Witness Name: ROBIN SWANN, MP

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UK COVID-19 INQUIRY

WITNESS STATEMENT OF:

Robin Swann

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

Department of Health, Northern Ireland

UK COVID-19 PUBLIC INQUIRY

MODULE 7 RULE 9 REQUEST – M7/Swann/01

DEPARTMENT OF HEALTH (NI)

Contents

SCOPE OF THIS STATEMENT 5

A. INTRODUCTION 5

1. Role 5

a. Department of Health 5

b. Ministerial Role 6

c. Leadership and Responsibility for Test, Trace, Isolate 9

2. Chronology of decisions taken by the NI Executive 13

B. TESTING 15

1. Capacity 15

a. Local Testing (Pillar 1) 15

b. National Testing Programme (Pillar 2) 21

c. Groups Prioritised for PCR Testing 35

d. Covid-19 Testing Strategy 38

e. Decision Making 39

f. Actions to address Adequacy of Supply 44

g. Working with Local Councils, Directors of Public Health and Emergency Preparedness Groups 45

h. Liaison with Other UK Nations and Consistency of Approach to Eligibility and Prioritisation 48

C. CONTACT TRACING 49

1. Contract Tracing Service – Test, Trace and Protect 49

a. Strategic Context 49

b. Date of Establishment 51

c. Purpose and Key Functions 54

d. Governance and Accountability and Organisational Structure 56

e. Legacy Operations 60

f. Attendance of Key Individuals at Decision-Making Meetings 60

g. Privacy Considerations 61

h. Communication with other Devolved Nations on the Development of Tracing Apps 62
i. Comparison of other UK and RoI Contact Tracing Models 63
j. Engagement 64
k. NI StopCOVID App and Public Communications 64
D. ISOLATION 64
1. Evolution of the Guidance on Isolation 65
2. Drivers and Evidence Informing the Changes 68
3. Groups Disproportionately Impacted by TTI Isolation Requirements 69
4. Support 71
E. DECISION MAKING STRUCTURES 73
1. Working with Northern Ireland Executive Ministers 73
2. NI Assembly 74
3. Public Health Agency 75
4. HSC Trusts 75
5. The Health and Social Care Board 76
6. Collection and sharing of data 76
7. Data That Was Not Available 80
8. Coordination, Dissemination and Analysis of Data 81
F. PUBLIC COMMUNICATION 83
1. Strategic Context 83
2. Role in Communication 86
3. Role of Executive and Executive Information Service 87
4. Public Health Agency 88
5. Communications Regarding Tracing Requirements and the StopCOVID NI app 88
6. Equalities 88
G. LESSONS LEARNED 95
1. Lessons Learned Exercises 95
a. Rapid Review of the Contact Tracing Service – October 2020 96
b. UK Chief Medical Officers' Technical report on the Covid-19 Pandemic in the UK .. 97

c. Public Health Agency Review Refresh Programme – December 2020 98

2. Personal Reflections 99

STATEMENT OF TRUTH 101

WITNESS STATEMENT OF ROBIN SWANN

1. I, Robin Swann, former Minister of Health for Northern Ireland, make this statement in response to the request from the UK Covid-19 Public Inquiry ("the Inquiry"), dated 10 September 2024 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 7.

SCOPE OF THIS STATEMENT

2. This statement is provided from the perspective of my former role as Minister of Health in relation to the Department of Health's approach to testing, tracing and isolation in Northern Ireland during the Covid-19 pandemic between January 2020 and June 2022. I have provided the information herein to the best of my recollection.

A. INTRODUCTION

1. Role

a. Department of Health

3. A comprehensive description of my overall role and responsibilities as Minister of Health can be found in my statement to Module 3 of the Inquiry [RS7/001 INQ000492281] at sections B (1 and 2). However, in order to give some context, I have provided a brief description of the remit of the Department of Health (DoH), the Department's emergency response role and the role of a Minister of the Northern Ireland (NI) Executive.

4. The Department of Health's operational decision-making remit, and therefore mine, at the time, covers policy and legislation relating to:
    - Health and social care - this includes hospitals, family practitioner services, community health and personal social services;
    - Public health - to promote and protect the health and wellbeing of the population of Northern Ireland, and
    - Public safety - this covers fire and rescue services.

5. In April 2010, in line with Cabinet Office best practice guidance, the Department defined its Lead Government Department role [RS7/002 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.

6. The Civil Contingencies Framework for NI (2011) [RS7/003 INQ000086932], published by TEO, also required the Department to maintain, review and update its Emergency Response Plan (ERP) [RS7/004 INQ000184662] and to test and exercise the plan's 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, for which 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[1] and Arm's Length Bodies (ALBs) in response to emergencies for which it had been designated lead. In such circumstances, the Health Minister is required to lead, direct and co-ordinate the response for NI, reporting as necessary to the NI Executive under the Northern Ireland Central Crisis Management Arrangements (NICCMA) Protocol [RS7/005 INQ000103601] when an emergency has been categorised as Serious or Catastrophic and requires a cross-departmental or cross-governmental response.

7. 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 (ERP) 2019, and 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. This ERP was reviewed and updated in 2024 [RS7/006 INQ000503896].

b. Ministerial Role

8. In a ministerial role, a Minister will exercise the functions assigned to the ministerial office that they hold and have full executive authority within any broad programme agreed to by the Northern Ireland Executive and endorsed by the Northern Ireland Assembly. Ministers are expected to act in accordance with the Northern Ireland Executive Ministerial Code [RS7/007 INQ000262764] and the functions of a department are, at all times, exercised

[1]Health and Social Care Board (dissolved April 2022) Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency; Northern Ireland Guardian ad Litem Agency, Northern Ireland Social Care Council, Northern Ireland Fire and Rescue Service (NIFRS); Northern Ireland Practice and Education Council; Public Health Agency (PHA); Business Services Organisation (BUSINESS SERVICES ORGANISATION); Patient and Client Council (PCC); Northern Ireland Ambulance Service (NIAS); Western Health and Social Care Trust (WHSCT); South Eastern Health and Social Care Trust (SEHSCT); Belfast Health and Social Care Trust (BHSCT); Southern Health and Social Care Trust (SHSCT); Northern Health and Social Care Trust (NHSCT); Regulation and Quality Improvement Authority (RQIA)

subject to the minister's direction and control as per Article 4 of The Departments (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. As Minister of Health for Northern Ireland both health and social care were my responsibility.

9. As mentioned above, as Minister of Health, I was required to lead, direct and co-ordinate the health response for Northern Ireland during the Covid-19 pandemic, reporting as necessary to the NI Executive under the Northern Ireland Central Crisis Management Arrangements (NICCMA) Protocol [RS7/005 INQ000103601]. In this role my responsibilities included the regulations made in response to the Covid-19 pandemic (discussed further below), test, trace and protect policy and strategy (except in those areas set out immediately below), oversight of the healthcare response to the pandemic, including the establishment of Nightingale hospitals, guidance in relation to shielding, guidance in relation to deaths and the development and roll out of the vaccination programme.

10. An Executive paper brought by the First and deputy First Minister on 14 May identified that if regulations were needed to require people arriving in the UK to make declarations and self-isolate, they would be made under the Coronavirus Act. Section 48 of and Schedule 18 to the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health alone to make regulations in response to the Covid-19 pandemic. However, policy in this area was brought to the Executive Committee for discussion, consideration and agreement (see further detail below). For example, I asked for the Executive Committee's agreement on the Department's reviews of International Travel Regulations; agreement to implement a system of pre-departure and post-arrival testing for all international arrivals to NI; the need for the completion of a passenger locator form; and the enforcement of these measures.

11. Within the scope of Module 7, I was responsible for setting policy in relation to the isolation of those with symptoms, suspected cases, positive cases and close contacts. However, the Department for Communities (DfC) had the lead role in providing support for those that were self-isolating, including the provision of financial support through its Discretionary Support Scheme.

12. It is pertinent here to explain how ministers receive information and make decisions in Northern Ireland. Typically, submissions are sent from officials setting out the background

to the issue and making recommendations. It is then for the Minister to consider that advice and decide. Submissions are generally cleared by a senior civil servant before a minister receives them; as such, they are not generally documents that can be produced, cleared and decided upon in minutes. During the Covid-19 pandemic there was not always the capacity and time to follow usual procedures and, at times oral updates, either in person, by phone or teleconferencing, proved necessary. The result of this is that there is not always a record of how and when I was informed of changes or of the decision I took (other than the action implementing the decision) and this is evident in some of what I say below.

13. It is also relevant to explain that my decision-making role was limited when the issue had a cross-cutting nature. In such circumstances, paragraph 2.4 of the Ministerial Code requires ministers to bring matters to the Northern Ireland Executive:

> "Any matter which:-
>
> (i) cuts across the responsibilities of two or more Ministers;
>
> (ii) requires agreement on prioritisation;
>
> (iii) requires the adoption of a common position;
>
> (iv) has implications for the Programme for Government;
>
> (v) is significant or controversial and is clearly outside the scope of the agreed programme referred to in paragraph 20 of Strand One of the Agreement;
>
> (vi) is significant or controversial and which has been determined by the First Minister and deputy First Minister acting jointly to be a matter that should be considered by the Executive Committee; or
>
> (vii) relates to a proposal to make a determination, designation or scheme for the provision of financial assistance under the Financial Assistance Act (Northern Ireland) 2009 shall be brought to the attention of the Executive Committee by the responsible Minister to be considered by the Committee.
>
> Regarding (i), Ministers should, in particular, note that:-
>
> - The responsibilities of the First Minister and deputy First Minister include standards in public life, machinery of government (including the Ministerial Code), public appointments policy, EU issues, economic policy, human rights, and equality. Matters under consideration by Northern Ireland Ministers may often cut across these responsibilities.
> - Under Government Accounting Northern Ireland, no expenditure can be properly incurred without the approval of the Department of Finance and Personnel."

14. Given that so many of the actions taken during the pandemic were cross-cutting, affecting all areas of society, I regularly brought papers to the Executive Committee which contained information on 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 (NPIs); the relaxation of NPIs based on the weekly estimates of 'R' (where 'R' is the number of people that one infected person will pass on the virus to, on average); and regular reviews of NI specific modelling. While section 48 of and Schedule 18 to the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health alone to make regulations in response to the Covid-19 pandemic, the responsibility for decisions to introduce statutory NPIs lay with the Executive, as these restrictive measures impacted across the wider society and economy of NI and therefore were significant, controversial and cut across the responsibilities of two or more Ministers. At all times the advantages and disadvantages of proposed changes were subject to detailed debate, as evidenced by the handwritten notes of the Executive meetings [RS7/008 INQ000065769].

15. On occasion I made decisions on technical details that arose in the drafting of the Regulations, informed by advice from officials on the practical out working of Executive decisions and how these could be technically translated into workable legal text. In these cases, I wrote to Executive colleagues to advise them of the decision(s) taken. These decisions included, for example, amendments to correct a figure in the regulations, or an anomaly or inconsistency between provisions.

16. In relation to the scope of Module 7, namely Test, Trace and Isolate (TTI), I set the overall course of the programme and approved strategy and policy decisions. While I regularly updated the Executive on delivery of the programme and policy changes, with a few exceptions set out in the chronology below, the Executive was generally asked to note the changes.

c. Leadership and Responsibility for Test, Trace, Isolate

17. The TTI policy element and an operational aspect. As Health Minister I had, and retained, overall responsibility for the programme, determining the strategic direction and approving policy decisions. I received advice from the Chief Medical Officer (CMO) and Chief Scientific Adviser (CSA) which I carefully considered before taking any decision. Decision-making in relation to policy and strategic aspects of testing and contact tracing remained with my Department throughout the pandemic. The PHA was the lead body responsible for

the operational delivery of both the testing and contact tracing programmes, working with a range of partners for example as part of the National Testing Programme (see further detail below). The Department worked to ensure that strategy and policy decisions were informed at all times by expert professional advice and that all aspects of the TTI policy programme was managed and coordinated. This was achieved through very close working with the PHA who led and coordinated operational delivery.

18. The testing and contact tracing programmes were key strategic elements of the pandemic response and were interdependent and complex programmes which required strategic coordination. I consider that the collaborative way in which the Department and the PHA worked throughout the pandemic in delivering the TTI programme significantly helped meet the unprecedented demands of the pandemic and helped make the most of available experience, skills and expertise. This close joint working I believe had a positive impact in NI.

19. A number of key groups were established to support delivery of TTI including the Test, Trace, Isolate, Protect Strategic Oversight Board (TTP Board), the NI SMART Programme Board, the Contract Tracing Steering Group, the Department's Strategic Intelligence Group (SIG), and the Department's Expert Advisory Group on Testing (EAG-T).

Testing

20. Testing was a key element of the NI response to the pandemic and my Department was responsible for setting all strategic policy in relation to testing for Covid-19. In addition to setting policy, the Department worked through its EAG-T and the PHA to develop advice and guidance in relation to testing at a wider population level. The EAG-T was a Departmental Group which I established at the request of the CMO, that advised on updates to testing strategy and policy throughout the pandemic and helped oversee and coordinated implementation of testing. The advice and guidance produced covered a wide range of sectors including, but not limited to, policy in relation to testing in care homes and other adult social care settings; testing to support clinical pathways in Health and Social Care (HSC) Trust services; testing in schools, schools for children with special educational needs and higher education; workplace testing; and testing to support key workers including healthcare workers. Further detail is provided in Section B below.

Contact Tracing

21. Between February and March 2020, the PHA undertook contact tracing on all cases of Covid-19 under business-as-usual arrangements within its Health Protection function

where it had existing expertise in contact tracing as a routine part of response to public health incidents and outbreaks, such as tuberculosis or pertussis (whooping cough). The PHA was able to use existing structures and capacity because of the relatively small number of cases at that time and its established expertise in risk assessment of incidents and outbreaks. Existing expertise within the PHA and specifically within its Health Protection service was key to test and trace in the very earliest weeks of the pandemic. I understand that similar agencies carried out this role in England, Scotland and Wales in the early phases of the pandemic. On 12 March 2020 contact tracing was paused in line with a decision which was taken by the Cabinet Office Briefing Room Ministerial Meeting (COBR (M)). Contact tracing in NI remained paused until it was reintroduced by the PHA on 27 April 2020, initially through a pilot phase and then with the full launch on 18 May 2020. In the intervening period from 12 March 2020, contact tracing continued in health and social care settings including care homes.

22. My Department retained control of all strategic policy matters in relation to contact tracing throughout the pandemic, and responsibility for these matters was not delegated at any time. Operational and delivery responsibility for the Contact Tracing Service was managed by the PHA. On 1 May 2020, the CMO, with my agreement, established a Contact Tracing Steering Group to oversee the establishment of the Contact Tracing Service and to provide strategic direction for its operation. Dr Elizabeth Mitchell, a former Deputy Chief Medical Officer (DCMO), and Mr Alistair Finlay (Queens University Belfast) were appointed by the Department as joint Chairs of the Steering Group, and the Group reported progress to the Department. The Steering Group was subsequently stood down at the end of September 2020 when operational responsibility for the Contact Tracing Service in its entirety and associated governance and accountability arrangements again transitioned to the PHA as part of their normal line of business (further detail on the Steering Group is set out later). Placing the operational aspect of the Contact Tracing Service in the PHA throughout the pandemic was important as it (the PHA) already had the Health Protection Function which undertook contact tracing as a routine part of responding to public health incidents and outbreaks, hence aligning with existing required experience and expertise.

23. I do not believe it is possible to determine whether this transition had any impact on the effectiveness of TTI. The PHA worked to develop and maintain the Contact Tracing Service, supported by the Department, and there is no doubt in my mind that the service played a critical role in the pandemic response. In general terms, contact tracing is most effective when prevalence and the number of cases are relatively low. While the PHA maintained contact tracing throughout the epidemic, at times of very high prevalence the

efficiency of the service was reduced (see further detail below at section C) and the impact on transmission will likely have been much less. I understand that this is likely to have been similar across all UK nations. Maintenance of the service, however, was important for example in terms of public messaging and perception.

24. The PHA continued to report progress on the operation and performance of the Contact Tracing Service to my Department through oversight arrangements. I received regular updates, and I also provided regular updates to the NI Executive both verbally and in written papers [see for example, RS7/009 INQ000375892]. The CMO and CSA also attended Executive Committee meetings to give verbal updates.

Isolation

25. The Department was responsible for setting strategic policy in NI in relation to the isolation of those with symptoms, suspected cases, positive cases and close contacts. In NI there was not a legal duty to self-isolate for domestic cases and contacts and rules and guidance were classified as "very strong guidance". While DfC had the lead role in supporting those who were isolating, the importance of adherence to advice regarding isolation was promoted by both the Department's own ongoing communication [RS7/010 INQ000371427], and as part of an integrated cross Departmental communications approach, including under the auspices of the NI Executive's COVID-19 Taskforce which formed in February 2021 [RS7/011 INQ000348965]. The PHA also played a key role in this integrated communications approach.

26. There was, however, a legal requirement to self-isolate under the international travel regulations (The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020; The Health Protection (Coronavirus, International Travel and Public Health Advice for Persons Travelling to Northern Ireland) (Amendment) Regulations (Northern Ireland) 2020; The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2021, and The Health Protection (Coronavirus, International Travel, Operator Liability, and Information to Passengers) Regulations (Northern Ireland) 2021). These placed a number of duties on travellers, including a legal requirement to self-isolate depending on the country from which they travelled.

27. I did not have a direct role in the enforcement of these Regulations. UK border policy and operations are UK Government reserved matters, and a fixed penalty notice regime introduced under the Travel regulations was operated by Border Force and enabled its officials to issue fixed penalty notices to those arrivals who did not comply with the

necessary requirements for example in relation to testing packages. Further, PSNI officers were given powers under the regulations to issue fixed penalty notices to those contravening the regulations and were also given powers to direct a person who did not comply with the self-isolation requirements to return to the place of isolation or to remove them to the place of isolation. Isolation, including support for this isolating, is discussed further in Section D below.

2. Chronology of decisions taken by the NI Executive

28. As stated above, other than in the area of International Travel, I set the overall course of the TTI programme and approved policy decisions. While I provided regular updates to the Executive on TTI, these were generally for my ministerial colleagues to note and not to agree and take decisions on. However, on a number of occasions I did ask the Executive to consider, agree and approve proposed changes. From a review of available records, the reasons for requesting the Executive's agreement in these small number of instances is not documented.

29. All decisions taken by the Executive in respect of TTI are listed chronologically below:

- **August 2021:** I submitted a paper on 11 August 2021 which was tabled for discussion at the Executive meeting on the 12 August. It set out advice relating to proposed changes to the management of self-isolation of close contacts of Covid-19 cases who had been fully vaccinated with a MHRA-approved vaccine. I asked that the Executive agree the implementation of a revised approach to self-isolation for close contacts, whereby close contacts would no longer need to self-isolate subject to certain conditions and mitigations being met. This was agreed by the Executive [RS7/012 INQ000531581] and came into effect from 16 August 2021.

- **November 2021:** I issued a paper to the NI Executive dated the 22 November 2021 in relation to additional measures to accompany the introduction of Covid-19 status certification in a domestic setting [see RS7/013 INQ000357313]. The Executive had agreed, at its meeting on the 17 November 2021 [RS7/014 INQ000581142], that the additional measures as outlined in the paper should be taken forward. The paper provided further detail on the proposed changes that I was considering in the approach to the testing regime recommended for individuals (vaccinated and unvaccinated) who were close contacts of confirmed cases of Covid-19. I also recommended measures in respect of promoting Lateral Flow Device (LFD) testing prior to attending a social gathering and increasing the uptake of testing in schools.

- **November/December 2021:** In a paper to the Executive dated 27 November 2021 I set out recommended changes to the testing of close contacts of confirmed Covid-19 cases [RS7/015 INQ000348900]. The paper was tabled for discussion at the NI Executive meeting on the 2 December 2021. The NI Executive was asked to consider and support the changes outlined in the paper to testing arrangements for close contacts of confirmed Covid-19 cases. These included the requirement for fully vaccinated individuals to take a daily LFD test starting as soon as possible following their identification as a close contact until 10 days post exposure, in addition to Polymerase Chain Reaction (PCR) testing requirements; unvaccinated or incompletely vaccinated adults to take a second PCR test on day 8 and to complete a full 10 day period of self-isolation even if the PCR result was negative; and post primary school aged children and young people to be asked to book a second PCR test 8 days after exposure, with the recommendation that they take a daily LFD from the day after their initial negative PCR test until 10 days after the exposure. The proposed changes were agreed by the NI Executive on the 2 December 2021 [RS7/016 INQ000236761].

30. Policy in relation to International Travel was brought to the NI Executive for discussion, consideration and agreement. For example, I asked for the NI Executive's agreement on the Department's reviews of International Travel Regulations; agreement to implement a system of pre-departure and post-arrival testing for all international arrivals to NI; the need for the completion of a passenger locator form; and the enforcement of these measures. There was also a requirement for testing and / or self-isolation for people entering NI, and this too was a matter which the Department referred to the NI Executive for consideration, agreement and approval. I understand that The Executive Office supplied all Executive papers and minutes to the Inquiry for Module 2C and therefore they should be able to provide the relevant information on Executive decisions.

31. In the absence of an identified lead policy department within the NI Executive, my Department agreed to establish an International Travel Directorate within the Chief Medical Officer's Group. This directorate coordinated the review of all relevant papers, information and data which was subsequently reviewed and considered by CMO and CSA to inform advice provided to me and to the NI Executive. The Department's policy development in relation to border health measures including testing, was underpinned by International Travel Regulations, and continued to be guided by information on the risks associated with international travel, provided from UK Government national analysis. Relevant papers underpinning changes to the regulations and testing arrangements were then submitted to the NI Executive. The Department also prepared and made the final regulations which were

considered by the NI Assembly Health Committee. My Department did not have a lead role regarding implementation and enforcement of the policy. My Department did make tests available for use by the public, for example working with local airports to make LFDs available to aid those travelling.

B. TESTING

1. Capacity

Development of Testing Capacity

32. As Health Minister I was responsible for setting the strategic direction of the TTI programme and related policy decisions. This included strategic decisions in relation to where existing capacity should be directed and to developing capacity.

33. I presented the Executive with the Department's first Covid-19 Testing Strategy [RS7/017 INQ000103649] on 6 April 2020. The Strategy explained at paragraph 3.3 that '*Testing [capacity] has been scaled from 40 tests per day in January 2020 and the current capacity is up to 736 tests per day*'. Significant efforts were made by my Department working with a range of partners to develop PCR capacity in NI – this was delivered primarily through two routes: firstly, through the existing NI Health and Social Care laboratory network (often referred to as Pillar 1); and secondly, through NI's participation in the National Testing Programme (often referred to as Pillar 2) which was managed on a UK wide basis by the Department of Health and Social Care (DHSC), and latterly, from its establishment October 2021, by the United Kingdom Health Security Agency (UKHSA). Further detail on how available capacity was prioritised is set out below.

a. Local Testing (Pillar 1)

Laboratory Testing Prior to the Covid-19 Pandemic

34. Prior to the Covid-19 pandemic, each of the five HSC Trusts in NI had its own hospital laboratories (including microbiology and serology capacity). There is also a Regional Virology Laboratory (RVL) and regional services for genetic testing (including pathogen testing for public health purposes) which is based in Belfast HSC Trust. In January 2020, the baseline PCR capacity across all HSC laboratories was the 40 tests per day capacity at the RVL. The RVL is a WHO influenza testing site and provides respiratory virus (and respiratory bacterial and fungal) testing for the region. The ability to provide diagnostics to newly emerging and pandemic potential viruses remains an important component of this RVL service. In addition to our own HSC capacity, NI has well established relationships

with the Public Health Laboratory network in the UK for specialised testing which is not available locally.

35. Local laboratories including the RVL have ability to scale up in the event of a need for increased laboratory testing. There is additional capacity in Queen's University Belfast and in the Agri-Food and Biosciences Institute (AFBI – a Veterinary Service Laboratory), both of which were utilised by the Department during the Covid-19 response. In addition, there is significant private sector capacity (principally in Randox and in Almac, both private companies) which can be utilised to increase testing capacity in the event of public laboratory capacity being insufficient.

36. This local infrastructure was referred to as Pillar 1 testing and was in place prior to my taking up office; therefore, I had no role in establishing it or scaling it up to the pre-pandemic baseline level. Pillar 2 testing refers to testing under the National Testing Programme, which is discussed further below in section B(1)(b).

37. The Department did not define or set numerical targets in relation to the expansion of testing capacity. The general strategic approach in relation to scaling PCR capacity was that it should be scaled as quickly as possible through Pillar 1 including the Academic Consortium and through the Pillar 2 programme until sufficient to meet need. I have set out in later sections how the Department worked with a range of stakeholders to deliver access to PCR and LFD tests for the entire population, and decision making in relation to how available capacity was utilised and prioritised.

38. Initial testing for Covid-19 was carried out using PCR and commenced in NI at RVL on 7 February 2020. This involved testing of suspected cases on a case-by-case basis and close working with the PHA. NI did not have its first confirmed positive result for Covid-19 until 1 March 2020.

Scaling Up

39. In the early weeks following confirmation of the first positive case, when NI had a very small number of imported cases to test, existing PCR capacity in the HSC NI laboratory network was sufficient for diagnostic purposes in meeting early clinical need and epidemiological case definition in the community, and to support intensive contact tracing on the small number of imported cases. Established systems in place at that time, including the ability to share data regarding test results between RVL and PHA to inform public health actions, were sufficient while case numbers were at a low level. However, very quickly, as demand

for testing and case numbers rapidly increased, it became clear that existing capacity and supporting systems and infrastructure were insufficient. As such, it was clear that the existing NI laboratory network was not sufficiently scalable to the surge levels/ periods that would be required during the pandemic and therefore it was necessary to consider ways in which additional capacity could be provided.

40. To assist with rapidly scaling up Covid-19 testing capacity within the HSC and the wide NI laboratory infrastructure, in March 2020 I agreed to a proposal from the CMO that the Department establish an academic consortium to assist in increasing local PCR testing capacity. The academic consortium (known as the Covid-19 Scientific Advisory Consortium) involved the Queen's University Belfast (QUB), the University of Ulster (UU), the Western HSC Trust's Clinical Translational Research and Innovation Centre, the AFBI laboratory (a government laboratory sponsored by the Department of Agriculture Environment and Rural Affairs (DAERA)) and the Almac Group [RS7/018 INQ000530961 and RS7/019 INQ000503827], a commercial laboratory partner. Progress regarding the set up and operationalisation of the additional PCR testing capacity through the Consortium was a regular agenda item at the EAG-T meetings.

41. Further, during the pandemic, the NI Pathology Network, which had been launched in October 2009, established the Pathology Network Covid-19 Testing Group to assist with the planning and coordination of the expansion of Covid-19 testing in HSC laboratories, working with and reporting progress to EAG-T. A number of Network stakeholders were involved in the Group including the Microbiology & Virology and Point of Care Specialty Fora, commissioners, public health leads, Business Services Organisation (BSO) Information Technology Services (ITS) and Belfast Health and Social Care Trust Lab IT leads who supported work on data and connectivity, and BSO Procurement and Logistics Service (PaLS) who provided input on contracting, procurement and logistics. The NI Pathology Network also took the lead role in the coordination of the deployment of the new rapid Covid-19 testing technologies determined to be appropriate for use in Pillar 1 settings – these included LumiraDX, LIAT and SAMBA II.

42. These new technologies offered non laboratory based, point of care testing which was an important factor in increasing testing capacity and were utilised across a range of settings in the hospital network [see for example RS7/020 INQ000381429]. The new technologies were used only in specific use cases and under specific circumstances in line with manufacturers' instructions, and only as agreed by the NI Pathology Network and EAG-T. For example, the LumiraDX test was used in the Emergency Department setting and

permitted medical staff to identify more quickly that a patient did not have the virus, and so improved patient flow in the Emergency Department and the wider hospital system. Following further pilots, from April 2021 LumiraDX was also used in maternity settings and to test patients suitable for discharge.

43. Partnership working through the NI Pathology Network, the Regional Virus Laboratory and the Scientific Advisory Consortium allowed NI to maximise existing testing capabilities using a variety of testing platforms and to standardise testing arrangements. The Consortium was an important factor in increasing Pillar 1 PCR testing capacity, in helping to diversify testing platforms used and to build access to resilient HSC capacity. The Consortium partners worked closely with the EAG-T and in particular with scientists in the RVL to operationalise testing arrangements including validation of testing platforms and to build data sharing arrangements.

44. From a baseline capacity of 40 PCR tests in January 2020, Pillar 1 capacity increased to a highest reported level of 5368 daily tests on 22 July 2022 (which included PCR and testing technologies such as LumiraDX). The NI Pathology Network produced a weekly Pillar 1 Capacity Report for EAG-T which I also received [RS7/021 INQ000530960].

Private Sector Laboratories

45. As described above, there is significant private sector capacity in NI, primarily through Randox and Almac. Almac was contracted as part of the Scientific Advisory Consortium to provide testing from 26 August 2020. While the Department did not contract with the Randox laboratory, I understand it was contracted by the Department of Health and Social Care (DSHC)/ UKHSA as part of the UK National Testing Programme (NTP) to provide significant PCR testing capacity throughout the pandemic, including for NI – more information is provided in Section B(1)(b) below.

46. I agreed with the DAERA Minister that AFBI would undertake testing [RS7/022 INQ000439346, RS7/023 **INQ000530962** and RS7/024 INQ000467709] starting from 21 May 2020. Almac commenced testing on 26 August 2020. Funding to support testing at Almac was provided by the Department of Health. Funding to support testing at AFBI was provided by the Department of Health and DAERA.

47. The contracting arrangements with both AFBI and Almac were put in place by the Belfast HSC Trust, where the RVL was located and who managed testing volumes under the contracts based on need. Contracts were kept under review taking account of a range of

factors for example expanding available capacity in HSC laboratories including RVL, community prevalence, the continuing need for rapid access to additional contingency PCR capacity, and optimising use of capacity offered through the contracts. Taking account of these factors, contracts were extended a number of times at the request of the Department as deemed necessary based on advice from EAGT and RVL. The decision to bring the Consortium on board and to retain contracts was also important as it enabled access to diverse testing platforms used across the Pillar 1 network which helped build access to resilient HSC capacity base. The NI Pathology Network maintained a range of data regarding Pillar 1 testing capacity for PCR and for new testing technologies and this was used to inform capacity optimisation and resilience planning across the Pillar 1 network. This report was provided weekly to EAG-T, to CMO and senior officials in the department and to me.

Laboratory Capacity Increases

48. Other than the baseline capacity of 40 for the RVL prior to the pandemic I do not know the pre-pandemic capacity of the existing laboratories. I only took up post on 11 January 2020 and cannot now recall receiving information on the pre-pandemic capacity of the existing laboratories. However, methods employed to manage scale up capacity have been described in the preceding sections.

Utilisation of Laboratory Capacity

49. In relation to Pillar 1 capacity, the Department put a protocol in place early in the pandemic to guide the targeted and prioritised use of available Covid-19 testing. This was set out in the first version of the Department's Interim Protocol on Testing (IPT) which was dated 19 March 2020 [RS7/025 INQ000120705]. At this time, PCR testing capacity was constrained and as a result testing was primarily targeted in clinical care of the sickest individuals requiring inpatient care, protecting those caring for them, and in the management of outbreaks for example in care homes. The IPT was kept under continuous review by the Department with priority groups for testing extended regularly in line with emerging scientific, clinical and public health evidence and with expansions in testing capacity. Further detail on the prioritisation of capacity and updates to the IPT is set out below

Development of Testing for Variants

50. I understand that the principal method used for testing to confirm Variants of Concern in NI and across the UK, and indeed internationally, was Whole Genome Sequencing (WGS). WGS testing in NI was undertaken on samples from both Pillar 1 and Pillar 2 PCR testing and was undertaken by RVL and Queens University Belfast (QUB).

51. WGS was in place in Northern Ireland from an early stage and was maintained throughout the pandemic. In April 2020, the clinical laboratory team in the RVL initiated a work stream on whole genome sequencing of the SARS-CoV-2 virus, as part of the national COVID-19 Genomics UK Consortium (COG-UK) sequencing programme. NI participated in the development of the COG-UK, the outputs of which informed understanding of variant spread and significance. The data derived from COG-UK was used to help UK Public Health Agencies manage the Covid-19 outbreak in the UK and inform vaccine research efforts. During the pandemic, regular updates were also provided by the UKHSA in relation to new and emerging Variants of Concern and Variants of Interest and were discussed at UK wide scientific meetings in which NI participated (Scientific Advisory Group for Emergencies (SAGE), New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), Senior Clinicians Group) and within NI as appropriate (at SIG, Modelling Group, EAG-T etc).

52. WGS on its own was not sufficient to understand the emergence of new variants or to undertake risk assessments to inform policy responses. WGS was combined with other analyses, including how the virus was behaving in the population, to what extent it was outcompeting other established variants, or escaping previous immunity, and, in particular, the clinical severity of the associated infection. WGS made an important contribution to the overall public health approach taken which was to monitor for the emergence of new variants and to assess their potential significance clinically and from a public health perspective. This assisted in seeking to contain the initial spread of new variants when first detected through local enhanced or surge testing, including the deployment of mobile testing units, and enhanced contact tracing, where appropriate, as undertaken by the PHA. This ensured testing of the greatest number of people who had possibly been exposed, offering isolation and public health advice, and offered the best chance of curbing onward spread.

53. Wastewater sampling (WWS) was also undertaken in NI and helped signal circulation of Covid-19 variants of concern and supported tracking lineages of Covid-19. A full NI surveillance programme was initiated by DAERA commencing in April 2021 (32 wastewater treatment sites, 4 samples per week). In March 2021 I agreed that the Department would support a cross-Departmental 2021/22 funding bid submitted by DAERA, and that DoH officials would engage further with DAERA and other partners to progress the waste water project. The Department then led the programme from September 2021 and I approved further funding to NI Water for the period 31 January 2022 to 31 July 2022. From August

2022, NI's WWS continued with sampling taken twice weekly across 24 treatment sites, until March 2023, when I understand that the Department formally closed the WWS Programme, with any ongoing surveillance then to be taken forward by the Public Health Agency under business-as-usual arrangements [RS7/026 INQ000581144].

54. WWS was not used as a primary resource for variant detection but was triangulated with other data. WWS was also helpful as it gave early warning of circulation of Covid-19 variants of concern. This sampling combined with WGS was used to inform targeted public health responses by the PHA, including for example targeted outbreak testing and assisting in the attempted containment of initial transmission of more transmissible variants. WWS was delivered in NI through collaborative working with a range of partners including the Department, DAERA, the PHA, QUB, the RVL and NI Water [RS7/027 INQ000276620].

55. As Minister, I was aware at a strategic level of arrangements for the delivery of WGS and WWS testing in NI and was provided with relevant updates as necessary throughout the pandemic by officials including CMO and CSA. Regular verbal and written updates were also provided to the NI Executive on the emergence of new variants and their potential significance in terms of community transmission, outbreaks, and hospital pressures [RS7/028 INQ000303969 and RS7/029 INQ000303968]. The analysis of the potential impact of these new variants was contained in the weekly R paper [RS7/030 INQ000411384; RS7/031 INQ000431349] and also informed the advice that the CSA and CMO provided to me and to the NI Executive on Non-Pharmaceutical Interventions (NPIs) and other public health measures.

b. National Testing Programme (Pillar 2)

56. Along with the rest of the UK, NI was part of the NTP from 22 March 2020. Delivery of the NTP in NI was underpinned by a Memorandum of Understanding (MoU) between the Department and the Health Secretary acting through DHSC, England, and then from October 2021, by the UKHSA. Along with the Health Ministers of the other devolved administrations I signed an MoU. I understand that each MoU had minor adjustments to take account of local issues where relevant. I signed the original MoU on 29 April 2021 [RS7/032 INQ000467330] and a revised version on 12 October 2022 [RS7/033 INQ000503807 and RS7/034 INQ000503803].

Membership of the NTP

57. Under the terms of the National Testing Programme MoU, the UKHSA was able to enter into contracts to secure the provision of equipment, goods or services for the NI Health

Service; in a case where the Department requested this and agreed to reimburse UKHSA for same. As such, NI benefitted from a wide range of contracts put in place and managed by UKHSA under the MoU. All supply, procurement and supporting legal, commercial and Value for Money considerations as part of the NTP were undertaken by DHSC colleagues, and latterly UKHSA, on behalf of the devolved administrations, from the initial market approach through to award and monitoring of the contract with the supplier. This includes procurement in relation to antibody testing and all the new emerging testing technologies (including for example LFDs, LAMP, Lumira DX and SAMBA II).

58. The PHA worked closely with DHSC/ UKHSA, and with the local service provider who operated the test sites, to manage and oversee operational delivery. Officials in the Department also worked closely and effectively with both the PHA and with DHSC / UKHSA teams.

59. Testing services enabled in NI through the MoU included for example the set up and operation of the public facing, walk-in PCR test sites and other delivery channels (including mobile testing units; home delivery testing and care home testing through the Satellite Channel). The MoU also provided for procurement and contract management arrangements by DHSC / UKHSA on behalf of NI in relation to all the supporting logistics, distribution, digital infrastructure (test booking and results reporting; and backend data collation and reporting functionality) and the laboratory processing capacity at Lighthouse Laboratories. The vast majority of PCR tests taken by NI citizens were processed at the local Randox laboratory which was contracted by DHSC/ UKHSA as part of the NTP.

60. By April 2020 the NTP had been stood up to provide population testing in NI and across the UK at an unprecedented scale. Testing at the Lighthouse Laboratory provided high throughput PCR test processing at speed, and a digital infrastructure was created to track and locate tests and communicate results, and link to HSC and Contact Tracing records. The first testing centre in NI established as part the NTP opened at the SSE Arena in Belfast on 4 April 2020. Available capacity was initially prioritised for health and social care staff but this was later expanded to include other keyworkers and then, from 18 May 2020, was widened to provide symptomatic testing to the general public [RS/035 INQ000497453]. From that date everyone over the age of five years with symptoms of COVID-19 was eligible for testing. This was the same across the UK.

61. The overall management and monitoring of the PCR capacity allocation across all delivery channels was managed centrally on an ongoing basis by the DHSC / UKHSA teams. The

allocation available to each nation fluctuated over time due to a range of factors, for example the available allocation increased as additional capacity was procured by DHSC / UKHSA and brought online across the network (for example as part of Winter surge planning) and may have decreased, for example if there were processing issues at particular laboratories or if a laboratory contract ceased.

62. I recall one such instance in September 2021, when, in response to increased demand following the return to school, DHSC agreed to enhance NI capacity from a baseline of 15,000 per day to 25,000, which was above the Barnett consequential. This was monitored closely by DHSC / UKHSA colleagues, together with officials from NI, and was returned to baseline levels when the increased demand reduced. This was a particularly good example of the benefits of the NTP operating in practice as a single networked laboratory capacity, overseen and co-ordinated centrally by DHSC / UKHSA, where demand pressures in one nation could be assisted for a short period of time by overall capacity and demand management across the network. I do not consider that there were any drawbacks to the NTP operating in practice as a single networked laboratory capacity; indeed, a clear benefit of it operating in this way was that it allowed central oversight of the system which enabled it to flex, when necessary, as the example above highlights.

Funding Structure

63. The general funding arrangements underpinning the National Testing Programme across the four United Kingdom nations meant that, in summary, NI 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. This meant that, in line with the Barnett formula at the time, NI received a 2.85% population share.

64. In relation to the Pillar 2 National Testing Programme capacity, each devolved administration had access to PCR testing capacity in line with its population share (Barnett) allocation. I therefore had control of how the Barnett share allocation was used in line with policy choices regarding eligibility and prioritisation criteria. The exception to this was the Home Ordering PCR Channel where I understand daily capacity was set and managed at a UK-wide level by DHSC / UKHSA.

65. From 1 April 2021, under the terms of the MoU which I signed and is referenced above, devolved administrations had the ability to opt-in or out of significant procurements (over a

value of £25m threshold) of new testing technologies procured under the NTP (for example, procurement of LFDs or LumiraDX).

66. To support the funding and financial arrangements underpinning the NTP MoU, and in recognition of the complexity, officials in the Department worked with DHSC/ UKHSA to agree Devolved Administration's Financial Guidance [RS7/036 INQ000503801]. In summary, expenditure and funding under the NTP fell under three broad headings:

- UK-wide expenditure, which covered the majority of NTP spend: for example, the networked Lighthouse Laboratory PCR capacity; IT infrastructure costs including the digital booking, ordering and results reporting platforms; and supply chain and logistics costs which involved the end-to-end supply chain across the whole UK, for example, international procurement of LFDs, warehousing and storage of kit and materials, transport and fulfilment to end destination for all PCR and LFD testing throughout the UK, return logistics for PCR tests back to laboratories for processing, and the ancillary services to support IT and people.
- Expenditure that was for England and at least one other devolved administration: for example, the procurement of new testing technologies where a devolved administration opted-in (such as NI opted-in to LumiraDX procurement). The devolved administration element was charged against the year-end financial reconciliation by UKHSA and resulting Budget Cover Transfer (BCT); and
- Expenditure which was England only and therefore attracted a Barnett consequential for devolved administrations in the normal way, for example Contact Tracing and Pillar 1 laboratories in England.

67. The Devolved Administration's Financial Guidance supplemented the NTP MoU and was aimed at ensuring transparency and accuracy around processes for ensuring that appropriate Barnett consequentials from procurements were identified and made available to the devolved administrations. The guidance also helped ensure that the supporting detailed and complex financial reconciliations that underpinned the NTP funding arrangements – which were undertaken and overseen by DHSC/ UKHSA, for example to take account of the financial impacts of DAs opt-in/ out procurement decisions - were transparent. Following these detailed UKHSA reconciliations, Budget Cover Transfers (BCTs) were calculated by UKHSA and transfers made as required in relation to each relevant financial year. Reconciliations were the responsibility of UKHSA. There were ongoing discussions between UKHSA and DAs, including regular update reporting by UKHSA to DAs.

68. As described above, I signed an amended MoU underpinning the NTP on 12 October 2022. One key change in the updated MoU was the revised financial funding arrangements, effective from the start of 2022/23 financial year between the devolved administrations and the UKHSA in relation to the NTP. Departmental officials were involved in discussions and negotiations on these changes and I received updates.

69. These meant that instead of receiving a Barnett share of testing capacity procured by UKHSA as part of a UK-wide programme, devolved administrations could advise the UKHSA of specific requirements in line with each nation's policy requirements. The cost of such services - beyond those which were funded on a UK-wide basis in 2022/23 (one example funded on a UK-wide basis was the decommissioning of Pillar 2 tests sites) - were then reimbursed by the Department directly to UKHSA. The reimbursement amount was accounted for by UKHSA as part of its financial reconciliation processes and resulting BCTs. There was no change to procurement and contract management of services, all of which continued under the NTP to be undertaken by UKHSA in the same manner as before.

Integration or Interoperability with Northern Ireland's Domestic Testing Capacity

70. PCR capacity that NI availed of through the NTP was not integrated or interoperable with HSC Pillar 1 PCR testing capacity. However, data collection and secure data sharing arrangements of PCR and LFD test results as part of the NTP to the NI Central Test Registry were established and provision for data sharing was made in the MoUs (see below).

National Testing Programme - Methods of Data Collection

71. Under the NTP, UKHSA established reporting systems to ensure that the results of PCR and LFD tests were communicated, by SMS text message or email, promptly to the individual who had taken the test, and to the PHA via the Business Services Organization (BSO). Data sharing arrangements were provided for in the relevant Schedules to the NTP MoU [RS7/037 INQ000503880]. These reporting systems supported tests taken regardless of the delivery channels – for example, in-person test sites, home ordering etc.

72. From March 2020 to June 2020, Covid-19 test results were available for Pillar 1 laboratories only, with data provided by secure electronic transfer to both the Department's Information and Analysis Directorate (IAD) and to the PHA from HSC Trust laboratory systems. Data was analysed and processed by IAD and published on a daily basis on a Public Facing Covid-19 Dashboard.

73. From June 2020, Covid-19 test results for both Pillar 1 and Pillar 2 were received in twice daily batches by BSO and were accessible to both the PHA and the IAD. The PHA used this data to monitor a range of indicators including infection rates, and data was also made available to the PHA's Contact Tracing Service for appropriate action. The Department's IAD had to download tests for each Pillar separately, before creating a single merged dataset for Covid-19 tests results. The IAD continued to publish updated data on the Public Facing Covid-19 Dashboard at 2pm each day.

74. In October 2020 the Department's Digital Health & Care Directorate (DHCNI) commissioned the BSO to create and maintain a Central Test Results registry to hold Covid-19 test results for NI citizens reported across all testing platforms (including Pillar 1, Pillar 2 – including both PCR and LFD - and antibody testing sometimes referred to as Pillar 3). This feed was updated 24 hours a day and the results were drawn from, and fed to, different sources and systems as illustrated in the data flow diagram [RS7/038 INQ000531577]. Positive Covid-19 test data contained within the test registry fed into the PHA including the contact tracing system.

Methods of Data Sharing

75. Between 24 March and 19 April 2020, the Public Health Agency published a daily bulletin which provided a summary of the information to date including the number of new cases, the number of tests reported and, in due course, the number of deaths. It was replaced by the Department of Health's Dashboard on 19 April 2020 [RS7/039 INQ000371501].

76. 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 [RS7/040 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.

77. This made data publicly available to decision makers, HSC staff, the media, analysts, other Government Departments, and to the public. The Dashboard was key to data transparency and engaging with the public on planned public health interventions, by providing the data used to support decision-making, and sharing evidence of the impacts of those

interventions. It provided a common data set which included a wide range of data in relation to testing and other key datasets for example [RS7/041 INQ000400122]:

- the number of individuals testing positive;
- the rate of individuals testing positive per 100K population;
- the total number of individuals tested by Local Government District;
- information provided from PHA about numbers of outbreaks in care homes and the extent of outbreaks;
- Intensive Care Unit bed occupancy and availability;
- Hospital Bed Occupancy data for Covid-confirmed and non-confirmed patients to help assess pressure on hospital services; and
- the number of deaths reported by HSC Trusts that were associated with Covid-19.

78. Additional information and analysis were added to the Dashboard as the pandemic response evolved and better-quality data became available. For example, I announced, on 3 September 2020 [RS7/042 INQ000373436], that the Dashboard would provide additional information on testing data including providing a breakdown of the number of individuals testing positive during the last seven days by Local Government District and age bands. The practice of releasing further comprehensive data was aimed at raising public awareness and informing NI's response to the virus.

79. Common definitions and presentation of information were adopted to permit comparison across the UK four nations and to enable UK wide reporting. The Department also shared testing data with the DHSC which was included in UK national press releases and the UK Covid-19 Dashboard.

Providing Access to Testing Across Northern Ireland

80. The decision to join the National Testing Programme and the development of the capacity through the Pillar 1 network, including through the formation of the Academic Consortium, was key to providing ongoing access to PCR testing for the population across NI throughout the pandemic. I have set out below in later sections how available PCR capacity was prioritized and how the footprint of Pillar 2 PCR test sites expanded across NI through the pandemic.

81. In addition, I secured access to new testing technologies as these became available – for example Lateral Flow Device tests (LFDs). On 18 November 2020 I wrote to my then counterpart, Matt Hancock, requesting circa 4 million LFD tests for NI to enable testing at

population level [RS7/043 **INQ000304295**]. Mr Hancock agreed to this request on 26 November 2020. [RS7/044 INQ000530968]. I believe that this enabled NI to begin early planning and piloting to better understand how best to use the new LFD technology at scale and to consider how they could have most beneficial impact. I found this response time to be acceptable as, as stated in my letter, "I recognised the scale of this ask". As a Minister I am aware of the checks that would have been necessary before fulfilling my request and therefore was content in receiving a response 8 days later. I do not consider that this impacted local planning and it allowed us to commence pilot exercises at the start of December 2020 just before the holiday period.

81a. Under the direction and guidance of the Department's EAG-T, a small number of pilot exercises using LFDs first commenced in NI to test university students in December 2020 [RS7/045 INQ000439437], and subsequently a pilot to test older secondary school students (in sixth and seventh year) and teachers in a small number of schools commenced in December 2020 involving close joint working between the PHA and the Education Authority (EA). [RS7/046 **INQ000439437** and RS7/045 INQ000439437]. These pilots operated under the auspices of the NTP managed by DHSC, with local oversight from, and reporting of progress to, the Department's EAG-T.

82. In January 2021 a similar pilot commenced in a local agri-food business that had been working with DHSC on asymptomatic testing on its English sites. I was advised that the Department's EAG-T were supportive of the proposal and would maintain links with DHSC and with Moy Park during the project to provide support as required; to observe progress and to ensure that local requirements and links, including for example with the Contact Tracing Service in PHA, were established and operating appropriately [RS7/047 INQ000581150].

83. In March 2021, I agreed to the establishment of the Department's NI SMART (Systematic, Meaningful, Asymptomatic, Repeated Testing) which oversaw all aspects of the introduction of community testing using LFDs and was chaired by the CMO. From early 2021 onwards, I made a number of decisions which greatly expanded access to LFDs for the population across Northern Ireland and the NI SMART Programme Board was key to delivering this expansion. and was assisted by a small administrative team. These included:

- Expansion of the asymptomatic testing to NI Translink; Northern Ireland Fire and Rescue Service, and Ministry of Defence (MoD) testing to MoD bases in Northern Ireland in February 2021 [RS7/048 INQ000581151 and RS7/049 INQ000530981];

- Further expansion of asymptomatic testing, prioritising testing in higher prevalence local council areas, National Critical Infrastructure sectors and Emergency Services. Departmental officials also worked with DAERA officials to extend testing throughout the food and drink sector [RS7/050 INQ000375891].
- Approval of the launch of the Department's Covid-19 workplace testing programme on 10 March 2021 as part of the targeted expansion of asymptomatic testing [RS7/051 INQ000581154; RS7/052 INQ000276617]. This expansion focused on private and public sectors performing critical functions or delivering key services; workplaces with more than 50 employees who could not work from home; and areas that involved higher exposure to risk of infection for staff or customers. Four sectors of private industry were prioritised for the first phase of the programme: agri-food; manufacturing; essential retail, and construction.
- Further extension of the programme, in early April 2021, to include all private sector employers with more than 50 employees who could not work from home [RS7/053 INQ000348898].
- Expansion, in late April 2021, to all organisations with 10 or more employees or volunteers, who could not work from home [RS7/054 INQ000382936].

84. At its peak, the Workplace Testing scheme overseen by the NI SMART programme working through UKHSA had a total of 479 registered businesses and organisations from across NI providing test kits to staff. This included a diverse range of both public and private sector businesses and organisations including from agri-food, utilities, education and training, childcare, construction, transport including local airports to aid those travelling, community and voluntary sector, retail, hospitality and manufacturing. This also included various groups and organisations supporting vulnerable and marginalised groups including for example groups supporting people mental health needs; autism and learning disability needs; addiction services; women's aid and other women's support groups; cancer care; and organisations supporting those who were homeless and supporting refugees.

85. In terms of further expanding access to tests for the NI Population, on the 19 April 2021 I approved the extension of the UK free LFD home ordering service to NI [RS7/055 INQ000581155 and RS7/056 INQ000530988]. This enabled people to order free LFD tests online and via the 119 national number to be delivered to their home and expanded accessibility and equity of access to free LFD tests for the NI population [RS7/056 INQ000530988]. I also launched new Pharmacy Collect service on 1 September 2021 **RS7/057** INQ000383070]. At its peak there were 515 participating community pharmacies

across NI which again greatly expanded access to free LFD tests including for vulnerable groups and for those living in rural communities.

86. There are also a number of examples where I worked constructively and in agreement with other Executive Ministers in relation to testing programmes. Relevant examples include, but are not limited to, working with the Education Minister with regard to testing in schools **RS7/058** INQ000382889] and with the Infrastructure Minister in relation to testing of hauliers in January 2021 **RS7/059** INQ000381443].

Communication and Cooperation on TTI and the NTP

87. There was open and regular engagement between the health ministers of the 4 nations from the onset of the pandemic where there were regular, at least weekly, meetings. Due to the regularity of these meetings, at least initially, from a health perspective the relationship between the health ministers of the 4 nations was built on trust and mutual respect: we were all facing the same challenges and were able to have open and frank discussions. Unfortunately, as the Secretary of State for Health of Her Majesty's Government changed, so too did the frequency and opportunity of the meetings. I continued to have a good relationship with Sajid Javid, following his appointment in June 2021, but was unable to secure meetings with either Thérèse Coffey or Steve Barclay following their respective appointments **RS7/060** INQ000485715; **RS7/061** INQ000485716].

88. While any decisions took place via official channels: teleconferences, letter, emails and conversations, I would have occasionally communicated with my counterparts in the UK via WhatsApp. I have already disclosed all WhatsApp messages as part of Module 2C of this Inquiry [RS6/062a INQ000353810; RS6/062b INQ000353812; RS6/062c INQ000353813; RS6/062d INQ000353815 and RS6/062e INQ000353816].

Communication and Co-operation with the Republic of Ireland on Testing

89. The Republic of Ireland (RoI) 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 RoI has its own separate advisory structures and committees in addition to European expert advisory structures such as the European Centre for Disease Control.

90. The primary form of engagement with my counterpart in the RoI was through quad meetings, North South Ministerial meetings and 1-2-1 meetings. From the outset of the

pandemic, I had a good and open working relationship with Simon Harris TD but, following the change in Government in RoI after their election in February 2020, this unfortunately did not continue with Stephen Donnelly TD where engagements were more structured and intergovernmental with the formation of their coalition government in June 2020. At one point Minister Donnelly declined to meet me over cross border outbreaks for a number of weeks, stating that officials should meet instead [**RS7/062** INQ000485717; **RS7/063** INQ000485666; **RS7/064** INQ000400882].

91. I can recall discussing testing, but this would have been at a high level and there were no discussions on shared testing as NI was part of the UK system.

92. In addition to meeting with my ministerial counterpart, I sought, where possible, to use the strong working relationships already in place between the two Chief Medical Officers, the Public Health Agency and the Health Services Executive. I am aware that the CMO, CSA, and DCMO met regularly with their counterparts in the RoI CMO Office throughout the pandemic and discussed and appropriately shared information on testing strategies but I do not recall any detail.

Legacy Aspect of Testing Capacity for Mass Testing Roll-out During a Future Pandemic

93. I believe that NI's membership of the NTP was key to our being able to expand the testing capacity the way in which we did and I do not consider that we could have done so as quickly on our own. While I am no longer in office, and have not been since 28 May 2024, I understand that the operational legacy of enhancements to test and trace systems remains with the PHA and is also being progressed under a *PHA-led Reshape Refresh* programme.

2. Supply of Tests

Pillar 1

94. Prior to the Covid-19 pandemic, each of the five HSC Trusts in NI had its own hospital laboratories (including microbiology and serology capacity). As set out above, in January 2020 the baseline PCR capacity in NI Pillar 1 was 40 tests per day at the RVL. While this was sufficient very early on to meet clinical need and early intensive contact tracing on the small number of imported cases, very quickly it became clear that existing capacity and supporting systems and infrastructure were insufficient. Pillar 1 sites were used primarily to provide testing to support clinical and in-hospital pathways (as set out in the Interim Protocol on Testing – see further detail below) and in the management of

outbreaks in care homes. I have described earlier in this statement the actions that I and the Department took working together with partners to scale up Pillar 1 capacity.

Pillar 2

95. The first testing centre in NI established as part of the NTP was opened at the SSE Arena in Belfast on 4 April 2020. A second centre opened in the City of Derry Rugby Club on 17 April 2020; a third in Craigavon on 23 April 2020; a fourth in Enniskillen at St Angelo Airfield on 28 May 2020; and a fifth in Antrim at Antrim Business Park on 21 January 2021. Capacity in this early phase was up to 400 tests per day at each site.

96. The number of test sites and facilities available in NI through the NTP continued to grow and at its peak there were five Regional Test Sites (RTSs), ten local walk-in sites (LTSs) in operation, and access to sixteen Mobile Testing Units (MTUs) with an additional one in reserve. Details regarding the location of all test sites was made publicly available on the PHA website and on the NI Direct website which were updated regularly during the pandemic. This included access and booking arrangements and, where relevant, specific detail relevant to each site was also available, such as accessibility, parking etc. The NI Direct website was a key source of advice and guidance for the public over the course of the pandemic.

97. Home Test Kits were also available for people who were unable to attend a test site, which greatly assisted access to testing for those who needed it but were unable to travel to a test site. A *Satellite Testing Channel* also operated as part of the NTP to provide PCR testing kits to support the regular programme of testing in care homes.

98. Operational delivery of the NTP in NI was managed under contracts put in place by DHSC / UKHSA and the PHA worked closely with DHSC / UKHSA to manage and oversee operational delivery, and on the planned rollout and expansion of the test sites network. This included the lead PHA official in NI working with DHSC / UKHSA on the identification of suitable location of sites. Site identification and selection was considered by the PHA with a core public health lens and included consideration for example of how best to optimise access for the whole population and how best to mitigate inequalities in terms of access and accessibility. I understand that DHSC / UKHSA and the PHA also led on engagement with local government where that was necessary regarding the rollout of test sites, but I cannot recall any detail of this engagement. The Chair of the Department's EAG-T was also a Deputy Director in the PHA and played a lead role in this work with her team in PHA. The Department received regular updates with regards to the expanding

footprint of Pillar 2 test sites and locations. I was kept appropriately updated about expansions in testing capacity and I provided updates to the NI Executive.

99. The table below sets out the test site locations for RTSs and LTSs at January 2022 and the daily capacity. The table also lists the number of MTUs available to NI and the daily testing capacity at each, but not the location as this was changeable. I understand that a complete record of how the portfolio of Pillar 2 sites evolved and expanded in NI throughout the pandemic, including dates that sites opened and all locations for MTUs, is not held by the Department.

Table 1 - Test Site Locations and the Daily Capacity - January 2022

Site	Daily Booking Capacity
RTS Belfast	1224
RTS Derry	1020
RTS Craigavon	1020
RTS Enniskillen	765
RTS Antrim	1224
LTS Belfast	288
LTS Derry/ Londonderry	288
LTS Coleraine	288
LTS Old Ballymena	-
LTS Lisburn	288
LTS Belfast	144
LTS Newry	288
LTS Omagh	288
LTS Ballymoney	144
LTS Downpatrick	144
MTU 1009	500
MTU 1021	500
MTU 1029	500
MTU 1052	500
MTU 1059	500
MTU 1084	500
MTU 1111	500

MTU 1112	500
MTU 1217	500
MTU 1218	500
MTU 1246	500
MTU 1296	500
MTU 1312	500
MTU 1405	500
MTU 1439	500
MTU 1472	500
Strategic Reserve	-

100. The PHA monitored available testing capacity and uptake of testing on a daily basis across the region at Pillar 2 sites and worked to optimise available capacity at test sites and to manage population need and accessibility. MTUs were an important tactical asset during the pandemic response with the location of MTUs kept under continuous review by the PHA. The PHA moved location of Units based on local need, for example, to support outbreak testing, to target and prioritise areas of high prevalence and/or stubbornly high prevalence, and to enable enhanced testing in response to concerns to the emergence of a new variant of Covid-19.

Funding of PCR tests

101. The funding arrangements to enable PCR testing under the National Testing Programme (Pillar 2) have been described previously in this statement. These arrangements also included provision of new testing technologies for example Lateral Flow Devices and LumiraDX. The NTP funding arrangements were underpinned by the NTP MoU which I signed and agreed, and were further supported by the financial guidance developed at official level within the parameters of the MoU.

102. Funding to support delivery of overall HSC laboratory services (including Covid-19 Pillar 1 testing) was provided under Departmental funding arrangements, which were modified during the pandemic given the emergency response nature. This included additional funding in the pandemic period from the Department to support increased whole genome sequencing and additional PCR capacity through the Academic Testing Consortium at AFBI (part funded with the Department and DAERA) and Almac.

c. Groups Prioritised for PCR Testing

Interim Protocol on Testing

103. Testing capacity was significantly constrained in the early stages of the pandemic and the Department had put the Interim Protocol on Testing (IPT) in place early in the pandemic to guide the targeted and prioritised use of the available capacity. This was an operational tool which provided information on the eligibility for testing and advice on how to access testing. While I was aware of the use of the IPT and that it was updated regularly, I did not approve the initial version, nor its various iterations, for issue. The Chief Medical Officer approved the IPTs for issue. Much of the detail focused on in-hospital and clinical testing to support patient services and pathways. Any key TTI policy changes and decisions that were reflected in the IPT were approved by me, either through written submissions or verbal updates.

104. I understood that the purpose of the IPT was to set out how available testing capacity was to be prioritised for use. It was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity. The IPTs also took account of policy developments in the other UK nations and in the RoI. One of the key roles of the Department's EAG-T was to make recommendations for updates and amendments to the IPT taking account of this wider evidence base. Draft IPTs also included input where appropriate from the CSA and final drafts were endorsed by EAG-T, which included input for example from colleagues in PHA and RVL, and by the Deputy Chief Medical Officer. IPTs were then submitted by the Covid-19 Response Directorate to the CMO for consideration and final approval before issue.

105. In total there were 10 versions of the IPT. I have described the main changes in each one below.

106. Version 1 IPT

The first version of the IPT [RS7/025 INQ000120705] set out priority groups for testing and acknowledged a need for an approach which supported testing healthcare workers under certain conditions. The order for priority testing was:

- **Group 1 (test first)** - patients requiring critical care for the management of pneumonia, Acute Respiratory Distress Syndrome (ARDS) or influenza like illness (ILI), or an alternative indication of severe illness has been provided, for example severe pneumonia or ARDS.
- **Group 2** - all other patients requiring admission to hospital for management of pneumonia, ARDS or ILI.
- **Group 3** - Health Care Workers (HCWs) working in the following settings:

a) Physicians and surgeons involved in the care of acutely ill patients;
b) Emergency Departments;
c) Critical Care Units/Intensive Care Units;
d) Primary Care;
e) Frontline Ambulance staff; and
f) Cases where family members were causing the HCWs to self-isolate and symptomatic HCWs who were self-isolating.

- **Group 4** - clusters of disease in residential or care settings, for example long term care facilities and prisons.

107. Version 2

This version of the IPT, dated 26 March 2020 [**RS7/065** INQ000362314], was disseminated to the HSC for implementation and was operational from 28 March 2020. The main changes included the extension of testing to nurses and Allied Health Professional's involved in the care of acutely ill patients and frontline care staff in the Community, to include HSC Trust and non-HSC Trust employed staff. Version 2 also provided clarification about which staff within Primary Care could access testing and explained that testing for other HCWs or critical staff not listed could be considered on a case-by-case basis at the discretion of the Medical Director of each HSC Trust.

108. Version 3

The third iteration, dated 19 April 2020 [**RS7/066** INQ000103724], was operational from 19 April 2020. The main changes set out in Version 3 included two new priority groups for testing symptomatic residents in care homes and cancer patients.

109. Version 4

This was dated 4 May 2020 [**RS7/067** INQ000469808] and was operational from then. The primary change was the inclusion of all health and care workers as eligible for testing. Additional changes also included the further expansion of testing in care homes; testing of all elective and non-elective patients (including asymptomatic patients) admitted overnight into hospital; the availability of testing to all key workers and to members of their household if they had symptoms that caused a key worker to self-isolate; and testing for all new overnight admissions to paediatrics, learning disability and mental health in-patient wards within 24 hours of admission.

110. Version 5

The fifth version of the IPT was operational from 23 May 2020 and extended testing to residents and staff of supported living centres if there is an outbreak of more than 2 cases **RS7/068 INQ000416776**. It also stated that testing should be provided for all maternity admissions from the 18 May 2020 and for all new admissions to prison. This version also provided that symptomatic members of the public could book a test through the national platform. Version 5 of the IPT also reflected that from 18 May 2020 symptomatic members of the public could book a test through the national platform, as announced by the Secretary of State for Health [RS7/035 INQ000497453]. As I have referenced above, this was announced by the Secretary of State for Health and applied to the wider public across the UK from that date. This was a significant expansion in the criteria for those eligible for PCR testing and was possible as available capacity through the NTP Pillar 2 network had significantly increased by this stage.

111. Version 6

Version 6 of the IPT, dated 9 July 2020 [**RS7/069** INQ000535688], was operational from 10 July 2020. It provided advice on the regular testing of staff working in specialities with vulnerable patients when there was evidence of nosocomial infection; clarification about the requirement to retest learning disability and mental health patients after a weekend discharge; and expanded the groups eligible for testing to include planned day case admissions, individuals with symptoms attending Emergency Department who did not need to be admitted, international key workers, and symptomatic children under the age of 5.

112. Version 6.1

Updated advice on staff exposures was provided in version 6.1 of the IPT which was implemented on 24 July 2020 [**RS7/070** INQ000469795]. It recommended a risk assessment if a staff member had a breach in their PPE or was not wearing PPE and came into close contact with a patient or resident with Covid-19 or with symptoms of it. It provided that if the risk assessment considered the breach to be significant the healthcare worker should remain off work for 14 days.

113. Version 7

The seventh iteration of the IPT, dated 12 October 2020 [**RS7/071** INQ000530994], came into effect on the 15 October 2020. It included information on the SARS-CoV2- Immunity and Reinfection Evaluation Study (SIREN study) advice; encouraged testing for virological clearance in severely immunosuppressed patients; whole genome sequencing testing; information on the regular programme of testing in care homes and testing when there was a confirmed or suspected Covid-19 outbreak; updates to the testing of cancer patients and

day case admissions; and an expansion of the groups eligible for testing to include RQIA Inspectors, long stay hospital patients (where long stay was over 3 months) to include staff testing, and admissions to hospices.

114. Version 8

On 20 July 2021 an eighth version of the IPT was implemented [**RS7/072** INQ000535689]. It provided instructions on testing requirements for different cohorts, including for acute admissions to hospital (elective and non-elective); planned day case and inpatient admissions; maternity services; Emergency Departments, and Supported Living facilities. It also expanded the groups eligible for testing to include asymptomatic visitors to care homes and hospices; the regular testing of prison staff, and the regular testing of asymptomatic healthcare workers.

115. Version 9

The ninth version of the IPT was operational from 6 October 2021 [**RS7/073** INQ000377265] and its main changes included updates on testing for acute admissions to hospital (elective and non-elective); hospital admissions for learning disability and mental health; planned day case and inpatient admissions; maternity services; Emergency Departments; care homes, and asymptomatic HCWs. It also provided advice on testing for individuals undergoing cancer surgery to minimise the risk of cancellation; advice on testing when there was a late cancellation of an elective care slot, and advice on patients hospitalised due to Covid-19. Groups eligible for testing were expanded to include chemotherapy patients and their families, asymptomatic visitors to hospitals, asymptomatic domiciliary care staff and asymptomatic personal assistants.

d. Covid-19 Testing Strategy

116. I presented the Executive with the Department's Covid-19 Testing Strategy [RS7/017 INQ000103649] on 6 April 2020. In it I highlighted my decision to prioritise the testing of frontline workers alongside people in hospital with respiratory conditions. Delivery of the Strategy was supported by the IPT, and the priorities set out in the Strategy reflected those in the IPT and were initially identified as:

- People with respiratory conditions admitted to hospital and requiring critical care;
- People with respiratory conditions admitted to hospital and not requiring critical care;
- Key health and care workers;
- In circumstances to support the risk assessment and management of outbreaks/clusters in residential and other care settings (e.g. care homes and/or prisons); and

- Sentinel surveillance in primary care/the community.

117. Given the fast-paced nature of events, the Department kept the Covid-19 Testing Strategy under review. Following review by the Department's EAG-T, I approved an updated Covid-19 Testing Strategy [**RS7/074** INQ000582395]. I presented the Strategy to the NI Executive on 21 May 2020 [**RS7/075** INQ000103650] reflecting key changes and developments since the first Strategy. A key change was the inclusion of testing for essential or key workers in sectors other than Health and Social Care. The May Strategy focused on rapid identification of cases and contacts, supported by testing and isolation. The approach was designed to:
    - Break the chain of transmission of the virus by identifying people with Covid-19,
    - Tracing people who may have become infected by being in close contact with them; and
    - Supporting those people to self-isolate so that if they have the disease they are less likely to transmit it to others.

e. Decision Making

March 2020 – June 2020

118. As I explained above, the IPT was an operational tool and, as such, I did not approve the various iterations for issue. However, again as I explained above, I did approve key TTI policy changes reflected in the IPTs. The final form of policy and professional advice to me was generally agreed by the CMO. Exceptions to this were when CMO was unavailable, for example, when on leave. I understand policy and professional advice was formed through engagement and discussion with the CSA and DCMOs, policy teams including those in the Department's COVID-19 Response Directorate, and external sources of expert information. Such sources included for example, advice, evidence and best practice recommendations from a wide range of clinical, scientific and public health advisory forums, including for example SAGE, 4 UK CMOs meetings, UK Senior Clinicians and others; and advice and input from local organisations (including PHA), teams and advisory structures including for example EAG-T, NI SMART (in relation to use of LFDs), the Strategic Intelligence Group and the Test, Trace, Protect Oversight Board and their members. Advice also took account of developments in the other UK nations, and in the RoI where that was relevant.

119. Over the course of the pandemic, knowledge of all aspects of the virus, including its transmission, evolved and as such policy was kept under continuous review and was

updated on an ongoing basis. For example, I approved updates to policy as testing capacity increased, which allowed the expansion of groups eligible to be tested.

Care Home PCR Testing

120. Protecting residents and staff in care homes was a key priority for me and the Department from early on and throughout the pandemic. The expansion of PCR testing in care homes progressed in a phased way throughout the pandemic from initial Covid-19 testing of care home residents and staff displaying symptoms, to Covid-19 testing made available to all residents and staff (including those with no symptoms), and later to visitors. The EAG-T was responsible for advising and recommending Covid-19 testing proposals for care homes which were considered by the Department's policy leads to inform advice to CMO and then to me for review and approval. The PHA managed the detail of establishing and maintaining the testing programme in care homes, and of the delivery, logistics and operations. The collaborative and multi-agency working partnership including between the Department, the PHA, the HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the care homes themselves and the Pillar 1 (local HSC laboratories) and Pillar 2 (the NTP) enabled the successful delivery of testing in care homes.

121. I approved several expansions to PCR testing in the period up to June 2020 and beyond. Examples include:

- On 24 April 2020, the EAG-T considered a further expansion of Covid-19 testing in Care Homes. Taking into account an increase in the number of Care Home outbreaks and increased testing capacity, the EAG-T recommended that for new outbreaks in Care Homes, all residents and all staff should be tested for Covid-19 as part of the initial risk assessment of each outbreak. I announced the change on 27 April 2020 [**RS7/076** INQ000103694].
- On 13 May 2020, I announced a further expansion of testing for Care Home residents and staff [**RS7/077** INQ000103693], and provided further detail on 18 May 2020 [**RS7/078** INQ000103704]. The testing programme in Care Homes was to be extended with Covid-19 testing made available to all residents and all staff including in Care Homes which had not experienced a Covid-19 outbreak, with the intention of completing this in June 2020. This expansion would be informed by advice being prepared for Government and the NHS by the Scientific Advisory Group for Emergencies (SAGE) and the Department's Strategic Intelligence Group (SIG).

- On 28 July, I announced detail of a planned programme of regular PCR testing for all residents and staff [**RS7/079** INQ000276488]. The programme commenced from 3 August 2020.
- On 3 November 2020, I announced an increased frequency of Covid-19 testing for Care Home staff [**RS7/080** INQ000381353], with regular testing of asymptomatic staff increased from once every two weeks, to once a week.

122. The Department continued to keep Care Home Covid-19 testing arrangements under active review, with subsequent decisions and announcements taken in line with the pandemic's progression and taking into account all new and emerging scientific and medical evidence, including the impact of new variants, and with the later availability of LFDs. As Module 6 of the Inquiry will consider the Care Sector and as I understand the Care Home Covid-19 testing arrangements are set out more fully in the Department's Corporate Statement, I have not sought to replicate here.

July 2020 onward

123. Following the decision on 18 May 2020, it was the case that everyone in the general public remained eligible for a PCR test through the National Testing Programme, until the Department's Test & Trace Transition Plan which I approved for launch in March 2022 [**RS7/081** INQ000348966]. However, the use of PCR capacity through the NTP continued to be kept under review and I made further decisions in relation to eligibility and prioritisation of Pillar 2 PCR capacity.

124. On 24 December 2021, due to a period of exponential growth in Omicron case numbers in NI, I approved a range of updated policy measures across TTI policy aimed at optimising available PCR capacity and contact tracing capacity. This included changes to isolation and management of positive cases and of close contacts, with the latter no longer required to take a PCR test; an agreed PCR prioritisation plan should that be required in the weeks ahead with further pressure on PCR capacity anticipated; and an operational escalation of the PHA's Contact Tracing Service contingency plan. I informed the NI Executive of these changes on 24 December 2021 [**RS7/082** INQ000348903].

125. These measures were kept under continuous review by the Department in that period and I agreed further policy interventions on 3 January 2022 to remove the need for a confirmatory PCR following a positive LFD result, which took effect from 5 January 2022 [**RS7/083** INQ000383198]. These changes were in line with policy changes in the other UK nations. The proposal took account of available scientific and public health evidence that,

in summary, as prevalence of Covid-19 in the population increased, the chance that an individual's positive LFD result was a false positive reduced. Therefore, the benefit of requiring a confirmatory PCR test to prevent unnecessary isolation became less. Removing the requirement to take a confirmatory PCR test following a positive LFD also helped make best use of the range of test types available and protect PCR capacity to provide the most public health and clinical benefit. In order to protect capacity, there were also communications from both the Department and the PHA urging the public to only take a PCR test where necessary [**RS7/084** INQ000530959].

Prioritisation and Eligibility Decisions in Relation to LFDs

126. I have set out in a previous section above an overview of decisions in relation to the expansion in eligibility, prioritisation and use of LFDs. In addition to the areas listed above, I also agreed or approved the use of LFDs for asymptomatic testing across other settings including for example for testing of university students and expanded programmes in schools [**RS7/085** INQ000382971] and testing using LAMP technology in schools for those with special educational needs [**RS7/086** INQ000276619].

127. This approach to using LFDs for asymptomatic testing as an additional 'test to find' was the general policy approach regarding the use of LFDs until later in the pandemic. Further uses for LFDs emerged throughout 2021 across the UK for example to facilitate early exit from isolation. I approved a proposal that, with effect from 5 January 2022, positive cases could leave self-isolation on Day 7 providing they had two negative LFD tests at least 24 hours apart, no earlier than Days 6 and 7. This approach was in line with the other UK nations [**RS7/087** INQ000467025]. Later, with effect from 21 January 2022, I approved that the period of isolation for confirmed cases be reduced from 6 full days to 5 full days, with release on day 6 providing the case had two consecutive negative LFD test results 24 hours apart, with the first taken no earlier than day 5 [**RS7/088** INQ000348904].

127a. At the time I agreed this change in the guidance I considered that it was clear; however, 5 years on, and no longer as immersed in the pandemic response as I was then, I can appreciate that at times the fast-changing nature of advice and guidance may have been challenging for some members of the general public. The Department made significant efforts to provide clear communications to accompany policy changes [see for example **RS7/083** - INQ000383198]. Clear communications and advice will be critical once again in any future pandemic response and I believe that recommendations and lessons learnt from the Inquiry will be particularly important in this regard.

Covid-19 Test, Trace and Protect Transition Plan - March 2022

128. In March 2022, I approved the Department's Covid-19 Test, Trace and Protect Transition Plan [**RS7/081** INQ000348966 (as above); **RS7/089** INQ000383253; **RS7/090** INQ000303935 and **RS7/091** INQ000348848]. This represented a significant change in prioritization and eligibility for testing. The Plan recognised that by that stage NI - like the rest of the UK and the RoI – was at a very different stage of the pandemic:
    - The vast majority of the adult population had been fully vaccinated, and more than half had received a booster vaccination, with further boosters planned for those people at higher risk of infection;
    - Vaccines had dramatically reduced the risk of serious illness requiring hospitalisation for those infected with Covid-19;
    - The vaccination programme combined with the fact that a significant proportion of the population had been infected and had recovered meant that the NI population had a high level of immune protection against the virus which causes Covid-19; and
    - Covid-19 specific treatments were available and deployed in NI further reducing the risk of serious illness in those who were at higher risk should they become infected. These treatments bolstered our ability to protect vulnerable patients and reduce their risk of developing serious illness.

129. As a consequence, the risk to the general public of serious illness from Covid-19 had greatly reduced. It was no longer necessary or proportionate given the reduced risk posed by the virus at population level to continue to test, trace and isolate across the whole population at the scale which had been undertaken to date.

130. The Covid-19 Test, Trace and Protect Transition Plan set out a period of transition to a more targeted approach which focused test and trace activity to protect and support the most vulnerable and those at highest risk of serious illness should they contract Covid-19. This new phase prioritised:
    - Test to Treat – to support diagnosis of the disease and timely access for those who could benefit from the new Covid-19 treatments; protecting our sickest and most vulnerable from serious illness. Testing also remained available to inform clinical pathways, care and treatment;
    - Test to Protect – to protect those living, working and visiting high risk and other vulnerable settings including hospitals and care homes;

- Outbreak Management - continued use of proportionate and targeted test and trace in the management of outbreaks with a continuing strong focus on high-risk settings such as care homes, in line with advice from the PHA; and
- Surveillance – testing to monitor virus progression and to identify early the emergence of new variants so that an appropriate public health response could be delivered.

131. While I recall that the timing of changes differed across the four UK nations, the core strategic policy aims as set out in the Department's March 2022 Covid-19 Test, Trace and Protect Transition Plan reflected the general plans for transition in the other UK nations. That was, to deliver a more targeted approach which focused test and trace activity to protect and support our most vulnerable and those at highest risk of serious illness should they contract Covid-19.

f. Actions to address Adequacy of Supply

132. Other than at the outset of the pandemic, my recollection is that the supply of and access to LFDs and PCRs was generally adequate in NI. There were some periods of particularly high demand for testing when access to sufficient PCR capacity was a challenge in NI and, indeed, across all UK nations. For example, I have described elsewhere how, in September 2021, NI was able to benefit from an increased PCR allocation in agreement with UKHSA during a period of significant demand when schools returned.

133. I also recall an incident, in September 2020, during a period of high demand for tests, where the NTP PCR booking platform was causing some problems and concern for NI citizens and public representatives. The booking platform directed a small number of NI citizens to Pillar 2 test sites in Scotland as the nearest available test site. This was linked with a functionality issue whereby the booking platform did not recognise the Irish Sea and journey times. I understand that Departmental records date from 4 September 2020 when officials were copied into an email chain dated 2 September 2020 between the PHA and DHSC querying issues with the platform. I cannot be certain when I was alerted to the issue but it would have been around the 4 September 2020. I raised the matter directly with Matt Hancock whereby I sought swift action to remedy the problem [**RS7/092** INQ000373440]. A digital fix was resolved by DHSC but, with the passage of time, I do not now recall how long this fix took to resolve and from a review of its records the Department has been unable to locate the specific information for me. However, I was content that DHSC had taken the matter seriously and prioritised accordingly. In the intervening period while the fix was progressing, the Department encouraged anyone who tried to book a test and was unable

to do so or was offered a location or date and time which was not convenient, to wait a few hours and try again.

134. With regard to decisions or acts that I took related to adequacy of supply of LFDs, I recall during the period December 2021 to January 2022, there was also a considerable increase in demand for LFD tests. The Department issued proactive communications which sought to reassure the public that there was sufficient supply of LFDs in NI and sought to assist the public by again highlighting the range of collect and online ordering options. The Department also highlighted that, due to the high demand, tests available via the national online and 119 telephone ordering home delivery service may be released in batches throughout the day, and that should the public not be able to order tests immediately, they were encouraged to check again regularly throughout the day [**RS7/093** INQ000383175]. I was also aware of efforts by the Department working with UKHSA and BSO to help ensure LFD stocks in pharmacies were replenished on a timely basis during this period, including establishing at short notice a schedule of additional deliveries over the weekend and holiday periods [**RS7/094** INQ000383192].

135. In relation to ensuring adequate ongoing supply of LFDs for NI, I also made decisions to approve the NI opt-in to procurements of LFDs which were led by UKHSA as part of the NTP [**RS7/095** INQ000582396 and **RS7/096** INQ000582397], and agreed loans of LFDs to NHS colleagues when I was assured that NI had sufficient stock [**RS7/087** INQ000467025 (as above), **RS7/097** INQ000452308 and **RS7/098** INQ000531586]. These decisions were supported by submissions from officials including an assessment of LFDs stock levels and projected demand taking account of existing and changing policy.

g. Working with Local Councils, Directors of Public Health and Emergency Preparedness Groups

Local Councils

136. I recall there was a range of mechanisms that the Department and PHA used to engage with local councils in relation to planning and rollout of both testing and contact tracing. For example, close engagement and joint working with local government was key to the establishment and maintenance of community testing using LFDs as part of the NI SMART programme, which I had approved as referenced above. The PHA also issued communications in a range of languages to improve engagement on contact tracing, testing and vaccination. Operational expansion of asymptomatic LFD testing in NI required the Department to work in close partnership with a broad range of local partners, including the

DfC, local government, other public sector agencies, and a range of business sectors. A senior Local Government Advisor was part of the NI SMART Programme Board. Through the NI SMART work with local government and third sector organisations, a total of 39 collect sites were established and available for both staff, the public and wider community groups including those supporting vulnerable and marginalised groups.

136a. The NI SMART programme worked with a total of 479 registered businesses and organisations from across NI, providing test kits as part of the National Testing Programme. This included a diverse range of both public and private sector businesses and organisations including from agri-food, utilities, education and training, childcare, construction, transport (including local airports to aid those travelling), community and voluntary sectors, retail, hospitality and manufacturing. This also included various groups and organisations supporting vulnerable and marginalised groups, including for example: groups supporting people with mental health needs; autism and learning disability needs; addiction services; women's aid and other women's support groups; cancer care; and organisations supporting those who were homeless and supporting refugees

137. There was also direct engagement and information sharing with local councils in NI by the Department in respect of levels of community transmission and response measures including in relation to contact tracing and testing. I believe that the CMO and CSA met with the CEOs of NI's eleven District Councils (local government councils) on a number of occasions. Some of these meetings were specific to Councils with high community transmission. Some of these were arranged by the Department and others were coordinated by TEO and provided an opportunity to provide updates to Council CEOs. I was kept up to date in relation to key issues emerging from these discussions as appropriate.

Directors of Public Health

138. There is only one Director of Public Health position in Northern Ireland and that office is held within the Public Health Agency. I am aware that the CMO, DCMOs, CSA and other senior officials in the Department had ongoing communication and discussion and close joint working with the postholder and with other senior PHA colleagues on all matters related to the TTI programme – including those in key positions, for example the PHA Chief Executive, the Assistant Director of Public Health (who was also chair of the Department's EAG-T) and the Director of Contact Tracing Services. This included engagement with senior PHA counterparts on an *ad hoc* basis and through a range of key groups which were established to support delivery of TTI including the Test, Trace, Protect Oversight Board,

the NI SMART Programme Board, Clusters & Outbreak meetings, Strategic Intelligence Group (SIG), the Testing in Care – Task and Finish Group, the NI Modelling Group and the EAG-T. There were also a number of more tactical operational PHA groups supporting the Test, Trace, Protect Strategy.

139. As I described above, the testing and contact tracing programmes were key strategic elements of the pandemic response and were interdependent programmes which required strategic coordination. This necessitated close and flexible joint working at all times between the Department and the PHA throughout the course of the pandemic to coordinate strategic and operational delivery of the TTI programme and to make the most of available skills, expertise and resource. The Test, Trace, Protect Oversight Board (further detail is explained elsewhere) played a key role in ensuring effective working in this regard.

Emergency Preparedness Groups

140. The Civil Contingencies Group (Northern Ireland) (CCG (NI)), is the principal strategic civil contingencies preparedness body for the public sector. At the time of Covid-19, CCG (NI) was chaired by the Head of Civil Service (HOCS) and membership comprised representation from all NI government Departments as well as local government, the Food Standards Agency, the emergency services and the Met Office. CCG(NI) is responsible for providing strategic leadership to civil contingencies preparedness by agreeing policy and strategy on cross cutting issues. CCG(NI) has oversight and responsibility for pandemic planning in non-health areas in NI including sector resilience.

141. Within the Department, the Emergency Preparedness Groups were Health Gold and Health Silver within the Department and HSC system and are described in my Module 2C statement [**RS7/099** INQ000412903 paragraphs 23-32]. As explained there I received regular verbal updates and written submissions from officials.

142. I am not aware of any wider NI Emergency Preparedness Groups.

143. I can only comment on how I and the Department engaged with relevant stakeholders. TEO is best placed to advise the Inquiry on how the NI Executive engaged with stakeholders.

h. Liaison with Other UK Nations and Consistency of Approach to Eligibility and Prioritisation

144. As I have described, there was open and regular engagement between the health ministers of the 4 nations from the onset of the pandemic where there were regular, at least weekly, meetings. At times these meetings did have a focus at a high level on testing capacity, testing technologies, testing strategy and funding but, with the passage of time, I do not now recall significant ongoing discussion regarding alignment of eligibility and prioritisation decisions.

145. I believe that, in general, consistency of approach regarding eligibility and prioritisation was important but that it was one of many important factors. It was also important, for example, that such decisions took account of local assessment and advice including for example in relation to changing disease prevalence and trajectory and demand for tests.

146. Officials in the Department maintained close contact with counterparts in the other UK nations and policy submissions often also contained advice on the evolving policy across the UK nations. While I do not now remember the detail of all policy changes, timings and differences, I believe that, in general, across the course of the pandemic, eligibility and prioritisation of PCR and LFD testing at strategic, population level was generally consistent. For example, the decision on 18 May 2020 that symptomatic members of the public could book a PCR was a significant expansion in the eligibility criteria which applied UK wide and from that date onward.

147. Further, while asymptomatic LFD testing differed slightly across the UK nations, largely in the timing of its deployment, the overall strategic aims were broadly similar including the use of repeat testing to detect positive cases among asymptomatic individuals (as a 'test to find' additional positive cases who would otherwise not have tested in the absence of symptoms); testing prior to an activity to reduce risk; as part of wider asymptomatic testing to support outbreak management; and, later in the pandemic, for those isolating and contacts to assess their infectiousness and to facilitate early exit from isolation.

C. CONTACT TRACING

1. Contract Tracing Service – Test, Trace and Protect

a. Strategic Context

148. I approved the Department's Test Trace Protect Strategy (the Strategy) on 18 May 2020 and this was published by the Department on 27 May 2020 [**RS7/100** INQ000381319 and **RS7/101** INQ000120704]. The Strategy set out the Department's strategic approach to the testing, contact tracing and isolation aspects of the pandemic response and was designed to augment the other measures in place to help minimise community transmission of Covid-19. Implementation of the Strategy was central to the NI Executive's planned pathway out of the pandemic [**RS7/102** INQ000104467] and the testing and contact tracing programmes were the subject of significant political scrutiny and media interest. As Health Minister, I set the overall course of the programme and approved major policy decisions. As Chair of the Test, Trace, Protect Oversight Board (the Oversight Board), the CMO had sight of and steered strategic delivery of the programme.

149. The Strategy was informed by the Department's Covid-19 Testing Strategy which was first issued on 6 April 2020 with an updated version issued on 21 May 2020, as described in a previous section. Both strategies had an explicit focus on the need to rapidly scale testing capacity to support contact tracing. The Strategy signalled a programme of work to reduce the spread of the Covid-19 virus among the population in NI, minimising Covid-19 transmission in the community and, in doing so, preventing and limiting exposure to the virus and reducing the risk of serious illness. Its key elements were:

- Early identification and isolation of possible cases;
- Clusters and outbreaks of infection; rapid testing of possible cases;
- Tracing of close contacts of cases; and,
- Early, effective and supported isolation of close contacts to prevent onward transmission of infection.

150. The Strategy had a population focus which set the context for implementation of robust public health measures appropriate to the prevailing risk and was supported by an evolving digital infrastructure and an ongoing programme of public communications.

151. The Strategy was first developed and implemented at a stage in the pandemic when neither a vaccine nor specific treatments for Covid-19 were available and the disease was resulting in high rates of serious illness, hospitalisation and death among some of those infected.

The Strategy acknowledged that test, trace and isolate would become a part of everyday life in NI until an effective vaccine was developed and a vaccination programme for Covid-19 was implemented. Identifying cases through widespread testing and isolating cases and their contacts was, in the absence of an effective Covid-19 vaccine and treatments, deemed by the Department and myself, as a necessary and proportionate response, given the consequences of the infection spreading in a population with no previous exposure or natural immunity (including those who were vulnerable), prior to the availability of sufficient vaccination and specific treatments for Covid-19.

152. The Strategy was initially referred to as 'Test, Trace, Isolate, Support' based on the pillars of testing people, tracing their contacts, advising cases / contacts to isolate, and supporting them to do so as appropriate. It changed relatively early in the pandemic to become known as "Test, Trace, Protect" to better reflect the need to provide people who had been asked to isolate with access to appropriate support mechanisms to protect others in the community, which was the fundamental objective of the strategy. As I have described later in more detail (see Section D – Isolation), DfC had the lead role in providing the support that was needed for those that were self-isolating, including financial support through its Discretionary Support Scheme. The Department worked closely with DfC colleagues under the auspices of the Oversight Board (see section C(1)(d) on Governance section below). In addition, I wrote to the Executive [RS7/013 INQ000357313] and separately to the DfC Minister [RS7/103 INQ000346709] highlighting the importance of financial support and other support mechanisms for those self-isolating; the importance of ensuring the support measures were accessible to all; and any plans for additional support measures to be put in place. Further detail on isolation including support for those isolating is set out in Section D.

153. The Chief Medical Officer's Group (CMOG) in the Department played a significant role in overseeing, at a strategic level, the planning and delivery of the Strategy in NI. Throughout the course of the programme CMO and the CSA provided regular updates directly to me and also to the NI Executive as was required on all matters across the wider pandemic response, including TTI and delivery of the Strategy.

154. The Covid-19 testing and contact tracing programmes were key strategic elements of the pandemic response in interrupting transmission and reducing community transmission. Both programmes were complex and there were significant operational matters which overlapped with policy dimensions in a fast moving environment. As such these interdependent programmes required strategic coordination and close, integrated working between the

department and PHA. I consider that the strategic approach to test and trace and close working throughout the pandemic with the PHA as operational lead was an important vehicle to achieve necessary alignment.

b. Date of Establishment

155. As I explained above, on 12 March 2020 contact tracing was paused in line with a decision which was taken by the Cabinet Office Briefing Room Ministerial Meeting (COBR (M)). I believe the decision was in line with the UK-wide agreed Protocol for Moving from Contain to Delay [**RS7/103a** - **INQ000049539**] and with the UK-Wide Coronavirus Action Plan dated 3 March 2020, which was agreed by the 4 UK governments with advice from the UK CMOs and government scientists. I referenced this in my statement to the NI Assembly of 9 March 2020 [see **RS7/103b** – INQ000103639]. I do not now recall any specific discussion or advice that NI should adopt a different approach, but there were operational pressures on contact tracing services and limited testing capacity at this time, which made it difficult for both to continue in the community. The NI First Minister and deputy First Minister also attended the COBR meeting, along with officials from TEO, and I do not recall that at any point it was queried whether NI should continue contact tracing. As the First and deputy First Minister were also at the meeting, I did not consider there was a need to refer the matter to the NI Executive. As they made no such referral either, I can only assume they also thought it was not necessary.

155a. Contact tracing in NI remained paused until it was reintroduced by the PHA on 27 April 2020, initially through a pilot phase and then with the full launch on 18 May 2020. Prior to the pause, there were relatively small numbers of cases. The aim of contact tracing was to identify and manage all cases and contacts using existing structures and capacity available at that stage as part of the PHA's normal line of business Health Protection function, which had established expertise in risk assessment of incidents and outbreaks, and in undertaking contact tracing. At this point, when case numbers were small, tracing of cases could potentially have significant impact on the course of the pandemic and indeed a realistic chance of delaying community transmission. However, whilst pre pandemic this approach was an effective way of combatting the spread of disease under normal circumstances, it was never intended to address an outbreak on the scale of Covid-19. Community testing and contact tracing had never before been undertaken at the scale required and, early in the pandemic, we did not have the testing or contact tracing capacity to ensure that all individuals could access a test and that contact tracing would be completed in a timely manner in order to break chains in transmission.

156. On 1 May 2020, the CMO established a Contact Tracing Steering Group to oversee the establishment of the Contact Tracing Service in NI and to provide strategic direction for its operation. The work of the Contact Tracing Steering Group focused on areas of recruitment; supporting IT platforms; developing call handling scripts; accommodation; staff training requirements; funding requirements; data sharing and governance. The Contact Tracing Service launched on 18 May 2020 following a pilot phase operated by the PHA from late April 2020. During the pilot phase processes and systems required for contact tracing were developed, tested and refined using staff mainly redeployed from other areas of the health and social care system and from which lessons learned were used to help inform the design of the new Service.

157. I understand there was a wide-ranging programme of engagement with stakeholders undertaken during the Contact Tracing Service development stage including with political parties; the Human Rights Commissioner for NI; the Equality Commission; the NI Commissioner for Children and Young People; the Older Peoples Commissioner; and representatives from potentially hard-to-reach groups including the homeless population and the Roma community. In addition, an Action Plan, which I shared with Executive colleagues on 2 September 2020 [**RS7/104** INQ000375903 and **RS7/105** INQ000375902], was developed by the PHA for hard-to-reach groups, including vulnerable groups and people from ethnic minority backgrounds. I believe that this assisted in PHA's approach to further encourage adherence to TTI advice, for example as part of the response to outbreak incident management.

158. I recall that the CSA advised the PHA on a number of occasions on the required size of the contact tracing service based on modelling undertaken by the NI Modelling Group. On 20 April 2020 the CSA estimated there would be a need for 300 – 600 contact tracing staff in NI. I understand he was assured that over 500 were in training [**RS7/106** INQ000353669]. Based on the European Centre for Disease Control (ECDC) estimates from April 2020, this would have been sufficient for a contact tracing service to handle over 1000 cases per day [**RS7/107** INQ000346697]. On 13 May 2020, the CSA provided further advice to the Contact Tracing Steering Group meeting that, in his view, there would be up to 500 cases per day with a requirement to trace 5,000 people per day. This advice was repeated at a meeting with the PHA on 17 September 2020 [**RS7/108** INQ000353671]. Ultimately, however, the PHA employed fewer contact tracers. While I consider that I was kept appropriately informed regarding the Contact Tracing Service, I do not now recall whether I received specific reasons why the PHA employed fewer contact tracers than modelling

indicated was required. As an ALB of the Department the principle of subsidiarity applies: i.e. decisions are taken at the most appropriate, or lowest, level possible. The PHA retained lead responsibility for operational delivery of the Contact Tracing Service and may be best placed to provide further detail on service planning and staff numbers.

159. The decision to recommence contact tracing in May 2020 was taken at a phase in the pandemic when there was no vaccine or specific treatments available. At that time this was in combination with the other Non-Pharmaceutical Interventions (NPIs) such as physical distancing; good respiratory and hand hygiene; wearing face coverings in enclosed spaces; and the 'lockdown' regulations which included restrictions on businesses and individuals in order to reduce population mixing in public spaces and in the workplace, and was considered a necessary and proportionate response to the pandemic, given the consequences of the virus spreading unchecked in the population. In my statement to the NI Assembly on 28 July 2020 [**RS7/079** INQ000276488 (as above)], I reiterated that the establishment of an effective Contact Tracing Service (CTS) was a key priority for me and that there was a strong international consensus that this work was a critical measure for bringing down the value of R, and thereby preventing or minimising further waves, whilst allowing other restrictions to be lifted in due course.

160. Contact tracing is most effective when positive cases are contacted within 24 hours and their close contacts within 48 hours of notification to the CTS. As such, these were key metrics used by the CTS to measure and report its performance. Throughout the pandemic the PHA published weekly Management Information Updates on the activity of the CTS, based on its internal data collection and reporting systems [**RS7/109** INQ000535718]. I received regular verbal updates and submissions from officials.

161. When re-established on 18 May 2020, the PHA maintained contact tracing throughout the pandemic. While there were periods of peak demand during which contact tracing capacity and performance were challenged, for example in respect of the significant rise in cases with the return of schools in September 2020 and following the emergence of the Omicron variant, in general the CTS maintained a relatively good level of performance against its key performance metrics, as above. There were also periods when it was necessary for the PHA to employ escalation measures within its Contact Tracing Operational Contingency Plan at times of peak demand on services to seek to optimise performance.

c. Purpose and Key Functions

162. As set out in the Strategy I understood the purpose and key functions of contact tracing to be a means by which community transmission could be reduced and chains of infection interrupted. Contact tracing was a key element of the overall strategy which was aimed at the early identification and isolation of possible cases, clusters and outbreaks; rapid testing of possible cases; tracing of close contacts of cases; and early, effective and supported isolation of close contacts to prevent onward transmission of infection. If a reduction in spread could be achieved it had the ability to prevent severe disease, hospitalisations and deaths from the virus and to help alleviate the associated pressures on the HSC's capacity. Contact tracing was one of the first lines of defence against Covid-19 and, along with the rest of the UK, it was a key part of the pandemic response in NI. This involved the tracing of contacts of Covid-19 cases and the timely provision of self-isolation and other public health advice to them, and their close contacts, to interrupt chains of infection and to reduce community transmission. The overall aim of the service was to assist in reducing the number of people with Covid-19, and in turn severe disease, hospitalisations and deaths from the virus.

163. The key function of the manual CTS was to trace contacts of Covid-19 cases and the provision of timely self-isolation and other public health advice, to interrupt chains of infection and to reduce community transmission. The NI CTS was mostly staffed by healthcare professionals including nurses and medical students. This was important and helped contain the spread of the virus, for example, through conducting risk assessments and managing what could often be complex cases involving clusters and outbreaks. High-risk settings and large outbreaks were risk assessed by the clinical team with oversight by the public health consultant, with more complex situations managed by the core Health Protection service. Separate teams within the PHA supported care homes, schools, early years and some other settings, working with the Service as required. In many instances, this professional-led input was also of benefit in providing advice and support to those experiencing extremely difficult personal and family circumstances including bereavement and the hospitalisation of family members.

164. The Service evolved from a person-led model at the outset of the pandemic whereby contact tracing staff contacted the person who had tested positive, to a hybrid model which utilised health care expertise together with the development of a number of digital solutions including:

- The digital self-trace platform;

- A texting service;
- The StopCOVID NI App (the Proximity App);
- The COVID Care App NI; and,
- The internal PHA Contact Tracing Platforms.

165. All of these component parts contributed to the overall efficiency of the Service. A report illustrating the scope of the digital, largely self-contained but aligned, suite of products supporting TTI and their performance was provided to the Department's Top Management Group in November 2020 [**RS7/110 INQ000574184**].

166. The main function of the Proximity App was that it aimed to alert citizens anonymously that they were at risk from acquiring the virus. The App enabled smartphone users to be alerted to having been in close proximity to another person who had subsequently tested positive for Covid-19. It could also alert others if the user of the app had subsequently tested positive for the virus. This meant that people were alerted to the risk of transmission of the virus and could begin to take steps including self-isolation to help prevent its further spread and in so doing enabled manual tracers to focus on the more challenging and complex cases. On 1 October 2020 the department announced that the Proximity App was available to 11-17-year-olds and was the first region in the UK to extend use to this age group. This was considered to be an important boost in the response to the Covid-19 pandemic. It was believed that the Proximity App would help schools, further education colleges and universities to provide additional protection to their students and staff. Further information on the Proximity App is detailed later in this statement.

167. The Digital Self Trace online platform was developed to support the CTS to manage the high volume of cases experienced during the pandemic, and, similar to the Proximity App, further assisted contact tracing staff to focus on more challenging and complex cases. It was launched on 9 October 2020 and enabled NI citizens who had tested positive to provide their details and details of their known contacts online. Cases and contacts were then sent automated SMS messages with appropriate public health and isolation advice. Several media campaigns ran during the pandemic to optimise all of the different components of contact tracing in NI, and in particular to increase the public's awareness of the benefits of Digital Self Trace and the STOPCovid NI app. Further detail on communications is provided later in this statement.

Contingency Planning

168. The PHA developed its CTS Contingency Plan in December 2020. The Plan was based on the PHA's Framework for Escalation and Prioritisation of Resources and was revised and updated by the PHA throughout the pandemic [**RS7/111** INQ000535710 and **RS7/112** INQ000552986]. The purpose of the Contingency Plan was to set out how contact tracing resources were to be used differently and most effectively to manage situations of significant increased demand ensuring that the most high-risk situations were prioritised in order to deliver maximum public health impact from the contact tracing resource. The Plan was considered and approved by the Oversight Board on 22 December 2020 and I agreed it on 24 December 2020.

169. The Contingency Plan was first implemented by PHA over the 2020 / 2021 Christmas and New Year period in anticipation of significant increases in index cases and contacts, with just under 12,000 cases notified to the system in the 7 days between 28 December 2020 and 3 January 2021. Some of the operational contingency measures deployed included, for example, an increase in targeting the public uptake and use of the Digital Self Trace platform; a pause or stop to enhanced contact tracing (implemented by the CTS on 16 November 2020); prioritisation of positive cases by dealing with each new day's cases first and then focusing on cases within 72 hours of reporting, and the mobilisation of trained PHA / HSC staff as additional contact tracers.

170. On 19 July 2021 I was made aware of further planned contingency arrangements [**RS7/113** INQ000535711], again in response to modelling which indicated a significant rise in case numbers driven by the Delta variant within the younger population. At this time, as a further evolution in relation to implementation of the CTS, a revised service delivery model was developed by the PHA involving a significant expansion of the CTS workforce through the HSC Workforce Appeal, and redeployment of internal PHA staff to undertake the contact tracing role. On 18 November 2021 I was advised that the Contingency Plan was being escalated to Red Status with immediate effect following a 23% increase in the number of confirmed cases over the previous 7-day period [**RS7/114 INQ000439051**].

d. Governance and Accountability and Organisational Structure

171. As Health Minister, I set the overall course of the TTI programme and approved major policy decisions. As Chair of the Strategic Oversight Board and Senior Responsible Officer for the programme (see below), the CMO had sight of and steered strategic delivery of the programme.

172. Importantly, the Strategy set out the Department's strategic approach to this aspect of the pandemic response (testing, contact tracing and isolation), and it did not refer to a separate organisation or entity to be established by the Department to deliver the population level public health pandemic response in NI. Unlike other parts of the UK, in NI there were no separate organisational structures established for population-based contact tracing. My Department retained control of all strategic policy matters in relation to contact tracing throughout the pandemic.

173. The PHA leadership team, the CMOG, led by CMO and which included his professional and policy colleagues and expert advisors (including in respect to TTI, DCMOs, the CSA and senior medical officers), worked together to ensure the most effective arrangements to address emerging issues and challenges and the many demands faced. This collaboration was facilitated by the establishment of a number of groups, such as the Strategic Oversight Board and the EAG-T. In addition, senior officials and professional staff from both the Department and the PHA participated in national expert advisory and working groups, which further informed the strategic and operational working groups charged with delivering TTI.

174. Throughout the pandemic response the PHA, in keeping with its extant health protection roles and responsibilities, retained responsibility and leadership for the operational side of testing and contact tracing, including the further development of the CTS and the systems of internal operational control within the service. As such, the PHA would be best placed to provide further detail and information on the operational development, organisational governance and accountability structures, and process for implementation.

Test Trace Protect Oversight Board

175. In terms of the Department's governance and accountability structures, the Department established the Test Trace Protect Oversight Board (the Oversight Board) in May 2020, chaired by the CMO in his role as Senior Responsible Officer for the programme; it was ultimately accountable to me.

176. In terms of its evolution, the Oversight Board continued to meet regularly during the period May 2020 to February 2022 under its original remit and terms of reference [**RS7/115** INQ000137363]. Later in April 2022, the Board's Terms of Reference were updated [**RS7/116** INQ000137364] to oversee the implementation of the Covid-19 Test, Trace and Protect Transition Plan [**RS7/081** INQ000348966 (as above)].

177. The key role of the Oversight Board was to provide strategic oversight of both the contact tracing and testing programmes and to manage the interfaces; to oversee progress regarding operational development and delivery (informed by the updates received from PHA); and to provide advice to me in terms of policy implementation, effectiveness and evolution of both programmes. The Oversight Board ensured that the Department was able to seek and obtain assurance regarding delivery of the Strategy, and to provide assurances and regular updates to myself as Health Minister and to the NI Executive on both the testing and contact tracing operational delivery programmes, recognising that they were both key strategic elements of the pandemic response in breaking chains of transmission and reducing community transmission. This included, for example, the sharing of Contact Tracing performance data and intelligence on clusters and outbreaks (from the PHA data and surveillance systems). The advice from the Oversight Board and its membership was incorporated where relevant, together with other relevant expert evidence and advice, to inform recommendations and submissions from officials regarding key strategic policy decisions and to provide updates to the Executive on the Contact Tracing Service.

178. Strategic oversight of all aspects of work relating to the establishment and development of the Contact Tracing Service (including manual tracing, digital service, information governance and public communications) were brought together under the leadership of the Oversight Board informed by the updates provided by the PHA and Departmental officials. This included strategic oversight of the scale up and utilisation of testing capacity, and the approach to communications to support delivery of the Strategy.

Contact Tracing Steering Group

179. As I described above, with my agreement CMO established a Contact Tracing Steering Group on 1 May 2020 to oversee and support the PHA in the establishment of the CTS in NI and to provide strategic direction for its operation. This approach helped ensure that, although operational responsibility for the Contact Tracing Service was managed by the PHA, the Department retained control of strategic policy. The key aims of the Steering Group included to deliver a comprehensive Contact Tracing Service for NI in the context of its service model; technology; to oversee recruitment; and governance. The Steering Group reported directly into the Oversight Board.

180. Dr Elizabeth Mitchell (a former Deputy CMO in the Department) and Mr Alistair Finlay (Queen's University Belfast) were appointed as joint Chairs of the Contact Tracing Steering Group. The remaining members were comprised of officials from the Department of Health; PHA; Business Services Organisation (BSO); the Patient and Client Council (PCC); the NI

Council for Voluntary Action (voluntary and community sector representative organisation), and local Universities (QUB and Ulster University). Dr Mitchell provided a weekly update on progress of the work of the Steering Group to the Oversight Board.

181. The Contact Tracing Steering Group was subsequently stood down at the end of September 2020 when operational responsibility for the CTS in its entirety, and associated governance and accountability arrangements, transitioned to the PHA as part of their normal line of business. The Steering Group presented its closure report to the Oversight Board at its meeting on 10 November 2020 [**RS7/117** INQ000535706]. The PHA continued to report progress on the operation and performance of the Contact Tracing Service through the PHA Chief Executive and to the Department via the Oversight Board. This in turn enabled the Oversight Board to keep me advised in my role as Minister.

Rapid Review

182. Following a significant rise in the number of positive test results reported each day and a marked increase in the workload of the CTS, the CMO commissioned a Rapid Review of the Service on 3 October 2020. The Rapid Review was underpinned by a key assumption that there would be a significant escalation in Covid-19 infections over the weeks and months ahead (from Autumn 2020) and that, in order for the contact tracing service to be effective, positive cases had to be contacted within 24 hours and their close contacts within 48 hours of notification to the CTS. The main purpose of the Review was to support the ongoing and future delivery of the contact tracing function by looking at the elements of the service model that had worked well to date, and to consider what measures were required to effect improvements in the service including more efficient and effective contact tracing processes and increased use of technology. The Rapid Review reported on 12 October 2020, and set out a number of key findings and learning points which were subsequently taken forward by the PHA, reporting progress to the Test, Trace, Protect Oversight Board, which contributed to important improvements in the Service including in the areas of resourcing and recruitment; data management; quality assurance; and, increased public communications and improvements to messaging.

183. I subsequently wrote to the Executive on 3 November 2020 [RS7/009 INQ000375892] providing an update on the CTS, outlining the improvements to the Service following the Rapid Review exercise and detailing plans for future enhancements to the delivery model.

Departmental Structures

184. There were also a number of key changes to Departmental structures that were established to assist with the response to the pandemic. This included the establishment of a Covid-19 Response Directorate within the CMOG, led by a Grade 5 Director. The primary role of the Covid-19 Response Directorate was to provide policy direction and oversight in relation to Testing and Contact Tracing, reporting to the CMO and DCMO. To inform policy options, the Directorate worked extremely closely with, and secured inputs from, senior professional colleagues (including the CMO, DCMOs and CSA), other Departmental policy officials where relevant, and a range of other key stakeholders and partners including principally the Department's EAG-T, the Oversight Board, public health professionals from the PHA and policy counterparts across the UK. In June 2021, a Covid-19 Strategy Directorate was also established. The role of the Covid-19 Strategy Directorate was to oversee a range of new evolving responsibilities including Waste Water (WW) Surveillance, coordination of the relationship with the then soon-to-be established UKHSA; and support for the International Travel Programme.

e. Legacy Operations

185. In terms of legacy operations, I understand that the operational legacy of enhancements to test and trace systems, including Contact Tracing, remains with the PHA and is also being progressed under a PHA-led *Reshape Refresh* programme. I have elaborated further on this below at section G(1)(c), Lessons Learned.

f. Attendance of Key Individuals at Decision-Making Meetings

186. As described above, the Test, Trace, Protect Oversight Board was the key TTI governance forum and was established to provide strategic oversight of both the contact tracing and testing programmes. The Board was chaired by the CMO and membership included the two Departmental DCMOs; the then PHA Chief Executive; PHA Director and Deputy Director of Contact Tracing Service; the Chair of EAG-T; PHA Assistant Director of Communications; Departmental Solicitors Office; the Department's Information Governance Lead; the Department's Digital Health & Care Directorate, and policy staff from the COVID-19 Response Directorate. The Oversight Board met on a weekly basis from its first meeting on 12 May 2020 until September 2020, and then fortnightly. The Board's role was to provide strategic oversight of both the contact tracing and testing programmes and to manage the interfaces, to oversee progress regarding operational development and delivery, and to provide advice in terms of policy implementation, effectiveness and evolution.

187. As described, as Minister, I took key strategic and policy decisions in relation to the TTI and the normal process for a decision was for officials to provide me with a submission detailing information, options if appropriate, and the advice and recommendation of officials. The advice of the Oversight Board and its members was incorporated where relevant, together with other relevant expert evidence and advice, to inform recommendations and submissions to me regarding key strategic policy decisions. The final form of policy and professional advice to me was agreed by the CMO taking account of a wide range of inputs and advice as I have described elsewhere.

188. Departmental advisors, including the CMO, CSA, deputies and respective policy teams, continued to provide information and advice to me and the NI Executive when required in relation to TTI. The volume of advice and updates to inform decisions in relation to TTI was substantial during the pandemic and was generally routed through my Private Office. I agreed final advice from my Department to the Executive. In addition, the CMO and CSA also accompanied me to pre-NI Executive meeting briefings with the First Minister (FM) and deputy First Minister (dFM) on an *ad hoc* basis in the first few months of the pandemic and then more regularly later in 2020 when these became more routine. The CMO and CSA also attended NI Executive meetings to give presentations on the latest 'R' paper, provide updates on the TTI and to answer questions posed by NI Executive Ministers.

g. Privacy Considerations

189. In relation to the Proximity App, a StopCOVIDNI Expert Advisory Board was constituted during the development phase to ensure public concerns over privacy, security and accessibility were addressed, despite the urgency of the need to develop the app. A copy of the Terms of Reference of that group is provided [**RS7/118 INQ000574185**]. Information regarding the Proximity App was also published on the Department's public facing external website [**RS7/119** INQ000137418].

190. Use of the Proximity App was voluntary and was dependant on possession of a compatible phone. Whilst basic download and phone type information was collected from the Apple/ Google Stores no demographic information was collected. An undertaking was made to key stakeholders prior to the launch of the Proximity App to limit the data collected to help address any privacy concerns. A copy of the Department's Data Privacy Impact Assessment and the response from the ICO is provided [**RS7/120** INQ000535714 and **RS7/121** INQ000535715]. No demographic or use data was collected.

191. As noted above the PHA's Digital Self Trace online platform was developed to support the CTS to manage the high volume of cases experienced during the pandemic, and further assisted contact tracing staff to focus on more challenging and complex cases. A Data Privacy Impact Assessment and relevant privacy notices produced by the PHA were made available on the PHA website and NI Direct website. There was no requirement or need for decision-makers or policymakers in the Department to have access to personal level data from testing and contact tracing systems. Public confidence in the confidentiality of the retention and use of this data was essential in maintaining voluntary engagement with contact tracing, the sharing of information on close contacts and the potential setting and activity associated with infection.

h. Communication with other Devolved Nations on the Development of Tracing Apps

192. My Department worked collaboratively with the other UK regions and the RoI in developing the STOPCovid NI Proximity App. For example, my Department cooperated with its IT counterparts in NHS England, NHS Scotland and NHS Wales regarding the use of smartphone proximity apps as part of an informal four nations IT collaboration group. Decisions taken by the Department on technical aspects of the app, including the use of the Google / Apple based Exposure Notifications Application Programming Interface, were informed by these conversations. I understand that informal arrangements existed pre-pandemic through which the digital service leaders across the 4 UK nations were in communication with each other, with similar arrangements in place between NI and RoI.

193. To ensure the required interoperability with the RoI, NHS England and Scottish proximity apps, and that NI citizens would need only install and use one app, it was agreed that the NI app should use the Google/ Apple design model. The ability of the Proximity Apps in NI and RoI to communicate with one another was also an important factor in the management of Covid-19 cases in border areas, facilitating the exchange of non-identifiable exposure information across the border to protect the population on the island of Ireland and was key to promoting the use of the Proximity App. The NI Proximity App was the first of its kind, worldwide, to work across a border between two jurisdictions. It was also interoperable with the Scottish and Jersey apps [**RS7/122** INQ000373476].

194. The emergence of an international standard for "proximity app" detection and interchange of information mechanisms drove the convergence of all jurisdictions (UK, RoI and EU) to adopting a similar interchange model, with back-office information processes tailored to their healthcare ICT infrastructure. As noted above, the NI Proximity App was an early

adopter of the Google / Apple supplied mechanisms (covering the majority of mobile phones in use) and therefore was fully interoperable with all other UK apps, the RoI app and apps across the EU.

i. Comparison of other UK and RoI Contact Tracing Models

195. An overview of the cross-UK operational differences and similarities in relation to contact tracing, including in relation to functionality and service delivery models, is included within the 4 CMO's Technical Report (Chapter 7 from page 217) [**RS7/123** INQ000203933]. In summary England set up a new national system whereas Scotland, Wales and NI adapted existing structures for large-scale contact tracing.

196. The CTS delivery model in NI has been described above with the digital solutions involved to augment the manual aspects of the service. In England, during the early stages of the pandemic, contact tracing was carried out by Public Health England (PHE) working with local authorities. NHS Test and Trace (NHS T&T) was created on 28 May 2020 to lead the government's test, trace and contain approach. NHS T&T worked in conjunction with the PHE, local authorities, and commercial and academic providers to provide testing and tracing services including supporting people to self-isolate. Contact tracers were employed under contract by SERCO.

197. In Scotland, the overall approach was to use existing organisations and partnerships and to pivot these rather than set up new services. Test and Protect was a Scottish Government-led partnership between NHS health boards, Public Health Scotland and NHS Scotland, and was established in May 2020. Operational delivery was through a local / national partnership model with each local health board recruiting a contact tracing team, and a national contact centre was also set up.

198. In Wales, the contact tracing service used existing public sector structures and was delivered through joint local–regional–national working. The Welsh Government provided national oversight, Public Health Wales provided technical expertise and experience, for example writing an operating framework for regional teams and writing scripts, and health boards and local authorities delivered the contact tracing service using their local intelligence and knowledge.

199. I understand that the operational service delivery model for contact tracing in the RoI was broadly similar to that in the UK nations in that it utilised a combination of manual tracing and digital innovations.

j. Engagement

200. As the PHA was operationally responsible for delivery of CTS they are best placed to provide the Inquiry with information on engagement with Local Resilience Forums, Local Authorities and healthcare bodies. TEO will be able to provide information on how the NI Executive engaged with the same bodies.

k. NI StopCOVID App and Public Communications

201. My Department led the development of the StopCOVID NI Proximity App which I launched in NI on 31 July 2020 for those aged 18 or over [**RS7/124** INQ000373403] as part of the NI Test, Trace, Protect Strategy. The public campaign to promote the StopCOVID NI app, which supported and supplemented the PHA's existing telephone contact tracing service, emphasised that the NI health service was using "Test, Trace, Protect" to help beat Covid-19 as a way to encourage the public to download the app. In the lead up to the launch I provided a number of updates to the NI Executive on the Proximity App including a paper on the Options for Digital Contact Tracing [**RS7/125** INQ000130398]; progress on developing a NI specific Proximity App [**RS7/126** INQ000120718; and, of the planned launch of the Proximity App including details of the features of the app and cases to illustrate its use [**RS7/127** INQ000130399 and **RS7/128** INQ000317480].

D. ISOLATION

202. I have addressed these questions, in the main, in the context of my decision-making role in relation to TTI policy decisions at population level regarding isolation of those with symptoms, suspected cases, positive cases and close contacts, rather than isolation as a result of Covid-19 Regulations ('Lockdown' regulations).

203. In both England and Wales, cases and their contacts had a legal duty to self-isolate and breaching self-isolation could result in fines. This was changed to guidance in spring 2022. However, In NI there was not a legal duty to self-isolate for domestic cases and contacts. Rather, rules were classified by the Department of Health as "very strong guidance". This

was the same in Scotland but, in both jurisdictions, there was a legal duty to self-isolate after international travel.

1. Evolution of the Guidance on Isolation

204. The timeline of changes below outlines how rules and guidance relating to self-isolation in NI evolved during the pandemic:

13 March 2020

205. In line with the decision taken at the COBR (M) meeting 12 March 2020, from 13 March 2020 individuals developing symptoms (new persistent cough and / or fever) were advised to self-isolate for 7 days. I attended the COBR meeting along with the NI FM and dFM. The CMO and officials from TEO also attended. I understand this change applied across all UK nations from that date [**RS7/129** INQ000531578].

16 March 2020

206. Following a decision at COBR (M), members of the immediate household (close contacts) of a case were also advised to self-isolate for 14 days. This change applied throughout the UK.

30 July 2020

207. The guidance was updated to extend the self-isolation period from 7 to 10 days for those who had coronavirus symptoms or a positive test result [**RS7/130** INQ000137383]. I understand this change applied across all UK nations. The change was underpinned by a statement on 30 July 2020 by the UK CMOs [**RS7/131** INQ000582398]. I wrote to the NI Executive advising of the change [**RS7/132** INQ000381316]. Evidence, although still limited at that time, had shown that people with Covid-19 who were mildly ill and recovering had a low, but real, possibility of infectiousness between seven and nine days after illness onset.

14 December 2020

208. The guidance was updated to reduce the self-isolation period for close contacts of a confirmed positive case from 14 days to 10 days [**RS7/133 INQ000532755** approval and **RS7/134 INQ000442434**]. The change, announced on 11 December 2020, was based on a recommendation by the 4 UK Chief Medical Officers [**RS7/135** INQ000137384]. The announcement confirmed that the change would apply in NI, England and Scotland from that date and that it was already in place in Wales. The decision was based on the available

evidence at the time regarding the likelihood of a contact being infectious after 10 days of self-isolation, and also took account of modelling papers from Public Health England and SPI-M, and advice from SAGE. My memo to the Executive confirmed that Health Ministers across the four nations were in agreement with the change [**RS7/136** INQ000304966].

16 August 2021

209. The guidance was updated so that close contacts who were fully vaccinated no longer needed to automatically self-isolate for 10 days. Instead, they were advised to get a PCR test on day two and day eight of the 10-day period. If they tested positive following a PCR test, they were advised to continue to self-isolate. If they developed symptoms, they were advised to self-isolate and book a PCR test in line with the extant guidance for those with symptoms. The NI Executive agreed the changes [RS7/012 INQ000531581; **RS7/137** **INQ000348896** and **RS7/138** INQ000531583].

210. People who were not fully vaccinated still needed to self-isolate for 10 days. The policy change applied to close contacts only. There was no change in relation to those with symptoms or those who tested positive. People who had Covid-19 symptoms, whether vaccinated or not, were advised to immediately book a PCR test and self-isolate until the result. People who received a positive PCR test were advised to keep self-isolating for the 10-day period.

211. Policy in relation to exemption from self-isolation for fully vaccinated close contacts was fast moving across all the UK nations around the time of this change (August 2021). The changes introduced in NI broadly aligned with the policy changes planned or already implemented in other UK Nations around this time, with some specific requirements associated with the change in approach in each country.

17 December 2021

212. The guidance was updated so that close contacts who were fully vaccinated were once again advised to self-isolate immediately for 10 days and book a PCR test. If the PCR test was negative, isolation could stop but the close contact was advised to take a daily lateral flow test every day after the negative PCR result until the 10th day after the last date of contact. The previous advice for fully vaccinated close contacts to take a PCR test on day 2 and 8 was removed [**RS7/139** INQ000531584, **RS7/140** INQ000531585 and **RS7/141** INQ000348902].

213. I agreed this update to the guidance in response to the emergence of the more transmissible Omicron variant and this represented a strengthening of the self-isolation guidance for close contacts of confirmed cases. The changes were introduced with the objective of keeping positive case numbers as low as possible while the accelerated vaccine booster programme was delivered.

214. The submission provided to me by officials at the time [**RS7/140** INQ000531585] indicated that the approach differed in other UK nations; and set out, for example, the approach in England was that fully vaccinated contacts were to undertake daily lateral flow testing from day one having been identified as a close contact (there was no advice to isolate immediately and no advice to take PCR tests unless a lateral flow test was positive or they developed symptoms). I do not recall why there was a difference in approach but I was clearly aware of the difference, on foot of the submission provided to me. In any event,as health is a devolved matter the DAs were able to differ from the approach in England.

5 January 2022

215. The guidance was updated to reduce the required self-isolation period after a positive Covid-19 test. Positive cases could leave isolation on Day 7 providing they had two negative LFD tests at least 24 hours apart, no earlier than Days 6 and 7. This approach was in line with the other UK nations. Further, fully vaccinated close contacts were no longer required to take a PCR test and could release from isolation following a negative LFD test and provided they continued to return a daily negative LFD test result thereafter until the 10th day after last contact with the positive case. The position with unvaccinated close contacts remained unchanged [**RS7/087** INQ000467025 (as above) and **RS7/083** INQ000383198 (as above)].

216. I agreed the changes on the 24 December 2021; however, the timing of introduction was kept under review, taking account of positive case numbers. The changes were implemented with effect from the 5 January 2022 when many businesses and services returned to normal working after the Christmas and New Year holidays. At that time, the rate of community transmission was growing rapidly, with large increases in confirmed cases expected in the coming days and weeks. I noted in my memo to Executive colleagues [**RS7/098** INQ000531586 and **RS7/142** INQ000531587] that the changes were necessary to optimise the public health response and seek to control community transmission and detection of symptomatic disease. In addition, the changes to self-isolation policy would reduce the impact of the self-isolation requirements on both cases and contacts and on the delivery of critical services.

21 January 2022

217. I agreed that the period of isolation for confirmed cases be reduced from 6 full days to 5 full days, with release on day 6 providing the case had two consecutive negative LFD test results 24 hours apart, with the first taken no earlier than day 5 [**RS7/143** INQ000532756, **RS7/088** INQ000348904 (as above) and **RS7/144** INQ000357327]. I understand that the same change took effect in England from 17 January 2022, and was under active consideration in Scotland and Wales at the time of introduction in NI.

2. Drivers and Evidence Informing the Changes

218. My decision making in relation to changes to the isolation guidance was informed by the professional, technical and policy advice and submissions provided to me by Departmental officials, including by the CMO and the CSA. I understand that knowledge about the virus and its behaviour was largely derived from discussions at SAGE and its subgroups, along with other sources considered by the Department's Strategic Intelligence Group (SIG), including international practice, and at UK Senior Clinicians and the 4 UK CMOs group meetings. This in turn informed the advice that was given by CMO and CSA to me and to the NI Executive.

219. The Department's SIG was a key source of advice and expertise to inform the NI response to the pandemic. It was established in or around 27 April 2020 and chaired by the CSA Professor Ian Young. SIG considered scientific and technical evidence emerging from SAGE and other sources alongside NI data on the trajectory of the pandemic, much of which also fed into NI modelling. The evidence considered and the analysis provided by SIG informed the advice that the CMO and CSA provided to me and in turn to the NI Executive. This advice helped inform policy decisions by Ministers during the pandemic, particularly in respect of the potential health impacts of Covid-19 in NI and the approaches to mitigating these.

220. The Department's NI Modelling Group **RS7/145** INQ000137356] was also chaired by the CSA. The role of the group was to undertake population level modelling work and to estimate the value of 'R' in NI. The group considered information and modelling generated from across the UK and within NI to inform their work and this was submitted to the NI Executive and published on the Department's website. Outputs of this modelling and, in particular, the projected number of cases was one strand of data considered by the PHA in TTI planning. While the Department did not undertake specific modelling for TTI, as I have

referenced above, I recall that the CSA provided recommendations to the PHA on numbers of contact tracers required in 2020.

221. Scientific evidence relating to the virus and behaviour was shared across the UK and was discussed both at SAGE and the senior clinicians' group. As such there was, in general, close alignment in terms of advice and decisions about self-isolation periods between the four nations of the UK. Policy decisions by the NI Executive also took into account other factors, including economic considerations and assessments of impact on society and family life.

222. The evolution of guidance was informed from the start of the pandemic by knowledge of the virus and its behaviour, awareness of particularly vulnerable individuals and populations, the availability of vaccination and epidemiological data. For example, advice on the duration of self-isolation changed with increasing understanding of the duration of the period in which individuals were likely to remain infectious. In general, the trigger for self-isolation to commence was determined as the best estimate of the point at which it was known that an individual was likely to be able to transmit the virus to others, and the end of the self-isolation period was the timepoint at which it was considered that an individual was unlikely to be able to transmit the virus to others. Knowledge about this developed as the pandemic progressed.

3. Groups Disproportionately Impacted by TTI Isolation Requirements

223. The NI Executive, Department of Health, the PHA and I were aware of the potentially disproportionate impact of the pandemic and restrictions, including isolation rules and guidance, across society in general, with a greater impact on certain socioeconomic groups, ethnic minority groups, the elderly, the young, those with a disability and those who required health care. In general, it is not possible to disaggregate the impacts of an individual NPI measure such as isolation requirements. However, it is the case that the impacts of the wider NPIs and self-isolation guidance were not felt equally by all and that some were significantly disadvantaged as a consequence.

224. I recall that the Department and the PHA commissioned or led a number of reviews that considered the impact of the pandemic and the NPIs which were introduced to reduce community transmission, including contact tracing and isolation requirements. For example, at the start of the pandemic the Health Intelligence Unit in the PHA developed an evidence overview on inequalities which was shared across the Department and used to inform policy.

225. In 2020 during the first wave of the pandemic, the Department commissioned the Institute of Public Health Ireland (IPHI) to complete a series of reviews of the potential impact of the pandemic on the indicators in the NI Executive's Public Health Framework, "Making Life Better", the overarching strategic framework for public health in NI. The reports provided evidence drawn from local, national or international sources on trends in these indicators during the pandemic and research reports on likely impacts on these indicators (including for example, poverty, employment and economic security; educational attainment; drug use, homelessness, domestic violence; mental health and suicide; and loneliness and social isolation). The first two reports were produced in May 2020 [**RS7/146** INQ000276461 and **RS7/147** INQ000276462] and the third report in July 2020 [**RS7/148** INQ000276463]. Each report provided updates on new evidence or research in any of these areas since the last report was collated. Evidence came from a variety of sources and included government reports, academia, community / voluntary organisations and the WHO.

226. In both June and December 2020, the Department published the Coronavirus Related Health Inequalities Reports. These reports present an analysis of Covid-19 related health inequalities by assessing differences in infection rates, hospital admission rates and deaths between the most and least deprived areas of NI and within Local Government District (LGD) areas for Covid-19 infection and admission rates.

227. These reviews collectively informed the advice I and the Department provided to the NI Executive reviews of the NPI restrictions. The public health guidance around self-isolation for positive cases and close contacts was different to the Covid-19 Regulations ('Lockdown' regulations), which were in force in NI at different stages and with changes throughout the pandemic. The regulations were introduced to put NPIs on a statutory footing and were subject to regular reviews by the NI Executive. Each review considered the public health implications of the NPIs, as is reflected in the relevant review of regulations papers which I submitted to the NI Executive, and which took account of advice from CMO, CSA and the evidence base described above. Any potential emerging equality issues which required amendments to the regulations were reflected in the reviews. From the second Review of the Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020 [**RS7/149** INQ000346705] and thereafter throughout Wave 1 of the pandemic [**RS7/150** INQ000346706, **RS7/151** INQ000346707, and **RS7/152** INQ000346708] and subsequent waves, the NI Executive papers considered not only the impact of the pandemic itself, but also the measures put in place to control the spread of infection including the impact of self-isolation and social isolation more generally as a result of the wider NPIs.

228. I highlighted potential adverse impacts of restrictions including isolation periods in these papers submitted to the NI Executive; for example, impacts on mental health and loneliness were considered in the context of advice given on "bubbling" arrangements in the December 2020 period. Wider impacts on mental health and wellbeing and discussion of domestic violence were highlighted in the third review of the need for restrictions [**RS7/153** INQ000448941]. The fifth review of the need for restrictions highlighted issues relating to drug and alcohol misuse [see **RS7/152** INQ000346708 (as above)].

4. Support

229. The risk of exacerbating existing inequalities was repeatedly highlighted in these submissions and the Department also provided advice to DfC on the need for mitigations to support self-isolation. DfC had a lead role in providing the support that was needed for those who were self-isolating, including the provision of financial support through its Discretionary Support Scheme. I wrote to the NI Executive on 22 November 2021 [RS7/013 INQ000357313] highlighting the importance of financial support and other support mechanisms for those self-isolating and that this was a collective role for all Departments. In the same letter, I highlighted again the need for adequate financial support for those isolating and that such support must be accessible for all that needed it, in particular the most economically vulnerable.

230. I also wrote to the then Communities Minister highlighting the continuing importance of financial support to those isolating and seeking an update of the financial support measures in place and consideration of enhancements that may be required to support self-isolation particularly those on low income [**RS7/103** INQ000346709]. The Communities Minister's reply set out the range of supports actively being delivered by her department (including the Discretionary Support Scheme for those isolating and how DfC was working with PHA to support individuals in the event of a Covid-19 cluster outbreak), and further supports under consideration by her department [**RS7/154** INQ000453240]. The Department worked closely with DfC counterparts under the auspices of the Test, Trace, Protect Oversight Board. For example, I recall that the Department worked with DfC during mid-2020 to put arrangements in place for priority access to online grocery shopping slots for those who were Clinically Extremely Vulnerable and isolating. This included food box deliveries to those who were unable to access food through online shopping, family, friends or local support networks.

231. Advice in different accessible formats for those self-isolating and information regarding sources of support was available on NI Direct and via the COVID CareNI App and the COVID CareNI Helpline. Advice on the self-isolation period was essentially uniform and applicable to all, apart from bespoke advice to those who were considered to be particularly vulnerable. The Department recognised that there were different risks of virus exposure for different segments of the population, and the impacts of rules and regulations would also differ. This was addressed in various ways, through targeted messaging and communication, some sector specific guidance and through specific support. For example, specific letters were issued to those considered to be particularly vulnerable as a result of physical disabilities and/or physical health conditions [see for example **RS7/155** INQ000120706 and **RS7/156** INQ000130315]. I recall also there were targeted interventions by the PHA aimed at minority ethnic groups identified as at particular risk and areas where individuals were living in crowded or cramped accommodation, and regular meetings were held with religious and faith leaders including those from minority religious groups and faiths to provide information and hear their concerns. The PHA work was supported by its Contact Tracing Vulnerable Groups Action Plan **RS7/104** INQ000375903 (as above)] to assist in its approach to engagement with hard-to-reach groups. I shared the PHA Action Plan with the NI Executive on 2 September 2020 **RS7/105** INQ000375902 (as above)].

232. Further, the Department recognised that many people saw a deterioration in their mental health during the pandemic and that this was exacerbated by the NPIs, including the guidance for self-isolation and repeated periods of self-isolation. A range of initiatives from the Department's mental health cell were put in place to mitigate these effects, including public information campaigns highlighting, for example, the advice available on the Mind Your Head website. NI Direct also directed people to sources for advice and support and a Northern Ireland Covid-19 Community Helpline, managed by the third sector organisation Advice NI, was available 7 days a week to support anyone who was feeling isolated and connected people to a range of practical and emotional support services, including local volunteer supported shopping and local or community food support organisations. A Covid-19 Virtual Wellbeing Hub was launched in mid-June 2020 providing access to self-help guides and tailored information from local mental health and well-being charities. While these did not all directly result from decisions that I made, they are examples of important resources designed to help maintain and promote positive mental health and well-being both during and after the Covid-19 pandemic, including for those in disproportionately impacted groups.

233. In September 2021, the Education Minister and I agreed updated advice on the policy for contact tracing and isolation in schools. The change took account of updated advice from the 4 UK CMOs and of available analysis by the PHA and in other jurisdictions of the disproportionate impact that the contact tracing and subsequent isolation was having on children from lower socioeconomic groups. A more targeted approach to the identification of close contacts of Covid-19 cases in schools was introduced in order to strike a balance between safeguarding children's education and wellbeing and measures to contain Covid-19. The approach also took account of a range of other factors including the very low risk of severe disease in children and the impacts caused by longer periods of isolation to children's education. The approach was changed to minimise exclusion when additional evidence suggested it was proportionate to do so [**RS7/157** INQ000305111 and **RS7/158** INQ000137386]. On 30 September 2021, I wrote to advise the NI Executive of the decision to extend the more targeted approach to Contact Tracing in schools to certain out-of-school settings, so as to align these with in-school contact tracing. This change brought arrangements in registered school-age group childcare settings, sports clubs and similar settings into line with those introduced in schools [**RS7/159** INQ000303749].

E. DECISION MAKING STRUCTURES

234. I believe that TEO is better placed to comment on the Executive's engagement with healthcare bodies on TTI matters. I am not aware of significant engagement that the NI Executive had with the NI Assembly, the HSCB, HSC Trusts or the PHA in relation to TTI matters. I have described below how I and my Department engaged and co-operated with various bodies.

1. Working with Northern Ireland Executive Ministers

235. I consider that in general the Northern Ireland Executive responded well to the pandemic particularly given that we had only returned to government on 11 January 2020. This included joint working at times in relation to areas within scope of Module 7. For example, in relation to International Travel, I believe the Executive adopted and took decisions in accordance with, and appropriate to, the advice which I received both from the CMO and CSA. There is no doubt that, at times, there were tensions and frustrations among us as an Executive: we all had different stakeholders who were impacted in various ways by the NPIs and who required championing. These have been explored more fully in previous modules to the Inquiry, in particular Module 2C. In general, however, I would consider that throughout the course of the pandemic I had reasonably effective working relationships with each of my ministerial colleagues.

236. I, and the Executive as a whole, received a wide range of scientific, medical and modelling advice from a number of sources, including the CMO, the CSA, SIG, the modelling group and SAGE. This advice was always considered, discussed and used to inform mine and the Executive's decisions – this was important to effective engagement and decision making.

237. As described elsewhere in this statement, there are also several examples where I worked constructively and in agreement with other Executive Ministers in relation to testing programmes such as with the Education Minister with regard to testing in schools; with the Infrastructure Minister in relation to testing of hauliers in January 2021, and with the Agriculture Minister in relation to testing at AFBI as part of the academic consortium.

238. In terms of what might be improved, I held regular media briefings, alone, with the Chief Medical Officer and with other Minsters. These allowed open channels of communication with the media which was important for keeping the public and others updated. I believe these worked best when they involved both the FM and dFM and I believe this involvement should have been more fully maintained throughout the duration of the pandemic.

2. NI Assembly

239. The main scrutiny by the NI Assembly of the decisions and actions taken by my Department and I was undertaken by the Assembly's Health Committee, and this included at times decisions and delivery in relation to TTI. I appeared in front of the Committee 16 times, throughout the course of the pandemic, usually accompanied by the CMO and occasionally with the CSA. My engagements were in my view generally constructive.

240. As I described earlier, the Coronavirus Act 2020 amended the Public Health Act (NI) 1967 to provide powers for the Department of Health alone to make regulations in response to the Covid-19 pandemic. I believe the format and approach of the NI Assembly in how it managed regulations brought under the Coronavirus Act could have been more agile at times, as, on a number of occasions, the regulations that were being debated in the Assembly had been superseded by further amendments, although these were mainly on the easing or lifting of restrictions. However, by the time the Assembly came to debate Covid regulations they had already been scrutinised and accepted by the Assembly's

Health Committee and had also been through the office of the "Examiner of Statutory Rule".[2]

241. At the early onset of the pandemic when the NI Assembly ceased to function there was a noticeable increase in the number of Assembly Questions for Written answer. This naturally had an impact on Departmental officials, who along with progressing urgent policy and legislation in relation to Covid-19, also had to answer an increasing number of questions. The Executive wrote to the speaker raising concerns about the number of questions and seeking a reduction in the number that members were encouraged to ask. I also wrote with similar concerns and seeking the same reduction, which was subsequently allowed, although it was voluntary.

3. Public Health Agency

242. As I have described, the role of the Public Health Agency was central to the pandemic response in Northern Ireland including in particular to delivery of testing and contact tracing. There was considerable close joint working between my Department and the PHA, aided by the establishment of a number of working groups and programme boards in relation to TTI as I have described elsewhere. This close collaboration was both necessary and proportionate to support effective strategic and policy delivery of TTI and helped make the most of available experience, skills and expertise. As I have said previously, this close joint working I believe had a positive impact in NI.

243. When Public Health England was abolished in March 2021, I did not contemplate a similar move in relation to the Public Health Agency in Northern Ireland as I considered it an essential part of the health care system structure. The PHA was central to our response and due to the small number of individuals working in public health it would have caused unnecessary upheaval without a clear benefit to Northern Ireland's response. The Department also did not have the capacity or resource to scope such a dramatic move.

4. HSC Trusts

244. I have set out in my previous statement to Module 3 of the Inquiry covering a range of policy and service delivery areas my detailed role, engagement and involvement with HSC Trusts and with the wider health and social care delivery systems [RS/001 INQ000492281]. In

[2] The Examiner assists the Assembly and the appropriate Statutory Committees in the technical scrutiny of statutory rules and draft statutory rules which are subject to procedures before the Assembly (that is, affirmative resolution, negative resolution, confirmatory procedure or laying in draft for approval).

relation to TTI policy and the scope of Module 7, I do not recall that I had significant direct engagement with HSC Trusts. I have set out above my role in increasing capacity in Pillar 1 HSC laboratories including through the Academic Consortium and, under the NTP MoU which I agreed, the procurement of new testing technologies utilised in Pillar 1 across hospital sites. I have also described the process for development of the Interim Protocol on Testing, which set out testing to support clinical pathways and care, and for testing in care homes which was a significant priority for me and for the Department throughout the pandemic. I was also aware that the Department had supported and enabled programmes of testing for healthcare workers (both symptomatic and asymptomatic).

5. The Health and Social Care Board

245. The Health and Social Care Board (HSCB), now Strategic Planning and Performance Group (SSPG) within the Department, formed Health Silver along with the PHA and Business Services Organisation (BSO). The HSCB (now SPPG) and its senior management team, supported by the PHA in keeping with their extant role and responsibilities, played a significant role in the oversight and coordination of the wider HSC response through their role within Health Silver reporting initially to Health Gold and later to the integrated Covid-19 Gold Command Group and the Management Board for Rebuilding HSC Services. The Silver response was aligned with the strategic objectives set by Health Gold; I was provided with regular updates.

246. In relation to TTI policy and the scope of Module 7, I do not recall that I had significant direct engagement with HSCB. I was aware of the role played by the regional NI Pathology Network (which was hosted by the then HSCB, now SPPG within the Department), for example, which worked to enable planning and coordination of the expansion of Covid-19 testing in HSC Laboratories (often referred to as Pillar 1), working with and reporting progress to EAG-T. The roles and responsibilities of HSCB have been described more fully in previous statements that I and the Department have given to the Inquiry, in particular to Modules 2C and 3 **RS7/099** INQ000412903; **RS7/160** INQ000411550; **RS7/161** INQ000421800, **RS7/162** INQ000485167 and RS7/001 INQ000492281].

6. Collection and sharing of data

247. Data collection was a critical component of the Covid-19 response. There was a wide range of data sets, and supporting data collection and flows, which were used by the Department to support strategic and policy TTI decision making, and also the wider public health

response. There was also a range of Expert Advisory Groups and boards that officials in the Department had involvement with during the pandemic. In relation to TTI these included the Test, Trace, Protect Oversight Board, the NI SMART Programme Board, International Travel Directorate, the Department's SIG, the Department's Modelling Group, and the Department's EAG-T. While I did not attend any of these myself, I would have received relevant updates and advice from the officials who did attend and, at times, this advice would also have been presented to the Executive to aid in our decision making. Further detail on the role and key outputs from these groups has been set out elsewhere in this statement.

248. Data from the TTI system was made available to me throughout the pandemic in various ways for example through periodic reports/ updates, in written submissions, and in verbal updates and presentations. Data was similarly made available to the NI Executive in written papers from my Department which I agreed, and verbally by CMO, CSA and I at meetings of the Executive, and in pre-NI Executive meeting briefings with the FM and dFM which I attended often supported by CMO and CSA. These series of meetings provided an opportunity for both CMO and CSA to explain some of the nuances of emerging / evolving science and epidemiology to aid Ministers in making decisions and, in particular, to make clear the uncertainties involved in modelling and other aspects of the science. I am aware that TTI data was also used routinely to inform targeted operational public health interventions by the PHA, for example to support outbreak management in local council areas and settings (including workplaces).

249. The following are key examples of the types of such data and analysis, including data sources, that I had access to and that was made available to me which informed policy and professional advice to me and to the NI Executive to aid decision making:

- From 12 February 2020, the PHA produced a daily surveillance report which initially included data on testing and positive tests. By 20 March 2020 this report was being published as a bulletin and its content expanded to include data on Covid-19 deaths and to provide analysis of positive Covid-19 cases by geographical area, age and gender, and Surveillance of Acute Respiratory Infections consultations in primary care.
- The Department's Covid-19 Dashboard commenced in mid-April 2020 and was updated throughout the pandemic [**RS7/163** INQ000130401]. The Dashboard was shared on a daily basis with me, the CMO, CSA, and other key individuals. The PHA daily bulletin referenced in the point immediately above was stood down when the Covid-19 Dashboard commenced. The Dashboard provided a common data set which included a wide range of data in relation to testing and infection rates for example:

- The number of individuals testing positive;
- The rate of individuals testing positive per 100K population;
- The total number of individuals tested by Local Government District;
- Breakdowns of the number of individuals testing positive by Local Government District, gender and age bands;
- Information on outbreaks including in care homes and the extent of outbreaks; and
- Hospital beds available and occupied; Intensive care Unit beds available and occupied including the number occupied by Covid-19 patients; and the number of Covid-19 discharges.

- On 28 May 2020, the Department submitted to the NI Executive the first 'R' paper produced by the NI Modelling Group [**RS7/145** INQ000137356 (as above)]. The 'R' paper was accompanied by a second paper which provided briefing and data, including on confirmed cases, deaths, tests, cases in other UK jurisdictions, cases in care homes, cases and deaths in RoI, testing capacity, and numbers of tests of staff and residents in care homes. From 8 June 2020, the Department published weekly 'R' data on its website alongside 7 day rolling average figures for new cases and hospital admissions. The analysis of the potential impact of new variants and their potential significance in terms of community transmission, outbreaks, and hospital pressures was also contained in the weekly R paper. The 'R' paper was submitted weekly to the NI Executive and was presented by myself, CMO and the CSA verbally at NI Executive meetings.
- The PHA captured and reported a suite of surveillance and epidemiological information. For example, the PHA published weekly information on its public facing website relating to cases, incidents, clusters and outbreaks [**RS7/164** INQ000432329]. The information was captured through Enhanced Contact Tracing, testing, and public health risk assessment and management of incidents, outbreaks and clusters. The analysis of such information by setting informed the advice provided to me by CMO and CSA and to the NI Executive in relation to the effectiveness of and adherence to restrictions in different settings and activities, and also informed discussions about what impact specific easements in restrictions were having on transmission and incidence of Covid-19. The same intelligence on clusters and outbreaks informed discussions on the need for targeted local actions operationally led by the PHA and other agencies.
- The PHA also maintained local management information systems to assess and report its performance in relation to the contact tracing services – including, for

example, the volume of cases and contacts successfully traced, the number of positive cases contacted within 24 hours, the number of close contacts contacted within 48 hours of notification to the contact tracing system, the number of telephone attempts made to positive cases, and the uptake and usage of digital self-trace. This data was disaggregated and used internally by the PHA to inform its decisions regarding planning and operational delivery of the CTS and was publicly reported in the PHA Weekly Bulletin. It was also discussed with the Department as part of oversight arrangements, and regular updates were also made available to me and to the NI Executive (including as part papers provided by my Department to inform review of the NPI Regulations – see for example, **RS7/165** INQ000065591 and **RS7/166** INQ000065604].

- The Pathology Network maintained a range of data regarding Pillar 1 testing capacity for PCR and for new testing technologies. This was reported weekly to EAG-T and to CMO and I and was used to inform capacity optimisation and resilience planning across the Pillar 1 network.
- Queens University Belfast (QUB), RVL and the PHA maintained data systems in relation to Whole Genome Sequencing (WGS) testing undertaken on suitable samples from both Pillar 1 and Pillar 2. WGS testing was used to confirm the identification of new variants and to support risk assessments and public health response by the PHA. Data was used to inform targeted public health responses guided by the PHA, including for example targeted outbreak testing, assisting in the attempted containment of initial transmission of more transmissible variants or those with increased disease severity. This data was used to inform the analysis of the potential impact of new variants which was contained in the weekly R paper, as I have described above.
- Wastewater Testing: QUB developed a GIS-based (Geographic Information System) interactive dashboard to present the results from wastewater testing and provided a weekly WW surveillance summary report to the PHA and to the Department indicating prevalence across the tested sites, sequencing outcomes and comparisons between normalised wastewater data and ONS data. The findings were shared in a weekly summary report with the Department, and with the PHA to inform the public health response. I was kept appropriately updated with WWS testing results and analysis.

250. As I have described elsewhere, consideration of quantitative datasets was supplemented and supported by consideration on an ongoing basis of other information, evidence, expert

consensus recommendations from a variety of sources – local, national and international - to help inform the development of TTI policy advice and decision making.

251. In general, I considered that the data presented to me was reliable. Decisions were made in circumstances where there was often an incomplete and emergent evidence base, and it was a case of having to act on the best available information and evidence in a rapidly changing and very complex environment. Further, it was often the case that no single piece of data was considered in isolation, rather it was the combination and triangulation of all data and information that informed advice to me from officials and my decision making.

252. I carefully considered all information provided to me before taking any decision. This included the detailed scientific, medical and technical advice from the CMO and CSA which also took account of the wider evidence base, expert advice and recommendations as described. Where I required further data, information or explanation I requested these from officials before making a decision.

7. Data That Was Not Available

253. Throughout the pandemic new data sources and information flows were established and developed across the pandemic response, including in relation to TTI. The data available to the Department in the first few months of the pandemic was limited compared to what became available in later months and years. The rapid expansion of testing in NI necessitated the provision of timely Covid-19 data reporting to inform policy, support operational decision-making and to facilitate monitoring of testing capacity and activity. There were some challenges early in the pandemic obtaining reliable, accurate and timely data in relation to Covid-19 testing. Business as usual data capture and reporting mechanisms in place at the time of the outbreak were not sufficient to support the response to a public health emergency such as Covid-19 and it was necessary to create many new data capture and reporting systems. In many ways this was a particular challenge for NI given that the Department and the PHA had, by comparison, significantly less resource available to it as compared to other UK jurisdictions.

254. The initial phase of the pandemic, in particular, was highly complex and rapidly evolving, and there was an urgent need to develop robust arrangements to ensure the timely sharing of accurate and up-to-date information. These challenges were the same across the UK as we sought to ensure robust and comparable data sets to track the pandemic. The PHA worked at pace with public health and policy colleagues across the UK to agree definitions

and associated systems to capture information on cases, contacts, deaths, and numbers in hospital. The approach adopted by the PHA was similar to that of other public health bodies in the UK. Throughout the pandemic the PHA continued to work closely with the Department and with colleagues across the UK to both collect and report public health data on the progress of the pandemic. DHSC / UKHSA also worked at great pace to establish data systems and data flows with DAs to support the operation and delivery of the NTP.

255. There were also difficulties in NI in that routine data flows did not allow the identification of trends in the transmission and infection rates of Covid-19 within some community population groups including those of different ethnic backgrounds. Available data did permit identification of trends in geographical areas by council areas or post codes, and detailed analyses of trends and impacts based on age, sex and socioeconomic deprivation which was used to inform policy across the pandemic response. Due to poor coding of ethnicity in health care records it was not possible to look at trends in those from different ethnic backgrounds. With regard to the possibility of considering ethnicity trends in any future pandemics, the ongoing roll out of the 'Encompass' programme which is an integrated digital Electronic Health Care Record across the HSC Trusts should allow for more robust collection of patient ethnicity data. However, it would remain the case that quantitative analysis may remain difficult due to the very small number of individuals from some ethnic backgrounds in NI. The Encompass system was implemented in the South Eastern Health and Social Care Trust (SEHSCT) in November 2023, Belfast Health and Social Care Trust (BHSCT) in June 2024 and Northern Health and Social Care Trust (NHSCT) in November 2024. It will be rolled out across all Health and Social Care Trusts in Northern Ireland by the end of 2025.

256. I do not now recall any other specific examples of advice or data from TTI that was not being made available to me that I felt would have been beneficial to inform decision-making processes.

8. Coordination, Dissemination and Analysis of Data

257. Overall, I believe there was adequate coordination, dissemination and analysis of data relating to testing and tracing shared with a wide range of external partners by my Department and me. This included for example local data sharing with the NI Executive, other government departments and decision makers, the PHA and wider health and social care system, and with local councils. I have set out a range of relevant examples across this statement including for example ongoing written submissions/ papers and verbal

updates to the Executive, and the wide range of datasets that were published daily and weekly by my Department and by PHA (for example, the COVID-19 Dashboard and weekly reporting by PHA on Contact Tracing performance and on Clusters & Outbreaks by setting). Publishing data and public sharing of information and being open and transparent was important to help maintain and build trust and public confidence.

258. I have described already how there was open and regular engagement between the health ministers of the 4 nations from the onset of the pandemic where there were regular, at least weekly, meetings. These meetings included discussion where necessary on matters related to TTI and within scope of Module 7, and in my view facilitated appropriate sharing of information. Due to the regularity of these meetings, at least initially, from a health perspective the relationship between the health ministers of the 4 nations was built on trust and mutual respect. Unfortunately, as I have described, as the Secretary of State for Health of Her Majesty's Government changed, so too did the frequency and opportunity of the meetings.

259. I was aware also that departmental officials maintained close contact with counterparts in the other UK nations and there was close and appropriate sharing of emerging strategy and policy options across the nations to assist in informing policy development in each respective nation.

260. In general in terms of the United Kingdom involving Northern Ireland Ministers or senior civil servants in decision-making that impacted Northern Ireland, from a health perspective I believe that there was positive engagement between Northern Ireland and United Kingdom Government Ministers and civil servants, for example on Personal Protective Equipment, vaccine deployment and testing.

261. The primary forms of engagement with my counterpart in the Republic of Ireland was through quad meetings (meetings attended by UKG Ministers, the SoS for NI, the NIO, Irish Government and the Executive **RS7/167** INQ000582399]), North South Ministerial meetings and 1-2-1 meetings. From the outset of the pandemic, I had a good and open working relationship with Simon Harris TD but, following the change in Government in the Republic of Ireland after their election in February 2020, this unfortunately did not continue with Steven Donnelly TD where engagements were more structured and intergovernmental with the formation of their coalition government in June 2020.

262. In addition to meeting with my ministerial counterpart, I sought, where possible, to use the strong working relationships already in place between the two Chief Medical Officers, the Public Health Agency and the Health Services Executive. The CMO, CSA, and DCMOs met regularly with counterparts in the RoI throughout the pandemic and discussed and appropriately shared information on the pandemic response including matters related to TTI policy. Overall, issues that did arise were generally resolved through co-ordination with the relevant bodies and groups in the Republic of Ireland and across the United Kingdom.

263. I have described above, and in previous statements, the engagement my Department and I had with the PHA, HSCB, HSC Trusts, Local Councils, UK Government, other devolved administrations, RoI and other areas of healthcare in Northern Ireland across all aspects of the pandemic response. TEO would be better placed to comment on the coordination, dissemination and analysis of data relating to testing and tracing amongst the Northern Ireland Executive and those bodies.

264. From my point of view, as I have stated in my Module 2C statement **RS7/099** INQ000412903] at paragraph 50, "Initially Covid-19 was treated very much as a "health" issue, as other Ministers were settling into new roles with their own challenges, priorities and expectations that had been raised from the New Decade New Approach Agreement. It was never envisaged when we took up office that there would be a widespread lockdown which would affect all parts of society, the economy and the education system."

265. While the Executive did work together, I cannot now recall significant involvement that the Executive had in the coordination, dissemination and analysis of data relating to testing and tracing among the health-related bodies listed. I am not aware of engagement that the Executive had with the UKG, the other Devolved Administrations or RoI in relation to TTI policy. My view is that TTI was viewed largely as a health matter and therefore responsibility lay with the Department of Health and myself, as Health Minister, to engage. As described above, I provided my Executive colleagues with regular updates on TTI.

F. PUBLIC COMMUNICATION

1. Strategic Context

266. With regards to communications generally across the pandemic response, the NI Executive Office's Executive Information Service (EIS), the Department and the PHA public messaging on TTI was, for the most part, integrated into overall public messaging on Covid-

19 safety measures and on the importance of NPIs more generally, as opposed to separate public communication campaigns with respect to TTI (although I did make a significant number of TTI specific announcements – see below). This was important as the spread of Covid-19 presented many challenges, not least asymptomatic spread; therefore test, trace, and isolate, although an important component of the pandemic response, would never have been a complete solution and was more effective when the reproduction rate of the virus and community prevalence were low. Adherence to the advice on good respiratory hygiene, social distancing, adequate ventilation, and the wearing of face coverings indoors in public spaces were all important behaviours in reducing transmission, in addition to TTI. My Department and I contributed to the development of these strategic communications campaigns as I have set out later in this section.

267. Throughout the pandemic response there was regular engagement between my Department and respective communication teams in government departments in the other jurisdictions and public health bodies across the UK, including the PHA, to coordinate and develop public communications and core public health messages and guidance with respect to the importance of NPIs, including testing, contact tracing and self-isolation. While I was not directly involved, the Department also participated in regular UK-wide communications discussions, led by the Cabinet Office, with regard to the overall pandemic response – which included messaging regarding the importance of testing, contact tracing and isolation. The data and analysis informing these discussions was available to the Executive Information Office and my Department. This helped ensure the informed, clear, consistent public health messaging that I and my Department gave to promote public understanding of the importance of TTI along with the other NPIs in breaking chains of infection and reducing community transmission. In addition, I was aware that CMO, CSA, and DCMOs met regularly with counterparts in the DAs and the RoI to exchange intelligence and also discussed public health advice and scientific advice to inform public communication strategies with respect to NPIs, including TTI, drawing on the information available from behavioural science and both UK wide and NI survey data.

268. The integrated approach to communications campaigns evolved over each wave of the pandemic informed by, and taking account of, survey and marketing data (including in relation to adherence), behavioural science information and in anticipation of further periods of increased transmission. Further, I understand that the NI Executive's public information campaigns (see further detail below) identified a number of key sub-audiences to target including those aged 60 and over and those with underlying health conditions; those living

in economically disadvantaged areas; young people; ethnic minority groups; people living in areas of higher transmission / local outbreaks; and, those who were least compliant.

269. An Adherence subgroup of the Executive Covid-19 Taskforce (ECT) was established around February 2021, chaired at Permanent Secretary level [RS7/011 INQ000348965]. This followed a request that I made to the NI Executive for a greater emphasis on enforcement and adherence to NPIs [RS7/009 INQ000375892]. Membership of the Adherence Subgroup included a range of Government and public sector bodies along with the PHA, the Deputy CSA and my Department's Director of Communications. The Adherence Subgroup's role included gathering and monitoring data on public adherence to Covid-19 NPI measures and public messaging. It used behavioural science and other messaging techniques to find ways of presenting messages in an accessible and impactful way and received advice from the NI Innovation Laboratory and Behavioural Insights Team, part of the Department of Finance, on adherence and enforcement issues relating to Covid-19 safety measures.

270. These inputs, information and advice all helped inform the NI Executive's strategic communications and methods used, and my Department's day-to-day communications on key areas including Covid-19 testing, self-isolation, tracing, contact with others, and adherence to the legislation about travel and other matters. Campaigns including communication on TTI were reviewed and adapted over the course of the pandemic and the messaging modified according to the anticipated trajectory of the pandemic, the changing level of risk, and monitoring of the effectiveness of the approach. While less effective when rates of transmission are high, the ability of the test, trace, and isolate system to keep rates of infection under control relies on how well people adhere to guidance on testing, provide details of contacts, and self-isolate, which in turn depends on their knowledge, motivation, and opportunity to do so. As such, the method and content of the public communications and campaigns on NPIs more generally, and TTI specifically, were informed by behavioural science and monitored through UK-wide survey data collated and shared by the Cabinet Office with the Department and TEO as well as local survey data commissioned in NI. This was provided and considered on an ongoing basis and informed the content, method and evolution of approach adopted. For example, findings from research suggested that practical support and financial reimbursement were likely to improve adherence, and that targeting messaging and policies to men, younger age groups, and key workers might also be necessary. These findings were shared with NI Executive and the Adherence Subgroup and informed my correspondence with DfC, as referenced

previously, in respect of support to those self-isolating and both the Department's and the PHA's communication approach on TTI.

2. Role in Communication

271. In my role as Minister of Health I played a prominent role along with CMO and CSA in my Department's public-facing messaging and communications. This was informed by the behavioural science evidence that showed the importance of key trusted authoritative voices in communications with the public around the need for and importance of NPIs including TTI. Public communications and messaging took multiple forms, including through joined up working with other communications and media teams across NI government departments, the PHA, HSC Trusts and local government and other stakeholders.

272. The Department's strategic communication and media activity was supported by regular planning and engagement between myself and senior officials, including the CMO and CSA and the Department's Director of Communications. There were also weekly and *ad hoc* meetings between myself, Permanent Secretary, CMO and CSA to agree key messaging and communications including in relation to TTI policy and implementation. The main roles of the Department's communications team during the pandemic included providing strategic communications advice and support to myself as Health Minister and senior officials including assisting the CMO and CSA in the public facing aspects of their roles.

273. My Department ensured regular and prominent updates were issued to the public and the media in relation to TTI policy updates and operational priorities [**RS7/168** INQ000400118 and **RS7/169** INQ000400113]. These type of communication methods were important in order to reach as wide an audience as possible. My specific role in these regular and prominent communications included:

- Regular press conferences and media briefings by myself, CMO and CSA, particularly in the early stages of the pandemic to emphasise the importance of adherence to the advice on NPIs including TTI.
- Regular press engagements on radio and television by myself, CMO and CSA .
- I gave a number of Ministerial Statements around NPIs, including TTI, to the NI Assembly and intended for onward sharing by elected representatives through their networks [a chronology of these is presented **RS7/170 INQ000552983**].
- I approved regular press releases at every stage of the pandemic and throughout the pandemic response to update citizens on public health advice and guidance in relation

to TTI policy and operational priorities [a chronology of these is presented RS7/170 INQ000552983. This included communications in relation to the importance of tracing requirements [see for example RS7/010 INQ000371427, RS7/171 INQ000373383 and RS7/172 INQ000381393].

- From 15 November 2020 onwards my Department published some 'mythbuster' articles intended to address misinformation and misunderstandings about Covid-19 and the actions taken in response to the pandemic RS7/0173 INQ000381373];
- Direct ongoing engagement by myself and senior Departmental figures, including the CMO and CSA, with a range of stakeholders and representative groups, including with local government, faith leaders and groups, retailers, hospitality groups and the education sector.
- I also supported the integrated communications approach across my Department, TEO EIS and PHA as I have described above [RS7/0174 INQ000535694; RS7/0175 INQ000383025 and RS7/0176 INQ000535695]. I also worked in partnership with other Executive Ministers to promote sector specific TTI messaging, for example as described elsewhere in this statement I worked with the Education Minister to support testing in schools. Further, on 23 April 2020, I launched a remote interpreting service for sign language users [RS7/177 INQ000346720], jointly funded with DfC. The service enabled British Sign Language and Irish Sign Language users to access NHS111 and health and social care services during the Covid-19 pandemic. The service was available 24 hours a day, 7 days a week.

3. Role of Executive and Executive Information Service

274. TEO and the Executive Information Service (EIS) based within TEO was responsible for the NI Executive's Covid-19 public information campaigns throughout the pandemic and coordinated communications and messaging with respect to NPIs, including the importance of test, trace and self-isolation if a person tested positive. While I had no role in approving decisions taken by TEO about information campaigns, I am aware that officials in my Department contributed to the shaping and development of the NI Executive's Covid-19 public information campaigns on a number of aspects including professional advice from the CMO and CSA and regular input from the Department's communications professionals. There was close co-operation in general between the Department and EIS/TEO throughout the pandemic on public messaging. For example, different facets of the public information and advertising campaigns were signed-off by the CMO and CSA from a technical public health and scientific perspective. I recall that EIS ran a significant number of high profile public campaigns during the pandemic period. These included a number of campaign strands including Stay at home to save lives, Wear one for everyone face coverings, Don't

pass it on, Limit your contacts, Safe shopping, Vaccination roll out, Keep following the public health advice, and the launch of the StopCOVID NI app.

4. Public Health Agency

275. My Department's Press Office worked very closely with counterparts in the PHA to ensure aligned and complementary communications campaigns and press releases in relation to TTI. The PHA Assistant Director of Communications was also a member of the Department's Test, Trace, Protect Oversight Board which assisted with this aligned approach. My Department was responsible for announcements and communications explaining the various strategic policy developments, which I approved, while the PHA led on public information campaigns supporting delivery of the test and trace programmes.

5. Communications Regarding Tracing Requirements and the StopCOVID NI app

276. As I describe above, I made a number of press statements and gave Ministerial Statements regarding TTI overall and which addressed tracing requirements and digital innovations [for example RS7/010 INQ000371427 and **RS7/172** INQ000381393 (as above)] and prompted the use of the StopCOVID NI app **RS7/124** INQ000373403 (as above)]. As noted above, EIS also launched a significant public campaign to promote the newly-launched StopCOVID NI app on 31 July 2020 which was supported by my Department through the integrated communications approach described.

6. Equalities

277. All aspects of my Department's and the PHA's response to the pandemic were established and managed through a public health lens which had inherently, and at its core, a focus on accessibility and equity and on protecting those who were most vulnerable. This was also the case in relation to TTI both in its policy intent and in the operational rollout led by PHA and other delivery partners.

278. Both the Department and I recognised from early in the pandemic the potential for negative impacts across society in general, and the potential for greater impact on certain groups. Risks and implications of inequalities in relation to vulnerable groups were factored into decision-making in relation to TTI from very early in the pandemic. For example, as described earlier, testing capacity was significantly constrained in the early stages of the pandemic. This led to difficult choices regarding the need to prioritise available capacity. The basis of decision making by the Department was to prioritise available capacity to

protect the most vulnerable. Both the Department and I were aware at that early stage that there were risks and implications of unequal access to testing for at-risk, vulnerable or lesser-heard groups, but prioritised limited capacity to best protect those known to be at most severe risk or who might have the greatest impact on spread to those at severe risk. I have described elsewhere in this statement in more detail the basis for that prioritisation, but, in summary, testing was primarily targeted in clinical care of the sickest individuals requiring inpatient care, protecting those caring for them, and in the management of outbreaks for example in care homes. This was set out early in the pandemic in the Covid 19 Testing Strategy and in the earliest version of the IPT which was dated 19 March 2020. As testing capacity increased this allowed the expansion of groups eligible to be tested and, throughout the pandemic, there was a continued focus by myself, my Department and the PHA on ensuring equality of access to testing for those who needed it, including for those in at-risk, vulnerable or lesser-heard groups.

279. The decision for NI to join the NTP was significant and greatly assisted in enabling access to Covid-19 testing that was accessible to all citizens and service users, including for those in marginalised and vulnerable groups and those with protected characteristics. This included access to and use of both LFD and PCR testing. The range and geographic spread of in-person test sites and PCR / LFD delivery channels helped to provide widespread access to testing for all of the population. Further, there are many examples of targeted support and assistance aimed at maximising access and equity of access. I am aware that these steps are set out in more detail in the Department's statement but these included, for example, significant measures to help ensure that the delivery of testing and the communication of information in relation to testing at Pillar 2 test site facilities were accessible for those who had mobility and dexterity issues, hearing or visual impairment and people with other disabilities, and that services were tailored to help meet specific needs. This included provision of the following features:

- Step-free access;
- Clear and appropriate signage;
- Accessible family-sized testing booths i.e. large enough to accommodate a wheelchair and at least one other person;
- Reception desk height at wheelchair level;
- Option to be accompanied by a companion who can assist the person to test themselves;
- Test instructions available in a range of accessible formats, when requested. This included instructions in braille which were available by post;

- British Sign Language (BSL) DVD available by post;
- The 119-telephone helpline operated as part of the National Testing Programme and was available to help members of the public with any issues processing a PCR or Lateral Flow Device test, including the ordering and results reporting journey. Telephone lines were open every day (7am to 11pm) and support provided in 200 languages. BSL services were also available via the 119 contact centre (SignVideo); and
- Textphone or phone text relay (text-to-speech and speech-to-text translation) via the 119 contact centre.

280. The provision of free Home Test kits, both PCR and LFD, through the home ordering channel (via 119 telephone helpline and online ordering) also greatly assisted with accessibility of testing and helped reduced inequalities. Home ordering was of benefit to all citizens including those in lower income groups and those with limited or no access to private or public transport, including in more rural areas.

281. Alternatives to ordering tests and reporting results online was also particularly important for those that did not have access to digital services or were less comfortable navigating online processes, including for example some citizens in older age groups. The availability of in-person test sites within a reasonable distance from home, and the ability to order tests and report results via the 119 telephone line, were important in this regard. A summary of the guidance and further assistance available for citizens to order, take, and report the result of a test was made available on the Department's website, with links from the Department's site to NI Direct which offered further relevant help and guidance for the NI population and to the PHA's website. These sites were updated throughout the pandemic as guidance changed. The NI COVID Care Helpline also provided an accessible telephone support service for NI citizens by assisting callers with checking symptoms of Covid-19, booking a test and getting appropriate advice relating to Covid-19. This included providing support for older people, those with a disability and people with an underlying health condition.

282. In relation to equity of access to LFDs, throughout the development and operation of the NI SMART programme there was extensive and ongoing stakeholder engagement with a wide variety of groups. This included those representing marginalised and vulnerable groups, and thus sought to ensure equitable widespread availability and access to LFD tests. I have set out further details of these groups in an earlier section. The NI SMART programme initially prioritised four sectors of private industry for support in the first phase of the

programme: agri-food; manufacturing; essential retail, and construction where many of these occupations included a high proportion of the workforce drawn from minority ethnic groups and migrant workers.

283. With some evidence that older groups may have a preference for collecting tests in person, maintaining a network of collection points within the local community served by public transport, and with sufficient parking, was important to help ensure equality of access. I have described earlier in the statement the range and geographic spread of in-person test-sites, LFD Collect and Pharmacy Collect services which were critical to improving equity of access.

284. LFDs' Instructions for Use were also available online in large print and easy read versions, with easy read versions available in 17 languages. An audio version of test instructions (in English) was also available on the Royal National Institute for the Blind (RNIB) Information Line. RNIB was also commissioned to provide alternative format versions of testing instructions. The free *Be My Eyes* app was available to help visually impaired users to carry out a test more independently through an online video and step-by-step guides to take a lateral flow test. Users were also able to get live video assistance from NHS Test and Trace staff in helping them with how to order tests, use tests and register their test results.

285. I have previously provided in this statement some detail on other testing programmes and protocols which prioritised accessibility of testing to support other vulnerable groups and high-risk settings throughout the pandemic. Areas of testing policy which were targeted and designed specifically to support vulnerable groups include a significant programme of testing of care home residents, staff and visitors (both symptomatic and asymptomatic); children with learning disabilities attending schools for those with special educational needs were offered testing (in line with the arrangements for those schools); prioritised testing was put in place for learning disability and mental health patients on in-patient wards; and regular asymptomatic testing for staff in Supported Living facilities and those caring for vulnerable people. As an additional mitigation, testing for visitors to vulnerable settings, for example hospitals, care homes and hospices, and testing in prison settings. Further clinical testing set out in the Interim Protocol for Testing, from Version 1 and throughout all subsequent iterations up to and including the final IPT (version 9 dated 6 October 2021), had a clear focus on targeted and differentiated testing to help protect the sickest and most vulnerable individuals requiring care and those caring for them, including health and care workers and other vulnerable groups. The Department recognised a heightened need to

test these vulnerable cohorts, including those in hospital, in care homes and others, and made testing available accordingly.

286. The Department's Covid-19 Test, Trace and Protect Transition Plan (March 2022) [**RS7/081** INQ000348966] set out a period of transition as the overall risk posed by the virus had reduced. However, the plan maintained a clear focus on test and trace activity to protect and support our most vulnerable and those at highest risk of serious illness should they contract Covid-19. The Transition Plan included prioritisation of 'test to treat' to protect the sickest and most vulnerable from serious illness; 'test to protect' those living, working and visiting high risk and other vulnerable settings including hospitals and care homes; and testing to support outbreak management, with a continuing strong focus on high-risk settings such as care homes. Test kits remained available free of charge to all citizens to support all areas of testing set out in the plan. The Pharmacy Collect Service was also maintained to support access to testing after the Home Ordering through the NTP ceased at the end of March 2022.

287. The Department also issued and updated sector specific guidance and communications across a range of other programmes of care supporting high-risk and vulnerable groups. These included, but were not limited to, domiciliary care and supported living (for example, Department Guidance 21 October 2020 **RS7/178** INQ000130358]); and, guidance for the management of Covid-19 in the following settings: Residential Children's Homes (for example, Guidance 10 May 2021 [**RS7/179** INQ000145687]); Foster Care and Supported Lodgings (for example, Guidance 22 December 2020 [**RS7/180** INQ000145693]); and Adoption Services (for example, Guidance March 2021 [**RS7/181** INQ000145701]). While not specific to TTI, this guidance addressed as relevant sector specific TTI advice and guidance.

288. On 23 April 2020 I launched, jointly funded with the Department of Communities, a remote interpreting service for sign language users [**RS7/177** INQ000346720 (as above)]. The service enabled British Sign Language and Irish Sign Language users to access NHS111 and health and social care services during the Covid-19 pandemic. The service was available 24 hours a day, 7 days a week.

289. Whilst not work undertaken by me or my Department, as I have described, the PHA undertook significant direct engagement with vulnerable groups and the BAME population on Covid-19 matters throughout the pandemic. For example, I understand when developing the Contact Tracing model around April 2020, the PHA undertook a wide-ranging

programme of engagement with stakeholders during the CTS development stage including with political parties; the Human Rights Commissioner for NI; the Equality Commission; the Children/Young People Commissioner; Commissioner for Older People NI; and representatives from potentially hard-to-reach groups including the homeless population and the Roma community. The PHA also developed its Contact Tracing Vulnerable Groups Action Plan to assist in its approach to engagement with hard-to-reach groups. I shared the Action Plan with the NI Executive on 2 September 2020 [**RS7/105** INQ000375902 (as above)]. I understand the Action Plan included a range of actions which utilised the PHA's wide network of links with community and voluntary groups, whose staff at times attended mobile testing sites to support testing of people from various ethnic backgrounds. I understand these groups also supported PHA-led Outbreak Incident Management Teams through follow up communication with target groups, and links were established with a wide range of community and voluntary sector groups to share messaging and communication, including in a range of languages. The Action Plan recognised the increased risks for specific vulnerable groups within the NI population as well as a need to put measures in place for pro-active support to optimise testing, tracing and to assist further adherence with Covid-19 Guidelines and also recognised the importance of effective communications to support test and trace. Further, whilst again this was work led by the PHA, following a series of outbreaks in the Mid-Ulster and Craigavon areas linked to the meat processing plants/ agri-food sector, I recall the PHA led a considerable and focused programme of enhanced measures including enhanced testing which targeted support for large cohorts of the workforce who were from ethnic minority backgrounds. The programme also had a dedicated approach to testing in houses of multiple occupancy and focused on enhanced and targeted communications. This programme involved partnership working with community groups. The Department was kept updated with PHA activity for example through the Test, Trace, Protect Oversight Board and Clusters & Outbreaks Meetings [**RS7/182** INQ000447245 and **RS7/183** INQ000459443].

290. The PHA also provided in person public health advice and support through its contact tracing service acknowledging that at times those self-isolating were doing so in difficult personal circumstances, for instance when they had an underlying health condition or when another family member may have been ill in hospital. In such circumstances, the personalised and professional nature of the support was important.

291. I have also previously described the lead role that DfC had in providing the support that was needed for those who were self-isolating, including the provision of financial support through DfC's Discretionary Support Scheme; and the work to put arrangements in place

for priority access to online grocery shopping slots for those who were Clinically Extremely Vulnerable. I have set out further detail in relation to DFC's role in the earlier section above regarding *Groups Disproportionately Impacted by TTI Isolation Requirements,* and have also described a range of further support measures that were in place. I have also explained in that section how research and reports commissioned by my Department informed policy options and my decision making role and advice to the NI Executive in relation to NPIs – these included the Coronavirus Related Health Inequalities Reports published in June and December 2020 [**RS7/184** INQ000137375, **RS7/185** INQ000137376, and see **RS7/186** INQ000183436], and the work of the Institute of Public Health Ireland.

292. While not directly related in full to TTI, during the pandemic I was directly involved in ensuring that a range of further mitigation measures were in place to protect at-risk, vulnerable or lesser heard groups and/or those with protected characteristics. These included for example:

- In April 2020, in partnership with the Education Minister, I outlined a package of measures, worth around £12 million, to support vulnerable children and the children of key workers [**RS7/187** INQ000400104] including:
  - A bespoke Approved Home Childcare Scheme aimed at enabling key workers to have their childcare needs met in their own homes;
  - Enhanced support for registered childminders who provided childcare for key workers and vulnerable children;
  - Support for registered daycare settings to remain open for key workers and vulnerable children in locations where key worker parents needed them most and for those settings which had been forced to close;
  - Childcare advice and guidance for parents who were key workers, including a helpline, and Advice and guidance for registered settings and providers.
- On 29 April 2020, along with the Minister of Justice, I issued guidance on maintaining contact between parents and children during Covid-19, stating that the mandatory stay at home message does not apply to children moving between households.

293. As previously described in both my M2C and M3 statements the Chief Medical Officer asked the Chief Executive of the Patient and Client Council on 27 May 2020 [**RS7/188** INQ000346716] to undertake research to "inform the relaxation of some of the restrictions around outdoor exercise and possible subsequently meeting family outdoors in small numbers with appropriate safeguards and precautions." The research was supported by myself and by the First Minister and deputy First Minister of Northern Ireland. To align with this work I published a statement encouraging people who were Clinically Extremely

Vulnerable, and those supporting them, to participate in the survey, the aim of which was stated to 'understand the impact shielding has had on individuals, to inform the steps and processes that must be considered now and in the future, and to ensure that the voice of those impacted by shielding was heard' [**RS7/189** INQ000348702].

294. The final Patient and Client Council survey report [**RS7/190** INQ000344088] was published in July 2020. The findings of the survey indicated that fear of Covid-19, and the risk it represented, was the dominant concern among those surveyed. In addition, shielding appeared to have had detrimental social and psychological effects on a significant group of respondents, although relatively very few of those surveyed mentioned a need for professional support or counselling. The survey found that those who were shielding prioritised being kept informed with clear advice and guidance, along with the scientific rationale for this advice. A considerable number of respondents felt that the shielding community was often 'forgotten' or 'ignored' as changes to guidance and restrictions for the wider population were announced. The need for the provision of updated advice and guidance to Clinically Extremely Vulnerable people was kept under continuous review and took account of the research undertaken by the Patient and Client Council including the mental health impact of shielding.

295. I was also very aware of the impact my decisions would have on those groups with health-related concerns, particularly those who received 'shielding letters'. As a result, the letters offered advice on staying safe; how to access further information and support, including through the Northern Ireland Community Helpline; advice on indoor exercise and mental health tools and enabled those in receipt of a letter to access support schemes being offered to the most vulnerable by the Department for Communities [**RS7/156** INQ000130315].

G. LESSONS LEARNED

1. Lessons Learned Exercises

296. In answering a question on lessons learned in my statement for Module 3 of this Inquiry I referred to the staffing pressures experienced within the Department of Health and the need for the Northern Ireland Civil Service (NICS) to develop procedures to allow the quick redeployment of staff between all Departments to ensure that the staffing pressures experienced by the Department of Health would not occur again during a pandemic. I believe there is merit in reiterating in the context of this module that the NICS must be more agile in redeploying its staff to areas under pressure. It should also pay more regard to the

expertise and skills of its employees and ensuring sufficient sharing of knowledge and experience.

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

298. I have also reflected on the detail included in the Lessons Learned section of the Module 7 Corporate Statement and agree with the lessons identified. I have not sought to replicate all these here but have referenced a few by way of example: I agree with the emphasis on the need to continue to invest in research and science as undoubtedly science will once again be critical to the path out of any future pandemic. Further, there is also a critical need to build future scalable capability and capacity across government to identify and respond to future risks and to test the resilience of that capability and capacity on an ongoing basis.

299. Joint working with Ministers across the UK and the RoI played an important role in providing a coordinated approach to the response to Covid-19 and in making progress on shared challenges and approaches such as the rapid development of the National Testing Programme, and in relation to international travel. This joint working and open, appropriate sharing of information will be important in future in order to help make best use of collective resource, experience and expertise.

300. I am aware of a number of reviews and lessons learned exercises relevant to the scope of Module 7 and included in the Department's Corporate Statement. These include reflections relevant to strategy and planning, decision-making and policies, and roll-out and implementation in relation to TTI.

a. Rapid Review of the Contact Tracing Service – October 2020

301. As referenced previously in this statement, on 3 October 2020 the CMO commissioned a Rapid Review of the contact tracing service and its delivery model to reflect on the key issues influencing provision and to provide assurances on capacity. The focus was to support the ongoing and future delivery of the contact tracing service by looking at the elements that had worked well, and to consider what measures were required to effect improvements in the service with a focus on more efficient and effective contact tracing processes, supported by appropriate technology and high-quality information systems.

302. The Rapid Review [RS7/191 INQ000137388] reported on the 12 October 2020 and made several key findings which were subsequently taken forward by the PHA, supported by the Department. The key recommendations of the report were across the areas of governance, workforce planning, data analytics and improved communications to maximise update of digital innovations to support contact tracing, including the new digital self-trace platform. I agree with the Department's view that the programme of work taken forward by the PHA to address the Review's findings significantly contributed to the ongoing development of the Contact Tracing Service. I was kept updated by officials [RS7/192 INQ000552989 RS7/193 INQ000552990] and I updated the NI Executive on the outcome of the Rapid Review as part of a wider communication on the Contact Tracing Service in November 2020 [RS7/009 INQ000375892].

b. UK Chief Medical Officers' Technical report on the Covid-19 Pandemic in the UK

303. The UK CMOs co-authored a "Technical report on the Covid-19 Pandemic in the UK" published on 1 December 2022 [see RS7/123 INQ000203933 (as above)] which included chapters on Testing, Contact Tracing and Isolation. The purpose of the report was to share information and the learning from their experience of the pandemic with their successors as CMOs and DCMOs who may need to respond to a future pandemic. I am aware of the report which highlighted important areas of learning across both testing and contact tracing. I have not replicated all findings here but have set out a few.

304. The limitations in testing capacity and an end-to-end system to effectively use the outputs of testing was a major constraint in the initial stages of the pandemic. The major efforts required to expand testing capacity highlighted the importance of building testing systems that maintain the capacity for an adequate contingency response, or at least retain expertise on how to surge scalable TTI should that be required.

305. I have referred previously in my statement to the importance of communication across all aspects of TTI. Similarly, the CMOs' Technical report draws out the importance of communication in the context of testing, particularly in regard to the communication of the rationale and practical requirements of testing strategies and changes to testing policy whether with the public or professionals. The report also highlights the use of pilot phases as a helpful tool in understanding how new strategies or policies might operate and how people might respond to them.

306. Regarding contact tracing the report considers that large-scale contact tracing should, wherever possible, build on existing systems and expertise. This concurs with my earlier comments in this statement in which I have highlighted the approach of the NI contact tracing model which built on the pre-existing expertise that was available in the PHA as part of their line of business Health Protection function. In addition, the report acknowledges the importance of the development and deployment of digital innovations to complement traditional person-led contact tracing to support delivery of contact tracing at scale; again this was key to the NI model.

c. Public Health Agency Review Refresh Programme – December 2020

307. Recognising the very significant demands on the PHA and the likely longer-term nature of these, CMO agreed with the senior leadership team of the PHA an external organisational development review with a focus on capacity and capability. This was jointly commissioned by the Department and PHA to carry out a rapid, focused external review of the PHA's resource requirements to respond to the Covid-19 pandemic over the subsequent 18-24 months. The final report **RS7/194** **INQ000102852** was delivered to the PHA Chief Executive, PHA Chair and to the CMO in his professional capacity and as head of PHA sponsor branch in December 2020. The Review contained four high level recommendations relevant to the scope of Module 7 of the Inquiry:

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

308. These were accepted by the Department and Public Health Agency and I agreed to the establishment of comprehensive programme management arrangements to oversee the reform and transition of PHA to a new operating model. A PHA Reshape Refresh Oversight Board was established to oversee the implementation of the recommendations, which was initially co-chaired by CMO with the CEO of the PHA before this transitioned to the Board of the PHA in December 2023 following completion of the first two phases of the programme. Phase 3 of the programme is now led by the PHA and is planned to run for two years from January 2024. Further detail of this organisational development programme would be best provided by the PHA if of assistance to the Inquiry. I understand that the Department is kept updated through sponsor control arrangements.

2. Personal Reflections

309. The Department's Corporate Statement details lessons learned from the pandemic which I have reviewed, and again with which I concur. I have not sought to replicate these in full here but lessons identified include the need to retain baseline contingency capacity for testing and contact tracing; and the need for scalable TTI capacity and capability as part of our future pandemic resilience planning, and that these plans are tested robustly and periodically. I understand that the operational legacy of the TTI systems, including enhancements made during the pandemic, remain within the PHA. The PHA-led Reshape Refresh programme referred to above offers an opportunity for further development. The expertise and experience build up by the PHA during the pandemic should also be captured and embedded in planning for the future. This includes the need to build increased capacity in Behavioural Science within the PHA as this will be critical to any future pandemic response to help ensure more effective engagement and more tailored communications to effectively modify behavioural response through improved understanding, knowledge and adherence within specific groups. Such an approach is likely to improve adherence with TTI which in turn will increase its effectiveness and should be factored into future planning for scalable TTI capability.

310. The use of innovative technology and development at pace was critical to the pandemic response – examples in NI include the Covid-19 Proximity App and the digital self-trace platform – and digital and technological innovation will undoubtedly be important in any future pandemics. Agility and the ability to work flexibly with partners is an important lesson that should form part of future planning.

311. The Covid-19 pandemic raised significant challenges for care homes. The protection of care home residents, their families, friends, and staff was a key priority for me and for the Department throughout the course of the pandemic. There was a significant collaborative multi-agency approach across HSC partners during the pandemic which helped ensure a sustained focus on actions required to effectively support and reduce the impact of Covid-19 on care homes. There should be efforts to capture and build upon these experiences and networks to enhance such joint working so that we can make care homes more resilient with respect to Infection, Prevention and Control and the provision of "in reach" clinical care as important features in future pandemics.

312. While not directly related to this module, in relation to isolation, the shielding advice issued to those identified as clinically extremely vulnerable resulted, in some cases, to prolonged

periods of isolation. While NI recognised this, and did not reintroduce shielding once it was 'paused' in July 2020, I do not think that such a move should be asked, in any future pandemic, of those who are already vulnerable. I also believe that there should be a regular review of how quickly systems can identify those who would be deemed vulnerable and clinically extremely vulnerable, potentially through Encompass.

313. Throughout my statements to the Inquiry I have reflected on Exercise Cygnus and Operation Nimbus: simulated exercises to gauge the impact of an influenza pandemic in the UK. Leaving aside that each concentrated on an influenza pandemic, I believe that a focus of such exercises in the future should be on the scalability of testing and tracing alongside the emergency response systems. Such exercises should be held regularly with the scenarios reflecting emerging viruses and what is known about them, as well other as phenomenon that may provoke an international or global response. The Northern Ireland Executive should also conduct an exercise, either as a stand-alone event or in cooperation with the Republic of Ireland and other UK Nations, to assess their preparedness and to ensure a joined-up, co-operative approach.

314. I am no longer Health Minister nor a Member of the Legislative Assembly (MLA) but I would hope that the rapid scale up achieved during the Covid-19 pandemic in respect of TTI, and the consequent 'muscle memory' is capitalised on to ensure that it is not lost. Such a scale up needs to be achievable again should that be required, possibly even more quickly, and IT systems used for such an event are kept refreshed and up to date.

315. As part of its response to the Inquiry's recommendations in Module 1, the Cabinet Office has developed a Risk Vulnerability Tool with the Office of National Statistics. This tool maps different risks across the United Kingdom and shows where there are vulnerable groups who might be disproportionally impacted. This should be utilised by the NI Executive and integrated into its planning assumptions for any future pandemic.

316. At the time of writing the Inquiry has published its report on Module 1 Resilience and Preparedness. I would hope that the recommendations in this are being examined and implemented, not just in NI, but in the UK as a whole.

STATEMENT OF TRUTH

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

Signed:

Personal Data

Date: 8 April 2025