Witness Name: Heather Reid
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF HEATHER REID

I, Heather Reid of the Public Health Agency for Northern Ireland will say as follows:

1. This statement is made on behalf of the Public Health Agency (PHA) in response to a request for evidence by the Inquiry pursuant to Rule 9 of the Inquiry Rules 2006. There are 74 Exhibits produced with my statement. This is my first statement in relation to Module 6 of the Covid-19 Inquiry.

2. I am making this statement in my capacity as Interim Director of Nursing, Midwifery and Allied Health Professionals within the PHA. I was appointed to my current role in May 2023 and am responsible for public health issues as they relate to nurses, midwives and allied health professionals. To note that the term 'nursing' incorporates health visiting, health care assistants and other support staff, while the term 'midwifery' includes midwives and maternity support workers. 'Allied health professionals' represents art therapists, dietitians, dramatherapists, music therapists, occupational therapists, operating department practitioners, orthoptists, orthotists, paramedics, physiotherapists, podiatrists, prosthetists, radiographers, and speech and language therapists. Through the directorate, the PHA also provides regional leadership for quality, safety, personal public involvement and patient client experience.

3. I qualified as a nurse in September 1989 and after working in a number of roles in 1994, I joined the HSC Graduate Management training programme where I completed a Masters in Health Service Management. Upon the completion of that programme, I joined the Public Health Department of the then Eastern Health and Social Services Board where alongside my day to day duties I worked towards specialist practitioner registration with the UK Public Health Register. In January 2012, following a period of earlier secondment to the Department of Health, Northern Ireland (NI), I was appointed as a Public Health Consultant within the PHA working on a range of areas which included maternal, child and perinatal mortality surveillance and wider service improvement areas. I remained in this post until 2023 when I assumed my role as an interim Director within the Agency. As I was not in post during the period covered by this Module, I have sought input from a number of colleagues, some retired, in completing this statement.

Introduction

4. The system of healthcare in NI does not mirror that in place across the other regions of the UK. Whilst the universal system of healthcare, free at the point of use, was established in 1948, the 'NHS' as an entity does not exist in NI. In 1973, health and social services were integrated by the Health and Personal Social Services Order (NI) 1972 which created four Health and Personal Social Service Boards (HPSSBs) for commissioning health and social care from local Trusts. The colloquial term used at that time to describe the service was 'the HPSS' although it never existed as a tangible entity.

5. In 2009, the four HPSS Boards were replaced by a single Health and Social Care Board (HSCB) under the provisions of the Health & Social Care (Reform) Act (NI) 2009. The HSCB was the main body responsible for commissioning services from the HSC Trusts and managing the performance of the HSC Trusts against various targets and performance indicators. In April 2022, following an earlier series of reviews of the HSC in NI, the HSCB was dissolved and replaced with a new body called the Strategic Performance and Planning Group (SPPG) which is part of the Department of Health.

6. Given the relevant period as defined in this Module, I will mostly refer to the HSCB. I will refer to the Department of Health as 'DoH' or 'the Department'. From 2009 and until the present day, the term 'HSC' is used to describe the collective system of health and social care in NI. However, as with the HPSS, the HSC is not a body in its own right. I will use the term 'HSC' to describe the system of health and social care throughout this statement. My statement will be in relation to the adult social care system, in respect of care homes and care at home, given that it is the focus of this Module.

Regulation

7. Within NI, there is no legal definition of a 'care home', instead facilities are registered with the Regulation and Quality Improvement Authority (RQIA) as either Residential Care Homes or Nursing Homes. In the interests of brevity, I will use the term 'care home' to refer to either type of facility. RQIA inspect care homes at least twice each year using regulations and minimum care standards to evaluate the quality of care delivered. In NI, domiciliary care agencies are also regulated but it is important to note that it is the domiciliary care agency itself that is regulated as opposed to the quality of the service provided by the domiciliary care agency. The majority of care is commissioned by the HSC Trusts with provision provided in the independent sector. The HSC Trusts retain a statutory responsibility to ensure the quality of the care being delivered on their behalf.

Overview of the Public Health Agency

8. The PHA was established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (NI) 2009. The PHA subsumed the Health Promotion Agency which had been established in 1990 to advise the DoH on health promotion matters, sponsor research/evaluation and prepare publishable material relative to health promotion. The PHA was also to have several other functions as set out below (para 9-14) which were subsumed on a regional basis following the dissolution of NI's four health boards (Eastern Board, Northern Board, Southern Board, Western Board) in April 2009.

9. The PHA is a statutory body and its functions can be summarised under three broad headings:

    - Improvement in health and social well-being – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to improve the health and social well-being and reduce health inequalities in the population of NI;

    - Health protection – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising from environmental hazards. The PHA also has a lead role in the public health response to major incidents and other emergencies;

    - Service development – working with the SPPG with the aim of providing professional public health input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with SPPG, the PHA has an important role to play in providing professional leadership to the HSC.

10. The PHA also facilitates research and development across the HSC. To do this the Agency co-ordinates a wide range of research programmes and supports capacity to undertake research across the health service by funding research infrastructure in HSC organisations.

11. The Health & Social Care (Reform) Act (NI) 2009 is the legislation under which the PHA was founded and Schedule 2 of the Act sets out requirements for the Agency's officers, remuneration, committees, accounts and annual report. Additionally, there are a number of other pieces of primary and secondary legislation under which PHA operates. The key legislation includes:

- The Public Health Act (NI) 1967 - sets out the statutory requirements on medical practitioners in NI to inform the Director of Public Health about notifiable diseases (Covid-19 was declared a notifiable disease on the 5 March 2020). To note, that the DoH published a review of the Act following a public consultation and in 2024 undertook a further consultation on the policy to underpin a new Public Health Bill. It is anticipated that an updated list of notifiable diseases will be included in the new Bill;

- The Health and Personal Social Services Order (NI) 1972 - sets out requirements, roles and functions of various bodies in the HSC system in NI. The Act provided for the establishment of local boards (now HSC Trusts) with the responsibility for both health and social services in their area. The Act also set out a duty for local boards to co-operate with other public bodies such as councils to 'secure and advance' the health and social welfare of the people of NI;

- The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003 - places a statutory duty of quality on HSC bodies in the delivery of their services and allows the regional regulator (RQIA) to review and inspect these services in order to evaluate the quality of them;

- The Health and Social Care Act (NI) 2022 which dissolved the regional HSC Board.

12. The 2009 Reform Act (referenced above) imposed a statutory duty of involvement on certain HSC bodies. This means that they must, by law, involve and consult patients, service users, families, carers and local communities on the planning, delivery and evaluation of services. The PHA has the responsibility for leading implementation of Personal and Public Involvement policy across the HSC and has team dedicated to this work.

13. Prior to the pandemic, the Agency was structured under four directorates:
    - Public Health;
    - Nursing, Midwifery and Allied Health professionals;
    - Operations;
    - HSC Quality Improvement.

    An organisational organogram reflecting the Agency's leadership structure at that time is included (Exhibit HR/01 - INQ000520256).

14. As part of the pandemic response, the Agency established a new Directorate of Contact Tracing in December 2020. With the closure of the Contact Tracing Service (CTS) in June 2022, the Agency reverted to its pre-existing structure which remained in place until 2024 when a number of structural changes were enacted as part of the Agency's Reshape and Refresh reform programme (Exhibit HR/02 -INQ000572221) (Exhibit HR/03 - INQ000547833).

Relationship with DoH

15. The PHA is an Arm's Length Body (ALB) of the DoH and operates under the provisions of a Management Statement and Financial Memorandum (MSFM) drawn up by the DoH. The MSFM sets out the broad framework under which the PHA operates including its overall aims, objectives, roles and responsibilities of key personnel (Chief Executive, Chair, Permanent Secretary and Executive Sponsor), rules, guidelines, accompanying duties, functions, powers and the accountability arrangements in place between both bodies. The PHA board is responsible for setting the strategic priorities of the Agency in line with Ministerial priorities, it does not have any decision-making functions in relation to acute public health issues.

16. During the period of the pandemic the PHA's Executive Sponsor within the DoH was the Chief Medical Officer (CMO).

17. In common with all DoH ALBs, the PHA is subject to formal governance arrangements including:

- An annual self-assessment of board governance submitted to DoH;
- Publication of an Annual Report as per legislative requirements;
- Formal twice-yearly accountability meetings between the Chief Executive, Chair and the CMO (as Executive sponsor of the Agency and Permanent Secretary; and
- Regular Sponsorship Review Meetings between the DoH and the PHA Executive Team.

18. Additionally, there is ongoing interaction between the PHA and DoH which, whilst not part of formal accountability, is normal between an ALB and its parent Department - for example in the provision of information or advice to inform policy decisions. Throughout the pandemic, PHA staff had ongoing discussions and conversations with the DoH regarding the pandemic response. Further information on the PHA relationship and liaison with the Department specifically during the pandemic is provided in paragraphs 48 - 51.

19. In 'normal' times, the PHA is responsible for a range of issues in respect of the adult care sector as set out in the body of this statement.

Emergency Preparedness and Response

20. The Emergency Planning and Environmental Hazards (EPEH) team is part of the Health Protection division of the Public Health Directorate. The EPEH team is responsible for emergency preparedness including the development of public health emergency plans for major incidents (including pandemics) as well as the provision of support for HSC and non-HSC organisations during the period of an emergency.

21. In fulfilling this role, EPEH is responsible for:
    - Developing and updating of the Joint Response Emergency Plan (JREP) (Exhibit HR/04 - INQ000102841) (Exhibit HR/05 - INQ000547834) which covers the response of the PHA, HSCB and the Business Services Organisation (BSO) to major incidents;

- Responding to public health emergencies (including chemical and biological) through the provision of robust local arrangements 24/7;
- Providing an early risk assessment of the actual or likely impact these incidents may have on public health or public safety;
- Ensuring that an effective ongoing public health response/advice is provided for chemical contamination or other pollution that could have an adverse impact on the health of the population;
- Ensuring that out-of-hours contact and 'on-call' arrangements are maintained and that the provision of 24/7 public health advice is sufficient during an emergency response;
- Establishing, running and contributing to a Scientific and Technical Advice Cell as and when required;
- Participating in multi-agency emergency preparedness and response as set out within the civil contingencies' framework; and
- Working with the resources available to provide HSC organisations with emergency preparedness guidance, advice and training as required.

22. In the early days of the pandemic it became clear that the EPEH team was too small to be able to discharge all the required functions while also participating in the pandemic response; given the same a number of appointments were made. The profile of the team including Agenda for Change (AfC) banding is set out below:

    - One Senior Emergency Planner AfC Band 8C (in post at start of pandemic);
    - One Emergency Planning and Business Continuity Manager AfC Band 8A (appointed January 2022);
    - Two Emergency Planning Officers AfC Band 7 (one in post at start of pandemic and a second appointed from July 2020);
    - One Environmental Hazards Officer AfC Band 7 (from July 2020); and
    - One Emergency Planning Support Officer AfC Band 4 (from March 2022).

One Health Protection (HP) consultant provides input to the team in respect of environmental hazards.

Health Protection team including Acute Response and Duty Room

23. The term 'Acute Response' is used within the PHA to describe the work the Health Protection Team do to ensure timely and appropriate public health action is taken in response to potential threats that could harm the health of individuals or groups in the population - including in care homes. The day-to-day service is delivered via the Health Protection Duty Room (HPDR) where enquiries and calls are handled.

24. Most of the day-to-day work is in relation to the public health management of infectious diseases of public health significance. This could be responding to a laboratory report showing that an individual has an infection with potential public health implications or providing advice on the management of an outbreak to local council environmental health teams as a means to investigate potential cases and outbreaks. The Duty Room is staffed using a rota drawn from the wider Health Protection Team of nurses, specialty registrars in public health and HP consultants. Phone calls, emails and laboratory reports come into the Duty Room and are managed by the team as required. The Duty Room operates from Monday to Friday on a 9:00 - 17:00 basis. Outside of these hours an on-call service is delivered by specialty registrars and consultants in public health.

25. The staffing profile of the Duty Room at March 2020 was:

- One AfC Band 8b Nurse Consultant
- Five AfC Band 7 Health Protection Nurses
- Two AfC Band 6 Health Protection Nurses
- Three AfC Band 4 administrators

26. As set out in the preceding paragraphs, the work of the Duty Room would have been supported by a cohort of specialty registrars in public health. This is a multidisciplinary cohort of trainees from a range of backgrounds who

follow a five-year nationally set programme to achieve specialist registration in public health which is typically required to apply for a job as a consultant in public health. As at March 2020, the Duty Room would typically have had access to a single specialty registrar on a given day.

27. The following staffing enhancements have been made to the Duty Room since March 2020:

- Uplift of an existing AfC Band 8b Nurse Consultant to an AfC 8C role (2021)
- Two new specialty doctor roles (January 2023)
- Two new AfC Band 8A Senior Health Protection Nurses (June 2020 & Jan 2022)
- Two additional AfC Band 7 Health Protection Nurses (August 2021)
- One additional AfC Band 6 Health Protection Nurse (September 2021)
- One new AfC Band 5 administrative manager (February 2021)
- Regular reliance on additional AfC Band 3 administrative agency staff.

The current establishment of the Duty Room stands as follows:

- One AfC Band 8c Nurse Consultant
- Two AfC Band 8a Nurses
- Five AfC Band 7 Health Protection Nurses
- Three AfC Band 6 Health Protection Nurses
- One AfC Band 5 Administrator
- Two AfC Band 4 Administrators
- Three AfC Band 3 Administrators.

28. In addition to input from specialist registrar and speciality doctors, the Duty Room has dedicated consultant cover to support escalation of more complex issues. Since the pandemic oversight structures have been further enhanced as follows:

- A core team has been established, comprising a consultant in health protection, a nurse consultant and an operations manager, who have oversight and responsibility for team management and effective delivery of the acute response service including arrangements for escalation;
- Strengthened governance arrangements with weekly operational multidisciplinary team meetings and a monthly operational governance meeting with the Director of Public Health;

29. Prior to the pandemic, the health protection team had well-established relationships with care homes as part of their role in supporting them with outbreaks of other infectious disease like that of influenza, gastroenteritis and c difficile. As is still the case, when care homes identify two or more cases of symptomatic disease or a single case of a notifiable disease, they are required to contact the PHA Health Protection Team for advice and support. Duty Room staff undertake a detailed risk assessment with the nurse or manager in charge, part of which is to determine if the situation warrants classification as an outbreak. The initial risk assessment identifies the number of affected residents/staff and the severity of illness and also considers any immediate infection prevention control (IPC) issues or actions that could be undertaken as a means to reduce the risk of further spread within the home.

30. Where outbreaks are declared, the Duty Room supports the care home through regular calls, typically made on a daily basis, until the outbreak is over. These calls are used to gather live information on the status of the outbreak, provide further relevant IPC advice and address any questions from the home itself. Care homes in outbreak are also asked to submit an electronic daily return setting out the evolving position. This also serves as a record of events in addition to the information recorded on HP Zone by Duty Room staff.

31. Prior to the pandemic, where a care home outbreak was adjudged by the Duty Room to be particularly complex, by virtue of its severity or size, then on site

visits were undertaken by PHA health protection staff to provide additional support and guidance. See Table 1 below.

Table 1: Care home support Visits 2014-2020 completed to Independent Sector Nursing and Residential facilities in Northern Ireland (breakdown as per HSC trust area)

Year	Visit BHSCT	Visit NHSCT	Visit SEHSCT	Visit SHSCT	Visit WHSCT	Total Visits
2014	12	11	10	3	3	39
2015	14	10	14	7	4	49
2016	9	8	10	1	2	30
2017	2	17	9	7	5	40
2018	12	18	14	3	9	56
2019	6	9	6	0	3	24
2020	2	0	0	2	3	7

Source: PHA HPDR
Note: support visit may have been completed due to a single case of infection or due to increased incidence/outbreak of an infection.

32. The first probable outbreak of Covid-19 in a care home in NI was identified on 16 March 2020. During March/April 2020, the number of calls from care homes in relation to Covid-19 increased rapidly as demonstrated in tables 2 and 3 below.

Table 2:
Number of calls from Care Homes to the PHA Health Protection Duty Room 2019-2020

	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
2019	30	14	17	24	14	8	18	14	10	20	18	52
2020	25	16	194	254	260	196	181	252	419	734	660	594

Source: PHA HPDR

Table 3: Number of outbreaks/incidents managed by the acute response team 2014 – 2020

Year	GI Illness (viral)	Respiratory Illness	Other pathogens e.g. scabies or other infection identified
2014	93	5	3
2015	125	47	2
2016	115	18	0
2017	103	25	5
2018	91	53	5
2019	85	25	5
2020	24	536	5
2021	23	520	3
2022	67	754	0
2023	84	403	0

Source: PHA HPDR

33. By mid-March 2020, in response to the emerging pandemic, the Duty Room team was providing an enhanced seven-day service. At this point, the majority of the work related to calls from care homes who had symptomatic residents and staff. The team was bolstered through the use of Agency staff and a small number of staff recruited through the regional HSC Workforce Appeal recruitment portal. The HSC Workforce Appeal, was established in March 2020 by the DoH as a means to manage the urgent temporary HSC workforce needs during the pandemic. Nursing and other health care professionals working in alternate parts of the PHA were also redeployed to the Duty Room, working under supervision, to provide additional capacity so that it could respond to the increased volume of calls and the requirement to support many more care homes than normal.

34. The approach to managing notifications of suspected communicable disease and outbreaks did not alter significantly during the pandemic. A regular rhythm of support calls to care homes affected by outbreaks was maintained as a means of providing regular contact to provide intelligence and also work though any issues as they arose. Guidance was also provided to Duty Room staff to support risk assessment for care homes who had self-identified as having concerns - sample included by way of exhibit (Exhibit HR/06 - INQ000547835).

35. On site visits previously undertaken by Duty Room staff were not possible during this period, however this gap was addressed through the provision of support from HSC Trust IPC teams as outlined in paragraph 87.

36. Care homes are used to dealing with residents with significant healthcare needs and would have been very familiar with standards of IPC. Maintaining adequate IPC standards is a requirement for registration for all care homes.

37. The main issue faced by the Duty Room during the pandemic was coping with the volume of calls it was receiving from care homes in outbreak. In the early stages of the pandemic, this was compounded by the speed at which guidance was being produced and revised on a national basis. Staff within the Duty Room had to review and understand new guidance as it emerged, cross referencing it with previous versions to identify where changes had been made and what the implications for care homes would be.

38. Information relating to the management of Covid-19 outbreaks was recorded using HP Zone (HPZ) which is an established, business as usual product used by the PHA for the management of outbreaks of infectious disease. HPZ was developed primarily as a case management system rather than a comprehensive data source for surveillance. It was not designed to support the management of large-scale outbreaks such as Covid-19. Although HPZ continues to be used in the PHA, work is ongoing to identify and implement a replacement system that would be better placed to provide up-to-date time-critical outbreak situation monitoring and reporting. In the interim the PHA has put in place contingency systems which could be used to manage mass scale outbreak data if required.

39. In April 2020, as more intelligence on transmission became available through pre-existing communication channels and reporting process, the PHA became aware of concerns that the region could experience an exponential growth in the number of care homes affected by Covid-19 (Exhibit HR/07 - INQ000137411). In response to the concerns, following agreement at Silver Command, an Operational Group co-Chaired by the PHA and the HSCB was

established to oversee the implementation and monitoring of the Regional Surge Plan for the NI Care Home Sector which had been developed for the sector (Exhibit HR/08 - INQ000591840). Further information on this is set out at paragraph 98 of this statement.

Nursing and Allied Health Professionals

40. In 2019 the PHA, through regional transformation funding, funded a nurse to provide additional focused support to care homes in the provision of high-quality care through a programme of education and in-reach activities. As far as I am aware, the need for the role was identified in response to the recommendations made in 2018, following investigations that had taken place in relation to Dunmurry Manor care home (Belfast) (Exhibit HR/09 - INQ000514711). Although the remit of the post did not extend to domiciliary care, training opportunities provided for care homes were also made available to the domiciliary care sector. In addition, through this dedicated post, the Agency in partnership with Age NI rolled a training and awareness programme designed to improve the skills and confidence of staff in nursing and residential care homes (ENRICH).

41. During the course of the pandemic, two senior nursing staff members and a senior Allied Health Professional (AHP) were redeployed to care home support. Nursing staff were also redeployed under the PHA's Business Continuity Plan at various points, including to support the Duty Room with managing outbreaks in care homes as already set out.

Staffing

PHA Chief Executive role

42. Prior to the appointment of Mr Aidan Dawson as PHA Chief Executive in July 2021, and following the retirement of Mr Eddie Rooney (who was Chief Executive from the Agency's formation in 2009 until his retirement in 2016), the PHA Chief Executive role had been held on an interim basis by two now retired employees as set out below:

- Valerie Watts, interim PHA Chief Executive, October 2016 – March 2020
- Olive Macleod, interim PHA Chief Executive, March 2020 – July 2021.

It is important to note that during her period as Chief Executive of the PHA, Valerie Watts also held the role of Chief Executive of the then HSCB.

Director of Public Health role

43. Prior to the appointment of Dr Joanne McClean to the Director of Public Health (DPH) role in September 2022, the role was held by a number of staff members as set out below:

- Dr Carolyn Harper, April 2009 – February 2018
- Dr Adrian Mairs, March 2018 – February 2020 *interim basis*
- Professor Hugo Van Woerden, February 2020 – December 2020
- Dr Stephen Bergin, December 2020 – August 2022 *interim basis.*

The DPH has professional responsibility and accountability for the delivery of the public health function within the Agency. This function incorporates the PHA Duty Room whose role in relation to the management of infectious disease within care homes has been set out earlier in this statement.

44. Prior to the pandemic, the Agency's public health directorate had a number of staff vacancies as well as a number of key posts that were filled on a temporary basis. A standalone corporate risk in relation to public health staffing issues was created in June 2020 (Exhibit HR/10 - INQ000389913). There was a specific challenge surrounding the number of HP consultants employed within the Agency. In 2019, three out of eight HP consultant posts were vacant, and although two permanent and two locum posts were offered and accepted in October 2019, by November 2019 two consultants retired and another indicated a move to another organisation. In early 2020, a third locum post was appointed, initially on reduced hours but increased to full time working during the pandemic. A locum HP consultant was also recruited on a substantive basis during this period. As previously noted, HP consultants provide a daily point of escalation for the PHA Duty Room. During the course

of the pandemic, HP consultants were also involved in work aligned to care home testing, visiting and the roll out of guidance.

45. The Agency also had a shortfall in specialist epidemiological resources which had arisen due to year on year increases in both the volume and complexity of the workload within the Health Protection Service. An epidemiological specialist (epidemiologist) is a public health professional who specialises in understanding the cause and locations of outbreaks - studying data to learn how diseases develop and spread. They also investigate patterns and cause of disease with the aim of reducing risk and poor outcomes. This was a known risk to the PHA and in 2019 a business case had been prepared to seek additional funding for four posts to bolster the Agency's Health Protection Service. One of the roles contained within the business case was that of a Health Protection Nurse (AfC Band 6) which would have been aligned to the care home response through the Duty Room. Additional resources were sought in 2020 to further enhance professional expertise and capacity to continue to respond to the Covid-19 pandemic including:

- Health Protection Consultants
- Specialist Health Protection Nurses
- Support for implementation of vaccination programmes
- Surveillance and monitoring capacity
- Emergency preparedness and environmental hazard management.

46. I am not aware of any significant vacancies in the Directorate of Nursing, Midwifery and AHPs.

47. Despite the level of vacancies apparent within the Agency, I do not believe that this significantly impacted the PHA's ability to support the care sector during the pandemic. The majority of the Agency's work was redirected to the Covid-19 response and staff were redeployed to support efforts to mitigate against harm in more vulnerable populations.

Liaison with DoH

48. Between January and June 2020, the PHA operated under the model described in the JREP. This outlines arrangements for a joint response by the PHA, the HSCB and BSO in an emergency to ensure that the response of the three regional HSC organisations was coordinated and effectively managed. The DoH operated as Gold Command - that is the level of management which is concerned with the broader and long-term implications of the emergency. Daily reports and updates were provided to Gold Command by the PHA, BSO and the HSCB, all of whom operated as Silver Command. The HSC Trusts, operating as Bronze Command (defined as the level at which the management of hands-on work is undertaken at the incident site) in turn provided updates to Silver. Silver Command is the level at which the emergency is managed, including issues such as, allocation of resources, the procurement of additional resources and the planning and co-ordination of ongoing operations. In the early stages of the pandemic a number of cell management groups were created as set out below. A number of groups directly related to the care home sector were also established on which further information is provided later in this statement.

- Executive
- Logistics and Supply
- Infection Prevention Control
- Communications and Media
- Knowledge Management
- Technical Scientific
- Resource (HR and Finance)
- Surge - Integrated Care
- Surge - Acute
- Social and Community
- Business Continuity
- Covid-19 Business General

49. As the pandemic progressed and it became clear that a longer-term response was required, some of the work of the PHA changed at the direction of the DoH. By way of example, in early April 2020, the PHA was directed to design, implement and undertake the running of a dedicated, large-scale Contact Tracing Service (CTS) under the leadership of the CMO as the Senior Responsible Officer. The CTS formally closed in June 2022.

50. The PHA was also asked to lead on the operational delivery of public health advice, raising awareness and providing guidance for the residents of NI. None of these changes diminished the PHA's central role of providing public health expertise to the DoH and wider HSC. During the period to which this Module relates, the Agency would have provided advice to the DoH on a frequent basis primarily via the offices of the CMO/DCMO and Chief Nursing Officer (CNO) on both a formal and informal basis. The Agency does not have a chronological list of each interaction. The CMO established several groups to ensure that there was an effective response to the pandemic and the PHA was represented in a number of key groups including the Nosocomial Support Cell, the Strategic Intelligence Group and the Regional Modelling Group established by the Chief Scientific Advisor (CSA).

51. Throughout the pandemic there was close collaboration between PHA and the Department and work was taken forward jointly on a number of strategic areas. The relatively small teams in each organisation collaborated to make the best use of resources. For example, the Department's Information Analysis Unit led on the development of a Covid-19 information dashboard. The PHA was also asked to lead Departmental initiatives such as the Expert Advisory Group on testing (EAG-T); whilst in others PHA staff were part of larger groups representing the wider HSC (Exhibit HR/11 -INQ000591848).

Liaison with Other Stakeholders and Bodies

52. Aside from the work described later in this statement in relation to communications, the PHA had no direct working with the NI Executive during the pandemic. As an ALB of the DoH, any interactions with the Executive were managed through the DoH in line with established protocol.

53. The PHA provided expert advice to the CMO, CNO and the CSA as and when it was requested. PHA staff also sat on a range of groups Chaired by the Chief Professional Officers as referenced earlier in this statement.

54. Staff from the PHA also attended, and on occasion Chaired, a nursing and midwifery huddle group that had been established by the CNO to address key system wide issues as and when they arose relating to multiple aspects of the pandemic response such as visiting, vaccination, staffing. This group was established to share information and ensure that senior nurse leadership was kept abreast of the situation as it evolved.

55. The PHA shared intelligence and information with Chief Professional Officers and their staff on a regular basis. When necessary the PHA submitted formal papers to the Chief Professional Officers.

56. PHA staff attended the following DoH groups that were specifically in relation to adult social care:

- Adult Social Care Governance - Surge Planning (Exhibit HR/12 - INQ000498846)
- Co-Chaired by Chief Social Work Officer and CNO

- Care Homes Visiting Review Group
- Chaired by Deputy CNO

- Care Home Vaccination Programme
- Chaired by DoH

- Rapid Learning Initiative Task and Finish Group (Exhibit HR/13 - INQ000591850
- Chaired by Deputy CNO

- Testing in Care Homes - Task and Finish Group
- Chaired by Deputy CMO

57. The HSCB had specific responsibilities for the enactment of the JREP and for the HSC in general. The PHA was charged with providing professional public health focused medical, nursing and AHP advice to the HSCB and this continued throughout the pandemic response.

58. The HSC Trusts, working at a tactical support level, worked together with the PHA to optimise support and for care homes including outbreak management and IPC. The Agency also worked closely with Trusts on a range of wider work including development of arrangements for mutual aid, surge planning and service continuity.

59. The PHA worked closely with RQIA in sharing information about care homes in order to build intelligence about the sector and support homes when they experienced outbreaks. As the regulator, RQIA has up to date information on homes on the live register. The PHA also worked closely with RQIA in developing a single daily return on individual care homes Covid-19 status which was then shared across relevant stakeholders. This negated the need for homes to provide multiple returns.

60. The Commissioner for Older People (COPNI) shared information and concerns about individual homes or the wider sector in general. The PHA used this information to provide support either directly to the care home, the individual resident/family involved or indirectly via the Commissioner's Office. Communications from the Commissioner's Office were varied in nature, relating to issues such as: regional visiting guidance and the challenges faced by individual visitors, testing arrangements for both visitors and residents, and care home access for Care Partners. On occasion, the PHA also received information via the Patient and Client Council (PCC). The PCC provided a carers platform and also identified service users to provide input to the Normalising Visiting Forum.

61. The PHA facilitated regular meetings with representatives from independent Health and Care providers and worked closely with them to inform the development of policy and guidance. This included providing direct advice and information through engagement with HP consultants and nursing colleagues in the Agency as requested.

62. The PHA did not have any specific engagement with the Nursing and Midwifery Council or the Northern Ireland Social Care Council (NISCC).

Engagement with Counterparts in the UK

63. A UK IPC cell was established to facilitate collaborative working across the four nations (England, NI, Scotland, Wales) as a means to optimise the safety of patients, service users and staff in relation to IPC during the Covid-19 pandemic. Of note, NI policy on IPC followed closely that from the other UK nations. The IPC cell was established in March 2020 and its membership is set out in the terms of reference (Exhibit HR/14 - INQ000416768) and included:

- NHS England and NHS Improvement
- UK Health Security Agency
- Public Health Wales
- Antimicrobial Resistance and Healthcare Associated Infection, Scotland
- PHA, NI
- Ambulance Service
- Department of Health and Social Care
- Office for Health Improvement and Disparities.

64. In the area of testing, the PHA was, through its leadership of the EAG-T, included in a range of four nations meetings as well as discussions on a one to one basis with Public Health England (PHE) and the UK Health Security Agency (UKHSA) on the rolling out of the national testing programme and associated protocols and specific operational requirements for NI.

65. In respect of communications, the DoH and wider NI Executive led on messaging around government policy in relation to the pandemic. The role of the PHA in this space was to lead on the operational delivery of public health advice raising awareness and providing guidance for the residents of NI.

66. The PHA worked with the NI Executive and the other Devolved Administrations to inform and support the roll out of a range of Covid-19 campaign programmes. PHA communication leads contributed regularly to

joint Devolved Administrations communication/marketing meetings to coordinate and discuss messaging and delivery of UK-wide campaigns. The campaigns included UK-wide campaigns led by the Cabinet Office and NI-only campaigns led by the NI Executive.

Care Home sector

67. The care sector within NI is a complex space in which a number of different stakeholders have roles and responsibilities. There are around 470 registered care homes in NI. Just under 50% provide residential care only. A small number of homes are managed by HSC Trusts (46) with the rest being run by the independent sector. Across the sector the number available beds is affected by a number of factors but typically there are around 14 - 14.5 thousand residents being cared for at any one point in time.

68. HSC Trusts retain a statutory duty of quality for the care provided on their behalf in all care homes. RQIA is responsible for monitoring and reporting on the quality of services provided in the regulated sector.

69. All Nursing staff in Care Homes are required to be registered with the Nursing and Midwifery Council (NMC), non-registrant staff who provide direct care or have contact with residents are required to be registered with the Northern Ireland Social Care Council (NISCC). Staff have differing responsibilities according to their code of practice.

70. Although the DoH remains responsible for policy within the sector and has developed regulations and standards in relation to care, most care homes are independent, private businesses that determine their own operating model to best meet their requirements and the needs of their residents.

71. Given the rapidly changing landscape in the early stages of the pandemic, it is understandable that some stakeholders might have felt that lines of communication were not as clear as they could have been. Indeed, reviews of the sector prior to the pandemic have found that it can be difficult for residents and their families to navigate the landscape with many having no prior knowledge, information or experience of the care system (Exhibit HR/15

- INQ000591845). I expect that during the early days of the pandemic, these difficulties would have been more acute.

72. I am not aware of any specific challenges in the relationship between PHA and DoH in respect of the care sector, but I believe there may have been occasions when there were differences of opinion or challenges that placed a strain on parties as colleagues tried to balance the risk of infection within care homes against the negative impact to residents and their wider social networks as a result of visiting restrictions. It is however my view that everyone was trying to do a good job in exceptional circumstances. Overall however I believe that relationships were good with a common goal to protect vulnerable people in the care sector.

73. In relation to the July 2020 findings of the Rapid Review of the Epidemiological Function within the Public Health Department of the PHA, I was not party to any discussions that took place regarding the Review (Exhibit HR/16 - INQ000001196). Based on the feedback I have garnered through the preparation of this statement, it is my understanding that at the onset of the pandemic, the demand for information, data and intelligence was unprecedented. The DoH, media, politicians and the public all had a need for information and in many cases, they turned to the PHA to provide it. The volume and frequency of these requests placed considerable pressure on the Surveillance and Health Protection teams of the Agency.

74. The requirements and requests for 'live' accurate information and data pertaining to the pandemic was considerable. At the time, the PHA did not have access to the technical infrastructure to enable fully automated data processing and the unyielding pace of the demands did cause both internal and external frustration. Information about the numbers of deaths attributed to Covid-19 being one such example of this. In the absence of a pre-existing system to inform PHA about deaths, the interim Chief Executive of the PHA wrote to the HSC Trusts on 26 March 2020, requesting them to report in-hospital deaths where the patient had been diagnosed with Covid-19 to the PHA via an internal web portal built on Microsoft SharePoint (Exhibit HR/17 -

INQ000381494). This did not however allow for the reporting of deaths in other settings such as care homes and in the community. Further information related to deaths reporting is provided at paragraphs 160 - 170 of this statement. The PHA Acute Response Health Protection team, as part of their routine response to care home outbreaks, received a daily report from independent sector nursing and residential facilities that were reporting increased incidence of an infection or outbreak. In addition to the standard outbreak metrics the reports also identified any deaths that had occurred.

75. As already noted, the care home sector within NI is complex and as such all core decision-makers in the DoH may not have had a granular understanding of the operational landscape in which individual homes managed their residents. This is not unexpected given that the DoH has no operational oversight of the sector. That said, the DoH would have had a number of professional staff with both nursing and social work backgrounds who would have understood many of the intricacies of the care sector. The DoH would also have working relationships with each HSC Trust (who commission social care services for their area), RQIA and both the HSCB and the PHA.

76. In relation to the level of consultation and communication with the PHA by the DoH, the Agency recognises that the DoH was often making policy decisions quickly and the capacity to consult and engage was not available to the extent it would have been prior to the pandemic. It would also be reasonable to say that the value of protracted engagement may have been limited given that any key decision or policy change was made as a result of evolving information in respect of Covid-19. Overall, it is my view that the PHA and the DoH maintained an effective and successful working relationship through the pandemic.

Operational support for the Care Sector

77. At the outset of the pandemic, the PHA support for care homes was largely delivered through Nursing and Allied Health lines, working closely with the

Social Care colleagues in HSCB and the CNO/CSW policy leads offices. Outside of the operational response for outbreaks in care homes, PH consultants were focused initially on supporting wider system mitigation. By April 2020, additional capacity was centred on care homes and staff across the Agency worked closely to share intelligence and plan. Many discussions took place on an informal basis as the teams worked in the same building (social distancing maintained) and had good relationships already established.

78. During the pandemic, operational support for the management of outbreaks, including contact tracing, was managed through the HPDR. Further detail is provided in paragraphs 33 -37. Additional resources were developed to support care homes with decision making as the pandemic progressed - sample included by way of exhibit (Exhibit HR/18 - INQ000547836).

79. The NI Direct Covid-19 telephone service had no specific role in terms of support to care homes. A number of communication channels were offered for care homes depending on the nature of the issue. Official guidance from either PHA or the Department was always issued to care homes directly via RQIA to maintain continuity (Exhibit HR/19 - INQ000591843) (Exhibit HR/20 - INQ000572279) (Exhibit HR/21 - INQ000547837). Questions on testing were managed through a dedicated e-mail. Regular meetings were also established between senior nursing leads and representatives of the independent care home providers. The PHA and the Department worked closely in providing answers to any questions from the public relating to care homes.

80. Operational support for care homes was provided by a number of organisations. The Department directed HSC Trusts to repurpose Acute Care at Home and Enhanced Care at Home teams to provide support to the Care sector (Exhibit HR/22 - INQ000547838). Senior RQIA staff also provided support to care homes, following up on any homes retuning an amber or red status on their daily return (see paragraph 59). In addition to the support directed by the Department, HSC Trusts had well established teams who kept in daily contact with the care homes in their area to help with testing during

outbreak, access to PPE, vaccination, mutual aid etc. Regular weekly meetings of all stakeholders were convened by PHA and attended by HSC Trusts, RQIA and Department staff. This allowed for information on issues to be shared. Actions agreed from each meeting were circulated and followed up at subsequent meetings. Cross organisational working was a core aspect of the care home response throughout the pandemic (Exhibit HR/23 - INQ000547839).

81. The PHA facilitated a series of ECHO sessions for care homes to support education and training:

31/3/20	- Overview of Covid-19
2/4/20	- Role of RQIA SST in Covid-19
16/4/20	- Palliative Care in Partnership
3/6/20	- Environmental Cleanliness – Terminal Clean Process
25/6/20	- Environmental Cleanliness – Terminal Clean Process
29/7/20	- Balancing the risk and rights of visiting during pandemic
2/9/20	- Environmental Cleanliness – General Principals
14/9/20	- Environmental Cleanliness – General Principles

82. Training was also provided as e-learning and Zoom sessions, free of charge to care homes. Specific programmes were written / revised for pandemic. The top 5 accessed were:

- Verification of Death
- Covid-19 - Assessment & Management of the Acutely Ill In-Patient
- Covid-19 - Fundamentals of Care
- Covid-19 - Respiratory Care and Management of the Patient (Registered Nurses)
- Intravenous Administration of Medicines (Adult)

83. Communications developed by the PHA in conjunction with stakeholders were shared with care homes to support risk assessment for infection and morbidity (Exhibit HR/24 - INQ000547840) (Exhibit HR/25 - INQ000547841) (Exhibit HR/26 - INQ000547842). Resources were also provided with advice on reducing risk of transmission through care home staff movement between

homes and for visiting staff (Exhibit HR/27 - INQ000547843) (Exhibit HR/28 - INQ000547844) (Exhibit HR/29 - INQ000547845).

84. PHA staff leading on the care home response also worked closely with HSC Trusts to support care home outbreak management in instances where high proportions of residents had tested positive and in addition were reporting high levels of morbidity requiring medical input. Residents have the right to continue to be cared for by the GP that they were registered with prior to admission to the care home. In some instances, care homes are required to interface with a large number of GPs in an outbreak scenario. This added further work and stress to Care Home Mangers trying to secure face to face visits or assessments and treatment. Maintaining a reduced foot fall was also important. PHA and HSC Trust staff worked with Primary Care representatives to explore the development of a primary care medical model whereby care homes could be supported by a single practice and the use of 'virtual' ward rounds. Unfortunately, it was not possible to deliver a new regional model at the time.

85. The PHA also aided the HSC Trust IPC teams by placing a senior nurse/midwife from the Agency within each HSC Trust locality. The primary purpose of these roles was to support community IPC activity which included input and support to care sector. The work of the HSC Trust based IPC teams was also supplemented by a group of approximately 40 dentists, identified by the PHA and the HSCB. The dentists, who had existing skill and knowledge of IPC, were placed alongside regional IPC Support Nurses and under the direction of the HSC Trust IPC teams they provided advice and support to care home staff in relation to IPC, PPE and wider testing.

Onsite Visits to Care Homes

86. As set out earlier in this statement, prior to the onset of the pandemic, care home site visits were an established part of the PHA's response where there was a particularly complex outbreak of infectious disease. Visits provided an opportunity for the Agency to assess a given care home and provide bespoke advice. Through the course of a visit, a member of the Health Protection

team would review multiple aspects within a home including practices of cleaning, IPC and the use of PPE. Following the visit, both the care home and the regulator would be furnished with a report containing any recommendations that had been identified through the course of the visit.

87. Visits to care homes by the PHA ceased in March 2020 and did not resume during the period to which this Module relates. Although the cessation of visits did hamper the Agency's ability to provide particularly nuanced advice to care homes in outbreak, through the Duty Room lines of communication with care homes were retained and readily relied upon throughout the pandemic. During the period, care homes also had the benefit of outreach visits undertaken by HSC Trust based IPC teams following a request from the CMO and CNO.

88. In relation to the Agency's support to the care sector, I believe that PHA did the best job possible at the time in respect of providing adequate and timely support to the care sector, in the context of a pandemic whose scale and duration had not been experienced within living memory. There is learning for the PHA and looking back, it was the case that the Agency's support to the care sector was being managed largely through two different Directorates in which a number of discrete workstreams were being progressed such as visiting, testing and the day to day support being provided by the Duty Room. An alternate model in which a senior member of staff had oversight of the entire care home response may have provided for a better approach to the care sector within the Agency.

Emergency Operations Centre

89. An Emergency Operations Centre (EOC) led by the PHA was stood up on 23 January 2020. The purpose of the EOC at that stage was to manage the large amount of information coming to the PHA and to ensure this information was shared with the right people and/or groups for action; and to ensure that actions were progressed as required. There were also numerous queries

coming in to the Agency seeking information/guidance and a robust mechanism to manage and record this was required.

90. The EOC operated seven days a week and whilst the hours of operation were flexed according to demand, they were generally 9am to 9pm Monday to Friday and 9am to 6pm across the weekend.

91. On 16 March 2020, in line with the move from containment, the EOC transitioned from a Health Protection led EOC (leading on guidance, communications, response to public health queries and contact tracing) to a support centre for HSC organisations for the next phase. From 16 March, HSC Silver Command, which had been Chaired by the PHA from its establishment, was Chaired by the HSCB. The DoH took on the chair role for Health Gold which was activated on 9 March 2020.

92. The EOC did not deal with calls from the care sector. It was agreed that the PHA should continue to manage queries and outbreaks through their pre-existing acute response. Any calls to the EOC in respect of the care sector were redirected to the Duty Room.

Contact Tracing Service

93. The Contact Tracing Service (CTS) did not provide any support for the care sector. Where a case or close contact was identified as living or working in a care home, this was passed to the PHA Duty Room to manage.

NI Direct Covid Care Telephone Service

94. The NI Direct Covid-19 Care Telephone Service was initially established to support the CTS. It was designed as a way for people who had no access or found it difficult to use online resources such as the Symptom Checker App or online test booking platform. The service essentially acted as a proxy for people unable to use these products in order to try to ensure equity for people without digital access. NI Direct is an online platform for information related to NI public services. Call handlers would have answered queries where they could by searching the website for the most up to date guidance. Where

there were questions that couldn't be answered using the scripts or other NI Direct webpages, these were forwarded to the PHA for the provision of a response to enable NI Direct to provide a call back. There was no specific role in terms of support for the care sector.

Surge Plans

95. During late January/early February 2020, in response to the risk of the emerging pandemic, surge planning commenced in NI. The HSCB established a Covid-19 Surge Planning Support Group that included representation from PHA medical and nursing staff. The group reported to Silver Command and its purpose was to support the planning for a Covid-19 surge (Exhibit HR/30 - INQ000343988).

96. Staff from the PHA, alongside colleagues from the HSCB and BSO, attended a meeting with the CMO on the 11 February 2020, where they were directed to work up integrated surge plans from community and primary care through to acute care (Exhibit HR/31 - INQ000137326). The Chief Executive of the HSCB, wrote to the CMO via letter on the 20 February 2020, to provide an assurance in relation to surge planning and the work underway between the HSCB, PHA and HSC Trusts (Exhibit HR/32 - INQ000130371). Care home surge planning was included within the broader scope of social care services and planning focused on supporting people to receive care and treatment in the community and ensure effective and efficient discharge of hospitalised patients (Exhibit HR/33 - INQ000381485).

97. In relation to the Surge Plan: Social Care and Children's Services, it is my understanding that the DoH requested the HSCB to lead on the development of this document which provided a framework for the maintenance of services in line with thresholds of staff absence. PHA staff would have worked alongside colleagues within the HSCB and the HSC Trusts on the development of this plan.

98. As the pandemic continued, focus was redirected to the increasing number of infections and outbreaks within the care home sector. The PHA worked in partnership with HSCB through an Operational Group to develop a dedicated PHA/ HSCB Covid-19 Regional Surge Plan for the NI Care Home Sector with three overarching objectives of prevention, mitigation and resilience (Exhibit HR/34 - INQ000561001). The Regional Surge Plan was frequently updated to reflect the changing needs of the sector (Exhibit HR/35 - INQ000591855).

Discharge Policy

99. As far as I am aware, the PHA had no input regarding the plans to discharge patients from hospitals into care homes which I understand was developed as a means to improve the flow of patients within hospitals to ensure that capacity existed for critically ill patients (Exhibit HR/36 - INQ000547846).

100. The severe impact of Covid-19 on care homes became evident as the number of cases increased in the early weeks of the pandemic. The impact of asymptomatic or presymptomatic transmission became more widely understood as the pandemic unfolded so that by April/May 2020 it was broadly accepted that asymptomatic spread was possible. In the early stages of the pandemic guidance to care homes advised that all new admissions to care homes should be isolated for 14 days as an IPC measure. As testing capacity increased, the discharge policy was changed so that in April 2020 all people discharged into a care home were tested in advance of admission to the home (Exhibit HR/37 - INQ000547847).

Testing Policy

101. In March 2020, the DoH convened the EAG-T which was Chaired by a member of staff from the PHA. The EAG-T reported directly to the CMO given that policy responsibility for testing remained with the DoH. The key role of the EAG-T was to develop the NI approach to Covid-19 testing and to oversee/coordinate implementation of testing. Membership of the EAG-T is set out below:

- Brid Farrell (Chair), PHA

- Lourda Geoghegan, DoH
- Gillian Armstrong, DoH
- NR, PHA
- NR, Pathology Network Manager
- NR Adept Fellow, DoH
- NR, Belfast HSCT Virology lab
- NR Southern HSCT
- Dr Brian Smyth, Retired Public Health doctor and Consultant Epidemiologist
- Prof Ian Young, DoH
- Prof Stuart Elborn, Universities/AFBI consortium
- NR Procurement and Logistics Service
- NR PHA

102. The EAG-T met twice weekly for the first year of the pandemic. The first discussion on care homes was recorded on 10 April 2020, with information about case numbers and the approaches being used in both the Republic of Ireland and PHE shared with the group. At this session, the EAG-T discussed and subsequently recommended the need for all symptomatic care home residents to be tested where there was a suspected outbreak of Covid-19. This change in practice was communicated to care homes by RQIA on the 12 April 2020 and incorporated into version 3 of the Covid-19 Protocol for Testing which was issued on the 19 April 2020. Prior to this date, it was established practice to test a maximum of five residents in a care home in which there was a suspected outbreak. This practice related to the measures that were already in place for Influenza testing that were applied to Covid-19 in the early stages of the pandemic.

103. The EAG-T provided regular guidance to services on the priority groups for testing as testing capacity increased and as more evidence about transmission and the severity of the virus became known. As already mentioned, the significance of presymptomatic and asymptomatic transmission was not fully appreciated in the early weeks of the pandemic.

104. The EAG-T reviewed national guidance issued and the approaches being taken by the other four nations and the Republic of Ireland. The EAG-T did not undertake any impact assessments of testing but relied on surveillance of cases in the community and care homes to inform their decision making.

105. In relation to the Care Home Task and Finish Group (chaired by Department) which met monthly from May 2020: this was a group that the PHA participated in with the initial meetings relating to the one-off testing of all residents in NI care homes which was undertaken jointly with the HSC Trusts and the NI Ambulance Service. It is my view that the Task and Finish Group was formed at an appropriate point of the pandemic as it was primarily tasked with providing direction and guidance in relation to the expansion of care home testing. Prior to the first meeting of the group on the 8 May 2020, the risks in relation to care home residents as a result of Covid-19 would have been an active part of regional decision making.

106. By the end of June 2020, following the completion of the testing exercise referenced in the preceding paragraph, regular testing of care home residents and staff was co-ordinated through pillar 2 testing (national labs) with an online booking platform for care homes to order their tests. The actions from these meetings were communicated to care homes and HSC Trusts via letter and operationalised by care homes in association with the PHA and the HSC Trusts. The PHA monitored results from care homes on a monthly basis and these were reviewed at each meeting. A regular monthly Care Home Testing Report was provided from October 2020 onwards (Exhibit HR/38 - INQ000591856).

107. Testing for Covid-19 in care homes was initially facilitated by the Regional Virology Laboratory in the Belfast HSC Trust. The case definition criteria for testing was agreed at a four nations level and was endorsed by the DoH for local implementation. As new clinical evidence emerged in relation to atypical presentations in vulnerable and older populations, the case definition was expanded. This served to alert clinicians and care homes to the need for a

higher index of suspicion regarding possible atypical Covid-19 presentations. Following expansion of the case definition for the care home population, Covid-19 guidance was amended to advise that all residents in care homes with atypical symptoms should be managed as probable positive cases. In such circumstances, care homes were asked to ensure implementation of all appropriate IPC procedures. Care homes were also provided with updated advice on symptoms (see paragraph 83).

108. On the 24 April 2020, whole home testing was introduced for care homes with a new outbreak. Initial pillar 1 (local labs) testing was undertaken to determine the extent of the outbreak with all staff and residents tested on day 0 and then followed up on days 4 - 7. Pillar 1 testing was used due to the rapid turnaround for results (less than 24 hours) which facilitated early IPC intervention. HSC Trusts were responsible for oversight of initial care home outbreak testing at day 0 and days 4-7. HSC Trusts provided labels, test kits and supported administration for outbreak testing as well as supporting administration of the tests (nose and throat swab) as required. The PHA Duty Room supported risk assessment of the outbreak and advised on scope of testing.

109. In early May 2020, a whole care home testing policy was applied retrospectively to all open outbreaks notified prior to 24 April 2020 and not closed on or before 7 May 2020 (92 homes). An additional 23 care homes had outbreaks notified prior to 24 April 2020 but were closed on or before 7 May 2020. In late May 2020, a decision was taken to test all staff and residents in care homes, this included homes that were not, and had not, experienced an outbreak of Covid-19. On 13th June 2020, the then Minister advised that all staff and residents in care homes should be tested before end of June 2020.

110. As a precautionary approach the DoH, on the advice from the EAG-T revised the testing policy in care homes to introduce a programme of regular testing in all Covid-19 free care homes, this was supported by a booking platform that care homes used to order tests. On 28 July 2020, a letter was issued to announce the implementation of a planned programme of regular Covid-19

testing for all residents and staff in care homes, with staff being tested every 14 days and residents every 28 days. This programme came into effect on 3 August 2020 with updated operational guidance issued shortly thereafter. On 3 November 2020, the then NI Health Minister announced that regular testing of staff was to increase from once every two weeks to once a week. Testing arrangements were extended in December 2020 to facilitate polymerase chain reaction (PCR) testing for care home visitors and care partners over the Christmas period. Testing was facilitated as part of regular weekly testing in care homes and at drive through and mobile community test sites. A letter from the CMO was issued on the 18 December 2020 to update on Covid-19 testing arrangements for nursing and residential care homes. Regular PCR testing for care partners was established as part of care home weekly regular testing in February 2021.

111. The PHA would accept that some care home outbreaks of Covid-19 were as a result of the movement of people from hospital to care homes, although these were likely a small minority compared to the larger number of outbreaks that arose from the normal connections between care home residents, staff, visitors and the wider community (Exhibit HR/39 - INQ000591857) (Exhibit HR/40 - INQ000591858) (Exhibit HR/41 - INQ000234332) (Exhibit HR/42 INQ000325326) (Exhibit HR/43 - INQ000522018).

112. The PHA does not have information about the total number of staff within care home settings recorded as either having been hospitalised or died as a result of Covid-19 as the PHA does not have access to a list of care home staff in NI to identify this cohort. Care home staff were at high risk of exposure to Covid-19 due to the nature of their work, being in close proximity to the people whom they worked with and cared for, beyond their normal contacts in the community. On the basis that evidence indicates that only a small fraction of care home outbreaks was associated with hospital discharge, it is likely that a smaller proportion of infections in care home workers were associated with hospital discharges (as they also would have also been part of additional transmission chains outside the care home environment). Social care staff were highlighted as being an occupational group at very high risk of Covid-19

in a report from The Health Foundation, based on Office for National Statistics (ONS) data from England and Wales. In an analysis of deaths registered by occupation in England and Wales between March and May 2020, ONS reported that 'Men and women working in social care, a group including care workers and home carers, both had significantly raised rates of death involving Covid-19, with rates of 50.1 deaths per 100,000 men (97 deaths) and 19.1 deaths per 100,000 women (171 deaths)'. This compared to a rate of 19.1 for men and 9.7 for women per 100,000 total working aged population. (Exhibit HR/44 - INQ000591862). The impact of Covid-19 on the health of social care staff could, with the agreement of key stakeholders, be undertaken through record linkage of those registered with the NISCC to healthcare data in future, using anonymised data through privacy-protecting means, such as the Honest Broker Service and/or the NI Trusted Research Environment. This would be a useful source of information to understand the burden of infection in this population, and inform future guidance to protect and support them.

113. As already mentioned within this statement, as part of its acute health protection response the PHA has responsibility for managing cases, clusters and outbreaks of infectious diseases in NI. For care homes, the unit of analysis and operation is at the institutional level (i.e. by care home), rather than at individual level. The units of reporting are the number of care homes in outbreak, count of affected individuals and duration of outbreak.

114. Changes in Covid-19 testing policy for staff and residents of care homes influenced the ability of the acute response to identify, classify and report Covid-19 outbreaks.

115. The PHA conducted a surveillance study in April 2020 in a sample of care homes to confirm the potential for transmission from symptomatic, pre-symptomatic, and asymptomatic individuals. Findings highlighted that testing only symptomatic residents and staff would not identify all individuals with SARS-COV2. This work informed the NI policy for testing all residents and staff for Covid-19 in care homes with new outbreaks regardless of symptoms. Changes in testing policy, such as increased testing and proactive

asymptomatic testing, undoubtedly contributed to the reduction in the reproduction number as infections were identified earlier and public health interventions, such as isolation, reduced the opportunities for transmission. The impact of which can be seen in the change of care home outbreak epidemiology between the first and second waves of the pandemic.

Testing in other care settings

116. The PHA acute health protection response did provide support to domiciliary care agencies in the management of clusters and outbreaks of Covid-19 within domiciliary care staff. The EAG-T guidance issued on the 19 April 2020, emphasised the importance of supporting domiciliary care workers with no access to an occupational health service and that PCR testing could be organised via RQIA. The guidance issued on 4 May 2020, included reference to domiciliary workers being able to self-book PCR tests. In August 2021, regular testing of asymptomatic domiciliary workers was made available. The Agency did not have access to accurate data in respect of those receiving care and those working in domiciliary care from which to assess impact.

117. In respect of future learning, the Agency is aware of the approach taken in Wales where it is mandatory for all domiciliary care workers to be registered with Social Care Wales. The population of domiciliary care workers in Wales during the Covid-19 pandemic was therefore known, and could be linked to anonymised data, including health and administrative data thereby providing an opportunity to explore a range of health outcomes.

Implementation of the testing programme

118. In recognition of that fact that care homes are distinct from other care settings, PHA staff managed the customisation and implementation of a comprehensive Covid-19 testing arrangement for care home residents and staff. In implementing and customising the delivery for NI, engagement took place with the key stakeholders, namely: care home providers, HSC Trusts and RQIA.

119. As set out earlier in this statement, all care homes in NI were supported with regular, asymptomatic PCR testing from May 2020 with the programme later expanded to include Lateral Flow Test asymptomatic testing and testing for care partners and visitors to care homes. PHA led on all aspects of implementation and delivery of this programme to include:

- Direct liaison and working closely with DoH colleagues (CMO and DCMO) on the many work areas attached to development and delivery of this programme;
- Hosting engagement sessions with main care home providers in advance of a series of Zoom ECHO sessions with all care homes;
- Sharing information on care home policy and testing changes via the PHA website and wider social media channels;
- Establishing and managing a dedicated email address for care homes to use for queries, comments and feedback. Although individual communications were varied in nature and related to the particular circumstances of each care home, by way of example, queries were made in relation to resident and staff testing, IPC practice, PPE and visiting. Feedback received through the email address was shared with colleagues and used, alongside other channels of information, to help inform the delivery of the programme, the content of the Agency's ECHO sessions and the wider guidance for the sector;
- Monitoring key performance metrics on an ongoing basis in terms of PCR testing end to end performance including results turnaround times;
- Measurement of the effects of this programme is linked health surveillance data highlighting early identification of positive cases, numbers of outbreaks: both symptomatic and asymptomatic with ongoing work to reduce transmission thereafter;
- Membership of DoH steering group for care homes;
- Facilitating HSC Trust / care home provider group for collaboration for care home support to include testing.

120. This programme was made possible through a collaborative and robust multi-agency partnership between the PHA, the DoH, RQIA, the HSC Trusts, the NI Ambulance Service and importantly the staff working within the care homes themselves.

121. Regarding the impact of the testing programme on Covid-19 infection, hospitalisation and mortality rates in care homes, the PHA's evaluation indicated that proactive asymptomatic testing reduced the length and severity of outbreaks seen in care home settings. This conclusion is supported by modelling work exploring the impact of repeat asymptomatic testing policies for staff on Covid-19 transmission potential which identified that regular testing reduces the size and likelihood of outbreaks in closed populations (Exhibit HR/45 - INQ000536508).

122. Community prevalence of Covid-19 affected the prevalence of the virus in care home settings. The association has been explored using NI data by plotting the number of people who would have tested positive for Covid-19 in the ONS Covid-19 Infection Survey (Covid-19 Prevalence) and incident care home outbreaks per day. The gradient of this relationship was different in the pre-vaccination and post-vaccination time periods (Exhibit HR/46 - INQ000438437). Due to this association, the implementation of the testing policy across the wider population, for example direct access to testing, impacted the care home population as infectious people were identified and isolated. This would have contributed to a reduction in the reproduction number and subsequent reduction in the growth of the epidemic. While the public health messaging advised isolation based on symptoms, receipt of a positive test result provided a rationale for individuals to continue to isolate and identified the individual for participation in contact tracing.

123. Maximising the effectiveness of regular testing and subsequent public health actions requires high adherence. There are features of the care home resident and staff population which may have acted as a barrier to high adherence to the testing programme. An English study identified factors that may have influenced testing and isolation behaviour (Exhibit HR/47 -

INQ000503454). Long term care facilities with frequent employment of agency nurses or carers were associated with significantly increased odds of infection in residents and staff and resultant outbreaks. Conversely, protective factors against infection and outbreak included care settings where staff were entitled to paid statutory sick pay as opposed to settings with no sick pay. The implementation of testing policy is intertwined with broader economic policies and interventions to support health and care staff to undertake public health interventions such as isolation. The study also identified that settings that were unable to isolate residents due to non-compliance (for example, residents living with dementia) were associated with significantly increased odds of infection in residents and staff, and outbreaks compared to settings with the ability to isolate residents. The success of the testing policy on reducing infections, hospitalisations and deaths is dependent on being able to implement the relevant actions when a resident is identified as having Covid-19.

Contact Tracing

124. As set out earlier in this statement, the decision was taken early in the pandemic that care homes outbreaks were to be managed within the PHA Duty Room, a remit which included the provision of contact tracing. It should be noted that with the onset of an outbreak, visiting within a given care home would have been suspended which would have impacted the necessity to contact trace.

125. At the start of the pandemic contact tracing was difficult given the volume of other work that was being undertaken at the same time. Contact tracing was being done by Health Protection staff within the PHA and given that most cases were associated with international travel, this was a complex process. However, I do not believe that these challenges had an adverse impact on PHA's support for the care sector at the time. The PHA had well-established processes in place for supporting care homes through outbreaks of infectious disease. At the outset of the pandemic, this also included contact tracing for cases of Covid-19 in care homes.

126. Regarding the cessation of contact tracing on 12 March 2020, although the PHA was not involved in these discussions, I do not believe that policy decision had any impact on the care sector given that NI moved to lockdown shortly after that date. In relation to the comments made by the Commissioner for Older People, NI, that, '*it was clear at the outset of the pandemic that the government did not feel a test and trace type approach was suitable for care home residents'.* It is the Agency's belief that this was the case because given their make-up, the 'unit' of contact tracing was generally the whole home, rather than the individuals within it. Although contact tracing did cease during March 2020, outbreaks within care homes continued to be monitored throughout the pandemic and ad hoc studies of epidemiology were undertaken (Exhibit HR/48 - INQ000458898).

Guidance

127. During the pandemic the PHA did not have the capacity, expertise or access to the most up to date information to attempt to produce technical guidance from scratch. Generally, guidance from PHE, UKHSA and other devolved nations was amended to reflect NI structures and nomenclature. This approach also had the advantage of ensuring that broadly similar approaches were being taken to issues including testing, isolation and IPC across the UK.

128. In a small number of areas where approaches varied from other countries, specific guidance was developed locally. Examples included guidance for Care Partners to work more closely with care home staff to support loved ones in receipt of nursing or residential care or home testing using Lateral Flow Tests for visitors.

129. As the pandemic progressed and other Regional NI bodies such as the Education Authority, began to produce their own dedicated guidance, the PHA provided comment and input when requested.

130. The PHA believes that the guidance provided to the care sector by the DoH was as clear and consistent as it could have been at the time. At times, guidance changed frequently and all parties including the DoH worked hard to

ensure that the content was adequate for its purpose and communicated in a timely way. Consultation with relevant stakeholders would have been problematic during the early stages of the pandemic in 2020 when there was an urgent need to produce and share guidance at pace.

Visiting Arrangements

131. The PHA provided advice to care homes to reduce the risk of transmission during visiting in May 2021 (Exhibit HR/49 - INQ000547848) (Exhibit HR/50 - INQ000547849). The was augmented with a dedicated ECHO session which was delivered by an independent Legal Health and Social Care Education Consultant. The session was accessed across 143 separate locations.

132. In December 2020, the DoH sought advice from the PHA in respect of Christmas visiting guidance which was issued to all care homes (Exhibit HR/51 - INQ000381489). The Agency also received correspondence from DoH during this period asking the Agency to lead on further implementation of the care partner concept and appropriate visiting (including end of life) through developing a risk assessment and visiting planning process. Information leaflets on Visiting in Care Homes and Care Partner arrangements were developed for issue to families/carers of all residents and issued to HSC Trusts for onward distribution on 28 January 2021 (Exhibit HR/52 - INQ000374210).

133. In February 2021, the DoH again wrote to the PHA requesting that the Agency lead the development of a plan for the care home sector to move to a more normalised situation with regards to visiting to help inform DoH policy. In response to the request, the PHA established and chaired a Normalising Visiting Forum, the purpose of which was to establish a pathway to resuming normal visiting into and out of care homes, co-produced with key stake holders including residents, families and care home providers (Exhibit HR/53 - INQ000591869).

134. The pathway identified steps to support families to engage in a meaningful way with their loved ones, including visits outside of the care home. It

provided direction to enable residents to engage safely with their local community including pastoral visits, social events and engagement with external agencies. The pathway provided the required public health and clinical advice to inform DoH policy. The Forum also agreed a list of key data variables which the PHA monitored to establish the impact of the relaxation of visiting restrictions in respect of Covid-19 infection rates within care homes.

135. Regarding the timeliness of the Forum's creation, it is my view that this was done at an appropriate juncture. By February 2021, the roll-out of the vaccination programme had been completed within care homes and enhanced testing was available for residents, staff and some visitors. IPC control measures were more embedded across the system as was the use of PPE. With these mitigations in place, alongside the reduced prevalence of Covid-19 across the community, the risks associated with restricting access to family caregivers and visitors had started to outweigh the risks associated with the virus itself.

136. Co-production was a critical element of the Forum's work. Membership came from across the region and included representation from families, the PCC, COPNI, HSC Trusts and Independent Health Care Providers. The work was also supplemented by a Pulse Check survey, on which more detail is provided later in this statement. This approach was both beneficial and effective in that it ensured that as far as possible, all parties had a voice and all views were considered and factored into the proposals. The process was open and transparent something which was very much valued by all involved and helped support the roll out of the pathway in a measured and controlled manner. It is my view that this co-production approach was adopted at an appropriate part in the pandemic.

137. 'Visiting with Care: A Pathway' was endorsed by the DoH and formally launched on the 7 May 2021 as its new approach to visiting in care homes. The Pathway provided a risk-assessed, staged approach to allow residents to receive visitors, as well as facilitating them to leave the home to visit other

households, community facilities and have excursions (Exhibit HR/54 - INQ000591870).

138. On 24 May 2021, the DoH requested that the PHA provide four weekly cycles of reviews based on a range of data to advise the Minister of progress in moving along the different stages of the Pathway. Over the intervening 16 months, the provisions of the Pathway were subject to ongoing scheduled reviews, based on the consideration and assessment of relevant data by a panel of Public Health Officials. Based on the outcome of those reviews, PHA wrote to the Minister recommending whether to further progress along the Pathway at that time. Throughout this time the PHA supported ongoing engagement through the Normalising Visiting Forum to garner the views of stakeholders (Exhibit HR/55 - INQ000591871).

139. Progress was made along the Pathway, culminating in the development of a return to normal visiting pathway designed by the PHA and key stakeholders. 'Visiting with Care – The New Normal' took effect from 1 September 2022 (updated December 2022) setting out the contemporary arrangements for care home residents to receive visitors (Exhibit HR/56 - INQ000381492). The guidance was based on the principle that there should be no unreasonable restrictions placed on any resident to prevent them from being able to receive visitors or to leave the care home for external visits. The guidance set out the expectations for how visiting arrangements should be managed: in 'normal' circumstances; during a localised outbreak; and during incidence of wider community transmission or increased severity.

140. Under the leadership of the CNO, the PHA played a lead role in the development of the NI Care Partner Scheme. This was a scheme through which a resident's close family member or friend took on the role of being a care partner; a defined practical role to provide additional support to an identified need such as encouraging them to eat and drink. The scheme involved additional training and regular testing of care partners in line with staff testing guidance on safe and effective visiting (Exhibit HR/57 - INQ000374211).

141. Whilst the PHA did not carry out any formal research into the impact of visiting restrictions on residents their families and staff in care homes, it did publish a Pulse Check Report and a Snapshot Report reflecting the experience of staff, residents and families in care homes - further detail in respect of this work is set out later in this statement. I am not aware of any resident in a care home being denied access to treatment, care or support in relation to a non-Covid-19 condition.

IPC and PPE

142. As previously set out, the PHA was a member of the National IPC cell which included membership from all four UK nations. The National IPC cell produced guidance on IPC and it is this guidance that was followed in NI throughout the pandemic. Guidance was produced in a collaborative way, using the best-available evidence as its basis.

143. The extant NI IPC manual remained a key document for guidance during the pandemic as its principles still remained relevant. The manual remains a live open access resource which is updated regularly to ensure its guidelines are based on current evidence and best practices. The PHA acknowledges Antimicrobial Resistance and Healthcare Associated Infection, Scotland and NHS England for permission to use their respective manuals' literature reviews, graphics, images, etc., to ensure that local NI guidelines are aligned within the UK https://www.niinfectioncontrolmanual.net/ Covid-19 specific IPC guidance for the care sector was developed by PHE and recommended for use in NI. As the understanding of the virus and means of transmission increased, guidance was reviewed and adapted accordingly.

144. In addition to the National IPC cell, a regional Covid-19 IPC cell was established to oversee the co-ordination of IPC across HSC systems, primary care, including services provided by community, voluntary and independent sector care providers. The cell was Chaired by the PHA then Director of Nursing Midwifery and AHPs and through its operation provided professional

advice in relation the adaptation of national IPC guidance working closely with Health Protection Consultants and DoH policy leads.

145. In respect of care homes, the regional IPC cell worked to adapt IPC guidance that was designed for secondary care to be appropriate for the sector as required.

146. I am not aware of any instances where care staff had to use PPE that was out of date or not CE (Conformity European) marked. However, it would be reasonable to say that in the early days of the pandemic there may well have been issues of availability and supply of PPE to homes. PHA liaised with HSC Trusts to ensure that any issues were address as soon as possible. I am aware that requests for equipment such as FP3 masks were refused as these were not deemed necessary in the care home sector as aerosol generating procedures were not performed within this environment.

147. In relation to the use of PPE, work did take place in relation to the impact of respirator masks on skin integrity, with the Agency developing a poster and accompanying factsheet to provide guidance for wearers Exhibit HR/58 - INQ000343921) (Exhibit HR/59 - INQ000591876). Following a request from the regional HSC Staff Health and Wellbeing Group, work also took place in relation to the development of hydration guidance for PPE wearers, with the British Dietetic Association's hydration advice ultimately being shared across the HSC network (Exhibit HR/60 - INQ000591877).

148. In relation to the use of transparent masks, it was widely accepted that face masks, while protective, could create significant communication barriers for a wide range of people including, for example, those who are deaf and hard of hearing, and people with mental health, cognitive, and learning disability-related communication support needs. For those individuals who used sign language, guidance was developed to support practitioners requiring the use of sign language interpreter services. IPC training was also provided for sign language interpreters.

149. As a region, NI received an allocation of ClearMask™ products from the UK government in Autumn 2020 which, following assessment by HSC staff aligned to the Medicines Optimisation Innovation Centre, the IPC Cell and the Product Review Group could only be used in line with an agreed protocol (Exhibit HR/61 INQ000471328. Subsequent to this, NI linked into the Four Nations Transparent Mask Engagement Panel Meeting that was established to explore further options for compliant products.

150. It is important to note that the Acute Shortages Guidance introduced by PHE on 17 April 2020, was not implemented within NI because the region was not deemed to have experienced an acute shortage of PPE (Exhibit HR/62 - INQ000477524). An acute shortage would be a position in which items of PPE where unavailable necessitating the use and reuse of PPE until such times as adequate re-supply was in place.

151. Throughout the pandemic, care homes had to balance the IPC needs to protect life with the legal requirement to ensure that residents were not unnecessarily deprived of their liberty. This was a challenging space for care homes and particularly difficult where they had to isolate residents with dementia or other cognitive impairment which impacted their ability to understand the need to isolate and for whom walking with purpose (wandering) was a part of their condition. There was also particular impact upon residents with learning difficulties who were often tactile and now had to live in a setting with stringent IPC procedures in place. The physical environment in some care homes was not conducive to isolation measures and the PHA worked with care home managers to find solutions to these issues on a case by case basis. By way of example, in some care homes, shared bedrooms were reduced to single occupancy whereas in other care homes, patients were cohorted together when using communal spaces.

152. It is difficult to surmise that the data on deaths in the care sector during the pandemic indicates that there was a failure of IPC. Care home residents are a vulnerable population, be it in relation to their age or the presence of co-morbidities, which make them more susceptible to the impacts of an infectious

disease like that of Covid-19. It is also recognised that maintaining stringent IPC measures for extended periods of time in a care home setting is extremely challenging.

153. With regards to any future pandemic, it is likely that the IPC guidance would follow the same principles if transmission is via a respiratory route. Given that guidance and IPC practice will be determined by the transmission route of the disease itself and is to some degree therefore reactive; there is a limit to the preparation that can be undertaken. Good IPC practice continues to be encouraged in the sector as care homes work in accordance with the extant IPC manual and the training available via the HSC Clinical Education Centre

Collection of Data

154. Two care home reports were produced by the PHA. (1) The PHA Duty Room produced a daily Care Home Outbreak Report which was in place both prior to and during the pandemic. The report contained information on outbreaks within the care sector, including:

- Name of care home
- Town
- Trust area
- Date PHA notified
- Onset date of outbreak
- Status of outbreak (new, ongoing, terminal cleaning, over)
- Organism identified.

155. The report also contained a map showing the location of the care homes in outbreak and graphs plotting the number of new outbreaks by time (Exhibit HR/63 - INQ000591880) (Exhibit HR/64 - INQ000547850). Data that informed this daily report was gathered by the health protection acute response team during risk assessment with care home staff. The information was entered into HPZ for the purposes of outbreak management and then

entered onto a specific Care Home Outbreak SharePoint. Access to HPZ is only in place for staff whose role was aligned to Acute Response - namely PH consultants, health protection nurses and a number of administrative staff. The Care Home Outbreak Report remains in existence and continues to be issued by the Duty Room to nominated individuals from each of the HSC Trusts and RQIA.

156. (2) From April 2020, the PHA's Health Protection Surveillance team also produced a weekly PHA care home Data SitRep focused on Covid-19 (Exhibit HR/65 - INQ000591881). The Health Protection Surveillance team work as part of the Agency's wider public health directorate to collect information about incidence, prevalence and behaviour of infectious disease in the population. Prior to the onset of the pandemic, it was comprised of four small teams: gastrointestinal and respiratory diseases; blood borne viruses, sexually transmitted infections, vaccine coverage and vaccine preventable diseases; surgical site infections; and healthcare associated infections and antimicrobial resistance. The team was led by a graduate of the PHE run Field Epidemiology Training Programme.

157. Data from the Care Home Outbreak SharePoint was entered into a respiratory outbreak database in Microsoft Access. The database was populated with additional information from HPZ, the initial risk assessment proforma and the summary outbreak report. This included:

- Onset of first case
- Total staff and residents
- Number of residents and staff ill
- Total residents/staff vaccinated
- Outbreak end date
- Final symptom status (symptomatic vs asymptomatic).

158. The data on the respiratory outbreak database was quality checked 1-2 times per week by cross referencing with SharePoint and HPZ. This report continues to be issued weekly by the surveillance team.

159. Both reports suffer from the same limitation in that they are reliant on reports made to the PHA Duty Room by care homes. The accuracy of the data is dependent on the quality of information recorded in the initial risk assessment. Data from an RQIA daily reporting form acted as a further data source for the acute response team to triangulate data from care homes to identify those requiring further support.

160. In relation to deaths reporting, on the 26 March 2020, the then interim Chief Executive of the PHA wrote to the HSC Trusts requesting that they report deaths to the PHA through an internal web portal built on Microsoft SharePoint (referred to as the rapid daily reporting system). The definition used by the PHA in recording deaths in care was updated the following day, 27 March 2020, to align with the PHE definition which included patients who had died within 28 days of first positive SARS-CoV-2 specimen result, whether or not Covid-19 was the cause of death (Exhibit HR/66 - INQ000591882). The general approach of accepting anyone who had who died within 28 days of a positive test as a proxy indicator for the number of people who died due to Covid-19 allowed for the faster relaying of information in comparison to the Northern Ireland Statistics and Research Agency (NISRA) process which had a number of time lags (Exhibit HR/67 - INQ000591883).

161. The reporting form asked for the 'setting where patient died' with an option for residential/care home. The reporting form would not have identified care home residents who died in hospital as the address of the deceased was not recorded.

162. The definition of deaths that occurred within 28 days of a positive Covid-19 test was used because of the need for timely information. It also allowed comparison to other regions that followed the same reporting protocols. By way of disadvantage, the definition was not specific about whether Covid-19 was known to have contributed to a given death. The definition also required manual reporting by HSC Trust teams.

163. The rapid daily reporting system was not able to differentiate between deaths contributed to or caused by Covid-19 and those unconnected to Covid-19. The definitive source of data on deaths was, and remains, NISRA who identify deaths where Covid-19 is a causative or contributing factor based on information recorded on the death certificate. The PHA DPH published a blog on 11 May 2020 outlining the differences between reporting of Covid-19 deaths (Exhibit HR/68 - INQ000591884).

164. Deaths occurring in NI are registered on the Northern Ireland General Register Office's Registration System (NIROS). This is the primary source of death statistics in NI. NISRA weekly provisional death statistics count all deaths where Covid-19 was mentioned on the death certificate by the doctor who certified the death, whether or not Covid-19 was the primary underlying cause of death. The figures include cases where the doctor noted that there was suspected, or probable coronavirus infection involved in the death. As a result of this recording process, the weekly totals reported by NISRA were higher than the relevant PHA daily figures.

165. NISRA use information recorded in the medical certificate of cause of death to identify care home residents where:

- The death occurred in a care home
- The death occurred elsewhere but the usual resident of the deceased was recorded as a care home.

166. This level of detail was not available via the PHA rapid reporting tool which only identified deaths that occurred in care homes

167. All care homes in NI participated in a monitoring scheme through which they submitted daily aggregate data to the RQIA via a custom developed application which I believe commenced in April 2020 and continued until July 2020 when the updates moved to an RQIA Web Portal for the remainder of the pandemic. The Daily Care Home Status Update relied on data entry from

care home providers and managers to provide an assessment of the status of the home. This included the status of the workforce, PPE and equipment status, domestic cleaning and overall status. As part of the data entry, care homes were asked to input the current numbers of staff and residents who had been tested, numbers of staff and residents who were symptomatic and the numbers of staff and residents testing positive. This was introduced to minimise duplication of reporting from care home staff (Exhibit HR/69 - INQ000547851).

168. The information collected by this process was a much broader assessment of the status of the care home than the information collected and shared by the PHA. The information collated around testing, symptomatic people and positive cases was shared with the PHA acute response to identify care homes that required risk assessment or additional support in the management of an outbreak.

169. By way of summary, the data held by the PHA through its rapid daily reporting system, launched 26 March 2020, identified 501 people who died within 28 days of a positive Covid-19 test where the place of death was a residential or care home. The reported deaths occurred between 28 March 2020 and 12 May 2022. The rapid reporting tool was stood down in May 2022.

170. The PHA acknowledges that this is an underestimate of the number of care home residents who died as it does not identify care home residents who died in another location or those with a clinical diagnosis of Covid-19.

171. NISRA is the definitive source for death statistics and their analysis of deaths of care home residents by place of death, showed that there was a total of 1,281 deaths of care home residents involving Covid-19 (including deaths that took place outside the care home such in a hospice or hospital) occurred up to 13 May 2022. From 18 March 2020 to 13 May 2022, Covid-19 had been mentioned on the death certificate of 4,601 deaths. Of these deaths, 978 (21.3%) occurred in a care home Weekly deaths bulletin – week ending 13 May 2022 | Northern Ireland Statistics and Research Agency. This

divergence highlights the extent of the under detection of deaths in care homes reported via the PHA's rapid reporting tool.

172. There is a need to improve the quality of and access to care home data to support pandemic response. In a rapidly evolving situation, access to real-time data and ability to perform data linkage would improve the PHA's ability to understand the impact of the infection in the population and inform public health advice. This would also facilitate identification of infections, hospitalisations and deaths within the care home population without relying on notification from HSC Trusts or care homes at a time of significant pressure.

173. A key limitation in the pandemic response was the absence of an agreed minimum data set, this is needed to understand the health needs and outcomes of this population and improve the ability to evaluate the impact of public health interventions. The data set should provide anonymised individual-level data to enable linkage across a range of administrative data sets with the ability to de-anonymise data in specific circumstances to provide targeted support.

174. The proportion of care homes residents recorded as having died with Covid-19 in hospital is held by NISRA. The PHA does not have information about the total number of care home residents recorded as having died of Covid-19, as PHA does not have access to a list of care home residents in NI to identify this cohort and is reliant on cases being reported to acute health protection response.

175. The PHA does not have information about the total number of care workers recorded as having died of Covid-19, as the PHA does not have access to a list of care home staff in NI to identify this cohort. The PHA does not hold information on the source of care workers infections.

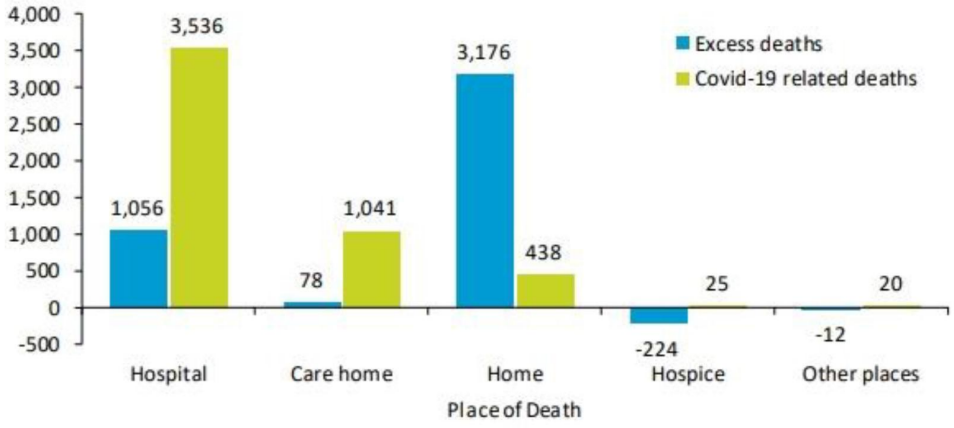
176. Excess mortality is the difference between the observed number of deaths in a particular period and the number of deaths that would have been expected in that period, based on historical data.

177. As noted previously, the approach used to estimate excess deaths by ONS and the devolved administrations prior to February 2024 provided a comparison between the number of deaths registered in the current year and the average number over a recent five-year period. This approach did not consider the ageing and growing population of the UK (generally more people means more deaths, particularly if a greater share of the population is elderly); nor did it reflect recent trends in population mortality rates, which were generally falling until 2011 before levelling off until the onset of the pandemic.

178. A methodology paper was published by the Office of National Statistics in February 2024 outlining a new agreed model for estimating excess deaths (Exhibit HR/70 - INQ000591885). This approach superseded work that PHA and NISRA were undertaking with OHID to address challenges in the previous methodology to estimate excess deaths.

179. As shown in figure 1, excess deaths in hospitals (1,056) are much lower than the Covid-19 related deaths in hospital (3,536). Care homes also had smaller levels of excess deaths (78) compared to Covid-19 related deaths (1,041). In contrast, the estimate of excess deaths at home (3,176) was around seven times the number of Covid-19 related deaths at home (438) and accounts for 77.9% of the total excess deaths over the period.

Figure 1: Excess deaths and COVID-19 related deaths, by place of death, March 2020 to December 2022, Northern Ireland



Source: NISRA

Patient and Staff Experience Surveys

180. In June 2020, the CNO established a Rapid Learning Initiative (RLI) to consider the learning in relation to the transmission of Covid-19 relating to care homes, identify monitoring and/or measurement processes and propose recommendations for improvement. The RLI adopted a collaborative approach between HSC organisations, the independent sector, residents and their families to produce knowledge as quickly as possible over a defined three-month period. The PHA was represented on the RLI Steering Group and Chaired the 'Experience' RLI subgroup. The resulting report 'Care Homes & Covid-19 - The lived experience of care home residents, their relatives and staff during first wave of Covid-19 Pandemic' was published in September 2020 (Exhibit HR/71 - INQ000416806).

181. Promotion of the project was led by the PHA in collaboration with the DoH, RQIA and the HSC Trusts. A variety of approaches were adopted to engage each as outlined below:

- Residents of care home: Each Care Home in NI (483 in total) received 10 copies of the resident's survey with stamped addressed envelopes. Care homes could request more copies through the Regional Office. Surveys could also be completed through telephone consultation or video conference.

- Relatives of a resident in a care home: Relatives were invited to share their experience via an online link promoted on social media or by requesting a printed survey via the regional 10,000 More Voices office. This was promoted through NISCC and RQIA. Relatives from the Deaf community were also engaged through zoom calls facilitated by the British Deaf Association.

- Staff working in a care home: All staff were invited to share their experience via an online link. Staff could also request an interactive pdf version which could be returned by email or printed and return by post.

This included staff from HSC trusts who were redeployed to support care homes during the first wave of the pandemic.

182. The project made findings in respect of:

- Technology – the benefits and challenges of using technology to facilitate visiting and connections to the local community.
- Communication, Information and Guidance – the need to ensure timely and effective communication with homes and then on to residents and families; as well as involving staff, residents and families in developing guidance and share their expertise.
- Health and Wellbeing – the value of meaningful engagement and activities with residents and families in order to maintain health and wellbeing. The need to ensure effective and timely input into the care home from services in primary care such as GPs and Allied Health Professionals.
- Safe and Effective care – the importance of strong, compassionate and collective leadership and the value of training for all staff.
- Working in partnership – care homes wish to develop better working relationships with stakeholders including RQIA, PHA and Trusts. Families wish to be recognised as advocates for their relatives and trusted partners in ensuring a good quality of life in the home.

183. This project was commissioned by the DoH and reported to the Department in order to take action on the findings.

184. In May 2021, the PHA published its 'Pulse Check Report' which reflected the experience of staff, residents and families in care homes in order to inform the development of the care homes visiting pathway (Exhibit HR/72 - INQ000583246).

185. The PHA in collaboration with the PCC carried out the Pulse Check survey to gather the experience of residents, relatives and staff of care homes affected

by the visiting restrictions in place. The findings related to experiences shared from 31 March 2021 to 26 April 2021 and were presented to the Normalising Visiting Forum to inform and shape the Visiting with Care Pathway.

186. 1,407 completed surveys were returned, with families completing 67%, care homes completing 25% and residents completing 8% of returns. The following key findings were reported:

- The importance of visiting in respect of health and emotional wellbeing of residents and the negative impacts on mental and emotional health when visits were not allowed. The need for physical contact as well as visits and the negative impact of social distancing.
- The need for privacy at times when visiting rather than only using communal spaces.
- The need for flexible arrangements to ensure the needs of the resident and the families were met.
- The need to ensure safety as far as possible by promoting good IPC practice, vaccination and screening for visitors.
- The need to communicate well with families and residents so they understand the guidance in place. This sits alongside the need to engage with residents and families in producing such guidance.

187. 'Visiting with Care – a Snapshot Report' was published in June 2022 and reflected the experiences of staff, residents and families as they had progressed to stage three of the visiting pathway (Exhibit HR/73 - INQ000591888). Based on the outcome of the surveys returned, the key messages were:

- The importance of visiting in maintaining residents' health and wellbeing.
- The need to continue to reintroduce more flexible arrangements in respect of visiting.
- The value of the Care Partner role.

- The need to introduce more meaningful activity for residents in the home.
- The challenges in balancing visits with IPC measures when a home experiences an outbreak.
- The need to continue to improve communication especially to residents who may not fully understand the concepts at play.

188. The report was shared with PHA colleagues responsible for working on the visiting guidance and used to inform this work.

Health Inequalities

189. To my knowledge there has been no specific targeted work completed within the PHA in relation to how the Covid-19 pandemic impacted pre-existing health inequalities specifically within the care home sector in NI.

190. Inequalities in health across the life course is also manifest across the care home population, however this is not easily captured. The PHA did not, and still do not, have access to a 'live' register of care home residents so it is not possible to provide detailed analysis in relation to age, disability, gender, ethnicity or other factors which may point to indications of inequality specific to the care home population. The PHA is in the process of completing further work on excess mortality which will explore in more detail basic demographic attributes such as age and gender.

191. By the nature of requiring 24/7 care, it would be reasonable to assume that there may be a higher proportion of residents in care homes with more advanced frailty, disability and illness than in the wider community setting.

Inequalities issues affecting care providers, workers and/or adult recipients for care that arose or were exacerbated during the relevant period.

192. I am aware that evidence has shown that the pandemic exposed different groups to different types and levels of vulnerability. The PHA does not have access to information on age or ethnicity of staff working in care homes.

193. A higher proportion of staff from minority ethnic groups work in care homes than in other HSC settings in NI. This is estimated by NISCC at around 35%. By way of context about 3.4% of the population of NI are from a minority ethnic group compared to over 18% in England and Wales.

194. Access to paid statutory sick leave is widely recognised as a driving factor in staff being able to follow health protection guidance related to communicable disease. During the pandemic funding was provided to cover sick pay for those staff who would not have been eligible prior to the pandemic (Exhibit HR/74 - INQ000587692).

195. As noted previously, those residents who had conditions which impacted on their capacity to understand or conform to guidance, for example dementia or learning disability were particularly affected during periods of isolation. This was a very challenging issue for care homes to manage within an already stretched workforce. The development of the Care Partner programme is an example of steps taken to try to ameliorate the situation.

Lessons Learned

196. I believe that the Agency's response to the care sector was as good as it could have been in the face of a pandemic whose scale and duration was unprecedented. There is however learning and reflection for the PHA in a number of areas, namely:

- Data was an issue across many aspects of the pandemic. Whilst the challenges in access to care sector data were understood prior to the pandemic, these were made much starker during this period. Access to real-time data and the ability to perform data linkage would have improved the ability of the Agency to understand the impact of the infection on the care home population. This would have facilitated the identification of infections, hospitalisations and deaths within the care home population without relying on notification from HSC Trusts or care homes at a time of significant pressure for the system. Work is ongoing to address this situation.

- In terms of response structures specific to care homes, I believe that had the Agency's collective response fallen under the oversight of a single senior officer, it would have facilitated more opportunities for improved communication and co-ordination across teams and directorates.

- Whilst gaps in capacity within the PHA Health Protection services were actively being addressed prior to the pandemic, further reflection prompted additional actions. The acute health protection service within the PHA is now operating with enhanced capacity and governance structures and continues to work towards further improved surveillance and data capture systems.

- Given the increasing complexity and frailty of residents being cared for in care homes, opportunities for improved service planning for care in these settings should be explored to optimise targeted mitigation of harm due to ill health from frailty, chronic or communicable disease. This should include development of minimum data sets.

- System level approaches across primary and secondary care to support 'best interests' decision making could deliver significant improvements for residents and their families, for example, the use of strategies such as frailty identification and management and Advanced Care Planning

- Learning from the pandemic identified the need to provide care homes with ongoing access to validated training in addition to support from the Agency's Acute Response Service and access to the principles of the regional IPC manual. Ongoing access to training on a range of issues has now been made available to care home staff via the HSC Clinical Education Centre.

On a personal note – I would like to sincerely acknowledge the loss and grief experienced by so many during the Pandemic – the burden of loss was so heavily felt in our older population. The proportion of older people in society is expected to continue to grow over the coming decades. It is imperative that we see this not as a burden but rather recognise the enormous contribution that older people have made and continue to make to our society. It is incumbent on us all to support and care for them to the very best of our ability.

I would also like to acknowledge the families and staff who cared for our loved ones in care homes in hospitals and in their own homes across the country.

Finally, I would like to recognise the efforts of staff across the system who did their very best, day after day, in an enormously challenging situation.

Statement of Truth

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

Signed:

Personal Data

Dated: 02 June 2025