Module 2c (Northern Ireland) Week Two

Witnesses

- **Richard Pengelly** (former Permanent Secretary for Department of Health Northern Ireland)
- **Professor Ian Young** (Chief Scientific Advisor, Department of Health, Northern Ireland)
- **Lord Peter Weir of Ballyholme** (former Minister for Education, Northern Ireland)
- **Diane Dodds** (former Minister for the Economy, Northern Ireland)
- **Deirdre Hargey** and **Carál Ní Chuilín** (former Ministers for Communities, Northern Ireland)
- **Naomi Long** (Minister for Justice, Northern Ireland)
- **Edwin Poots** (former Minister for Agriculture, Environment and Rural Affairs, Northern Ireland)
- **Sir Brandon Lewis** (former Secretary of State for Northern Ireland)

Richard Pengelly (former Permanent Secretary for Department of Health Northern Ireland)

Before the pandemic the waiting lists were 400,550 people out of a population of 1.9 million. Since then, the statistics have gotten worse and there are now over half a million waits.

The system of healthcare is certainly suboptimal. The structure of our system wasn't and isn't yet right for the services we're trying to provide to the population of Northern Ireland. We entered the pandemic with a very, very tired workforce. Up to the point of the pandemic the continual provision of high-quality health and social care was reliant on the goodwill of staff. There is not an infinite well of goodwill. People are tired, they have been going above and beyond. They entered the pandemic with a degree of fatigue flowing from the state of health and social care.

We were carrying large numbers of vacancies from both the pay system and from workload pressures which just compounded the problem. It would not be putting it too high to say the health services in NI were fragile in Jan 2020. Ideally a hospital should run at no more than about 85% capacity. All our hospitals were routinely running well in excess of 85%. That impacts the number of vacancies and the tired workforce. So, I think all those issues contributed to the service not being as resilient as it otherwise would have been.

The CMO is part of the management structure of the dept of health. It's not an independent role, but his professional advice is independent.

6th Feb – email from CMO Group saying that it was not necessary to activate the contingency arrangements. We were not saying “don’t activate NICCMA” we were saying that we were not requesting that it being activated. Establishing the arrangements comes at a cost because it pulls colleagues away from other work so would mean that something else wasn't happening. At this early stage in February, we were still a number of weeks away from the first case in Northern Ireland so from a health perspective we were not looking for the activation.

21 Feb – I shared with other Perm Secs that our position was we were not yet calling for establishment of NICCMA. Establishing these arrangements comes at a cost in terms of other work being stood down. My view remains that it's a call that can only be made when you have the transparency about both the work that needs to be done in other sectors and the cost of doing that to other preparation work.

We certainly weren't saying NICCMA wouldn't ever be needed, it's always a judgement call about what point you trigger it. The value of establishing NICCMA in February would have had a greater cost in terms of what was lost. At some point we reached a crossover point and I think it's a fine judgement about when that crossover point was.

There was no modelling capacity in Northern Ireland until the CSA Prof Ian Young came back into office after a period of leave, and then it wasn't instituted until the end of March 2020. The quality of any modelling work is directly proportional to the amount of data. We only had one case by 27 February so any modelling work that was done in late February and early March would have had such a low confidence level attached to it, because of the scarcity of data. It wouldn't have been possible to do comprehensive modelling work in the early and mid-part of March until case numbers started to escalate.

There were concerns that the PHA surveillance figures in general were not accurate. I was concerned that the PHA wasn't taking our concerns seriously enough. Minister Swann was concerned about the data because he was making public statements so wanted the figures to be accurate. That was important for the public to have confidence. When we raised this with the PHA they didn't seem to recognise the problem and was not robust about undertaking to fixing it rapidly. The issue resolved itself as we moved into April and The Department of Health took over responsibility for the data.

In an email on 20 April the PHA said that 500 people were being trained to conduct contact tracing. It turned out that was not the case at all. It is clearly not a representation of what happened. Contract tracing was stopped on 12 March. That flowed from the COBR decision to move from Contain to the Delay phase. It was linked to testing capacity too, so we needed to pivot more towards clinical testing for people on admission to hospital until such times as we grew testing capacity.

We did seek out the Commissioner for Older People for engagement. The difficulty was the pace of the issues that had to be addressed so when we shared draft guidance, he didn't feel he had sufficient time to engage and consider and respond to that. I understand and sympathise with that point, but that's different from not engaging at all. My colleagues were also speaking with care homes directly. The message they were hearing loud and clear was colleagues in care homes were urgently requesting clear guidance on the emerging latest position, so it was trying to marry those two issues, we didn't always get it right and the pace overtook us at times.

Strategy published on 30 March. I accept it doesn't mention the care sector but there were separate complex workstreams for care homes. The fact that it was not mentioned within this document is not to suggest that this wasn't a strategically important issue of great concern for us in the department.

Testing. The strategy said testing must not hold up discharge to care homes. That was on the basis that other mitigations would be in place. I agree it had the potential to be dangerous but there were other mitigations. I do not agree it was reckless. For an individual who is clinically fit to be discharged from

hospital, to be retained in hospital is potentially highly dangerous to that individual. The approach here is about trying to balance a series of risks and the solution, whilst imperfect, is hopefully achieving the best alignment of all those competing factors

Professor Ian Young (Chief Scientific Advisor, Department of Health, Northern Ireland)

The amount of data which was available close to my return even was extremely limited in Northern Ireland, and in terms of effective modelling, the key to it is having effective data inputs to allow the modellers to work. I think it would have been possible to do some modelling before my return to work, but that there would have been considerable uncertainties around it.

When I came back, I felt that it was inevitable that there needed to be severe, strong non-pharmaceutical interventions, effectively lockdown as we came to refer to it, and that there was no alternative at that stage.

There wasn't reliable data available on hospital admissions until towards the end of April 2020.

One of the key learnings for me is the absolute need for much faster roll-out of testing, because so many aspects of our understanding and our response were inhibited by lack of access to testing.

The very first modelling paper I prepared, which was at the beginning of April 2020, said that there would be a second wave. It said that there would be a second wave when the restrictions were relaxed.

In general, every time a policy decision was made, either to relax or to introduce a new set of restrictions, it took two to three weeks before we could be confident what effect that was going to have.

EOTHO certainly wasn't helpful in terms of the transmission of the epidemic. The idea was that EOTHO was supposed to take place in Covid secure environments. I was generally unhappy with the idea of Covid secure environments. I made that point repeatedly. With the best will in the world, people eating indoors without face coverings in properties where often ventilation was quite limited, they can't be Covid secure, the side that they could be was naive.

In September the advice from SAGE was for a circuit breaker. By 8 October we'd reached the point where there was a realistic danger of the healthcare system becoming overwhelmed if there was not a rapid intervention. Ultimately our pathway out of the pandemic required us to achieve a high level of population immunity, preferably through vaccination, but also as a result of natural exposure to the virus. At that stage, vaccination was still a number of months away, and there were not really any very effective treatments to reduce the risk of death. So our concern was that the hospital system would become overwhelmed by very ill patients who would mainly be older patients with Covid, and that that would lead to a very large number of deaths over a short period of time. The only way to avoid that was to greatly lower the level of transmission of the virus in the community and the only way to achieve that was full lockdown for a period.

I sought to provide advice on a wide range of options, including the benefits in terms of reducing transmission, but also highlighting the areas where there would be harms in terms of the interventions. The pushback was very robust at times, the criticism and the conversation but it did not alter in any way the advice which I was giving or my analysis of the situation.

I think the decision was taken to have a four-week lockdown with schools open but with an extended half term. So it was rather less than the lockdown which had been used in wave 1. I didn't feel at the time that my advice wasn't being taken, I felt that by the majority of ministers the advice had been understood, received and accepted and that ministers had appropriately factored in a range of other considerations around education, economy, society and family life, and taking account of the broad range of factors had decided to go with the four-week intervention that we have described. I didn't feel my advice was rejected, I thought it was understood.

We had observed R falling to around 0.7 during the first lockdown when there was a very high level of adherence and compliance to the restrictions in place. While schools were closed and adherence to the restrictions was not as good as it had been in the first lockdown, we observed R falling to a little bit less than 0.8. So that was probably unsurprising that with schools open again, R rose further and was probably not very far below 1. If the intention had been to try to reduce R to 0.7 it was unsuccessful and therefore hospital pressures remained high.

I think that the decisions which were made were effective but not as effective as we needed them to be, and some of that relates to the timing of the interventions as well as the nature of the interventions. Earlier is better.

The cumulative effect of what had happened from the end of September meant that we had a very high baseline running into the two weeks before Christmas. The observed consequences in January were predominantly a result of the two weeks before Christmas.

Lord Peter Weir of Ballyholme (former Minister for Education, Northern Ireland)

I am sceptical about the report that said NI was 18 months behind the other parts of the UK in pandemic planning. I am a little bit sceptical that had there been ministers in place, that a lot of time would have been spent on scenario planning of potential events that could happen into the future. I wouldn't disagree that there were issues with contingency planning at the time. I wasn't particularly aware that the arrangements had not been reviewed for 20 years. I assumed whatever was in place for Civil Contingency arrangements was fit for purpose. It would have been helpful if I had been made aware.

I thought school closure was a possibility, but it was not something I envisaged happening. If we needed to go to remote learning the department was in fairly good shape to make that happen. I thought we might have to close a few schools; I didn't think it would be a full shutdown of schools at that stage.

There was an impression certainly given by the Department of Health that while there were problems potentially coming down the line, there wasn’t that level of immediacy, and I think that was maybe one of the mistakes that was made.

12 March the Republic of Ireland announced school closures. We had a meeting following that and was concerned that school closures would mean that health care would be collapsed due to parents needing to provide childcare. There was also concern about free school meals and the impact on the economy of having 340,000 children at home and the impact that would have on the ability of frontline workers to work. I think also the advice from SAGE was that the impact on transmission would be marginal. Whereas however good the alternative arrangements that we could put in place for education, there was no doubt in my mind that there would be a very detrimental impact on the quality of provision of education.

18th March the UK PM announced school will close and NI followed suit. We were seeing a rise in the speed of the pandemic and the medical and scientific advice then became this was the right time to take this action. Indeed, that we needed to take every action possible which led ultimately to a lockdown.

The other thing which made the wider context of a decision on schools and indeed wider lockdown possible was the UK Government then committed to issues such as furlough, such as high levels of financial support. That made the choice of a wider lockdown and the closure of schools something that was plausible.

I accept that ultimately there was not enough cognisance given to the difficulties that were created for children and very specifically for both vulnerable children and the vulnerable in general. There was a range of mitigations put into place very quickly for vulnerable children but at best they were mitigations, there would still be major implications.

Once schools reopened rates of transmission went back up, so we looked at more localised restrictions in particular hotspots. Those interventions didn't have the desired effect.

8th October – The Department of Health and the CMO were saying that things had reached a very serious point and that there were real concerns that health services in Northern Ireland wouldn't be able to cope.

11th October – There was meeting between the CMO, the First Minister and the deputy First Minister. The message being conveyed was that they were extremely concerned the point was about to be reached where health services would be overwhelmed. The recommendation was a six-week lockdown save that schools could remain open.

That recommendation wasn't accepted by ministers and instead there was a decision to have a four-week lockdown, but with schools open, albeit with a longer half term break.

There was a very major concern. The department of economy had produced a paper showing that the impact on people's livelihoods and on the economy was potentially devastating. They had estimated that the 4-week lockdown would result in a £400 million hit. That was a concern which needed to be weighed in the balance. Sometimes it's presented as livelihoods against lives. It's not as straightforward as that. If you plunge society into levels of poverty that has a very major impact in the long run in terms of health.

I did support this being handled by a cross-community vote. It is something which is designed to try and ensure that minority voices are not ignored. Traditionally it used to prevent the majority forcing something through against the wishes of the minority. Getting a unity of purpose was something that we should be striving for.

I think that there was a failing in relation to care homes. There was level of trust with the Department of Health that the actions that needed to be taken in care homes was being done. It was raised by a number of ministers from April onwards on a consistent basis and the response we often got from health was this is being done or we are issuing this new guidance"

I think this is one of the things we got badly wrong. If heaven forbid, we find ourselves in a situation like this there should be a much more laser like focus on care homes. There was an assumption that everything was getting sorted out. I think that there was not enough of a fast tracking with hindsight in terms of doing everything that they possibly could. There was an assumption that if somebody was being released back into a care home from a hospital that they were completely free of any virus. I think there probably wasn't enough checks in relation to it.

Collectively as an Executive we didn't get it right. It didn't do the job that ultimately it should have done. How much of that was absolutely apparent at the time maybe questioned.

Diane Dodds (former Minister for the Economy, Northern Ireland)

On 12 March Department of Health took a decision to stop testing, and I do believe that that was in part because there were not enough tests to actually facilitate the mass testing that we might have otherwise concluded.

The pandemic was primarily a health challenge, and the focus of the Executive was always on the issue of how to save life and minimise the issues for families. But the wider ramifications of the pandemic and the economic downturn that it caused, the challenge to families, to vulnerable workers, to people on zero-hours contracts, those were very, very real. The challenge in all of this was to take the health advice but also try to look at the issue in a rounded way by looking at all of the people who were impacted by the pandemic.

I think the learning is that we need to place more emphasis on things that maybe we were so concerned with the transmission of the virus that we also need to place more emphasis on things that we may not have seen as central to what we had to do to save lives.

Social distancing at 2 metres for many businesses would have made them unviable, so they simply couldn't have opened. We were receiving advice from the CMO and the CSA about the potential impact of the reductions, but no one was saying they shouldn't be done. The idea was to have an incremental approach to easing restrictions. I don't think we could have had compliance if we hadn't made some efforts in order to try to ease life for people in Northern Ireland.

The Bobby Storey funeral was the biggest issue in compliance and the spread of the virus. Thousands of people were on the streets on the same day other families had to bury their loved ones. The Storey family were allowed into the crematorium when others weren't. That act in attending was almost the signal that

you can do as I say but not as I do. I don't have scientific data for it, but I do think it was very, very significant.

Deirdre Hargey and **Carál Ní Chuilín** (former Ministers for Communities, Northern Ireland)

The department's overall aim was tackling disadvantage and building sustainable communities.

There was planning with the advice sector to establish the Covid community helpline which launched on 27 March, so planning for that would have been before 13 March, and one of the key reasons we set the helpline up was for those vulnerable categories, those who would have been shielding, was to ensure that they did have a point of contact in which we could give advice and information and importantly signpost people to support.

In hindsight we can now see that if we had have done things earlier that would have been a better outcome. If you were doing it again you would ensure that those contingency arrangements and the planning would have been done sooner. You would ensure that whilst one department may take the lead, that all departments were around the Executive table and that we could have been engaging and planning around those intersectional issues much earlier.

I do recognise that there are areas that we definitely need to improve. I think for example having Disability Action involved in the emergency leadership group and other strands of work is a definite learning that we can pick up. We did try to move at pace to make sure that that group was reflective as much as it could be. But there were shortcomings and lessons to be learned. A big learning is to codesign and produce with the sector

8th October – CMO said he was never more concerned, but he didn't offer a recommendation. For the CMO to come to an Executive meeting and to say that he was never more alarmed in his role as CMO and then not to offer advice or a recommendation, I just couldn't understand the logic of it.

I did agree with the circuit breaker being extended by 2 weeks. I don't know why it was so controversial. It was the first time that the cross-community vote was used. In my experience, previous to that, any votes that were taken were done on a majority basis. The scientific and medical advice that was given. We were free to disagree with advice, but I felt it was disregarded. When the cross-community vote was called for I just felt it was a completely inappropriate use of a mechanism that was brought in to protect minority rights, equalities and human rights. I could not and still don't understand why that was called in.

Naomi Long (Minister for Justice, Northern Ireland)

The Health Minister brought recommendations to the Executive. The DUP indicated they would not support those recommendations. They didn't only vote against them; they triggered a cross-community vote. It effectively operated as a veto and the health ministers' proposals were blocked. I felt it was an egregious abuse of a process that was conceived to protect minorities. Instead, it was being deployed on an issue that had no differential bearing on either community. This was not about a protection of a

minority; the DUP were the largest party on the Executive. They were also deploying it against a minister who was also a Unionist, which to me shows starkly how egregious the abuse of the mechanism was.

Impact of leaks: At times it created panic in the public and created a debate prior to Executive having been able to even consider the evidence. That created a sense that the Executive was incompetent, and it led to me finding out from the news what would be discussed at Executive. It's very difficult to know what the motivation was. I think in some cases it was to put pressure on ministers to take certain positions, particularly around the circuit-breaker.

There did not appear to be adequate thought given by either the Irish Government or the UK Government about the impact of divergence in their approach on part of the UK that had a land border with a neighbouring state. It would be fair to say that was a fairly consistent failing in UK policymaking.

I felt we lacked the same level of expertise as we gained from the Department of Health from other sectors to inform our decisions. That's not to say those sectors weren't considered, but the weight we could attribute to them was affected by the lack of an equal weight of expert advice. We lacked expert opinion in other areas e.g. we didn't have a Chief Economist in the way that we had a Chief Medical Officer.

Care Homes: Responsibility for policy resided solely about the Department of Health. Theoretically the Executive Committee could have considered that the decisions in care homes were so significant that it came within its purview but in practice it would have been impossible for us to deliver. The accountability is to the individual minister, and so it would be a considerable overreach for the Executive to direct the individual ministers' officials or to seek to influence those officials.

People were released from hospital directly to care homes without a stepdown facility like a hotel for instance. Within prisons, we quarantined all new committals for 14 days to ensure that anyone arriving in prison did not enter the general population until such times as they were symptom free or Covid free. I shared that learning with the Executive. I believe it would have been useful in managing the care home situation. But it was a matter for the Department of Health how they opted to implement that.

Edwin Poots (former Minister for Agriculture, Environment and Rural Affairs, Northern Ireland)

Had previously been the Minister for the Dept of Health 2011 – 2014. The health service in Northern Ireland was in a greatly undermined state prior to 2020. Michelle O'Neil was Heath Minister until 2016 until she resigned. In the 3 years when there was no health minister in place the deterioration that took place under the Civil Service was quite incredible. The statistics for waiting times in particular, they rose rapidly, so the health service was already in a compromised state because of a lack of leadership and decision-making.

I saw things like banning people from going to graveyards as being wholly ineffective in terms of saving lives, but utterly cruel in terms of how they affected the relatives of the deceased. I was entirely supportive

of the regulations at that time, but I was in the same position as everybody else, we were entering the unknown and heavily reliant on medical advice.

The power vested in the Department of Health minister, the CMO and the CSA was quite incredible. They needed neither the Executive nor the Assembly to introduce punitive measures without recourse to others.

I don't think the information coming into the Executive was sufficient on the wider societal and economic impacts. This was a health crisis, and it was led by the Department of Health, and their focus was Covid-19, and it was Covid-19 to the exclusion even of other health matters. I think we got the balance of the focus wrong. That focus was driven by the Dept of Health.

I think the initial response was the right response. If anything, the lockdown should have happened more quickly, but we were largely waiting on what was happening with Her Majesty's Government. We couldn't have organised a lockdown without the backing of HM Treasury.

To move people directly from hospital to residential care or nursing care homes without having any form of quarantine or any form of testing, in my view, was a reckless act. I am critical of the Department of Health in Northern Ireland for following Westminster's approach on this. The evidence was there for everybody to see. A little foresight would have shown we should not be putting people from hospitals into a care facility where there's other vulnerable elderly people, without having some form of quarantine or testing. The scientific advice should have been that if we believe we need beds in the hospital, then we need to empty these beds in a manner which doesn't cause further problems. The removal of those people from the beds should have been done in a much more structured way as opposed to just divest them all to the nursing and residential homes, without any form of testing or quarantining. It was done without my knowledge. It was the decision of the Health Minister. It should have been taken by the Executive. It was a major decision which caused the deaths of many people needlessly.

I had a dispute with the Chief Medical Officer that instead of locking down everybody, we should be focusing on the people who are most likely to die from Covid-19 if they caught it. The CMO indicated that would be discriminatory against the older population. I said we're discriminating against the entire population and the younger people in particular who are not likely to die from Covid-19 by preventing them having their education. There was a real fear at the very outset that we were going to lose many children. We recognised that that wasn't the case, so for me the focus should have then switched from the entirety of the population to the people who were most vulnerable to the condition which was Covid-19. I don't think it would have been easy, but it would have been easier to do it in NI than other part of the UK.

I agreed with the Cross Community vote. We always strive for consensus, but we were moving towards a majority which would have been a step backwards in my view.

Sir Brandon Lewis (former Secretary of State for Northern Ireland)

Sec of State from Feb 2020. The role is representing the best interests of Northern Ireland within central government.

Civil Servants had done a great job keeping things ticking along but there had been no Executive function for 3 years, and that meant that when Covid came upon them, the Minsters were still very new to their roles.

The Departments are in silos. The head of the Civil Service does not have any direct power over individual departments and the individual departments are run by ministers from different parties. That reinforces that structural silo. Covid aside, we would have issues where a particular department would want to do something but couldn't get the department for finance to agree. So it would generally be two different departments as well as two different political parties, and that is a real challenge for how the Government actually works and delivers for the people of NI.