Witness Name: Professor Sir Michael McBride
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UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF PROFESSOR SIR MICHAEL MCBRIDE

I, **Professor Sir Michael McBride**, will say as follows: -

1. Introduction

1.1 I, Professor Sir Michael McBride, Chief Medical Officer (CMO) for Northern Ireland (NI), make this statement in response to the request from the UK Covid-19 Public Inquiry (the Inquiry) dated the 12 August 2024 under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838), requiring me to provide the Inquiry with a witness statement in respect of specified matters relating to Module 6. In preparation of this statement, I have written the statement to the best of my recollection of events as they occurred. To assist in this, I have reviewed relevant Ministerial submissions and Departmental records available to me. I have drawn on my personal witness statements and my professional and policy input to the Department's corporate statements with respect to Module 1, Module 2C, Module 3, Module 4, and Module 7, in addition to Module 6, of the UK Covid-19 Public Inquiry. I have also referenced relevant sections within the UK CMO Technical Report of the Covid-19 pandemic in the UK to which I personally contributed [MMcB6/001 - see INQ000203933] and which in its entirety is relevant to

NI. I have not sought to provide any additional interpretation of the report, given the resolved and expert nature of the contributions, which also contains our considered reflections as UK CMOs which we hope will be of assistance to our successors in a future pandemic.

1.2 Given the sheer pace and complexity of events, the number of key decisions made and the passage of time, it is inevitable that some of my recollections may be incomplete. Due to the changes to normal working arrangements and the time taken to reallocate staff, particularly in respect of notetakers, there may be some gaps in the written records and my personal recollection of early meetings. It is also inevitable that others may have a different recollection of events. Where my recollection is less clear, I have considered the available written records to assist me. Given the sheer pace of events, I cannot now be certain that all advice to the Health Minister and decisions were formally presented in submissions or in written advice particularly in the early weeks and months of the pandemic in the period leading up to the first lockdown in March 2020. It was simply not possible to do so while responding in real time to a rapidly evolving situation. While this can never be acceptable, and I acknowledge this will be a source of frustration to the Inquiry in identifying learning, it was the reality of the complexity and pace of events in the first weeks and January to mid-March 2020 which is, even now, difficult to adequately communicate and convey.

1.3 I have, however, endeavoured to fully reflect my recollection to the best of my ability, notwithstanding these shortcomings. In the interests of transparency, I have also sought input from other colleagues within the Chief Medical Officer's Group (CMOG) and across the Department to help prompt my recall of events and have indicated where I have done so. In all such circumstances, the recollections and observations in the statement are my own. I am, however, cognisant of the fact that I have, in

preparation of previous witness statements and providing evidence to the Inquiry, considered a significant volume of documentation, some of which I was not aware of contemporaneously. It is now increasingly difficult to make this distinction. Where I am unable to recall the specific details, I have indicated what would have normally occurred in the context of the circumstances in question. I have also made this clear in my statement when I have done so.

1.4 One of the most complex and difficult areas during the pandemic was the role of residential and nursing home (hereafter described as Care Homes) providers in providing care and HSC Trusts as commissioners of that care in protecting those most vulnerable to the virus in Care Homes, who required close personal care, while managing the adverse health consequences of isolation and loneliness due to separation from family and friends as a consequence of the very measures introduced to protect them. I appreciate the bereavement and loss suffered by many who feel they were denied the opportunity to be with their loved ones in their final days and weeks of life and are still seeking answers as to what more could have been done to protect them and to alleviate the isolation and loneliness.

1.5 The commitment of all those care workers in Care Homes, and those who continued to provide domiciliary care to people in their own homes, was commendable and undoubtedly as in all areas across health and social care aspects of their experiences during the pandemic were distressing and harrowing. While it is perhaps difficult now to fully capture and reflect this in this statement, I do not underestimate personally or professionally the distress of families and care workers. I shall return to this with respect to my reflections and learning. I am mindful that there are a range of significant issues in respect of the care sector which will be of material interest to those directly and indirectly impacted by the pandemic and the

action and timing of decisions taken. Where I have not addressed these issues in this statement, this should not be interpreted as an indication that these matters are not considered to be important. Some issues will relate to matters in which I was not significantly involved, and some issues are covered in other statements to this module, including the corporate statements to which I have contributed where I was the policy lead or provided professional advice or oversight. I have, however, indicated my awareness and knowledge of work that others were leading. I do this to be of assistance to the Inquiry and have advised in respect of those issues where others may be able to provide additional information.

1.6 The demands and complexity of the pandemic response were such that, in keeping with the principle of subsidiarity, those with expert knowledge and experience of respective sectors continued to lead on policy and oversight of the operational response as they were best placed to do. This approach was consistent across all health and social policy areas and operational services. While I appreciate these are matters which have already been considered by Module 1 of the Inquiry, this, in my view, is one of the most essential elements of preparation and response to a future pandemic. It is imperative that planning and preparation for any future pandemic is both cross-Departmental and across departments reflecting a whole of government approach. As such it must be understood that it is for policy teams in every Department to work with their respective sectors to ensure appropriate planning and response arrangements.

1.7 As CMO, I do not have expert knowledge of the social care sector. CMOG provided relevant policy input and professional medical and scientific technical advice when requested. The primary areas where I was more directly involved included the establishment of arrangements to facilitate the roll out of Covid-19 testing and the Covid-19 vaccination programme in

the social care sector and in Care Homes. In order to support respective policy and professional colleagues, and to facilitate the provision of professional and technical advice in a coordinated manner, I established several groups which are described in this statement, including the Testing in Care Homes - Task and Finish Group. As CMO, my role was to oversee arrangements to quality control the professional public health and medical advice, from my team within CMOG, that informed policy relevant decisions. I was not the policy or professional lead for the adult care sector. This is a sector out with my professional knowledge and expertise and, given my wider responsibilities, other colleagues were best placed and more appropriate to lead and coordinate the preparation and response. In my experience, they did so to the best of their ability in the most challenging and complex of circumstances, balancing many complex considerations as I have described later in this statement.

2. Role of the Northern Ireland Chief Medical Officer

2.1 I have been the CMO for NI from September 2006. In 1986, I graduated from Queen's University Belfast with a MB BCh BAO medical degree, with distinction in Medicine and Surgery. In 1991, I attained a Research Fellowship at St Mary's Hospital Medical School and Imperial College London, conducting research into new drug treatments for HIV (Human Immunodeficiency Virus). From 1994 to 2006, I worked as an HIV Consultant within the Genitourinary Medicine service at the Royal Group Hospitals Trust and was appointed Medical Director of the Royal Group of Hospitals in August 2002. In September 2006, I was appointed as NI's CMO. I was appointed acting Permanent Secretary of the Department of Health (the Department) and Chief Executive of NI Health and Social Care (HSC) between March and August 2009 at the request of the then Health Minister. In November 2014, at the request of the then Health Minister, I was appointed as Chief Executive of Belfast HSC Trust, serving until

February 2017 while continuing in the role of CMO. As such, I have significant policy and healthcare leadership and management experience, including leading and coordinating the health response to the 2009 H1N1 pandemic in NI. It was undoubtedly the case that my previous experience in the H1N1 pandemic was of benefit in the collective response of the Department and that of the wider HSC system although, on reflection, the intensity, complexity and duration of the challenges faced during the Covid-19 pandemic were of a different order, and the response to the Covid-19 pandemic represented the most challenging period of my professional career.

2.2 I am a Fellow of the Royal College of Physicians of London, and a Fellow of the Royal College of Physicians of Ireland. I have been awarded an Honorary Senior Fellowship by the Faculty of Medical Leadership and Management (FMLM) for my contribution to healthcare. In July 2021, I was made an honorary Professor of Practice by QUB and awarded an honorary degree of Doctor of Medical Science for Distinction in Medicine. In March 2022, I was elected to Honorary Fellowship of the Faculty of Public Health. I was Knighted in 2021 for services to public health in NI.

2.3 As CMO, I am responsible for CMOG and, as such, I am a member of the Department's Strategic Leadership Team (SLT) (previously known as the Top Management Group (TMG)). In the period leading up to the pandemic, CMOG included two policy Directorates (Population Health and Safety, Quality and Standards (now Quality, Safety and Improvement Directorate)) and a team of medical advisors. CMOG also included the Chief Pharmaceutical Officer (CPO), the Chief Dental Officer (CDO), the Chief Environmental Health Officer (CEHO) and the Chief Scientific Advisor (CSA) and their respective policy and professional responsibilities for which they were individually responsible, within the scope of CMOG.

2.4 As CMO and a member of the Department's SLT, I have a wide range of roles which cut across my professional, executive and leadership responsibilities within the Department. I also hold roles in relation to the Department's general direction and oversight of HSC organisations, which plan and deliver services for the population of NI. Although not a substitute for, or an alternative to, the extant system accountability or governance arrangements, an important aspect of my professional leadership role as CMO exists to provide informed evidence-based policy and professional system challenge, and systems leadership as required. This aspect of my role is particularly important when any matter has the potential to impact directly or indirectly on the health of the population. In such instances, I have a professional duty to advise, challenge or support. This is an important aspect of the role of the CMO and, in my view, a role which will be essential in any future pandemic response. Given the many demands during the pandemic and my wider responsibilities there were limitations in the professional support I could, at times, provide. Maintaining the professional leadership and policy and professional advisory responsibilities of the office during the pandemic proved extremely challenging. I also liaise on a regular basis with my CMO colleagues across the United Kingdom (UK) and the Republic of Ireland (RoI) on a collaborative basis concerning public health issues and this continued throughout the pandemic response and, in my view, was highly effective. My roles and responsibilities as CMO are described below.

2.5 As CMO, I am accountable to the Health Minister and the Permanent Secretary in the Department. My role is to provide independent professional advice to the Health Minister. While I am accountable to the Health Minister, my professional advice remains independent of political consideration or influence. I continued to provide my advice on this basis throughout the pandemic and I believe this was understood and respected by NI Executive Ministers.

2.6 Both prior to, during and after the pandemic, CMOG (until wider Departmental restructuring in November 2023) had responsibility for all domains of public health policy, including health protection and health improvement, both of which are particularly relevant to the Inquiry and respective Modules. For example, the Population Health Directorate within CMOG included the Department's policy responsibility for: health protection including vaccination programmes, population health screening programmes and emergency planning; health improvement including healthy living, smoking prevention, drugs and alcohol, obesity prevention, teenage pregnancy and related policy areas.

2.7 The Department's Population Health Directorate also sponsored the Public Health Agency (PHA). The PHA is an Arms-length Body (ALB) of the Department and has a pivotal role to play in our response to incidents and outbreaks. The role of the PHA was central to the pandemic response in NI. I worked particularly closely with the leadership team and colleagues in the PHA, who provided professional advice and support in coordinating the public health response. The PHA played a key role in the implementation of routine testing in the Care Home sector. The PHA also provided expert advice to Department policy and professional leads, the Health and Social Care Board (HSCB) and Trusts in respect of infection prevention and control, including within adult social care such as the Care Home sector. As described in my previous witness statements to Module 2C and Module 3 of the Inquiry [MMcB6/002 - see INQ000226184 and MMcB6/003 - see INQ000421784] and later in this statement, in some instances the PHA, in addition to their extant role and responsibilities, at my request led on key elements of the pandemic response. Given the scale and complexity and the sheer pace of events, it was necessary to adapt previously established working and organisational arrangements to most effectively make use of the experience and expertise of policy teams

and professionals within the Department. A similar approach was taken to utilise the operational and professional technical experience and expertise of HSCB and PHA colleagues. In my view, this collaborative and collective approach was a key strength of the pandemic response in NI which ensured an effective alignment of policy and operational response.

2.8 In addition, during the relevant period I had policy responsibility for a range of healthcare quality, safety and health improvement policy areas. The Quality, Safety and Improvement Directorate (QSID) which sat within CMOG had policy responsibility for: the HSC Complaints Process; Serious Adverse Incidents (SAIs) Reporting and Investigation; Adverse Incidents involving Medical Devices; 'Never' Events; the relationship between the Department and the National Institute for Health and Care Excellence (NICE) which issued Covid-19 related advice and guidance throughout the pandemic; Certification of Deaths including the completion of Medical Certificates on the Cause of Death (MCCDs); Openness and Candour in health and social care; and the Regulation and Inspection of HSC services.

2.9 This Directorate also sponsored the Regulation and Quality Improvement Authority (RQIA), an ALB of the Department which provides regulation and assurance of HSC services. As described at paragraph 2.38, during the pandemic, my team and I worked closely with the Chief Social Work Officer (CSWO) and policy colleagues in the then Social Service Policy Group (SSPG). In the relevant period the CSWO, in addition to his professional advisory role, was also the policy lead for SSPG within the Department. As described in the Department's statement to Module 6 of the Inquiry, SSPG consisted of the Office of Social Services (OSS), the Family and Children's Policy Directorate and the Mental Health, Disability and Older People Directorate. The CSWO was supported by his professional social work advisers within the OSS. OSS provided the

social work policy and professional lead across several areas of responsibilities, including the social work professional lead for older people / community care / safeguarding and reform of adult social care. While the CSWO will be best placed to describe these responsibilities, to assist the Inquiry I have described these as they pertain to the main policy and professional responsibilities of SSPG and the Strategic Planning and Performance Group (SPPG) during the relevant period in the paragraphs below.

2.10 The CSWO is responsible for leading a team of professional officers in the OSS to support Ministers, the Department and other government departments and agencies to ensure that local social work and social care services are responsive to the needs of the population in NI and are of the highest standard. The OSS provides professional advice and input to the formulation and implementation of NI government departments' policies on social care services and related social and professional practice matters. These matters include: safeguarding children; looked after children; sponsorship of the Northern Ireland Social Care Council (NISCC) and regulation of the social care workforce; adult social care; older people and carers; mental health; dementia and disability (including learning disability; social work and social care training policy).

2.11 Elderly and Community Care Unit (ECCU) within SSPG in the Department has general policy and legislative responsibility for community care services, with a specific focus on the Older People's Programme of Care (POC). Policy is aimed towards the development of a range of modern, flexible and responsive community care services designed to support people to live safely and independently in their own homes where possible. Main policy areas within ECCU's remit include:

- Care Homes, including residential and nursing homes, and the development and implementation of the charging regime for residential care, including review, update and providing advice on the Charging for Residential Accommodation Guidance (CRAG);

- The care management, provision of services and charging elements of community care provision including the assessment and placement process;

- Domiciliary care services - defined as the range of services put in place to support an individual in their own home. In essence, the provision of personal care and associated domestic services necessary to maintain an individual person in a mutually agreed measure of health, hygiene, dignity, safety, and ease in their own home;

- Supported Living for Older People; and

- Unpaid/Informal Carers;

2.12 In NI, adult social care services are delivered within a mixed economy of care in the statutory sector, private sector and the voluntary sector. Statutory services are those directly provided by the HSC Trusts. The private sector includes organisations and individuals that own and run services for a profit. Many of their adult social care services are provided under contract with HSC Trusts. The voluntary sector is comprised of organisations, often registered as charities, which operate on a non-profit making basis. Many of their services are also provided under contract with HSC Trusts.

2.13 Up until 31 March 2022, the HSCB was responsible for the commissioning, monitoring and improvement of health and social services. The Department's SPPG was formed on 1 April 2022 and is responsible for planning, improving, and overseeing the delivery of effective, high quality, safe health and social care services within available resources. In the main, the role and responsibilities of the HSCB transferred to SPPG. The Directorate of Community Care within SPPG is responsible for planning and overseeing the HSC commissioning of social care including domiciliary care and Care Home provision. Throughout the pandemic response, the Director of Community Care was Brendan Whittle who is a professional social worker by professional background. While the Director of Community Care has responsibility for planning and oversight of the commissioning of social care, the operational delivery and local commissioning of these services sits directly with service providers and is carried out by the five HSC Trusts across NI.

2.14 During the pandemic, there was effective collaborative work across all respective teams. An example of, in my view, a highly effective joint initiative between SSPG, the CSWO and CMOG in the first wave of the pandemic was use of the expertise of RQIA in supporting Care Homes and domiciliary care providers. This included ensuring regulatory flexibility in terms of inspections to reduce the risk of the introduction of infection into Care Homes [MMcB6/004 - see INQ000103688] and the re-alignment of RQIA staff to establish a Service Support Team (SST) [MMcB6/005 - see INQ000137313; MMcB6/006 - see INQ000137315; and MMcB6/007 - see INQ000137316] which was announced by the Health Minister on 14 April 2020 [MMcB6/008 - see INQ000137317] (see paragraphs 7.8 to 7.9 below for more detail). The establishment of this support team was the outworking of collaborative work between CMOG which sponsored RQIA and SSPG which had, among other areas, policy responsibility for Care

Homes (residential and nursing homes) and domiciliary (home based) care.

2.15 The shape and nature of the two main Directorates within CMOG have changed significantly since the pandemic commenced and both look different in form now to what they did in March 2020. QSID was integrated and reshaped throughout 2021 and 2022 through work that I initiated, and, in 2023, QSID moved to the Department's Healthcare Policy Group (HPG). The Population Health Directorate has been reshaped into two separate Directorates (Emergency Resilience and Protecting Health Directorate and Population Health Directorate) following a review which I led and coordinated, reflecting on the learning from the pandemic and, in 2023, these directorates moved to the Department's Social Care and Public Health Policy Group (SCPHPG). I will also comment further on this later in my statement in respect of my reflections and learning.

2.16 Separately from these responsibilities, I have policy responsibility for Health and Social Care Research policy working closely with the CSA. I also work closely with the CPO who is the Department's most senior professional adviser on medicines and pharmaceutical matters and I support the CPO with her policy responsibilities. The CPO is accountable to the Health Minister and Permanent Secretary and reports to me within CMOG. During the Covid-19 pandemic, the CPO was a member of Health Gold Command (Health Gold) and led the medical supplies cell and provided professional advice relating to the response to the Covid-19 pandemic, which included the Covid-19 vaccination programme, Covid-19 therapeutic treatments and maintenance of access for the public to essential pharmaceutical care and medication supplies and business continuity arrangements. She also worked with British Oxygen Company (BOC) Limited to ensure suitable oxygen supply to HSC sites providing critical care. The CPO represented NI's interests at a national level in

areas including the United Kingdom Medicines Supply programme, which oversees all aspects of medicines continuity and involves direct working with senior officials of the Medicines and Healthcare Regulatory Agency (MHRA) and the Department of Health and Social Care (DHSC) and the Devolved Administrations, which helped inform helped inform local decisions in NI relating to the deployment of countermeasures including vaccines and antivirals. The CPO was the named person for the Department's Wholesale Dealers Licence for the maintenance of medicines stockpiles. During the pandemic, the CPO also led the Department's response to European Union transition, responsible for advising the Health Minister on NI Executive matters relating to European Union medical supplies. Actions were also taken by the CPO to bolster community pharmacy services in NI to maintain access to medicines, including home deliveries for vulnerable patients, and provide reliable access to the advice of pharmacists across the country.

2.17 While the CMO in each jurisdiction provides independent advice to their respective Ministers (and this was the case during the pandemic), as CMOs we have always worked closely on public health policy, generating evidence and independently advising respective Ministers as decision makers. Examples of this joint work include our work on the development of the UK CMO Physical Activity Guidelines, and similar work to develop the UK CMOs Low Risk Drinking Guidelines. Similarly, I have engagement with my counterpart in the RoI, for example in alcohol policy. This cooperation was, in my view, highly effective during the pandemic and ensured effective and appropriate professional challenge and discussion on the understanding and interpretation of emerging evidence and in informing independent advice to respective Ministers. The utility, effectiveness and importance of such professional interactions needs, in my view, to be fully reflected in the learning for future potential pandemics.

2.18 I also provide professional leadership to the medical profession in NI. With my CMO colleagues in England, Scotland and Wales, we provide collective leadership and guidance to the profession across the United Kingdom on a range of clinical and professional matters. This was particularly important during the pandemic, recognising the extremely challenging unrelenting demands and, at times, distressing circumstances within which teams were working amid significant uncertainty, often at great personal risk.

2.19 As CMO, I also have an important role in communicating with the public on key public health issues and actions that are important to protect and improve public health and wellbeing. This was an aspect of my role during the pandemic and one that I sought to fulfill to the best of my ability along with my wider professional and policy responsibilities.

CMO Role During the Pandemic

2.20 My role, as CMO, in response to any emergency (including a pandemic) is described in detail in the Department's Emergency Response Plan (ERP) [MMcB6/009 - see INQ000184662] which was last updated in 2019. The full range of individual roles, structures, systems, and processes to be enacted in an emergency are defined in the ERP. The ERP describes the roles and responsibilities of Senior Officers and business areas within the Department as well as the roles of various organisations which are expected to be involved in a response to an emergency. The Department's ERP was activated in January 2020 [MMcB6/010 - see INQ000137322 and MMcB6/011 - see INQ000137323], with the stand up of the Emergency Operations Centre (EOC) on 27 January 2020. The EOC was led by CMOG, and it provided and was responsible for the quality and timeliness of information critical to help inform effective decision-making.

2.21 As a result, from January 2020 onwards my role and responsibilities, and those of colleagues, significantly changed and a flexible and dynamic approach was taken to Departmental structures as they were adapted to meet the challenges of the pandemic as these evolved. This involved the roles of individual staff, including Chief Professional Officers, teams and Directorates being repurposed to focus on aspects of the Department's response to Covid-19. It also involved the creation of new teams and structures, including Directorates and staff from HPG, led by its Deputy Secretary, being repurposed to focus on the response to Covid-19. Despite this, the resources within the Department were finite, and there was significant and unrelenting pressure on staff and in particular key members of the team within CMOG which, at many times, was barely sustainable although these pressures were experienced across the Department. There are currently plans for additional restructuring which could provide the opportunity to further enhance the Department's ability to respond to future emergencies and crises and to consider the resilience of these arrangements, notwithstanding other priority policy work and wider resourcing constraints.

2.22 To secure maximum benefit from any enhanced capabilities within the Department it is essential, in my view, that the learning from the pandemic is reflected in wider NI Civil Service capacity and capability. This learning should be reflected both in emergency planning and response, and in the recognition of the requirement for specialist skills and experience, as opposed to generalist civil servant grades filling key positions within The Executive Office's (TEO) Civil Contingencies Branch, to ensure that the proportionate priority and resources are afforded to this work. These are specialist roles and need to be regarded, recognised and remunerated as such to attract those with the skills, expertise and experience to effectively fulfill the roles. During the Covid-19 pandemic response while individuals

occupied designated and defined civil contingencies roles, some did not have the relevant experience and expertise and this, in my view, at times adversely impacted on the cross-government response and placed inappropriate and unnecessary additional demands on the Department whose focus was correctly on the health response. I will expand on this further, with specific reference to the Care Home sector in my reflections and learning from the pandemic.

2.23 As CMO, unless otherwise unavailable due to other commitments, I chaired the ERP's Strategic Cell when Health Gold was formally activated. If I was not available, another member of TMG deputised on my behalf. This followed an extraordinary meeting of TMG on the 4 March 2020 (which I had called) to ask that respective policy cells be established. Consequently, while the necessary preparatory work was already underway, the first formal meeting of the Strategic Cell was held on 9 March 2020, at which updates were received from the chairs of the respective specific policy cells. The Strategic Cell is a strategic decision-making group which is usually chaired by the CMO, and membership includes TMG senior policy officials and the Department's professional officers from the medical, nursing and social care disciplines. The overall organisational structure for Health Gold, which was comprised of the Strategic Cell and 13 subject-specific policy cells, has been provided [MMcB6/012 - see INQ000103633]. The remit and staffing for each of these policy cells is also provided [MMcB6/013 - see INQ000103634]. The Strategic Cell set the overall objectives of the pandemic response and each policy cell, in keeping with the principle of subsidiarity, had responsibility and accountability for leading on implementation and achievement of those objectives.

2.24 As described in paragraph 6.23 from early March, as part of Health Gold, there was a surge policy cell which had responsibility for preparation and

response across health and social care. Updates to the Strategic Cell from the surge policy cell were provided by respective policy leads. Subsequently from early May 2020, recognising the significant challenges facing the care sector, SSPG established a specific Care Home policy cell under the Strategic Cell for the social care sector, including domiciliary, nursing and residential care. The Care Home policy cell was normally chaired by the CSWO or, in his absence due to other commitments, by the Director of Mental Health, Disability and Older People within SSPG. Membership of the Care Home policy cell included senior managers from the Department, the HSCB, and the Chief Executive of the RQIA to oversee the pandemic response across the social care sector. The chair of the Care Home policy cell will be best placed to advise of its role and the work undertaken.

2.25 While the ERP's Strategic Cell was the structure in place to oversee the Department's response during the first wave of the pandemic, I commissioned an 'in flight review' of these arrangements in preparation for anticipated subsequent waves, having recognised the need for a more sustained response and appropriate strategic oversight and coordination arrangements. The Strategic Cell was stood down in June 2020 following this review and a decision was taken by the Department, and approved by the Health Minister, to establish the new temporary Management Board for Rebuilding HSC Services. The new arrangements involved the establishment of an Integrated Covid-19 Gold Command Group, which largely replaced the Strategic Cell, consisting of senior Departmental officials, alongside senior HSCB and PHA officials. The integrated Gold Command Group was chaired by the Department's Permanent Secretary. This change reflected the move from the immediate emergency response under the ERP to business continuity arrangements, as the pandemic response became the primary focus of the entire Department, and my role was to continue to provide strategic leadership and coordination of the

increasingly complex aspects of the public health response and to continue to provide professional advice and support to the new Rebuilding Management Board and integrated Gold Command not withstanding other commitments.

2.26 In August 2020, a Social Care Surge Group was established by the CSWO and co-chaired with the Chief Nursing Officer (CNO). I understand its purpose was to strengthen coordination and collaboration across the Department and wider system [MMcB6/014 - see INQ000103715] and to support the HSCB in implementing the regional Care Homes Action Plan they had developed. Membership of the Social Care Surge Group included representatives from the HSCB and PHA, and the role and responsibilities of this group is described in paragraph 52 – 57 of the Department's statement to Module 6 of the Inquiry [MMcB6/015 – see INQ000613603]. Those who chaired and were members of these groups will be best placed to provide further detail and to advise on the interface with, and respective roles of, more operational groups at Health Silver led by the HSCB with support from the PHA.

2.27 Throughout the duration of any emergency, as CMO I am expected to continue to discharge the roles and responsibilities I have described above. This is something which I did throughout the period January 2020 to March 2022 to the best of my ability and continue to do while supporting the Covid-19 Inquiry. However, much of my wider policy and professional responsibilities during the pandemic response were, by necessity, paused as I assumed significant new and additional professional and policy responsibilities. Those I have outlined below are in addition to my responsibilities in supporting the Health Minister in 4 Nation meetings and meetings with our RoI counterparts. Furthermore, in support of the Health Minister, I regularly attended NI Executive meetings and meetings of the Health Committee. Over 150 NI Executive meetings took place between

the beginning of March 2020 and the end of February 2022, and I also attended 16 meetings of the Health Committee to the end of March 2022. This was in addition to a significant number of other 4 UK Ministerial meetings in support of the Health Minister, First Minister (FM) and deputy First Minister (dFM) on all aspects of the pandemic response. Throughout the relevant period there were, in addition, regular professional meetings including the UKCMOs meeting (which took place several times a week in the early stages of the pandemic and were attended by the 4 UK CMOs and their Deputy Chief Medical Officers (DCMO)) and the UK Senior Clinicians Group (which met regularly between March 2020 and March 2022 and was also attended regularly by DCMOs). The UK Senior Clinicians Group provided a forum for discussion and the sharing of papers and research from within the UK and around the globe touching on almost every conceivable aspect of our response to Covid-19 including Care Homes.

2.28 I was accompanied to most of the NI Executive meetings by the CSA, or his Deputy, who regularly gave presentations on the latest 'R' paper which set out modelling of the best case, worst case and reasonable worst-case scenarios, based on a range of values for the reproduction rate (Rt) of the virus. The CSA and I then answered questions posed by NI Executive Ministers and provided additional information, when possible, to address their questions. I also attended pre-NI Executive meeting briefings, alongside the Health Minister and CSA, with the FM and dFM on an ad hoc basis in the first few months of the pandemic and then regularly when these became more routine later in 2020. All policy decisions were made formally at the NI Executive. While there were informal social media communications between officials and, at times Ministers, these did not consider or predetermine significant decisions of the NI Executive to the best of my recollection.

2.29 The Department is headed by a Permanent Secretary with this role undertaken, for most of the duration of the period covered by this statement, by Mr. Richard Pengelly, CB. Mr. Peter May has been the Department's Permanent Secretary since March 2022. The Permanent Secretary in the Department in terms of overall governance and accountability is also the Chief Executive of the HSC system in NI.

2.30 The internal structure of the Department is organised into several Groups with each Group sub-divided into Directorates. The Heads of each of these Groups were members of the Department's TMG (now SLT), chaired by the Permanent Secretary. TMG was responsible for the governance, operational and financial management of the Department and Departmental policy. The Departmental Board has responsibility for overseeing the effective discharge of corporate governance within the Department. The Heads of each Directorate (Directors) are members of the Senior Civil Service.

2.31 Whilst the vast majority of the Department's staff are career civil servants, the Department also includes staff who are health care professionals. These health care professionals include myself, as CMO; the CNO; the CSWO; the CPO; the CDO; the CEHO; the CSA; the Chief Allied Health Professions Officer (CAHPO), as well as the Chief Digital Information Officer (CDIO) and the Director of Communications. The Chief Professional Officers combine their roles of providing leadership to their profession with the provision of professional advice within the Department. The Chief Professional Officers have responsibilities for specific areas of policy and are integrated into the Department's management structure, working alongside career civil servants. Some of these policy responsibilities have subsequently changed as part of wider Departmental restructuring. These new arrangements (of which I am supportive) provide for greater separation between direct policy responsibility and

professional advice to inform policy and remove some of the financial and human resource responsibilities which ensure the role and responsibilities of the CMO and CMOG are more manageable.

2.32 Separate Groups and Directorates in the Department have been established for business management purposes. These Groups and Directorates are not intended to create artificial barriers (silos) to working within the Department and did not do so during the pandemic. Rather, I consider that the structure of the Groups allowed for the appropriate and effective delegation of tasks during the pandemic response with the policy and professional teams with responsibility and knowledge of specific sectors and policy areas best placed to engage and action matters arising and to seek further professional input as necessary. The Department's staff, including professional advisors, can (and do in my experience) work seamlessly on policy and professional matters which span the responsibility of more than one policy area and / or professional discipline. This was a major strength during the pandemic response as, in effect, most other policy work ceased, and all staff worked collectively in common purpose and joint endeavour. However, this has resulted in significant other policy work being paused or delayed.

2.33 As the principal healthcare professional advisor to the Health Minister and to other Policy Groups within the Department, I lead a small team of doctors who provide professional medical advice. This is comprised of myself, two DCMOs (Professor Lourda Geoghegan and Dr Naresh Chada), and several Medical Advisors. During the relevant period both DCMOs had specific policy responsibilities within my Group, alongside their role as professional advisors. Professor Geoghegan had many significant responsibilities during the pandemic response which included chairing the Testing in Care Homes - Task and Finish Group, overseeing the establishment of the Nosocomial Cell and development of the

Nosocomial Dashboard to assist HSC Trusts with healthcare associated outbreaks of Covid-19 and providing professional and technical health protection advice with respect to testing and contact tracing. During the pandemic Dr Chada was the senior responsible officer for the Covid-19 vaccination programme, in addition to holding other significant responsibilities. Further details of their respective roles including their responsibilities for testing and vaccinations, are covered later in this statement. Professor Geoghegan and Dr Chada worked closely with the former and current Director of Public Health (DPH) in the PHA and a range of PHA Public Health consultants on the provision of public health advice and communications, and on the response to emergencies and infectious diseases. This continued throughout the pandemic and both DCMOs, the CSA and I together provided professional advice to policy areas across the Department, including primary care, secondary care, workforce, mental health, elderly care, family and children's services.

2.34 The Department policy leads for these areas sit in other Groups within the Department including, for example, the Groups led by the Deputy Secretary of HPG. The CSWO and the CNO also head up their own groups. While policy responsibility for the care sector did not sit with me, I worked closely and, in my view, effectively with both the CSWO and CNO throughout the pandemic on issues affecting the care sector, when my professional advice and support was sought insofar as my other commitments and responsibilities allowed, and I have provided some examples of this below from paragraphs 2.39 to 2.44.

2.35 In instances where specific specialist advice is required which is outside the area of expertise of this team of Medical Advisors, my staff and I work to secure the necessary expert advice from outside the Department from HSC organisations, academia and if necessary, from outside NI, including

sourcing advice from other specialist advisory groups. This was the case during the pandemic, and such advice was obtained from NI specific groups I established (or agreed needed to be established) during the pandemic, such as the Strategic Intelligence Group (SIG), the Expert Advisory Group on Testing (EAG-T), and the Testing in Care Homes - Task and Finish Group. More information on these groups is provided at paragraphs 2.42 and 2.43 below. Advice was also sought from UK wide expert groups such as the Scientific Advisory Group for Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) described in paragraphs 2.60 - 2.63. Other professional leads in the Department operate in the same way, including providing relevant professional advice to policy areas within my Group.

Care sector Responsibility, Support & Professional advice

2.36 The Department's statement to Module 6 from paragraph 12 – 36 [MMcB6/015 – see INQ000613603] describes the role and responsibilities of the Department, the HSCB (now SPPG within the Department) the HSC Trusts, and the professional and policy arrangements within the Department with reference to the adult social care sector. The details of these arrangements and the respective roles and responsibilities is out with my direct professional knowledge and experience, and I have not, therefore, repeated in this statement as others will be best placed to provide further detail on these arrangements. To be of assistance to the Inquiry I have described the arrangements as I understood them during the relevant period. During the pandemic, policy and professional lead responsibility for matters within the scope of Module 6, including the adult social care sector and specifically Care Homes (residential and nursing homes) and domiciliary care, remained with the then CSWO and his policy and professional team within SSPG. The CSWO was supported by his policy team led by the then Director of Mental Health, Disability and Older

People within SSPG, with professional policy advice provided by the OSS, in addition to the professional operational advice and support provided by the Director of Community Care and his team in the Directorate of Community Care in the HSCB (now SPPG in the Department) and HSC Trusts' Executive Directors of Social Work to assist in operational decision making. Professional advice with respect to health protection (and specifically infection prevention and control) was provided by the PHA in keeping with their extant roles and responsibilities. The then CNO and Chief Nursing Officer Group (CNOG) also provided professional support and advice to the CSWO and SSPG. In addition, the CNO and CNOG supported the Infection Prevention Control Cell (IPC Cell) of the PHA, reporting to Health Silver, which was chaired by the Director of Nursing in the PHA and which provided advice with respect to infection prevention and control.

2.37 Given the expertise and experience of other professional and policy colleagues, the CSWO, the CNO and their respective teams, it would not have been appropriate for CMOG or I to lead on key elements of the pandemic response in the social care sector, neither would it have been possible, given the many other demands and areas of the pandemic response on which I was leading. This is not a reflection of the priority I afforded the response in the care sector, rather a reflection that other professional and policy colleagues in the CSWO team, SSPG, the then HSCB and PHA had the professional, technical and operational experience of matters within the scope of Module 6 of the Inquiry and in particular the social care sector which I did not have, and in my view were best placed to lead and coordinate this work.

2.38 While responsibility for policy or operational decision-making in the care sector sat elsewhere in the Department, CMOG did provide policy and professional support to both the SSPG and CNOG teams. As CMO, I did

issue (as necessary) circulars and guidance to the HSC, sometimes in conjunction with the other Chief Professional Officers, including the CNO, CSA, CSWO, CDO or the CPO. This was done with the intention of keeping health service managers and frontline staff fully informed on developments such as testing, contact tracing, therapeutic interventions, and Non-Pharmaceutical Interventions ("NPIs"), including travel restrictions and vaccination requirements. The CSWO and the Director of Mental Health, Disability and Older People were the established primary points of contact for the sector within the Department prior to and during the pandemic. Although I was not directly involved in the work to develop Care Home guidance or visiting guidance, the DCMO and I did support policy colleagues' engagement with the Commissioner of Older People, Age NI and Independent Health Care Providers (IHCP) and other stakeholders on a number of occasions to discuss relevant guidance or changes in guidance. I was also involved in the implementation of visiting guidance and recognised the importance of visiting for those people living in Care Homes. By way of example, on 30 June 2020, [MMcB6/016 - see INQ000103666] the Health Minister announced changes to restrictions on visiting across all care settings from Monday 6 July 2020. Following publication by the NI Executive on 12 May 2020 of the five-step approach to relaxing lockdown restrictions, it was then considered timely to review the extent and application of restrictions on visiting across all care settings. As part of this review process, and while I was not directly involved, the Department's Strategic Clinical Advisory Cell (which I had established), undertook a review of the evidence relating to coronavirus infection and the impact of hospital visitors on disease transmission. This review was designed to inform the professional advice of the CNO. A summary of the evidence used was subsequently included in the resulting revised guidance [MMcB6/017 - see INQ000103667], which recognised the right of people to visit their loved ones in hospitals and Care Homes, while balancing the ongoing risk from Covid-19. All relevant guidance was

circulated within the Department and to external stakeholders, including the PHA and RQIA, by SSPG for professional input prior to issue. Given other significant commitments (and the fact that the relevant expertise resided within the PHA) CMOG's opportunity to provide meaningful input was limited. With respect to the Care Home guidance, colleagues within SSPG sought professional and technical input as required from the Deputy CNO and / or the DCMO on areas that required further clarification. The guidance described actions for both HSC Trusts and for Care Homes, including requests of HSC Trusts to work in partnership with nursing and residential Care Homes. More information on visiting guidance is provided in section 10 of this statement.

CMOG Policy and Professional support to SSPG policy team and CNOG

2.39 CMOG provided professional and technical input to SSPG to inform policy and relevant guidance on Care Homes and the adult social care sector. On occasion, this was provided through two specific groups which I had established to ensure greater coordination of specific health protection policy implementation with respect to testing in Care Homes and to supplement the expert operational advice already being provided by the PHA and the IPC Cell in the PHA. These were the Testing in Care Homes – Task and Finish Group and the EAG-T. To assist the Inquiry, I have again summarised the Groups' roles and responsibilities and these are also described in paragraph 2.62.

2.40 The Testing in Care Homes - Task and Finish Group was chaired by the DCMO and it had oversight of the implementation of the Care Home testing programme, but it also provided additional health protection policy advice as described at paragraph 2.65. Professional advice was also provided to SSPG colleagues outside of the Task and Finish Group,

although sometimes in relation to issues considered by the Group. The role of the EAG-T is described in more detail at paragraph 2.43. In addition, from its establishment in July 2020, the Covid-19 Vaccination Programme Board (which I chaired) had oversight of the implementation of the vaccine programme in social care sector including Care Homes.

2.41 The Testing in Care Homes – Task and Finish Group met for the first time on 8 May 2020, with subsequent meetings scheduled on a regular basis, and with the final meeting on 28 January 2022. As mentioned above, the Group was chaired by the DCMO and I attended when other commitments allowed. Membership included social care policy leads within the Department such as the Director of Mental Health, Disability and Older People (after the initial few meetings), the PHA and the RQIA. The Testing in Care Homes – Task and Finish Group provided direction, guidance and support in the development and implementation of the Covid-19 testing arrangements within Care Homes. From its initial establishment its key function was to identify and agree the necessary steps to deliver the Health Minister's commitment to test all Care Home residents and staff, including Care Homes which did not, and had not, experienced a Covid-19 outbreak by June 2020, and to monitor progress and the outcome of this initial phase of the Care Home testing programme. The meetings of the Group allowed members to provide updates on actions being taken by their respective organisations to implement and support the Covid-19 testing arrangements in Care Homes. Members were also able to escalate matters requiring further consideration for discussion and / or agreement. The remit of the Testing in Care Homes – Task and Finish Group was not to take decisions about Covid-19 testing policy. Members did, however, provide their expert knowledge and advice to appropriately inform and shape testing policy proposals, including how to effectively expand the provision of Covid-19 testing arrangements in Care Homes.

2.41a The expansion of testing in care homes was a key priority for the Department, with care home residents and staff with symptoms of Covid-19 identified as a priority group for testing in March 2020. In April 2020, further expansions to the care home testing arrangements saw the introduction of Covid-19 testing of all residents and all staff where there was an outbreak in a care home. At that point, there was no requirement for a specific Care Home Task and Finish Group to be established, as the EAG-T was responsible for advising and recommending Covid-19 testing proposals for care homes.

2.41b In early May 2020, having discussed a further extension to the testing arrangements in Care Homes with the Health Minister, I decided to establish a Care Home Task and Finish Group. An early function of the Care Home Task and Finish Group was to ensure that the Health Minister's commitment which was subsequently announced on 18 May 2020 was successfully delivered. That commitment was for Covid-19 testing to be made available to all residents and all staff, including in care homes which had not experienced a Covid-19 outbreak, and to be completed in June 2020.

2.42 Throughout the pandemic response, and as it evolved, the Testing in Care Homes – Task and Finish Group meetings provided, in my experience, an effective arrangement for the PHA to provide verbal updates about the programme of Covid-19 testing in Care Homes to include: the overall position on Covid-19 outbreaks across Care Homes; Covid-19 positivity rates for asymptomatic and symptomatic Care Home staff and residents; turnaround times for Covid-19 test results; and relevant developments in the National Testing Programme. From December 2020, the Testing in Care Homes – Task and Finish Group also received updates on the implementation of the Covid-19 vaccination programme across Care

Homes. As necessary, the Group also provided an opportunity to update members on relevant amendments to Covid-19 testing advice for Care Homes as proposed by the EAG-T and endorsed by the Department. More information on the Testing in Care Homes – Task and Finish Group is provided in the sections on IPC, Testing and Visiting.

2.43 The EAG-T was responsible for advising and recommending Covid-19 testing proposals for Care Homes which was considered by the Department's policy leads to inform advice to myself and the Health Minister for review and approval. It also more generally provided an opportunity to provide professional and public health policy advice to the CSWO and his policy team within SSPG on matters raised at the meeting or following the meeting. Similarly, the DCMO also provided additional professional advice when requested to the CNO, the DCNO and her team, who were leading and coordinating extensive work in the provision of training and support with respect to: the effective use of personal protective equipment (PPE); enhanced IPC training; staff self-testing; swabbing of residents; guidance on visiting; and a range of other interventions. This enhanced training was provided with support from the PHA, HSC Trusts, RQIA, Clinical Education Centre, and the NISCC. I was not directly involved in this, however as chair of the Strategic Cell from March to June 2020 I was aware of and supportive of this operational training support to the care sector. More information on testing in Care Homes has been provided at section 8 of this statement.

2.44 I established the EAG-T to advise the Department on the implementation of Covid-19 testing in NI and to provide expert advice which was then considered by policy leads. Recommendations from the EAG-T informed my advice to the Health Minister (see, for example, [MMcB6/018 - see INQ000381321]). For example, the EAG-T reviewed and recommended revisions to the Interim Protocols for Testing (IPTs) on the optimum use of

Covid-19 tests and the introduction of new tests which I considered for approval. The purpose of the IPT was to set out how available testing capacity, which expanded over time, was to be prioritised for use. The IPT was an operational tool which provided information on eligibility for testing and advice on how to access testing. Draft IPTs included input where appropriate from the CSA and final drafts were endorsed by the EAG-T and the DCMO. IPTs were then submitted by the Covid-19 Response Directorate to myself for consideration and final approval before issue and the Health Minister was advised of any significant changes. Relevant updates to the IPTs would have been reflected by the Care Home team within SSPG in guidance issued to Care Homes.

Working arrangements and relationship with the NI Executive and within the Department during the pandemic

2.45 The NI Executive had returned after an absence of three years some three weeks prior to the start of the pandemic. In my view it was advantageous to have the NI Executive restored to provide strategic leadership and to make policy decisions to mitigate the consequences of the pandemic, particularly given the significant impact of those decisions on the people of NI. It was undoubtedly the case that Ministers were new to their respective policy responsibilities and relationships with officials were being established.

2.46 While the then Health Minister will have his own view, I believe that I established an effective professional working relationship with the Health Minister who, in my experience, both sought and carefully considered the professional technical and policy advice provided. I found that he had a good understanding of the scientific and public health evidence and basis for this advice. More generally, it was my experience that the long standing and, in my view, effective working relationships between the

CNO, CSWO, CSA and the Permanent Secretary were key in the managing the unrelenting demands of what was an extremely complex and fast-moving situation. There are several practical examples of the effectiveness of this collective approach, which are described in paragraphs 4.12, 7.7, 8.30, 10.4, 10.10 and 11.5.

2.47 As set out in para 2.3 above, the CSA, Professor Ian Young is also within the CMOG reporting directly to me and he provided key professional leadership, scientific advice and support during the pandemic. In my view, he was highly effective in communicating complex scientific concepts to all NI Executive Ministers and to the public. My professional relationship with him during the pandemic was, I believe, highly effective and I am professionally indebted to him for his support and leadership.

2.48 The CSA is not a standing member of Health Gold and has no specific responsibilities for pandemic preparedness and planning. However, during emergencies, the CSA is required to work closely with me and other Departmental officials to provide scientific / medical / technical advice to the Health Minister which also can form part of the Health Minister's advice to the NI Executive to inform its decisions. His role in the Department is a part-time one (equivalent to three days per week, although this increased by necessity to full-time during the pandemic). The role has three main aspects:

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

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

c) Head of profession for the Healthcare Science workforce in the HSC (Chief Scientific Officer), a role similar to that of other Heads of Profession (CMO, CNO, CPO, CSWO, CAHPO).

2.49 In my experience, the organisational arrangements and working relationships with NI Executive Ministers were generally effective in ensuring the provision of professional and technical public health and scientific advice to inform decisions by the NI Executive, in what was a fast-moving highly complex environment. NI Executive Ministers listened to the advice that the CSA and I provided and, in general, the arrangements allowed for informed and constructive challenge of professional advice. This was despite the fact that individual NI Executive Ministers did place different emphasis on the health, economic and societal implications of the pandemic response in their decision making. It is my view that, in general, NI Executive Ministers understood and respected the independence of the professional health advice provided, however, NI Executive Ministers did consider wider factors in addition to the health advice in reaching their decisions. While NI Executive Ministers will have their own views, it was my experience that the discussion and challenge of the professional advice at NI Executive meetings helped with the sharing of information and intelligence and improved the understanding of the complexity and difficult choices faced by the NI Executive. This was important given the enormity of the issues being considered by NI Executive Ministers and the consequences of those decisions.

2.50 In the earlier weeks and months of the pandemic, there was a great deal of uncertainty and, in this context, professional judgement and advice had to be considered and carefully constructed. This was especially the case when providing advice to the Health Minister, and through the Health

Minister to other departments and the NI Executive. Understandably, multiple requests were made to the CSA and I for professional advice from other departments. Throughout the pandemic, the NI Executive made key decisions concerning the public health response to mitigate the impact of Covid-19 in respect of the implementation of NPIs, and the advice that the CSA and I provided was used to inform the NI Executive's considerations and decisions. NI Executive Ministers were faced with difficult choices and took account of advice and information from other departments when arriving at decisions to apply or relax statutory NPIs, including considering a range of non-health related factors alongside the advice and input from the Department, the CSA and myself.

2.51 In addition to NI Executive papers prepared by the Department that required NI Executive consideration and approval (such as decisions on NPIs and the review of the Covid-19 regulations), the Department kept the NI Executive informed and regularly updated about decisions for which it retained exclusive policy responsibility. It also informed the NI Executive about the Department's actions within these policy responsibilities which were taken in response to the pandemic, including more operational matters. This routinely included mitigations designed to alleviate the impact of the pandemic on the delivery of HSC services, including the social care sector.

2.52 The impact of decisions by the NI Executive with respect to NPIs and the association with pressures on the health and social care sector and workforce including nosocomial outbreaks in hospitals and outbreaks in the care sector was, in my view, understood by NI Executive Ministers. Later in the pandemic, the updates to the NI Executive provided details of the planning undertaken by the HSC to rebuild health and social care services following the disruption in the delivery of routine services, and

action in respect of the health and social care workforce. Throughout the pandemic, there was a need to balance surge capacity for people with Covid-19 with maintaining an appropriate level of care and support for other health and social care needs. Regrettably, I do not believe there was any other way at the time in which it would have been possible to free the capacity necessary within the health service to respond to Covid-19, reduce the risk to patients and staff and to maintain other services. The alternative scenario of trying to maintain capacity across the entire health service, the health service being overwhelmed, and people being unable to access emergency care for other conditions would, in my opinion, have resulted in not only more people dying from Covid-19 but also other acute conditions. Several SAGE papers and the advice provided by the CSA and myself to the NI Executive highlighted the negative impact on other aspects of health and the health system of decisions with respect to NPIs. The implications of these decisions on wider public health, waiting lists and waiting times were, I believe, understood and were highlighted in papers submitted by the Department to the NI Executive and described in press releases and statements from the Health Minister [MMcB6/019 - see INQ000373432]. These concerns were repeatedly referenced in papers and in briefings to the NI Executive by myself and the CSA, as were the extraordinary pressures that were being experienced in health and social care and by health and social care staff across all sectors.

2.53 With respect to the social care sector, including Care Homes, these updates were provided verbally by the Health Minister, supported by the CSA and myself. On occasion, other health officials may also have been present at these verbal update meetings. NI Executive papers on the care sector, including the operational response and support to the care sector, were prepared by relevant policy and professional colleagues within SSPG. Publicly available data from the Covid-19 dashboard, in addition to reports from the PHA, provided data on the numbers of outbreaks in Care

Homes. A weekly dashboard report was prepared for the Health Minister which provided a high-level summary of Care Home self-assessed ratings (RAG - red, amber, green risk) for PPE, Workforce and Cleaning. This information was based on regular daily reports to the Department on intelligence from the RQIA Service Support Team. The data from RQIA was used to prepare the weekly R paper and provided the NI Executive with the level of community transmission, the trajectory of the pandemic, and insight into the pressures on the health and social care system. It frequently highlighted the consequences of increased community transmission with outbreaks in health and social care facilities including Care Homes. The Health Minister used all this information to ensure that the NI Executive was kept fully informed on the situation with respect to Care Homes. The CSA and I routinely responded to specific questions from NI Executive Ministers that required scientific or public health input. These reports and updates are described more fully in the Department's statement to Module 6 [MMcB6/015 – see INQ000613603].

2.54 Even at this time, it remains difficult to fully describe the intensity and pressures of the demands and the burden of responsibility felt by all during the pandemic. Many individuals across the Department were working extremely long hours, including weekends, and undoubtedly those pressures were, at times, evident. There was, however, a powerful sense of common purpose and the circumstances required an adaptive, flexible, and dynamic response, with appropriate delegation and collective endeavour. It was my experience that there were effective working relationships across the Department and wider HSC evident in the many innovative responses to complex challenges. This was essential in ensuring that the defined policy and operational goals of the overall response to save lives and to prevent the health and social care services being overwhelmed were achieved insofar as was possible. While the scale of the response required presented significant capacity challenges,

given the relative size of the Department and its ALBs, including the PHA and the HSCB, in my view the integrated health and social system and the established trusted working arrangements and networks were a key attribute in the response.

Collaborative working across the wider system

2.55 The effectiveness of the working relationships between professional and policy leads within the Department and the collective approach taken to working with the HSC, academia and the private sector were a key part of the structures and processes in place for the generation, consideration, discussion and provision of professional advice and information about data and modelling. In my view, a major strength was the already established networks between the health service, academia, other government departments and their ALBs, and industry. This was particularly important, for instance, in the development of Covid-19 testing capacity and the establishment of a Scientific Consortium which allowed NI to maximise existing testing capabilities, using a variety of testing platforms given the challenges at the outset of the pandemic. Areas where I was directly involved within the scope of Module 6 included: work with the PHA on contact tracing and the oversight by the Test, Trace, Protect Oversight Board which I chaired; the Covid-19 Vaccination Oversight Board which I also chaired, and the oversight of the Covid-19 vaccination programme, including the implementation in the care sector and Care Homes. Similarly, I established (or was directly involved in the establishment of) SIG which reviewed scientific evidence and research including papers of immediate relevance to the Care Home sector, the Modelling Group which modelled the potential trajectory of pandemic, and EAG-T.

2.56 Strategic decisions within the Department are made by the Health Minister. The normal process for a decision by the Health Minister is for officials to provide the Health Minister with a 'submission' detailing information, options if appropriate, and the recommendation of officials. However, in some instances, decisions met the crossing cutting criteria set down in the Ministerial Code [MMcB6/020 - see INQ000262764] which required individual NI Executive Ministers to refer the decisions to the NI Executive for its consideration. The criteria for referral of Covid-19 related decisions to the NI Executive were routinely met during the Covid-19 pandemic. More operational matters relating to health and social care services including those within the scope of Module 6 and the impact of the pandemic on adult social care and measures taken to mitigate the consequences were regularly provided to the NI Executive by the Health Minister in verbal updates and in also in NI Executive papers provided by the Department. In addition, the NI Executive regularly received updates on the number of outbreaks in Care Homes in the weekly R paper and on the Covid-19 dashboard from 7 May 2020 which provided: the total number of acute respiratory outbreaks; the number of outbreaks which were confirmed Covid-19; the number of outbreaks which were suspected Covid-19; and the number of closed outbreaks. This analysis continued to develop and from 2 December 2020 the dashboard included a breakdown of the confirmed Covid-19 outbreaks in Care Homes by those who were asymptomatic, symptomatic and unknown. From 21 December 2020, the dashboard also included a breakdown of the number of outbreaks in Care Homes by geographical area.

2.57 As outlined above in paragraph 2.46, in my experience there was an effective working relationship with the Health Minister and the Permanent Secretary in matters relating to the scope of Module 6, and more generally, in the wider pandemic response. My experience of supporting

the Health Minister at meetings of the NI Executive was that all NI Executive Ministers listened to the professional advice provided.

2.58 Departmental advisors, including myself, provide information and advice to Ministers and the NI Executive when required, but the constitutional position is that it is the responsibility of Ministers to take decisions. This advice role became even more important and substantial during the pandemic. In providing my advice, my primary objective was to enable NI Executive Ministers to take decisions which would minimise the potential deleterious impacts on health, save lives by preventing severe disease and deaths, prevent the health service from being overwhelmed, and ensure that people could receive the care they required. I continued to be guided by this primary objective throughout the pandemic and was never deflected from this in the professional advice that I provided.

2.59 As CMO, I had an essential role, along with the CSA, in prioritising science and supporting the direction and coordination of research from the outset. The priority given to science and research was reflected in the agreed initial coronavirus action plan in March 2020 with the priorities being "contain, delay, research, mitigate".

2.60 Research to develop scientific and public health evidence to inform policy and clinical practice was crucial in the early stage and throughout the pandemic response. This is considered more fully in Chapter 3 of the UK CMO Technical Report, [MMcB6/001 - see INQ000203933] to which I contributed. During the pandemic, one of the main sources of evidence in the UK was SAGE, which is discussed in more detail at paragraphs 6.1 to 6.4. The advice and evidence provided by SAGE was developed by assessing and reviewing evidence from multiple different centres of

expertise and taking account of the views of a wide range of nationally and internationally recognised experts. SAGE is not a forum which any of the Devolved Administrations has the capacity to fully replicate, nor would it be scientifically or technically feasible nor operationally warranted to duplicate their work.

2.61 While NI representation at SAGE, either with observer or participant status, is dependent on the nature of the emergency and there is no automatic representation of NI on SAGE, as was apparent in the early stages of the Covid-19 pandemic. I, or a representative, attended meetings from the 7 February when Devolved Administrations were invited to nominate observers to SAGE meetings. This was after the 5th meeting of SAGE [MMcB6/021 - see INQ000425552]. In the absence of NI involvement in the first five meetings of SAGE, summaries of SAGE's views and discussion in the form of minutes were received by NI for the 3rd, 4th and 5th meetings. The attendance of myself and, subsequently, the CSA ensured that policy makers were kept more fully aware of discussions relating to scientific uncertainty and the full range of opinions contributing to the consensus views of SAGE. However, prior to NI attendance at meetings of SAGE, from the 24 January 2020 there were also regular 4 UK CMO calls to discuss Covid-19 and there was full and appropriate information sharing and discussion on key emerging information, including from SAGE, at these meetings.

2.62 From the 5th meeting of SAGE until the end of March 2020 I, or a professional representative from CMOG, attended meetings. Subsequently the CSA and / or his Deputy represented NI in this capacity and attended SAGE meetings as observers or full participants. As CMO, I had access to, and considered, relevant SAGE papers, consensus views and minutes throughout the pandemic response. NI was also represented on a number of SAGE subgroups. Over the course of the pandemic, I

chaired or attended a number of key groups or had access to expert views and recommendations along with a wide range of other scientific evidence and papers. I was assisted in my consideration of these by the CSA and the DCMOs. All of this contributed to the formulation of my advice to the Health Minister. Many of these other groups also considered research evidence and expert opinion from a wide variety of sources across the UK and internationally.

2.63 The Department was also represented on NERVTAG by Professor Stuart Elborn, QUB. NERVTAG is an expert committee of the DHSC, and the CSA also attended on occasion. NERVTAG advised me as CMO and, through me, the Health Minister and NI Executive Ministers. SAGE advised DHSC and other UK Government departments, providing scientific risk assessment and mitigation advice on the threat posed by new and emerging respiratory viruses and on options for their management. This, along with all other scientific information, informed advice to the Health Minister.

2.64 I agreed to a proposal by the CSA to establish a NI Group specifically to focus on scientific evidence. SIG was established in April 2020 [MMcB6/022 - see INQ000103642] and the first meeting was held on the 27 April 2020. SIG was chaired by the CSA and I attended meetings. SIG considered a wide range of scientific papers throughout the course of the pandemic, including those developed by SAGE and it provided advice to the CSA and myself. The specific role of the group was to consider the scientific and technical concepts and processes that were key to understanding the evolving Covid-19 situation, and its potential impacts in NI and the approaches to mitigating these. SIG's role was to apply the advice coming to the four nations from SAGE and other appropriate sources of evidence and information, including from RoI, and use it to

inform me as CMO and the Health Minister to aid with decision making in NI during the pandemic.

2.65 I also established or approved the establishment of several other key NI groups which also generated information and advice for the same purposes. However, I was not always able to attend these meetings due to other significant commitments and other key meetings, such were the then demands. These groups also considered evidence from many different sources around the world as well as evidence and information generated from within NI. They included:

- The Expert Advisory Group on Testing (EAG-T) [MMcB6/023 - see INQ000137354] (which was established at my request). This was a Departmental Group led, at my request, by an Associate Director within the PHA, Dr Brid Farrell. A key function of this group was to advise on implementation of Covid-19 testing in and to provide expert advice which was then considered by policy leads to inform advice to myself and the Health Minister.

- Testing in Care Homes – Task and Finish Group [MMcB6/024 - see INQ000137355]. This Departmental group was established at my request on the 8 May 2020 to provide direction and guidance to support the development and implementation of Covid-19 testing arrangements within Care Homes. Meetings were chaired by the DCMO, Professor Lourda Geoghegan. I attended the initial meeting of this group and thereafter, due to other demands on my time, I attended as many meetings as possible when other commitments allowed. As previously described, I established this Group to oversee the implementation of the Health Minister's commitment to the full implementation of the first phase of Care Home testing by the end of June 2020. It also provided advice more generally on testing and other

related matters such as IPC to social care policy leads within the Department who, throughout the pandemic, led on the development of relevant guidance to Care Homes and domiciliary care. The Group included membership and the active participation from the PHA, RQIA and policy leads from within SSPG following the initial few meetings.

- The NI Modelling Group [MMcB6/025 - see INQ000137356] which was established at my request and chaired by the CSA, Professor Ian Young, was a Departmental group. I attended meetings of the Group from January 2021 when the CSA was unavailable for a period. During this time, the meetings were chaired by the Deputy Chief Scientific Advisor (DCSA). I continued to attend these meetings after the return of the CSA. The role of the group was to undertake population level modelling work and to estimate the value of 'R' in NI. The group considered information and modelling generated from across the UK and within NI to inform their work, and this was submitted to the NI Executive and published on the Department's website. The NI Modelling Group did not undertake health service modelling. I understand that the Regional HSCB Surge Plan developed prior to the first wave in March 2020 used some information provided by the Department's Covid-19 modelling group. There was subsequent additional specific operational modelling by Trusts, and some further modelling commissioned by the HSCB that informed planning although I had no involvement in this. In my view, it would not have been possible to undertake modelling in the Care Home sector given the complexity and unique circumstances of each Care Home outbreak - at that time each Care Home constituted its own microenvironment, and once infection was introduced into a home, the extent to which it spread would be primarily related to a range of local factors such as the effectiveness of infection prevention control (IPC) measures and the number of residents and staff in the home. Given

that each Care Home was its own small microenvironment, I did not think that separate modelling of the Care Home sector would be meaningful, and I am not aware that any such modelling took place in NI or elsewhere. The risk of infection being introduced into a Care Home would relate to IPC measures and the extent of movement of staff, visitors and patients into an individual home, and the main determinant of the risk of infection in epidemiological terms would be the rate of transmission in the broader community. This was what we were modelling, and I did not think that modelling of the Care Homes sector specifically would add anything useful.

- The Nosocomial Support Cell (NSC) - In December 2020, I established a regional Nosocomial Support Cell (NSC) as part of the Department's approach to supporting Trusts to address the challenges arising from Covid-19 in healthcare settings [MMcB6/026 - see INQ000137357]. The key objective of the NSC was to provide multidisciplinary support to the region and HSC Trusts experiencing clusters or sustained complex outbreaks of healthcare associated Covid-19 infections in acute settings. The primary responsibility for the prevention and the management of such outbreaks remained with the relevant HSC Trust, with the expert support of the PHA available on request. The establishment of this group was to provide additional support in recognition of the additional challenges presented by Covid-19. The HSC Trusts, supported by the PHA, continued to provide support and advice to Care Homes with outbreaks of Covid-19 throughout the pandemic.

2.66 All these groups and meetings involved the sharing of emerging intelligence on the characteristics of the virus, how transmissible it was, and the clinical severity of infection. This was particularly relevant with the emergence of new variants. These groups provided information and

advice and made recommendations on various aspects of the public health response. We also had access to evidence on the effectiveness of NPIs and behavioural interventions etc. They ensured strategic coordination of elements of the response, which was especially necessary during the early months of the pandemic. Advice to the Health Minister and NI Executive was agreed by the CSA and I, having considered and taken into account a number of factors including the impact on the 'R' number. To ensure the accuracy and reliability of information when formulating professional and technical advice, it was reviewed with the CSA and DCMOs. Consideration included the evidential basis for the scientific and public health advice, along with relevant recommendations from expert groups as described at paragraphs 2.35 and 2.62 to 2.63, including where there were differences of interpretation. The advice subsequently was also informed by engagement and discussions that the CSA and I had with professional networks which involved examination and discussion of the relevant evidence. The advice was, in most instances, agreed jointly by the CSA and myself, with input from the DCMOs where relevant. While verbal updates were provided to the Health Minister and NI Executive Ministers, written submissions containing advice to the Health Minister or NI Executive papers containing advice would have generally been reviewed and approved by me following discussion and agreement with the CSA.

2.67 As the outbreak in China continued to develop, with cases being identified in other countries, all four UK CMOs came together to provide advice on the threat of the outbreak becoming a pandemic and we advised respective Ministers and governments. Furthermore, through the pandemic we met each week to review data on disease activity, potential growth and direct health service pressures in each jurisdiction to provide advice to the Secretary of State for Health and respective Health Ministers and governments on the UK Covid-19 Alert level. Again, early in the

deployment of the Covid-19 vaccine, in a further wave of infection, we provided joint advice to Health Ministers on the evidence to prioritise first doses of the vaccine, and to lengthen the dose interval to protect as many people as possible as soon as possible. During the pandemic response, the 4 UK CMOs, as requested by the UK Health Ministers, worked together to provide joint advice to the UK government and the Devolved Administrations on specific matters.

2.68 Throughout the pandemic as previously described, my DCMOs and I met regularly with our counterparts in Great Britain to exchange information and provide mutual advice and support. These 4 UKCMO meetings attended by respective CMOs and DCMOs took place approximately three times per week in 2020, and approximately two times a week in 2021 and early 2022.

2.69 The 4 UK CMOs, including myself, also participated together in other UK wide groups and meetings, for example the UK Senior Clinicians Group. The DCMOs also attended these meetings. As previously described earlier in paragraph 2.27, the UK Senior Clinicians Group provided a forum for discussion and the sharing of papers and research from within the UK and around the globe, touching on almost every conceivable aspect of our response to Covid-19, including provision of critical care, PPE, Guidance, Care Homes, Testing and Tracing, periods of infectiousness, isolation periods etc.

2.70 In formulating advice, due regard was also given to the experience and intelligence emerging from other jurisdictions which was factored into NI specific advice. This was highly relevant as, at various points in time, other jurisdictions were either ahead or behind NI in relation to disease trajectory, its impact, and in their experience of new variants. In my view this engagement, sharing of data and intelligence, and collective working

was highly effective and it will be important in responding to any future pandemics.

2.71 I met regularly with the CMO for the RoI to share information on, for example, clusters in border areas and to support joint work between the Irish Health Services Executive (HSE), the PHA and both Departments. We kept each other informed of developments and discussed the respective policy approaches which might possibly be taken in each jurisdiction. We did this as we were very mindful of the importance of the general alignment and communication of public messaging, notwithstanding the fact that ultimately these were matters for Ministers. We shared modelling data from respective jurisdictions, and data on the emergence of new variants of the virus. Subject to the consideration and agreement of Ministers, we also explored options for coordinating respective responses which most visibly took the form of joint statements urging the population on both sides of the Irish border to exercise restraint in their social contacts to prevent or reduce transmission of the virus.

3. Pre-pandemic Structure and Capacity of the Care Sector in Northern Ireland

3.1 As CMO, I did not and do not have professional or policy responsibilities for the adult social care sector in NI, and I have no professional or technical expertise in this area. Other policy colleagues within SSPG, and the CSWO, will be better placed to provide an informed assessment of the structure and capacity of the care sector in NI. I understand that this will be addressed in the Department's corporate statement in response to Module 6 of the Inquiry.

3.2 Between 2017 and 2020 in general terms, in the absence of the NI Executive, the Department had very limited ability to take any long-term strategic policy decisions. This position was further compounded by the absence of a multi-year budget, which in turn inhibited longer term strategic planning due to uncertainties in relation to recurrent funding. While initial preparatory work on much needed wider system reform (including reviews of the adult social care sector and several clinical services reviews) had progressed, the changes required to deliver on the outcome of these reviews had yet to be implemented.

3.3 In the absence of long overdue structural change, the attendant efficiency in current models of treatment and care, workforce gaps and the limitation of annual budgets, the health service and the adult care sector was, in my view, increasingly unable to meet the changing health and social care needs of an ageing population in a timely way with the associated need exceeding the health and social system's ability to meet those needs. This was evident prior to the pandemic in the unacceptable waiting times for elective or planned care and in the delayed discharge of patients from hospital when an episode of acute care was completed. While others will be better placed to provide expert comment, adult social care reform has not, in my view, been sufficiently progressed, resulting in suboptimal arrangements for general and specialist adult social care to meet the needs of an ageing population and those with increasingly complex needs.

3.4 Moreover, there is a fundamental need to invest more in population health, in prevention, early intervention and anticipatory care models, alternative care pathways, in diagnostics and new treatments. With respect to challenges presented by an aging population, a greater policy focus on healthy ageing, and maintaining physical and mental health and maximum independence is required. With respect to adult social care, in my

professional view, there is a need for a more regular planned preventive and holistic approach to assessments and review of older people's health and care needs which anticipates what may be required, together with a system that responds flexibly and preemptively to meet those needs before a breakdown in independence occurs. In essence, this requires an approach to adult social care designed to intervene early and to provide care and support in the community and closer to people's own home. While I recognise these matters are complex, and others may have different views, the current financial constraints, along with the funding model and cycle, have constrained the potential improved realignment of the system of care.

3.5 Whilst policy and professional colleagues in social services and nursing would be better placed to make more informed comments, I believe that the lack of transformation and investment in adult social care, learning disability services, family support and children's services and community mental health services are material contributory factors. While NI has had an integrated health and social care system since 1973, with health and social care provision the responsibility of HSC Trusts, many would argue that the full benefit of that integration has not been realised, and that the funding of social care services has for many years suffered because of the more visible profile and higher priority afforded to hospital waiting lists and delays at Emergency Departments. There needs to be greater acknowledgement that the pressures in Emergency Departments, where the majority of people who wait the longest are over 75 years of age with complex health and social care needs, are symptomatic of the need for fundamental wider health service and social care structural reform, with greater emphasis on preventative and anticipatory care models and alternative care pathways, to provide care closer to home with greater capacity and investment in primary care and community and voluntary services. Equally, addressing these pressures requires a fundamental

reorganisation of adult social care which must be adequately resourced with the requisite training and skills to improve the appropriateness and responsiveness of social care to prevent unnecessary inpatient care and provide appropriate support and enablement after the treatment of any acute episode. This will require a more fully integrated multidisciplinary team approach than is currently the case.

4 Initial Response to the Pandemic

4.1 Submissions to the Health Minister with respect to the care sector throughout the pandemic were provided primarily by the CSWO and his policy team within SPPG. Generally, CMOG provided professional and technical advice further to that advice which had been provided by the PHA, when requested. To my knowledge, CMOG did not provide a specific submission to the Health Minister on the care sector. In January and February 2020, policy actions were taken by the Department in the context of the emerging threat, including the dissemination internally within the Department of key updates to ensure readiness across all policy teams and within the wider health and social care system. Very early in the pandemic, and while out with the period in scope of Module 6 between January and March 2020, not all advice was recorded and provided in a written submission. This was prior to the realignment of Departmental resources which ensured that notetakers were present at all key meetings, which had not been assiduously recorded in the early days of the pandemic, given the pace of events and sheer number of meetings. As such there is an absence of complete and comprehensive written records in this period.

4.2 Professional advice on the potential impact of the pandemic was provided primarily in oral briefing to the Health Minister prior to, and including, the NI Executive meeting on 16 March 2020. Given the pace of events and

the passage of time, it is problematic to try to identify and isolate information and advice provided by myself and others for particular meetings given the challenges with providing written briefings. The rapid pace of events, and the comparatively small nucleus of people then involved meant that verbal briefings were often more efficient than written briefings during the relevant period. However, the sum total of what the Health Minister, and NI Executive Ministers, would have known and understood at any point in time would have reflected in the briefings they had received at NI Executive meetings over the course of those days and weeks as well as NI Executive papers, press releases, Ministerial Statements, and knowledge accumulated through participation in both COBR (M) meetings and discussion at NI Executive meetings over the same period.

4.3 Briefing on Covid-19 for Departmental policy leads to inform appropriate action and submissions by respective policy colleagues was provided in a paper from the Director of Population Health within CMOG to Departmental policy leads on 5 February 2020 [MMcB6/027 - see INQ000425583] to convey the urgency with which preparation should now be undertaken across the Department and HSC and other government departments. This paper provided an assessment of risk more generally to the population and the consequences for health and social care services including hospitals and Care Homes. The paper stated that unfortunately, as expected, the virus was continuing to spread globally and reported that, on the advice of the UK CMOs, the risk level in the UK had been raised from low to moderate following the WHOs declaration of a PHEIC and confirmation of the first cases in the UK.

4.4 Furthermore, the paper advised of the planning and preparation in NI to date, including: the stand up of the Department's Health Gold Emergency Operations Centre (EOC) on Monday 27 January 2020; the establishment

of HSC Health Silver, led jointly by the PHA, HSCB and Business Services Organisation (BSO) from 22 January 2020; ongoing daily calls between Health Gold and Health Silver to aid co-ordination; establishment of a dedicated 24 hour helpline to provide advice for members of the public who had returned from China in the past 14 days, or who have been in contact with a confirmed case of novel Coronavirus; the establishment of transfer arrangements to the Regional Infectious Disease Unit, Ward 7a Royal Victoria Hospital if a decision was taken to admit a patient who tested positive for coronavirus; and that plans were also being drawn up to enable a patient to be transferred to a High Consequence Infectious Diseases (HCID) Unit in England, if required.

4.5 The briefing also noted that "*The UK CMOs have now agreed that, given the potential health and social consequences of a major epidemic, it is now appropriate to plan and prepare for the* ***reasonable worst-case scenario of Influenza pandemic moderate severity, without a vaccine****. DHSC has proposed, and this has been agreed with the DAs, that existing Pandemic Flu guidance would be the most appropriate model to use in the event of planning for the potential impact on health and society*."

4.6 The update advised of the ongoing daily teleconferences hosted by DHSC to ensure the whole of the UK was appropriately prepared and that a consistent approach was taken. Furthermore, it advised that the PHA continued to work with the relevant public health organisations across the UK and the RoI, and that the Department and the PHA remained in regular contact with RoI counterparts.

4.7 The update advised that a positive case in NI would have a wide impact across the health and social care sector. In preparation for this, policy leads were asked to "*consider what preparations can and should be made in your respective policy areas now, to ensure the Department is*

sufficiently equipped in the event of a positive case. As agreed at TMG on the 3 February, in addition it would be prudent for areas to revisit their business continuity plans. We are also receiving requests for input to UK groups to consider specific issues, such as the potential impacts on social care. Relevant policy leads will need to engage in such discussions and we will forward these on to you as they arise. In discussion with the CMO, given other pressures across the Department, we have decided not to active the Departmental Strategic Cell at this time. However, we will keep this under active review."

4.8 While this was an internal memo, as opposed to a formal submission, it demonstrates the general briefing and situational awareness which was provided at that time, the assessment of the level of risk posed to the population, and the potential impact in what was a rapidly developing situation. This memo reflected the information that was being conveyed in meetings and in verbal updates and briefings throughout that time to policy leads and the Health Minister. It demonstrates the concern conveyed that there would be a widespread impact across health and social care, and the potential risks and pressures that Covid-19 would present to health and social care including hospitals and Care Homes in NI. The risks of transmission of infection in enclosed environments, including health and social care facilities, are well recognised and present challenges each winter with outbreaks of seasonal influenza and norovirus. The briefing reflected the concern about the potential impact in enclosed environments such as Care Homes and the impact on hospitals for those requiring hospitalisation with severe disease. These concerns had already been identified, and action was being taken by the PHA and HSCB to develop surge plans and other subsequent action which I have covered more fully below.

<u>Regional Planning</u>

4.9 As set out in paragraph 4.3 in the ERP which states: "Once activated, Health Gold Command will assess the viability of critical health and social care infrastructures, including medical / clinical supply chains, stockpiles and countermeasures, and make strategic policy decisions about service delivery and surge capacity based on recommendations received from HSC Silver", I anticipated that it was likely that Health Gold would be leading the strategic policy response to the surge in health and social care pressures and would be required to give direction to the regional coordination of the response to the surge in demand. Therefore, to facilitate the enhanced strategic management of the surge, I asked the Deputy Secretary responsible for the Department's HPG and the CNO to assist me with the coordination of the Department's policy input to surge planning for the health service.

4.10 The Deputy Secretary (HPG) immediately established a Covid-19 Strategic Surge Planning Directorate to provide leadership to the Surge Policy Cell and report into the Strategic Cell. The terms of reference for the Covid-19 Strategic Surge Planning Directorate are provided in [MMcB6/033 - see INQ000325160]. The new Directorate was headed by a dedicated Director at Senior Civil Service Grade 5 level.

4.11 With respect to my role, in anticipation of health and social care capacity demands and to ensure appropriate service preparation, following a meeting with the senior leadership team of the HSCB and PHA on the 11 February 2020, I had requested in writing [MMcB6/030 - see INQ000137326] (on the 17 February 2020) that they develop integrated 'surge' plans setting out how health and social care would respond to any significant increase in Covid-19 cases. These plans were to cover community and primary care through to acute care, including those areas

where it was anticipated there would be particular demands, such as critical care.

4.12 The HSCB Chief Executive replied to me on 20 February 2020 [MMcB6/031 - see INQ000130371] advising that surge planning was underway and that the HSCB and PHA had established a regional operational Surge Planning Subgroup to ensure that there was an appropriate and proportionate level of HSC preparedness across the HSC in response to Covid-19.

4.13 As described above, the overall responsibility for the coordination of this work (along with regional health and social care preparation and the subsequent service operation response to the pandemic) remained with the HSCB, supported by the PHA as Health Silver. However, in late March 2020, I commissioned further additional work to quality assure the initial surge plans already in place which had been developed by the HSC Trusts and coordinated and approved by the HSCB and PHA. On receipt of the HSCB and PHA initial surge plans, I identified gaps in the initial surge plans, recognising that the lack of specificity at this time of the potential health and social care service pressures made surge planning problematic. The quality assurance was designed to address these gaps and to work with those involved in preparing the plans to support improvements in planning and monitoring. It was carried out by a team of assessors tasked by myself and my Chief Professional Officer colleagues, including the CSWO and CNO, to undertake a review of the social care HSC Trust Covid-19 surge planning for the Independent Care Home sector (nursing and residential Care Homes) and for HSC Trusts' directly managed inpatient and residential mental health and learning disabilities services (including supported living), critical care and secondary care sectors. The CWSO and his policy and professional team took the lead in the co-ordination and the development of guidance on Social Care

including for Care Homes and Domiciliary Care with input from HSC staff e.g. in the PHA, his own team, the CNO and from staff in CMOG. He and his team were also the first point of contact in the Department for consideration of HSCB surge plans for Social Care.

4.14 Although I was not in attendance, I understand that a Surge Planning workshop was convened by the HSCB on 5 March 2020 to consider the HSC Trust surge plans and ensure regional consistency where possible. While I was not directly involved, I understand there followed intensive engagement between the Department, HSCB, the PHA and HSC Trusts. The Department asked the HSCB to draw up a surge plan for social care, Surge Plan: Social Care and Children's Services dated 15 March 2020 [MMcB6/028 - see INQ000120731], which was reviewed, revised and agreed with the Department. This plan supplemented the Health and Social Care (NI) Summary Covid-19 Plan for the period Mid-March to Mid-April 2020, published on 19 March 2020 [MMcB6/029 - see INQ000103714]. The Plan summarised the key actions taken by the HSC from mid-March to mid-April 2020 to ensure that there was sufficient capacity within the system to meet the expected increase in demand from patients contracting Covid-19 during this period. This was a dynamic plan, which was to be constantly refined in light of the emerging issues. As CMO, I was not involved in advising on, or providing professional advice on, operational matters in the surge plan

4.15 As I recall, the initial regional surge planning for the social care sector, when submitted, was predicated on a model of staff absence being the most significant risk factor for the continuation of services. A revised regional escalation plan set out 'a plan on a page', for Care Homes, mental health and learning disability sectors, with explicit expectations in respect of prevention, mitigation of risk, management of symptomatic patients and support for service continuity.

Local Planning

4.16 Each HSC Trust had a secondary care plan at local level. However, on reviewing these plans I identified that further work was required to ensure that the individual HSC Trusts' plans related to each other coherently. As part of planning for the wider secondary care response I assessed that these individual plans had to connect at a regional level to ensure consistency across the region. The secondary care plans also had to connect to the total system of health and social care, from critical care, community and Covid-19 hubs, to protected non-Covid services. It was a complex task for the HSCB and PHA as commissioners, and for HSC Trusts as providers of services, to ensure continued access to essential health services in the context of a highly transmissible virus, given the IPC requirement to protect potentially vulnerable individuals who were at risk of severe disease, and to prevent outbreaks in health care settings and among health and social care workers. An essential element of the health service preparation and the quality assurance of the plans submitted was to ensure the continued access to emergency and essential services, including services in the care sector. Policy colleagues in SSPG will be best placed to advise of the service adaptations that were initiated to maintain services in the care sector in so far as was possible. All these pathways and new service arrangements progressed were coordinated by Health Gold Command Strategic Cell with the respective policy cells leading on considering and identifying further work required and or making recommendations for approval.

4.17 While I was not directly involved in the operational arrangements and service adaptations by HSC Trusts and their consideration by Health Silver, as chair of the Strategic Cell during the first wave of the pandemic, a clear objective set was to ensure continued access to essential health

services in so far as possible. As chair of the Health Gold Command Strategic Cell I received updates on work that was undertaken by the specific policy cell (to ensure continued access) and was requested to approve regional changes. In late March 2020 as described above, I requested further additional work on these plans to quality assure the initial plans, which were already in place, as developed by the Trusts and assessed and approved by the HSCB and PHA, while also reviewing and improving these during the process.

4.18 As part of this additional quality assurance I commissioned engagement with the Care Home sector, which started on 27 March 2020, and meetings with regional leads from the Trusts on 1 April 2020. The final report for this work was delivered on 1 July 2020 [MMcB6/032 - see INQ000459860]. The work I commissioned in the Care Home sector was, I understand, on completion subsequently integrated into the initial plans which had been developed by the HSCB. It is my view that this additional quality assurance work improved the quality and robustness of the initial surge plans while recognising these initial plans were flexible and dynamic by necessity.

4.19 As CMO, I was not involved in providing professional advice on operational matters relating to the continuation of the critically necessary and substantial levels of care and support to adults living in their own home and / or adults living in Care Homes and therefore cannot comment on the surge plan for social care and children's services [MMcB6/028 - see INQ000120731]. These are matters outside my professional expertise and competency. Such matters would have been normally coordinated by policy leads within SSPG led by the CSWO and working with the Director of Community Care within the then HSCB supported by the PHA.

4.20 Despite the considerable efforts by the HSC, there was regrettably a significant impact on non-urgent elective activity and a range of other planned services, including routine screening programmes and support services including in the social care sector. Extensive efforts were made to provide as many of these services by alternative means as possible, while minimising the risk of infection. Later in the pandemic, there was a particular focus on the support provided to Trusts in preventing outbreaks of Covid-19 in healthcare settings. With respect to the acute sector, I established a "Nosocomial (health associated infection) Cell" to provide specific advice and support to Trusts. This led to the development by the Department of a "Covid 19 nosocomial dashboard" which provided Trusts with close to real time access to data on Covid-19 infections that had arisen in hospital settings. This was used to support IPC and the management of outbreaks. The PHA and Trusts similarly continued to provide support to the Care Home sector experiencing outbreaks.

4.21 In due course, with the roll out of the vaccination programme and greater levels of population immunity, the strategic focus shifted to the reopening of services under the Rebuilding Management Board (RMB) while ensuring proportionate IPC measures were in place to protect patients and staff. Relevant guidance and advice for the health and social care sector was updated at that time. At this later stage in the pandemic, it was essential to ensure that the risk of infection and outbreaks was balanced with the need for the public to access health and social care services. It was recognised that the combination of behavioural change in health seeking behaviour by the public and changes in access to services was in itself creating potential harm in terms of delays in treatment and care, which could potentially impact on outcomes. Recognising the changes in public behaviour and access to care, the Health Minister and the Department issued public statements advising that the health service was

still there for the public when needed and not to delay seeking care and advice. This is described in more detail at paragraph 16.13.

5 Key Decisions

5.1 Operational arrangements and decisions to discharge patients from hospital following the completion of an episode of care are clinical decisions for inpatient teams following detailed assessment. As CMO, I did not provide specific advice or guidance on patient discharge.

5.2 Other than my commissioning the initial surge plans and further work to quality assure the surge plans submitted by the HSCB as described in paragraphs 4.10 to 4.15, I had no direct involvement in the development of surge plans for adult social care, children's services or other health care services and did not contribute to the 13 March 2020 "Surge Plan: Social Care and Children's Services" [MMcB6/028 - see INQ000120731], or the 19 March 2020 "Health and Social Care (NI) Summary Covid-19 Plan Mid-March to Mid-April 2020" [MMcB6/029 - see INQ000103714]. This work was coordinated by the relevant policy area in the Department working with the HSCB, PHA and Trusts.

5.3 Dedicated guidance for the management of Covid-19 in residential and nursing Care Homes was first issued by the Department to the sector on 17 March 2020 [MMcB6/034 - see INQ000120717]. A draft of this version was circulated on 14 March 2020 to all relevant colleagues within the HSC, the CNO, the RQIA and PHA colleagues, and to myself. The guidance set out actions for both HSC Trusts and for Care Homes, including clear expectations for HSC Trusts to work in partnership with nursing and residential Care Homes. Likely challenges with staffing were recognised, there was more detailed guidance on Personal Protective Equipment, and references were made to infection prevention and control

and admission and discharge. I was not involved in the development of this guidance, or its consideration given my other commitments, but it was shared with and considered by professional colleagues within CMOG, although I would also expect that their input would have been significantly limited, given the other pressures and demands on them at that time. My understanding was that this guidance was informed by the advice and guidance developed by Public Health England (PHE) and by health protection advice from the PHA. Neither I, nor CMOG, had any role in the 7 April 2020 correspondence from the CSWO to the Chief Executives of Arm's Length Bodies in respect of the pausing of annual care plan reviews [MMcB6/035 - see INQ000103690]. Prior to April 2022, the HSCB was an Arm's Length Body (ALB) of the Department and, as CMO, neither I nor CMOG had any role in providing input to correspondence from the HSCB to other HSC ALBs and organisations, including the correspondence on 25 March 2020 to the RQIA [MMcB6/036 - see INQ000103689].

5.4 On 26 March 2020, the Permanent Secretary wrote to the Chief Executives of HSC Trusts [MMcB6/037 - see INQ000325159] on the issue of "COVID-19: Preparations for Surge". That correspondence included a range of actions that Trusts were asked to take to maximise surge capacity in hospitals, including that *"it will be more important than ever for Trusts to implement effective discharge arrangements for patients as soon as they are well enough to leave hospital in order to release beds for newly admitted patients. Trusts should also work to maximise and utilise all spare capacity in residential, nursing, and domiciliary care."* This request was aligned with approaches which were being taken across other parts of the UK at that time, as all healthcare systems were activating surge plans in anticipation of potentially high Covid-19 admissions during the first wave. This involved a range of measures to maximise capacity in hospitals, including through effective discharge arrangements. There were also recognised risks to patients remaining in hospital when medically fit to

be discharged becoming infected because of limited testing capacity with the risk of nosocomial outbreaks. While I was aware of this correspondence from the Permanent Secretary, I do not believe that CMOG or I provided policy or professional advice or input to the correspondence.

5.5 In due course, I became aware in general terms of concerns in relation to hospital discharge, although with the passage of time I am unable to recall the source of those concerns or when I became aware. In preparation of this statement, correspondence dated 30 March 2020 has been brought to my attention by the Inquiry [MMcB6/038 - see INQ000256495]. I do not believe I or my office received or were copied into this email, and to the best of my recollection, it was not brought to my attention, and I was not asked to consider the correspondence or to provide advice.

5.6 The NI Assembly Health Committee Report on the Inquiry Report on the Impact of Covid-19 in Care Homes was published on 1 February 2021 [MMcB6/039 - see INQ000431849]. The Health Committee considered existing reports, research papers and international best practice. In addition, the Committee commissioned further research from NI Assembly's Research and Information Service (RaISe) to assist in its consideration of the discharge of Care Home residents from hospital and the experience of public versus private Care Home settings. The Health Committee was also keen to learn directly from the experience of residents of Care Homes, their families and Care Home staff. This engagement, as I understand, was carried out by holding virtual informal meetings with family members of Care Home residents facilitated by the Patient Client Council (PCC), COPNI and AGE NI, and through an online survey seeking the views of owners / managers, staff and residents / family members.

5.7 The Committee held oral evidence sessions with key stakeholders as well as oral evidence sessions, with senior officials from the Department, including the CSWO, CNO and the Director of Mental Health, Disability and Older People providing evidence to the Health Committee as professional and policy leads. I did not provide evidence to the Health Committee, and I am unable to provide comment on the views expressed by those who provided evidence. As is normal practice, the relevant policy area led on the response and action on the findings and recommendations. While I had no direct involvement in the preparation of the Department's overall response, policy and professional colleagues within SSPG liaised with CMOG as necessary. I did approve the final CMOG response for the Health Minster's consideration which had been considered by the DCMO for recommendations 7, 8, 10, 13 and 14 and I also approved CMOG input to recommendations 15 and 16 [MMcB6/040 – see INQ000577498 and MMcB6/041 – see INQ000577499].

5.8 Revised Guidance for Nursing and Residential Care Homes in NI was re-circulated on 18 April 2020 [MMcB6/042 - see INQ000145673 and MMcB6/043 - see INQ000137415] and it included the updated position recommended by PHE that anyone discharged from a hospital setting into a Care Home, including those who tested negative, should isolate for 14 days. This draft Guidance was widely shared by the then Director of Mental Health, Disability and Older People within SSPG around the Department and stakeholders for comments with changes to be supplied by 21 April 2020. A submission from SSPG went to the Health Minister on 23 April 2020 [MMcB6/044 - see INQ000130366] for approval to publish the revised guidance. The Health Minister raised a number of queries on the submission and guidance [MMcB6/045 - see INQ000130357]. The queries were responded to on 24 April 2020 [MMcB6/046 - see INQ000130365] and the Health Minister approved the guidance on the same date [MMcB6/047 - see INQ000130378]. Notification of the

approval was received from Private Office on 27 April 2020 [MMcB6/048 - see INQ000130372]. A letter from the CSWO and the revised guidance issued on 26 April 2020 to HSC Trusts and the RQIA for issue to the sector. The revised guidance was published on the Department's website on 27 April 2020 [MMcB6/049 - see INQ000087760]. Neither CMOG nor I were directly involved in the development of this guidance given other responsibilities. Policy colleagues developed this guidance, informed by PHE recommendations and based on the expert infection prevention and control advice from the IPC cell in the PHA whose membership included HSC Trust IPC leads and RQIA which in my professional view was appropriate.

5.9 Guidance that patients who were discharged from a hospital to a Care Home must be tested for Covid-19 48 hours in advance of discharge was first set out in Version 3 of the Interim Protocol for Testing for Covid-19 dated 19 April 2020 [MMcB6/050 - see INQ000103724]. This revision to the guidance was recommended by EAG-T which, as described at paragraph 2.65, was a Departmental Group established at my request and chaired by a consultant in Public Health, acting on behalf of the Department. I considered and approved this revision to the guidance. Version 3 of the Interim Protocol was communicated to HSC Trusts on 19 April 2020. Updated Departmental guidance on Covid-19 in residential and nursing Care Homes which issued on 27 April 2020 included this updated approach to managing the discharge of patients from hospital to a Care Home. The guidance directed that all patients who were to be discharged from acute hospital care to a Care Home were to be tested 48 hours prior to discharge. In addition, all patients/residents who were to be transferred into a Care Home from any setting, whether that be from hospital, supported living or directly from their own home, would be tested 48 hours prior to admission to the Care Home. This would help Care Home staff to understand each resident's status and to plan their care effectively. The

updated guidance clarified that all patients who were discharged from hospitals into Care Homes – whether they had tested negative or not – should be subject to isolation for 14 days [MMcB6/049 - see INQ000087760].

5.10 A letter dated 25 April 2020 from the Permanent Secretary to Chief Executives (HSC Trusts, PHA, HSCB, NIAS, and the RQIA) about key changes to testing for Covid-19 also reiterated the requirement for patients discharged from hospital to a Care Home to be tested 48 hours in advance of discharge. In addition, this correspondence advised that all new admissions to Care Homes from community settings, including from supported living accommodation, should have their Covid-19 status checked 48 hours before admission to the Care Home [MMcB6/051 - see INQ000145670]. This reflected the advice of the EAG-T which was approved by the DCMO.

5.11 As previously described in paragraphs 4.10 – 4.12, at the start of the pandemic I asked the HSCB and the PHA to initiate surge planning for health services in NI and I requested further work to quality assure the plans. In response to a request from the Department, the HSCB produced a surge plan for social care "Surge plan: social care and children's services" dated the 13 March [MMcB6/028 - see INQ000120731]. The surge plan anticipated significant pressures in hospitals and, in my view appropriately, included consideration of steps to increase hospital capacity. The surge plan included a focus on expediting the safe discharge of those patients who were medically fit for discharge. This surge plan supplemented the Department's 'Health and Social Care (NI) Summary Covid-19 Plan for the Period Mid-March to Mid-April 2020' which was published on the 19 March 2020 [MMcB6/029 - see INQ000103714]. The summary plan also highlighted the importance of implementing effective discharge arrangements for patients as soon as

they are well enough to leave hospital and noted proposed staff pre-deployment arrangements to facilitate safe discharges and maximise patient flow through the health and social care system.

5.12 Decisions on patient discharge remained, appropriately in my view, matters for clinical teams who were best placed to make those decisions. While respective policy colleagues within the Department had oversight and coordinated the preparation and response across health and social care services, including in the hospital and Care Home sectors, the more operational elements of the response were coordinated by Health Silver which was led by the HSCB and PHA. Neither CMOG nor I were leading on the response at Trust level or decisions on hospital discharge, and I did not undertake any analysis of operational processes and decisions with respect to discharge from hospital and their potential impact. The initial surge plan and the summary plan are described in more detail in the Department's statement to Module 6 of the Inquiry.

5.13 SAGE had a Social Care Subgroup which provided advice on the evidence of measures to reduce the risk of infection in Care Homes and NI was represented on this group by the PHA and, on occasion, CMOG professional and policy colleagues would also have attended when other commitments allowed. The PHA provided the Department with updates on matters considered by the group and emerging learning and recommendations. The work of this SAGE Subgroup and other contemporaneous research papers and studies collectively contributed to the Department's and my understanding of the range of factors contributing to infection rates in Care Homes as well as the impact and outcomes. In November 2020, DHSC commissioned the SAGE Social Care Working Group (SCWG) to produce a consensus statement on the impact of hospital discharge on the association between the discharge of patients from hospitals and Covid-19 in Care Homes. This statement was

to take into account work already undertaken by NHS England (NHSE) and PHE and any relevant analysis from the Devolved Administrations. In July 2021 DHSC revised the ask to cover PHE, Public Health Wales (PHW), Public Health Scotland and the Department of Health NI studies.

5.14 In November 2021, CMOG reviewed and amended the proposed draft input which set out the findings of earlier research published by the Department on discharge patterns from HSC hospitals across NI during early 2020 and which explored any link with Covid-19 outbreaks in Care Homes [MMcB6/052 - see INQ000438222]. The consensus statement was published on 26 May 2022 [MMcB6/053 – see INQ000215624].

5.15 The statement noted the findings of the 'Clinical Analysis of Discharge Patterns from HSC Hospitals in Northern Ireland during early 2020 and any link with COVID-19 Outbreaks in Care Homes' report to the Health Minister in November 2020 [MMcB6/054 - see INQ000348240] which identified that the weekly pattern of Care Home outbreaks during the first wave of Covid-19 appeared to be more closely correlated with Covid-19 hospital admissions rates during the same week (a reasonable surrogate for general community transmission and infection) than with the associated rates of unscheduled discharges to Care Homes. It also found that patient-level analysis of those testing positive during weeks when the number of people discharged to Care Homes was more than usual (weeks 11 and 13), found that only about 1% (5 out of 465) of those people tested positive for Covid-19 in the fortnight after discharge to a Care Home, based on testing of symptomatic residents. It did not support a hypothesis that this group of people was a substantial cause of Covid-19 outbreaks in Care Homes. Uniquely, the NI report includes a survey of 31 consultants responsible for discharge decisions which suggested that there had been no change in discharge decision making in respondents. The learning from the SAGE Subgroup and other research studies was used to inform

the ongoing work with Care Homes both from an operational and policy perspective. Evidence from previous influenza epidemics had previously established the role played by the introduction of infection by staff.

5.16 Throughout the pandemic and successive waves, outbreaks in Care Homes were closely related to community prevalence with higher levels of community transmission leading to increased infection in Care Homes with evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community. Epidemiological and genetic evidence from across the UK suggests that, while some outbreaks in Care Homes were introduced or intensified by discharges from hospital, this was not the dominant way in which Covid-19 entered most Care Homes. The discharge of patients to Care Homes does however connect two health and social care environments with high staff patient contact. Managing this interface and the potential associated risks needs to remain a high priority for preventive actions in future similar pandemics. Even with the significant restrictions on visiting and the infection prevention control measures in place during the pandemic, infection could be introduced through staff living in the wider community and the movement of staff between Care Homes. The associated risks were increased by the close personal care that was required to support residents with the activities of daily life. The evidence and learning from the Covid-19 pandemic with respect to the epidemiology of pandemic in Care Homes is reflected in the findings of the UK CMOs Technical Report on the Covid-19 Pandemic in the UK, dated the 1 December 2022 under the heading "*Epidemiology of the pandemic in Care Homes"* [MMcB6/001- see INQ000203933_0297 to INQ000203933_0298].

5.17 On 12 November 2020, the Department published the research (carried out by Dr Niall Herity), which analysed discharge patterns from HSC hospitals across NI during early 2020 and explored any link with Covid-19

outbreaks in Care Homes, looking at discharges of patients to Care Homes [MMcB6/054 - see INQ000348240]. This research was commissioned by the then Permanent Secretary. As I recall, the Permanent Secretary discussed the proposed research with me. The purpose of this work was both to reflect on decisions taken during the early stages of the pandemic and also, importantly, to further inform our understanding of Covid-19 to effectively support future policy considerations. The research looked at data for discharges, as well as considering if there was any correlation between discharges from hospitals and infection rates in Care Homes. The study was circulated to the Care Home sector to highlight the findings regarding correlation between Care Home outbreaks and hospital admissions and community transmission.

5.18 While I was not involved in this work or the preparation of the report, the analysis identified a decline in the numbers of people discharged from hospitals, including to Care Homes, from mid-March 2020 onwards. This was reflective of an overall decline in Emergency Department attendances and hospital admissions at that point. The study examined two specific weeks in 2020 where the number of people discharged to Care Homes after an unscheduled hospital admission was slightly higher than the typical weekly average. Of the 465 patients discharged to Care Homes during these two weeks, five people (1.1%) tested positive within two weeks of discharge and 460 (98.9%) did not. Within the period examined, this did not support a hypothesis that this group of people was a substantial cause of Covid-19 outbreaks in Care Homes. I have addressed this in my consideration of lessons learned at the end of this statement.

5.19 The findings from the report and the early findings from a similar study in Wales were also reflected in a paper from the Health Minister to the NI

Executive dated 21 October 2020 [MMcB6/055 - see INQ000269016]. Decisions with respect to hospital discharge, which is a matter for clinicians, can be a very complex and challenging area. It is undoubtedly the case that discharge decisions were even more complex during the initial weeks and months of the pandemic when testing capacity was limited. This limitation in testing further increased the risk of exposure to infection of those clinically well enough to be discharged who remained in hospital longer than was necessary. The report published in November 2020 found no evidence to support a view that Ministerial or Departmental communications changed clinicians' discharge decision-making during the first pandemic surge, including decisions to discharge people to Care Homes. The review was an important additional piece of work to help further inform the Department's learning and understanding of Covid-19 and its spread.

5.20 The Vivaldi 1: Covid-19 Care Homes study report published on 3 July 2020 examined Covid-19 infections in 9,081 Care Homes in England (all with responsibility for providing dementia care or care for older residents (aged 65 years and over), and survey results of managers of those Care Homes; 5,126 Care Homes responded to the survey. It produced a number of conclusions in relation to risk factors for infection in residents and staff.

5.21 The Vivaldi study's suggestion that Care Home staff were more likely to transmit infections to residents, than vice versa, contributed to the evidence to appropriately inform the proposed testing approach for Care Homes which did not have a Covid-19 outbreak. More detail on this is provided at paragraphs 7.20 and 7.21. The Department's initial testing proposal had suggested monthly Covid-19 testing of residents and staff in Care Homes without a Covid-19 outbreak [MMcB6/056 - see INQ000346702]. Taking the Vivaldi findings into consideration, the

Department subsequently adopted a more frequent testing approach, with Care Home staff advised to test for Covid-19 every 14 days rather than monthly [MMcB6/057 - see INQ000346703]. This rolling programme of regular Polymerase Chain Reaction (PCR) testing started on 3 August 2020. More information on this is available at paragraph 8.25.

6 Management of the Pandemic

Strategic Intelligence Group

6.1 In the week prior to the CSA's return on 23 March 2020, I verbally agreed with him key priority areas for action. I asked that he establish a NI Covid-19 modelling group as a priority. As described in paragraph 2.64 above, I also agreed a proposal by the CSA to establish a NI Group specifically to focus on scientific evidence (SIG). There had not initially been any independent group of scientific experts to consider papers and outputs from SAGE and its subgroups or other scientific papers and reports from an NI perspective and to inform scientific and medical advice to the Health Minister and the NI Executive. From January to the end of March 2020, the emerging scientific evidence and the recommendations of SAGE were fully considered by both DCMOs, my Senior Medical Officers and myself and informed our professional advice to policy teams and the Health Minister with relevant emerging information being relayed to colleagues in the PHA and the HSCB during interactions and meetings.

6.2 SIG was an additional mechanism to consider the increasingly complex and significant volume of emergent scientific evidence. Chaired by the CSA, the first meeting of this group took place on 27 April 2020 [MMcB6/022 - see INQ000103642]. SIG included representation from the PHA, QUB, Ulster University and Cambridge University as well as the

Department, from a range of medical, scientific and other disciplines. The group met regularly and provided advice throughout the pandemic.

6.3 As outlined at paragraphs 2.60 and 2.61 above, given its relatively small size, NI does not have its own equivalent of SAGE and relies on the independent scientific advice provided by the UK remit of the group. This was the case throughout the pandemic, and in particular during its early months. The role and membership of SAGE has previously been addressed in paragraphs 122 to 133 of my written statement [MMcB6/058 - see INQ000421704] and in oral evidence to Module 2C of the Inquiry. NI does not have the capacity to fully replicate the role of SAGE, nor would it be scientifically or technically feasible, nor operationally warranted, to duplicate their work. In general, NI was very well connected to UK scientific advisory structures and fully participated in discussions throughout the pandemic, benefitting significantly from this, and it was not immediately felt to be necessary to establish local NI arrangements to further review scientific evidence in addition to advice from SAGE. From late March onwards, on his return to work following an unplanned absence, the CSA (or occasionally the deputy CSA) attended SAGE as a participant. Prior to that I was the nominated NI contact for SAGE in NI and attended meetings or, on occasions, one of my team observed on my behalf when I had other significant commitments. In the absence of NI attendance at some meetings, summaries of SAGE views and discussions, in the form of minutes, were regularly received and reviewed by the DCMOs and me (from the 3rd SAGE meeting onwards) and were widely circulated within the Department.

6.4 All SAGE advice and recommendations were reflected in oral briefings to the Health Minister and / or other NI Executive Ministers. In addition, as previously described in paragraph 2.61, from the 24 January 2020 there were regular 4 UK CMO calls to discuss Covid-19 at which there was full

information sharing and discussion on key emerging information, including consideration and recommendations from SAGE. I do not believe that the earlier establishment of the SIG would have materially impacted on the advice provided to the Health Minister or to the NI Executive. Given the increasing volume and complex of scientific and technical advice when established, SIG was of significant benefit and helped reduce the demands on the DCMOs, SMOs and me in reviewing the scientific evidence and provided dedicated additional capacity to do.

6.5 The Department's Chief Statistician, both DCMOs and the DPH in the PHA were members and attended meetings of SIG. As indicated in the M2C-IYO-001 statement, at paragraph 48 [MMcB6/059 - see INQ000409589], and in M02C-CMO-002 paragraph 142 to 143 [MMcB6/058 - see INQ000421704], the main role of SIG was to provide scientific advice to myself and the CSA to inform the advice which we then provided to the Health Minister and the NI Executive. SIG considered a wide range of evidence including many SAGE papers, and reports and evidence from a variety of other sources. SIG members were invited to table papers or reports for discussion when they considered these to be relevant or informative. Potential advice to Ministers was, in many cases, discussed with SIG members to seek their views. In general, SIG advice aligned closely with advice emanating from SAGE and there was no significant divergence between SIG's advice and SAGE's advice that impacted on the adult social care sector. In addition, the advice took account of the somewhat different progression of the pandemic in NI and also the potential impact of specific cultural and geographical features of NI, including the progression of the pandemic and relevant policy decisions in the RoI. One of the main roles of SIG was to ensure that evidence was interpreted in the specific context of NI - in this respect it compensated for the fact that most SAGE advice was generated mainly in the context of the situation in England / GB. During any future pandemic

or health emergency, it would be desirable, in my view, to stand up SIG or a similar body at an earlier stage to serve a similar function. This would ensure that, at the earliest possible stage, scientific advice emerging from SAGE or other bodies could be considered and interpreted in the context of any relevant NI specific factors. SIG was focused on the health impacts of the pandemic; as I have indicated elsewhere, in my professional view, it would also be desirable in addition to have a cross-government scientific / technical advisory group which would seek to integrate health advice with other considerations (educational, economic and social). It would also be, in my view, preferable to have representatives from the devolved administrations participating fully in SAGE meetings as soon as SAGE is stood up in an emergency.

6.6 SIG considered relevant SAGE papers and other scientific papers and research studies of direct relevance to the care sector including Care Homes. The advice provided by the CSA and myself to the Health Minister and the NI Executive took account of discussions at SIG and was based on the totality of the evidence available to us at any given time from the full range of sources previously described. It is, therefore, not possible to give specific examples of how the work of SIG informed or impacted upon the advice the CSA and I provided during the pandemic as it was the summation of all the evidence, its consideration and discussion, which informed the professional and technical advice provided to policy colleagues in SSPG by CMOG, the DCMO, the CSA and me. This evidence also informed discussions and was relayed in advice to policy colleagues during or following meetings of the Testing in Care Homes – Task and Finish Group.

6.7 By way of a specific example relevant to the Care Home sector of how SIG informed the advice provided to policy and professional colleagues overseeing management of the pandemic, on 14 May 2020 SIG

considered a Care Home paper that examined how best to address outbreaks in Care Homes, noting that the data was from England and Scotland [MMcB6/060 – see INQ000422018]. The note of the meeting [MMcB6/061 - INQ000347377] summarises the discussions which I have reflected here to assist the Inquiry. Three of the questions considered in the paper addressed issues that were considered to be potentially of relevance to NI.

6.8 On the issue of transmission mechanisms between and within Care Homes there was a sense that NI was performing relatively well in this area, probably due in part to its integrated health and care system and the small number and size of Care Homes.

6.9 On the issue of swabbing and testing, while there was an aspiration to ramp up testing in the NI Care Home sector, it was noted that universal testing was not expected to be possible given the numbers of residents / staff involved and the demand for testing in other sectors. NI was already testing more people per 100,000 than any other part of the UK and had expanded Care Home testing ahead of the other jurisdictions. It was noted that the National Testing Programme would be providing some support to the HSC in this area, including four mobile testing units and the citizens' portal but, in the immediate term, there would not be sufficient capacity to carry out Care Home testing on a weekly basis as suggested in the paper. The top priorities for testing at this stage were any home experiencing two or more cases in a 14-day period which would require everyone in the home to be tested and any home where one person was symptomatic, in which case they alone were tested. Some Trust areas were experiencing lower outbreaks in Care Homes than others, the reasons for which were not yet fully understood. The PHA had been asked to carry out anticipatory testing in homes that had not experienced an outbreak, primarily on staff, with the aim of keeping them infection-free.

There followed some discussion of the "Safe at Home" model where Care Home staff would 'live-in'. At the time, this was currently being finalised and was expected to be issued to the Care Home sector as a model they might like to follow.

6.10 The paper also considered the impact of three approaches to risk:

- Non-rotation of care workers – SIG noted that the RQIA inspection team had been re-purposed early in the pandemic to become a support team across the Care Home / domiciliary care sector. Single points of contact had been implemented in each Trust, and the support provided by Trusts had included supplying staff to Care Homes and tracking / limiting staff movement between care facilities.

- Cohorting of residents – while most Care Home residents occupied single rooms, it was noted that it was often difficult to cohort in Care Home settings.

- Handwashing / surface cleaning – there were challenges in this area and the RQIA inspection team, which included infection control expertise, would be providing valuable support to Care Homes, as would Trust staff.

6.11 The CSA would have provided relevant papers to the DCMO and information and discussions from SIG would have been shared directly with policy colleagues with responsibility for the Care Home sector either at the time or through the Testing in Care Homes – Task and Finish Group. All members of SIG including the PHA would have received copies of relevant papers to inform their professional advice to HSCB colleagues.

Adult Social Care Governance - Surge Planning Covid-19 Working Group

6.12 As described earlier at paragraph 2.25, as part of business continuity arrangements new structures were established by the Department in October 2020 to manage further Covid-19 surges, and a number of integrated policy and operations cells were stood up. These involved staff from the Department, the HSCB and the PHA to facilitate collaborative working and this included a surge cell for adult social care [MMcB6/062 - see INQ000137359]. I understand the remit of this cell included the co-ordination of Covid-19 activity across adult social care, including Care Homes, domiciliary care, supported living and all learning disability services. It also considered the social care workforce, service resilience, admission and discharge from social care, communications, and safeguarding. The cell was co-chaired by the Department's CSWO and CNO and included senior members from the then HSCB and the PHA. The HSCB and PHA, as members of this group, provided professional and operational advice on the care sector through the then Director of Social Services in the HSCB, and health protection and specifically IPC advice was provided as appropriate by the PHA. While, as I recall, the DCMO had been invited to be a member of this group this was not possible with concurrent other demands. While CMOG was not directly represented on the group, the Testing in Care Homes - Task and Finish Group continued to provide professional and technical advice to Departmental policy colleagues. It is my view that, given our other significant commitments, the membership and representation on the group was appropriate with additional professional and technical advice available from the Testing in Care Homes – Task and Finish Group or separately as required.

<u>The Long Term Care Policy Network (LTCPN)</u>

6.13 The Health Minister submitted a paper to the NI Executive in July 2020 [MMcB6/063 – see INQ000103717] which set out a timeline of the range

of actions taken to respond to the Covid-19 pandemic in Care Homes and provided information on emerging best practice measures to respond to Covid-19 in Care Homes. In keeping with the extant policy and professional responsibilities for the social care sector and Care Homes, this paper was prepared by the then Director of Mental Health, Disability and Older People and the paper was approved by the Health Minister [MMcB6/064 – see INQ000577501; MMcB6/064a – see INQ000577502; MMcB6/063- see INQ000103717; MMcB6/064b – see INQ000577507; MMcB6/064c - see INQ000577508 and MMcB6/065 - see INQ000577506]. This included the advice and guidance provided by the British Geriatrics Society (BGS) to help Care Home staff support residents during the pandemic and which made a number of recommendations which are in place in NI. For example, BGS recommended that all staff working with Care Home residents should recognise that symptoms among this group can be atypical and should measure and monitor vital signs in order to help recognise deterioration in residents. This point was formally communicated to Care Home providers in NI by way of regional guidance and a letter was issued by the CSWO [MMcB6/066 – see INQ000577510, MMcB6/067 – see INQ000256636, MMcB6/068 – see INQ000353600 and MMcB6/034 - see INQ000120717]. Additional funding was made available to provide for specialist equipment to measure and monitor residents' vital signs and symptoms.

6.14 As described at paragraph 760 of my second witness statement to Module 2C [MMcB6/058 - see INQ000421704], a further, more detailed briefing paper was prepared by SSPG colleagues in the Department for the NI Executive meeting of 6 August titled "2020 E (20) 187 (C) Executive COVID-19 Action Plan: Quantitative Information on the Actions Taken within Care Homes to reduce Infection and their Effect". This paper identified and provided a useful summary of the actions that had been taken in relation to Care Homes [MMcB6/069 - see INQ000208770]. The

paper highlights my role as CMO and that of CMOG with the establishment of the Departmental Covid-19 Testing in Care Homes – Task and Finish Group [MMcB6/024 - see INQ000137355]. As described at paragraph 2.65, I established this group with the agreement of the Health Minister, and the group was subsequently chaired by the DCMO. The group met for the first time on 8 May 2020, with regular meetings scheduled thereafter to provide direction and guidance to support the development and implementation of Covid-19 testing arrangements within Care Homes. The group also provided advice more generally on testing to social care policy leads within the Department and included key participation from the Department, EAG-T, the PHA and the RQIA. As previously indicated, policy and professional colleagues within SSPG and the OSS, including the CSWO and CNO, supported by the Director of Social Work in the HSCB and PHA provided advice to the Health Minister on policy and operational management matters with respect to the care sector including Care Homes and would have considered examples of best practice across the UK and internationally on the management of the care sector during the relevant period. Specific examples are described later in my statement at paragraphs 10.4 and 7.10 with reference to the "Care Partner Scheme" and the "Safe at Home" initiative.

6.15 The Long Term Care Policy Network (LTCPN) also published a paper describing measures that have been put in place in fifteen international countries. The aim of the LTCPN paper was to provide a compilation and summary list of actions that have been reported as being taken in each country. It did not provide a measurement of the standardisation of these measures across countries or the effectiveness of these actions. I understand that the then CSWO or members of his team may have attended meetings of this network and further details are provided in the Department's statement to Module 6 of the Inquiry.

6.16 While I did not attend meetings of this network or consider any analysis provided to the CSWO as professional and policy lead, it is my understanding in preparation for the Inquiry that comparative benchmarking indicated that NI had in place most measures which were being adopted in other international countries. For example, NI had rapid response teams to support Care Homes, visiting restrictions, provision of PPE, use of telehealth, and redeployment of HSC staff. It should be noted that there were international differences across countries in the implementation of these measures. As described as paragraph 6.5, evidence from scientific papers and studies in relation to the effectiveness of measures to reduce the introduction of Covid-19 into and transmission within Care Homes were considered at meetings of SIG and shared with policy colleagues and were also available to the PHA as members of SIG.

Technical Report on the Covid-19 Pandemic in the UK

6.17 As described in the Technical Report on the Covid-19 Pandemic in the UK [MMcB6/001 - see INQ000203933] dated 1 December 2022 to which I contributed, at an early stage in the pandemic there was an awareness of the risk posed to those living in Care Homes from Covid-19 and that increased transmission in Care Homes followed increased levels of community transmission, although it was only as knowledge on the infectiousness of the virus and modes of transmission emerged that the fully potential impact of those risks become better understood.

6.18 Throughout the pandemic, the primary aim of the advice that I provided to the Health Minister, Permanent Secretary and Departmental policy leads

was to inform and contribute to actions that were taken by respective policy and operational teams to mitigate the risks to those who were most vulnerable including people in Care Homes with the overall aim of preventing severe disease and death and to prevent the health and social care service being overwhelmed. My knowledge of the vulnerability of people in Care Homes and the association with high levels of community transmission was reflected in the both the advice I provided and the actions that I took in overseeing key elements of the policy response and implementation in Care Homes.

6.19 The epidemiological relationship between increased community transmission, followed a week to ten days later by increased hospital admissions and hospital outbreaks, with high Care Home transmission and increased number of outbreaks following around two weeks later became increasingly evident during the first wave of the pandemic between March and July 2020. This association had previously been observed in epidemics of seasonal influenza, with evidence of infection being introduced from the community because of footfall into Care Homes for a variety of reasons. The association of infection rates in Care Homes and the close relationship to community prevalence was also observed in regional variation in transmission rates in Care Homes in NI with larger Care Homes disproportionately affected given the greater number of opportunities for the virus to gain entry.

6.20 My awareness of the potential association and the subsequent observation of the association with Covid-19 outbreaks in Care Homes informed the advice that I provided which had two main purposes. The first was to inform the action of policy colleagues in the Department and the wider HSC in their preparation and response to mitigate the risks across health and social care including in the care sector, and the second was to inform the NI Executive's understanding of the direct link between

high levels of community transmission, subsequent hospital pressures and outbreaks and high transmission in Care Homes. This epidemiologic relationship was significant in that it informed the advice that I provided to NI Executive Ministers and the CSA and I used this repeatedly in NI Executive papers and verbal briefing to the NI Executive to highlight that the most effective approach to protect those people most at risk, including those in Care Homes, was to reduce levels of wider community transmission through the use of population based NPIs. Through verbal and written advice provided to the NI Executive I sought to ensure that this informed policy decisions by the NI Executive regarding the overall management of the pandemic. I believe this association was understood by NI Executive Ministers.

6.21 Arrangements to protect those living and working in Care Homes were frequently discussed at NI Executive meetings, including consideration of the details of the number of outbreaks, the roll out of the testing programme in Care Homes, and supply of PPE wear. The NI Executive Committee meeting on 8 April 2020 shows that NI Executive Ministers were aware of testing in Care Homes and the need to prioritise it [MMcB6/070 - see INQ000065725] and there was further NI Executive discussion on 15 April 2020 [MMcB6/071 - see INQ000065735]. Again, on 20 April 2020 the NI Executive discussed PPE and testing in Care Homes [MMcB6/072 - see INQ000065691]. On 27 April 2020 and 11 May 2020 Care Homes were also discussed. Some of these discussions are covered in more detail in paragraphs 8.42 - 8.46 below. Discussions at the NI Executive included regular updates by the Health Minister on the number of outbreaks in Care Homes, operational pressures and the support provided, with the CSA and I responding to provide further detail as required. During these discussions the association between high community transmission being followed around 2 weeks later by increased transmission in Care Homes was repeatedly highlighted in verbal updates

and briefings to the NI Executive. It was referenced in the weekly R paper and presentation and was reflected in the advice that the CSA and I provided to the NI Executive that the most effective way to reduce outbreaks in Care Homes was to reduce community transmission. Again, in my view, this was understood by NI Executive Ministers.

6.22 Some specific examples of the advice I provided and how I sought to inform policy and operational decisions are outlined earlier in the statement and I have highlighted some of these in further detail. As described at paragraph 4.3, a briefing paper on Covid-19 was provided by the Director of Population Health within CMOG to Departmental policy leads on 5 February 2020 to inform appropriate action and submissions by respective policy colleagues including SSPG and HPG and to request that they consider what preparations were required. On the 11 February 2020, as described at paragraphs 4.9 – 4.12, I requested a meeting with the then CEO of the HSCB and PHA and respective senior teams to provide advice on the potential impact based on what was then known and to commission surge plans for health and social care including the care sector. On receipt, I requested further work to independently quality assure these plans.

6.23 As outlined at paragraph 2.23, I called an extraordinary TMG meeting on 4 March 2020 at which I again updated Departmental policy and professional leads and indicated that the Health Gold Strategic Cell now needed to be activated. The first meeting of the Strategic Cell took place on the 9 March 2020 and included a surge policy cell. A dedicated social care surge cell was later established by professional and policy colleagues within SSPG and this continued to provide regular updates to the Strategic Cell. The detailed policy preparation and oversight of the operational response was the responsibility of individual policy cells and chairs working with Health Silver with the overall strategic aim of reducing

community transmission, preventing severe disease and death and preventing the health service being overwhelmed.

6.24 Normally the provision of care and IPC are primarily operational matters for the Care Home sector as providers and HSC Trusts as commissioners of that care, with support from the HSCB and PHA. However, given the vulnerability of people in Care Homes and in light of the advice and anticipated risks, the Department took a significant role in a range of issues such as: the provision of guidance; supply of PPE; enhanced training for Care Home staff; visiting in Care Homes; and subsequently outreach clinical support which other policy and professional colleagues in the Department, PHA and HSCB will be better able to provide information on.

6.25 As described in paragraph 2.43, additional training and support was provided to the Care Home sector from organisations including the HSC Trusts, the PHA supported by RQIA, the Clinical Education Centre, NISCC, and the work of the CNO and the CSWO in this regard. Although not directly involved, I was fully aware of and supportive of this work in my role as chair of the Strategic Cell. As described previously, the training and support was wide ranging and covered a range of issues including: the effective use of personal protective equipment (PPE); infection prevention control (IPC) measures; staff self-testing; and the testing of residents.

6.26 Covid-19 testing was an important element of the response to protect people living in and working in Care Homes and a key priority of the Health Minister. The Testing in Care Homes - Task and Finish Group ensured a coordinated regional approach which provided direction and guidance to support the development and implementation of Covid-19

testing arrangements within Care Homes as soon as testing capacity allowed.

6.27 In addition to the implementation of the Care Home testing programme and testing in the wider adult social care sector, the other significant aspects of the care sector response which I had policy responsibility for and coordinated the overall implementation of, was the roll out of the vaccination programme as covered in my M4/CMONI/01 statement [MMcB6/073 - see INQ000474249] working with the DCMO as Senior Responsible Officer (SRO), policy and professional colleagues within the Department, PHA and the HSCB. As in other parts of the UK and the RoI, NI prioritised vaccination of vulnerable people in Care Homes. Vaccination in Care Homes coincided with the first day of the programme on 8 December 2020. By 26 February 2021, all Care Home residents and staff had been offered 2 vaccine doses.

Vulnerability and Risk in Care Homes

6.28 Throughout the first wave of the pandemic, the scientific understanding of the virus, including its modes of transmission, infectiousness, the role of asymptomatic infection, disease severity and an understanding of those most at most risk of severe disease accumulated over time. I have addressed the understanding of these factors, and the risks posed, more fully in paragraphs 59 – 74 of my statement to Module 3 of the Inquiry and I have not sought to repeat here in this statement [MMcB6/003 - see INQ000421784]. The developing understanding of the virus and of the increased risk of transmission in certain environments, including in Care Homes, is comprehensively summarised in the CMOs' Technical report on

the Covid-19 pandemic in the UK, Chapter 1, and the associated papers and studies referenced [MMcB6/001 - see INQ000203933] to which I contributed, and I am a co-author. Chapter 8.2 of the report considers the experience and learning in the Care Home sector during the pandemic. As is indicated in the report, Care Homes were a significantly higher risk setting for Covid-19 because so much of the vulnerability and risk of severe disease was in older people and the virus spread occurred most effectively in indoor environments. This was not always the case in previous pandemics and epidemics and could be different in any future pandemic. The experience and learning from Covid-19 will be most directly relevant in epidemics or pandemics where older people are particularly at risk, and where respiratory infection and close contact are important routes of transmission. In addition, as with many other infectious diseases, the clinical presentation of Covid-19 was often atypical in older people and not necessarily with the more commonly recognised symptoms. Consequently, there needed to a high degree of vigilance and a lower threshold for investigation of older people who showed any deterioration. As previously described, regional guidance on this was issued by the CSWO.

6.29 As the risks to those living in Care Homes became better understood, including: the proportion of people with asymptomatic infection; that asymptomatic transmission could occur; and the relative contribution of asymptomatic transmission in wider transmission of the virus, the arrangements to protect those living and working in Care Homes was frequently discussed at NI Executive meetings and included consideration by policy and professional teams of the testing programme in Care Homes, details of the number of outbreaks, and the supply of PPE wear. I did not provide professional advice to the Health Minister on PPE or visiting although I was supportive of the work of professional and policy colleagues as described in the paragraphs below.

6.30 As has been previously described at paragraphs 4.14 and 6.24, normally the provision of care and IPC are primarily operational matters for the Care Home sector as providers, and for HSC Trusts as commissioners of that care, with support from the PHA and then HSCB. However, professional and policy colleagues in the Department, including the CSWO and SSPG, the CNO and CNOG, the CSA and myself, the Director of Social Services and his team within the HSCB and health protection colleagues within the PHA, were aware of the existing vulnerability of people in Care Homes and the increased risks posed by asymptomatic infection and this informed the advice from CMOG and myself on collective actions that were required and the steps to be taken across a number of areas to mitigate those risks in so far as was possible. The CSA and I provided the Health Minister and the NI Executive with public health and scientific advice which was mainly at the population level and aimed at reducing community transmission. However, there was an undoubted consequential and beneficial impact in reducing community prevalence and outbreaks in Care Homes, given the relationship between community transmission and Care Home outbreaks. The CSWO and CNO, working with their respective teams with expert IPC advice being provided by the PHA, provided more specific targeted advice to the residential and nursing home and domiciliary care sector on a range of issues such as: the provision of guidance; supply of PPE; enhanced training for staff in the IPC; visiting in Care Homes; and subsequently outreach multiprofessional clinical support to residential and Care Homes. The advice provided was revised and updated as new evidence emerged and additional professional and technical advice was provided by the Testing in Care Homes – Task and Finish Group on specific aspects when requested.

Understanding of transmission of Covid-19 and role of asymptomatic transmission

6.31 At the start of the pandemic, in January and February 2020, the initial understanding of the causative virus Covid-19 was very limited, and the initial assessment of risk and transmission was, therefore, largely based upon what was known about similar coronaviruses. While asymptomatic infection and transmission were considered possible, existing knowledge of related human coronaviruses suggested the extent of this was not understood. Work was, however, needed to clarify the proportion of infections that were asymptomatic and the role of asymptomatic transmission. It should be noted that asymptomatic infection does not necessarily lead to asymptomatic transmission, though it is a prerequisite, and this was not always well understood in some public reporting.

6.32 Asymptomatic infection had been discussed as a possibility by SAGE on 28 January 2020, but it was not until 13 May 2020 that asymptomatic transmission was confirmed by NERVTAG as occurring and this was discussed by SAGE on 14 May 2020 [MMcB6/074 - see INQ000422033] and by SIG on the 18 May 2020 [MMcB6/075 – see INQ000422038]. Further research studies were needed to clarify the proportion of infections that were asymptomatic and the role that asymptomatic transmission played.

6.33 Transmission of infection from asymptomatic cases can be difficult to control, particularly in higher risk environments such as residential and nursing homes given the underlying vulnerability of the individuals and close personal care required daily. The infectious timeline is also difficult to establish in the absence of symptoms as a marker of infection or infectiousness, adding complexity to disease control. To detect asymptomatic cases, to establish the proportion of such cases, and to

determine whether asymptomatic infection was occurring requires testing to be available, and testing capacity was significantly constrained in the initial phase of the pandemic. This therefore contributed to the delay in estimating the extent of asymptomatic cases. Research reviews and analysis that considered many study types, including case and cluster reports, and outbreaks, were helpful in highlighting settings which posed most risk. Throughout the pandemic the advice that the CSA and I provided to Ministers continued to be informed by the assessment and recommendations of expert groups such as NERVTAG, SAGE and other advisory groups such as Joint Committee on Vaccination and Immunisation (JCVI).

6.34 Knowing the proportion of infections that were asymptomatic was important for case detection strategies and determining the infection fatality rate. Understanding the role of asymptomatic transmission was important for identifying which public health measures were necessary to bring R below 1. Asymptomatic cases cannot be detected in the absence of testing, and as indicated, the paucity of tests was a constraint globally and in the UK in the initial phase of the pandemic, and this delayed the estimation of asymptomatic cases and active case finding to reduce transmission and control outbreaks in residential and nursing homes in particular and in other health and social care settings.

6.35 Early case and cluster reports raised the possibility of asymptomatic infection and transmission but often with poor differentiation between asymptomatic and pre-symptomatic transmission. In the first few months of the pandemic, robust data on asymptomatic infections and whether they may be infectious to others was not available and estimates of the proportion of asymptomatic individuals varied widely. After a few months, studies of outbreaks in closed environments and facilities provided early estimates of the proportion of PCR-confirmed asymptomatic cases.

However, many of these studies may have included some pre-symptomatic cases. Over time, evidence of positive tests in asymptomatic individuals increased with more reliable data on asymptomatic transmission. With respect to timelines and changes in understanding of the transmission of the virus by mid-2020, estimates of the asymptomatic proportion in closed and or institutional facilities and settings had been published and the first evidence that infectious virus could be recovered from asymptomatic individuals emerged [see footnotes 244, 245, 246, 251, 252, and 253 of MMcB6/001 - see INQ000203933].

6.36 Early review studies of the number of people with asymptomatic infection followed, with initially wide variation in the estimates of asymptomatic infection. Studies that were able to differentiate between pre-symptomatic and asymptomatic cases provided lower estimates [footnotes 238 and 242 of MMcB6/001 - see INQ000203933]. It was, however, not until large random sample swabbing studies, such as Real-time Assessment of Community Transmission (REACT) and those led by the Office for National Statistics (ONS), that robust regular estimates were established of the proportion of people with asymptomatic infection. By mid to late 2020, studies of household transmission were in place and were able to identify asymptomatic infections and transmission and the viral load dynamics (how much virus was being carried and shed) in asymptomatic individuals had been characterised [footnotes 243, 254, and 257 of MMcB6/001 - see INQ000203933]. The fact that asymptomatic transmission occurred was confirmed well in advance of establishing what proportion of transmission was from asymptomatic people and whether, if all symptomatic transmission ceased due to case isolation, asymptomatic transmission alone was capable of sustaining the reproduction number (R) above 1.

Covid-19 Testing in Care Homes

6.37 With the emerging understanding of the risk and consequences associated with asymptomatic transmission, in NI regular testing of asymptomatic patient-facing staff became an essential element of our strategy to reduce transmission of Covid-19 in the community and in particular to mitigate the risk of healthcare acquired Covid-19 infection, including in the context of residential and nursing homes and domiciliary care.

6.38 The testing of health and social care workers to identify asymptomatic infection was to protect patients primarily, but also reduced the risk of staff to staff transmission in the workplace causing significant workplace outbreaks, with the associate impacts on patients and Care Home residents at greater risk of severe disease and to reduce the impact of staff absence on care and support.

6.39 As described at paragraph 6.28 and 8.41, there was an awareness of the risk posed to those living in Care Homes from Covid-19 at an early stage although, as knowledge on transmission and particularly asymptomatic transmission emerged, the risks and challenges in protecting those in Care Homes became better understood. As such, the arrangements to protect those living and working in Care Homes was frequently discussed at NI Executive meetings. This included consideration of the testing programme in Care Homes, details of the number of outbreaks and supply of PPE wear. This is covered in more detail at paragraphs 8.41 to 8.46.

6.40 The PHA had been capturing data on Covid-19 outbreaks notified to them from when the disease was first reported in mid-March 2020. As outlined earlier at paragraph 6.14, a detailed briefing paper was prepared by the Department for the NI Executive meeting of 6 August 2020 titled "2020 E (20) 187 (C) Executive COVID-19 Action Plan: Quantitative Information on

the Actions Taken within Care Homes to reduce Infection and their Effect". This identified the actions that had been taken in relation to Care Homes [MMcB6/069 - see INQ000208770] and provides a useful summary. The paper highlights my role as CMO with the establishment of the Testing in Care Homes – Task and Finish Group [MMcB6/024 - see INQ000137355] as outlined above at paragraph 2.41 which had an important role in supporting the development and implementation of Covid-19 testing arrangements within Care Homes as rapidly as possible given the evidence of risks associated with asymptomatic transmission.

6.41 Care Homes are distinct from other care settings due to their enclosed environment and the specific and increased risk profile of residents as a result of the strong age-related association with poor outcomes, compounded by underlying health conditions frequently seen in the older population. These underlying factors and risks presented specific challenges particularly in the context of asymptomatic transmission. Protecting residents and staff in Care Homes was a key priority for the Department throughout the pandemic. As I recall, this informed my advice to the Health Minister of the additional risks presented by asymptomatic infection and the Health Minister was clear that the rapid expansion of testing was a priority. I recall NI moved before other parts of the UK to increase Covid-19 testing across its Care Homes [MMcB6/076 - see INQ000425655]. For example, NI moved to testing of all symptomatic Care Home staff on 28 March 2020, while England announced symptomatic testing for all social care workers on 15 April 2020 and Wales began symptomatic testing on 18 April 2020. Testing for Covid-19 was part of a package of comprehensive measures for adult Care Homes in NI that was recommended and advised by the Department from early in the pandemic informed by my advice, with the support of the EAG-T and the Testing in Care Homes – Task and Finish Group. Care Home testing capacity was a significant constraint during the first wave of the pandemic,

and I believe all of us providing advice to the Health Minister would have preferred to be able to expand testing in Care Homes earlier and more rapidly. More information on the testing programme in Care Homes is provided in section 8 on Testing.

6.42 Testing in Care Homes was an essential element of understanding rates of infection and transmission. Data from testing was an important input in relation to modelling the progress of the pandemic. In paragraph 2.66 above, I have explained that scientific and public health evidence was crucial to inform the professional advice that I provided, including in relation to the care sector. At paragraphs 2.60 to 2.65, I have provided detail on the sources of evidence and modelling available to me, including SAGE, NERVTAG, SIG, NI Modelling Group, EAG -T, Testing in Care Homes - Task and Finish Group and the Nosocomial Support Cell. I also had access to evidence on the effectiveness of NPIs and behavioural interventions etc.

6.43 Modelling is an important tool to support understanding of the trajectory of the pandemic at a given point in time and to inform understanding and awareness of the potential impacts of different policy choices and options. However, a model is only as good as the data underpinning it and, as noted earlier, it is important to ensure that data collection processes are timely and efficient and that agreed definitions are in place. Over the course of the pandemic, the availability of surveillance data evolved, and included data sourced from the Covid-19 dashboard (please see paragraph 6.50 below), the UK wide ONS Survey, and Waste Water Surveillance data.

6.44 As described at paragraph 2.53, information about the transmission of Covid-19 in Care Homes, including deaths, was reported to and collated by the PHA and RQIA. The Department, through SSPG and OSS, also

received a daily return from RQIA which provided data on Care Homes. This included individual Care Home information on occupancy levels, Covid-19 outbreak status, PPE, workforce and testing [MMcB6/077 - see INQ000503354; MMcB6/078 - see INQ000503355 and MMcB6/079- see INQ000503356].

6.45 As outlined above in paragraph 6.35, in the first few months of the pandemic early mortality data and outbreak studies indicated that enclosed settings for vulnerable individuals such as Care Homes, care settings for those with learning disabilities and domiciliary care settings, were higher risk environments. Weekly Care Home outbreak reports were produced by the PHA, and a weekly dashboard was produced by RQIA which was shared with SSPG and subsequently shared within the Department. The PHA also investigated and advised on response measures in relation to individual outbreaks. Information about the number of outbreaks in Care Homes and the extent of outbreaks formed part of PHA reporting to the Department and was discussed at meetings at which I was present. The NI Modelling Group did not raise any specific concerns about the level of knowledge available from the Care Home sector for their purposes and I did not ask for nor receive any separate data in relation to Care Home transmission or outbreaks. My view at the time was, and remains, that each Care Home constituted its own microenvironment, and that once infection was introduced into a Care Home, the extent to which it spread would be primarily related to a range of local factors such as the effectiveness of IPC measures in that Care Home, the number of residents and staff in the home, the extent of movement of staff, visitors and patients, and the rate of transmission in the broader community. I did not believe that separate modelling of the totality of the Care Home sector would be meaningful, and I am not aware that any such modelling took place in NI or elsewhere.

6.46 The keys to protecting the Care Home sector were to reduce community transmission, implement effective IPC measures within the sector, and minimise uncontrolled movements in and out of individual Care Homes. Testing played an increasingly important role as it became more available later in the pandemic, as did vaccination, with the Care Home sector being prioritised for both within available capacity. With the benefit of hindsight, I think that more could have been done to protect the Care Home sector, and this is covered in the UK CMOs Technical report. I have summarised the learning from this pandemic in paragraph 7.24 which specifically references the UK CMOs Technical Report [MMcB6/001 - see INQ000203933] and I will return to this again in paragraph 18.8 on learning during the relevant period.

6.47 The report 'Rapid analysis of the possible growth of respiratory outbreaks in Nursing and Residential Care Homes in Northern Ireland' [MMcB6/080 - see INQ000137411] dated April 2020 stated *"in summary, the modelling suggests that by the end of May 2020 we may have between 160 and 360 Nursing or Residential Care Home outbreaks of respiratory infection in Northern Ireland. It is reasonable to assume that most of these will be COVID-19, even where testing of cases is negative. We may see a rise from around three care/ nursing home outbreaks per day up to around 14 outbreaks a day by the end of May 2020."* From a review of contemporaneous emails, I can confirm that this report was shared with me by the then DPH on the 18 April 2020 and shared by the Director of Community Care in the HSCB with the CSWO [MMcB6/081 – see INQ000442885 and MMcB6/082 – see INQ000439599]. I believed at the time that this was a report prepared by the PHA for Health Silver to inform their operational coordination of the response in the Care Home sector.

6.48 From my further consideration of the report in preparation of this statement, it appears that this report was indeed prepared by the PHA for

the joint HSCB / PHA Health Silver and operational preparation and response in the Care Home sector. Colleagues in the PHA and the HSCB will therefore be better placed to advise on further action they took at that time. The paper outlines intensive action with respect to nursing and residential Care Homes and references extensive advice on IPC measures and the provision of PPE, including the provision of staff from HSC Trusts to Care Homes. The paper also indicates that that there was ongoing engagement between the HSCB and the PHA to consider Care Home outbreaks, that this matter would be discussed again at Health Silver, and that further meetings were being scheduled between representatives of the HSCB and PHA and Trust representatives, including Directors of Social Care and Nurse Directors. This was entirely consistent with what I would normally have expected the HSCB and PHA to be doing at that time, given the known risks in the Care Home sector and consistent with their extant roles and responsibilities at Health Silver.

6.49 To assist the Inquiry, I can confirm that the NI Modelling Group met on 24 April, 1 May and 16 May 2020. The then DPH, who was a member of the group, was invited but did not attend, although other PHA staff were present. While there is no record that Care Homes were specifically raised or discussed, Rt was estimated to be 0.75 – 0.8 at the 24 April 2020 meeting, and all epidemiological indicators were falling because of the then wider restrictions in place. From a data and modelling perspective, this provides the context as to why the modelling in the PHA report [MMcB6/080 - see INQ000137411] dated April 2020 would have been rejected and considered invalid at that time, as it assumes that the pandemic would continue to increase unabated up until the end of May 2020. The PHA modelling, therefore, relied on assumptions which did not take account of the impact of policy decisions and should be viewed in this context. In keeping with this, the number of Care Homes with Covid-19 outbreaks fell throughout the months of May and June 2020 to a very low

level, as recorded on the DoH Covid-19 dashboard, in marked contrast to the PHA modelling.

The Covid-19 Dashboard

6.50 Building on my learning from the 2009 H1N1 pandemic in relation to media reporting and the need for up-to-date data, with the agreement of the Health Minister, I commissioned work to develop a Covid-19 Public Information Dashboard to provide a common data source covering a wide range of data that was made publicly available. While I am uncertain as to the exact date of when I commissioned this work, I spoke with the Department's Chief Statistician on or before 17 March 2020 requesting his input into how we could serve information needs through summary dashboards [MMcB6/082a – see INQ000459840]. Between 24 March and 19 April 2020, the PHA published a daily bulletin which provided a summary of the information to date including the number of new cases, the number of tests reported and, in due course, the number of deaths. It was replaced by the Department's Dashboard on 19 April 2020 [MMcB6/083 - see INQ000130401]. In line with the NI Civil Service policy and practice, the Dashboard was designed to meet the requirements of the pillars of the Code of Practice for Statistics [MMcB6/084 - see INQ000092790] in terms of trustworthiness, quality and value. The Dashboard included NI wide summary information about the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19. Although the Dashboard was based on similar information published by other UK jurisdictions, the NI Dashboard included additional data about capacity and availability. The additional information provided on the NI Dashboard offered a comprehensive summary of bed occupancy, detailing both ICU and general hospital beds allocated to or occupied by Covid-19 patients, number of ventilated and non-ventilated patients, with all information presented at both the individual hospital level

and a view of overall hospital bed occupancy within NI. It helped to minimise multiple requests to the Department for the same information or briefings and avoided duplication. It was also central to public transparency and, in my view, helped engage the wider population in seeing and understanding the need for public health interventions and the restrictions and the difference they were making notwithstanding the significant consequences.

6.51 The Covid-19 Dashboard was the primary vehicle for the collation and dissemination of all official pandemic-related data and analysis. Several systems and processes were developed and utilised by the Department to collate the relevant data for this Dashboard. The Dashboard was produced using data collected or received into Departmental statisticians' Covid-19 Analytics and Modelling Platform (CAMP) [MMcB6/085 - see INQ000130403], which is an information source available for internal HSC users including detail and breakdowns of information. The then HSCB was tasked with developing a process specifically to collate Hospital Bed Occupancy data for Covid-confirmed and non-confirmed patients to help assess pressure on hospital services and this information was forwarded to the Department for publication on the Covid-19 Dashboard. To collect relevant and standardised data from the HSC Trusts, the HSCB and PHA, a Data Coordinating Group was established on 18 March 2020 in the Department and was chaired by the Principal Statistician in the Information and Analysis Directorate in the Department. Membership included Information Leads in the relevant organisations. A summary of the data items collected is set out in [MMcB6/086 - see INQ000400122]. This information was primarily used to create analyses and statistics for publication on the Department's Covid-19 Daily Dashboard of Statistics. In addition, the PHA continued to produce a range of public updates and reports including data on the operation of the Contact Tracing Service, data on clusters and outbreaks including outbreaks in Care Homes. The

Northern Ireland Statistics and Research Agency (NISRA) also produced a weekly bulletin that contained a breakdown of information in relation to deaths of Care Home residents [MMcB6/087 - see INQ000103711].

6.52 This composite information, in addition to modelling from the NI Modelling Group with respect to R and the trajectory of the pandemic, was available to the CSA and informed the advice we provided to the Health Minister and the NI Executive on interventions and measures needed to reduce community transmission, and to reduce the impact of the pandemic in the care sector. As identified in the UK CMO Technical report [Chapter 8.2 of MMcB6/001 - see INQ000203933] the first and second waves of the pandemic tragically had a profound impact on Care Home residents, with high rates of infection and large numbers of deaths.

6.53 For social care and Care Home providers and HSC Trusts who commissioned care, the care sector more generally, and Care Homes particularly, represented one of the most difficult and challenging areas in which to protect those who were vulnerable to the virus. Many of the individuals in Care Homes were at increased risk due to age and / or underlying health conditions and many required close personal care for the activities of daily life. It is recognised that the measures taken to reduce transmission, such as visiting restrictions, also had a profoundly negative impact on residents. This included increasing loneliness and isolation with increased stress and distress for residents, families and staff who had to manage residents dealing with the adverse health consequences of isolation and loneliness due to separation from family and friends, while also supporting relatives. While the consequences of isolation and loneliness particularly affected those in Care Homes, other groups such as the elderly, those receiving domiciliary care who were often housebound, and individuals with poor mental health before and during the pandemic were also negatively affected.

6.54 The commitment of care workers in Care Homes, and those who continued to provide domiciliary care to people in their own homes, was commendable and undoubtedly (as in all areas across health and social care) there will have been aspects of their experiences during the pandemic which were distressing and harrowing. Whilst I know that the Department and all provider organisations took steps to try to address the physical and mental health needs of these different groups, I fully recognise that whatever action was taken was unlikely to have ever been able to fully address the needs of everyone, or to mitigate the full impact on many of these vulnerable groups and their relatives. These are important considerations and areas which require further research and consideration of potential future adaptations and approaches which I shall return to later in the section on learning.

6.55 I was not the lead for the overall management of the care sector but my advice to, and briefings for, the Health Minister and the NI Executive were focused on the science in terms of the interventions and measures needed to reduce transmission and reduce the impact in the care sector. One of the most difficult and challenging aspects of protecting those most vulnerable in Care Homes was managing the adverse health consequences of isolation and loneliness due to separation from family and friends. Whilst this was a significant factor in the advice that I provided to the Health Minister, it was also one that all NI Executive Ministers had to consider in trying to achieve a balance between the health implications and advice and a wide range of other factors such as economic advice, financial considerations, impact on education, family life, and societal and cultural considerations. However, I am not aware of any occasion when the Health Minister did not follow the advice of myself and the CSA in respect of the care sector.

6.56 In Autumn 2020, as the pandemic progressed, I proposed and agreed with the CEO of the PHA that Dr Ruth Hussey, former CMO for Wales, would be jointly commissioned by the Department and the PHA to carry out a rapid, focused external review of the PHA's requirements to respond to the Covid-19 pandemic over the subsequent 18-24 months. This rapid review was conducted between mid-November and mid-December 2020 and the final report (the Hussey Review) was delivered to the PHA and the Department in December 2020 [MMcB6/088 - see INQ000102852]. The report identified that, in the view of the PHA, there was "*insufficient capacity to manage NHS / Care Home outbreaks*" and that, in relation to infection control, "*roles and responsibility blurred between respective agencies (RQIA / HSCB / Trusts) especially for Care Homes*". The report contained four main, high-level recommendations, which through their implementation, would constitute a major change programme for the PHA, leading to a new model for operational delivery of the core public and population health function in NI. The recommendations were to:

I. Strengthen the public health system in NI;
II. Strengthen health protection capability within the PHA;
III. Develop science and intelligence capability (in the PHA); and
IV. Build a modern, effective and accountable organisation (viz., the PHA)

6.57 The operational capacity in the PHA and indeed in all other public health bodies across the UK and RoI was significantly stretched during the pandemic. The capacity and capability of any ALB, including the PHA, are primarily matters for the Executive Team and Board of that organisation. However, given the central role of the PHA in responding to the pandemic, the Department sought to support the PHA in several ways. This included agreement to and support with the secondment of individuals with a range of skills across senior leadership, general management and professional expertise from other organisations within NI including other HSC

organisations such as RQIA, other departments and academia including the return of retired colleagues. I made direct personal contact with respective organisations and several individuals to secure agreement to release individuals to assist the PHA to increase their capacity to respond across all areas of their responsibilities. In addition, the Department and CMOG established several groups including for example the NI Modelling Group, the EAG-T, the Testing in Care Homes – Task and Finish Group, the Covid-19 Response Directorate and the Covid-19 Vaccination Oversight Board to ensure effective collaborative working and to maximise the expertise and experience of all.

6.58 In my view, from a strategic level, the role and responsibility of HSC Trusts, the RQIA and the HSCB with respect to Care Homes was clearly described and articulated in relevant extant guidance, commissioning arrangements and legislation. Those with more direct operational oversight and service delivery may have a different perspective. It was my experience that, in general during the pandemic response, there was effective collaboration and partnership working between the RQIA, HSCB and Trusts in support of the Care Home sector which included enhanced support and outreach from HSC Trusts and new and innovative arrangements such as the RQIA SST.

6.59 To assist in the Inquiry, I have sought and been provided with an update from the current policy team in the Department. They have advised that Department-led Pandemic Resilience Planning is underway within the HSC including work to develop HSC Operational Plans, which will include a plan to prevent, mitigate and build resilience in relation to any future pandemic and the impacts in the Care Home sector. I have been informed that work has commenced on the development of draft operational pandemic plans across a range of service areas. This includes a plan for care homes which was being led by SSPG. Planning for a respiratory

pandemic remains a core focus as this is considered the highest risk at the current time and aligns with work across the four nations to develop a UK Respiratory Pandemic Response Plan for health and social care. It is anticipated that the initial draft operational plans will be completed in advance of Exercise Pegasus which is due to commence in September 2025. However, this is an ongoing piece of work as we continue to collaborate with our UK partners to develop response capabilities together where there is close policy and delivery alignment. This includes adapting plans to other disease transmission routes. It is also important to consider and incorporate lessons learned from Exercise Pegasus and emerging findings from the Covid-19 Inquiry. While I have not been involved in the development of this or provided professional input, I understand the plan will provide guidance for HSC Trusts to support Care Homes in the delivery of safe, effective care throughout a pandemic and to strengthen partnership working and arrangements for IPC.

6.60 The public health response to the pandemic evolved over the course of 2020, with significant changes in clinical testing and the alternate use and relaxation of non-pharmaceutical interventions, balanced by an increase in surveillance and monitoring to feed into, and underpin, the public health risk assessment. It became clear that the complexity and demands on the health protection service provided by PHA would only increase. This would place even greater focus on the need for high quality, easily accessible public health intelligence and data on the epidemiology of the pandemic in NI, and also on the capacity and expertise of PHA's specialist public health workforce to lead and support all aspects of the pandemic response locally.

<u>Reshape and Refresh Programme PHA</u>

6.61 The PHA and Department accepted the findings of the Hussey Review and established a programme to reshape and refresh the PHA to ensure that it could not only effectively deal with the current pandemic but would be better equipped to deal with future pandemic challenges as they arose. The Programme would also ensure that the PHA was well placed to maximise the additional strategic and operational benefits from new UK-wide arrangements been taken forward by the UK Health Security Agency (UKHSA), including pandemic preparedness and capabilities as they developed and to ensure alignment and complementarity with our own public health capacity and capability requirements in NI. It would further ensure that PHA could effectively interact with the reformed HSC system, in the context of the planned closure of the former HSCB and the new integrated care model for services also planned to come into operation.

6.62 The refresh and reshape Programme commenced in March 2022 and, until January 2024, implementation of the recommendations was under a Programme Board jointly chaired by the CEO of the PHA and myself. The Programme and the Programme Board has become fully integrated internally within the PHA and is now at an advanced stage of implementation across the PHA. The PHA will be best placed to provide further details of progress and implementation of the recommendations, including any action taken on receipt of the report to increase operational capacity to support the manage Care Home outbreaks, if this is of assistance to the inquiry. The Programme was developed using a phased approach, with Phase 1 completing with an "As-is" assessment in September 2022. Phase 2a saw the development of a target operating model which was completed in May 2023 with Phase 2b/c (full implementation) commencing immediately thereafter. The Programme comprises three workstreams: the Transformation Management Office, People & Organisation, and Change & Communications. A further

workstream relating to Data and Digital commenced in Autumn 2023. Following agreement on the new Target Operating Model in January 2024, which included a high-level organisation structure, responsibility for implementation has passed completely to the PHA and its Board and work is fully underway to refine a structure which is based on functional areas and multi-disciplinary teams, which includes ensuring that there is capacity and capability in relation to pandemic preparedness. This work and progress is monitored by the Department through its current governance and accountability arrangements, including PHA sponsorship review ground clearing meetings and the PHA accountability meetings.

7. Infection Prevention and Control Measures

7.1 The IPC guidance for Covid-19 was developed on a 4 UK nations basis. [MMcB6/089 - see INQ000257936]. This supported not only consistency in practice but importantly a shared understanding of the scientific evidence across the UK. In NI, the local IPC Cell (which was chaired by the Director of Nursing in the PHA), led on IPC measures, including the development of appropriate IPC guidance, arrangements, and policies to apply across the region in all health and social care sectors. This was consistent with the PHA's extant roles and responsibilities. Neither CMOG nor I provided professional expert advice on guidance and policy with respect to IPC - this was provided by the PHA and the local IPC Cell. The IPC Cell, which reported to Health Silver and the Director of Nursing in the PHA, was supported by CNOG and the CNO in the Department. The DCMO in CMOG would have provided additional professional technical advice and support to the CNO and DCNO, when requested, particularly on aspects of interpretation of IPC advice.

7.2 Although neither I nor CMOG was represented on the IPC cell, as CMO (and along with DCMO colleagues and the CNO), I did receive and

consider updates on proposed revisions or planned reviews being undertaken by the UK 4-Nations IPC Cell at the UK Senior Clinicians meeting. This latter group was an information sharing group and had no formal approval role or remit. I provided my professional advice in my role as CMO to inform the overall strategic approach in such discussions, recognising the highly specialist nature of the advice and guidance. Any reviews or changes to the extant guidance were based on a critical expert appraisal of any new evidence by UKHSA and consideration by the UK 4-Nations IPC Cell. Any proposed changes to the guidance also involved discussion and consultation with professionals and their representative bodies. As CMO, I had no direct involvement in this engagement or these discussions.

7.3 It was essential throughout the development and reviews of the IPC guidance to ensure that it was consistent with established IPC practice, was understood by staff, and was implementable in all health and care settings. During the pandemic it was important that clear, up to date, evidence-based IPC guidance was available for the safety and morale of the workforce and to support and reassure clinicians who were responding to a new virus and who were understandably concerned for the safety of their patients, colleagues, families and themselves.

7.4 The guidance document "Covid-19: infection prevention and control (IPC) Guidance on infection prevention and control for seasonal respiratory infections including SARS-CoV-2" was first published on 10 January 2020. The guidance was issued as official guidance jointly by DHSC, PHW, PHA NI, NHS National Services Scotland, UKHSA and NHSE. I understand that all IPC Guidance ratified in NI followed this guidance document and its subsequent updates, cascading via the HSCB to all GP practices in NI. I did not provide any professional input into this guidance and was

satisfied that the relevant professional input had been secured from those with expertise in infection prevention and control.

7.5 Infection prevention and control is integral to the provision of care in Care Homes, given the environment and the vulnerability of residents. Care Home providers have experience in managing outbreaks of norovirus and respiratory viruses each winter, and support and expert advice is routinely provided by HSC Trusts and the PHA in managing such outbreaks. It is, however, the case that the infectiousness of Covid-19 presented particular challenges and required IPC measures, and a level of PPE not normally used in residential and nursing homes. Recognising these challenges, additional training and support was provided to the Care Home sector as outlined above at paragraphs 2.43 and 6.25. Although I was not involved in this training and support, I understand that it covered a range of issues including: the effective use of PPE; IPC measures; staff self-testing; and swabbing of residents. As chair of the Strategic Cell, I was fully supportive of this additional support and training and was aware of this at a strategic level. Those organisations most directly involved in providing the training, including the HSC Trusts and the PHA, would be best placed to advise of their assessment of the feasibility of care providers ensuring that such arrangements were followed.

7.6 Subsequently, with the roll out of the vaccination programme and greater levels of population immunity, it was essential to ensure that the risk of infection and outbreaks in all healthcare settings was balanced with the need to access health services while ensuring proportionate infection prevention control measures were in place to protect patients and staff. As set out in paragraph 2.41, the Departmental Covid-19 Testing in Care Homes – Task and Finish Group [MMcB6/024 -see INQ000137355] was established at my request to provide direction and guidance to support the development and implementation of Covid-19 testing arrangements within

Care Homes and to provide advice on testing to social care policy leads within SSPG in the Department. The Task and Finish Group, which met for the first time on 8 May 2020, included active participation from the PHA and the RQIA. Although not its primary role or responsibility, more generally in addition to advice on testing, the Group would have provided an opportunity for policy colleagues in SSPG with responsibility for the care sector including Care Homes to seek further professional and technical advice on the interpretation and implementation of regional IPC guidance.

7.7 Understandably, clinicians and those working in Care Homes and social care were concerned that IPC practices and resources available would not only protect them from becoming infected at work and subsequently infecting their patients but were also appropriate to the levels of risk in different settings and for different activities and procedures. There was significant and widespread concern in some professional groups, especially in the early stages of the pandemic, that the IPC measures being recommended were not sufficient. Although they were not raised directly with me, I was aware of concerns that had been raised directly with the Health Minister and the CNO and I discussed the basis of these concerns and how they might be appropriately addressed with the CNO and CSWO. I believe these concerns were, in part, based on a perception that IPC was being driven by supply constraints, as a consequence of undeveloped supply chains, rather than IPC responding to an understanding of the science. At no point did supply constraints influence the recommendations I made, or those made by UK CMO colleagues. Our advice was solely based on the expert technical advice provided in the recommendations to me and to UK CMO colleagues and was not influenced by supply constraints. In my experience, it proved extremely difficult to provide assurances that the supply chain did not influence guidance on IPC practices, and this remained a challenge throughout the

pandemic response. Notwithstanding the resourcing implications, to provide greater reassurance to health and social workers on the resilience of PPE supply prior to any future pandemic, in my view several actions should be considered. Firstly, work could be carried out to ensure greater resilience of supply lines, including options to repurpose and scale up local manufacture; secondly, a greater supply of PPE stock could be held with HSC organisations; and thirdly, an increased level stock of PPE could be held within the pandemic stockpile. In my view it would be beneficial if these contingency arrangements were embedded and transparent within future pandemic plans and associated communication of same.

7.8 As I recall, in the early weeks of the pandemic, the IHCP felt there was a lack of strategic leadership, communication and support by the HSC Trusts. It was felt that this had left Care Home staff 'feeling vulnerable'. My recollection of events at the time is that policy colleagues (under the direction of the CSWO and the Director of Mental Health, Disability and Older People within SSPG) as policy leads and the recognised primary Departmental contacts for the sector worked proactively to understand and address any concerns through engaging with all key HSC organisations, including representative organisations for older people and the Care Home sector. CMOG was represented at a number of these meetings by the DCMO or me. My team in CMOG and I worked closely with RQIA to utilise their expertise to support Care Homes, domiciliary care providers and supported living services. This included introducing regulatory flexibility [MMcB6/004 - see INQ000103688] in terms of statutory inspections to reduce the risk of the introduction of infection into Care Homes by reducing the footfall of RQIA inspectors into Care Homes and the movement of inspectors between Care Homes. It also involved, through collaborative working with SSPG (which had policy responsibility for Care Homes, domiciliary care and supported living) and RQIA management, the utilisation of RQIA staff to establish a Service Support

Team (SST) providing a liaison role between Care Homes and HSC Trusts [MMcB6/090 - see INQ000137410].

7.9 The main objective of the RQIA SST was to ensure that Care Homes, domiciliary care and supported living providers had an identified single point of contact to raise issues and receive the most up to date advice, guidance and support from the RQIA's expert teams of inspectors who were all registered nurses, social workers or Allied Health Professionals. I firmly believed at the time, and remain of the view, that the temporary introduction of regulatory flexibility was a proportionate and appropriate step in reducing the risk of outbreaks in Care Homes and allowed for the appropriate use of the skills and expertise of health professionals within RQIA to provide much needed support to the Care Home sector. During the first wave of the pandemic, I understand that RQIA dealt with almost 3,500 contacts with homes and over the Easter weekend in 2020 alone, RQIA contacted approximately 400 providers to ensure they were managing the situation and to offer assistance. The role and support provided by the SST was independently considered by the NI Assembly Committee for Health in their Inquiry Report on the Impact of Covid-19 in Care Homes findings [MMcB6/039 - see INQ000431849].

7.10 In April 2020, the Department's respective policy and professional teams were aware of the impact of high levels of community transmission and the relationship with outbreaks in Care Homes. There were significant and increasing concerns about the impact of Covid-19 on Care Homes, the vulnerability of residents, and the risk of the inadvertent introduction of infection due to movement into Care Homes for whatever reason. The available evidence indicated that restricting staff movement in and out of the Care Homes from the community could contribute to a reduction in the introduction of infection. The Department considered further steps as to how this might be achieved, including developing options for what became

known as the "Safe at Home" model. This proposed approach involved staff living in the home for a 7-day shift, following 48 hours of self-isolation, with enhanced monitoring of staff and residents including additional testing of both staff and residents to minimise the risk of transmission. The proposal was considered by the PHA's Expert Group on Testing on 17 April 2020 [MMcB6/091 - see INQ000437572]. A Safe at Home Pilot Learning Group (SHPLG) was established and jointly chaired by the CSWO and CNO who took this work forward. I understand that the PHA confirmed in principle that it was content to support the pilot study and the proposed testing requirements associated with the approach. Neither I nor my CMOG colleagues were represented on the group, however the proposal was discussed with me by the CSWO and CNO, and I was supportive of the proposed approach as it had the potential to reduce the risk and link between high levels of community transmission and subsequent outbreaks in Care Homes. While I was not directly involved, I understand that Trade Unions raised concerns about the impact on staff, including the supply and use of PPE. Those directly involved in the work of the SHPLG would be best placed to provide further details in relation to this. In my view, this was a potentially innovative approach with much potential benefit, although ultimately it did not proceed, and to my knowledge therefore there was no formal evaluation. I believe the practicalities of such a model merit further consideration in preparation and planning for future pandemics.

Assurances around implementation of IPC measures

7.11 As CMO I had no policy or professional role in seeking assurance that appropriate IPC guidance was being followed operationally in Care Homes. The Department has no direct responsibility for the oversight of the implementation of these extant policies. Primarily this responsibility rested with the Care Homes and domiciliary care providers themselves to

comply with extant policies and guidance, and secondly with the relevant HSC Trust as the commissioner of that care. As set out in paragraph 7.9 above, RQIA established a Service Support Team (SST) to provide advice, guidance and support to Care Homes, domiciliary care providers and supported living services. The RQIA also provided the Department, through SSPG, with regular reports which included intelligence from the SST. The daily RQIA reports contained individual Care Home information on bed status (occupancy levels), Covid-19 status (whether in outbreak or not), PPE and workforce status and any testing issues. The data from RQIA was used to prepare a weekly dashboard for the Health Minister which provided a high-level summary of Care Home self-assessed ratings (RAG - red, amber, green risk) for PPE, Workforce and Cleaning. The dashboard also provided a summary of Trust Surge status based on an analysis of Care Home reported information on the four indicators in the HSCB / PHA Care Home Surge Decision Support Framework which included: Covid-19 Outbreak; Workforce; PPE and Equipment required for management of Covid-19 and Residents in acute decline. These reports were circulated by SSPG colleagues to respective policy and professional teams in the Department, and as CMO, I would have had sight of these. I would fully expect any concerns with respect to adherence to guidance to be addressed by providers initially, and any matters of persistent concerns to be matters for HSC Trusts and RQIA to consider and address with escalation to the Department only as necessary.

7.12 Alongside running the SST, RQIA maintained their inspectorate function and continued to take enforcement action where necessary over the course of the pandemic, as per their duties set out in the Health and Personal Services (Quality, Improvement and Regulations) (Northern Ireland) Order 2003 (The 2003 Order). RQIA inspections are based on minimum care standards and the standards for both nursing and residential homes include Infection Prevention and Control measures

[MMcB6/092 - see INQ000417369 and MMcB6/093 - see INQ000417368]. Between April 2020 and June 2020, RQIA conducted 62 inspections of registered establishments.

IPC guidance, training and support

7.13 While I was not directly involved in the development of the guidance and training of staff, there was, to my knowledge, no IPC guidance developed solely in NI and the IPC cell within the PHA in NI did not diverge from the UK wide IPC guidance. The IPC guidance developed over the course of the pandemic to reflect the evolving healthcare situation in the UK, moving from initially focusing on managing patients with Covid-19 during the first wave to balancing this with supporting the safe restoration of health and care services from the middle of 2020 onwards with the establishment of risk-based clinical pathways.

7.14 As outlined in paragraph 7.3 above, IPC guidance had to be consistent with established IPC practice, understood by staff, and implementable in all health and care settings. This was essential for the morale and reassurance of a dedicated workforce who were responding to a new virus and were understandably concerned for the safety of their patients, colleagues, their own families and themselves.

7.15 Collaboration between organisations across the UK resulted in consistency of approach across the 4 UK nations. Engagement with other stakeholders, such as the Academy of Royal Medical Colleges (AoMRC), the Health and Safety Executive (HSE) and ventilation experts, added additional expertise to the development of the IPC guidance.

7.16 Although I was not directly involved in the work of the IPC cell, I am aware that the Department and the PHA provided overarching, as well as sector-specific, guidance and training which was supplemented by additional resources, for example NISCC's free online resource on infection control, hand hygiene and PPE. While others more directly involved in the provision of, or in receipt of, such training will be better placed to advise, given the considerable efforts of the CNO and her team in particular, I have no reason to believe that the IPC guidance and the associated support, advice and training was other than adequate and helped to ease staff concerns. I would have expected any concerns with respect to adherence to guidance to have been addressed by Care Home providers initially, and that any matters of persistent concern would be matters for HSC Trusts (as commissioners of the care) to ensure that those concerns were addressed and for RQIA to consider as appropriate. It is undoubtedly the case that the guidance and the enhanced training provided played a key role in reducing the transmission of the virus and protecting patients, staff and visitors.

UK CMOs Technical Report and relevant research

7.17 Given that this was a new virus, early in the pandemic there was much less known about the virus, including modes of transmission, the relative importance of asymptomatic infection, and common transmission settings. One of the factors that also influenced data availability at the time was the initial constraints on testing capacity. The initial constraints on testing presented challenges in understanding the relative importance of modes of transmission and effective interventions. Understanding the role of asymptomatic transmission was important for identifying which public health measures were likely to be effective, and particularly in health and social care environments.

7.18 As previously described at paragraph 5.16 and in the UK CMOs Technical Report [MMcB6/001 - see INQ000203933_0298] outbreaks in Care Homes were closely related to community prevalence, and the level of community transmission throughout the pandemic. There is genetic evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community. While Care Homes were largely closed to visitors early in the pandemic, infection was introduced through staff living in the wider community, often in local communities who had higher levels of infection, and potentially through the movement of staff between Care Homes. In the Covid-19 pandemic, age and underlying health conditions were strongly associated with increased vulnerability and increased the risk of severe disease. The risk of transmission of a highly infectious virus was significantly increased because of the close personal contact required to provide care and support to older people with the activities of daily life such as eating, dressing and toileting. The most effective general interventions throughout the pandemic to protect Care Homes and vulnerable residents were population measures to reduce the level of community transmission, and to maintain it at low levels, supported by IPC measures within Care Homes.

7.19 During the pandemic, larger Care Homes were more badly affected with outbreaks of Covid-19, reflecting their greater number of entry points of the virus and a greater risk of staff movement. It is undoubtedly the case that staff shortages, worsened by the pandemic with staff absent due to illness or who were isolating, increased the risks of staff movement between Care Homes. In the context of a highly infectious virus, with some people experiencing only minor or no symptoms and asymptomatic transmission, interventions to reduce the entry of the virus through asymptomatic testing and avoidance of cross-deployment were only partially successful when the level of community transmission was high.

This will be the reality in dealing with any future pandemic of a highly transmissible respiratory virus where age and underlying health conditions increase the risk of serve disease.

7.20 I was aware of and considered the Vivaldi Study, published on 3 July 2020 [MMcB6/056 - see INQ000346702], which examined Covid-19 infections in 9,081 Care Homes in England, including survey results of managers of those Care Homes. This Vivaldi 1: Covid-19 Care Homes study identified a number of key findings:

- that regular use of bank staff was an important risk factor for infection in residents and staff;
- that infections in staff were a risk factor for infection in residents; and
- that infections in residents were a risk factor for infection in staff.

The study suggested staff were more likely to transmit infections to residents than vice versa and this contributed to the evidence to appropriately inform the proposed testing approach for Care Homes which did not have a Covid-19 outbreak. Further information on testing of staff and residents is outlined below in section 8 on Testing. Prior to the empirical evidence in July 2020, I was aware of the potential for staff movements impacting on infection levels given the inherent risk and general principle. As I recall, I highlighted this to policy colleagues in meetings of the Testing in Care Homes – Task and Finish Group and this was reflected in guidance provided. For example, the minutes of Task and Finish Group meeting on 8 May 2020 [MMcB6/094 – see INQ000437695] note that "*as the movement of residents both within and outside the Care Home setting is limited, staff may be a source of infection when entering the Care Home for their shift*" and that "*to prevent the spread of infection, PHA has issued an instruction that staff should only enter/ work within one Care Home and not work across difference Care Home locations.*" Again,

at the Task and Finish Group meeting on 10 July 2020 [MMcB6/095 - see INQ000438220] it was noted that "*due to ongoing staffing challenges there was some movement of bank staff between Care Homes. CMO outlined his concerns about the movement of staff and stressed that it was imperative that the risk to Care Homes was minimised.*"

7.21 Understandably, clinicians and those working in Care Homes and social care were concerned that infection prevention and control practices and resources available would not only protect them from becoming infected at work and subsequently infecting their patients but were also appropriate to the levels of risk in different settings and for different activities and procedures. The findings from Vivaldi, and all relevant papers and studies which indicated the risks associated with the cross deployment of staff, were discussed at SIG and would have been reflected in professional advice from CMOG provided to policy colleagues in SSPG. I understand this advice was considered in the Department's approach in seeking to reduce the risk of and managing outbreaks of Covid-19 in Care Homes and ensuring staff, in so far as possible, did not move between homes, given the risks of transferring infection. As such, this became a core element of the overall strategy to mitigate infection in Care Homes. For example, the COVID 19 Guidance for Nursing and Residential Care Homes in NI, [MMcB6/034 - see INQ000120717], published on 17 March 2020 (see paragraph 5.3) stated that "*as far as possible homes should seek to limit turnover … We recognise that there may be a tension between ensuring homes are appropriately staffed and minimising the number of different staff members working in the home*". Further guidance for nursing and residential Care Homes issued in January 2021 [MMcB6/096 - see INQ000325173] also stated that "*Trusts should ensure staff and volunteers are deployed to homes in a way which minimises the risk of transferring infection between Care Homes. This should mean staff only working in one home, as far as is practicable. It may also mean*

cohorting staff for Care Homes with and without infections or isolating some staff between working in different Care Homes." Although I was fully supportive of this guidance and it was consistent with advice provided by CMOG, the guidance itself was developed by colleagues in the Department's SSPG and, as such, I was not directly involved in advising the Health Minister on introducing measures to prevent or reduce cross-deployment and cannot comment on their effectiveness. Balancing the need to maintain safe staffing levels to ensure that Care Home residents had the care and support required, while managing high levels of absence due to sickness absence and staff self-isolating proved challenging. It is important to recognise that, while preventing cross deployment of staff was highly desirable in terms of reducing the risk of introducing infection, this needed to be balanced with the potential danger of exposing residents to a different set of risks as a result of insufficient staff to provide the level of care required to individual residents and to provide this care safely.

7.22 Care sector staff were under intense and unprecedented pressure and undoubtedly, as with all staff across health and social care, they were physically and mentally exhausted and, as previously described, had to contend with extremely distressing circumstances. Staff retention and wellbeing was an important issue, and while I was not directly involved given other responsibilities, the Department sought to ensure social care staff in the independent care sector provider organisations had access to HSC Trust wellbeing helplines and other support services. Minimising staff absences was key to maintaining safe staffing levels in Care Homes, while also ensuring that staff who had been identified as contacts, or who were symptomatic, were supported to remain at home. In turn, reducing the need for cross-deployment and staff movement, along with effective IPC practices were key to minimising staff absences by reducing the risk of outbreaks. The higher incidence of outbreaks in larger Care Homes

reflected the greater impact of staff movement and turnover in these Care Homes. I am unaware of any formal assessment of the impact of staff movement on the management of the pandemic within the care sector in NI. Significant nursing support was provided by HSC Trusts to support Care Homes, including specialist IPC nursing support during the pandemic, particularly in the first wave.

7.23 I am also aware that the Department provided significant additional financial support to the care sector and policy colleagues in SSPG who provide advice to the Health Minister on such matters will be best placed to provide further information. The Department took steps to provide financial support, including provision for sick pay which was designed to support those working in the care sector who needed to take sick leave or to self-isolate to do so. At a meeting of the Care Homes - Task and Finish Group on 28 May 2020, the issue of Care Home staff refusing to be tested was raised and it was understood that this was due to potential loss of earnings as well as not understanding the importance of testing. I stressed the importance of addressing the remuneration issue as well as reassuring and educating home care staff about the purpose of testing [MMcB6/097 - see INQ000438195]. The introduction of the Care Partner Scheme and the efforts to introduce the "Safe at Home" model where Care Home staff would 'live-in' were all examples and efforts by the Department to reduce the entry of Covid-19 into Care Homes. Similarly, while I was not directly involved, I believe policy colleagues within the Department understood, through the regular informal discussions with providers, that the possible financial loss associated with being placed on sick leave (and therefore statutory sick pay) was a factor in these decisions. Consequently, funding for enhanced sick pay was made available to both Care Home workers and domiciliary care workers [MMcB6/098 - see INQ000518435]. While I was not directly involved, I have confirmed in preparation of this statement that funding provided to independent sector

employers was available to pay staff up to 80% of their salary (or average salary, based on the 3 months December 2019 to February 2020) when they were on sick leave because they were self-isolating, shielding or ill due to Covid-19. This would have included those individuals employed on zero-hour contracts. The provision of enhanced sick pay was considered necessary to ensure staff working in Care Homes who had tested positive for Covid-19 were adequately supported to take the necessary time off work thereby reducing the risk of transmission to other staff and residents in the care home.

7.24 The UK CMOs Technical report [MMcB6/001 - see INQ000203933], to which I contributed, identifies several points which reflected on the learning and experience of the pandemic that may be of assistance in the management of future pandemics with respect to the Care Home sector. I have summarised these to assist the Inquiry and I will return to these in the later section on professional and personal reflections and learning:

I. First, people in Care Homes for older people are very likely to be at high risk of serious disease in any future respiratory disease epidemic or pandemic. In the absence of effective treatments or a vaccine, measures to reduce the ingress (entry) of the causative agent into care facilities via staff, visiting professionals or visitors and minimise transmission, while at the same time maintaining the delivery of and the quality of care, will be a high priority.

II. Second, NPIs that reduce personal contacts, particularly isolation from family, will have a considerable impact on the quality of life of Care Home residents and families, and balancing the benefits and harms is not straightforward. In my view, this balance was not always maintained during the pandemic, with profound consequences for individual residents and families - a point I shall return to later in this

statement. The length and extent of limits on visiting inward and outward, on the social interactions of residents, and the use of masks by staff during the Covid-19 pandemic were unprecedented in Care Homes. The use of technology to support social contact, designated 'essential carer' or as in NI, the Care Partner Scheme, with appropriate infection prevention and control arrangements were useful measures to mitigate the harms of isolation. In my own view, they were however not a substitute for, nor could they replace face-to-face and personal contact no matter the efforts made by staff.

III. Third, controlling transmission in Care Homes also depended on alignment with wider public health, social care and healthcare systems. Preventing entry of Covid-19 into Care Homes proved extremely difficult during periods of high community transmission and high case rates in hospitals required careful management of discharges into Care Homes. The structure of the care sector itself across the UK, including NI, presented challenges (although policy and professional colleagues more directly involved with the sector will be better placed to provide comment). There is enormous diversity of facilities, and many staff moved from one facility or care role to another within the same week or even day. The adult social care workforce, although trained to provide care, lacks the status of registered professionals, is relatively poorly paid and insecurely employed, with high vacancy rates and poor sick pay provision.

IV. Fourth, the value of reliable and comprehensive routine population and health data describing the population living and working in residential care to inform policy decisions and evaluate the impact of interventions cannot be overstated. Routine and bespoke data sources enable calibration of interventions to address vulnerability and impact, through an understanding of: ingress routes; attack rates; case fatality; and

hospitalisation in different groups of residents. Testing early and often is key in understanding and responding to ingress routes into Care Homes, although if testing capacity is limited as in the early months of the Covid-19 pandemic there will need to be careful prioritisation of available testing capacity.

V. Fifth, advice from behavioural and social science was essential in informing good practice in the support and management of care staff and in protecting residents. This highlighted, for example, that there was a risk of stigmatisation and fear, and the need for financial and other support for staff when isolating to reduce the movement of staff. Research and innovation to improve Care Homes' resilience to respiratory and other infections is needed and could inform, among other things, building regulation and best practice.

7.25 With respect to learning and future pandemics and what more could have been done with respect to staff movement, in my view, it is essential that there is greater recognition of the vital contribution made by the adult social care workforce and the importance of their role is valued and recognised. In the context of an aging population and future social care needs, a more resilient and valued workforce will require consideration of pay and conditions and security of employment. In addition, more on-going training of staff working in the sector with health care support and specifically with respect to infection prevention and control would be of benefit. I shall return to these points in the section in this statement on reflections and learning.

8. Testing for Covid-19

Initial approach to testing

8.1 The UK Influenza Pandemic Preparedness Strategy 2011 [MMcB6/099 - see INQ000188766] provided proposals for a coordinated, UK-wide strategic approach to planning for, and responding to, the demands of an influenza pandemic. The 2013 Northern Ireland Health and Social Care Influenza Pandemic Preparedness and Response Guidance is closely linked to the 2011 Strategy and was developed by the Department to support preparedness and response planning for HSC organisations in an emergency response to an influenza pandemic.

8.2 The 2011 Strategy recognised that, in the initial phase of pandemic influenza, detection, diagnosis and reporting of early cases through testing and contact tracing would be part of the proportionate response to local outbreaks in Care Homes. The 2013 Guidance set out the requirement that all patients presenting with influenza like illness in primary and community care will need to be tested. Neither the 2011 Strategy nor the 2013 Guidance made reference to asymptomatic testing for Care Homes. It is clear that future pandemic planning and preparation in the care sector and specifically the Care Home sector will need to be more explicit with respect to the contingency arrangements for a rapid scale up in testing in the sector in the context of any new respiratory pathogen. These matters and the recommendations of Module 1 of the Inquiry are currently being progressed by policy colleagues in the Department working with SPPG, the PHA and HSC Trusts.

8.3 The initial approach to Covid-19 testing in individual Care Homes was informed by the approach previously taken in the context of influenza outbreaks where the active finding of cases and the timely isolation of confirmed and suspected cases were key aspects in reducing transmission of infection and controlling outbreaks. This meant that testing in Care Homes was focused on prompt identification of cases and

support for the subsequent management of the outbreaks. Testing of an initial number of symptomatic residents in the context of a suspected outbreak in a Care Home was undertaken to confirm the causative organism with subsequent diagnoses of other cases of infection based on the symptom profile demonstrated among residents: this is described more fully in paragraph 8.11 below. This approach was actively and continually reviewed as the pandemic progressed and informed by SAGE and its subgroups, the emerging scientific evidence, and advice from the Department's EAG-T, although initially testing capacity was a significant constraint in expanding testing as rapidly as we would have wished.

8.4 As Chair of the Strategic Cell, as defined in the Department's ERP, I had responsibility for ensuring the coordination of the planning and preparation of the response to the first wave of the pandemic and the overall response in the first wave. This included all strategic and policy matters in relation to testing which was taken forward by the Testing Cell. Prior to the establishment of the EAG-T, advice on testing was provided to the Health Minister through the Policy Testing Cell, which was chaired by the DCMO, Dr Naresh Chada. Following her secondment into the Department in March 2020, Professor Lourda Geoghegan provided the main policy advice on testing within the Department. Throughout the pandemic, the DCMOs, the CSA and I worked closely with policy and professional colleagues and the PHA with respect to testing. The Testing Cell provided updates and advice to the Strategic Cell, which I normally chaired. Subsequently, as part of the move to business continuity arrangements, the Covid-19 Response Directorate was established in September 2020 to oversee policy in relation to Testing and Contact Tracing. This directorate remained within CMOG working closely with EAG-T. The PHA was the lead operational and coordinating body in NI for both the testing and contact tracing programmes. The PHA leadership team and CMOG worked together to ensure the most effective arrangements to address

emerging issues, challenges and the many demands faced. This collaboration and collective endeavour was facilitated by the establishment of a number of strategic oversight boards such as the Test, Trace, Protect Oversight Board, which I chaired. As described, a number of expert advisory groups such as the EAG-T were led at Director level within the PHA acting on behalf of the Department. Strategic and policy decisions relating to policy on testing are a matter for the Health Minister and my role, and that of my CMOG colleagues, is to provide information and advice to the Minister.

8.5 Testing was a critical part of the NI pandemic response. Throughout the pandemic, in addition to the overarching advice and guidance for the general population, the Department took a targeted, risk-based policy approach across various sectors and sub sectors, including the testing of residents, staff and visitors to Care Homes. As set out at paragraph 6.41 above, Care Homes are distinct from other care settings as they are enclosed environments and have a specific and particular risk profile, so residents in Care Homes were identified early in the pandemic as being at increased risk, given the strong age-related association with poor outcomes, compounded by underlying health conditions frequently seen in the older population. Protecting residents and staff in Care Homes was a key priority for the Department throughout the pandemic and the role of testing was fundamental in managing this risk. All of this was considered in the context of the feasibility, logistical and other practical challenges of introducing entirely new testing arrangements in the Care Home sector at an unprecedented scale and the impact on residents and staff. This involved consideration of the issues of consent and capacity of residents, consideration of the discomfort of testing, and training and support for staff. Extensive guidance, training and support was provided by the PHA and HSC Trusts as described at paragraph 2.43 above.

8.6 Early in the pandemic, when testing capacity was insufficient to identify all cases that needed to be contact traced among the general population and available tests needed to be prioritised for clinical care and in settings with vulnerable people such as Care Homes, the Department put a protocol in place to guide the targeted and prioritised use of available Covid-19 testing. This was set out in the first version of the Department's IPT which was dated 19 March 2020 [MMcB6/100 - see INQ000120705]. This is covered in more detail at paragraph 8.13 below. At this time, due to limited capacity, PCR testing was primarily targeted for clinical care of the sickest individuals requiring hospital inpatient care, protecting those caring for such individuals, and for the management of outbreaks in enclosed settings such as, for example, in Care Homes. The IPT was an operational tool which provided information on eligibility for testing and advice on how to access testing.

8.7 The expansion of testing in Care Homes progressed in a phased way throughout the pandemic from initial Covid-19 testing of Care Home residents and staff displaying symptoms, to planned regular asymptomatic Covid-19 testing being made available to all residents and staff, and later also to those visiting Care Homes. My advice to the Health Minister was that testing of residents and staff in Care Homes needed to be expanded as quickly as possible, while recognising this needed to be implemented in a planned way, given the logistical considerations, and that testing capacity initially limited the progress of expansion of testing. I believe it accurate to say that all of us wish we had been able to expand testing within Care Homes more rapidly and the Health Minister was clear this was a priority, however this was not a straightforward endeavour. The initial limitations in testing capacity resulted in very difficult policy decisions, and while my advice to the Health Minister was consistently that we needed to expand testing in Care Homes as soon as possible, the practicalities at the time were regrettably that there were limitations in

what was possible. At all times, the Department's approach to testing was designed to protect residents from infection and to protect health and social care workers from becoming infected and inadvertently transmitting the virus to residents and / or to their own families. When capacity allowed, the approach adopted was to use testing of family members and relatives as an additional assurance to them and to Care Home providers. Testing was used to support visiting in Care Homes and, in all circumstances, testing was to be employed in combination with, and in addition to, the package of other IPC measures which Care Homes were implementing in order to support the safety and wellbeing of their residents. I have provided specific examples below of the advice I provided to the Minister, and the arrangements I put in place to implement the expansion of testing in Care Homes in keeping with the Minister's prioritisation and the urgency we all recognised.

8.8 It was clear to me that the evidence base for the most effective use of testing for Covid-19 was increasing rapidly and that there was a need to ensure that NI had a coordinated approach to consider the evidence. I advised how to make the most effective use of existing capacity in NI, while at the same time rapidly expanding testing capacity having considered the recommendation of the EAG-T. This local expansion included, for example, at my request, the formation of new local partnerships to deliver increased capacity through the Scientific Advisory Consortium, which I asked to be established as part of what was known as Pillar 1. This used existing laboratory testing in NI, and with the approval of the Health Minister, we participated in the UK National Testing Programme which was known as Pillar 2 and testing capacity increased further. Covid-19 testing as part of the UK National Testing Programme was procured and contract managed nationally on behalf of UK nations by DHSC and latterly by UKHSA.

8.9 Under the initial emergency response to the pandemic, the Department activated Health Gold Command on 9 March 2020 in line with the guidance set out in its 2019 Emergency Response Plan [MMcB6/101 - see INQ000184662]. Health Gold Command comprised a Strategic Cell and 13 subject-specific policy cells, including a Testing cell, led by the DCMOs. I established the EAG-T, which first met on 28 March 2020, to assist in developing the NI approach to Covid-19 testing, to oversee / coordinate implementation of testing, and to advise on updates to testing strategy and policy throughout the pandemic. This was a key advisory group in relation to all elements of Covid-19 testing, as well as policy and operational delivery in NI. This included advising and recommending Covid-19 testing proposals for Care Homes. The terms of reference are available at exhibit [MMcB6/023 - see INQ000137354]. A key function of this group was to advise on implementation of Covid-19 testing in NI and to provide expert advice, which was then considered by Departmental policy leads to inform the advice to me, and subsequently the advice that I gave to the Health Minister. The group played a significant role in advising on testing, as well as in the coordination of delivery of the expansion of testing capacity. One of the key roles of the EAG-T was to make recommendations for updates and amendments to the IPT, taking account of the evolving national clinical and scientific understanding and evidence base, and developments in the other UK nations. The EAG-T recommendations were then presented by CMOG testing policy teams to me for consideration and approval. Where appropriate, this included input from the CSA and DCMOs. In total, 10 IPTs were produced and approved by the Department between 19 March 2020 and 6 October 2021. Membership of EAG-T comprised a range of colleagues from the PHA including public health consultants, virologists from the Belfast Health and Social Care Trust (BHSCT) Regional Virus Laboratory, representation from HSC Trusts, HSC Laboratories Pathology Network (within SPPG), BSO procurement, and the Department's Director of Covid-19 Response and

members of his team. Others from across the HSC system and beyond were co-opted or invited to attend meetings as relevant matters were discussed, for example the South Eastern Health and Social Care Trust (SEHSCT) Prison Healthcare Team attended on a number of occasions to discuss testing in prisons.

8.10 As outlined in paragraph 2.41, I established a Testing in Care Homes - Task and Finish Group in May 2020 and this was chaired by the DCMO, Professor Lourda Geoghegan, and comprised key policy and professional representatives from the Department, EAG-T, PHA, and the RQIA. The Group's remit was to provide effective direction, support and guidance to successfully complete the expansion of Covid-19 testing of all residents and all staff across Care Homes as rapidly as possible, with the aim of completing this by June 2020. This commitment had been announced by the Health Minister on 18 May 2020 [MMcB6/102 - see INQ000103704]. Although not a decision-making group itself, the Care Homes – Task and Finish Group members also provided their expert knowledge and input to help appropriately inform and shape testing policy proposals, including how to effectively expand the provision of Covid-19 testing arrangements in Care Homes and the timing of the advice to myself and the Health Minister when further expansion could be achieved.

8.11 My understanding was that the initial approach advised by the PHA to Covid-19 testing in Care Homes was consistent with that taken to risk assess and promptly identify outbreaks of respiratory illness prior to the pandemic. This was consistent with extant practice and testing protocols operated by the PHA for potential clusters and outbreaks of infectious respiratory diseases such as seasonal influenza in residential or nursing homes. This approach recommended testing up to a maximum of 5 symptomatic residents to confirm the cause of the respiratory outbreak, with all other diagnosis made on a presumptive basis in those residents

and / or staff presenting with respiratory symptoms. Although the early IPTs which I approved did not reference testing a maximum of 5 residents, the EAG-T note of the meeting on 10 April 2020 [MMcB6/103 - see INQ000437570] confirms that: *"As part of PHA risk assessment, 5 swabs per home are being taken based current protocol."* Health protection colleagues in the PHA with relevant expertise will be best placed to explain the extant protocols. It is my understanding that once an outbreak of a particular respiratory pathogen was confirmed then this triggered additional advice and support from the PHA to the individual Care Home on the necessary and appropriate IPC arrangements which were required (including isolation and / or cohorting of infected residents). This was the approach recommended by the EAG-T and described in the 19 March 2020 IPT [MMcB6/100 see - INQ000120705]. At that time, testing capacity was significantly limited and testing all residents and staff in a care facility which had a confirmed case of Covid-19 would not have been practically possible, nor was the significance of asymptomatic transmission fully understood.

8.12 While I was not a member of EAG-T, and did not myself provide professional or technical advice, I did accept the recommendations of the EAG-T. I was fully aware of concerns raised by the care sector with policy colleagues in regular informal meetings, a number of which I and / or my DCMO (Professor Geoghegan) attended. I was also aware of representations made to the Health Minister and concerns highlighted at meetings of the NI Executive and the NI Assembly Health Committee. As indicated in the later section on reflection and learning, while testing was prioritised for residents and staff in Care Homes, I believe we all wish we could have expanded testing in residential and Care Homes more rapidly than we were able to do so. Given the constraints on testing capacity in the early phase of our response, the approach adopted during the first wave of the pandemic concentrated on using testing to rapidly identify and

confirm / refute when the Covid-19 virus was present and causing residents to experience symptoms in a Care Home setting (through prioritising an agreed number of symptomatic residents to be tested), and then using the findings of this testing to inform specialist advice and support for Care Home providers to risk assess and manage the outbreak and to limit further transmission of infection.

8.13 As outlined at paragraph 2.44 above, the Department's IPT was an operational tool providing information on eligibility for testing and advice on how to access testing. It was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity. Care Home residents were identified as a priority group for testing in the first IPT (dated 19 March 2020 and operational from 20 March 2020) which I approved [MMcB6/100 - see INQ000120705]. As set out in Version 1 of the IPT, the NI hospital laboratory capacity for testing was 200 tests per day and was expected to increase to 800 tests per day over the next 7 to 10 days. At that point, testing was provided for residents in residential or care settings where there was a possible cluster or outbreak of Covid-19 infections. Staff working in Care Homes were not included in the definition of a HCW as Covid-19 testing was limited at that point by the need to protect laboratory capacity for testing hospitalised patients, for whom the result would influence clinical management and infection prevention and control decisions. As testing capacity at this time was significantly limited, it would not have been possible to then test all Care Home residents and staff in a Care Home with a confirmed case of Covid-19 at that stage. This was an example of the outworking of the limitations in testing capacity. The IPT was kept under continuous review, with priority groups for testing extended regularly – including greater testing of healthcare staff - in line with emerging scientific evidence and with expansions in testing capacity.

8.14 I approved Version 2 of the IPT (dated 26 March 2020 which was operational from 28 March 2020), which enabled testing of Care Home staff who were symptomatic or isolating if a member of their household was symptomatic [MMcB6/104 - see INQ000362314]. As set out in Version 2 of the IPT, the maximum total NI hospital laboratory testing capacity at that point was 1000 tests per day. As described at paragraph 8.29, as policy and professional lead the CSWO issued a letter to Care Homes to ensure that the care sector was fully informed of this change in the latest version of the IPT.

Expansion of testing capacity

8.15 On 14 April 2020, the Health Minister made a statement in which he said "*I also want to make clear that testing of any Care Home resident or staff member displaying Covid-19 symptoms is being undertaken*" [MMcB6/008 - see INQ000137317]. This reflected a recommendation from the EAG-T on 10 April 2020 that testing be extended in Care Homes to test all symptomatic residents, as outlined in paragraph 19 of the paper on 'Overview of Health in Care Homes', provided by the Health Minister to the NI Executive on 17 April 2020 [MMcB6/105 - see INQ000103673]. Prior to this policy change, and as previously described, a maximum of 5 residents were tested in each Care Home reporting a possible outbreak or cluster. At that stage, capacity was not as significant a constraint as it had previously been, and this informed the advice I offered to the Health Minister. I believe this is what may be reflected in the handwritten notes of an NI Executive meeting dated 15 April 2020 in which the Health Minister is recorded as saying that DoH "*have ability - but timeline is issue.*

Balance time with commitment. Have capability to test" [MMcB6/71 see INQ000065735_0005]. I would highlight that these handwritten notes were not reviewed or approved by the Department and will represent the note taker's understanding of what was said. Again, this is not a criticism merely a reflection of the brevity of these notes which attempted to summarise complex matters. At that stage in the pandemic, there was no recommendation to carry out testing of asymptomatic individuals. From a professional and technical perspective, it was clear to me that in NI we needed to expand our testing capacity as rapidly as possible and that the approach to testing for Covid-19 would need to be actively and continually reviewed as evidence emerged / developed. I therefore established the EAG-T to develop the NI approach to Covid-19 testing; to advise and coordinate the implementation of testing; and to update the Testing Strategy throughout the pandemic, as testing capacity increased and new tests became available. Decisions relating to expanding and implementing Covid-19 testing were informed by the SAGE and its subgroups, the wider emerging scientific evidence, and advice from the EAG-T.

8.16 One of the key roles of the EAG-T was to advise on implementation of Covid-19 testing in NI and to provide expert advice, including on issues related to testing in Care Homes. The EAG-T advice was considered by policy leads in the Testing Cell (later the Covid-19 Response Directorate) to inform advice to myself and the Minister. Notes of the EAG-T meetings have previously been issued to the Inquiry, exhibited as part of the Module 2C Annex 2 disclosures [MMcB6/105a1 – see INQ000437566; MMcB6/105a2 - see INQ000437569; MMcB6/105a3 - see INQ000437571; .MMcB6/105a4 - see INQ000437573 to MMcB6/105a34 – see INQ000437603; MMcB6/105a35 – see INQ000437608 to MMcB6/105a37 – see INQ000437610; MMcB6/105a38 – see INQ000437612 to MMcB6/105a44 – see INQ000437618; MMcB6/105a45 – see

INQ000437620 to MMcB6/105a52 - see INQ000437627; MMcB6/105a53 – see INQ000437630 to MMcB6/105a60 – see INQ000437637; MMcB6/105a61 – see INQ000437644 to MMcB6/105a64 – see INQ000437647; MMcB6/105a65 – see INQ000437649; MMcB6/105a66 – see INQ000437654; MMcB6/105a67 – see INQ000437658 to MMcB6/105a70 – see INQ000437661; MMcB6/105a71 - see INQ000437665 to MMcB6/105a72 – see INQ000437666; MMcB6/105a73 – see INQ000437672; MMcB6/105a74 - see INQ000437677 to MMcB6/105a77 – see INQ000437680; MMcB6/105a78 – see INQ000437684 to MMcB6/105a85 - see INQ000437691; MMcB6/105a86 - see INQ000438175; MMcB6/105a87 – see INQ000437619; MMcB6/105a88 – see INQ000437628; MMcB6/105a89 – see INQ000437629; MMcB6/105a90 – see INQ000437683; MMcB6/105a91 – see INQ000437682]. Given the policy priority and the Health Minister's commitment to expand testing in Care Homes as rapidly as possible, dedicated strategic and operational leadership and oversight was, in my view, required to address the significant logistical challenges I anticipated. I therefore established the Testing in Care Homes – Task and Finish Group which is described at paragraph 2.41 to provide strategic oversight and support of the operational delivery of the Covid-19 testing programme for Care Homes. Throughout the pandemic the PHA issued operational guidance to the Care Home sector. As described at paragraph 2.39 the EAG-T and the Testing in Care Homes – Task and Finish Group worked, in my view, highly effectively together to oversee the implementation of testing in Care Homes as rapidly as possible. Both groups were complimentary with the EAG-T providing expert policy recommendations and the Testing in Care Homes – Task and Finish Group overseeing the practical and operational implementation by the PHA.

8.17 On 23 April 2020, a submission was forwarded to myself and the Health Minister on Increasing Utilization of Testing Capacity for Covid-19

[MMcB6/106 - see INQ000439983]. This submission was considered by both the Health Minister and Special Adviser, who both provided comments [MMcB6/107 - see INQ000440007]. This advice changed on 24 April 2020, when the EAG-T considered the further expansion of Covid-19 testing in Care Homes. Taking into account an increase in the number of Care Home outbreaks and increased testing capacity, the EAG-T recommended that for new outbreaks in Care Homes, all residents and all staff should be tested for Covid-19 as part of the initial risk assessment of each outbreak. This approach replaced the previous approach of only testing staff and residents when they had been displaying symptoms of Covid-19. On 25 April 2020, an updated submission was forwarded to myself and the Health Minister [MMcB6/108 – see INQ000440008]. This submission sought to clarify the Health Minister's and Special Adviser's earlier comments and included a number of important revisions in respect of the following: approach to testing in Care Homes with suspected outbreaks of Covid-19 and move to testing all residents and staff; testing prior to discharge from hospital as before and updated to include testing prior to admission from the community; testing of all patients admitted to hospital for emergency / elective care. The expansion to the Care Home testing arrangements was effective from 24 April 2020 and also announced by the Health Minister on 27 April 2020 [MMcB6/109 - see INQ000103694].

8.18 On 13 May 2020, the Health Minister announced there was to be a significant expansion of testing for Care Home residents and staff and that this expansion would be informed by advice being prepared for the UK Government and the NHS by SAGE and for the Department by SIG [MMcB6/110 - see INQ000371406]. On 14 May 2020, SIG considered a Care Homes Analysis paper [MMcB6/060 - see INQ000422018] which said that "*Within homes, there is a strong scientific rationale to test all residents, irrespective of whether symptomatic or not, given strong*

evidence of asymptomatic transmission in Care Homes." and that *"For the same reasons, there is a strong scientific rationale to test all staff working in homes.".*

8.19 The detail and scope of this expanded testing was announced by the Health Minister in a press release on 18 May 2020. The testing programme in Care Homes was to be extended, with Covid-19 testing made available to all residents and all staff including in Care Homes which had not experienced a Covid-19 outbreak, with the intention of completing this in June 2020 [MMcB6/102 - see INQ000103704]. This reflected the work that I had initiated to implement the roll out of Care Home testing with the establishment of the Testing in Care Homes – Task and Finish Group and the significant contribution and efforts of all HSC Trusts, the PHA and the HSCB to implement the Health Minister's policy decision and the priority he afforded the rapid expansion of Care Home testing.

8.20 Following this announcement, the Health Minister wrote to all Care Homes on 19 May 2020 about the expansion of the Covid-19 testing arrangements, and to also provide information on the wider package of measures in place to support Care Homes (including additional funding, PPE supplies, Covid-19 training, Departmental guidance, sourcing and provision of palliative medications and equipment, and the availability of expert advice and support) [MMcB6/111 - see INQ000185454].

8.21 This extended programme of Covid-19 testing in Care Homes was delivered through two distinct pathways: testing in Care Homes with suspected or confirmed Covid-19 outbreaks, and testing in 'green' Care Homes, that is those homes which did not have a Covid-19 outbreak. HSC Trusts were responsible for administering the testing programme for Care Homes which had or were in outbreak. The National Testing

Programme supported the independent sector and the HSC Trusts to test all residents and staff in the 'green' Care Homes.

8.22 To progress this as rapidly as possible and to offer practical support, the Northern Ireland Ambulance Service (NIAS) began providing, at my request, a mobile testing service for Care Homes during the week commencing 11 May 2020. I had contacted the CEO of NIAS over the preceding weekend to ask for assistance and had received confirmation that NIAS would provide mobile testing capability into Care Homes in NI comprising up to 4 mobile testing teams commencing 12 May 2020 to assist Care Home staff and HSC Trust teams who were already supporting Care Homes [MMcB6/112 – see INQ000425658]. This service was integrated into the HSC Trusts and PHA / HSCB teams who were working with and providing support to Care Homes. In addition, up to 40 nurses from the HSC were deployed to support testing in Care Homes.

8.23 On 19 June 2020, a submission was forwarded to myself and the Health Minister on "Update on testing Programme in Care Homes across Northern Ireland" [MMcB6/113 - see INQ000598338]. This submission provided an update on the comprehensive Covid-19 Care Home testing programme underway across NI and due to be completed by the end of June 2020. It also cites a BMJ article which referenced the approach taken by NI to provide data on active and concluding outbreaks of Covid-19 in Care Homes which had been recognised as an example of good practice by the Director of Evidence Based Medicine at the University of Oxford. The article also suggests that the Care Quality Commission and Public Health England should learn from NI as *"the concept of 'closing down' COVID-19 infections in confined spaces, such as Care Homes is incredibly important."* [MMcB6/114 - see INQ000439319]. By 30 June 2020, staff and residents in all Care Homes across NI had been offered Covid-19 testing. Given the significant

planning and logistical challenges associated with undertaking such an extensive programme of testing across a significant number of facilities in a relatively short period of time, this was, in my view, a positive outcome. The successful completion of this phase of the Care Home testing programme was made possible through a collaborative multi-agency partnership between the Department, the PHA, the HSC Trusts, the NI Ambulance Service and, importantly, the Care Homes themselves. This partnership working was reflected in many aspects of the pandemic response.

8.24 A submission to myself and the Health Minister [MMcB6/056 - see INQ000346702] advised that the PHA would submit information on each Care Home's tests, the numbers of staff and residents tested in each Care Home and the positivity rates for each group tested to the Department. The PHA collated data and produced a monthly Care Home testing Report which included: the numbers of Covid-19 tests completed each month from August 2020 onwards; Covid-19 positive and negative test results attributed to Care Homes; the number of Covid-19 tests undertaken by residents' age; and the pattern of both symptomatic and asymptomatic Covid - 19 outbreaks in Care Homes [MMcB6/115 - see INQ000432670]. The Care Home testing Reports supported operational decision-making by the PHA, including risk assessment and support to inform outbreak management, and also proved a valuable source of information, providing the Department with an overview of the significant scale of Covid-19 testing being undertaken across Care Homes, and importantly testing outcomes.

8.25 The Department continued to actively monitor and assess the current and emerging science and evidence relating to Covid-19 to further inform the approach to testing in Care Homes. The Department also continued to closely engage with HSC colleagues on appropriate arrangements for a

regular programme of Care Home testing. On 27 July 2020, the detail underpinning the final proposals for the introduction of a regular planned programme of Covid-19 testing in all adult Care Homes across NI was submitted to the Health Minister for his consideration and approval [MMcB6/057 - see INQ000346703 and MMcB6/116 - see INQ000439343]. While previous proposals on 8 July 2020 were to test both staff and residents on a monthly basis [MMcB6/056 - see INQ000346702], the submission advised that current evidence, including the findings from the Vivaldi study, indicated that staff were more likely to transmit infections to residents than vice versa. This suggested that staff should be tested on a more frequent basis. Further discussions at SIG, and between myself and professional and policy colleagues within CMOG, led to the decision to recommend that all Care Home staff be tested every 14 days and all residents every 28 days. All decisions with respect to the frequency of testing of residents and staff were informed by consideration of the extant evidence at that particular point in time, the level of community transmission, the greater risk of staff being infected in the community and inadvertently introducing infection into their place of work, and that testing for Covid-19 in older people was unpleasant and distressing. I am not able to comment on decisions made in other jurisdictions on their approach to testing at that time as I recall the approaches taken were similar. The submission also proposed that all staff and residents would be tested immediately following the positive test result of a single individual who was symptomatic. The Health Minister announced the next phase of testing in Care Homes on 28th July 2020 [MMcB6/117 - see INQ000103705]. The frequency of testing in Care Homes was kept under active review and continued to be informed by emerging scientific evidence and the level of community transmission of the virus. Following an assessment and advice which I had provided to the effect that this could proceed now that the testing capacity and logistics were in place, a rolling programme of regular PCR testing started on 3 August 2020 for all

residents and staff in 'green' Care Homes which did not have a confirmed outbreak of the virus, with the aim of helping to keep these homes free of Covid-19. At that point, it was recommended that asymptomatic staff should be tested on a fortnightly basis and asymptomatic residents tested monthly. The Health Minister also referred to the start of the rolling programme in his statement to the NI Assembly on 28 July 2020 [MMcB6/118 – see INQ000103706]. In addition to the rolling programme of asymptomatic Care Home testing, an enhanced testing protocol was in place for Care Homes with a suspected or confirmed Covid-19 outbreak.

8.26 From December 2020, the Department also worked with a range of partners to deliver an expansion of the availability of a regular programme of asymptomatic Covid-19 testing across a range of different sectors including visitors to Care Homes.

Domiciliary care providers and unpaid carers

8.27 As outlined above, the IPT was kept under continuous review with priority groups for testing extended regularly in line with emerging scientific evidence and with expansions in testing capacity. From Version 1 of the IPT and throughout all subsequent iterations up to and including the final IPT, Version 9 (dated 6 October 2021), there was a clear focus on targeted and differentiated testing to help protect the sickest and most vulnerable individuals requiring care and those caring for them, including health and care workers and other vulnerable groups.

8.28 In Version 1 of the IPT, domiciliary care workers and unpaid carers were not part of the group of healthcare workers considered eligible for Covid-19 testing. In this version, Covid-19 testing was prioritised for those healthcare workers involved in frontline patient facing clinical care working in the following settings:

a. Physicians and surgeons involved in the care of acutely ill patients
b. Emergency Departments
c. Critical Care Units/Intensive Care Units
d. Primary Care
e. Frontline Ambulance staff

Covid-19 testing was also extended to include family members causing the health care worker to self-isolate and symptomatic healthcare workers who were self-isolating.

8.29 I approved Version 2 of the IPT dated 26 March 2020 [MMcB6/119 - see INQ000362324] which included the testing of frontline care staff in the community. On 30 March 2020, the CSWO issued a letter which explained that this testing included key staff working in nursing and residential homes and delivering domiciliary care [MMcB6/120 - see INQ000362315]. I am not able to comment on the accuracy or otherwise of the handwritten note of the NI Executive meeting of the 8 April 2020 which records the Health Minister as stating that *"domiciliary not frontline staff"* [MMcB6/070 - see INQ000065725_0004]. I only became aware of this note in the course of the preparation of my written statement. In my experience, this was not the view of the Health Minister and I have no recollection of him having made this comment. I believe this handwritten note, when read in the context of the line spacing, is open to an entirely different interpretation.

8.30 On 4 June 2021, I issued a letter to all HSC Trusts requesting that they should develop robust preparations and plans for a significant expansion of regular asymptomatic testing of all patient-facing staff in all programmes of care, as a key priority [MMcB6/121 - see INQ000377271]. This included HSC Trust based domiciliary care workers. On 17 August 2021,

the CSWO and I wrote jointly to independent domiciliary care providers to advise that Lateral Flow Device (LFD) testing was available on a voluntary basis to asymptomatic staff employed by domiciliary care providers [MMcB6/122 - see INQ000520334]. On the same date, the Department also wrote to all HSC Trusts notifying all Personal Assistants providing care and support to individuals in NI that Covid-19 testing using LFDs was available. HSC Trusts were asked to put in place arrangements for this letter to be forwarded to clients in receipt of a Direct Payment, an Independent Living Fund Award, or a Thalidomide Health Grant [MMcB6/123 - see INQ000520335].

8.31 The publication of the Department's Covid-19 Test, Trace and Protect Transition Plan on 24 March 2022 set out a more targeted approach to testing, which focused on protecting those at higher risk of serious illness from Covid-19. On 22 April 2022, the PHA issued letters to independent domiciliary care providers [MMcB6/124 - see INQ000520336] and to HSC Trusts for forwarding to Personal Assistants [MMcB6/125 - see INQ000520337], informing them that no changes were planned to the advice on asymptomatic testing arrangements for domiciliary care workers or Personal Assistants. Independent domiciliary care workers were to continue to conduct self-testing using LFD tests on a twice weekly basis in their own home, prior to attending their place of work. Personal Assistants were also to continue to conduct self-testing using LFD tests on a twice weekly basis in their own home, prior to attending their place of work. For Personal Assistants who were not already part of an existing regular Covid-19 testing programme at work, they were able to continue to access LFD test kits either online for delivery to their home or were able to collect LFD test kits from participating community pharmacies.

8.32 In respect of unpaid carers, the Department did not differentiate its Covid-19 testing advice for this cohort from the testing advice which was

provided to the general public. The risks to vulnerable older people in Care Homes were different to those risks posed to individuals who were living in their own homes, and the advice on testing appropriately reflected this. People living in a Care Home (both residential and in nursing homes), particularly as opposed to those in their own homes, were likely to have more significant underlying medical conditions overall, increasing the risk of more severe disease. They tended to have a higher level of dependency and require close personal care and support with the activities of daily life, which increased their risk of exposure to infection. The care in residential and nursing homes is typically provided by a greater number and range of Care Home staff and other health professionals compared to the care provided to people living in their own homes, with staff in care homes moving freely between the community and care home. Care Home staff were likely to have significant contacts outside the care home, with family members or in retail environments, for example, increasing the potential for inadvertent introduction of infection into the care home setting. Consequentially, there were multiple opportunities for the introduction of infection into a care home compared with the risk of infection entering a domestic setting, depending on the effectiveness of IPC practices. The larger number of residents and staff in a Care Home compared with a domestic environment meant that following the introduction of infection there was a greater risk of spread; each care home effectively functioned as its own epidemiological unit once infection was introduced, as described at paragraph 6.19. Once a highly infectious virus such a SARS-COV2 was introduced there was a significant risk that that the virus would be transmitted within the care home, again depending on the effectiveness of IPC practice. The recommendation made by the EAG-T on testing, including in relation to domiciliary care providers and unpaid carers as with testing more generally, was continually reviewed and revised based on the totality of all the extant scientific evidence then available including relevant SAGE papers and recommendations. As

previously described, the Testing in Care Homes – Task and Finish Group's role was to oversee the implementation of testing in Care Homes.

8.33 From May 2020, unpaid carers who had symptoms of Covid-19 could, as members of the public, access PCR testing which was made available across a number of test sites in NI as part of the National Testing Programme. The availability of asymptomatic Covid-19 LFD testing across a range of different sectors continued to be progressed at pace and expanded throughout 2021.

8.34 On the 19 April 2021, the Health Minister approved the extension of the UK home ordering service to NI which enabled individuals with no symptoms of Covid-19 to order free LFD tests online and via the 119 national number to be delivered to their home. In addition, community collect and pharmacy collect sites were also established across NI to enable the general public with no symptoms of Covid-19 to access LFD tests.

8.35 On 15 June 2021, I wrote to Care Homes to advise that the Department was moving to extend the LFD self-testing initiative to all asymptomatic visitors. The letter [MMcB6/126 - see INQ000348909] explained that regular and ongoing testing of people who visited a Care Home could reduce the risk of Covid-19 by identifying people who were asymptomatic but who might be carrying the virus and may be spreading the virus unknowingly. Although there was no mandatory requirement for a visitor to have a Covid-19 test in advance of a visit, Care Homes were asked to promote and strongly encourage all visitors to avail of the free LFD self-testing kits which were made available, with visitors to undertake twice weekly LFD self-testing in the comfort of their own home. The letter advised that if the visitor had a positive LFD test result, they should

immediately self-isolate and book a confirmatory PCR test and must not visit the Care Home. The letter also explained that while a test for Covid-19 reduced the risk associated with visiting (as an additional risk reduction measure), it did not completely remove the risk. The Department reiterated the importance of all other IPC measures such as hand washing, maintaining social distance and wearing of PPE, including face coverings, continuing to be implemented at all times during each Care Home visit.

8.36 The PHA also issued correspondence to all Care Homes via the RQIA outlining the actions that Care Homes were to put in place to implement self-testing for Covid-19 using LFD devices for visitors to Care Homes. This communication advised that Care Homes were to provide visitors with packs of LFD tests. Care Homes were advised to encourage visitors to register their LFD test result using the Care Home unique identification number (UON) [MMcB6/127 - see INQ000348910].

8.37 From the 22 December 2021 [MMcB6/128 – see INQ000459409], with the emergence and rapid spread of the Omicron variant, the regular asymptomatic testing arrangements in Care Homes were augmented to continue to protect residents and staff. It was recommended that Care Home staff undertake 3 LFD tests each week, in addition to their regular weekly PCR test. Agency staff working in Care Homes were to take an LFD test before commencing every shift in any new home and, if working for an extended period in a single care home, agency staff were to follow the same testing pattern as permanent staff. There was no requirement for residents to undertake regular LFD testing unless they planned to leave the Care Home. Residents were to continue to be offered a PCR test every 28 days.

8.38 On 31 December 2021 [MMcB6/129 - see INQ000520325], the LFD testing frequency for Care Home staff increased from 3 LFD tests per week, to a daily LFD test, in addition to the weekly PCR test.

8.39 As set out in paragraph 8.31, the publication of the Department's Covid-19 Test, Trace and Protect Transition Plan on 24 March 2022 signalled a more targeted approach to test and trace, which focused on protecting those at higher risk of serious illness from Covid-19. On 22 April 2022 the Department issued a communication to key stakeholders, including Carers NI and the PCC, to advise that people with symptoms of Covid-19 and people without symptoms, including carers who provided close personal care for someone who was at higher risk if they contracted Covid-19, could still continue to access LFD tests. The recommendation was to test using an LFD test a maximum of twice a week. Carers were able to order LFD test kits online for free delivery to their home or they could collect from a participating community pharmacy if they did not have symptoms of Covid-19. Information for those groups who were permitted to continue to access LFD testing was also placed on NI Direct.

8.40 On 5 May 2022, the PHA issued a further update to Care Homes about testing arrangements including, amongst other things, advice on the following: the management and testing of residents and staff who had Covid-19 symptoms; testing when positive cases had been identified in a Care Home but outbreak not declared (Rapid Response Testing); and testing during an outbreak in a care home. Although optional, twice weekly LFD testing for visitors also continued to be promoted [MMcB6/130 - see INQ000348911].

<u>NI Executive discussions on testing</u>

8.41 There was an awareness of the risk posed to those living in Care Homes from Covid-19 at an early stage, although as knowledge on transmission emerged, the risks became better understood. As such, the arrangements to protect those living and working in Care Homes was frequently discussed at NI Executive meetings. This included consideration of the testing programme in Care Homes, details of the number of outbreaks and supply of PPE wear.

8.42 The handwritten notes of the NI Executive Committee meeting on 8 April 2020 show that the Health Minister raised the issue of ramping up testing capabilities from the start and that Care Homes were being prioritised from the start [MMcB6/070 - see INQ000065725].

8.43 The DCMO provided an update to the Health Minister ahead of the NI Executive Meeting on 15 April 2020 with regards to testing in Care Homes [MMcB6/131 – see INQ000454847]. The handwritten notes of the NI Executive Committee meeting on 15 April 2020 show that there was discussion of when all symptomatic people in Care Homes would be tested, and that Care Homes should get the support they need [MMcB6/071 - see INQ000065735].

8.44 The handwritten notes of the NI Executive Committee meeting on 17 April 2020 show a discussion of testing capacity and visiting guidance for Care Homes and that the Health Minister provided a summary of the priority categories for testing which included HSC staff and symptomatic people in Care Homes but that they did not have the capacity to test everyone [MMcB6/072 - see INQ000065691].

8.45 The handwritten notes of the NI Executive Committee meeting on 7 May show that the Health Minister gave an update on Care Homes, including that there had been more testing in Care Homes and that Care Homes remained the priority [MMcB6/132 - see INQ000065724].

8.46 The handwritten notes of the NI Executive Committee meeting on 11 May 2020 show that Care Homes were still a main focus and that NHS testing was being redirected to Care Homes and that all symptomatic residents and staff in Care Homes would be tested but that universal testing was not taking place due to capacity issues [MMcB6/133 - see INQ000065731]. Discussions at the NI Executive meeting reflected the priority that the Health Minister and all other NI Executive Ministers gave to the expansion of testing in Care Homes as rapidly as possible. I believe that Ministers were fully aware of, and understood, the constraints of testing capacity and were fully informed about the logistical challenges involved. While Ministers wished testing to be expanded as soon as possible and sought to understand the limitations, their comments were generally supportive. I do not believe the discussions influenced or changed the policy or priority that the expansion of testing in Care Homes was already being afforded.

9. Personal Protective Equipment

9.1 As part of the UK Pandemic Influenza Preparedness Programme (PIPP), the Department holds PIPP stockpiles for use in an emergency, which act as a buffer to the normal supply chain. PIPP stocks are only ever meant to tide the Department / HSC Trusts over in an emergency, until such time as normal supplies could be replenished or resume. These stockpiles include PPE such as gloves, aprons, gowns, facemasks, visors and eye protection. The PIPP stockpile was managed by the Department's Emergency Planning Branch which, at the time and throughout the pandemic response, was within CMOG. In NI, both before and during the

pandemic, the BSO's Procurement and Logistics Service (BSO PaLS) was and remains responsible for equipment supply chain and procurement activity on behalf of HSC Trusts and all other stock was managed by the BSO. During the initial response to the pandemic, the four UK countries worked closely together regarding management of PIPP stock, with PHE leading on 'Just in Time' contract negotiations.

9.2 As CMO, I participated in strategic level discussions at UK CMO meetings and UK Senior Clinicians meetings concerning regular reviews and updates to the UK wide IPC guidance which included advice on the most appropriate PPE in particular clinical circumstances, in keeping with emerging evidence and risk assessment. Neither I nor CMOG was involved in providing expert professional and technical advice to inform IPC guidance or PPE policy. These are highly specialist areas, and relevant policy and guidance was taken forward at a 4 national level under the UK 4 Nation IPC Cell. NI was represented and informed the work of this group through the PHA IPC Cell. My role as CMO with respect to PPE was to Chair the Strategic Cell during the first wave and, with the support and advice of the DCMO and Director of Population Health, to consider requests for the release of PPE from the PIPP stockpile to augment normal supplies. I have sought to summarise the work that was undertaken by others which I was aware of at the time to be of assistance to the Inquiry.

9.3 In the first wave of the pandemic there was a significant and intense demand for PPE across all HSC settings, at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a ban on the export of PPE by China, a leading global provider. It was essential that all health and social care workers had access to PPE appropriate to the setting and circumstance in which they were providing care, as set out in the IPC guidance and in keeping with

the advice of the PHA IPC Cell. CMOG was not generally involved in the provision or supply of PPE to residential care and nursing homes, domiciliary care or unpaid carers or the wider health and social care. In February and March 2020, issues were being escalated to the Department around the supply and availability of PPE, both within HSC Trusts, but also within parts of the HSC which would normally not use PPE daily, for example, Community Pharmacies or those who would normally source their own supplies, such as GP practices and dentists and the Independent Sector including Care Homes.

9.4 As outlined above at paragraph 7.3, it was understandable that staff were concerned about becoming infected at work and subsequently infecting their patients or those they were providing care for in the community, and that they had the right IPC resources available to prevent this. In the early stages of the pandemic especially, there was widespread concern in some professional groups that the IPC measures being recommended were not sufficient. I believe these concerns were based, in part, on a perception that IPC was being driven by supply constraints as a consequence of undeveloped supply chains rather than science. Although colleagues in the BSO or the PPE Supply Cell may be better placed to comment, while there were significant challenges in ensuring full and adequate stock levels to meet anticipated demand for PPE, to my knowledge there were no occasions when in NI we were not able provide appropriate PPE to health and social care staff including social, community and residential care staff. This was greatly assisted by considerable efforts by HSC Trusts, BSO and the PPE Supply Cell with respect to modelling and anticipated demand, additional procurement and efficient stock control and distribution and in additional close liaison with the other UK jurisdictions with respect to mutual aid and when this was necessary. There were also debates about what constituted an aerosol generating procedures (AGP) requiring higher levels of IPC and this was perhaps one of the areas of

greatest concern. Some clinicians proposed different approaches based on an interpretation of latest evidence. This is considered more fully in Chapter 10 pages 330 - 365 of the UK CMO Technical Report [MMcB6/001 - see INQ000203933].

9.5 Given the critical need for PPE, a decision was taken on 23 March 2020 to establish a distinct PPE Strategic Supply Cell, chaired by a Deputy Secretary within the Department. Prior to the establishment of the PPE Supply Cell, the Chief Pharmaceutical Officer chaired the Supply Cell, which had strategic oversight of medicines and PPE. The aim of the PPE Strategic Supply Cell was to prioritise the supply and distribution of PPE for the HSC and improve the robustness of the decision-making at the appropriate level. CMOG was not represented on the PPE Strategic Supply Cell and had no further role in local NI guidance or policy with regard to the provision and availability of PPE. This work was taken forward by the chair of the PPE Supply Cell, and her team working with relevant policy colleagues in the Department, BSO and HSC Trusts. The BSO as the HSC procurement lead ultimately retained responsibility for procuring PPE. BSO was supported by the PPE Strategic Supply Cell and the Construction and Procurement Delivery Division of the Department of Finance which was responsible for leading the procurement of PPE for the non-health sector.

9.6 The approach taken by the Department, particularly around supply, was to explore every viable channel locally and internationally to procure PPE. While I was not personally involved, I understand that there was near daily engagement to ensure efforts were coordinated and that opportunities were explored to source PPE locally and internationally. During this time there was a significant volume of approaches by potential manufacturers to supply PPE. While not involved, I was aware that arrangements were established in early April 2020 where all offers were channelled through

the Department of Finance, which undertook a first level triage before directing suitable offers to the BSO or elsewhere as appropriate. Those directly involved in the work of the PPE Supply Cell and the BSO will be best placed to provide further details if this is of assistance to the Inquiry.

9.7 Following engagement with BSO and the sector, SSPG issued guidance on 12 March 2020 stating that independent providers were responsible for sourcing their own PPE equipment, but that HSC Trusts would work closely with independent providers to ensure they had the appropriate equipment available to them, if suspected or confirmed cases of Covid-19 arose. Further Departmental guidance on 17 March 2020 stated that whilst independent service providers were required to work with suppliers to secure adequate PPE supplies, Trusts would provide support where they were unable to source items. I was aware of and supportive of the arrangements introduced for the provision of personal protective equipment to the independent sector through nominated points of contact within HSC Trusts where they were unable to source their own supplies [MMcB6/034 - see INQ000120717 and MMcB6/068 – see INQ000353600].

9.8 Again, while I was not directly involved, I was also aware of the reporting mechanism introduced from the week ending 11 April 2020 whereby each Trust reported to the Department on the volumes of PPE they provided to the independent sector – Care Homes and Domiciliary Care - on a weekly basis [MMcB6/134 – see INQ000417493 and MMcB6/135 – see INQ000471495]. Reporting and collation of this information concluded on 31 March 2023. I understand that the Department published updated advice for Informal (unpaid) Carers and Young Carers during the Covid-19 pandemic on 3 August 2020 [MMcB6/136 - see INQ000276428] which was revised and updated throughout 2020 and 2021 to align with wider

developments and guidance that included updates on access to PPE. I was not involved in the development of this guidance.

9.9 On 15 April 2020, on behalf of the Minister, I asked the Department's Internal Audit team to carry out a rapid review of PPE focusing on the appropriate receipt, storage, distribution and use of PPE across the HSC System. The report [MMcB6/137 - see INQ000137353 and MMcB6/138 - see INQ000137351] was received on 12 May 2020. The report made specific recommendations, which can be grouped into the following key headings:

- demand management and use of PPE;
- modelling;
- stock management and management of supplies across the system;
- resilience of supply chains;
- PIPP release mechanisms; and
- supporting staff.

9.10 The head of the PPE Supply Cell oversaw the Department's Action Plan to respond to the recommendations. Emergency Planning Branch was involved in the implementation of the PIPP recommendation which resulted in a PIPP release pro-forma being introduced.

9.11 As mentioned at paragraph 7.7, there was widespread concern in some professional groups, especially at the start of the pandemic, that the IPC measures being recommended were not sufficient. I believe in part, these concerns were based on a perception that IPC was being driven by supply constraints because of undeveloped supply chains, rather than science. I am aware that concerns were raised through initial reports on mainstream media (newspapers, television and other reliable news sources) and social media, for example through a report on 25 March 2020 by Belfast Live

"Healthcare workers in Northern Ireland say they are 'scared' to go to work as they aren't being properly protected from COVID-19'" [MMcB6/139 – see INQ000585011] and a report by Unison on 1 April 2020 which outlined *"The heads of Britain's health and social care unions have today (Wednesday) warned ministers that the lack of personal protective equipment (PPE) for health and social care workers is a "crisis within a crisis"* [MMcB6/140 – see INQ000339482]. Furthermore, at this time, there were discussions at the Department's TMG meetings about concerns being raised by staff that PPE was either not available to all staff across the Health and Social Care sector in a timely fashion, or that there were concerns about how this was being managed and shared around those who needed it.

9.12 Data on Care Homes including the adequacy of supply of PPE was collated by RQIA as they maintained contact details and had ongoing engagement with the sector with the establishment of the SST. This information was shared with others, for example local HSC Trusts, who could provide support including with the supply of PPE as required. The data from RQIA was used to prepare a weekly dashboard for the Health Minister which provided a high-level summary of Care Home self-assessed ratings for PPE, Workforce and Cleaning. The dashboard also provided a summary of Trust Surge status based on an analysis of Care Home reported information on the four indicators in the HSCB / PHA Care Home Surge Decision Support Framework which included: Covid-19 Outbreak; Workforce; PPE & Equipment required for management of Covid-19 and Residents in acute decline. This weekly report was received by SSPG and the CSWO and shared with policy and professional teams in the Department including CMOG.

9.13 While I was not involved, given concerns with respect to supply across health and social care including in residential care and nursing homes and

the wider care sector, in addition to work on supply chains, I was aware that at an early-stage work was also directed at processes to maintain confidence in supply. This included support and work to support and enable: the management of demand in HSC Trusts to ensure a more even distribution of stock across all HSC sites [MMcB6/141 - see INQ000120711]; provision of PPE to the Independent Sector by their local HSC Trust; and assess the level of immediate and forecasted demand. To inform the projected demand for PPE, initial modelling was undertaken by the HSCB in late March 2020. The modelling looked at PPE demand across hospital, community and primary care settings at extreme surge / worst case scenario [MMcB6/142 - see INQ000130316; MMcB6/143 - see INQ000120794; MMcB6/144 – see INQ000120795; and MMcB6/145 – see INQ000120796]. Neither CMOG nor the NI Modelling group were involved in this work.

9.14 I understand that, in response to staff raising concerns, the CNO met with the Health Minister on 17 April 2020 to discuss the issue and the Health Minister issued a statement on 27 April 2020 [MMcB6/146 - see INQ000371513] that said: "*ensuring that Care Homes have sufficient supplies of PPE is an absolute priority, and Trusts will work with Care Homes in their areas to ensure that each home has a buffer of PPE stock*". The PPE Supply Cell went on to establish a new dedicated mailbox to allow members of staff across the Health and Social Care workforce to raise issues of concern over the supply, quality and usage of PPE. Policy and professional colleagues directly involved in this will be better placed to advise the Inquiry if this is of assistance.

9.15 I did not provide any advice regarding the forms and standards of PPE that should be used by workers in both residential and nursing homes and domiciliary care settings. However, I understand that the PHA established a product review team designed to support the testing of PPE in a clinical

environment and that this helped ensure the maintenance of PPE standards. PPE guidance was issued by the IPC Cell in the PHA.

10. Visiting Restrictions

10.1 As I have said at paragraph 6 of my witness statement to Module 3 [MMcB6/003 - see INQ000421784], Care Home providers faced an incredibly difficult challenge in protecting those most vulnerable to the virus in Care Homes, who required close personal care, including managing the adverse health consequences of isolation and loneliness due to separation from family and friends. From a professional medical point of view, I recognised that measures taken to reduce transmission, such as visiting restrictions would cause increased stress and distress for residents, families and staff and I was concerned about the impact these issues could have on the health and wellbeing of patients, residents and their families. It was a key consideration throughout the pandemic response as to how best manage and seek to minimise the detrimental impact on vulnerable people.

10.2 As set out in paragraph 2.41, in May 2020, I established a Testing in Care Homes - Task and Finish group [MMcB6/024 - see INQ000137355] chaired by the DCMO. In addition to providing direction, guidance and support in the development and implementation of the Covid-19 testing arrangements within Care Homes, the group also more generally provided public health technical advice to the CSWO and his policy team and to the CNO and her team who were leading on and coordinating guidance on visiting and a range of other interventions in the care sector. Their work in the sector was with support from the HSCB, PHA, HSC Trusts and the RQIA in its revised support and liaison role. The Care Homes – Task and Finish Group met for the first time on 8th May 2020, with subsequent meetings scheduled on a regular basis, and the final meeting of the Group

on 28 January 2022. The notes of the Care Homes – Task and Finish Group meetings, including handwritten notes for meetings where there is no written minute, have previously been issued to the Inquiry, exhibited as part of the Module 2C Annex 2 disclosures [MMcB6/094 - see INQ000437695; MMcB6/147 – see INQ000425660; MMcB6/148 - see INQ000438182; MMcB6/149 - see INQ000438194; MMcB6/097 - see INQ000438195; MMcB6/150 - see INQ000437704; MMcB6/151 - see INQ000437708; MMcB6/152 - see INQ000437713; MMcB6/095 - see INQ000438220; MMcB6/153 - see INQ000449425; MMcB6/154 - see INQ000437737; MMcB6/155 - see INQ000438180; MMcB6/156 - see INQ000449426; MMcB6/157 - see INQ000449427; MMcB6/158 - see INQ000449428; MMcB6/159 - see INQ000449429; MMcB6/160 - see INQ000449430; MMcB6/161 - see INQ000449431; MMcB6/162 - see INQ000438223; MMcB6/163 - see INQ000449437; MMcB6/164 - see INQ000449432; MMcB6/165 - see INQ000438224; MMcB6/166 - see INQ000438225; MMcB6/167 - see INQ000438226; MMcB6/168 - see INQ000437785; MMcB6/169 - see INQ000437790; MMcB6/170 - see INQ000449433; MMcB6/171 - see INQ000437795; MMcB6/172 - see INQ000437797; MMcB6/173 - see INQ000449434; MMcB6/174 - see INQ000449435; MMcB6/175 - see INQ000437807].

10.3 My DCMO colleagues and CMOG provided professional technical advice primarily as it related to testing for Covid-19 throughout the pandemic to inform changes to visiting guidance for care settings. One such example from a practical perspective was in December 2020 when, recognising concerns from Care Home providers about visiting and care partner arrangements over the festive season, I moved with the agreement of the Health Minister to ensure that Covid-19 testing was made available to visitors, who were not displaying symptoms of infection, as an additional risk mitigation to support visiting within the Care Home setting and to provide further reassurance to Care Home providers. This was an

additional measure alongside existing guidance and IPC measures to support Care Home visiting.

10.4 While I was not directly involved in the work to develop Visiting Guidance, I do recall having discussions with the CNO and CSWO with respect to our respective significant professional concerns about the importance of visiting particularly for those people living in Care Homes and the potential health consequences of loneliness and isolation from family and friends. The CSWO and CNO, being aware of concerns raised around the extent to which some Care Homes were facilitating visiting in line with the visiting guidance, both wrote to HSC Trusts and to IHCPs on 12 November 2020 [MMcB6/176 - see INQ000256455] to reiterate the importance of visiting, options for how it could be facilitated, and encouraging the implementation of the Care Partner scheme for all who requested it. The CSWO, CNO and I subsequently had direct engagement with COPNI and his team, as well as with representatives of the IHCPs in NI who represented Care Homes and Day Care providers around this and to emphasis the importance of visiting for residents and families being supported by Care Home providers. This engagement reflected our concerns and our recognition that we needed to ensure that visiting was facilitated, in a manner that was in line with the guidance at the time. I understand that the development of the updated visiting guidance was further informed by consultation with a range of key stakeholders, including IPC professionals, HSC Trust Executive Directors of Nursing, COPNI, Mental Health Advocacy Organisations, the Commissioner for Children and Young People and Families Involved Northern Ireland (FINI).

Care Partners

10.5 Updated guidance, 'Covid-19 Regional Principles for Visiting in Care Settings in Northern Ireland' dated 21 September 2020 [MMcB6/176a –

see INQ000256450] was issued on 23 September 2020 and encouraged Care Homes to develop new Care Partner arrangements, a scheme which allowed the identification of an appropriate person to assist in maintaining each resident's physical or mental health. I had discussed this scheme with the CNO and the CSWO and was supportive of this approach as I recognised that Care Partners played an invaluable role in supporting their loved one's physical and mental health. At the Care Homes - Task and Finish group meeting on 8 January 2021, CMOG colleagues gave a commitment, in principle, to provide testing for Care Partners as part of the wider package of appropriate measures. Nominated Care Partners were subsequently offered regular PCR testing at the same frequency as staff, as set out in the Department's Visiting Guidance effective from 15 January 2021 [MMcB6/177 - see INQ000276331]. At the same time, from January 2021, the PHA was working closely with the Care Home sector on the deployment of LFD tests for visitors to Care Homes. The first Care Home began testing visitors on a voluntary basis during the week commencing 18 January 2021.

10.6 Care Partners were defined as: "*more than visitors and likely as having previously played a role in supporting and attending to their relative's physical and mental health, and/or provided specific support and assistance to ensure that communication or other health and social care needs could be met due to a pre-existing condition. Without this input, a resident could experience significant and/or continued distress.*" In my view, this definition was sufficiently clear in its intent to provide residents with ongoing contact, support and assistance from a loved one. It was important that the definition was not so precise as to exclude the right person for the role.

10.7 I was not involved in the development, design or implementation of the Care Partner arrangements, although I was supportive of the approach

when it was discussed with me by the then CSWO and CNO. They and their respective teams would be best placed to provide further information, if considered to be helpful to the Inquiry. I am aware that the Department engaged with representatives of families and other statutory organisations involved with the independent Care Home sector to look into concerns regarding the implementation of Care Partner arrangements in some settings. Departmental staff then engaged with the Independent Care Home providers involved, and relevant HSC Trust staff who were involved in commissioning care in those settings, to provide focused support to individual Care Homes around the introduction of the Care Partner concept.

10.8 While the Care Partner arrangements were introduced under the auspices of the Regional Guidance Principles, and were not mandatory or underpinned in legislation, there was a clear expectation that the scheme would be fully implemented in all Care Homes, and for all residents who desired it. To that end, the Health Minister announced additional funding on 22 October 2020 [MMcB6/178 - see INQ000276403] to be allocated to providers to ensure the necessary infrastructure and other necessary arrangements could be established. The expectation was that the steps necessary to introduce the Care Partner scheme should be completed by early November 2020. However, a small number of Care Home providers continued to require some intervention and encouragement from the Department, HSC Trusts, PHA and RQIA from time to time, after the initial implementation period, to encourage ongoing adherence with the Care Partner scheme recognising that this was a voluntary scheme and not mandatory. This is not a criticism of care providers, rather a reflection that at times, in my professional view, the immediate and manageable risks of facilitating visiting were not fully appreciated in the context of the significant adverse health consequences of isolation and loneliness of

Care Home residents. I do not believe the difficult balance of risk and benefit was always achieved.

10.9 I fully appreciated the complexities and the genuine concerns of Care Home providers in protecting individuals and other residents in Care Homes and that this led some Care Homes to stop visiting. However, I did not believe that these decisions were always proportionate or warranted, given that the risks associated with visiting could be mitigated with adherence to the relevant guidance. I still believe this to be the case, based on the evidence of risk and benefit. That said, I fully appreciate that such determinations were finely balanced and made to protect residents.

10.10 In response to those concerns, the CSWO, CNO and I issued a joint letter to the Care Home sector, HSC Trusts, the PHA, HSCB and RIQA, on the 16 December 2020 [MMcB6/179 - see INQ000256371]. The letter informed the sector that the Care Home regulator, the RQIA, would assess the approach being taken to visiting when it was undertaking inspections of residential and nursing homes, and would consider compliance with the relevant care standards. The letter also advised that the visiting policy and appropriate implementation of the policy into practice would therefore be a material consideration in the inspection and regulation of each care home. The RQIA thereafter reported weekly to the PHA, and where issues around compliance were identified, the CNO's team worked with the relevant HSC Trusts and PHA colleagues to maintain contact with the Care Home management to identify solutions and encourage that compliance. As an additional assurance, the letter advised that Covid-19 testing would be made available to one visitor or Care Partner per Care Home resident per week over the Christmas 2020 period and up to 8 January 2021, and that the testing would be bookable at existing testing facilities, using the established PCR tests. The letter emphasised that

safe visiting could already be accommodated as set out in regional guidance documents and should not stop after 9 January 2021.

10.11 A further letter was issued by the CNO and CSWO on 15 April 2021 [MMcB6/180 - see INQ000469788] which again reiterated that visiting policies and their appropriate implementation would be a material consideration in the inspection and regulation of each Care Home. Staff went to significant lengths to enable communication with relatives and between patients and their relatives including the use of digital technology. This, however, could not in my professional view adequately address the loss of face-to-face and human contact during such discussions or in-person visiting. I will provide further comment later in this statement in the section on reflections and learning. On reflection, had it been implemented fully by all Care Homes as intended, and earlier, I believe the Care Partner scheme could have had significantly greater impact and this is an important learning point for any future pandemic.

11. Access by / to Healthcare Professionals

11.1 Ensuring the continued access to emergency and essential services was an essential element of the health and social care services preparation and response. Extensive efforts were made to provide as many of these services, and the required care and support by alternative means, if possible, while minimising the risk of infection.

11.2 As stated at paragraph 2.38 above, I was not directly involved in developing Visiting Guidance, although I did have discussions with the CNO and CSWO about the importance of visiting, particularly for those people living in Care Homes. We also had direct engagement with COPNI and his team and representatives of the IHCPs in NI representing Care Homes and Day Care providers. It was a key consideration throughout

the pandemic response as to how best manage and seek to minimise the detrimental impact on vulnerable people, including those in Care Homes. To that end, my DCMO colleagues in particular, and CMOG provided additional professional advice during the pandemic to inform changes to visiting guidance for care settings when requested. I also provided additional advice on those matters related to testing, or further interpretation of advice provided by the IPC Cell as escalated to me, although my direct support and advice was understandably limited by other wider responsibilities. CMOG, DCMO colleagues and I also worked to ensure that Covid-19 testing was made available to all visitors, including Health and Social Care professionals visiting Care Homes to provide clinical assessment and care which, alongside existing guidance and IPC measures, helped to support Care Home visiting and the clinical assessment, care and support required.

11.3 As outlined above at paragraph 8.17, the Health Minister, informed by advice from myself and CMOG professional and policy colleagues, announced on 27 April 2020 [MMcB6/109 - see INQ000103694] that testing would be carried out on all staff and all residents in Care Homes when a home was identified to the Health Protection team in the PHA as having a potential outbreak or cluster of infections. This replaced the previous approach of only testing staff and residents when they had been displaying symptoms. On 18 May 2020 [MMcB6/102 - see INQ000103704], the Health Minister announced that Covid-19 testing would be made available to all Care Home residents and staff across NI; this included Care Homes which did not and had not previously experienced a Covid-19 outbreak. This was based on and informed by advice from myself and the CSA, and reflected evidence from SAGE and SIG. The Health Minister said it was intended to complete the roll-out of testing to all residents in June 2020. The Health Minister wrote to all Care Home providers on 19 May 2020 about these extended Covid-19 testing

arrangements. The initial phase of this extensive testing programme was completed in all Care Homes across NI by the 30 June 2020 as had been previously announced by the Health Minister.

11.4 The Department's Social Services Policy Group produced guidance dated 17 March 2020 on 'Covid-19 Guidance for Nursing and Residential Care Homes in Northern Ireland' which stated that *"providers must ensure relevant Health and Social Care professionals continue to have access to residents where they need to in order to carry out any necessary assessment or deliver care"* [MMcB6/034 - see INQ000120717]. As I've stated at paragraphs 5.3 and 7.21, although I was not directly involved in the development of this guidance, I was fully supportive of this approach. In my professional view, it was essential to ensure that the risk of infection and outbreaks was balanced with the need for access to health services and care when required.

11.5 On 13 May 2020 the Health Minister announced [MMcB6/110 - see INQ000371406] further intensive support for Care Homes, including strengthening by HSC Trusts of hospital-to-community outreach teams, building on important work already being undertaken by Care Homes and in partnership with the HSC. It was announced that outreach teams would deliver specialist care and support to older people in Care Homes and their own homes, working in partnership with GPs, district nurses, Allied Health Professionals and social care colleagues. This was designed to facilitate vital initiatives such as virtual ward rounds. A virtual ward round allowed clinicians to connect with staff in homes. Using a mobile phone or device, the clinicians could speak face to face with the home about the needs of each individual and could also observe and speak with residents. This assisted in reducing footfall into Care Homes, which was an important infection control priority at that time. The Department took a significant role in issues affecting the vulnerability of people in Care

Homes, working alongside the PHA and HSCB, and this included outreach clinical support which neither I nor CMOG was directly involved in. I did, however, engage with and offer professional advice to the CNO and a letter issued by myself and the CNO on 15 May 2020 [MMcB6/181 - see INQ000515717] stated that "*Given the challenges we now face in the Care Home sector we write to advise of the Department's support for the expansion, redirection and repurposing of Acute Care at Home and Enhanced Care at Home teams across Trusts to provide the necessary care and support to the most vulnerable in our nursing and residential care sector. We welcome the fact that all Trusts are working to strengthen their hospital to community outreach teams. Our approach must be to continue to deliver the necessary skills and expertise to older people wherever they live. This is particularly important now for those who are resident in our Care Homes, and therefore we are fully supportive of expanding and repurposing of Acute Care at Home and Enhanced Care Teams*".

11.6 I also understand that the PHA and HSCB produced a 'Northern Ireland COVID-19 Regional Action Plan for the Care Home sector' from September 2020 onwards [MMcB6/182 - see INQ000191290]. This was an operational plan for the Care Home sector and neither I nor CMOG was involved in this work.

12. Workforce and Funding

12.1 As CMO I have no role in decisions with respect to financial approvals or allocations. While I was not involved in guidance or policy in regard to additional funding for the care sector during the pandemic, CMOG did (as sponsor for RQIA) work with the CSWO and SSPG (who had policy responsibility for Care Homes and Domiciliary Care) to refocus some of RQIA's resources into a new support team to provide a liaison role between Care Homes and HSC Trusts. From a professional perspective, I

was also fully supportive of policy colleagues' advice to the Minster to provide additional funding for sickness absence to support Care Home staff with symptoms or who had been contacts to self-isolate, as set out in paragraph 7.23.

12.2 During the relevant period, the RQIA's SST was a key support mechanism and acted as the point of contact for providers of adult residential and nursing homes, domiciliary care and supported living services who had questions and issues arising from the pandemic, including the interpretation of and implementation of relevant guidance, staffing challenges or PPE supply issues. The main objective of this exercise was to ensure that Care Home, domiciliary care and supported living providers had an identified single point of contact to raise issues and receive the most up to date advice, guidance and support from the RQIA's expert teams of inspectors. These teams were comprised of individuals who were all registered nurses, social workers or Allied Health Professionals, and therefore were suitably experienced to support this function. The RQIA had key points of contact, identified in each HSC Trust, to ensure that the information being passed on was the most up to date, and to enable the referral of specific queries to Trusts, if they were unable to resolve the matter. In addition, the RQIA were afforded broad flexibility to work with providers to find bespoke solutions to specific issues beyond the remit of generic standards or regulations, to provide safe, pragmatic remedies on a case-by-case basis. While care home, domiciliary care and supported living providers will be able to reflect their experience I believe this support was well received and was an innovative and extremely beneficial additional support arrangement to Care Homes which utilised the skills and expertise of RQIA.

13. Vaccines and Vaccination as Condition of Employment

13.1 I established a NI Covid-19 Vaccination Programme Oversight Board in July 2020 [MMcB6/183 – see INQ000485669]. Its role was to set the direction for a future Covid-19 vaccination programme, oversee the progress of the development and implementation of the vaccination programme, as well as manage the strategic interfaces between the expanded 2020 / 21 seasonal influenza vaccination programme and the expected Covid-19 vaccination programme [MMcB6/184 - see INQ000276631].

13.2 The Oversight Board, chaired by me, was accountable directly to the Health Minister, and recommendations concerning strategic policy issues were submitted to the Health Minister for decision via oral briefings or written submissions, while I took key operational decisions, based on advice from the vaccination team lead. The Oversight Board's membership included representation from across the Department including Pharmacy, Nursing, HPG, Health Protection, Emergency Planning, as well as the PHA, HSCB and the Regional Pharmaceutical Procurement Service. Membership of the Oversight Board changed as necessary as the programme was implemented.

13.3 While an Implementation Group had been established by the PHA, this then subsequently became integrated into and under the control of the Department and the NI Covid-19 Vaccination Programme Oversight Board which I chaired in October 2020, when regular meetings began to be held. The complexities of the Covid-19 vaccination programme were considerable, and the significant policy and operational elements and interfaces required an integrated approach. The Implementation Group included key stakeholders from across the wider Health and Social Care system and it set up a number of key workstreams.

13.4 On 5 October 2020, on my recommendation to the Health Minister and the Permanent Secretary, Dr Patricia Donnelly OBE, was appointed as the Head of the Covid-19 Vaccination Programme to oversee and drive the planning and operational delivery of the vaccination programme. I had significant professional experience in working with Dr Donnelly over many years in her leadership roles at Director level within the HSC sector. Dr Donnelly held this position between October 2020 and the end of March 2022 when responsibility for the operational delivery of the programme fully transferred to the PHA. Dr Margaret Boyle, a retired Senior Medical Officer, was also appointed at my request to provide additional public health policy advice in relation to the vaccination programme over the period October 2020 to the end of March 2022. A small Departmental vaccination team, led by a Grade 7, was established within CMOG and this team worked directly with Dr Donnelly and Dr Boyle on all policy and operational issues. The Vaccination Team developed an implementation plan, which was approved by the Oversight Board and the Health Minister. The implementation plan was based on the JCVI eligibility and prioritisation advice, as well as MHRA advice, where each vaccine approved for use would be deployed in NI.

13.5 The vaccination programme in Care Homes in NI had started somewhat ahead of elsewhere in the UK and was further advanced when on 30 December 2020, the JCVI provided updated advice [MMcB6/185 - see INQ000276527] recommending increasing the intervals between vaccine doses (10 weeks in NI, 12 in other UK nations) to get more people vaccinated with a first dose. The Health Minister approved the proposal that in NI the new dosage interval would be set at 10 weeks for all eligible individuals to try and maximise the numbers offered a first dose.

13.6 However, the exception to this change in NI was in Care Homes. The resources secured to deliver this element of the programme were at risk of

being deployed elsewhere had they been stood down and may not have been available again if the planned schedule of visits was significantly altered. Therefore, the Oversight Board agreed at their meeting on the 29 December 2020 that, as a substantial number of Care Home residents and staff had already received their second dose, and plans were already in place to revisit the remaining Care Homes, the Trusts' plans should remain unchanged, and all Care Home residents and staff should receive their 2nd dose (after 21 days) as initially planned [MMcB6/186 - see INQ000276652]. The Health Minister had made clear that he regarded the vaccination of residents and staff in Care Homes as a priority, a priority which I fully supported, and our best way of protecting vulnerable residents and staff. I believe the early and expeditious vaccine roll out in the care sector in NI, which overcame significant logistical and regulatory requirements and was enabled by the CPO and her team through direct engagement with the Medicines and Healthcare products Regulatory Authority (MHRA), the HSCB, PHA and HSC Trust , was a significant achievement from which there was much learning and which NI shared with colleagues across the UK and RoI.

13.7 All policy decisions in relation to the Covid-19 vaccination programme were made by the Health Minister having considered the recommendation of the JCVI which advises UK Ministers on vaccination and immunisation programmes. At a 4 UK Health Ministers meeting on the 5 November 2020 the Ministers agreed to follow a number of principles, one of which was – "*We all agree to take due regard of the Joint Committee on Vaccination and Immunisation's (JCVI) advice in developing its policy position on prioritisation and utilisation of any successful Covid-19 vaccine(s)*" [MMcB6/187 – see INQ000276627 and MMcB6/188 – see INQ000276628].

13.8 The JCVI had issued an interim prioritisation list on the 25 September 2020, which helped focused planning considerations regarding delivery plans. The ranking of priorities by JCVI, was a combination of clinical risk stratification and an age-based approach, which aimed to optimise both targeting of those at greatest risk and deliverability. The Health Minister was updated orally on developments and in submissions on 4 November and 16 November 2020 [MMcB6/187 - see INQ000276627; MMcB6/189 - see INQ000276633; and MMcB6/190 - see INQ000276634].

13.9 The reality of a situation where novel vaccines are being developed during a global pandemic is that supplies will be limited initially, with increasing stock becoming available over time to meet demand. This is highly likely to be repeated in any subsequent pandemic. Prioritisation of specific population groups was, therefore, a necessary step in the planning process to ensure that those most at risk of severe consequences of Covid-19 had early access to vaccine. JCVI reviewed UK epidemiological and clinical data, including disease incidence, mortality and hospitalisation from Covid-19 data on occupational exposure, inequalities associated with Covid-19 mathematical modelling, and evidence from different vaccination programmes.

13.10 Based on this, JCVI advised that the first priorities for the vaccination programme should be prevention of mortality, and protection of health and social care systems and staff with high occupational exposure and interaction with vulnerable patients, with secondary priorities including vaccination of those at increased risk of hospitalisation and at increased risk of exposure. This was advice that my UK CMO colleagues and I fully supported. In line with JCVI advice [MMcB6/191 - see INQ000234638], all residents in a Care Home and their carers were the number 1 priority for vaccination as part of the NI Covid-19 vaccination programme.

13.11 On 2 December 2020, JCVI published their updated advice on prioritisation for vaccination [MMcB6/191 - see INQ000234638]. Based on JCVI advice the priority list for phase one of the vaccination programme was published as follows:

1. residents in a Care Home for older adults and their carers;
2. all those 80 years of age and over and frontline health and social care workers;
3. all those 75 years of age and over;
4. all those 70 years of age and over and clinically extremely vulnerable individuals;
5. all those 65 years of age and over;
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality. This also includes those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill;
7. all those 60 years of age and over;
8. all those 55 years of age and over; and
9. all those 50 years of age and over.

13.12 The JCVI prioritisation was supported by the UK Covid-19 Actuaries Response Group (which consisted of a group of concerned actuaries, epidemiologists and public health experts) who explored the rationale for the priority order, demonstrating significant differences in vulnerability between the groups, with the number of vaccinations required to save one life increasing rapidly from vaccination of 20 Care Home residents to prevent one Covid-19 death, to 8,000 vaccinations of 50 to 55 year olds to prevent the same. This evidence-based approach to prioritisation was essential and will continue to be essential in future pandemics.

13.13 Health and Social Care Workers (HSCWs) were also included in the initial prioritisation list. Although not highly vulnerable to severe disease, they had high exposures and interacted providing close personal care with a high number of those who were likely to experience severe disease if infected and potentially die from Covid-19, so even a modest impact on transmission could have a significant impact on mortality in their patients. There was evidence that infection rates were higher in residential Care Home staff than in those providing domiciliary care or in healthcare workers. Care Homeworkers were therefore considered a very high priority for vaccination [MMcB6/191 - see INQ000234638 (as above)]. This was communicated to all staff in the Chief Professionals letter issued on 7 December 2020 from myself and my chief professional colleagues [MMcB6/192 - see INQ000442055]. This ranking on the prioritisation list included domiciliary care workers and those working in the independent sector and on 18 January 2021 this had been extended to Dental, Pharmacy and Optometry staff [MMcB6/193 - see INQ000390065].

13.14 Prior to the launch of the Covid-19 vaccination programme, HSC Trusts had been instructed by the Department's Vaccination Team (under the direction of the Covid-19 Vaccination Oversight Board) to draw up a delivery schedule that would enable all Care Homes to be visited by the end of December 2020. At that time, there were approximately 483 Care Homes in NI (although this figure can change). The delivery schedule was to be visited and completed by the end of December 2020, subject to any restrictions in access due to outbreaks of Covid-19. The delivery schedule was largely achieved, as most Care Homes, not in outbreak, were visited and residents and staff offered their first dose of vaccine. Given the logistical challenges this was a significant achievement. In my all my experience as CMO, I have never previously encountered the level of collective effort and endeavour in the completion of the vaccination

delivery and implementation schedule such was the commitment of all concerned. I believe we all were acutely aware that every single vaccine administered reduced the risk of severe disease and death in Care Home residents. To witness the administration of Covid-19 vaccines in a Care Home on the first day following delivery of Covid-19 vaccines into NI and to hear the personal testimony of the first recipient was deeply moving for all of us professionally and for respective policy teams.

13.15 There were initial significant logistical constraints with the Covid-19 vaccines which were limited by the ability to store and deploy the Pfizer / BioNTech vaccine due to the large pack size (975 doses) all of which had to be used within the short 5-day defrosted shelf life.

13.16 The NI Covid-19 vaccination programme was the first part of the UK that developed a system which enabled the deployment of the Pfizer / BioNTech vaccine in Care Homes. This system was informed by direct engagement and discussion with the MHRA. To facilitate maximum vaccine deployment and uptake in the most vulnerable patients, the vaccination model prioritised deployment of vaccine by Trust mobile teams to Care Home residents. Each Trust was able to pack down smaller quantities of the vaccine for use by their mobile teams, which was transported to a Care Home where vaccination was offered to residents and staff. Based on this model, the programme was rapidly rolled out in NI and all Care Home residents and staff had been offered two vaccine doses by 26 February 2021. The HSC Trust mobile teams were then redeployed to residential and supported living settings. Since the spring booster programme of 2022, a community pharmacy led programme has been successfully used in Care Homes. This involves each Care Home being paired with a community pharmacy, who attends the home to offer vaccination to residents and staff.

13.17 The Department was very aware that despite widespread enthusiasm for the vaccine when the programme started there would be those who, for a variety of reasons, found it harder to either take up the offer of vaccination or were reluctant to receive the vaccine at all. The Department closely monitored the early vaccine uptake data to try and identify any particular cohort or groups that this applied to.

13.18 In February 2020, as part of the draft Coronavirus Bill, DHSC Ministers had suggested that it would be beneficial for powers to be introduced which would allow for mandatory vaccination, on a temporary basis, of health and care staff, to reduce staff absences from vaccine-preventable infections and reduce onward transmission of viruses such as influenza. The proposal included that the provision should apply to all those employed by a health or care organisation, not just those delivering frontline care. Vaccines mandated under the Bill would have been limited to those recommended as suitable for the cohort by the independent JCVI.

13.19 DHSC asked the devolved administrations if they intended to introduce similar powers and the Health Minister agreed to have this as an option via the Coronavirus Bill, if circumstances were to arise where it might be required. However, in early March 2020, DHSC Ministers subsequently dropped the powers regarding mandatory vaccination in the Bill, and no further action was taken in NI to introduce its own legislation due to other urgent priorities relating to the pandemic. While the issue was considered again during the vaccination programme in 2021 by Workforce Policy Directorate colleagues, in order to try and improve uptake rates, no policy decision to proceed was taken by the Department. This decision was reached as there were concerns that mandatory vaccination of health and care staff could have been counterproductive, in leading to workforce

challenges. Further, the timeframe to introduce legislation would also have been challenging, given other significant ongoing work pressures.

13.20 Throughout the course of the programme, vaccination remained entirely voluntary for everyone in NI and, while the Department encouraged everyone to take up the offer of vaccination as they became eligible, no one was required to receive the vaccine.

13.21 From the beginning of the programme staff were encouraged to take up the offer of vaccination and a letter signed by myself and the other Chief Professionals (CNO, CDO, and CSWO), was issued to encourage uptake. In this letter of 8 December 2020, healthcare workers were reminded that they have a professional and moral responsibility to take appropriate steps to protect patients, and that getting vaccinated, and endorsing and encouraging the uptake of the Covid-19 vaccination among colleagues, would help increase uptake rates and protect not only themselves but also their patients, family and community [MMcB6/192 - see INQ000442055]. The Department issued a press release on 11 January 2021 to inform domiciliary care workers and independent sector staff that they were now eligible to receive the Covid-19 vaccine and, in the press release, the CSWO encouraged colleagues to avail of the vaccine as soon as they could [MMcB6/194 – see INQ000390133].

13.22 The Vaccine Communications Subgroup was chaired by the Head of the Communications Team in the PHA, and included Trust press office representatives, Departmental press office representatives as well as a representative from the Department's Covid-19 vaccination policy branch. The Vaccine Communications Subgroup met weekly and provided an update and raised any substantive issues at each meeting of the Covid-19 Vaccination Programme Oversight Board. The Vaccine Communications Subgroup evaluated, reviewed, and planned messaging relating to key

themes, including vaccine misinformation, thereby addressing any emerging issues which may have negatively impacted the programme roll out. A specific vaccination leaflet aimed at staff was developed and distributed by the PHA, and HSC Trust communication teams issued regular bulletins to staff to encourage uptake. Despite this considerable effort, the impact of disinformation did significantly contribute to vaccine hesitancy and vaccine uptake in NI and was reinforced by some in positions of public profile. Quite apart from the impact during the pandemic, this disinformation and ill-informed commentary in NI and globally has, in my professional view, significant wider implications for public health which we have not comprehensively or fully addressed. While there will be other behavioural factors and wider considerations, this disinformation has evidently contributed to the decrease in the uptake of routine immunisations and vaccinations. It is the case that tragically in NI some individuals experienced severe disease or died because of not availing of the Covid-19 vaccine due to misinformed and misleading antivaccination disinformation.

13.23 In order to improve uptake of the vaccine by health care professionals, the Department sought engagement and support from professional bodies and Trade Union organisations, including representatives of Care Homes and home care providers, to help encourage staff to take up the offer of vaccination. These relationships proved invaluable at certain key stages of the programme for both providing and receiving information.

13.24 While the possible steps required to introduce mandatory vaccination for frontline health care workers and / or Care Home staff were considered, to improve vaccine uptake and further protect those more vulnerable and in receipt of health and social care, such a policy was not taken any further in NI and was not developed as policy.

13.25 In November 2021, the then Health Minister announced plans for a public consultation on mandatory Covid-19 and flu vaccination for new recruits to the health and social care workforce in NI. My recollection is that this was one of many measures considered to increase uptake of Covid-19 vaccination in health and social care workers to protect those receiving health and social care services. While I was not involved in any engagement at the time, it is my understanding that Trade Unions may not have been supportive of mandatory vaccines. I recall that concerns were raised by policy colleagues in SSPG that there may be unintended adverse workforce implications. A press release was issued on this subject, but no further action was taken and subsequently there was no public consultation [MMcB6/195 - see INQ000383134]. A decision to introduce mandatory vaccination for all new entrants to the health and social care workforce would have been a workforce policy decision for colleagues in Workforce Policy Directorate within the Department and the Health Minster. As such this was a matter outside my professional responsibilities and given that it would have applied to new recruits only, in my professional view such a decision at that time would likely have limited impact during the pandemic.

13.26 It was understood that if the policy was introduced, it could only be applied to new entrants as part of their terms and conditions, rather than changing existing terms of conditions of those staff who were already employed within the Health and Social Care system. I do not recall that I was asked to provide or provided professional advice on the evidence for mandatory vaccination.

14. Do Not Attempt Cardiopulmonary Resuscitation

14.1 Recognising the very real concerns of clinicians, in April 2020 I established the Covid-19 HSC Clinical Ethics Forum. I commissioned the

Forum to develop a Framework for advice and guidance to clinicians for clinical decision making during the pandemic period and to support the work of the individual HSC Trust Clinical Ethics Committees. Part 1 set out the framework and ethical principles and Part 2 provided practical guidance which included issues of ethical decision making in practice and processes for accessing clinical ethics support. I commissioned a Covid-19 HSC Clinical Ethics Forum task and finish group to develop guidance to assist clinical decision-making during the pandemic period, should situations arise when demand for clinical care exceeded resources available. The "Covid-19 Guidance: Ethical Advice and Support Framework" was published in June 2020 and updated in September 2020.

14.2 In preparation for Module 2C of the Inquiry, I also considered and viewed the impact statements and videos submitted to the Inquiry by those who had lost relatives during the pandemic and their concerns of lack of transparency and engagement with respect to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Many have unanswered questions and concerns about those decisions, and I fully recognise that this has added to their distress. Given the volume of evidence and documents I have now reviewed in supporting the Inquiry, it is increasingly difficult to differentiate between what I knew at the time and contemporaneously and what I now know. In my preparation for Module 2 and Module 3 of the Inquiry, I have considered statements by the Health Minister and correspondence and concerns that he had received with respect to DNACPR from MLAs in the summer of 2020.

14.3 It is my understanding that concerns about the use of DNACPR orders came to the Department following correspondence from MLAs in the summer of 2020, in addition to several questions from the media [MMcB6/196 - see INQ000531065]. I understand that most concerns raised with the Department were in early 2021 when there were several

correspondence cases and NI Assembly questions from political representatives, and direct correspondence from members of the public. While I was not directly involved in the consideration or response to this correspondence, it is my understanding that the Department believed that the basis for these concerns about the use of DNACPR orders arose following an article that had been published in The Guardian on 13 February 2021, which discussed Covid-19 deaths and people with learning disabilities, and referenced DNACPRs being applied to people with learning disabilities. I understand that the concerns raised were largely about the use of DNACPR notices generally, for example whether there was blanket use of DNACPR. There was no blank use of DNACPR in NI at any stage and any such approach would have been morally and professionally unethical and unacceptable as I described in my oral evidence to Module 3 of the Inquiry.

14.4 I do not now recall if I was specifically made aware of these concerns at the time, although I believe I must have been generally aware and that the Health Minister would have probably discussed a matter of this nature with me. It is apposite to note that, at this stage, it is difficult for me to reliably separate what I knew at certain points during the pandemic, from what I have subsequently learnt from my consideration of documents in preparation of statements for this Inquiry. To the best of my knowledge, and from my subsequent consideration of the records, I did not provide written advice to the Health Minister in respect of any such concerns, nor did I provide any professional input to the responses to the correspondence received from MLAs and was not copied into the correspondence or the responses. I did, however, as outlined above, establish the HSC Clinical Ethics forum which developed the Covid-19 Guidance Ethical Advice and Support Framework to support clinical decision making, including in relation to DNACPR.

14.5 Decisions on DNACPR are clinical matters for individual clinicians and HSC Trusts and not matters that I as CMO would have operational knowledge of. All such discussions need to be approached carefully and sensitively with due consideration of the relevant professional guidance. I cannot therefore comment on individual cases and the appropriate interpretation and application of extant professional guidance on the use of DNACPRs. I am not aware of any evidence, nor do I believe that there was or was ever considered the potential blanket use of DNACPRs in NI. As a doctor, the suggestion of such practice in my view is professionally unacceptable and unethical.

14.6 Cardiopulmonary resuscitation (CPR) is a treatment that could be attempted on any individual in whom cardiac or respiratory function ceases. A DNACPR order is an explicit statement to prevent the inappropriate, potentially harmful or futile intervention of cardiopulmonary resuscitation on a person who is in the terminal phase of their illness or who is unlikely to survive such an intervention or if it is deemed that the risk of CPR would outweigh the benefit to an individual. It is important to note that a DNACPR order does not refer to any other clinical intervention or treatment.

14.7 As has been previously stated in my evidence to the Inquiry, in NI, the policy on DNACPR follows the recommendations of the Resuscitation Council and advice from the General Medical Council (GMC) for cardiopulmonary resuscitation which seeks to restart the heart; and to not offer cardiopulmonary resuscitation in cases where resuscitation would be clinically futile (Resuscitation Council section on Guidelines for treatment decisions). As with other clinical decisions, the responsibility for making a DNACPR order rests with the senior clinician who has clinical responsibility for the patient during that episode of care. A DNACPR decision should be made in conjunction with other members of the

multidisciplinary team including the GP. A DNACPR decision is made on clear clinical grounds that cardiopulmonary resuscitation would not be successful and there should be a presumption in favour of informing the patient and / or their family of the decision and explaining the reason for it.

14.8 Advance Care Planning (ACP) is a voluntary process of person-centered discussion between an individual and their care providers about their preferences and priorities for their future care. Where there is no evidence of Advance Care Planning conversations with the individual and / or no Advanced decisions to refuse treatment (ADRT) or clinical recommendations for care and treatment in the event of a sudden decline in health or an emergency, including cardiac arrest, the clinician who is treating the person would make a 'best interests' decision. As the Resuscitation Council has recommended, integrating resuscitation decisions with other treatment decisions, such as invasive mechanical ventilation, in overarching advance emergency care treatment plans using the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process would increase clarity of treatment goals and prevent inadvertent deprivation of other indicated treatments. In NI, it is proposed that the ReSPECT process will be introduced as part of the implementation of the ACP programme. While I am no longer directly involved (as the policy responsibility currently is no longer with CMOG) I understand that planning for this is ongoing. As previously indicated in my oral evidence to Module 3 of the Inquiry, I believe that this is a vitally important area of work. Progress in this important area of work should address many of the concerns of families and relatives and, had this been further advanced in NI and across the UK prior to the pandemic, I believe this would have been advantageous. It is, in my view, imperative that the Inquiry considers and makes recommendations on advanced care planning.

14.9 Health Silver had requested that the Department consider reissuing a DNACPR form for use during the pandemic to support clinical decision making. On the verbal advice provided by the regional Clinical Ethics Forum, it was identified that there was a need for further work to develop a single integrated process for ACP to support the DNACPR process. I accepted this advice, and this form was therefore not agreed, not approved by the Department, and no such form or correspondence was issued to the service in respect to DNACPR.

14.10 I subsequently commissioned further work, and an ACP policy was co-produced through extensive consultation and subsequently approved by the Health Minister for publication in October 2022. In the interim period the Covid-19 Guidance: Ethical Advice and Support Framework supported DNACPR decision making for clinical teams [MMcB6/197 - see INQ000381325]. While repeatedly reiterated throughout the Framework, Page 30 -31 of the Framework set out guidance to be applied around DNACPR orders and explains, inter alia, that the process for putting in place such orders are sensitive and complex and should include considerations of: whether an advance decision to refuse treatment is in place; whether the wishes of the person are known for the circumstances that now arise and what treatment interventions might be appropriate – bearing in mind that DNACPR orders only relate to cardiopulmonary resuscitation, and do not mean that no other treatment or support will be provided.

<u>Covid-19 HSC Clinical Ethics Forum / Regional Clinical Ethics Forum</u>

14.11 As previously described in my evidence to Module 3 of the Inquiry [MMcB6/003 - see INQ000421784, paragraph 263 – 264] the Department worked with the then HSCB, the NI Critical Care Network and HSC Trusts to ensure that intensive care bed capacity was managed to meet the

demand for both Covid-19 and non-Covid patients for critical care during the pandemic. The commitment of all involved along with real time monitoring and careful management of the HSC surge plan ensured that demand and capacity was managed, and in my experience the critical care escalation plans worked effectively. I had taken several steps to support and oversee this work. In the first wave, as described at paragraph 4.10, I had directed the HSCB to develop comprehensive surge plans, including intensive care, and subsequently requested additional work to be undertaken to quality assure these plans.

14.12 I subsequently initiated a discussion with my counterpart in the RoI to seek support for a mutual aid agreement in respect of intensive care capacity in the event of capacity being exceeded in either jurisdiction. This was developed by respective policy teams and agreed with the RoI on 9 November 2020, although it was not subsequently required. Again, on 5 January 2021, with professional input from myself and colleagues, a new command and control structure Critical Care and Respiratory Operation Hub (CCRoHub) was developed by respective policy teams and operational teams to implement a revised Third Wave Critical Care Surge Plan. The Critical Care and Respiratory Operation Hub had authority to strategically manage critical care and respiratory admissions and transfers on a NI wide basis so that NI could deliver the level of critical care and respiratory support to all likely requiring such care during the third wave of Covid-19.

14.13 The pressure on staff was, however, unrelenting and the challenges in ensuring that those requiring respiratory support (including intensive care) received it, was significant. Understandably, throughout the pandemic response and successive waves, there remained concerns among clinicians that intensive care capacity might not be sufficient to meet clinical needs, and this was creating significant psychological stress and

ethical concerns among clinical teams with the potential for moral distress should this situation have arisen. Recognising the very real concerns of clinicians - concerns that I shared - in April 2020 I established the Covid-19 HSC Clinical Ethics Forum. I commissioned the Forum to develop a Framework for advice and guidance to clinicians for clinical decision making during the pandemic period and to support the work of the individual HSC Trust Clinical Ethics Committees. A Covid-19 HSC Clinical Ethics Forum task and finish group was established to develop a Framework to provide guidance to support clinicians in clinical decision-making during the pandemic period, should situations arise when demand for clinical care exceeded resources available with the subsequent development of the "COVID-19 Guidance: Ethical Advice and Support Framework document."

14.14 All HSC Trusts established Clinical Ethics Committees, which were linked to the regional Forum. These HSC Trust Committees contributed to and participated in the development of regional guidance which incorporated guidance from the GMC and BMA and was also based on principles laid down in extant rights-based legislation including the Northern Ireland Act 1998, the Human Rights Act 1998 and the Disability Discrimination Act 1995. While based on established professional guidance and legislation, the Framework was developed to assist in the resolution of ethical dilemmas in clinical decision making during the Covid-19 pandemic escalation, should situations arise when the demand for clinical care might exceed the resources available. As indicated, while the guidance simply reaffirmed established ethical principles and existing legislation and professional guidance, I believe that the process by which it was developed and agreed provided reassurance to all those involved and provided a practical resource to support clinical teams in the most difficult of circumstances and to ensure best practice.

14.15 The Covid-19 Guidance: Ethical Advice and Support Framework was first published in June 2020 [MMcB6/198 - see INQ000353597] with further updates in September 2020 [MMcB6/197 - see INQ000381325]. Part 1 set out the framework and ethical principles in a rights-based approach, which was aligned to the adapted guidance from the Committee on Ethical Aspects of Pandemic Influenza 2007. This revised version published in 2020 had links to relevant legislation on human rights, disability, equality and consent. Part 2 of the Framework sets out Practical Guidance which included issues of ethical decision making in practice, and processes for accessing clinical ethics support, that considered a range of issues and settings such as: advance care planning, DNACPR, access to critical care, Care Homes, end of life, visiting and mental health.

14.16 Initially this Forum was established as a sub-group of the Strategic Clinical Advisory Cell (SCAC). Membership was drawn from existing Trust Clinical Ethics Committees and others with relevant expertise such as clinicians, lay representatives, faith representatives and members of the regional Critical Care, Palliative Care and Frailty Networks. A full list of members can be found at Appendix 1(ii) of the Framework document [MMcB6/197 -see INQ000381325]. The Covid-19 Guidance for Ethical Advice and Support Framework [MMcB6/198 - see INQ000353597] was initially published 5 June 2020 and circulated to health and social care services, including primary care and hospices. In consultation with Disability Action, an easy read and plain version was published for service users, carers, and families and those who advocate on their behalf. Briefing on the Framework document was offered to the NI Commissioner for Children and Young People, the Equality Commission, the NI Human Rights Commissioner and the Commissioner for Older People in NI and these organisations were also given the opportunity to consult on the document.

14.17 The Covid-19 HSC Clinical Ethics Forum task and finish group and its work was concluded in June 2020 and was replaced with the HSC Regional Clinical Ethics Forum. The HSC Regional Clinical Ethics Forum has a wider membership and a mandate to: support Trust Clinical Ethics Committees; improve training and awareness of ethical issues in clinical decision-making; and advise the Department on policy. It was not within the remit of the Covid-19 HSC Clinical Ethics Forum task and finish group or the HSC Regional Clinical Ethics Forum to provide direct ethical guidance or advice to HSC staff during the specified period. Furthermore, to my recollection, no such advice was provided, and there is no record of such advice being provided. As members of the Covid-19 HSC Clinical Ethics Forum task and finish group included the chairs or senior members of every HSC Trust Clinical Ethics Committee, support for staff decision making and advice was provided at local level, in the line with the regional Guidance as published in June 2020 and during its period of development.

15. Changes to Regulatory Inspection Regimes within the Care Sector

15.1 At the time of onset of the Covid-19 pandemic the PHA and HSCB had a joint CEO. This joint role came about as a decision by the then Permanent Secretary not to reappoint a CEO of the PHA, following the retirement of the previous incumbent, given the expectation that the HSCB's functions would transfer to the Department. While this transfer was not imminent in the absence of a Health Minister, it was expected within a reasonably and defined period of time. Arrangements had been made to support the postholder in this joint role through the appointment of two experienced deputy CEOs, one in each organisation. Prior to the onset of the pandemic, the then joint CEO of the HSCB and PHA had indicated her intention to retire. I advised the Permanent Secretary that I felt an interim experienced CEO to lead the PHA was urgently required, and the then CEO of the RQIA, who had significant system and

professional leadership experience and had been a previous Director of Nursing in an HSC Trust, was duly appointed in an interim capacity.

15.2 The appointment of a CEO to an HSC organisation is, in normal circumstances, the responsibility of the Board of that organisation, with an "Accounting Officer Letter" being issued, the approval of the Departmental Accounting Officer and Permanent Secretary confirming the appointment, and the suitability of the individual and confirming the accountability arrangements. These were, however, not normal circumstances, and the vulnerability posed by the absence of a full-time CEO in either the HSCB or the PHA was assessed as a major system risk in the pandemic response and had to be addressed as matter of urgency. Given the central role in the pandemic response by both organisations, it was my view at the time and remains so now, that the extant arrangements represented a significant risk and a potential single point of failure in the leadership of both the PHA and the then HSCB, which required to be addressed. As described at paragraph 15.1 above this was addressed by the urgent secondment and appointment of an experienced CEO from the RQIA to PHA to address this significant system risk and vulnerability.

15.3 In addition to the redeployment of the CEO, Professor Lourda Geoghegan, who was at that time the Director of Quality within RQIA, was initially seconded to the Department to provide additional support to CMOG as there was a vacant DCMO post. This decision was appropriate, in my view, given her significant relevant professional experience in public health and in particular health protection. Professor Geoghegan subsequently applied in open competition and was appointed to the position of DCMO. I understand that the RQIA's head of business support was subsequently redeployed to PHA to assist with the contact tracing service. While any such moves undoubtedly meant greater challenges for RQIA, there were significant wider system risks and vulnerabilities which could not be left

unaddressed such were their potential consequences. While it would have been preferable to have strength and depth across all organisations during the pandemic this was simply not the case, and we had to mobilise relevant expertise and experience appropriately to prioritise capacity and capability across the wider system to ensure an effective and resilient response during the pandemic. In my view, such adaptation and flexibility will be key in any future pandemic response.

15.4 As described in the paragraphs immediately above, the appointment of the then CEO of RQIA as interim CEO of the PHA occurred in discussion with the then Chair of PHA, and the Permanent Secretary, as was supported by myself. I understand the Permanent Secretary had fully intended to engage directly with the then Chair of the RQIA, however due to other urgent, pressing and immediate priorities this discussion did not occur within the timeframes envisaged. It is recognised by the Department that such a discussion should have occurred. The individual appointed, Olive MacLeod, was an experienced CEO who was, at that time, the CEO of the RQIA. Given her role in RQIA, she had significant health system level leadership experience in NI, and she also had the advantage of coming from a health professional background, having held senior professional leadership roles. The appointment of a substantive or interim CEO is not normally considered or approved by the Health Minister although the Health Minister would be advised of the appointment. While I do not now recall the details given the passage of time, I would have expected the then Health Minister to have been informed by the Permanent Secretary of the appointment of an interim CEO to the PHA. The Health Minister would not routinely or normally be consulted with respect to the redeployment of staff within or between HSC organisations or other such operational matters and I do not recall that his approval was sought by the Permanent Secretary. I understand he was advised of the planned program of redeployments and approved, although this may have been after the then

CEO in the RQIA had been approached and asked to consider a redeployment such was the immediacy of the situation.

15.5 During the pandemic, and in accordance with the Health and Social Care (NI) Act 2009, the Department held five separate draft Emergency Powers Directions giving it the authority to direct and redeploy all necessary Health and Social Care resources across the HSCB, PHA, BSO, HSC Trusts and Special Agencies to deliver an effective health response for the duration of a health emergency. Each Direction is designed to be generic and to operate independently to ensure that it complies with the powers under which each organisation functions and that they remain fit for purpose. Each Direction is held in draft form and can only be signed if all other measures have been exhausted and health service partners are not compliant with the wishes of the Department, during an ongoing emergency. The Directions are informally reviewed annually and issued to HSC, ALB Chief Executives and copied to trade union representatives for consideration.

15.6 Despite the very considerable health service pressures arising from the pandemic, the Department did not sign the draft Emergency Powers Orders [MMcB6/199 - see INQ000188763, MMcB6/200 - see INQ000188764 and MMcB6/201 - see INQ000188765]. Due to the close cooperation and working between all organisations, these powers were not required, which I believe was a significant achievement. During this period actions were being taken, and decisions were being made, at pace. The normal arrangements for engagement with ALBs could not be maintained during the pandemic, and routine sponsorship and accountability meetings had been paused. This was compounded by remote working, which made what would have been previously normal discussion and engagement, more difficult. Given the necessary operational preparation and response, contact between the Department

and ALBs was primarily with their Executive teams. The sheer pace of events and the complexity of decision-making is, even now, difficult to fully convey, and the demands and pressures in my experience were unprecedented. It is the case that the effective "command and control" arrangements which were in operation once the Department's ERP was activated, with the establishment of Health Gold and Health Silver, did not then sit comfortably with the extant governance and accountability within organisations to their Boards, especially over such an extended period in what were extremely challenging times. A learning point for the future is that communication with the Boards of ALBs could have been better, however, the sheer pace of events and the atypical working arrangements made this challenging. This was subsequently addressed on 18 June 2020 when the Health Minister met with the HSC Chairs' Forum [MMcB6/202 - see INQ000276285] to discuss the temporary management and governance arrangements. The Forum comprises the Chairs of all of NI's 18 HSC organisations, including RQIA, and provides a vehicle for the chairs to discuss health and social care issues about which they have a shared interest. The Chairs met with the Health Minister on a six-weekly basis during the pandemic to ensure that he had a full picture of the position across HSC organisations, and that the Department's emerging strategy to rebuild service delivery was well informed and understood. Following each meeting of the Rebuilding Management Board, the Health Minister wrote to the Chairs to update them on issues discussed by the Rebuilding Management Board. The update letters were also published on the Department's website [MMcB6/203 - see INQ000276290 and MMcB6/204 - see INQ000276291]. However, given the pace at which events were unfolding there was a need for extreme urgency in decision making.

15.7 I recall that, building on long established effective professional relationships, I had ongoing and direct engagement with the then CEO of

RQIA, Olive McLeod, as to how to make the most appropriate use of the skills and expertise of the RQIA professional team in supporting the pandemic response in the Care Home sector. My discussions in respect of how best to deploy the RQIA resources actively sought the input and agreement of the RQIA CEO. An e-mail from the Head of Quality, Regulation and Improvement Unit to the RQIA dated 13 March 2020 included a line which read "*Lastly, there may be an opportunity to use RQIA staff on other work going forward. I favour the approach of asking them to work as a block of staff as opposed to piecemeal. It could be that they could help man help lines etc. I will keep you posted if any proposals emerge*." [MMcB6/205 - see INQ000377463].

15.8 CMOG, on behalf of the Department, Health Minister and Departmental Accounting Officer, acted as sponsor for the RQIA, ensuring the right balance between RQIA's operational independence and appropriate and proportionate oversight and governance. This relationship is routinely managed by sponsor branch which, at the time, sat within CMOG. On 10 April 2020 RQIA's Sponsor Branch within the Department received an e-mail from Covid-19 Gold Command Surge Planning Support [MMcB6/206 - see INQ000516962]. This correspondence advised that the Surge Planning Support Team, which at that time was overseeing surge planning across health and social care, had become aware of significant shortages in the Care Home sector for a range of staff, but more particularly for nurses. This had come about for a variety of reasons, including underlying staff shortages compounded by staff having to self-isolate, and a number of staff with underlying conditions who were having to remain at home as part of the shielded population.

15.9 It was considered that this shortage was likely to last for the duration of the pandemic and all agencies were considering what they could do to support the different sectors. It had been suggested that other ALBs, such

as RQIA, which had a reservoir of nurses, could be redeployed. Those nurses might otherwise have been on furlough or have otherwise worked from home or remained as part of a bank (bank nursing refers to a register of nursing staff who are prepared to come in at short notice to cover staff sickness, or to pick up extra shifts at busy times). The e-mail requested that the Department give some consideration to allowing such staff to be engaged in the care sector for this emergency period in the same way that other organisations were.

15.10 On 23 April 2020 I, as Executive Board Member sponsor for RQIA, wrote to RQIA on the need to provide more practical support to nursing and residential homes [MMcB6/207 - see INQ000398907]. This followed direct engagement with RQIA's Executive Team including the then CEO (please see paragraph 15.7 above). I asked RQIA to make inspection staff available to independent Care Homes and supported living services where the stability of services was threatened due to staff shortages and to arrange appropriate training to allow the RQIA inspectors to be redeployed. I stressed the need for RQIA to maintain adequate inspection staffing to allow necessary risk-related inspections to continue to be carried out, and to ensure that there was no conflict of interest between the support provided and RQIA's regulatory role. I expressed my gratitude for RQIA's ongoing commitment to support the independent sector during the pandemic, in particular the dedicated work of the SST. More information on the SST is provided at paragraph 7.9 above.

15.11 The RQIA's Acting Chief Executive responded on 29 April 2020 [MMcB6/208 – see INQ000398926] to say that RQIA's Executive Team felt "*the most important contribution to the safety and wellbeing of service users at this time could be made by focusing on support for services threatened by Covid-19, while also being ready to inspect if relevant concerns about care quality were to emerge.*" On further consideration

and reflection, I believe this to be more proportionate and appropriate as opposed to the retraining and redeployment of RQIA staff as had initially proposed by the Covid-19 Gold Command Surge Planning Support. This proposal had the benefit of providing immediate expert support as opposed to making inspectors available to address staffing shortages in the Care Home sector. This proposal from RQIA subsequently resulted in the establishment of the RQIA SST.

15.12 As outlined in paragraph 2.14 above, the SST was established as a result of collaborative working between CMOG, SSPG and RQIA management to provide a liaison role between Care Homes and HSC Trusts [MMcB6/090 - see INQ000137410]. The main objective of the SST was to ensure that Care Home, domiciliary care and supported living providers had an identified single point of contact to raise issues and receive the most up to date advice, guidance and support from the RQIA's expert teams of inspectors who were all registered nurses, social workers or Allied Health Professionals.

15.13 This was an additional temporary arrangement during the pandemic, set up to ensure that independent providers had access to the most up to date guidance during a fast-moving environment where information and advice was evolving on a regular basis. The SST also ensured that providers had a point of contact to raise questions about the guidance and to receive support in how best to implement it. RQIA, with its expert teams of Inspectors, had been provided with regulatory flexibility to reduce the frequency of its statutory inspection programme in Care Homes, with inspections to continue on an evidence-based, intelligence led and risk-assessed basis, and to cease its non-statutory inspection activity and review programme. This provided additional capacity within RQIA of skilled professionals who were ideally placed to carry out this role, given their local knowledge and experience of individual Care Homes. RQIA

had key points of contact identified in each HSC Trust to ensure that the information being passed on was the most current and to refer specific queries to Trusts if they were unable to resolve the matter. In addition, RQIA was afforded broad flexibility to work with providers to find bespoke solutions to specific issues beyond the remit of generic standards or regulations, to provide safe, pragmatic remedies on a case-by-case basis. The SST was also an important source of information for the Department as the regular reports that the RQIA provided the Department included intelligence from this team. The importance of this support function and the utility of the intelligence provided to the Department had not previously been appreciated prior to the pandemic and was not, at the time, undertaken by any other ALB. The functional role with respect to more timely information and data with respect to the sector, for example, in respect of capacity is, I understand, now being further considered, developed and progressed by SPPG (previously the HSCB).

15.14 I was not previously aware of the handwritten notes of the NI Executive meeting dated 20 April 2020 [MMcB6/072 - see INQ000065691_0027] in which the Health Minister is recorded as having said "*RQIA – move from policing body to advisory body for Care Homes*" and cannot comment on its completeness, but in a paper to the NI Executive, dated 17 April 2020 [MMcB6/105 - see INQ000103673] the Health Minister advised that the RQIA staff had been "*freed up to provide professional support to the HSC, including provision and coordination of support to independent sector providers of nursing homes, residential Care Homes and domiciliary care agencies through a Service Support Team (SST).*"

15.15 I understand that the handwritten notes of an NI Executive meeting dated 20 April 2020 show that the Health Minister was asked by the deputy First Minister "*RQIA - still doing regulatory role as well?*" and the Health Minister is recorded as saying "*yes - regulatory requirement, have to*

maintain standards" [MMcB6/072 - see INQ000065691_0028]. In his paper to the Executive on 17 April 2020 [MMcB6/105 - see INQ000103673], the Health Minister advised that "*RQIA continues to monitor homes and to consider when site visits or enforcement action may be necessary.*" While I am unable to comment on the completeness of this handwritten note, this exchange reflects in my view the factual position that RQIA continued to inspect the care sector as described at paragraph 7.12, in addition to providing much needed support to residential and nursing homes given the unprecedented challenges faced.

15.16 RQIA temporarily promoted / deputised staff within its organisation. The temporary promotion / deputising of staff within RQIA, resulting from any redeployment, would have required changes to RQIA's management structure and would have been an operational matter reserved for RQIA to implement and to ensure the effectiveness of these arrangements. The RQIA Acting Chair emailed sponsor branch on 17 April 2020 [MMcB6/209 - see INQ000502346] and advised: "*We never anticipated such major changes to RQIA's role and functions, the redeployment of so many senior staff and the speed of change has been challenging but I wanted to assure you that as an organisation RQIA is working hard to fulfil the new role and developing new working practices to respond to the challenges in supporting the workforce and maintaining the safety of vulnerable adults in the nursing homes, residential and domiciliary care sectors. The expertise of RQIA staff, their tenacity and commitment has been very evident over recent weeks, colleagues are playing their part under Dermot's leadership. RQIA's Board is responding well to the challenge of virtual oversight and support*".

15.17 RQIA continued to discharge its statutory functions in respect of registered establishments alongside running the SST. As outlined in paragraph 15.40 below, on 8 May 2020 RQIA advised the Department that, in relation

to reduced inspection activity, it would not be able to fulfil its statutory requirement as set out in the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005 (S.I. 2003/431 (N.I. 9)) using conventional approaches. RQIA also commented that they could develop alternative approaches to inspection fairly rapidly and that the volume of inspections deliverable using such approaches was highly dependent on the persistence of Covid-19 in Care Homes, which at the time was unknown, and the health of their staff team [MMcB6/210 – see INQ000577514].

Departmental Direction to RQIA

15.18 On 12 March 2020, Health Silver had sent a request to Health Gold, asking that consideration be given to stopping RQIA unannounced inspections [MMcB6/211 – see INQ000502267] and an e-mail was sent the next day from Health Gold OPS cell to the Head of RQIA Sponsor Branch asking for consideration of a request from HSC Silver - "*RQIA unannounced inspections – can consideration be given to stopping these*" [MMcB6/211 - see INQ000502267]. On 13 March 2020 QSID and Sponsor Branch, within CMOG, began engaging with RQIA about the possibility of the Department issuing a direction to pause unannounced inspections and the risks of doing so. RQIA's Chief Executive agreed that a pause of routine inspections was prudent [MMcB6/212 – see INQ000577516]. That same day, 13 March 2020, Sponsor Branch shared a draft Departmental direction [MMcB6/213 - see INQ000502268 - and MMcB6/214 – see INQ000502270] with RQIA's Chief Executive, who commented that it would be helpful if the Direction stated RQIA would pause all regulatory inspections except where they have concerns about risk or enforcement [MMcB6/215 - see INQ000502271].

15.19 The level of RQIA's inspectorate function varied in line with the HSC response to the pandemic. On 20 March 2020, the Department in a letter from myself gave direction to the RQIA [MMcB6/004 - see INQ000103688] to reduce the frequency of its statutory inspection activity and cease its non-statutory inspection activity and review programme with immediate effect until otherwise directed. This direction, approved by the Health Minister on the 19 March 2020 [MMcB6/216 - see INQ000502286, MMcB6/217 – see INQ000502293, MMcB6/218 - see INQ000502294, MMcB6/219 – see INQ000502299 and MMcB6/220 – see INQ000502301], was to enable RQIA to prioritise inspections on an evidence, intelligence led and risk-assessed basis to focus their activity where it was most needed in a flexible and proportionate manner and to reduce the risk of the introduction of Covid-19 into Care Homes through reducing inspection visits and the movement of inspectors between Care Homes, given the recognised association between high level of community transmission and footfall into Care Homes.

15.20 I was of the view then, and I remain of the view, that this was a proportionate and appropriate step at the time. At all times, the primary responsibility for maintaining standards remained with the provider of services and secondly with the commissioners of those services. In relation to the Care Home sector, the care provided by residential and nursing homes is commissioned by HSC Trusts and all wider HSC services were commissioned by the HSCB supported by the PHA. HSC Trusts, among other corporate responsibilities, have a statutory duty of quality [see section 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (21003 No. 431 (N.I. 9)] with respect to the health and social care services they provide. As commissioners, the HSCB and PHA then also had a statutory duty of quality with respect to health and social care services that they commissioned. While inspection and regulation is an important

element of maintaining standards and in providing assurance, in my view it is not a substitute for, nor does it replace, the primary responsibility of provider organisations and commissioners for the quality and standard of care provided in health and social care services.

15.21 The letter of 20 March 2020 followed a period of consultation with the RQIA, as detailed above, which aligns with the finding of the Nicholl Report at paragraph 10 that *"the decision to issue this Direction was not imposed on RQIA but was taken in consultation with, and with the full agreement of, the Chief Executive (and Executive Team) of the RQIA"*. This direction was to enable RQIA to prioritise inspections on an evidence, intelligence led and risk-assessed basis to focus their activity where it was most needed in a flexible and proportionate manner and to reduce the risk of the introduction of Covid-19 into Care Homes through reducing inspection visits. The letter was issued to the RQIA Chief Executive and copied to the RQIA Chair. RQIA had previously undertaken to notify the care sector.

15.22 The direction given to the RQIA also brought NI into line with regulatory practice in the rest of the UK and RoI rather than creating a difference:

- 12 March 2020: Health Information and Quality Authority (HIQA) in the Republic of Ireland - "*all routine inspections of designated centres have been cancelled until further notice*" [MMcB6/221 - see INQ000485710];

- 13 March 2020: Care Inspectorate (Scotland) - "*we have taken the decision to cease our inspections of care services …. at this time*" [MMcB6/222 - see INQ000485713];

- 16 March 2020: Care Inspectorate Wales - "*we have decided to pause all routine inspections from 5pm today*" [MMcB6/223 - see INQ000485712]; and,

- 16 March 2020: Care Quality Commission (England) – "*we will be stopping all routine inspections from today*" [MMcB6/224 - see INQ000485711].

15.23 As Executive Board Member sponsor for RQIA, I again communicated with RQIA by letter on 23 March 2020. This was to address issues raised by providers which required practical solutions out with the letter of standards and regulations, but in circumstances where RQIA was satisfied that all risks had been considered and mitigated. I seem to recall that I may have been asked by the interim CEO RQIA verbally that the Department consider affording such flexibility given the extraordinary circumstances. I do not now recall the specific details of the concerns raised by RQIA, although I believe it was to address circumstances where RQIA believed appropriate and practical solutions were required to provide appropriate care and support and manage risks which were not strictly within the letter of the standards and regulations. At this time, there was regular and ongoing engagement between RQIA and sponsor branch within CMOG, and such matters would have been brought to my attention by CMOG colleagues for further consideration, if they had not been raised directly with me by RQIA. The nature of any *"pragmatic approach"* adopted by RQIA was an operational matter for RQIA to consider on "*a case by case basis*", given their role as health regulator with operational independence and their considerable knowledge and experience of the care sector including individual Care Homes. This would also be the case for the types of *"solutions"* which would again be an operational matter for RQIA. RQIA will be best placed to advise of the

approach they took or any processes they put in place by way of a documented risk assessment where the usual standards or regulation could not be met, and how they satisfied themselves (as the regulator) when agreeing to any variance from the extant standards or regulations. RQIA would have carried out inspections on a risk-based approach: namely, by using intelligence from various sources, such as the public and HSC Trusts, to determine where they needed to inspect.

15.24 It is important to note that inspections were reduced and not suspended. RQIA continued to conduct its core functions in respect of registered establishments, as required in legislation, alongside running the SST. The RQIA did maintain an inspectorate function and continued to take enforcement action where necessary over the course of the pandemic. Throughout the pandemic RQIA, under its duty and responsibility for the registration and inspection of establishments and agencies (as named in the 2003 Order), took risk based, intelligence led decisions with respect to inspections to reduce footfall into nursing and residential homes.

15.25 RQIA worked with providers, in my view appropriately, to find bespoke solutions to specific issues beyond the remit of generic standards or regulations, to provide safe, pragmatic remedies on a case-by-case basis. In keeping with their statutory role and responsibilities, RQIA will be best placed to advise of the processes in place to inform their consideration and decisions with respect to any variation from the usual regulations, how they used the regulatory flexibility and any steps they took to mitigate the changes in its oversight of Care Homes. Throughout this period, in my view, RQIA maintained an appropriate balance between proactively providing support and assistance to Care Homes to maintain standards and the care and safety of residents and staff through the SST, while using their local knowledge and enhanced monitoring information to carry out risk based regulatory inspections and enforcement action as necessary.

Decisions on approaches to take and prioritisation of inspections were operational matters for the RQIA.

15.26 While I acknowledge the finding in the Nicholl Report that the "*decision to make the RQIA into a single point of contact and support for providers fundamentally altered the "purpose" of the RQIA"* [MMcB6/225 - see INQ000260638_0011], I believe this is a partial interpretation. The establishment of the RQIA SST was, in my view, a pragmatic and entirely necessary action which provided much needed additional support to Care Homes. It was a new and additional role for RQIA and, as such, partially altered the purpose of the RQIA. However, RQIA's regulatory and inspection activity continued, and to that extent I do not agree, on balance, that this was a fundamental change. In my view, it was an innovative and appropriate rebalancing of the role of RQIA, which made best use of the expertise and experience of their teams of inspectors. I also believe that the decision that RQIA prioritise inspections on an evidence-based, intelligence led and risk-assessed basis, focusing their activity where it was most needed in a flexible and proportionate manner, was entirely appropriate and reflected the reality of the situation and risks at that time. It was my experience that the establishment of the SST, and the professional knowledge and experience of the RQIA team of inspectors, provided much needed support to the Care Home sector during the extraordinary and unprecedented challenges faced during the pandemic and is in line with RQIA's role in providing guidance to Independent Providers. The response throughout the pandemic required significant adaptation, innovation and reprovision of services in all HSC organisations. Without this flexibility and agility in the redeployment of staff and redesign and repurposing of services, the HSC would not, in my view, have been able to meet the unprecedented demands during the pandemic and this would have created a different and greater set of risks.

15.27 On 11 May 2020, COPNI and the Northern Ireland Human Rights Commission wrote jointly to the Health Minister to "*seek assurances, in the absence of physical inspections in Care Homes at this time, that there are alternative measures in place that will ensure that the standards of care and treatment expected in Care Home settings is being provided.*" The Health Minister responded to COPNI in a letter on 18 May 2020, explaining the factual position that RQIA's statutory inspections were not suspended and that it had carried out a number of inspections and issued enforcement action. He went on to advise that RQIA were developing new approaches on how inspections would be carried out to gain assurance about the safety and quality of services but that it would focus its activity where it was most needed. He also advised that the HSC Trust safeguarding teams continued to operate.

Resignation of RQIA's Board

15.28 The Department did engage with RQIA's Executive Team in respect of the Direction of 20 March 2020 [MMcB6/004 - see INQ000103688], which directed the RQIA to reduce the frequency of its statutory inspection activity, cease its non-statutory inspection activity and review programmes with immediate effect until otherwise directed. Despite this engagement, on the 24 April 2020 the Department's sponsor branch e-mailed the Chair of the RQIA [MMcB6/226 – see INQ000516964] and apologised for the fact that a number of CMO letters which had issued recently to the RQIA had not also been copied to the Chair of the Board. This included the Departmental Direction to the RQIA to reduce the frequency of its statutory inspection activity. This was an unfortunate oversight, however I believe it must be viewed in the context of the significant pressures at the time and the pace of events that an inadvertent error such as this could have occurred. In the normal course of events, one might have reasonably expected that RQIA and the Board (Authority) would have

been in close communication, particularly at such a pivotal point in the pandemic. It appears that one might infer that communication within RQIA between the senior team and the Chair/ Board (Authority) was not optimal at that time. The fact that communication at that time was being carried out remotely as referenced by the RQIA Acting Chair in her email to sponsor branch on 17 April 2020 [MMcB6/209 - see INQ000502346] as described at paragraph 15.16 may have contributed.

15.29 On 28 April 2020, the Acting Chair of the RQIA, on behalf of the RQIA Board, sent me a letter [MMcB6/227 – see INQ000585028] in which it set out its concerns, including about the Direction, the establishment of a SST within RQIA, the redeployment of a significant number RQIA's senior executive team with a critical loss of experience and my letter of 3 April 2020 asking RQIA to make inspection staff available to the independent sector where staff shortages threatened the stability of services.

15.30 The letter advised that the Board was concerned about:

(a) The impact of this decision making on their governance role in a situation where the Board was given no prior indication or clarification of the role the Board would play in a 'repurposed RQIA'; and

(b) The inherent risks associated with the 'stepping down' of Trust Safeguarding teams and the associated reduction in Statutory Inspections.

15.31 The letter stated that the Board felt the process had impacted on the importance and validity of their statutory role because it had diluted their critical function as a regulator to maintain the protection of vulnerable adults in residential and nursing homes and children in care settings.

They asked for an ongoing review of the challenges faced in doing so and for clarification to be given in relation to their role at this time.

15.32 On 29 April 2020 [MMcB6/208 – see INQ000398926] the RQIA interim Chief Executive sent me a letter which acknowledged that the directions from the Department had followed engagement with members of RQIA's Executive Team and went on to state that the Board's concerns represent "*a position contrary to the position that has been upheld by the Executive Team since before 19 March 2020. Both internally and externally, Executive Team members have consistently held that the stepping down of the regular inspection programme was necessary to reduce infection risk for service users and staff, and that RQIA's temporary support activities were the best way of increasing protection for adults residing in residential care or nursing homes or supported by domiciliary care services. I am now aware that there is an appearance of a fundamental difference of approach between that promoted by the Chief Medical Officer, Chief Social Worker and RQIA Executive Team members, and that upheld by RQIA Board*".

15.33 On 5 May 2020, the then DoH Permanent Secretary wrote individually to the interim RQIA Chief Executive and interim RQIA Chair addressing the issues raised relating to Departmental Directives and concerns raised by the RQIA Board [MMcB6/228 - see INQ000377462 and MMcB6/229 - see INQ000516969]. The response confirmed that the Departmental direction of 20 March 2020 had asked RQIA to continue to respond to ongoing areas of risk, to focus activity where it was needed most to ensure safe care to reduce the infection risk to the most vulnerable, and to act flexibly and proportionately in order to mitigate against the inherent risks raised. The letter advised that RQIA continued to have a critical role to play in maintaining the protection of the adults who live in residential and nursing homes and children who live in care settings, and that the SST was

providing expert advice and support to the sector on matters such as IPC and PPE. The Permanent Secretary advised that, while the Covid-19 pandemic had resulted in the HSC having to adopt new ways of working, all decisions concerning the role of RQIA in the HSC response to the Covid-19 pandemic were made with the safety of services at the heart of the decision-making process. He concluded by stating that all these actions were necessary to protect residents, service users, staff and services during the pandemic and, therefore, were not a dilution of the statutory role of RQIA but rather the most appropriate response to the pandemic. While I do not recall that I provided any input into this letter, the views expressed by the Permanent Secretary accord entirely with my own.

15.34 Following this correspondence, the Head of RQIA Sponsor Branch remained in regular communication with the Interim Chair to address issues / concerns. A response was subsequently received from the RQIA Board Chair on 15 May 2020 advising that the Board welcomed the clarification from the Permanent Secretary on 5 May 2020 regarding the Department of Health's statutory role in the directives issued to RQIA. The Board noted its fundamental function in terms of governance including RQIA's adherence to Departmental Directives and advised it would welcome clarification of its governance role and Department's requirements during the exceptional Covid-19 pandemic. The Department's Sponsor Branch responded, requesting an opportunity to talk to the Board to explore these issues and find a way forward [MMcB6/230 - see INQ000516975].

15.35 On 17 and 18 June 2020, the then-Acting Chair and six remaining Authority Members of the RQIA resigned with immediate effect. At this juncture, it is apposite to note that in the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (21003 No. 431 (N.I. 9), RQIA

(the "Authority") consists of a Chair and other members of the Board, appointed by the Department. Given the ongoing engagement and correspondence, I found this a surprising and most regrettable action. In their letters of resignation to the Health Minister, the ex-Members of the RQIA set out their reasons for stepping down (as summarized in the Nicholl Report [MMcB6/225 - see INQ000260638_0006], including:

- Concern at the lack of effort made by the Department to consult or engage with the Authority prior to making key decisions affecting the core purpose and statutory remit of the RQIA;

- Particular concern over the decision by the Department at the end of March 2020 to (1) redeploy the RQIA Chief Executive to the PHA and (2) appoint (and extend the appointment of) an RQIA Temporary Chief Executive without any communication with or involvement of the Authority; and

- By excluding the Authority from involvement in any of these key decisions, the belief that the role of the Authority had been diluted and compromised.

15.36 Two other Members of the Board had resigned the previous week to take up other posts. These circumstances left the RQIA without an Authority (Board) and without any Members. The Health Minister made an announcement on the 18 June 2020 [MMcB6/231 - see INQ000516976] appointing a new interim Chair of the Regulation and Quality Improvement Authority. He stated that he would be considering the position of further interim appointments over the coming days and that he was assured that the changes to the board membership would have no impact on the day-to-day work of the RQIA. While the operational role of the RQIA was maintained, the resignations and departures of the Chair and other

members were significant and material in terms of the overall governance and accountability of the RQIA and presented an immediate additional serious challenge to be addressed during the pandemic response. While I fully appreciate the frustration of the Chair and members and their genuine concerns with respect to communication and changes in the role of RQIA, in my view, the decision to resign was not rational or reasonable and I was concerned that the Authority (Board) of RQIA did not appear to fully comprehend the enormity of the challenges faced, the necessary adaptation and flexibility that was required, and the extraordinary measures that had been introduced across all ALBs, together with the key role that RQIA was continuing to play in protecting some of the most vulnerable in society.

15.37 The membership of the RQIA Board / Authority was returned to being fully operational on the 18 June 2020 with the appointment of an Interim Chair and the temporary appointment of two Departmental Officials as non-executive members of the RQIA Board until 30 October 2020 when six interim non-executive members were appointed to the Board.

15.38 On 23 June 2020, the Department announced it had commissioned an independent review of the circumstances that gave rise to the resignation of the RQIA Board members. The report (the "Nicholl Report") was published by the Department on 19 July 2021 alongside an action plan detailing the Department's response and lessons learned. The Health Minister provided a Written Ministerial Statement on 19 July 2021 [MMcB6/232 - see INQ000506182] advising that he had accepted all the report's recommendations, and he subsequently published an action plan [MMcB6/233 - see INQ000485714]. I understand that, due to the pause in governance work during the pandemic, implementation of the recommendations in the independent review was initially delayed. On 10 August 2021, guidance was issued to Executive Board Members on the

process for Ministerial / Departmental Directions. On 12 October 2022, Revised Codes of Conduct and Accountability for HSC and Northern Ireland Fire and Rescue Service Board Members were issued. On 30 December 2022, guidance issued on ALB ground-clearing meetings and Accountability Meetings. On 22 December 2023, a revised DoH ALB Sponsorship Handbook issued.

15.39 The initial Direction issued to RQIA on 20 March 2020 made it clear that "*this (HSC response to COVID 19 pandemic) is an evolving situation which is subject to ongoing review*". As part of the HSC response to the pandemic, the Department therefore kept the Direction under review. On 8 May 2020. the Head of Sponsor Branch advised the RQIA interim Chief Executive that the Department was reviewing the Direction issued in March 2020 and seeking input from the RQIA to inform the review [MMcB6/234 - see INQ000502306 and MMcB6/004 - see INQ000103688].

15.40 A response was received from the RQIA interim Chief Executive on the same day [MMcB6/235 - see INQ000502309], which advised that RQIA would definitely not be in a position to fulfil its statutory requirement, in terms of the frequency of its inspections (as set out in the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005 (S.I. 2003/431 (N.I. 9)) using conventional approaches and probably not using alternative approaches. The response also advised that, due to ongoing risk of infections and the potential second wave, onsite visits would be unwise and unwelcome at times. It also noted that conventional approaches to inspection may not be appropriate for some time – possibly until a vaccine was deployed across the region. The interim Chief Executive stated that RQIA could develop alternative approaches to inspection fairly rapidly. The volume of inspections deliverable using such approaches would be highly dependent

on the persistence of Covid-19 in Care Homes, which at that point was unknown, and the health of their staff team.

15.41 On 15 May 2020, RQIA submitted a proposal for a draft inspection approach for the coming year which was subject to internal review [MMcB6/236 - see INQ000502310 and MMcB6/237 - see INQ000502312]. On 28 May 2020, the Department provided comments to RQIA on their proposed inspection methodology [MMcB6/238 - see INQ000502314]. The proposal highlighted that, since early May, there had been an increase in the level of concerns being raised with RQIA. On 4 June 2020, correspondence was received from the RQIA advising that, due to a reduced demand for the service, the hours of operation of the SST were being amended to Monday to Friday from 9am to 5pm (it had initially been operating 7 days per week from 8am to 6pm) [MMcB6/239 - see INQ000502317]. At this point in the pandemic, with a reduction in community prevalence and the number of outbreaks in Care Homes, the regulatory landscape and RQIA's priorities were changing and being adapted in keeping with the need to provide a balance between support and regulation.

15.42 In June 2020, the Department was moving away from the emergency response to the pandemic and towards rebuilding HSC services under business continuity arrangements. On 9 June 2020, a letter was issued from the Permanent Secretary to all Departmental staff regarding Rebuilding HSC services [MMcB6/240 - see INQ000502319; MMcB6/241 - see INQ000103722; and MMcB6/242 - see INQ000120757]. The letter outlined that the impact of the pandemic across HSC services, programmes and projects had been devastating, and it was anticipated that it would take a number of years and significant investment to rebuild the service capacity which had been lost. It further advised that a new "Management Board for Rebuilding HSC Services" would be established

in June 2020 for a period of two years, providing oversight and direction on the implementation of the Minister's priorities as reflected in the Department's "Strategic Framework for Rebuilding HSC Services".

15.43 On 19 June 2020, I received a submission seeking approval to rescind the Direction that had been issued to the RQIA on the 20 March 2020, enabling it to increase its activity across all areas of work [MMcB6/243 – see INQ000502338]. The submission stated that, as part of the recovery process and rebuilding of HSC services across NI, approval was now being sought to enable RQIA to increase its activity. The rationale provided was that:

- It had been three months since the Direction was issued and there had been many developments during that time that would enable RQIA to increase its activity, such as the fact that the R-rate of transmission had reduced (which lowered the risk associated with on-site inspections), and that RQIA had developed new methods of inspection;

- The increased statutory inspection activity would not be at pre-pandemic levels, and it was unlikely that RQIA would meet its statutory requirement of minimum inspections across all regulated establishments and agencies as a result. Rescinding the Direction would also enable RQIA to carry out non-statutory inspections where they were most needed, based on risk assessment, and to recommence its review programme; and

- RQIA had advised the Department that it planned to implement new inspection methodologies which would enable it to carry out some inspections remotely and follow up with a physical inspection if warranted. RQIA advised that it would also continue to focus its

activity where it was needed most to assess the provision of safe care and encourage quality improvement in the provision of services.

15.44 Following my approval, the decision to rescind the Direction was subsequently approved by the Permanent Secretary [MMcB6/243 – see INQ000502338] and Health Minister [MMcB6/244 – see INQ000502341]. On 22 June 2020, I issued a letter to the RQIA interim Chief Executive advising that the Direction was rescinded, given a reduction in community transmission and in light of the recovery process and rebuilding of HSC services [MMcB6/245 - see INQ000346701].

16. Deaths Related to the Infection of Covid-19

16.1 As CMO, communicating with the public to provide advice, information and data on a range of issues, including what was known about the virus, the risk of severe disease, hospitalisation and death, and what people could do to protect themselves was a crucial element of my responsibilities during the pandemic, and a role that I undertook along with the many other demands on my time. As early as April 2020, I was detailing in press briefings, for example, the limitations of data on the numbers of deaths. It should also be noted that the definition of Covid-19 related deaths evolved over the pandemic and was understandably a source of significant public scrutiny and comparison. It was also essential for the purposes of consistent and accurate reporting to the public. There was, and remains, often a procedural delay in the registration and reporting of deaths in the community. The definition of Covid-19 related deaths changed over the course of the pandemic.

16.2 Another issue of concern in relation to the data was the manner in which summaries of deaths when Covid-19 were mentioned on the death certificate and publication of these official statistics by the ONS and

NISRA. The latter was more comprehensive than the recording of hospital deaths where individuals had tested positive for Covid-19 which was used for monitoring the impact of the pandemic. Misinformation and disinformation on social media especially were also particular challenges. Further reflections on this are provided in the UK CMO Technical Report, Chapter 11, pages 373-376 [MMcB6/001 - see INQ000203933].

16.3 From the beginning of the pandemic, it was possible to assemble data on the hospitalisation of patients and deaths. In NI, the CSA and myself regularly presented data at weekly local media briefings, where analysis had to be continually adapted to understand the evolving epidemic [Chapter 4, page 159 of MMcB6/001 - see INQ000203933].

16.4 At the outset of the pandemic, the established system for monitoring and reporting on deaths in NI was through the General Register Office (GRO); data reporting was based on death certification recorded on the MCCD and, by necessity, this included a lag time in reporting as following each death, certification needs to be completed, the death reported to the GRO, and the data analysed and reported. This system continued to operate throughout the pandemic and remained the definitive source of reporting on deaths occurring in NI.

16.5 In a rapidly evolving context at the outset of the pandemic the PHA established an additional reporting system to capture information on deaths occurring in HSC settings (reporting based on deaths in individuals within 28 days of a positive test). This reporting and monitoring system was established by PHA in a timely manner, in my view, and it mirrored similar reporting systems established in other UK countries. This was important information in monitoring the severity of the impact of the pandemic. The Department supported the PHA as this data stream was established.

16.6 With respect to paragraph 32 of my first witness statement to Module 2C wherein I referred to *"...limitation of data on the number of deaths"* and again *"...how the definition of Covid-19 related deaths evolved over the pandemic"* [MMcB6/002 - see INQ000226184_0011], there were a number of contributing factors and I have attempted to explain this more fully below.

16.7 Undoubtedly delays in people presenting for care and reductions in secondary prevention such as the prescribing of statins and antihypertensives, postponement of elective care and screening will have led to later and more severe presentation of non-Covid illness both during and after the first 3 waves. The combined effect of this will have contributed to a period of non-Covid-19 excess mortality and morbidity even after the worst of the pandemic is over. Based on the ONS common UK-wide approach to producing national estimates of excess mortality, the years 2020 (1,490 excess deaths) and 2021 (1,574 excess deaths) had the highest level of excess deaths during the period 2011 to 2022. Male life expectancy decreased by 0.9 years from 79.0 years in 2019 to 78.1 years in 2021 and female life expectancy decreased by 0.8 years from 82.8 years in 2019 to 82.0 years in 2021. Further, in-depth analysis would be required to look at patterns in attendances of those with pre-existing and / or chronic conditions to assess the excess mortality and morbidity caused by delays in people presenting for care and reductions in secondary prevention. However, the NI Cancer Registry (NICR) found an adverse impact of Covid-19 across the cancer patient pathway with 12.6% fewer cases, higher levels of emergency admissions and stage shift from early to more advance stage disease when comparing patients diagnosed during April – December 2020 to equivalent 2018-2019 periods [MMcB6/246 - see INQ000469785].

16.8 It was my professional view, and a position I shared during verbal briefings and updates to NI Executive Ministers and in media briefings, that deaths during the pandemic would occur for a number of reasons and the true excess mortality would only become clear sometime after the pandemic was over. This included deaths directly from Covid-19 and indirect deaths if health services were overwhelmed and people with treatable conditions such as heart attacks and strokes or those requiring emergency surgery couldn't access care or because intensive care units were full. Other deaths and harm would occur as a consequence of both the introduction of NPIs and measures introduced by the health service causing delays in less urgent surgery and other services such as mental health. Finally, there were longer-term harms caused by loneliness, increased unemployment, lower educational achievement and increased deprivation on health outcomes and the health of the population, given the established links between deprivation and chronic or premature ill-health.

16.9 However, my advice throughout the pandemic was clear, that there would be harm and indirect deaths caused by the very measures we were using to control the virus and its impact and that the more extensive and longer those measures were in place the greater the harm would be. This is reflected in the content of the paper submitted by the Department to the NI Executive on 7 May 2020 [MMcB6/247 - see INQ000425610], the second review of the Coronavirus recommendations, in which the Department provided an assessment of the wider impacts of the introduction of NPIs including: "*The impacts on health are also profound, from the stepping down of screening programmes and elective care procedures through to the long-term impacts on health from interrupted education, job loss and financial stress. There has been a sharp downturn in people presenting to GPs and emergency departments, including a significant decline in the number referred for cancer investigations and treatment. We are also seeing a sharp rise in all-cause mortality, not all of which can be attributed*

to COVID infection and disease. We also know that there is a very real relationship between the level of deprivation in our communities and health outcomes." The Department recommended to the NI Executive that proportionality be one of the guiding principles in assessing the continuing need for restrictions. The paper also explicitly described the likelihood of further waves of the pandemic when restrictions were eased. The definition proposed for proportionality was: "*Proportionality. The detrimental impacts on health, society and the economy that can reasonably be attributed to the restriction or requirement should be tolerated only as long as the risks associated with withdrawal or modification are assessed to be more severe*."

16.10 There was no easy way, and there were only ever difficult decisions for Ministers, and a very difficult path to walk between introducing measures late and not extensively enough resulting in a large wave and excess direct deaths or introducing measures too early and too extensively with excess indirect deaths and harms. Separately, Ministers also needed to consider the wider societal, educational, and economic consequences.

16.11 By way of specific examples of briefing I provided, during one of the regular press conferences with the Health Minister, on 14 October 2020, I made the following points, in response to reported calls from "*doctors leaders*" for tighter Covid-19 restrictions on the economy:

"*…there are no easy solutions or simple answers to this, only a series of hard and very difficult choices, all of which have bad outcomes. Bad outcomes in terms of health – impact on health services – but also wider impacts on society and wider impacts on the economy."*

"Now what's good for our health is good for the economy and what's good for the economy is good for our health. I've said many times standing here

that socio-economic deprivation – unemployment, poverty – shortens and costs lives."

"And that's why these decisions made by the Executive are so very difficult because the Executive is seeking to balance all of those factors – the immediate pressures on our health service, to stop our health service and those working in it being overwhelmed, and the medium and longer term consequences on wider society, and on our mental health and well-being, on those people who have been shielding in the past, and on the wider economy. Because a good job is good for our health."

"And there are significant and fundamental risks in terms of young people and their long-term educational attainment and life opportunities which again I as Chief Medical Officer and I would urge all other doctors to be very mindful of. Poverty kills people. It always has, it always will do. And it's those difficult decisions that the Executive has had to struggle with." [MMcB6/248 - see INQ000446233].

16.12 Similar points were made by the CSA and me in our advice to the NI Executive, as the minutes below illustrate:

"The Chief Medical Officer and the Chief Scientific Adviser acknowledged the difficult decisions facing the Executive, and advised that it was more likely that they would be obliged to return to the Executive in mid-December to seek further interventions if easements were made to the current restrictions. The Chief Medical Officer advised of the prospect of excess deaths.

"The Chief Medical Officer advised of his view that the COVID pandemic would lead to excess deaths no matter which approach was agreed by the Executive, but that the likely level of excess deaths would depend on

decisions made by the Executive at this meeting; and on future actions; and that having some restrictions in place was preferable to allowing all current restrictions to fall. However, any reduction in restrictions may lead to a further intervention being required before Christmas. He recognised the difficult decisions required to balance short term COVID restrictions with longer term economic wellbeing.

"The Chief Scientific Adviser recognised the difficult choices facing the Executive as it sought to balance the need for health protection with economic difficulties resulting from COVID restrictions, advising that the nature of a pandemic is to cause deaths no matter what measures are put in place, but reiterating that anything leading to an increase in the R rate would have a short term and more visible impact. While the aim of 'lockdowns' and other NPIs was to reduce the number of direct Covid-19 deaths and those also those deaths due to the health service being overwhelmed."

16.13 The advice to the Health Minister and the NI Executive also informed actions with respect to access to healthcare provision during the pandemic and communication with the public. It was important that people with urgent or immediate health care needs continued to access care, and this was emphasised in public communications at that time [MMcB6/249 - see INQ000469783 and MMcB6/250 - see INQ000469784]. The Health Minister and I stressed repeatedly in public communications that emergency care was always open for business for those who required immediate and urgent care. Nevertheless, emergency presentation rates were much lower than normal during the first wave, which was a cause of concern which we sought to address in communications at that time, adapting language to seek to emphasise that emergency care was available for those who required it. It was necessary to balance the need for surge capacity with service adjustment to meet pandemic needs, while

maintaining an appropriate level of care and support for other health needs. This evolved over the course of the pandemic. As vaccines and Covid-19 treatments became available and the risk of severe disease associated with infection reduced, non-Covid-19 and non-urgent services were stepped back up. Between waves, routine non-urgent elective care was offered, while maintaining critical care surge capacity for further waves. Undoubtedly, and regrettably, some people who would and could have come forward did not, because of a sense of altruism or perceived risk of being in hospital.

16.14 The PHA is responsible for surveillance systems for infectious diseases and has its own processes in place to monitor infection rates. During a pandemic response, the Department's statisticians take the lead in publishing Official Statistics, including those on deaths and infection rates. On 14 April 2020, the Health Minister welcomed the commitment by NISRA to publish statistics on deaths and suspected deaths in Care Homes related to Covid-19 [MMcB6/251 - see INQ000103692]. NISRA published this information on a Dashboard from 19 April 2020 onwards, working closely with colleagues in PHA and other NISRA branches as necessary. The additional breakdown of Covid-19 deaths in hospitals, Care Homes, hospices or other settings was confirmed by NISRA in correspondence dated 23 April 2020 [MMcB6/252 - see INQ000212410]. The Dashboard included NI wide summary information about the volume of testing and the number of deaths reported by HSC Trusts that were associated with Covid-19.

16.15 With the passage of time I do not now recall with certainty or the details, but I believe I may have discussed with the Health Minister changes in NISRA's reporting of deaths in Care Homes to include the collection and recording of data and regular reporting of deaths in Care Homes, hospice or other settings and suggested that he write to request that this

information was published. I am not aware that I provided written advice to this effect. However, in my view, it was essential for transparency and wider public confidence that this further breakdown was provided. Given my experience on other policy areas, including during previous outbreaks of infectious diseases in NI, I was aware that GRO, NISRA and the Department's Information and Analysis Directorate (IAD) colleagues would be responsive to and supportive of such requests.

16.16 In a further statement [MMcB6/087 - see INQ000103711] on 29 May 2020 the Health Minister commented on the weekly bulletin produced by NISRA, welcoming the fact that NISRA's weekly bulletin now contained a more detailed breakdown of information in relation to deaths of Care Homes residents. The Health Minister had corresponded with NISRA prior to this and had specifically requested this additional information to be included in the bulletin, in the interests of greater transparency. The Minister stated that the Department's daily statistical dashboard also included more information in respect of Care Homes.

16.17 Deaths in care were monitored through a number of mechanisms over the course of the pandemic:

- Deaths occurring in Care Homes are 'notifiable events' - this means that, as part of the formal regulation of Care Homes by the RQIA, any deaths which occur in the Care Home setting must be notified by the home to the RQIA. During the pandemic the RQIA produced a weekly data stream, which commenced on 14 May 2020, reporting on deaths occurring in Care Homes, which they shared with partner organisations, including the Department. The data feed was sent from RQIA to SSPG in the Department; colleagues in SSPG used the data feed to provide regular updates to the Health Minister and also to inform situational updates and communications briefings and updates.

This changed to a fortnightly report from 9 July 2020. These updates were also shared with professional officers in the Department including with CMOG and myself. How RQIA received the data from Care Homes changed through the course of the pandemic. When RQIA introduced its App for Care Homes, information on deaths in Care Homes was, in most instances, reported through the App, however the principle of Care Homes advising RQIA of deaths in the Care Home setting was already established as part of the 'notifiable events' requirements of regulation of the sector and this allowed deaths to be monitored.

- Deaths occurring in Care Homes, as has been described earlier in paragraphs 6.51 and 16.2, were also monitored through mechanisms underpinning the publication of official statistics in NI. NISRA reported information relating to place of death, as captured through death certification, on a regular weekly basis. In this context, deaths occurring in Care Home settings, in hospitals and/or in hospices were reported on a weekly basis.

- At the outset of the pandemic, the PHA had established a rapid reporting system to monitor deaths occurring in healthcare settings, which was based on the definition of 'deaths occurring within 28 days of a positive Covid-19 test' and was operated through a Sharepoint system. While this data stream mainly captured deaths occurring in acute settings (namely hospitals) it included some information on deaths occurring in Care Homes, either because the Care Home in which the death occurred was an HSC facility and / or the PHA was advised of the death through their programme of support to Care Homes with incidents or outbreaks of Covid-19.

16.18 As stated above, the RQIA was reporting weekly figures with regard to the numbers of deaths in nursing and residential Care Homes. RQIA also provided the Department, through SSPG, with a rolling assessment of deaths which had been alerted to it in line with statutory responsibilities, as compared to previous years. This allowed the Department to assess the level of excess deaths across the sector. RQIA also provided this data, broken down by Care Home [MMcB6/253 – see INQ000446802] so that the Department could identify Care Homes which had the highest levels of excess deaths and consider any trends or relevant factors and whether any interventions were needed. As previously described at paragraphs 6.18 to 6.21, I repeatedly highlighted in my advice to NI Executive Ministers the relationship between higher levels of community transmission and outbreaks and deaths in Care Homes. This was to ensure that decision makers understood this correlation and the importance of population level NPIs in managing the pandemic and reducing deaths in Care Homes. While distressing and deeply worrying for families, in my view the visibility of deaths in Care Homes was important to ensure that NI Executive Ministers fully understood the implications of decisions.

16.19 During the pandemic, data flows were mostly accurate and timely in my experience, and the CSA liaised with PHA colleagues on this. Given the many issues I was managing, I was not aware of the detail of any challenges around data access in relation to the reporting of deaths, other than general concerns by the PHA identified in the "*Rapid Review of the Epidemiological Function Focused within the PHA with a Specific Focus on Contact Tracing*," July 2020 [MMcB6/254 - see INQ000001196]. I understand that this was an internal review commissioned from the HSC Leadership Centre (part of the BSO providing consultancy services) by the newly appointed interim CEO of PHA. Given that it was an internal review, I don't recall that the details of the report or its findings were shared with

the Department. As I understand it, there were general concerns raised during that review, mainly around the difficulties of reporting small numbers and the potential identification of individuals or families, including concerns in respect of confidentiality. In my view, these were genuine and reasonable concerns which I understand were addressed at the time.

16.20 Through close work with colleagues in the PHA, and other NISRA branches as necessary, the additional analysis and publication by NISRA of Covid-19 deaths in hospitals, Care Homes, hospices or other settings on a Dashboard from 19 April 2020 onwards (confirmed by NISRA in correspondence dated 23 April 2020 [MMcB6/252 - see INQ000212410]) provided greater transparency with respect to deaths in Care Homes. I believe this was important in monitoring the impact of the pandemic across all of health and social care and was also important in terms of public confidence.

16.21 With respect to the timeliness, by way of example, data updates were received by the NI Modelling group daily throughout most of the pandemic, with occasional periods during public holidays when these updates were less frequent. The data came directly from the PHA and via the IAD in the Department, with data flows being refined as the pandemic progressed. Data from hospital admissions and occupancy came directly from the PHA, including an estimate of hospital occupancy because of community acquired infection and of nosocomial infection acquired in hospital. The number of people tested for Covid-19, positive test results, along with Intensive Care Unit (ICU) data and deaths were provided via IAD daily. Positive test results in community settings, primary care, and hospital settings were not reported separately.

16.22 Particularly in the earlier stages of the pandemic and throughout the first wave of the pandemic, the number of confirmed cases significantly

underestimated the true number, due to limited testing capacity and the absence of widespread community testing. Recording of hospital admission numbers with Covid-19 was dependent on manual coding at a Trust level, and there could be a delay of several days before all admissions on a given date were captured.

16.23 During the pandemic, I was not routinely copied into minutes of NI Executive meetings and was not sighted on, nor was I asked to consider or approve, handwritten notes of NI Executive meetings where advice or comments were attributed to me. In preparation of my witness statements for the Inquiry, minutes and handwritten notes of NI Executive meetings have been provided for my consideration. I am struck by the brevity of the minutes of NI Executive meetings and the incomplete nature of detailed advice provided by the CSA and myself in these handwritten notes. This is not a criticism of the note taker: rather I believe a reflection of the detail and complexity of the information and advice that was provided to the NI Executive. While I do not now clearly recall advising the NI Executive on 3 May 2020 that: *"no other area of UK has so much detail as NI"* [MMcB6/132 - see INQ000065724_0003], I believe I may have said something to this effect as it was consistent with my view (both then and now) that NI had robust arrangements in place to provide operational assurances to policy colleagues within SSPG and the wider Department, including CMOG, on the impact of the pandemic on residential and nursing homes. As described at paragraph 6.50, while the NI Covid-19 Dashboard was based on similar information published by other UK jurisdictions, the NI Dashboard included additional data about capacity and availability not publicly available in the other UK jurisdictions including information on outbreaks in care homes. The data provided by the PHA on confirmed Covid-19 Care Home Outbreaks was first published on the Covid 19 Dashboard on 5 May 2020, and referred to the position at 4pm on 4 May 2020. It was this data that was discussed at the NI Executive

meeting on the 3 May 2020. The information on the NI Dashboard was in addition to reports from the PHA and the weekly dashboard report prepared for the Health Minister which provided a high-level summary of Care Home self-assessed ratings for PPE, Workforce and Cleaning based on regular daily reports to the Department on intelligence from the RQIA Service Support Team described at paragraph 2.53. As described at paragraph 16.2, NISRA was also publishing statistics on deaths and suspected deaths in Care Homes related to Covid-19 from 19 April 2020. All of this information was used for operational planning and response to the pandemic by the HSCB and HSC Trusts. It also informed the advice that the CSA and I provided to the NI Executive with respect to the wider health and social care pressures. The data from all these sources was also used to prepare the weekly R paper which, as previously described, provided the NI Executive with the level of community transmission, the trajectory of the pandemic, and insight into the pressures on the health and social care system. From my reading of the note of the NI Executive meeting of 3 May 2020 and my incomplete recollection, this involved the leaking of pre-publication data on outbreaks in Care Homes to the media and subsequent critical media coverage, which I recall may have suggested that such information was not going to be made publicly available. During the meeting concerns were raised by the FM and dFM and the Health Minister and I expressed frustration that information prior to its verification and publication was being leaked to the media with the potential to cause public concern and undermine public confidence adding words which have been noted as "*and now this detailed info is being used as a stick to beat us with*" referring to what was perceived as unnecessarily critical media coverage.

16.24 I believe the integrated health and social care system in NI was a significant advantage during the pandemic in this respect, and the close working relationship between Care Home providers, HSC Trusts,

supported by the SST in RQIA were key in the provision of data and soft and hard intelligence. As described at paragraph 2.53, publicly available data from the Covid-19 dashboard, in addition to reports from the PHA, provided data on the numbers of outbreaks in Care Homes daily. A weekly dashboard report was prepared for the Health Minister which provided a high-level summary of Care Home self-assessed ratings (RAG - red, amber, green risk) for PPE, Workforce and Cleaning and shared widely across policy and professional teams in the Department. This information was based on regular daily reports to the Department on intelligence from the SST.

16.25 By way of example of the data and intelligence available to the Department in relation to the Care Home sector during the first wave of the pandemic from March to July 2020, the SST operated seven days a week between the hours of 8.00 am – 6.00 pm. In total, there were 3,464 calls or contacts relating to Care Homes recorded from March to July 2020 of which 2,911 (84%) were Covid-19 related. In total, one third of these contacts were proactive calls initiated by RQIA, including their pharmacy team (as part of their Covid-19 Medicines management assessment exercise) or where the Care Home provider requested a call back via the RQIA status update App which originally launched in late March 2020 to allow providers to update RQIA on their status or to submit questions to RQIA. I am not aware that other parts of the UK or the RoI had similar reporting arrangements in place that provided the same frequency and detail of reporting.

16.26 As detailed in paragraph 2.53, updates on the impact of the pandemic on the social care sector including residential and nursing homes, were provided verbally by the Health Minister, supported by the CSA and me at each NI Executive meeting. On occasion, other health officials may also have been present at these verbal update meetings. NI Executive papers

on the care sector, including the operational response and details of the support being provided to the care sector, were prepared by relevant policy and professional colleagues within SSPG. The data from the PHA and the RQIA was used to prepare the weekly R paper and provided the NI Executive an update on: the level of community transmission; the trajectory of the pandemic; insight into the pressures on the health and social system, and it frequently highlighted the consequences of increased community transmission, with outbreaks in health and social care facilities including Care Homes and the associated consequences for staff. The Health Minister used all this information to ensure that the NI Executive was kept fully informed on the situation with respect to Care Homes. The CSA and I routinely responded to specific questions from NI Executive Ministers that required scientific or public health input. In our advice to NI Executive Ministers, the CSA and I regularly advised of the consequences of increased community transmission and the associated increase in outbreaks in Care Homes and other health and social care facilities. I believe this association was understood by Ministers. These reports and updates are described more fully in the Department's statement to Module 6 of the Inquiry.

16.27 I did not directly receive data relating to the direct impact of the pandemic on those working in the care sector, although this was provided to the Department and policy colleagues in SSPG or Workforce Policy Directorate (WPD) will be best placed to comment. On the 12 May 2020, I issued correspondence setting out the Health Minister's request for all HSC Trusts to advise the Department on a daily basis of the number of health and social care workers who had died with or from Covid-19 [MMcB6/255 - see INQ000490088]. This information was provided to policy colleagues in WPD and shared with the Health Minister. As described in paragraph 2.53, data was received daily by the Department from the Covid-19 dashboard, in addition to reports from the PHA, which

provided data on the numbers of outbreaks in Care Homes and I would have reviewed this information. A weekly dashboard report was prepared for the Health Minister which provided a high-level summary of Care Home self-assessed ratings (RAG - red, amber, green risk) for PPE, Workforce and Cleaning. This information was based on regular daily reports to the Department on intelligence from the SST. CMOG and I would have been routinely copied into these weekly reports by the CSWO and colleagues in SSPG and, while I would not have reviewed the daily reports, I would have considered the weekly dashboard reports.

16.28 As described at paragraph 16.17, during the pandemic, from 14 May 2020, the RQIA produced a weekly data stream, reporting on deaths occurring in Care Homes, which it shared with partner organisations, including the Department. The data feed was sent from RQIA to SSPG in the Department and colleagues in SSPG used the data feed to provide weekly updates, and from 9 July fortnightly updates, to the Health Minister. This data was also used to inform situational updates and communications briefings and updates. These updates were also shared with professional officers in the Department, including with CMOG and myself. These situation reports were used to prepare the weekly R paper for the NI Executive and by the Health Minister to ensure that the NI Executive was kept fully informed on the situation with respect to Care Homes.

17. Learning During the Relevant Period

17.1 Throughout the pandemic, my advice to the Health Minister following the initial wave and in all subsequent waves continued to be informed and refined by the available scientific and public health and sources described at paragraphs 2.62 to 2.65. It was the summation of all this evidence, relevant research papers and expert recommendations from SAGE and NERVTAG which continued to inform my advice. My advice, and that of

the CSA, was based on the totality of accumulated evidence at a given point in the pandemic, and not on specific pieces of evidence or the findings of individual reports. It is not possible, given the volume of evidence considered over the duration of the pandemic, the complexity of considerations and the frequency of advice provided to inform complex policy decisions, to relate specific scientific reports to advice at points in time and to seek to do does not fully represent the complexity and professional consideration and judgement involved. I continued to highlight to NI Executive Ministers the direct association between and consequences of high community transmission and outbreaks in Care Homes to inform their policy decisions on the management of the pandemic. I believe it was understood by NI Executive Ministers that reducing high levels of community transmission was the most effective means of protecting vulnerable older people in Care Homes and others in receipt of adult social care. While asymptomatic testing, effective IPC and appropriate use of PPE were essential, as previously described, there were significant challenges in preventing outbreaks when community transmission was at high levels.

17.2 As indicated previously at paragraphs 2.33 and 6.27, my primary policy and professional roles with respect to the adult social care sector were: advising on policy intervention at a population level to reduce community prevalence and transmission and thus reduce the risks of outbreaks in care sector including Care Home; on testing for Covid-19, informed by the recommendations of the EAG-T and the Testing in Care Homes – Task and Finish Group; and later the implementation of the Covid-19 Vaccination Programme. The SIG and the Testing in Care Homes – Task and Finish Group did provide scientific papers and technical advice to policy colleagues in SSPG throughout the pandemic. I have provided examples with respect to a relevant paper on the Care Home sector considered at SIG at paragraph 6.7 and my knowledge of the 3 July 2020

'Vivaldi 1: Covid-19 Care Home study report' [MMcB6/056 - see INQ000346702_0013-0014] at paragraphs 5.20 and 7.20.

17.3 As described at paragraph 2.37 above, neither CMOG nor I were involved in the operational preparation, planning and response in the adult social care sector including Care Homes. During the initial and subsequent waves of the pandemic, this was the responsibility primarily of Health Silver and the then HSCB, supported by the PHA who provided professional technical advice on IPC and PPE. As described above, within the Department, SSPG (reporting to the CSWO) established oversight and coordination arrangements, supported by the CNO. SSPG also produced guidance for the sector which they shared for professional input prior to this being issued. Colleagues in SSPG and the CSWO will be better placed to more accurately describe these arrangements and respective roles and responsibilities and how the arrangements evolved.

17.4 I have already described at paragraph 4.10 to 4.12 the actions that I took during the first wave to commission comprehensive surge capacity and my role as chair of the Health Gold Strategic Cell. Given my wider responsibilities, I provided no professional input to the 2 September 2020 'Northern Ireland Covid-19 Regional Action Plan for the Care Home sector' prepared by the PHA and HSCB [MMcB6/256 - see INQ000120732].

17.5 As described at paragraph 17.4, I was not directly involved in the 2 September 2020 'The Rapid Learning Initiative Into The Transmission of Covid-19 Into And Within Care Homes In Northern Ireland' report [MMcB6/257 - see INQ000276404]. The findings of this report were consistent with the findings in similar studies which demonstrated that hospital discharges were not the major driver or determinant of Care

Home outbreaks. Nevertheless, hospitals and Care Homes were environments that were connected by the movement of patients and residents with high close personal contact with staff in both settings. As such the risks had to be carefully managed.

17.6 I was not involved in, nor did I provide professional input into, the 10 November 2020 'The Rapid Learning Review of Domiciliary Care in Northern Ireland [MMcB6/258 - see INQ000276420]. As described at paragraph 18.23, I did propose a rapid learning review of the Care Home sector to identify learning in the first wave to the CNO and the Health Minister.

17.7 I did not lead on, or provide professional input to, the 21 October 2020 report to the NI Executive on the incorporation of the recommendations of the Rapid Learning Initiative into a revised regional surge plan nor, as described at paragraph 2.26, was CMOG or I members of the regional Adult Social Care Surge Group jointly chaired by the CSWO and the CNO [MMcB6/055 - see INQ000269016].

18. Lessons Learned

18.1 While the number will vary over time, there were approximately 483 Care Homes in NI and, in the period from the 1 March 2020 to the 6 May 2020, 232 Care Homes had no deaths. In the context of a highly transmissible respiratory virus which caused significantly more severe disease and deaths in older people with other health conditions, this was a considerable achievement by Care Home providers, managers and health care workers in the most difficult and challenging of circumstances. Care Home residents and their families made considerable personal sacrifices with respect to visiting to ensure that Covid-19 was not brought into their Care Home and this undoubtedly protected many residents. The NISRA

has estimated that there was a total of 1,289 deaths of Care Home residents involving Covid-19 between 18 March 2020 and 24 June 2022 (including deaths which took place in a hospice, hospital, Care Home or elsewhere, although no assumptions can be made in relation to where the deceased contracted the disease). This accounts for 27.7% of all Covid-19 related deaths [MMcB6/259 – see INQ000577517]. Many people are living with the consequences and circumstances of that loss including not being able to be with their family member in their final days of life. I recognise that is important to identify learning for future pandemics in terms of what worked well as much as identifying obstacles and missed opportunities.

18.2 In NI, there is an integrated health and social system and the HSC Trusts have a role in commissioning care from the care sector. In my view, the resultant knowledge and experience of the sector, along with well-established and effective relationships between SSPG in the Department and the HSCB and the IHCP organisations and other stakeholders, was of benefit in understanding and addressing the concerns in the sector.

18.3 In my experience, the collaborative leadership and coordination by the CNO and CSWO in working with other HSC partners to provide additional IPC training and support to the care sector was positive and very well received. The extent of IPC knowledge and level of PPE required was initially a challenge given the unprecedent requirements during the pandemic. This is an important learning point for the future.

18.4 Given global supply constraints, the early decision by the Health Minister to provide PPE to the sector and the identification of single points of contact in HSC Trusts for Care Homes requiring supply of PPE, supported by RQIA who assisted with any concerns, worked well. As these were

entirely new supply lines, it took time to establish these new arrangements and for these to bed in, and again this is a learning point for the future.

18.5 The early establishment of the RQIA SST and the role played by inspectors who were all health professionals with intimate knowledge of the Care Homes in their patch was, in my view, invaluable in supporting the Care Home sector. The development of the RQIA App and dashboard reporting pressures was also hugely beneficial in ensuring Care Homes received the care and support they required. Conversely, the initial absence of this data was an obstacle to ensuring the required support was provided.

18.6 We priortised testing in the care sector, particularly in those areas of highest risk, with a view to utilise available capacity at any one time to best effect. While we did expand testing in Care Homes as rapidly as possible, informed by the emerging evidence, I believe all wish we could have expanded this even more rapidly. A fundamental obstacle and constraint in the first few months of the pandemic was testing capacity. The importance of having diagnostic capacity to rapidly scale up testing capacity and capability for any new pathogen is an important learning point from this pandemic.

18.7 The expeditious roll out of the vaccine in the care sector, somewhat ahead of the rest of the UK, as the first supplies of vaccine arrived into NI was a significant success and was the result of the collective effort that, in my view, signified the priority afforded the sector in the overall response to the pandemic despite the many challenges faced.

18.8 As stated in paragraph 7.24, the UK CMOS Technical report makes a number of points to assist in the management of future pandemic with

respect to the Care Home sector which I have summarised again to assist the Inquiry.

I. First, older people in Care Homes are very likely to be at high risk of serious disease in any future respiratory disease epidemic or pandemic. In the absence of effective treatments or a vaccine, measures to reduce the ingress (entry) of the causative agent into care facilities via staff or visitors and minimise transmission while maintaining the delivery of quality of care will be a high priority.

II. Second, NPIs that reduce personal contacts, particularly isolation from family, will have a considerable impact on the quality of life of Care Home residents and families and balancing the benefits and harms is not straightforward. In my view, this balance was not always maintained during the pandemic, with profound consequences for individual residents and families. The length and extent of limits on visiting inward and outward, on social interactions of residents, and the use of masks by staff during the Covid-19 pandemic were unprecedented in Care Homes. The use of technology to support social contact, the designated 'essential carer' or as in NI the Care Partner Scheme with appropriate infection prevention and control arrangements were useful measures to mitigate the harms of isolation.

III. Third, controlling transmission in Care Homes also depended on alignment with wider public health, social care and healthcare systems. Preventing entry of Covid-19 into Care Homes proved extremely difficult during periods of high community transmission and high case rates in hospitals required careful management of discharges into Care Homes. The structure of the care sector itself across the UK presented challenges: there is enormous diversity of facilities, and many staff move from one facility or care role to another within the

same week or even day. The adult social care workforce, although trained to provide care, lacks the status of registered professionals and is relatively poorly paid and insecurely employed, with high vacancy rates and poor sick pay provision.

IV. Fourth, the value of reliable and comprehensive routine population and health data describing the population living and working in residential care to inform policy decisions and evaluate the impact of interventions cannot be overstated. Routine and bespoke data sources enable calibration of interventions to vulnerability and impact, through an understanding of: ingress (entry) routes; attack rates; case fatality; and hospitalisation in different groups of residents. Testing early and often is key in understanding and responding to ingress routes, although if testing capacity is limited there will need to be careful prioritisation of available capacity.

V. Fifth, advice from behavioural and social science was essential in informing good practice in the support, protection and management of care staff and in protecting residents. This highlighted, for example, that there was a risk of stigmatisation and fear, and the need for financial and other support for staff when isolating to reduce the movement of staff. Research and innovation to improve Care Homes' resilience to respiratory and other infections is needed and could inform, among other things, building regulation and best practice. With respect to learning and future pandemics and what more could have been done with respect to staff movement, in my view it is essential that there is greater recognition of the vital contribution made by the adult social care workforce and their important role is valued and recognised.

18.9 In the UK and NI, the impact on the adult social care sector and particularly Care Homes was profound and has had a lasting impact on those most directly affected. While considerable efforts were made by provider organisations, the community and voluntary sector, HSC Trusts, the HSCB and policy and professional colleagues in the Department, access to domiciliary care and support, respite and other specialist support service was impacted during the pandemic with adverse consequence for those directly affected including individuals and their families.

18.10 In my reflection on the learning that may be helpful to the Inquiry in considering recommendations that might assist in the response of the adult social care sector in any future pandemic, I have primarily focused on residential and nursing homes (Care Homes) as this was the sector most affected, given the significant mortality and the consequences of the measures themselves that were introduced to protect residents and staff. I do, however, recognise that the impacts on people requiring adult social were much wider than in the Care Home sector. As my professional and responsibilities primary related to advising the Health Minister and the NI Executive on NPI measures to control transmission at a population level, the expansion of testing, and the implementation of Covid-19 vaccination programme among other significant responsibilities, there will be more sector specific policy consideration and operational matters where there may be significant learning, however others will be best placed to reflect and provide more informed insight on those.

18.11 As previously indicated, the vulnerability of the Care Home sector to Covid-19 was similar in most countries with large populations of older people. This was recognised in the early months of the pandemic, when the risk factors for severe disease and the routes of transmission became known. As with many other countries, in NI and across the UK there were

significant challenges in identifying how best to respond. Balancing the care needed, while reducing the risks to vulnerable older people took longer than anybody would have wished, and the measures that were introduced to protect residents and staff also had significant adverse consequences and affected our ability to respond effectively.

18.12 A key success of wider public policy including the public health and the health service is that more people are living longer, although with more long-term conditions, and the complexity of meeting the health and social care needs of older people has become increasing challenging. The largest population growth in NI over the next 25 years is projected amongst the over 65 and 85 years of age groups. Over the next 25 years the population aged over 65 and 85 years are projected to grow by 49.6 per cent and 122.2 per cent respectively. This is a remarkable achievement, and it is to be celebrated, however it will require preparation and planning across government and wider society. Over the same period, the population of children (aged 0-15) is projected to fall by 23.1 per cent by mid-2047 and NI's projected population growth at 1.1 per cent over the next 25 years is the lowest across the UK, as set out in NISRA Statistical Bulletin 2022-based Population Projections for NI [MMcB6/260 – see INQ000577518].

18.13 This increase in older people in NI represents the greatest increase in the percentage of older people in the UK. From a health and social care perspective, these population projections of an ageing population will require careful consideration with respect to policy prioritisation and development with expansion and realignment of more age appropriate holistic health and social care services. While beyond the immediate scope of the Inquiry, and certainly out with my professional expertise and professional and policy responsibility, for its part, the adult social model

requires a fundamental structural review and adequate resourcing if we are to meet the needs of an aging population.

18.14 These demographic changes in the population have been recognised in NI with work commencing in 2016 with the appointment of an Expert Advisory Panel on Adult Social Care and Support to review adult social care. The Expert Panel produced sixteen proposals in the Power to the People Report published in December 2017. The report identified a number of priority areas, including a call for improvement of conditions for the social care workforce as well as an appraisal of the market of care provision and the true cost of providing care and support. Following this, notwithstanding the complexity and resourcing situation which will impact on progress, in January 2022 the Department published a public consultation on the Reform of Adult Social Care in NI setting out 48 reform proposals under six strategic priorities. The Department has now established a Social Care Collaborative Forum to take forward the agreed actions although, in my view, the current timeframe for the completion of this is not ideal as many of the consequences of the changes in the population are already being experienced in the pressures across health and social care and in the experience of the care provided to older people which is, at times, far from optimal. The work has, however, been prioritised and is being progressed in a phased way subject to available resources. While I am not contributing to this work, or a member of the Forum, and other policy and professional colleagues directly involved will be best placed to comment, it is my professional view that progress and strategic reform of adult social care is rightfully a Departmental and Ministerial priority. The current vulnerabilities in this sector were clearly highlighted during the Covid-19 pandemic.

18.15 In large part, the vulnerability of the adult social care sector across the UK is the structure of the care sector which itself presents challenges - some

might argue less so in NI with its integrated health and social care service. The sector is large, complex, varied, and fragmented. In NI, many Care Homes are operationally managed by private providers who act independently of the health and social care system with care commissioned by HSC Trusts. For example, in 2024, just over 80% or registered residential Care Homes were in the independent sector. While others with direct policy and operational experience will best be placed to provide informed commentary, in my view the sector was already under pressure and fragile even before the pandemic.

18.16 There is significant diversity of facilities, ranging from single providers in small facilities in repurposed buildings, to large purpose-built facilities run by provider organisations and these care for older and working-age adults, although older people make up a significantly greater number of residents. There is also a high turnover of care workers, and many work in multiple settings or for several different agencies.

18.17 While out with my professional expertise it is my view, and that of UK CMO colleagues, that there needs to be research to inform innovation as to how to better improve Care Homes' resilience to respiratory and other infections. This research needs to be undertaken well in advance of any future epidemic or pandemic. The finding of the research could subsequently inform changes in best practice, building regulations and Care Home standards for inspection by the RQIA in NI. The extant Residential Care Home Minimum Standards in NI during the pandemic dated from 2011 [MMcB6/261 – see INQ000577519] and these were updated in 2022 to include learning from the pandemic [MMcB6/262 – see INQ000506171]. The updated standards include clearly defined responsibility for IPC and clear lines of accountability throughout the home with key members of staff having responsibility for the implementation of IPC policies and procedures. It is now clearly stated that these policies

and procedures must reflect the Departmental policy in this area. The guidance includes written guidelines for staff on making referrals to infection control nurses and public health professionals, who have expertise in IPC, for advice and support. Outbreaks of infection are managed in accordance with the home's procedures, reported to the local Consultant in Communicable Disease Control and to the Regulation and Quality Improvement Authority and records kept.

18.18 These standards should be subject to annual consideration of the need for review, and should incorporate learning from significant outbreaks. The standards should also contain explicit reference to requirements for evidence of regular reviews of IPC practice, to include evidence of the training of staff in IPC and use of PPE following such outbreaks. The Care Home standards now include specific requirements for plans to manage outbreaks of infection and more robust escalation arrangements to obtain the necessary support from HSC Trusts (as the commissioners of care) and the PHA, with respect to specialist advice and support. While the scale and level of IPC required during any future pandemic of respiratory origin will be significant, ensuring good baseline training and IPC procedures is essential. In addition to RQIA inspections against the standards as part of its statutory inspection programme, HSC Trusts (as the commissioners of care) should proactively review these arrangements as part of their contract monitoring arrangements, and ensure any issues of concern are addressed by the provider, and that RQIA is informed.

18.19 The adult social care workforce is trained to provide care but the care needs of the those in the sector are changing. It is the case that, as the population ages, the health care needs of residents has changed, increased and become more complex with many older residents having significant comorbidities. There is need to consider how these increasing complex health needs are best met. During the pandemic there was

significant innovative arrangements to provide outreach support into Care Homes and, as described below, these models need to be adapted along with enhanced health training and supervision arrangements for care workers. Unfortunately, those working in the sector do not have the recognition or status of registered professionals, are relatively poorly paid by comparison and employment is often not secure. There are high vacancy rates and poor sick pay provision, as was identified and addressed during the pandemic. Given the key role they play, it is essential that the social care workforce feel more valued, and this should be reflected in improved levels of pay and conditions and security of employment. This, I believe, will contribute to a more resilient workforce with fewer staff moving from one facility or care role to another within their working week. More training and support with respect to IPC would be of benefit in protecting residents and providing care workers with greater confidence.

18.20 During the pandemic, the measures that needed to be introduced to protect people in Care Homes were hugely damaging, leading to loneliness, social isolation and deconditioning, as well as significant stress and distress for residents, staff and families. I do not believe that the correct balance of harm and benefit was always achieved, primarily because of the understandable fear in the Care Home sector of outbreaks and the impact on individual residents and other residents in the home. In my experience, reducing the risk of transmission in Care Homes involved the most complex assessments of risk to individuals of any part of the pandemic response. This included considering the care needs and rights of individuals as well as those of other residents. Balancing the risk of outbreaks of Covid-19 in vulnerable older people, maintaining safe staffing levels, ensuring access by other healthcare professionals, providing the personal care required by residents activities of daily life, facilitating visiting by relatives in what may be the last months of life, and

communication with residents while wearing PPE and ensuring quality of care and dignity particularly for those with dementia was not straightforward or easy. Similarly, I recognise personally and professionally the importance of the cultural and spiritual traditions in NI with respect to attending the dying and respecting the deceased person and the distress caused because of the advice provided to protect residents, staff and relatives. This was not what we would have wished but regrettably was necessary.

18.21 Reducing personal contacts, and isolation from family will have had a considerable impact on the quality of life of Care Home residents and their families, and balancing the benefits and harms was not easy. In my view this balance was not always maintained during the pandemic, with profound consequences for individual residents and families. The duration and extent of restrictions on visiting of families, on social interactions between residents, and the use of masks by staff during the Covid-19 pandemic were unprecedented in Care Homes and undoubtedly caused significant distress for residents, families and staff. While technology and the Care Partner Scheme were useful measures to mitigate the harms of isolation, they were not available early enough or applied sufficiently consistently, with some families not understanding why others could visit relatives, while they could not. While, in some circumstances, this may have been for good reasons, I don't believe this was always clearly communicated or understood.

18.22 While there may have been particular factual circumstances which impacted an individual Care Home's decisions, such as the structural lay out and lack of adequate facilities, or where a Care Home had an outbreak, there appeared to be other circumstances were there was no obvious reason why such visits were not being allowed. This caused great distress and distrust. I have, at paragraph 10.4, summarised the

steps that the Department, the CSWO, CNO and I took to try and address these inconsistencies. It is my firm professional view that future pandemic preparation and planning must include a recognition that visiting of close family members is an essential aspect of holistic care and support and research to inform innovative approaches as to how visiting can be maintained during a future pandemic.

18.23 As was evident during the pandemic, the health care needs of people in residential and nursing homes has become increasingly complex and this was reflected in the "The Rapid Learning Initiative" which I had proposed to the Health Minister and the CNO towards the end of the first wave in May 2020 and proposed medical representatives to provide professional input. On 2 June 2020, the Health Minister announced that this was underway to identify lessons from experiences of Covid-19 in Care Homes [MMcB6/263 - see INQ000103701] and, on 24 June 2020, the Health Minister announced that a group had been established to learn from the Care Home experiences of Covid-19 during the first wave and to take forward the Rapid Learning Initiative on Care Home experiences [MMcB6/264 - see INQ000103713]. The group was chaired by the Deputy CNO and included representatives from the independent Care Home sector, the Health and Social Care system and the Royal College of Nursing. Care Home residents, their loved ones and Care Home staff were critical partners in this work, providing insight and knowledge over a defined 3-month period to identify recommendations for action. On 9 September 2020, the Department published the 'Rapid Learning Initiative Report on Care Home Pandemic Experiences' [MMcB6/257 - see INQ000276404]. The Rapid Learning Initiative brought together a wide range of stakeholders through both its Steering Group and four Subgroups who undertook the work of the Initiative. The Subgroups examined four key areas in Care Homes and identified 24 recommendations to be used to focus learning from the transmission of Covid-19 into Care Homes

during the first surge to mitigate the impact on residents and staff of a potential second surge. The recommendations fall under 6 themes:

- Technology – leverage technology to keep people, knowledge and learning connected;
- Information – manage information and guidance to and from Care Homes more efficiently and effectively;
- Medical Support – provide consistent medical support into the Care Homes;
- Health and Wellbeing – enhance the health and wellbeing interventions of residents, families and staff;
- Safe and Effective Care – enhance safe and effective practices including access to training for Care Home staff; and
- Partnership – enhance partnership working across all organisations

18.24 The Initiative also identified three overarching structures and processes that will need to be established to support the delivery of outcomes and bring about a learning system:

- At strategic level, the collaborative partnerships established for the purposes of the Initiative should continue and develop further to support future development of strategy and policy;

- A regional learning system should be developed, including key quality indicators for Care Homes using real-time data for continuous improvement; and

- A quality improvement learning system should include building the capability and capacity within Care Home staff to use continuous improvement methodologies to implement operational improvement as a system.

18.25 It will be important to review and consider further how best to provide both primary and secondary care support to the Care Home sector, including palliative and end of life care which aligns with the person's own wishes as part of advance care planning. While this will be essential in preparing for any future pandemic, further consideration is required with respect to current models to ensure that Care Homes and Care Home staff are appropriately supported to meet the complex needs of older people without recourse to acute services and admission to hospital when this is neither necessary nor appropriate.

18.26 Finally, if we are to correctly identify the learning and lessons to assist in any future pandemic response it is important we consider the evidence. As I previously advised in oral and written evidence to Module 2C of the Inquiry, epidemiological and genetic evidence from across the UK suggests that, while some Care Home outbreaks of Covid-19 were introduced or intensified by discharges from hospital, hospital discharge does not appear to have been the primary or major way in which Covid-19 entered most Care Homes. Before testing for Covid-19 was widely available, the known risks of keeping Care Home residents in hospital when their medical treatment had been completed, at a time of increasing risk of nosocomial infection, had to be balanced with the risk that they might already have acquired Covid-19 and might introduce it to the care home. While steps were taken to reduce these risks, it is the case that hospital discharges to Care Homes did connect two high-contact environments, and reducing the associated risks should and must remain a priority in similar pandemics.

18.27 Most importantly, the unequivocal learning from this pandemic and the message for future policy and decision makers is that controlling

transmission in Care Homes is ultimately dependent on reducing community transmission and alignment with wider population NPIs. This is reflected in the experience during the Covid-19 pandemic that preventing entry of Covid-19 into Care Homes proved extremely difficult during periods of high community transmission and high case rates in hospitals required careful management of discharges into Care Homes. While I believe this was understood by NI Executive Ministers, it was not always reflected in some public commentary and vague mantras of a "ring of steel" to protect Care Homes. In my view, while such comments may have been well intentioned, they demonstrated a lack of understanding of the complexity of the issues and the challenges faced, and a misunderstanding that in this pandemic asymptomatic testing and PPE alone could prevent the virus entering Care Homes. I believe that some public commentary failed to appreciate the complexity of the risks and harms which had to be balanced by those working in Care Homes and Care Home providers and which were ultimately people's homes. I believe this unhelpful commentary also contributed to considerable and understandable concern among those with relatives in Care Homes and, in my view, caused further and, at times, unnecessary fear and anxiety in the care sector, which may have had implications for the consistent implementation of the visiting and the Care Partner Scheme.

Conclusion

18.28 Reducing the risk of transmission in Care Homes and the management of outbreaks involved some of the most complex assessments of risk to individuals as compared to any other aspect of the pandemic response. These were people's own homes, many of whom were in their last months of life and who were at high risk of severe disease and death from a new virus to which they had no immunity. This required consideration of the care needs and rights of individuals as well as the rights and needs of

their families. Balancing the risk of outbreaks of Covid-19 in vulnerable older people, maintaining safe staffing levels, ensuring access by other healthcare professionals, providing the personal care and support required by residents with the activities of daily life, and facilitating visiting by relatives in what may be the last months of life was extremely difficult. Undoubtedly, that balance was not always achieved and there is much learning as to how we might improve and do things differently. It was always my experience that, at every level, everyone was fully committed to doing their very best to achieve this.

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: 23 May 2025

Module 6 - Covid 19 UK Inquiry

Schedule to the statement of Sir Michael McBride

Exhibit Reference	INQ reference / Principal INQ reference to be adopted
MMcB6/001	INQ000203933
MMcB6/002	INQ000226184
MMcB6/003	INQ000421784
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