as well as additional respiratory equipment which included 45 Non-invasive ventilators (out of 175 ordered) and 300 High-Flow Nasal Oxygen (out of 300 ordered) intended for deployment in care home and community settings rather than in critical care units.

547. The submission advised the Minister that, in light of global lead times and latest Northern Ireland modelling data, had revised an order of 200 mechanical ventilators through a Republic of Ireland supplier down to a total of 85 units, with associated costs reducing from £5,655,000 to £1,860,453. Based on updated advice from CCaNNI and PaLS, the submission stated that outstanding orders through Health and Social Care supply chains (i.e. those procured locally outside the National Ventilator Allocation Programme) continued to be pursued with suppliers and were expected to be fulfilled in the weeks ahead; however, it also noted that the global supply chain for mechanical ventilators and other equipment continued to be uncertain regarding lead times.

2. Oximeters

548. In March 2021 the Medicines and Healthcare products Regulatory Agency issued alerts into the accuracy of oximeters varying depending on the skin tone of patients. The Department only became aware of it in March 2021 when the alerts were issued.

549. The Department is not aware of consideration being given to the use of Covid oximetry for home use and did not issue a letter or any guidance on the subject.

3. Critical Care Nurse Staffing

550. Critical care beds are described as Level 2 or Level 3 beds which relates to the level of organ support patients require. Level 3 patients are those requiring invasive ventilation and requiring the highest level of support. Patients are moved between levels as their clinical condition improves or deteriorates. Level 2 and 3 care have different levels of nurse-to-patient ratios in line with accepted national staffing standards. Level 3 beds are nursed at a ratio of 1 nurse to 1 patient and Level 2 beds are nursed at a ratio of 1 nurse to 2 patients.

551. As outlined in the Critical Care Escalation Plans [PM/5037 INQ000188771], it is recognised that the nature and cause of the escalation may have an impact on the number of skilled staff available for critical care. The escalation plans recognised that that although patients will receive as much of their care as possible from experienced critical care staff as the surge escalates, non-critical care staff may be redeployed to assist. When this occurs, additional training would be provided to non-critical care staff redeployed and the staff will also be supervised by experienced staff.

552. On an ongoing basis, the Lead Nurse Group within CCaNNI and the Nurse Education Group work with Trusts in identifying gaps in skills and actioning these either through formal sessions delivered or via members of the multi-disciplinary team locally[26]. Ongoing training is facilitated by Trusts. The Critical Care Network Northern Ireland Escalation Plan also indicated that local arrangements should be put in place to supplement and enhance intensive care medical staff when treating higher number of patients than normal from areas of reduced activity. Ongoing training is facilitated by Trusts.

i. Staffing

553. The role of the Critical Care Network Northern Ireland Education Sub- Group is to identify additional skills that are needed by Non-Critical Care Nurses to work in Critical Care and these arrangements inform skill training for non-critical care nurses.

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[26] There is an education nurse group active in Critical Care Network Northern Ireland that do training modules which cascade down to Trust education leads. Individual Trusts use the resources for training new starts and then another programme to train anaesthetic nurses to work within critical care. This was revised for use during Covid.

554. Nursing numbers can be increased in critical care by:

- Augmenting current staffing levels from areas of reduced activity;
- Redeploying staff with previous experience back to critical care;
- Reduction of normal patient nurse ratios of 1:1 as a last resort, and
- Through Trust continued training programmes based on Skills Framework.

555. Skills documents were refreshed and updated during Covid-19 by the Lead Nurse for Critical Care Network Northern Ireland in conjunction with the Lead Nurse Group and the Education Sub-Group taking account of national recommendations [PM/6225 INQ000417501]. Taking cognisance of National Health Service England publications, and as part of Northern Ireland preparations, the Lead Nurse in the Critical Care Network, in conjunction with Lead Nurses in each of the critical care units in Northern Ireland and the wider critical care network team, developed a paper to determine whether there were likely to be sufficient Critical Care and Non Critical Care Nurses, who were adequately trained, to support the first wave surge plan and also to gauge an agreed position on the 'Nurse to Patient' ratio at each level of surge [PM/6226 INQ000269986]. The paper concluded that:

- There would likely be sufficient Critical Care Nurses in the system to support each level of surge; however, additional nurses may be required for pre-surge. This is not uncommon as this reflects everyday escalation and Trusts increase capacity through Bank and Agency.
- In Medium surge it was recognised that there may be Critical Care Nurse deficits in the system and nurse-to-bed ratios may need to be reduced to that of high surge, i.e. 1:2 to 1:4, however Non-Critical Care Nurse nurse-to-patient ratio should remain at 1:1.

556. The next objective of the process was to scope whether there were adequate Non-Critical Care Nurses in the system that would have had the standard Critical Care Network Northern Ireland upskill training. In this regard over eleven hundred Non-Critical Care Nurses had received the Upskill Training Programme and had access to the associate Skill Acquisition Framework. This number of trained staff would be comparable to the number required for the current level of surge, and at the time of the report training was ongoing. At this time, three hundred and fifty of these trained nurses had already been identified to work under supervision in respective Critical Care Units [PM/6227 INQ000377172].

557. Critical care Staff Monitoring was put in place during second surge to monitor staffing, absences and vacancies and this remained in place and expanded to be provided on a daily basis as part of the role of Critical Care and Respiratory Operational Hub role.

558. Critical Care Network Northern Ireland was asked to capture the experience of Critical Care Nurses following the first wave of the coronavirus pandemic from the Chief Nursing Officer office and carried out a piece of work to do this, identifying areas that needed further exploration and action [PM/6228 INQ000377063].

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: 7 May 2024