COVID-19 INQUIRY

MODULE 3 REPORT

NI EXECUTIVE

RESPONSE

SEPTEMBER 2026

Contents

Foreword

On 19 March 2026, Baroness Hallett, Chair of the United Kingdom Covid-19 Public Inquiry, published the findings and recommendations arising from Module 3 of the Inquiry. Opened on 8 November 2022, Module 3 examined the impact of the Covid-19 pandemic on healthcare systems across the United Kingdom, including the experiences of patients, families and healthcare workers, and the effectiveness of the response during this unprecedented public health emergency.

The report sets out ten recommendations aimed at strengthening the preparedness, resilience and responsiveness of healthcare systems in the event of future pandemics and major health emergencies. The recommendations seek to ensure that healthcare services are better equipped to protect patients and support the healthcare workforce while maintaining the delivery of safe and effective care.

The Executive remains committed to considering and responding to the findings of the Inquiry. In doing so, it recognises the dedication and professionalism demonstrated by healthcare workers throughout the pandemic and acknowledges the significant impact of Covid-19 on patients, families, communities and those working across the health and social care sector.

Since the pandemic, progress has been made to strengthen preparedness and resilience across health and social care services. While acknowledging these developments, the Executive also recognises the importance of continued improvement and the need to learn lessons from the challenges experienced during the pandemic

As well as colleagues across the Four Nations, the Department of Health engages regularly with counterparts in the Republic of Ireland, including on matters relevant to the Covid-Inquiry.

The Inquiry's recommendations are wide-ranging and complex and require careful consideration across a number of organisations and sectors. Work is ongoing to assess the measures required to address the recommendations and to determine the most appropriate approach to implementation. This report sets out progress made to date, and further updates will be provided in the next progress report, scheduled for publication in May 2027.

The Executive recognises that some actions associated with implementation may have resource and funding implications, and these continue to be considered as part of the wider programme of work.

Finally, we would like to place on record our sincere thanks to the stakeholders who have contributed through evidence, consultation and partnership working. Their continued engagement and valuable insights have helped to shape and inform the response to the Inquiry's findings and will remain essential as this important work progresses.

Recommendations

1. Ensure that decision-making on infection prevention and control is underpinned by clear structures and a cautious approach to transmission risk

Recommendation 1:

The UK government must ensure that there is a body (equivalent to the UK Infection Prevention and Control Cell) in place ready to be convened at the outset of any future pandemic, to consider and draft infection prevention and control guidance for healthcare settings. This body must:

- have clear lines of responsibility and a clear, pre-defined role and remit during a pandemic;
- have multidisciplinary membership, including experts in the science of viral transmission as well as those with clinical expertise;
- ensure that its guidance accounts for the risk of all plausible routes of transmission until sufficient evidence emerges to rule out specific routes; and
- ensure that guidance clearly explains the underlying rationale for the precautions recommended.

Remains Under Consideration

Effective Infection Protection and Control (IPC) requires clear leadership, robust governance and defined lines of accountability. Future preparedness will depend on resilient and adaptable systems, supported by strong partnership working across the Department of Health (DoH), Public Health Agency (PHA) and the wider Health and Social Care system (HSC), with clarity regarding respective roles and responsibilities.

As part of Northern Ireland's response, a workshop jointly convened by the Chief Nursing Officer (CNO) and the PHA was held in July 2026, bringing together key stakeholders and clinical professionals from across the HSC system. The workshop considered lessons learned from the pandemic, identified current risks and opportunities, and explored actions to strengthen future Infection Protection and Control (IPC) arrangements. The outputs will help inform the strategic approach to IPC preparedness and resilience across the health and social care system.

IPC governance arrangements, manuals and guidance will be reviewed to ensure they remain evidence-based, fit for purpose and capable of supporting a cautious and proportionate approach to transmission risk. The findings of the COVID-19 Inquiry, together with lessons

identified through the pandemic response, will be used to strengthen future IPC arrangements and support preparedness for future health emergencies.

In addition, the Chief Nursing Officers of England, Wales, Scotland, Northern Ireland and the Republic of Ireland engage regularly to discuss a range of health issues, including Infection Prevention and Control (IPC), supporting the exchange of knowledge and best practice across jurisdictions.

2. Guidance for visiting restrictions

Recommendation 2:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should publish guidance for the implementation of visiting restrictions in hospitals in the event of a future pandemic.

The guidance should identify the circumstances in which visiting restrictions should be introduced, escalated, decreased and removed alongside the measures and exemptions at each level. The guidance should be led by the following core principles:

1. Measures applied should be the least restrictive possible, both in terms of severity and the length of time for which they apply.
2. Restrictions should be decided upon and applied at the most local level
3. Unless restrictions are applied at a specified level, trusts and health boards should take decisions on the severity of restrictions based on local risk assessments.
4. Communications with the public must clearly explain the measures in place and the reasons why restrictions apply.

The guidance should be reviewed every three years in line with the Inquiry's Module 1 Report (Recommendation 4).

Accepted in Principle

The Inquiry has recommended that guidance be developed to support the implementation of visiting restrictions in hospitals during any future pandemic. Work has commenced to consider how this recommendation should best be implemented within the HSC, recognising the need for a coherent and person-centred approach across hospitals, care homes and other care settings.

Existing guidance on visiting arrangements, together with the Care Partner arrangements, provide an important foundation for taking forward this recommendation.

DoH is working with colleagues across the UK to explore the development of a shared set of high-level principles to support decision-making on visiting arrangements, underpinned by a

person and family-centred approach. In parallel, DoH and PHA will undertake a light-touch update of existing guidance to remove COVID-19-specific references where appropriate and ensure the guidance can be applied more broadly in the event of future infectious disease incidents.

Given the integrated nature of Northern Ireland's Health and Social Care system, further consideration of this recommendation will also be informed by the findings of the Inquiry's Module 6 investigation into the care sector. The findings from Modules 3 and 6 will be considered together to help inform a coherent and consistent approach to visiting arrangements across health and social care settings.

3. Better preparation for fit testing

Recommendation 3:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should work with employers, including health boards and trusts, to review the availability of qualified fit testers and take steps to increase the number of fit testers accordingly. Availability should be reviewed every three years in line with the Inquiry's Module 1 Report (Recommendation 4).

The Health and Safety Executive and the Health and Safety Executive for Northern Ireland should update their guidance to employers to emphasise the need to ensure that sufficient fit-testing capacity is available.

Accepted in Principle

As part of Northern Ireland's response to the recommendation on IPC, a workshop jointly convened by the CNO and the PHA was held in July 2026 bringing together key stakeholders and clinical professionals from across the HSC. The workshop considered lessons learned from the pandemic, identified current risks and opportunities, and explored actions to strengthen future IPC arrangements. Fit testing was one element considered in this workshop. The outputs will help inform the strategic approach to IPC preparedness and resilience across the HSC.

4. Improve data systems to identify individuals at high risk during a pandemic

Recommendation 4:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive must ensure that health data and digital systems have the capability to identify

individuals at high risk of morbidity or mortality from a pandemic disease quickly and accurately in a future pandemic. This should include action to improve health data systems and patient record-keeping by:

- Improving patient data by enabling more granular diagnostic coding;
- Ensuring that care records are compatible across primary and secondary care; and
- Enabling secure data-sharing and linkage across multiple health datasets and systems for identifying individuals at high risk.

Accepted in Principle

- Improving patient data by enabling more granular diagnostic coding

The adoption of **Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)** would provide the most comprehensive solution for achieving detailed, standardised clinical coding across all care settings in real time. SNOMED CT defines a common clinical language within electronic health records, enabling the safe, accurate, and efficient exchange of information between healthcare systems. It includes the full range of clinical terminology required across the NHS/HSC, covering symptoms, diagnoses, procedures, clinical measurements, and medications. The UK Edition also includes UK-specific extensions, supporting requirements such as screening programmes, assessment scales, and British English terminology.

As the volume and complexity of clinical data continues to grow, the HSC's ability to rapidly identify and respond to high-risk individuals during any future public health emergency is becoming increasingly challenging. While elements of SNOMED CT are already in use, particularly within primary care through the automated standardisation of terminology, implementation has been fragmented and inconsistent.

Automation and artificial intelligence have the potential to enhance responsiveness, data analysis, and decision-making capabilities. Establishing a centrally managed SNOMED CT terminology service would provide a single, authoritative source for managing and maintaining clinical terminology across all HSC systems. It would ensure that clinical terms, codes, and updates are applied consistently, enabling different systems to interpret and exchange information in the same way.

There are opportunities to improve responsiveness and the quality of information through the use of automated clinical coding and AI-enabled support tools. We are giving consideration to how these measures could be funded.

- Ensuring that care records are compatible across primary and secondary care

Historically, data integration efforts within Northern Ireland have been predominantly focused on acute systems, particularly through use of the Patient Administration System (PAS). The PAS is an information service providing a foundation to all healthcare. It performs the basic but crucial function of recording non-clinical patient details, such as name, date of birth, and home address, as well as any additional contact details for next of kin in an emergency. PAS replaces paperwork associated with a patient's visit to hospital with electronic records that capture and use data in a more structured way. The PAS automates key processes, allowing users to enter information in a single system and then view that information across many departments. While this has provided a foundation, it has resulted in variability and limited interoperability between primary and secondary care records. Significant progress has been made in recent years to address these challenges through the development of data standards, common definitions, and data improvement initiatives.

However, achieving full compatibility across care settings remains a complex, long-term endeavour, requiring sustained focus on systems, standards, and workforce capability. This represents an important step forward, but progress will require continued investment, strong governance, and cross-sector collaboration to deliver truly compatible, end-to-end patient records that can support effective care delivery and population health management, particularly in the context of a future pandemic.

Consequently, ongoing work is progressing to secure the investment necessary to allow work to be undertaken which ensures that linkage capabilities can operate smoothly and efficiently across Primary and Secondary Care settings.

- Enabling secure data-sharing and linkage across multiple health datasets and systems for identifying individuals at high risk

During the COVID-19 pandemic, data-sharing and linkage were achieved through a range of ad hoc and rapidly developed solutions, which required the use of multiple datasets. While effective in the short term, these approaches were often fragmented and required significant manual coordination. Since then, there has been substantial enhancement in capability of the Northern Ireland Health Analytics Platform (NIHAP).

NIHAP provides a more robust and sustainable solution, enabling:

- Secure integration of data from multiple health and care systems into a single environment
- Application of consistent governance, access controls, and audit processes
- More efficient and timely data linkage to support population-level analysis and risk stratification

In addition, the General Practitioner Intelligence Platform (GPIP) dataset has strengthened access to primary care data, allowing this to be more routinely incorporated alongside

secondary care and other datasets. The GPIP is a single integrated view of GP practice data held in a central database, which extracts data from all GP practices in Northern Ireland across the 17 Federations. GPIP provides analytical support to GPs by supplying information through interactive dashboards that offer patient lists and views designed to enhance existing clinical systems. It also delivers data and analysis for wider use, including the provision of aggregated and anonymised data sets to health and social care stakeholders to support policy development, service planning, and research. The Data Institute's Analytics and Insight Team currently provides analytics and reporting services to support GPIP objectives. This represents a key step forward in developing a more comprehensive, whole-system view of patient risk. While these developments mark significant progress, ongoing work is required to:

- Expand dataset coverage (including wider system and non-health data where appropriate)
- Further streamline data access processes
- Ensure linkage capabilities can operate at pace during emergency response scenarios

5. Prepare to scale up urgent and emergency care capacity

Recommendation 5:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive, in conjunction with organisations responsible for delivering services, should plan for surge capacity in urgent and emergency care during a pandemic.

Plans must ensure that there is sufficient workforce capacity and the ability to surge, including the number and type of staff required, recruitment and training provision.

This should be completed as part of the whole-system civil emergency strategy recommended in the Inquiry's Module 1 Report (Recommendation 4). Plans should be published and subject to review every three years.

Accepted in Principle

The Department of Health has invested considerable time and resource implementing the Health and Social Care Workforce Strategy since its publication in 2018, with a strategic approach to workforce development. That has included better workforce planning, increased recruitment of staff and commissioning of pre- and post-registration training, reduced agency usage, and the development of initiatives to improve staff retention.

- This has resulted in significant stabilisation and growth in the HSC workforce since 2018 with a 20.3% (+11,538) increase in whole time equivalent (wte) staff in post reported between March 2018 (56,803 wte) and March 2026 (68,341 wte).
- Future commitments for commissioned training will be subject to the availability of funding resources.
- Increased capacity in urgent and emergency care requires reform, resource and workforce (skills mix changes, education and additional training places).

Since Covid-19, 30 newly qualified Emergency Department (ED) consultants have been appointed across all 5 Trusts to strengthen resilience and senior decision making across weekends and evenings. ED Nursing compliment has also been enhanced in recent years. Same Day Emergency Care (SDEC), Ambulatory Care and Acute Medicine investments have also been made, including the introduction of Urgent Care Centres and Multidisciplinary Teams (MDTS) in order to increase capacity away from ED front door. These services will be used as to minimise patients' exposure ("green pathways") in the event of a pandemic.

SPPG commissioned NHS England's GIRFT Acute Medicine Team to review HSC Acute Medicine Services to ensure services are in line with best practice and to maximise available resource for day to day and in the event of surge incidents. The GIRFT Team have completed their round of visits to Type 1 ED (a Type 1 ED is a consultant-led, 24-hour emergency department with full resuscitation facilities and designated accommodation for receiving all emergency patients) to assess opportunities and weaknesses. Trusts will be required to produce an action plan to address their findings, including the proposed adoption of clinical operating standards for ED to Acute Specialities' which will strengthen arrangements and translate to Green Pathways (Surgical and Medical Pathways designed to enable acute activity without exposure to virus's) in the event of a future pandemic.

6. Prepare for and test the ability to scale up hospital capacity

Recommendation 6:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should work with trusts and health boards to ensure that pandemic plans include practical steps to rapidly scale up hospital capacity to treat acutely unwell patients. This should include critical care services that can deliver multiple levels and types of organ support. It should also cover necessary equipment, supplies, space and staff, including redeployment and training.

All trusts and health boards must keep an easily accessible, up-to-date record of the information needed to implement these plans in the hospital sites they operate. This should

include technical aspects of critical care expansion such as power, ventilation, oxygen and waste management systems.

Plans for expanding capacity should be published, subject to review every three years and tested as part of the pandemic response exercises recommended in the Inquiry's Module 1 Report (Recommendation 6).

Accepted in Principle

Exploration of a critical care response unit is underway, subject to available funding. The unit will assume responsibility for the 7/7 sitrep report on occupancy, closures, etc., as well as implementation of actions required to support the surge response including training and education.

DoH Emergency Preparedness Resilience and Response (EPRR) Branch advised HSC Trusts on 16 June of the revised DoH Pandemic Preparedness Strategic Delivery Group arrangements. Under these structures the PHA/SPPG will co-chair the Pandemic Resilience Oversight Group and determine the workplan for 26/27.

- An early action by PHA/SPPG is to assess current High Consequence Infectious Disease (HCID) capabilities and pathways. Preliminary discussions have commenced in context of creating a HCID Network for NI and it is likely that resources will be required to contract with NHS HCID Networks for support to NI given the highly specialised nature of this work. In addition, PHA and SPPG issued updated viral haemorrhagic fever (VHF) pathways to primary care and HSC Trusts on 18 June 2026.

- Exploration of a critical care response unit is currently underway, subject to available funding. The unit will assume responsibility for the 7/7 sitrep report on occupancy, closures, etc., as well as actions required to support surge response including training and education.

- HSC Pathology Network Board / Pathology Blueprint will assess C3 Virology/genomic laboratory requirements although this will be dependent on capital and revenue funding which is currently unavailable.

7. A framework to guide the allocation of intensive care resources in the extreme event of saturation

Recommendation 7:

The UK government and devolved administrations should publish a UK-wide framework setting out ethical and operational principles to guide the allocation of adult intensive care resources in the extreme event that they are saturated during a pandemic.

That framework must:

- Be informed by comprehensive engagement with the public and developed in conjunction with professionals across healthcare, law and ethics, as well as with regulators of healthcare professionals;
- Set out clearly established triggers for its use, based at least in part on a UK-wide system that measures critical care capacity strain and facilitates mutual aid (such as the CRITCON tool used in England);
- Establish clinicians' legal and professional duties in applying the framework, which should be clearly explained to clinicians through guidance; and
- Be regularly reviewed with reference to contemporary patient data during a pandemic, and any future use of it must be evaluated and reported on publicly.

A plan and timeline for completing this work should be published within six months of this Report.

Application of the framework should be tested as part of the pandemic response exercises recommended in the Inquiry's Module 1 Report (Recommendation 6).

Accepted in Principle

DoH recognises the importance of clear and consistent ethical and operational principles to support clinical decision-making in the extreme event that critical care services become saturated during a future pandemic or other major public health emergency.

While health is a devolved matter, DoH agrees that there is value in developing a UK-wide approach to help guide the allocation of intensive care resources in such an emergency, while recognising the need to reflect devolved responsibilities and local circumstances. This is consistent with the principles set out in the UK Pandemic Preparedness Strategy, which emphasises collaboration in preparing for and responding to pandemic threats.

DoH is committed to working with partners across the UK to contribute to the development of shared principles or any future framework and to share learning from the COVID-19 pandemic, recognising the many complexities that may arise. This will be informed by the current ongoing review of Northern Ireland's COVID-19 Ethical Advice and Support Framework, which was developed through extensive engagement with clinical, legal, ethical and wider stakeholder representatives to support fair, transparent and compassionate decision-making during periods of extreme pressure on health services.

DoH will ensure that Northern Ireland's particular circumstances, including critical care capacity, geographical considerations and service delivery arrangements, are reflected in joint working with the UK Government and other Devolved Administrations. This will also contribute to the wider work being taken forward across the Northern Ireland across the HSC to strengthen preparedness, resilience and response capabilities for future public health emergencies consistent with Module 3 recommendations 5 and 6.

There is regular and ongoing engagement between respective policy and professional teams in the RoI and NI with respect to all aspects of pandemic planning and preparation.

DoH has noted and supports the position of the UK Government and other Devolved Administrations that these principles may not be deliverable within the proposed six-month timeframe, due to complexity and the need to engage multiple stakeholders on the outputs. DoH will work with the other administrations to jointly agree how to approach this work and the required delivery timeframe.

8. Systematically recording and publishing healthcare worker deaths

Recommendation 8:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive should work with their respective public health agencies and healthcare employers to develop nation-specific mechanisms to collect, analyse and publish data systematically on the deaths of healthcare workers in the event of a pandemic outbreak.

The UK Statistics Authority should work with data providers to ensure that the data are comparable across the four nations of the UK.

Accepted in Principle

DoH agrees with the Inquiry's intention that, in the event of a future pandemic, there should be a systematic way to record, analyse and publish information about the deaths of healthcare workers. This would support a clearer understanding of the impact of a pandemic on the workforce, help inform action to protect staff, and provide transparency for the public and for those working across health and care services.

The pandemic demonstrated the importance of timely, reliable and comparable information. In Northern Ireland, information about healthcare worker deaths was available through more than one route, including General Register Office (GRO) death registration data, which can include previous occupation. It was also available through the Silver Cell structure with information being provided by HSC Trusts. These sources helped provide important intelligence, but they were designed for different purposes, and each has limitations. Some are more timely but may be less complete; others are more robust for later analysis but are not suitable for immediate operational intelligence and decision-making. There was also the issue of disclosing small numbers of cases and the risk of personal identification.

The Department of Health's assessment is therefore that no single existing source is likely to meet all the possible needs identified by the recommendation. During a pandemic, data may be needed quickly to support public health action, workforce protection and operational planning. Over time, more detailed analysis will be needed to understand patterns by role, setting, geography and demographic characteristics, and to support public accountability. These different purposes may require different data sources, or a combined approach, rather than a single measure.

There are significant practical and ethical issues to resolve. Any approach would need to be accurate enough to command confidence, timely enough to be useful, and clear about coverage. It should consider healthcare workers outside directly employed HSC roles, including primary care, community services and independent providers where relevant. It would also need to avoid implying that a death was caused by occupational exposure where

that cannot be established. Publication would need to be handled sensitively, with appropriate context, recognising the impact on families, colleagues and the wider workforce.

The Department of Health will therefore take a proportionate, staged approach to implementation. We will work with the UK Government, the other devolved governments, the UK Statistics Authority, the Office for National Statistics, Northern Ireland Statistics and Research Agency (NISRA), the General Register Office (GRO), the NI Public Health Agency, HSC Trusts and relevant employers to identify the most appropriate mechanisms for Northern Ireland and to support comparability across the UK as far as is possible.

Preparatory work will also be required to consider the legal, information governance and operational arrangements that would allow any mechanism to be activated quickly in a future pandemic. Data sharing agreements would be required for linking GRO death registration data to health datasets. Other work will also include how data quality would be assured, and how outputs would be communicated clearly, responsibly and by whom. The aim is not to create a publication, but to ensure that information is available in a form that can support decisions, protect the workforce and maintain public trust.

The Department of Health will continue to develop this work with partners as part of the wider response to the Inquiry's recommendations. This will include agreeing the priority use cases for the data, testing the feasibility of the main data options, identifying gaps in coverage, and implementing the most appropriate solution ahead of any future pandemic outbreak.

9. A standardised process for advance care planning across the UK

Recommendation 9:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive, working with trusts and health boards, should establish and promote one standardised process across the UK (such as ReSPECT, the Recommended Summary Plan for Emergency Care and Treatment) for clinicians to ascertain and record their patients' wishes and preferences for future care and treatment in order to inform individualised decision-making, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices.

Remains Under Consideration

The Department of Health supports the need to improve and to fully embed effective advance care planning practice across our Health and Social Care system and agrees that citizens should be supported to have clear and meaningful discussions about what matters to them, including their care preferences and wishes. These discussions will support clinicians to make better decisions, together with patients and families.

The Department of Health has no current plans to pursue the introduction of a single, standardised process across the UK. Different policy and operational approaches to advance care planning are in place across the four UK nations, reflecting differences, for example, in respective legal frameworks, health and social care delivery structures, digital infrastructure and policy implementation timelines. The immediate focus of the Department is to establish

strengthened implementation arrangements for existing advance care planning policy - *For Now and For the Future: An Advance Care Planning Policy for Adults in Northern Ireland*.

The Department of Health recognises the value of maintaining collaboration between the UK Government and devolved administrations across the four UK nations where this can improve experiences and outcomes for individuals and those important to them. Building on the existing foundations and commitments to improved care planning across the UK, the Department is committed to work collaboratively with the UK Government and the other devolved administrations to identify areas where a joint-working approach can add most value. This may include, for example, sharing learning on workforce development and training and in other areas of best practice, and in helping improve arrangements for information sharing.

The Department of Health believes that achieving the best outcomes for citizens is best supported by strengthening and embedding implementation of existing advance care planning policy in Northern Ireland and by fostering ongoing collaboration across the UK to encourage shared learning and improvement. This is considered a more beneficial approach than pursuing a single, standardised UK-wide process.

10. Psychological and emotional support for healthcare workers

Recommendation 10:

The UK government, Scottish Government, Welsh Government and Northern Ireland Executive, working with healthcare employers and professional bodies, should put in place plans to deliver effective support for healthcare workers at scale from the outset of a pandemic. Plans should cover the nature and level of support that will be provided during and after a pandemic.

All four governments should develop a programme of peer support visits that can, from the outset of a pandemic, be targeted towards areas of acute hospitals under considerable strain. The purpose of the visits should be to support front-line staff, collect insights on the pressures that healthcare workers are facing and understand what further support they might need.

Accepted in Principle

DoH accepts the recommendation in principle but does not fully commit to developing a full programme of psychological support, including peer support visits, at this stage.

It is vital that healthcare staff can access the support they need during a pandemic. Covid-19 placed an enormous strain on our Health and Social Care staff in dealing with the additional demands placed on them. HSC staff felt grief-stricken and sad, vulnerable, exhausted and overwhelmed, and at the same time they were worried and anxious for their own health and wellbeing, and for the health and wellbeing of their families, colleagues and patients. These were very real and normal responses to working and living in stressful, challenging and upsetting times.

To ensure that all HSC staff and volunteers, irrespective of where they worked, had access to the information and support they needed, advice and guidance was made available on the Public Health Agency (PHA) website. A framework, 'Supporting the Well-being Needs of our Health and Social Care Staff during COVID-19: A Framework for Leaders and Managers', was developed and produced in partnership with the Trusts, PHA, HSC Board, Department of Health and the Health Trade Unions which guided leaders and managers of services to respond positively to the demands being placed on their staff. The framework captured the positive initiatives that were already being taken by HSC Trusts and other service providers.

The initial response to supporting the well-being needs of staff focused on building resilience and supporting psychological safety. In addition to existing occupational health services, a range of initiatives were implemented and made available to HSC staff working across health and social care organisations. We know the importance of continuing to build organisational resilience and improve staff experience during times of crisis, as witnessed during the Covid-19 pandemic. There has been considerable learning from services who were tasked with delivering support to frontline staff during the pandemic. Research conducted across NI HSC organisations by the Impact Research Centre, during and following covid 19, made specific recommendations based on staff experiences of support, which will be useful to consider as part of any planning for future support frameworks (Research Programmes | Impact Research | Northern HSC Trust, NI).

In the event of another pandemic, a range of evidence-based interventions should be made available to support staff in line with existing models of support (e.g., stepped care models). Core to any model of staff support, are service based actions, including leadership that is visible and present and peer support models. Plans to provide mental health support during and after a pandemic will require resources to be secured and deployed quickly. Any plans must be flexible and align with existing and developing staff wellbeing support.

Alongside specialist psychological interventions that can be offered directly to staff, as individuals and team, psychologists offer significant support to senior leadership ensuring leadership is guided by trauma-informed principles. Additionally, they offer training and support to health and social care professionals.

Regarding the model of peer support, further work will be needed to assess the appropriateness and the structure necessary to support this across Northern Ireland. Consideration would need to be given to the make up the review team, their scope, purpose and how they might both support and feedback their observations to the host organisation. Availability of additional resources will also be a key consideration.

We will continue to work with colleagues in DHSC, the Scottish and Welsh Governments to share learning and insight, including on peer support visits, and will continue to work with health and social care employers to ensure support reflects frontline experience and responds to need. The Northern Ireland Executive will also consider the potential for sharing learning across the island of Ireland, where applicable.

Next Steps

Recommendation 1: Ensure that decision-making on infection prevention and control is underpinned by clear structures and a cautious approach to transmission risk			
Action	**By When**	**Progress**	**Status**
Develop a strategic approach to IPC preparedness and resilience across the HSC system, informed by the findings and recommendations arising from the July 2026 stakeholder workshop.		Ongoing	In progress
Review IPC governance arrangements, manuals and guidance to ensure they remain evidence-based, fit for purpose, and support a proportionate approach to transmission risk.		Ongoing	In progress
Incorporate findings from the COVID-19 Inquiry and lessons learned from the pandemic response into future IPC arrangements to strengthen preparedness and resilience for future health emergencies.		Ongoing	In progress
Recommendation 2 - Guidance for visiting restrictions			
Action	**By When**	**Progress**	**Status**
Develop a shared set of high-level principles for visiting arrangements in collaboration with UK counterparts, underpinned by a person and family-centred approach, to support decision-		Ongoing	In progress

making during future pandemics or infectious disease incidents.			
Review and update existing visiting guidance, removing COVID-19-specific references where appropriate and ensuring it can be applied across a broader range of future infectious disease scenarios.		Ongoing	In progress
Consider and integrate the findings of Inquiry Modules 3 and 6 to inform the development of a coherent and consistent approach to visiting arrangements across health and social care settings		Ongoing	In progress
Recommendation 3 - Better preparation for fit testing			
Action	**By When**	**Progress**	**Status**
Development of a strategic approach to IPC preparedness and resilience across the HSC to include outputs in relation to fit testing arising from the workshop jointly convened by the CNO and the PHA in July 2026.		Ongoing	In progress
Recommendation 4 - Improve data systems to identify individuals at high risk during a pandemic			
Action	**By When**	**Progress**	**Status**
<u>Improving patient data by enabling more granular diagnostic coding</u>			
Progress the implementation of SNOMED CT across health and care settings to achieve granular, standardised real-time clinical coding.		Ongoing	In progress

Ensuring that care records are compatible across primary and secondary care			
TBC			
Enabling secure data-sharing and linkage across multiple health datasets and systems for identifying individuals at high risk			
Expand GPIP dataset coverage, including the incorporation of wider health, social care and appropriate non-health datasets to support a more comprehensive view of patient risk.		Ongoing	In progress
Further streamline data access processes to improve the efficiency and timeliness of data sharing and analysis.		Ongoing	In progress
Ensure data-linkage capabilities can operate rapidly during emergency response scenarios to support timely identification, analysis and risk stratification of affected populations.		Ongoing	In progress
Recommendation 5 - Prepare to scale up urgent and emergency care capacity			
Action	**By When**	**Progress**	**Status**
TBC			
Recommendation 6 - Prepare for and test the ability to scale up hospital capacity			
Action	**By When**	**Progress**	**Status**
PHA/SPPG to co-chair the Pandemic Resilience Oversight Group and determine the workplan for 26/27 under the revised DoH Pandemic		Ongoing	In progress

Preparedness Strategic Delivery Group arrangements.			
PHA/SPPG to assess current High Consequence Infectious Disease (HCID) capabilities and pathways		Ongoing	In progress
Progress the business case and implementation planning for a Critical Care Response Unit, subject to available funding.		Ongoing	In progress
Assess and develop virology and genomic laboratory capacity requirements through the HSC Pathology Network Board and Pathology Blueprint, subject to capital and revenue funding availability		Ongoing	In progress
Recommendation 7 - A framework to guide the allocation of intensive care resources in the extreme event of saturation			
Action	**By When**	**Progress**	**Status**
Work with UK Government and Devolved Administrations to develop shared principles or a framework for the allocation of intensive care resources during future pandemics or major public health emergencies.		Ongoing	In progress
Complete the review of Northern Ireland's COVID-19 Ethical Advice and Support Framework and use the findings to inform future		Ongoing	In progress

ethical and operational guidance for clinical decision-making			
Ensure Northern Ireland's specific circumstances, including critical care capacity, geography and service delivery arrangements, are reflected in UK-wide discussions and frameworks		Ongoing	In progress
Contribute to wider HSC preparedness, resilience and response programmes by incorporating ethical and critical care planning into future pandemic preparedness arrangements		Ongoing	In progress
Recommendation 8 - Systematically recording and publishing healthcare worker deaths			
Action	**By When**	**Progress**	**Status**
Develop a mechanism to systematically record, analyse and report information on healthcare worker deaths during a future pandemic.		Ongoing	In progress
Work with UK and Northern Ireland partners (UK Government, devolved governments, UK Statistics Authority, ONS, NISRA, GRO, PHA, HSC Trusts and employers) to identify the most appropriate data collection and reporting arrangements.		Ongoing	In progress

Develop arrangements for clear, responsible and sensitive communication of outputs, including roles and responsibilities for publication and reporting.		Ongoing	In progress
Establish the legal, information governance and operational arrangements required to enable rapid activation of the system during a future pandemic.		Ongoing	In progress
Implement the most appropriate solution ahead of any future pandemic outbreak.		Ongoing	In progress
Recommendation 9 - A standardised process for advance care planning across the UK			
Action	**By When**	**Progress**	**Status**
Continue engagement and collaboration on Advanced Care Planning (ACP) to explore and pursue areas where UK-wide common approaches are feasible and can add value		Ongoing	In progress
Share learning, training approaches and best practice to support the development and implementation of ACP		Ongoing	In progress
Recommendation 10 - Psychological and emotional support for healthcare workers			
Action	**By When**	**Progress**	**Status**
Develop a flexible, evidence-based staff wellbeing and psychological support framework		Ongoing	In progress

for future pandemics, including leadership support, trauma-informed approaches, peer support arrangements, and mechanisms for rapid deployment of resources to meet workforce needs.			
Continue working with DHSC, Scottish Government and Welsh Government to share learning and best practice, including on peer support visits.		Ongoing	In progress
Engage with health and social care employers to ensure staff support arrangements reflect frontline experience and evolving needs.		Ongoing	In progress