Tithe an Oireachtais
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Tuarascáil Eatramhach maidir le Covid-19 i dTithe Altranais

An Coiste Speisialta um Fhreagra ar Covid-19

Iúil 2020

Interim Report on Covid-19 in Nursing Homes

Special Committee on Covid-19 Response

July 2020

SCCR002

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Chairman's Foreword

Michael McNamara T.D.

I welcome the publication today of the Special Committee's Interim Report on Covid-19 in Nursing Homes

The impact of Covid-19 in Ireland has been most profound on the residents of our nursing homes. The fact that their deaths accounted for 56% of the overall total shows the extent to which our older and most vulnerable population was disproportionately affected and it calls for further investigation.

This Committee intends to return to this issue in September when it examines the HIQA report which was published in July and the forthcoming report from the Expert Advisory Panel. The Committee will then be in a position to determine how best to continue that investigation and whether a public inquiry is necessary to examine the impact of Covid-19 in nursing homes from March to May of 2020.

The examination by the Committee of this issue, as outlined in this report, has focussed on two inter-related issues, namely:

1. Whether residents in nursing homes were adequately protected, given what was becoming obvious from the experience of Spain and Italy during February and March, and
2. The extent to which the Covid-19 crisis has highlighted the need to move to a different model of care where more of our older population are looked after at home or, at least, in their communities, rather than in congregated settings.

The examination has facilitated a public debate on whether enough was done to protect our older population and whether there were avoidable deaths. It also allowed a review from which it is evident that, if there is a second wave of the virus, different measures will be taken. We know, for instance, that the discharge of patients from acute hospitals to nursing homes has been tightened up through testing and isolation procedures, which is welcome. However, the fact that the HSE still facilitates the placement of older persons in a nursing home with known infection control risks is, in the view of the Committee, indefensible. This practice must end.

Congregated settings, such as nursing homes, posed the greatest risk of clusters of infection and the medium to long-term response from the State will have to incorporate new ways of catering for these groups. In the case of our older population, we need a much better blend of care where the focus is on keeping older people in the community longer. If, and when, people ultimately require nursing home care, there must be a clear clinical pathway between the provider of the care and the local public health authority. A clinical director needs to be appointed to every nursing home, as was introduced in the UK in May of this year in direct response to the pandemic. Covid-19 provided a wake-up call to push the shortcomings in care for our older population higher up the agenda of our public health authorities.

I want to thank the stakeholders who engaged with the Committee, Members of the Committee Members and the Secretariat for their work on this issue.

I commend the report to the Dáil.

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Michael McNamara TD

Chairman

31st July 2020

Membership Of Special Committee On Covid-19 Response

 Colm Brophy, Fine Gael	 Colm Burke, Fine Gael	 Mary Butler, Fianna Fáil	 Jennifer Carroll MacNeill Fine Gael
 Matt Carthy, Sinn Féin	 Michael Collins, Rural Independent Group	 David Cullinane, Sinn Féin	 Pearse Doherty, Sinn Féin
 Stephen Donnelly, Fianna Fáil	 Norma Foley, Fianna Fáil	 John McGuinness, Fianna Fáil	 Michael McNamara (Chairman) Independent Group

			
Fergus O'Dowd, **Fine Gael**	**Louise O'Reilly,** **Sinn Féin**	**Matt Shanahan,** **Regional Independent Group**	**Róisín Shortall,** **Social Democrats**
			
Bríd Smith, **Solidarity-People Before Profit**	**Duncan Smith,** **Labour**	**Ossian Smyth,** **Green Party**	

1. Background

1.1 Introduction

1. The Special Committee on Covid-19 Response undertook as part of its work programme to examine the response to the Covid-19 crisis in nursing homes.

2. The Committee held three meetings in relation to this matter (see Table 2). Due to the Covid-19 restrictions on the length of sessions and number of witnesses, these meetings focused on engagement with Government Departments and State bodies and as well as representatives of the nursing homes sector and with representatives from Sage Advocacy who provided an insight into concerns of residents and families during the Covid-19 crisis.

3. To counterbalance the restricted nature of sittings and in order to get a wider view of the issue, the Committee also received 20 written submissions from medical experts, organisations and groups advocating for the rights of older people during its examination of the issue. (See Table 3)

4. The totality of the evidence illustrates the extent of the impact of Covid-19 on older people in nursing homes. It also heard evidence in relation to the measures which could be taken to ensure that improved systems of regulation and appropriate care is provided to older people.

1.2 Overview Of Impact Of Covid-19 On Nursing Homes

5. The impact of Covid-19 on older people in Ireland has shocked the nation. While our European neighbours Italy and Spain saw devastation in their acute hospitals at the height of the crisis, for Ireland, Covid-19 was most deadly in the nursing home residences of the most vulnerable of our older population. Dr. David Nabarro, a special envoy for the World Health Organization, told the Committee that Ireland was at the "upper end of the spectrum" when it comes to deaths in nursing homes.[1]

6. Ireland recorded its first case of Covid-19 on 29 February, but it was not until 16 March that clusters in two separate nursing homes were notified by the Health Protection Surveillance Centre. Cases peaked in the general population on 28 March but, around this time, cases increased in nursing homes.

7. Speaking to the Committee, Mr. Jim Breslin, the Secretary General of the Department of Health, said the peak of nursing home cases occurred almost four weeks later on 11 April 2020. [2]

[1] Dr. David Nabarro, Special Committee on Covid-19 Response 11 June 2020

[2] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

8. As of 29 June 2020, the total number of confirmed cases of Covid-19 in Ireland was 25,435, while 5,808 of these cases have been in nursing homes.[3] Sadly, the total number of people who have died because of Covid-19, including probable and possible deaths, was 1,735. The total number of deaths linked to nursing home clusters was 967.

9. There is a high Covid-19 morbidity and mortality in nursing homes in Ireland and internationally. Nursing home deaths in Ireland account for approximately 56% of all deaths from Covid-19 in Ireland.[4] In his evidence, Dr. Nabarro noted that, internationally, the figure for fatalities in residential care for older people is approximately 25%.

> *To break it down country by country, in Switzerland that figure is 53%, in Sweden it is 49% and in Scotland it is 46%. Ireland is certainly at the upper end of the spectrum in that regard.*

10. Dr. Nabarro told the Committee, however, that some countries were not very comprehensive in their counting of the deaths in residential care and nursing homes.[5]

> *Ireland has probably got the widest circle of inclusion of all the countries I have studied, which may be one of the reasons why there is a relatively high rate of deaths in nursing homes associated with Covid in Ireland.*

11. In addition, the Committee notes HIQA analysis, based on data from the death notices website, *RIP.ie*, which found that while there was clear evidence of excess mortality occurring since the first reported death, officially reported Covid-19 deaths may overestimate the true burden of excess mortality specifically caused by Covid-19.[6]

12. There has been a wide geographical variance in the level of outbreaks. While there were 253 outbreaks or clusters in nursing homes, the large majority occurred in the east of the country (121 outbreaks) followed by the north east (38 outbreaks) and the west (37 outbreaks).[7]

13. It is the case that not all nursing homes in Ireland have had cases of Covid-19. The Secretary General told the Committee that 56% of all nursing homes have remained virus free. It is noted that the geographic distribution of Covid-19 cases in nursing homes nationally was broadly consistent with that of the general population.

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[3] Epidemiology of Covid-19 in Ireland, HPSC, (29 June 2020)

[4] Epidemiology of Covid-19 in Ireland, HPSC, (29 June 2020)

[5] Dr. David Nabarro, Special Committee on Covid-19 Response 11 June 2020

[6] HIQA analysis of excess all-cause mortality in Ireland during the Covid-19 epidemic

[7] HPSC *Ibid*

14. The Secretary General also informed the Committee that "while 18% of the 30,000 residents of nursing homes have had a confirmed diagnosis of Covid-19, the majority of residents have not". This was due, he said, to the enormous efforts of staff in nursing homes throughout the period and the people who supported them. The regulator, HIQA, also commented on the commitment of staff to keep residents safe, noting consistent feedback from residents of appreciation for staff and management. The evidence in Section 4 of this report will take a greater look at some of the factors which led to the spread of the virus and the challenges faced by residents, their families and nursing home staff.

1.3 Policy Context

15. Long-term care for older people includes social, healthcare and support services provided in all public and private settings, including at home, through community-based services and in day-care centres, residential institutions, hospitals, hospices, prisons or other settings. It is provided by both formal and informal caregivers or support providers including volunteers.[8]

16. In Ireland, there are three main options for people requiring assistance with care, each bringing different levels of supports, costs and regulatory requirements:

- Nursing home care for those needing intensive support – HIQA told the Committee that there are 575 nursing homes or designated centres in Ireland, with 32,110 registered beds[9]
- Formal home care for those needing support to live at home
- Informal home care from a family member or other support person - 195,263 carers also provide 6.6 million hours per year of unpaid assistance to others[10]

17. While there is a statutory entitlement to the provision of nursing home care under the Nursing Home Support Scheme Act 2009, there is no entitlement to home care. [11]

[8] UN General Assembly (2019) *Substantive Inputs in the form of Normative Content for the Development of a Possible International Standard on the Focus Areas "Autonomy and Independence" and "Long-term and Palliative Care"* Working document submitted by the Department of Economic and Social Affairs (DESA) in collaboration with the Office of the High Commissioner for Human Rights (OHCHR).

[9] HIQA follow-up correspondence to the Special Committee on Covid-19 Response, 29 May 2020

[10] Age Action Ireland Submission to Special Committee on Covid-19 Response, 25 June 2020

[11] See section 6.1 for further discussion.

18. The nursing homes sector supports approximately 24,000 long-term care residents through the State's Nursing Homes Support Scheme (Fair Deal Scheme). [12]

19. HIQA told the Committee that there are 557 nursing homes, of which 443 (77%) are private (443 of 557) or voluntary nursing homes. Private nursing homes account for 79% of registered beds. The average capacity of a nursing home is 55 beds and approximately 38,000 staff are employed in these settings.

20. HIQA provided the Committee with information regarding the classification of nursing homes that is contained in Table 1 below.[13]

Classification	Number of designated centres	Sum of registered beds	% of registered beds
Private nursing homes	443	25,361	79.0%
Voluntary- S38 arrangement	5	450	1.4%
Voluntary- S39 assistance	14	623	1.9%
Public (Health Service Executive)	113	5,676	17.7%
Grand Total	**575**	**32,110**	**100%**

Table 1: HIQA classification of nursing homes on 29 May 2020.

Regulatory Framework

21. The Committee notes the high level of private nursing homes providing care (79% of total residential care beds) and notes that this is the outcome of past Government policy which incentivised private nursing home building and neglected the provision of public nursing home capacity.

22. The Committee understands that most care for dependent older people in Ireland is provided in nursing homes, and care is for the most part provided by registered nurses and healthcare assistants. The Central Statistics Office Census 2016 indicates that 3.7% of over 65s live in nursing

[12] The NHSS was established by the Nursing Homes Support Scheme Act 2009 (the Act). The Act was signed into law by the President on the 1st July 2009 and came into operation on the 27th October 2009. The Act was amended by the Health (Amendment) Act 2013, and the Health (General Practitioner Service) Act 2014

[13] HIQA follow-up correspondence to the Special Committee on Covid-19 Response, 29 May 2020

homes. OECD data informs the rate of people aged 65+ availing of long-term residential care is below many European counterparts, including Germany, France, Finland, Sweden and Norway.

23. The Nursing Home Support Scheme (Fair Deal Scheme) provides financial support towards the cost of long-term residential care. Once an individual is assessed as needing long-term residential care, a financial assessment is carried out to determine the financial contribution that the individual should make towards the cost of their care. An individual's contribution is based on their means and the State, through the Health Service Executive (HSE), pays the balance of the costs of care in public, private and voluntary nursing homes approved under the scheme.[14]

24. The HSE has statutory responsibility for administering the Fair Deal Scheme. The role of the HSE includes the preparation of guidance material and application forms, accepting applications, assessing an applicant's care needs, conducting a financial assessment to determine the level of contribution to be made by or on behalf of the resident, and disbursing payments to approved nursing homes in respect of the State contribution towards the cost of care.

25. Under the Health Act 2007, all nursing homes, both public and private, must register with HIQA and comply with the conditions and requirements laid down by HIQA in this context. Fees are payable by operators of nursing homes for initial registration, for variations of conditions of registration and an annual fee is also payable by each registered provider. Under the Health Act 2007, HIQA can inspect nursing homes for registration purposes and to ensure quality standards are being met.

26. Under the scheme, the National Treatment Purchase Fund (NTPF) negotiates the total price paid to each private and voluntary nursing home for residents in receipt of support from the Nursing Homes Support Scheme. The NTPF is independent in the performance of its functions. A nursing home cannot participate in the scheme unless it has agreed a price with the NTPF.

27. In the first instance, the primary responsibility for the provision of safe care and service to nursing home residents rests with individual nursing home operators. Registered providers must provide appropriate medical and health care, including a high standard of evidence-based nursing care in accordance with professional guidelines. Furthermore, regulations provide that the person in charge of a nursing home should be a medical practitioner or a registered nurse with the required qualifications and experience. However, the Committee accepts that ultimate responsibility for the appropriate care of older persons lies with the State.

28. Nursing homes have a duty to ensure continued adherence to the existing framework of regulation and standards framework. The prevention and control of healthcare-associated infections is a standard part of the operation of nursing homes and this is underpinned by regulation and standards. HIQA's 2018 *National standards for infection prevention and control in community services* are particularly relevant in this regard, including ensuring availability of PPE.

[14] Department of Health, Review of the Nursing Homes Support Scheme, A Fair Deal 2015

Model Of Care And Demographic Changes

29. The issue of how we care for older persons has been the subject of many reviews and reports. While there has been a move away from placing people in congregated settings, particularly in areas of disability and mental health, that has not been the model used in the care of older people. There has been slow progress moving to a model of own-door or community-based care for older people with wraparound supports. The Sláintecare report called for a single-tiered universal health model which supports integrated care that is person-centred and that provides quality excellence.[15]

30. Nursing home care in Ireland is not long-term care and the average stay in nursing homes is two years. Sage Advocacy told the Committee that there were substantial flaws with the "fragmented" current model of care. [16]

31. The population aged 65 and over is projected to increase from one in eight in 2015 to one in six in 2030 and the number of people aged 80 and over is projected to almost double during this period (ESRI). Furthermore, the proportion of the population aged 65 years and over will double from 12.8% in 2015 to 25.6% by 2050, and the proportion aged 80 years and over will almost treble from 3% in 2015 to 8.1% by 2050 (OECD). [17]

32. This demographic shift, within the space of ten years, will need a comprehensive strategy for the care of older people with varying needs. In the context of Covid-19, the need action in this area could not be more urgent.

[15] Special Committee on the Future of Healthcare Sláintecare Report, 2017, page 182

[16] Issues with the regulatory framework and clinical guidance of nursing homes are discussed in Section 6 of this report.

[17] Department of Health Summary on Nursing Homes

2. Oral and Written Evidence Considered by the Committee

2.1 Introduction

33. In this section of the report, there will be an analysis of the pertinent themes that arose during the Committee's engagements on this topic and there will also be a consideration of other materials of which the Committee has become aware of as a result of its consideration of this topic. Following this, the Committee will provide a summary of its recommendations in this regard.

2.2 Stakeholder Engagement

34. The Committee held three days of hearings in May and June 2020 to engage with relevant stakeholders to discuss the impact of Covid-19 on nursing homes.

35. Table 2 below provides details relating to written evidence received by the Special Committee on this topic. The submissions have been uploaded to the Oireachtas website and links are provided in the table.

36. Table 3 below identifies all stakeholders who gave oral evidence to the Committee, together with the date and the session during which they gave such evidence. Links to the Official Report of those meetings are available in this table.

Table 2 – Written Submissions

Name of organisation	Date received
Active Retirement Ireland	25 June 2020
Age & Opportunity	25 June 2020
Age Action Ireland	25 June 2020
ALONE	25 June 2020
Alzheimer Society of Ireland	25 June 2020
Individual submission from Anne Marie Woods	25 May 2020
Department of Health	15 June 2020
Health Service Executive	22 June 2020
HIQA	24 June 2020
Individual submission from Seamus Gallagher	25 June 2020

Irish Nurses and Midwives Organisation	26 June 2020
Irish Association of Social Workers	24 June 2020
National Treatment Purchase Fund	26 June 2020
Nursing Homes Ireland	25 June 2020
Individual submission from Professor Desmond O'Neill	26 May 2020
Safeguarding Ireland	24 June 2020
Sage Advocacy	17 June 2020
SIPTU Health Division	22 June 2020
The Irish Hospice Foundation	18 June 2020
Third Age	29 June 2020

Table 3– Meetings With Stakeholders

Date	Session 1	Session 2
19 May 2020	Dr. Tony Holohan, Chief Medical Officer, Department of Health Mr. Jim Breslin, Secretary General, Department of Health	
26 May 2020	Mr. Tadhg Daly, Chief Executive Officer, Nursing Homes Ireland Mr. Mervyn Taylor, Executive Director, Sage Advocacy Ireland	Mr. Phelim Quinn, CEO, HIQA Ms Mary Dunnion, Chief Inspector of Social Services and Director of Regulation, HIQA. Mr. David Walsh, National Director of Community Operations, HSE Ms Sandra Tuohy, Assistant National Director of Older Persons Services, HSE Dr. Siobhan Kennelly, National Clinical Advisory Group Lead (Older Persons), HSE
18 June 2020	Mr. Jim Breslin, Secretary General, Department of Health Ms Kathleen MacLellan, Assistant Secretary, social care division, Department of Health Mr. Niall Redmond, Principal Officer, social care division, Department of Health	

	Mr. Paul Reid, Chief Executive Officer, Health Service Executive Dr. Colm Henry, Chief Clinical Officer, Health Service Executive Mr. David Walsh, National Director of Community Operations, HSE	

3. Summary Of Recommendations

Recommendation 1
The Committee recommends that the Department of Health in conjunction with the HSE and HIQA take immediate steps to develop a plan that will ensure that staffing levels and infection control procedures in the nursing home sector are adequate to meet any possible second wave of Covid-19.

Recommendation 2
The Committee recommends that the Department of Health urgently review current regulations and standards relating to the care of older people in nursing homes to assess whether they fully/adequately protect patients' health and welfare in discharging patients to nursing homes which have been determined by HIQA to be non-compliant with infection control requirements. The Committee further recommends that no patients are discharged from hospitals to any nursing home which fails to meet infection control requirements and that no arrangement should be made by the State to place any older person in such homes under the Fair Deal Scheme.

Recommendation 3
The Committee notes the challenges faced by the nursing home sector in obtaining PPE. It recommends that the regulator review the resilience of the sector when it comes to obtaining appropriate medical supplies for crisis situations.

Recommendation 4
The Committee recommends that the HSE and HIQA ensure that all nursing homes are adequately stocked and supplied with PPE in the months ahead.

Recommendation 5
The Committee is strongly of the opinion that the lack of statutory clinical oversight of care for residents in the private nursing home sector is one of the biggest weaknesses exposed by Covid-19. The Committee recommends the Department of Health urgently review clinical oversight and governance arrangements for private nursing homes. The Committee is strongly of the opinion that we need to strengthen clinical oversight of individual nursing homes, both public and private, by requiring a designated medical officer be appointed to each nursing home.

Recommendation 6
The Committee recommends that the Department of Health urgently support public nursing homes which have planned capital works in order to fulfil statutory obligations under the Health Act 2007. The Committee recommends that this work is completed as a matter of urgency, given the ongoing threat of Covid-19 to the health of residents living in congregated settings.

Recommendation 7
The Committee calls on the HSE and Department of Health to intervene to ensure that no capacity in the voluntary or public sector of nursing home care is reduced in the coming period.

Recommendation 8
The Covid-19 crisis has exposed the potential threats to health and welfare of older people. The Committee recommends that the Department of Health plan for the care of older people as part of the implementation of the Sláintecare strategy and to account for demographic trends over the next ten years.

Recommendation 9
The Committee recommends that the Department of Health develop an integrated system of long-term support and care spanning all care situations with a single source of funding. In that regard, the Department should work closely with the Department of Housing to develop models of independent living, supported housing and sheltered housing to cater for the wide range of housing preferences among older people. This strategy should have a specific focus on moving care from congregated settings.

Recommendation 10
The Committee recommends the integration of private nursing homes into the wider framework of public health and social care.

Recommendation 11
The Committee recommends the enactment of legislation underpinning the regulation of and statutory provision and regulation of home care and, in the meantime, that additional funding for home care would be increased to clear the current waiting lists.

Recommendation 12
The Committee recommends that the current regulatory framework for the care of older people be examined by the Department of Health.

Recommendation 13
The Committee recommends that the Department of Health and the HSE review the criteria for allocation of patients under the current Fair Deal Scheme, to ensure that, first, patients' needs and care requirements are central to any placement and, second, that all people are not put in an undue risk situation by being placed in a long-term care facility that is not in compliance with HIQA standards on infection control.

Recommendation 14
The Committee recommends that regulations regarding staffing and staff ratios in nursing homes need to be strengthened in order to protect patient health and to prioritise the setting of nurse to patient ratios in line with best practice.

Recommendation 15
The Committee recommends that staffing structures in private nursing homes should be reviewed along with salary structures and terms and conditions of employment with particular reference to access for sick pay and security of employment to ensure appropriate resilience.

Recommendation 16
The Committee recommends that the Department of Health examine the regulation of the role of healthcare assistants.

Recommendation 17
The Committee recommends that there should be no unnecessary delay in implementing legislation on adult safeguarding.

Recommendation 18
The Committee recommends that a comprehensive system of testing and tracing among nursing home staff continues along with appropriate stockpiling of PPE and other essential supplies.

Recommendation 19
The Committee recommends that all future pandemic or crisis planning must cover the whole care system.

4. Preparation for Covid-19 in Nursing Homes

39. One of the key questions considered by the Committee was whether the needs of nursing home residents were adequately prioritised in the initial response to the Covid-19 crisis in February and March 2020.

4.1 Emergence Of Covid-19

40. Covid-19 emerged in China in December 2019, and it has spread widely and rapidly across the world. Dr. Tony Holohan, Chief Medical Officer, told the Committee that senior public health advisers began to confer and collaborate about the virus with colleagues internationally from early January.[18]

41. He said that there were high levels of preparedness arising from experiences with pandemic influenza, but it became clear quickly that the virus was different. Challenges included the ease of its transmission, its severity, particularly for those who are vulnerable, combined with the fact that there is no natural immunity to the virus, no medicines available for its treatment and no vaccines. He said it has presented "an unprecedented global public health challenge".

42. On 27 January 2020, the National Public Health Emergency Team (NPHET) held its first meeting. NPHET's role is to provide clear advice to the public, and where necessary provide advice to the Government regarding wider societal public health measures. On 30 January 2020, the World Health Organization declared a public health emergency of international concern.

4.2 Crisis Planning In The Initial Phase Of The Crisis

43. Nursing Homes Ireland told the Committee that the State had focused primarily on protecting capacity in the acute hospital system in the initial planning for the Covid-19 crisis.

44. The need to protect hospital capacity was in itself understandable, given the issues faced on a yearly basis as a result of bed shortages and the almost cyclical use of trollies for accommodating patients during the height of the flu season. Dr. Tony Holohan, speaking to the Committee, noted that "unprecedented action was needed to prevent the spread of infection, high rates of hospitalisation and intensive care unit admissions and significant mortality".[19]

45. Public health messaging clearly identified older people as medically vulnerable from the outset of the pandemic, and their protection formed a key motivating message to citizens to adhere to

[18] Dr. Tony Holohan, Special Committee on Covid-19 Response, 19 May 2020

[19] Dr. Tony Holohan, Special Committee on Covid-19 Response, 19 May 2020, page 8

[19] Dr. Tony Holohan, Special Committee on Covid-19 Response, 19 May 2020

public health advice. Stakeholders questioned how older people living in nursing homes were not prioritised at an operational level as a result.

46. The HSE presented as evidence to the Committee correspondence that demonstrated limited engagement with nursing homes in the early stages, but the Committee notes that there was a lack of substantial engagement, guidance, or two-way dialogue, especially considering the lack of nursing home representatives on the NPHET subgroup. While some guidance was issued to nursing homes from January on, this was inadequate, lacked a coherent overarching response, and was subsequently amended in light of this, and further, guidance issued on visitation protocols was incoherent, contradictory, and initially behind the sector's own sentiment, which led to further confusion. The correspondence indicated that the CEO of the HSE met with the CEO of Nursing Homes Ireland on 19 February, but that there was a lack of engagement from the Minister until a late stage and that Nursing Homes Ireland felt excluded from much of the process.

47. In correspondence sent to the Committee, the Department of Health states that the response to Covid-19 in long-term residential facilities was based on preparedness, early recognition, isolation, care and prevention of onward spread.[20] The Department notes that in February and early March 2020, local public health departments were both "proactively and reactively interacting with nursing homes". Nursing Homes Ireland reported the level of engagement was mixed and inconsistent. The Department stated that, initially, the seasonal influenza guidance was used as the source of the advice, and this guidance evolved to focused public health and infection prevention guidelines on the prevention and management of Covid-19 cases and outbreaks in nursing homes.

48. Evidence given to the Committee by Nursing Homes Ireland indicates that there was a high level of concern among those working in the sector that the State was moving on in its crisis planning without fully acting on its concerns. Mr. Tadhg Daly, CEO of Nursing Homes Ireland, told the Committee:

> *We were exasperated in early stages and felt the sector required a very specific plan. We knew Covid-19 had a disproportionate impact on older people. The planning and focus was almost exclusively on our acute hospitals. We were aware people in our nursing homes would be among the most susceptible to the virus and a national strategy and response was required.*[21]

49. Nursing Homes Ireland told the Committee that the Government's national Covid-19 response plan was published on 16 March. It is a detailed document, but it mentions nursing homes just once.

[20] Department of Health Summary overview paper on nursing homes, 15 June 2020

[21] Mr. Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020,

50. On the question of the lack of specific reference to nursing homes, the Secretary General of the Department of Health told the Committee that there were references to long-term care for older people and care for older people, and to transitional and long-stay beds in the national action plan. The Secretary General said that as to NPHET, again while the words "nursing homes" might not have been used, there were ongoing reports to NPHET from HSE community operations, that is, the non-hospital side of the HSE, which would have extended to nursing homes and issues of preparedness and long-stay facilities.[22] It is concerning that NPHET meeting minutes did not discuss nursing homes in detail until the reference at the meeting on 27 March to "increasing number of clusters, many of which are in nursing homes".

51. The Committee is of the opinion that the public health authorities were slow to respond to the threat posed by Covid-19 in nursing homes. The Committee is further of the opinion that, although engagement took place with the private nursing home sector and was used to inform the crisis response, such engagement was not substantial or fully collaborative in nature.

4.3 Communication With The Private Nursing Home Sector

52. Communication with the private nursing home sector in these early days has been part of the Committee's discussions on this issue.

53. Evidence provided to the Committee shows there was a significant level of regular interaction on the part of the Department of Health with stakeholders from the private nursing home sector from the end of January, with over 165 items of correspondence.[23]

54. The Committee notes that a key component of the initial crisis management planning and communication process was the establishment by NPHET of the vulnerable people subgroup, which was established on 6 March. Nursing Homes Ireland expressed disappointment that, as an organisation and a sector, it had no representation on any of these groups, an action he said was "unacceptable".

55. Representatives of the HSE and HIQA were on the vulnerable people subgroup of NPHET, but the CEO of HIQA told the committee that there was no specific reference at that point to HIQA being the voice of nursing homes[24] and that HIQA was present due to its remit for the regulation of health and social care services in Ireland.

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[22] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[23] On 25 May, the Department of Health provided the Committee with evidence of 165 records of correspondence between Department and Nursing Homes Ireland between January and May 2020

[24] Mr. Phelim Quinn, Special Committee on Covid-19 Response, 26 May 2020

56. Nursing Homes Ireland also told the Committee it was "exasperated" by the fact that it did not meet the Minister until the end of March.[25]

57. When asked whether Nursing Homes Ireland should have been represented at an early stage on NPHET and other committees, the Secretary General said that when preparedness structures for the pandemic were being put in place, the Department of Health did not seek a representative of every sector on the committee. It sought to put expertise in place and engage with experts on an ongoing basis. He noted there was significant engagement with the nursing home sector at this time.

> *I accept that Nursing Homes Ireland wanted to be represented on those structures. A committee was set up specifically in respect of nursing homes, and while it might seem obvious that Nursing Homes Ireland should have been on it, it was set up to devise the temporary assistance scheme, that is, the financial scheme that benefits the sector. The view I took as Accounting Officer was that Nursing Homes Ireland should be consulted throughout that process, but due the design of it, it was not proper to have the beneficiaries of the scheme in the room.*[26]

58. The fragmented nature of the structural relationship between key State actors and the private nursing home sector is seen by the Committee as another factor which led to the delay in response to the crisis in private nursing homes.

59. The Committee is of the opinion that steps should have been taken to collaboratively involve all relevant stakeholders in the nursing home sector at the planning stage of the Covid-19 crisis, given the acknowledged higher level of risk to older people and nursing home population.

4.4 Infection Control Standards In Nursing Homes

60. The primary responsibility for the provision of safe care and service to nursing home residents rests with individual nursing home operators. Registered providers must provide appropriate medical and health care, including a high standard of evidence-based nursing care in accordance with professional guidelines. [27]

61. Furthermore, regulations provide that the person in charge of a nursing home should be a medical practitioner or a registered nurse with the required qualifications and experience.

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[25] Mr. Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020

[26] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[27] Department of Health Summary Overview Paper on Nursing Homes, 15 June 2020

62. Nursing homes have a duty to ensure continued adherence to the existing framework of regulation and standards framework. The prevention and control of healthcare associated infections is a standard part of the operation of nursing homes and this is underpinned by regulation and standards.[28]

63. During the course of its hearings, the Committee heard evidence of a 2018 report from HIQA which indicated an 18% failure rate of non-compliance with infection control standards. The Committee questioned why residents are sent to homes which are either not fully compliant or are not compliant with regard to infection control.

64. The Secretary General agreed that the infection control standard in nursing homes is important and that the infectivity of Covid-19 has emphasised this point. He said that zeroing in on non-compliance is really important, but noted that the approach used was a standards-based approach:

> *This is a standards-based approach and it is intended to have an improvement focus. Every time an inspection is done, the nursing home has to come up with an action plan on how to address the findings and improve. That does not mean that because a nursing home falls down in respect of one standard, HIQA believes it is unsafe for it to continue in operation. If HIQA believes that, it has the power to go to the courts to seek the deregistration of the home.*[29]

65. Ms Mary Dunnion, Chief Inspector of Social Services with HIQA, told the Committee there are several reasons for non-compliance. The national standards for community centres called for a national integrated approach to infection control and antimicrobial stewardship. To date, this is not in place.[30] She added that one of the big causes of non-compliances was the premises. In this context, there is a statutory instrument that gives nursing homes until the end of 2021 to become compliant. Until they reach this level of compliance, they cannot be compliant with the standards of infection control.[31] The Committee is of the view that the poor national statutory clinical governance framework and lack of a cohesive structural relationship between nursing homes, the Department of Health and the HSE is a major reason for this, and that the continuing absence of this is a major concern.

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[28] Regulation 27 of S.I. No. 415/2013 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 'The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.'

[29] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[30] Ms Mary Dunnion, Special Committee on Covid-19 Response, 26 May 2020

[31] The issue of accommodation in public nursing homes and community hospitals is discussed in more detail in Section 4.11.

66. The Committee noted evidence from HIQA and the Department of Health that two lists of nursing homes that would have been assessed to be in the high-risk category were submitted by HIQA to the HSE and Department of Health in March 2020.

67. The HSE provided correspondence to the Committee on the list of 19 publicly-run nursing homes, designated as centres of concern by HIQA, which were run by the HSE or S39 bodies. In a letter sent on 13 March, HIQA said in its assessment the physical premises and the numbers of residents living in these centres created a situation where isolation for the purpose of preventing infection was "nearly impossible".

68. When questioned on the list, the HSE stated that there was not a correlation between the nursing homes that HIQA had most concern about and those nursing homes with the highest number of deaths. [32]

69. The Committee requested that HIQA provide it with the list of privately-owned nursing homes that were a cause of concern that had been sent by HIQA to the Department and HSE on 30 March, but it declined.

70. The Committee is of the view that HIQA and the HSE need to review the extent of the impact of Covid-19 on both the publicly and privately-run nursing homes on these lists.

71. Subsequent to the Committee hearing on nursing homes, it received a report from HIQA entitled "The Impact of Covid-19 on nursing homes in Ireland". [33] The Committee will examine this report in September in addition to an examination of the Report of the Expert Advisory Panel (see paragraph 168). Following on from these examinations, the Committee will present a final report to the Dáil as it will be in a position to scope the terms of a public inquiry that it will recommend be established to examine the impact of Covid-19 in nursing homes from March to May of 2020.

72. While a standards-based approach can help the sector develop, patients continue to be placed in non-compliant homes, even while there are questions over their ability to control infection. The Covid-19 crisis has exposed the weakness of this approach as it currently operates.

4.5 Visitor Restrictions On Nursing Homes

73. The Committee notes the impact visitor restrictions have had on nursing home residents across the country, meaning that families have been cut off from loved ones at a time of great stress and uncertainty.

[32] Mr David Walsh, Special Committee on Covid-19 Response, 18 June 2020

[33] HIQA The Impact of Covid-19 on nursing homes in Ireland, July 2020

74. However, it believes that given the level of community transmission of the virus, visitor restrictions were a necessary measure, as part of wider infection control measures, to limit the spread of the virus in nursing homes.

75. Stakeholders told the Committee that there was much confusion over the admission of visitors to nursing homes in early March. In its submission to the Committee, the HSE states that it engaged with Nursing Homes Ireland on 5 March and agreed to circulate guidance and posters. On 6 March, Nursing Homes Ireland unilaterally issued visitor restriction advice to all members, ceasing visitation.[34]

76. The Committee was told that on 10 March, NPHET advised that blanket socially restrictive actions around hospitals and nursing homes were not necessary. Within one day, however, visitor restrictions were recommended by NPHET for implementation on 13 March.

77. The HSE told the Committee that implementing visitor restrictions is not a decision taken lightly as visiting of family members is a fundamental component of social connectiveness and extremely beneficial to residents' well-being as well as for safeguarding residents' welfare.

78. Nursing Homes Ireland told the Committee that the decision of Nursing Homes Ireland to restrict visitors was informed by its nursing committee and not taken lightly:

> *Covid-19 was within our communities and the weekend presenting would see thousands of people engage in close contact with residents and staff*. [35]

79. Nursing Homes Ireland told the Committee that NPHET's decision on 10 March caused challenges as people telephoned nursing homes saying they had heard there was no requirement for visitor restrictions and they wanted to access the homes. It told the Committee it was a particularly difficult week for nursing homes as a consequence.

80. Speaking to the Committee, Dr. Tony Holohan said that NPHET was working off advice from the ECDC and it was concerned unilateral actions were being taken in nursing homes at that time which was not based on NPHET's advice. He said NPHET was concerned to ensure that all organisations operated in step with its advice and that is what happened re the advice given to the Government that was implemented by State agencies on 12 March. [This advice related not just to nursing homes, but schools, etc.]

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[34] HSE submission to Special Committee on Covid-19 Response, 25 June 2020

[35] Mr. Tadhg Daly, Special Committee on Covid Response, 26 May 2020

81. Dr. Holohan stated, however, that Ireland was the "quickest country" to implement such measures regarding the date of the first infection and implementing visitor restrictions. This was done before such advice was issued by the WHO and ECDC. He noted that there no reported clusters at the point at which visitor restrictions were recommended on 12 March. [36]

82. It is the opinion of the Committee, however, that Nursing Homes Ireland acted appropriately in limiting visitation to nursing homes on 6 March, given the growing level of infection at the time.

4.6 Testing And Tracing In Nursing Homes

83. One of the central public health measures identified in the response to Covid-19 was the use of testing and tracing to identify cases of infection. Several stakeholders noted a delay in carrying out testing during the initial phase of the response, which was compounded by long waiting times for results, delayed diagnosis and implementation of preventative measures.

84. In a survey of nursing homes in early April, 44% of nursing homes were waiting ten days or longer for results of Covid-19 tests.[37] Respondents noted long delays for results of staff testing and confusion as to whether the National Ambulance Service or private nursing homes staff would carry out tests.

85. The Secretary General told the Committee:

> *The fact that we were dealing in a national situation with the scaling up of PPE supply and testing did have implications for the nursing home sector but that was not the nursing home sector being discriminated against. It was quite the reverse. There was a clear focus on vulnerable older people, both in the community and in nursing homes, and a clear process in place to try to get as much support to nursing homes as possibly could be provided. That was continued throughout March and into April.*[38]

86. The Committee also heard evidence that some patients were discharged from acute hospital settings to nursing homes without being tested for Covid-19.[39] The Committee noted correspondence sent on 10 March from Nursing Homes Ireland which requested all discharges undergo a full risk assessment, medical assessment and be tested for Covid-19. Nursing Homes Ireland said that some risk assessment was done but testing was not in line with "what we would have felt" and a more rigorous programme of testing would have been appropriate.

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[36] Dr. Tony Holohan, Special Committee on Covid-19 Response, 19 May 2020

[37] Correspondence between the Department of Health and Nursing Homes Ireland, 9 April 2020

[38] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[39] See also Section 4.7 on this issue

87. The Chief Clinical Officer of the HSE told the Committee that people were being tested in hospital settings and elsewhere based on the symptoms and case definition at the time. Regarding people who were Covid-19 positive within hospital settings and who were due for transfer, the guidance issued on 10 March stated that there would be two negative tests prior to transfer out.

88. In her evidence to the Committee, the National Clinical Advisory Group Lead (Older Persons) of the HSE noted that asymptomatic transmission was not a feature of WHO or ECDC guidance until 18 March. [40]

89. She noted that WHO guidance indicated "possible" asymptomatic transmission, so everyone was applying a case definition based on symptoms. When patients were moved, they were not tested on the basis that they did not have symptoms. Also, if staff did not have symptoms, they were not being tested. She noted that they had learned a lot from the mass testing exercise in that regard.

90. Mr. Paul Reid, Chief Executive Officer, Health Service Executive, noted that geriatricians were taken aback at the presentation of positive cases and levels of asymptomatic patients. He said that as they learned more, the approach changed:

> *As we have gone through the process, our approach has changed, and as we go forward, I have no doubt our approach will change. That is part of what we have learned about the virus. Nobody is more upset than the healthcare workers who work in the system, both public and private, and have seen what has happened. Overall, I think our strategy approach was based on knowledge we had at a particular time and it did change as we gained more knowledge. I have no doubt learnings will be and should be made for the future.*[41]

91. The Committee notes that asymptomatic transmission was not a feature of WHO or ECDC guidance until 18 March. Given the infectious nature of Covid-19, however, it is of the opinion that a more comprehensive testing strategy should have been in place in nursing homes and for the transfer of patients from the acute hospital system.

92. The Committee is further of the opinion that delays in testing for the virus along with the delays in providing results to nursing homes impacted on the ability of nursing homes to fight the virus.

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[40] Dr. Siobhán Kennelly, Special Committee on Covid-19 Response, 26 May 2020

[41] Mr. Paul Reid, Special Committee on Covid-19 Response, 18 June 2020

4.7. Discharge Of Patients From Acute Hospital System

93. The CEO of the HSE told the Committee that the experience, particularly across Europe, was that a massive surge had impacted hospital and acute settings and that the HSE needed to provide massive supports also in acute settings.

> *We would have had an ongoing process of what we would call delayed transfers of care where people are deemed clinically fit and not suitable to be in an acute hospital setting for the transfer of those patients, and in most cases elderly patients, out of that care. That is a process we would have done, and that was the right thing to do at the point in time of doing it.*[42]

94. Dr. Siobhán Kennelly told the Committee it was important to understand that it was a very fast-moving situation.

> *One of the biggest concerns for me, both as a clinician and as a geriatrician who is very involved in the care of these patients, was that in the event of an anticipated surge in these acute hospitals, many of those who had finished their acute episodes of care would be at very high risk in terms of contracting Covid. Everything we did and all the guidance we issued - including the very comprehensive guidance that was issued again on 17 March regarding how patients would be cared for in nursing homes, regardless of whether they were in public or private facilities - was on the basis of the information we had and our understanding of the pandemic.*[43]

95. As discussed in section 4.6 above, however, Nursing Homes Ireland expressed concern at the lack of testing of asymptomatic patients transferring from acute hospitals in March.[44] Another issue was the likely impact of moving patients from one section of the health system into another. This risk was acknowledged by the HSE in clinical guidance on the transfer of patients from acute settings on 10 March.[45]

96. The Committee notes figures from the HSE which indicate that 1,767 patients availed of transitional care funding and were discharged to a nursing home bed between March and May 2020.[46]

97. Some 984 (55.7%) of these patients were admitted to 197 nursing homes which had a Covid-19 outbreak, while 783 residents (44.3%) were admitted to nursing homes which did not have a

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[42] Mr. Paul Reid, Special Committee on Covid-19 Response, 19 May 2020, page 37

[43] Dr. Siobhan Kennelly, Special Committee on Covid-19 Response, 26 May 2020

[44] Mr Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020

[45] HSE guidance on the transfer of patients from acute hospitals to RCF

[46] HSE Correspondence to the Special Committee, Follow up to meeting 18 June 2020.

Covid-19 outbreak. The Committee was not able to establish the extent to which there is any correlation between the nursing homes that had an outbreak and the list of nursing homes of concern supplied by HIQA to the Department and HSE on the 30 March and this needs to be examined.

98. The Committee was presented with evidence that there was a transfer of patients from the acute hospital system to nursing homes at the height of the crisis in March.

99. The HSE told the Committee that the largest number of applications for care funding occurred in March, which had a total of 1,363 applications, compared with 324 and 288 for months April and May respectively.

100. However, it must be factored in that by April, there would have been fewer patients in the acute hospital system and fewer patients needing discharge following care.

101. The Committee notes the challenging circumstances posed by Covid-19 for the health system but believes that greater consideration should have given to the impact of the discharge of patients from the acute system to the nursing home sector which does not have the clinical resources of the acute hospital system.

4.8 PPE And Equipment

102. Prevention and control of healthcare associated infections is a standard part of the operation of nursing homes and this is underpinned by regulation and standards. HIQA's 2018 *National standards for infection prevention and control in community services* are particularly relevant in this regard, including ensuring availability of PPE.

103. Nursing Homes Ireland told the Committee that nursing homes faced significant difficulty in the early phase of the pandemic due to a large increase in the required use of PPE. At the time, there was a global shortage and suppliers told providers that the HSE had priority over limited supplies.

104. The Committee notes that HIQA wrote to the HSE on 8 April raising concerns about the supply of PPE in nursing homes and the HSE acted to provide a PPE support system, based on these concerns.[47] The Committee has observed that the HSE had to obtain a list of nursing homes from HIQA for this purpose, which shows further evidence of a disconnect between the health service and long-term residential facilities.

105. The Committee also notes that there was a shortage of other clinical resources, including vital resources such as oxygen and fluids in some nursing homes.

[47] HIQA submission to the Special Committee on Covid-19 Response, 25 June 2020

4.9 Staffing Issues

106. Members of staff in nursing homes are core to ensuring safe care and support are provided to the residents of nursing homes. Given the nature and importance of the role of staff in delivering this care, significant provisions are included in regulation and national standards. Nursing home providers, for example, must ensure that:

> *At all times there are sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents… Contingency plans are in place in the event of a shortfall in staffing levels or a change in the acuity of residents*.[48]

107. In its evidence to the Committee, Nursing Homes Ireland claimed that there was "aggressive recruitment of nursing home staff initially by the HSE".

> *There was also was also, we would suggest, a targeting of people who were working in the sector. We would have made the point that denuded one element of the health service to support another element, which was counterproductive. We would have asked for a moratorium on recruitment.*[49]

108. According to data provided by the HSE, a total of 33 nurses and 28 health care assistants were recruited from nursing homes from January to 31 May 2020. The HSE told the Committee that it encouraged local recruiters to delay appointing nurses who were currently working within the private nursing home sector. [50]

109. The National Director for Operations of the HSE told the Committee he asked Nursing Homes Ireland on a number of occasions to flag such issues and it flagged a maximum of ten such cases. In a number of those cases, the recruitment was stopped. [51]

110. Age Action Ireland told the Committee that nursing homes recruited aggressively from the home care sector, impacting on the availability of care assistants. [52]

111. Stakeholders representing staff have voiced concerns over pay, conditions and staffing levels in the nursing home sector. In its submission to the Committee, the INMO noted a HIQA report which highlighted inadequate staffing numbers, which included senior nursing infection prevention and control expertise, in the nursing homes sector.[53]

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[48] Department of Health summary overview paper on nursing homes, page 2

[49] Mr. Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020

[50] HSE response to SCC19R Follow up from meeting 18.06.2020

[51] Mr. David Walsh, Special Committee on Covid-19 Response, 18 June 2020

[52] Age Action submission to the Special Committee on Covid-19 Response, 25 June 2020

[53] INMO submission to the Special Committee on Covid-19 Response, 25 June 2020

112. The INMO notes the need for the extension of the framework for Safe Nurse Staffing and Skill Mix in the sector. SIPTU states that "the provision of quality health care is dependent on quality jobs which attract and retain the best and most highly motivated health care workers".

113. In its evidence to the Committee, SIPTU highlighted the high level of infection among healthcare workers within the nursing home sector. Other stakeholders expressed the view that staff shortages and inadequate workforce planning on the part of nursing homes, the Department of Health, and the HSE, at sector and home level, created an unsafe environment for staff and residents, and did not allow for enough time for workers to fully recover from the effects of the virus on them before being encouraged back to work. Further, the fragmented nature of the sector contributed to this, as it did not allow for convenient staff and resident transfer to remedy the shortfalls in unsafe facilities.

4.10 Clinical Guidance, Oversight And Governance

114. HIQA told the Committee that the current model of private residential care for older persons has no formal clinical governance links with the HSE. This means that there is no national clinical oversight of the care being delivered to some of our most vulnerable citizens.[54] The Committee notes that the lack of formal governance links between private nursing homes and the HSE is a direct consequence of the over reliance on a privatised model of care.

115. The CEO of HIQA told the Committee:

> *Currently 80% of nursing homes are operated by private providers. Although funded through the Nursing Home Support Scheme (Fair Deal), the HSE did not know this sector. As a consequence, the infrastructure required by the HSE to support the private sector was under-resourced and became increasingly challenged.*[55]

116. The National Director of Operations from the HSE told the Committee that in local clinical governance, nursing homes have a system where they have GPs or medical officers assigned who take responsibility for clinical governance. He noted that the key issue is the lack of a specific national structure or control for clinical oversight of the care of people admitted to nursing homes.

117. The CEO of HIQA told the Committee that HIQA had written to the Department of Health on many occasions regarding the regulatory framework and the way it impacts the sector. He noted that HIQA had sent several regulatory models to the Department, which try to account for the older persons pathway and would not be specific to individual care settings. The CEO said there had

[54] Mr. Phelim Quinn, Special Committee on Covid-19 Response, 26 May 2020

[55] Mr. Phelim Quinn, Special Committee on Covid-19 Response, 26 May 2020

been engagement with the Department on things such as the statutory home case scheme. That scheme, however, appears to continue to be in development as a separate scheme. He told the Committee:

> *Our recommendation, however, based on our own experience within the sector, is that there should be more of a regulatory framework that spans the entirety of older persons services.*

118. The Committee is concerned that most nursing homes have limited or inequitable access to the expertise of consultant geriatricians, old age psychiatrists, gerontological nursing, and allied health professional expertise.[56] It also notes that end of life care and palliative care and expertise is not universally available in all care settings. [57]

119. The Committee is of the opinion that the lack of national clinical oversight of care for residents in the sector is one of the biggest weaknesses exposed by Covid-19. The Committee is of the view that there is a need for greater co-ordination of care and greater understanding of where care takes place.

120. The Committee is of the view that the Department of Health adopt recommendations made by the RCPI Clinical Advisory Group for Older People on the recommendation that a review takes place of clinical governance arrangements within private nursing homes to advise on the relationships of the person in charge with GP/medical officer, registered provider and care staff and in particular with the public health authorities, and to review the resilience of these structures in the context of a pandemic.

4.11 Accommodation

121. The Committee notes that HIQA originally set standards for 80% single room occupancy by 2016 and that the Minister for Health signed a statutory instrument which extended this deadline to January 2022.[58]

[56] Safeguarding Ireland submission to the Special Committee on Covid-19 Response, 25 June 2020

[57] Safeguarding Ireland submission to the Special Committee on Covid-19 Response, 25 June 2020

[58] In 2016, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 was amended through Statutory Instrument (SI) 293,1 thereby allowing registered providers until the end of 2021 to demonstrate compliance with Regulation 17 and Schedule 6 of the 2013 care and welfare regulations

122. The Secretary General told the Committee that it was unlikely this deadline will be met by all community hospitals and nursing homes due to Covid-19. [59]

123. Responding to a question as to whether the statutory instrument had cost lives, the Secretary General of the Department did not accept this as there were multiple factors, but he noted that there was a good national development plan in 2007 and it was never implemented, and only half of the money and much less for community services was made available over the subsequent period. He noted work was underway under the 2016 programme of investment.

124. HIQA told the Committee that meeting standards is an ongoing challenge for providers. HIQA feels very strongly about it and has taken many regulatory decisions based on the amount of space available for each resident. These regulatory decisions have been challenged by providers, and the statutory instrument allows them that opportunity until January 2021. Ms Dunnion from HIQA told the Committee:

> *We believe, however, that it is very important, not only for infection control but for residents' rights to personal possessions and freedom of space, to be able to have visitors and that privacy. We see that as an essential component of a person's life in a nursing home.*

125. The National Director of Community Operations from the HSE added that in regard to community hospitals, the HSE is in the middle of a major capital plan. He told the Committee the HSE will have to assess the impact of the current stalling of that plan because of the pandemic. The Committee calls on the HSE and Department of Health to intervene to ensure that no capacity in the voluntary or public sector of nursing home care is reduced in the coming period. Examples cited to the Committee included St. Monica's, St. Marys Telford and at Cherry Orchard in Dublin.

126. Given the infectious nature of Covid-19, the Committee expresses concern that patients in community hospitals and publicly-funded nursing homes are sharing rooms and that, in some cases, there are more than six patients in a ward together.

127. The Committee believes that there should be no delay in meeting the regulations, given the infectious nature of Covid-19 and the risk it poses to older persons, particularly in congregated settings.

[59] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

4.12 Recommendations

Recommendation 1
The Committee recommends that the Department of Health in conjunction with the HSE and HIQA take immediate steps to develop a plan that will ensure that staffing levels and infection control procedures in the nursing home sector are adequate to meet any possible second wave of Covid-19.

Recommendation 2
The Committee recommends that the Department of Health urgently review current regulations and standards relating to the care of older people in nursing homes to assess whether they fully/adequately protect patients' health and welfare in discharging patients to nursing homes which have been determined by HIQA to be non-compliant with infection control requirements. The Committee further recommends that no patients are discharged from hospitals to any nursing home which fails to meet infection control requirements and that no arrangement should be made by the State to place any older person in such homes under the Fair Deal Scheme.

Recommendation 3
The Committee notes the challenges faced by the nursing home sector in obtaining PPE. It recommends that the regulator review the resilience of the sector when it comes to obtaining appropriate medical supplies for crisis situations.

Recommendation 4
The Committee recommends that the HSE and HIQA ensure that all nursing homes are adequately stocked and supplied with PPE in the months ahead.

Recommendation 5
The Committee is strongly of the opinion that the lack of statutory clinical oversight of care for residents in the private nursing home sector is one of the biggest weaknesses exposed by Covid-19. The Committee recommends the Department of Health urgently review clinical oversight and governance arrangements for private nursing homes. The Committee is strongly of the opinion that we need to strengthen clinical oversight of individual nursing homes, both public and private, by requiring a designated medical officer be appointed to each nursing home.

Recommendation 6
The Committee recommends that Department of Health urgently support public nursing homes which have planned capital works in order to fulfil statutory obligations under the Health Act 2007. The Committee recommends that this work is completed as a matter of urgency, given the ongoing threat of Covid-19 to the health of residents living in congregated settings.

Recommendation 7
The Committee calls on the HSE and Department of Health to intervene to ensure that no capacity in the voluntary or public sector of nursing home care is reduced in the coming period.

5. Response To Covid-19 Infections And Clusters In Nursing Homes

128. Another key issue examined by the Committee was the response to infection and clusters in nursing homes from the period after the first phase of restrictions and social distancing measures were announced by Government on 13 March until June 2020.

129. Sadly, this is the period in which the greatest number of new cases of Covid-19 and deaths occurred in nursing homes. On 16 March, the Health Protection Surveillance Centre was first notified of clusters in two separate nursing homes. While the peak of cases in the general population occurred in the last week of March, the peak of new confirmed cases in nursing homes occurred in mid-April, which coincided with expanded testing in the sector.[60]

130. The Committee notes that updated guidance on the risk to older people was provided by the ECDC in late March. On 25 March, the ECDC published updated guidance which upgraded the risk of severe disease associated with Covid-19 for people in the EU/EEA and the UK. In its guidance, the ECDC assessed the levels of risk of serious illness as moderate for the general population and raised the risk from "high" to "very high" for older adults and individuals with chronic underlying conditions. [61] The ECDC advised that severe illness and death was more prevalent among the more vulnerable, from older people to those with chronic underlying conditions, in society who become infected.

131. At its meeting on 27 March 2020, NPHET discussed infection prevention and control in community and acute settings and agreed that a package of additional measures should be recommended to slow the spread of Covid-19 with particular focus on those aged over 70 years and the extremely medically vulnerable groups – introducing "cocooning" for these groups.[62]

132. Following difficulties with the provision of testing and results within the sector, and severe shortages of PPE, systematic supports were provided by the HSE and HIQA to the public and private nursing home sector. The Committee heard from stakeholders about increased levels of support and engagement across the system, but a lack of initial clear communication, guidance and direction as nursing homes and community hospitals fought the virus.

[60] Department of Health Summary Overview paper on Nursing Homes

[61] ECDC Coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – seventh update 25 March 202

[62] Department of Health Summary Overview paper on Nursing Homes

133. The Chief Executive of Nursing Homes Ireland told the Committee:

> *The evidence from Ireland and internationally is no individual health sector can manage the crisis presented by Covid-19 alone. The supports provided by HSE community services for residents are appreciated and have delivered valued resourcing supports. The support framework implemented by the Minister and colleagues has fulfilled a lead role in managing and curtailing the prevalence of the disease in our nursing homes.* [63]

5.1 Covid Response Teams

134. The Committee believes that a key factor in the enhanced response was the improved communication and working relationship between the HSE, HIQA, Department of Health and the private nursing home sector.

135. The HSE told the Committee that it implemented a Covid-19 care pathway across hospitals and the community as a response to managing the pandemic crisis and to organise the setting up of new services. It set up nine Area Crisis Management Teams (ACMT) in early March as well as a process for the co-ordination of demand and supply of PPE, treating private and voluntary nursing homes equitably with HSE services.[64]

136. Following this, the HSE formed additional Covid Response Teams in each ACMT as a dedicated resource to support public health outbreak teams, and this was for all residential services as well as home support settings. These teams of expert specialists provided a range of advice and support throughout the period, including on-site assessments of residents' needs. The HSE commenced this process on 27 March.[65]

137. The Committee notes that, as part of this process, a national monitoring group was formed including senior management, public health, infection control specialists and a consultant geriatrician for the purposes of ensuring the Covid-19 response teams were deployed at a local level and any queries arising could be addressed.

[63] Mr. Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020

[64] HSE submission to the Special Committee on Covid-19 Response, 25 June 2020

[65] HSE submission to the Special Committee on Covid-19 Response, 25 June

138. HIQA told the Committee that it believed that the creation of crisis management teams was crucial in protecting residents:

> *It must be acknowledged that the creation of crisis management teams in each CHO area and the resources provided by the HSE at the community level played a significant part in supporting the private sector, and importantly, in protecting residents.*[66]

139. The Committee concludes that the formation of Covid-19 response teams had a positive impact in supporting nursing home staff and residents.

140. The formation of a national monitoring group again highlighted the opportunity for additional oversight of the sector, and a vital missing link between the private and public healthcare sectors. In the opinion of the Committee, it is regrettable that these teams were not formed at an earlier stage of the crisis management process.

[66] Mr. Phelim Quinn, Opening statement from HIQA to the Special Committee on Covid-19 Response, 26 May 2020

5.2 Infection Control Supports

141. A number of measures were taken in March and April to support nursing homes in relation to infection control. They included the following:

Extra provision of PPE

142. The Committee heard that nursing homes faced significant challenges in obtaining supplies of PPE in the third week of March. [67]

143. Following this, a formal process for co-ordination of demand and supply of PPE was established. The CEO of the HSE told the Committee that €27 million has been spent on supplying PPE to voluntary and private nursing homes.[68] This funding is directly provided by the State. Nursing homes have not at this stage recompensated the taxpayer for this supply of PPE. Nursing homes can continue to obtain additional PPE from their own suppliers.

Testing regime in nursing homes

144. Speaking to the Committee, the Chief Clinical Officer of the HSE noted that the biggest predictor of outbreaks is community transmission:

> *Testing enables the public health actions that are necessary, that is, isolation of patients and infection prevention and control measures. Testing is not an end in itself. Looking back now, with our awareness of asymptomatic transmission, it is certainly possible that some people who had no symptoms who were transferred from acute hospitals to residential care facilities took the virus with them. It is equally possible that asymptomatic people who were working in residential care facilities transmitted the virus.* [69]

145. On 27 March, the case definition was expanded to alert clinicians for a higher index of suspicion regarding possible atypical presentations in nursing homes. Given the highly infections nature of the disease, long-term residential facilities were advised to treat all residents with symptoms, should there be a testing delay, as likely Covid-19 positive in facilities where a Covid-19 diagnosis had been confirmed.[70]

146. On 17 April, following a NPHET recommendation, the testing of all staff in long-term residential facilities was conducted; 95,900 tests were completed with a positivity rate of 5.5%. The HSE has

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[67] Ms Anne O' Connor, Special Committee on Covid 19 Response, 19 May 2020

[68] Mr Paul Reid, Special Committee on Covid-19 Response, 19 May 2020

[69] Dr. Colm Henry, Special Committee on Covid-19 Response, 18 June 2020

[70] Department of Health summary overview paper on nursing homes, page 11

now introduced a weekly rolling programme of testing staff in nursing homes for a four-week period to track and target any emerging infection.

147. On the question on whether non-testing of asymptomatic patients would have contributed to mortality, the HSE told the Committee it was hard to say. The first published report that really reflected the high prevalence of asymptomatic transmission, particularly in congregated settings, was on 27 March in the *New England Journal of Medicine*. The National Clinical Advisory Group Lead (Older Persons) of the HSE said that is how quickly things have been evolving in this pandemic, but she added that it is very difficult to say because we do not know what the mortality looks like in terms of patients who have tested positive but who were asymptomatic.[71]

148. On 10 April 2020, in line with the available emerging evidence, guidance was changed to formally include the testing of staff in residential care facilities as part of the outbreak response with escalation to full testing of all residents and staff in facilities with outbreaks from 18 April 2020. This was followed by a mass testing strategy which commenced 21 April 2020, with testing in all long-term care facilities completed by 15 May 2020.[72] The Committee was also told that a testing pathway was being put in place in order that nursing homes can perform tests on residents.[73]

149. The Committee notes the extremely high rate of infection in healthcare workers in nursing homes relative to other healthcare settings, as highlighted by reports of the Health Protection Surveillance Centre.

Staffing Supports

150. The Committee notes that the HSE provided 322 extra staff to nursing homes during this period.[74]

Change in protocol regarding testing and discharge of patients from acute hospitals

151. The National Clinical Advisory Group Lead (Older Persons) told the Committee that asymptomatic transmission was not a feature of WHO or ECDC guidance until 18 March. The CEO of the HSE told the Committee the HSE changed the approach to testing of patients and the case definition regarding possible asymptomatic patients. He noted that geriatricians were taken aback at the presentation of positive cases and levels of asymptomatic patients. He said that as they learned more, the approach changed.

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[71] Dr. Siobhan Kennelly, Special Committee on Covid-19 Response, 26 May 2020

[72] HSE submission to the Committee, 25 June 2020

[73] Dr. Siobhan Kennelly, Special Committee on Covid-19 Response, 26 May 2020

[74] HSE submission to SCCR19 Re Nursing Homes

152. The CEO of the HSE told the Committee:

> *As we have gone through the process, our approach has changed, and as we go forward, I have no doubt our approach will change. That is part of what we have learned about the virus. Nobody is more upset than the healthcare workers who work in the system, both public and private, and have seen what has happened. Overall, I think our strategy approach was based on knowledge we had at a particular time and it did change as we gained more knowledge. I have no doubt learnings will be and should be made for the future.*[75]

153. The HSE now recommends that transfers from acute hospitals are to be isolated and monitored for a 14-day period.[76]

5.3 Temporary Assistance Payment Scheme for Nursing Homes

154. The Secretary General of the Department of Health told the Committee that a special nursing homes subgroup was set up to devise a temporary assistance scheme which would benefit the sector.[77]

155. On 5 April, a Temporary Assistance Scheme to support Private and Voluntary Nursing Homes in preparing for and responding to a Covid-19 outbreak was announced.

156. The purpose of the scheme is to assist nursing homes in building resilience in reducing the risk of a Covid-19 outbreak and in supporting them in managing such an outbreak, should one occur. The HSE administers the scheme and processes payments to the nursing homes. The Department of Health has requested that the National Treatment Purchase Fund (NTPF) administer the application process and provide support and advice to the HSE. [78]

157. The scheme consists of a standard assistance payment and an outbreak assistance payment. To qualify for the outbreak assistance payment, the nursing home Covid-19 outbreak must be confirmed by public health and notified to the Health Protection and Surveillance Centre (HPSC). The first part of the scheme, the standard assistance payment, consists of a prospective standard assistance payment and a retrospective reconciliation, based on actual costs incurred. The outbreak assistance payment is in place to further financially support nursing homes when managing a Covid-19 outbreak.

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[75] Mr. Paul Reid, Special Committee on Covid-19 Response 18 June 2020

[76] Dr. Siobhan Kennelly, Special Committee on Covid-19 Response, 26 May 2020

[77] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[78] HSE Submission to the Special Committee on Covid-19 Response

158. The Committee has been informed that, as of 29 May 2020, a total of €9.1m in financial support had been made available to a total of 358 private nursing homes under prospective standard payments and all elements of the scheme are now live and available to be claimed.

159. Stakeholders from the sector expressed disappointment that the assistance scheme was not backdated to 1 March. The CEO of Nursing Homes Ireland told the Committee that that one section of the scheme is for outbreak assistance, which was welcomed, but that was only available to homes who suffered an outbreak and was not available to those who spent considerable money to keep a nursing home Covid-free. He told the Committee that the sector had spent millions of euro in addition to normal expenditure by 26 May 2020 on such measures.[79]

160. The Committee asked him if there was an ability within the sector to consider setting up a pandemic crisis fund. He said the issue was not finance, but access to PPE generally.

161. The Committee welcomes the Temporary Assistance Scheme as there was a clear need to support nursing homes at the height of the crisis.

5.5 Mortality Rates and Reporting

162. One of the ways to measure the impact of Covid-19 is mortality. As discussed in Section 1.2 of this report, there is a high Covid-19 morbidity and mortality in nursing homes in Ireland and internationally. Nursing home deaths in Ireland account for approximately 56% of all deaths from Covid-19 in Ireland.[80]

163. Countries throughout the world have reported different mortality rates to date. NPHET states it is difficult to compare mortality rates between Ireland and other countries in the EU due to the difference in numbers of people tested, mortality case definitions and reporting practices. It notes that factors impacting mortality will include demographic and socio-economic factors, geographic factors, population density and travel patterns as well as the effectiveness of public health measures.[81]

[79] Mr. Tadhg Daly, Special Committee on Covid-19 Response, 26 May 2020

[80] Epidemiology of Covid-19 in Ireland, HPSC, (29 June 2020)

[81] NPHET, Covid-10: Comparison of Mortality Rates between Ireland and other countries in EU and Internationally, 28 May 2020

164. NPHET notes the higher incidence rates, which may due to a higher testing strategy, but states that Ireland has lower reported mortality rates than UK countries, despite the fact Irish figures included confirmed and probable cases.

165. HIQA has analysed excess mortality in Ireland from 11 March to 16 June to determine whether the reported Covid-19 mortality provides an accurate estimate of excess mortality during the epidemic. [82] The analysis, which was based on data from the death notices website, *RIP.ie*, found that there was clear evidence of excess mortality occurring since the first reported death but that officially reported Covid-19 deaths may overestimate the true burden of excess mortality specifically caused by Covid-19. This may due to the inclusion within the figures of people who were close to end of life independently of Covid-19 or whose cause of death may have been due to other factors.

166. The Committee notes evidence that the Irish fatality rate was high by international standards and that, looking at excess deaths over the past five years, Ireland had the eighth highest fatality rate in Europe.[83]

167. The Secretary General of the Department of Health told the Committee a whole range of lessons have been learned. The types of measures that have been taken on testing and case definition have all been informed by international learning. He said he did not fully accept that we have a very high fatality rate.

> *I believe Dr. David Nabarro was correct in stating that we have been much more comprehensive in our recording of deaths. In addition, regarding the proportion of deaths that have taken place in nursing homes, while I will not say we have been fully successful, we have put in place many measures to suppress community transmission that avoided deaths in the community. This leads to a higher proportion of deaths being in nursing homes. If we had twice the number of community deaths, the percentage of deaths in nursing homes would be 40%, not 60%.*

168. The Committee was told that the Nursing Home Expert Panel was to explore this matter in greater detail and would examine outcomes in terms of differences between infection and mortality rates in the public and private sector.[84] The Report of the Expert Panel should be published by the Minister for Health and should be examined by the Committee in September.

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[82] HIQA, Analysis of excess all-cause mortality in Ireland during the Covid-19 epidemic, 03 July 2020

[83] Special Committee on Covid-19 Response, 18 June 2020

[84] Dr. Colm Henry, Special Committee on Covid-19 Response, 18 June 2020

5.6 End Of Life Care In Nursing Homes During Covid-19

169. The Irish Hospice Foundation told the Committee that many of the experiences of dying, death and bereavement during the Covid-19 pandemic have fallen short of the expressed wishes on the Irish people in relation to what they want for themselves or their loved ones at end- of-life.[85]

170. The Committee notes the significant trauma of residents, families and staff in nursing homes as cases and clusters of Covid-19 emerged and increased in the sector.

171. Safeguarding Ireland, in its submission, told the Committee:

> *People in nursing homes, are among the most vulnerable group in society. In terms of Covid-19, this group certainly bore the brunt of the suffering, with very many deaths. In addition, they suffered anxiety as a result of their vulnerabilities, sometimes lack of communication with them and their families, bereavement due to death of friends and acquaintances in large numbers and enforced extreme cocooning due to visiting restrictions.*[86]

172. The INMO told the Committee of the increased levels of stress and anxiety as health workers had no choice but to assist residents at end of life situations and family members could not be present with their loved ones.

173. As regard actions taken to improve end of life care during the crisis, the Committee was told that the National Clinical Programme for Palliative Care (NCPPC) Palliative Care Consultant Advisory Group has developed national guidance, which has been disseminated through webinars, GPs and specialist palliative care services. The guidance aims to assist health care professionals in meeting the palliative care needs of dying patients, including those living in long-term care facilities, such as nursing homes or other community settings. [87]

174. The Committee was told that a series of webinars facilitated by the All Island Institute for Hospice and Palliative Care have been provided for nursing homes and, disability services, with almost 8,000 staff signing up. Topics to date have included 'do not resuscitate' matters, how a palliative care approach to care can support nursing homes during the Covid-19 outbreak, anticipatory prescribing and related issues, and advance care planning.[88]

175. The Committee notes that the Irish Hospice Foundation, in partnership with the HSE, launched a bereavement support line to provide support to family members who have experienced the death of someone they love during the Covid-19 pandemic.

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[85] Irish Hospice Foundation submission to the Special Committee on Covid-19 Response, 25 June 2020

[86] Safeguarding Ireland submission to the Special committee on Covid-19 Response, 25 June 2020

[87] NPEHT Overview of the health system response to Covid 19

[88] NPEHT Overview of the health system response to Covid 19

176. The Committee is of the view that lessons must be learned from the experience of end of life care during the Covid-19 crisis. This is an experience that must not be repeated and must be avoided and actively planned for as part of any preparation for further waves of Covid-19 infection.

6. Structural Issues In Care For Older People Exposed By Covid-19 Pandemic

177. The Covid-19 crisis in our nursing homes has shone a light on deficits in our care system and has shown where gaps exist and where they have been exacerbated by the pandemic.

178. One of the most troubling aspects of the crisis was the fragmented relationship between public health authorities and the private nursing sector. As nursing homes were seen to be external to the overall public health system, the system was slower to respond, as it did not know the sector or play a role in clinical oversight of the sector. The Committee believes this was a key factor that contributed to the spread of outbreaks in nursing homes and the unfortunate loss of life during the Covid-19 pandemic.

179. In this section, the report highlights some of the most relevant structural issues in the care for older people which were exposed by the Covid-19 pandemic.

6.1 Model Of Care

180. The Committee believes that the Covid-19 pandemic has shown that the overall model of care for older people is not adequately integrated with the rest of the healthcare system and is deeply flawed. The Committee heard from many stakeholders who expressed concern at the siloed approach to long-term support and care for older people which has a clear bias towards placing older people in residential settings.

181. In its submission to the Committee, Age Action Ireland told the Committee that the lack of policy integration between home care and residential care continues to put people directly at risk. It notes that the current statutory right to nursing home care only can drive users to enter nursing homes earlier than needed due to inability to access adequate home care supports or, in recent months, due to the lack of community home supports. For many more, nursing home care has been unavailable due to the spread or risk of Covid-19 and people have been left in limbo between services.[89]

182. Age Action Ireland also expressed the view that alternative models of care for high dependency older people must be considered to promote older people's safety, rights, independence and quality of life.

183. Stakeholders also remarked on the inequalities that appear to exist within the current model of nursing home care, commenting that the current model created an unequal system where

[89] Age Action submission to the Special Committee on Covid-19 Response,25 June 2020

publicly funded care facilities had larger and more congregated settings, with older buildings whose residents were statistically more likely to have a higher degree of need.

184. A move away from congregated settings with old people living either independently at home or in sheltered housing units will require a change to housing policy. It will mean greater recourse to home refurbishments to allow for older living, such as the removal of steps and the insertion of handrails, to prevent people from injuring themselves through falls. It will also require the availability of smaller units, including retirement villages, which will free up bigger houses where older people have lived all their lives and which are now either not fit for purpose or simply too big, especially where the families of the older person or older couple have moved on.

185. Stakeholders also told the Committee that there was a need for a continuum of care including home care, split housing and boarding out to supportive housing, mutual and housing co-operatives and housing with supports. This continuum should also include nursing home care, but care needs to be taken to ensure it is patient-focused and offers the appropriate clinical supports in a holistic manner.

186. The Committee notes that the direction of policy in respect of care for older persons which has seen a focus on the placement of older persons in congregated settings run by private entities with public support though both the Fair Deal Scheme and though tax breaks for those who develop those nursing homes. This policy needs to be addressed commencing in 2021 and can be done within the context of legislation that will place the provision of care in a person's home on a statutory footing. There are other issues including those around funding for home care packages which are derived from a separate budget from the Fair Deal Scheme which needs a more integrated funding approach, and which should be addressed by the Oireachtas. The Committee agrees that, in line with what was done in the areas of mental health and disability, that there should be a move away from congregated settings when it comes to older persons.

6.2 Regulatory framework for Care Of Older People

187. Sage Advocacy expressed the view that the "architecture" of nursing home care provision is complex, lacking transparency and without an effective system of overall governance. It notes:

> *The National Treatment Purchase Fund buys the care from private providers without proper consideration of the range of needs, the HSE administers the scheme but the contract is between the older person and the nursing home, and HIQA sets the standards but has no role in setting the price; it inspects but has no powers to investigate complaints.*[90]

[90] Mr. Mervyn Taylor, Opening Statement to the Special Committee on Covid-19 Response, 26 May 2020

188. In addition to the issues mentioned by Sage Advocacy, the Committee notes that the current model of private residential care for older persons has no formal clinical guidance links with the HSE. This means that there is no national clinical oversight of the care being delivered to some of our most vulnerable citizens. There is no clear framework for the provision of medical care to the most vulnerable.

189. This is of grave concern to the Committee given the evidence that some private owners do not have a social or nursing background or adequate on-site medical support.[91]

190. Covid-19 exposed the flaws in this architecture which does not fully serve the needs of our most vulnerable people. The Committee believes this has led to ineffective co-ordination between statutory agencies at regional and national level.

191. Of particular concern to the Committee is the fact that the HSE approves the new placement of older people in nursing homes even though those said nursing homes do not have adequate infection controls arising from HIQA inspections. While in evidence the HSE said those nursing homes were still licensed to operate and it appears that the regulations, or at least their implementation, around this issue need to be reviewed, the Committee queries why the HSE does not use its authority as the paymaster under the Fair Deal Scheme to refuse to send new applicants to any nursing home which was non-complaint with infection control requirements. The Committee will recommend that this should become the practice so as to offer maximum protection for those who need nursing home care.

192. The Committee notes that Ireland has an ageing population. This will be key challenge over the next ten years, where it is expected that there will be 250,000 people over the age of 80 by 2031. Strategic planning for how we care for older people needs to be considered and actioned as a priority.

193. In its submission to the Committee, HIQA called for a review of the current regulatory framework and the introduction of an accountability framework to include a commissioning model.

> As *part of an accountability framework, HIQA believes that a system of care management could be introduced across the HSE's community service areas. Such a model would be closely aligned to the principles and goals articulated within Sláintecare, as the key aim of the system is to support people in, or close to their own homes as possible.*

[91] HIQA submission to the Special Committee on Covid-19 Response, 25 June 2020

194. The Committee believes there is a need for authoritative clinical governance, greater accountability of providers and improved co-ordination across the nursing home sector.

195. The Committee recommends that the current regulatory framework for the care of older people be examined by the Department of Health.

196. The Committee believes that Covid-19 crisis has exposed the potential threats to health and welfare of older people and a comprehensive systematic strategy for healthcare provision for older people is needed urgently.

6.3 Role Of The Regulator

197. During the course of its examination of nursing homes, the Committee was alerted to several issues regarding the statutory powers and standards applied by the regulator HIQA.

198. The Committee understands that, while clear legislative responsibility for regulation, registration of services and inspections of services rests with HIQA, during the Covid-19 crisis HIQA also had to facilitate co-ordination between the HSE, Department of Health, NTPF and the private nursing home sector. This was due to the complicated regulatory framework surrounding nursing homes and the practical difficulties arising from the fact that the HSE or Department of Health did not "know the sector".

199. The Committee notes that HIQA provided a list of at-risk institutions to the HSE and it provided the Department and HSE with access to its online notification system. It was also agreed on 21 April 2020 that a Covid-19 regulatory framework for the monitoring and inspection of long-term care facilities should be developed and implemented. In April, HIQA also rolled out a regulatory assessment process to support nursing homes without a case of Covid-19 to prepare for an outbreak, and to ensure that clear contingency plans are in place to maintain high standards of care for residents at all times.

200. The evidence available to the Committee is that in May, HIQA recommenced regulatory inspections, starting with risk-based inspections of those nursing homes that had a significant Covid-19 outbreak. Key findings to date reiterate the need for a responsive Covid-19 testing system, enhanced infection and control guidance from the HPSC, training, increased clinical staffing levels, and operational arrangements to ensure a meaningful life for residents is maintained.

201. The Committee heard that a standards-based approach to regulation is used by HIQA with an improvement focus. However, many stakeholders queried the national standards process, saying they were not set at a level sufficient to assess clinical leadership, expertise, resilience and reserve. In his submission to the Committee, Professor Des O Neill, Consultant Geriatrician, said:

> *The end result is a variability of care standards and resilience that is substantially out of step with other elements of the healthcare system*.[92]

202. The Committee notes the power of HIQA to go to the courts to seek deregistration of nursing homes in the case of non-compliance. The Committee heard evidence from HIQA's Chief Inspector of Social Services and Director of Regulation where she indicated that these powers were difficult to enforce when she stated:

> *We have enforcement powers but they are sometimes difficult to enforce. By way of example, three nursing homes which were taken to court over the past two years pursued two judicial reviews. We currently have legal cases pending on regulatory decisions I have made in the context of registration*.[93]

203. The chilling effect posed by the threat of lengthy legal challenges must be considered to weaken the regulator's statutory powers.

204. The Committee is also of the opinion that ongoing extension to deadlines regarding refurbishment of nursing homes undermines the role of HIQA as a regulator. The Committee was told by the Secretary General of the Department of Health that it was unlikely that the deadline of January 2021 would be met for capital works on community hospitals. The persistent delay in refurbishing community hospitals and community nursing homes will mean that it is likely that these facilities will continue to have challenges with infection control and non-compliance with regulations.

205. HIQA has acknowledged that there were flaws in the current regulatory system. The CEO of HIQA told the Committee that in recent years HIQA has sought a review of the regulations, which were developed initially in 2009 and in 2013, in order to keep pace with current models of care. The Committee notes that HIQA has also looked at the development of training and guideline materials to assist implementation of standards within health and care settings.

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[92] Professor Des O' Neill, Submission to the Special Committee on Covid-19 Response, 26 May 2020

[93] Ms Mary Dunnion, Special Committee on Covid-19 Response, 26 May 2020

206. HIQA also told the Committee that that a re-drafting of the Health Act 2007 is required to provide for a statutory home care scheme and to facilitate inspections by other bodies, for example, the HSA/Mental Health Commission.

207. As per section 4.11, the Committee recommends that works commence urgently on community hospitals and public nursing homes which need refurbishment in order to meet current regulatory requirements.

6.4 Staffing issues

208. Much of the evidence presented to the Committee concerning outbreaks of Covid-19 in nursing homes points to weak regulation of staffing in the sector.

Staffing Ratios

209. The Committee is deeply concerned about levels of staffing and the absence of a defined ratio of nurses to high dependency residents within a unit. The Committee was told that nursing homes must have "adequate staffing" as well as contingency plans. The Secretary General of the Department of Health told the Committee:

> *Going back to when the regulations were first done, the difficulty in specifying a particular ratio arises from the difference and variety among patients and the variety of accommodation and infrastructure available to any particular nursing home.*[94]

210. However, HIQA told the Committee that the regulations regarding staffing were weak. The Chief Inspector of Social Services and Director of Regulation told the Committee that staffing levels are determined by the provider of nursing homes. HIQA can identify a shortage of staff, but it is totally dependent on the provider:

> *Statutory nursing homes and private nursing homes will decide their own staffing levels, and I believe the regulations are poor in that context*.[95]

211. In its submission, HIQA highlighted the lower number of staff in private nursing homes along with an inability to sustain senior levels of senior nursing expertise as key challenges facing private nursing homes.

[94] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[95] Ms Mary Dunnion, Special Committee on Covid-19 Response, 26 May 2020

Skills Mix And Expertise

212. Stakeholders also expressed concern at the absence of regulation on the level of skills required by nursing staff in nursing homes, highlighting in particular an inadequate number of staff with infection prevention and control expertise. SIPTU told the Committee that the current regulations do not provide appropriate clinical guidance for the safe staffing of a unit or appropriate skill mix between disciplines.[96]

213. The Committee notes the recommendation of the RCPI Clinical Advisory Group on Older People in this context and recommends that staffing structures in nursing homes need to be reviewed to ensure appropriate skill mix and resilience with appropriate career pathways and educational opportunities to be developed.

Cover for sick leave

214. The Committee heard that many nursing homes struggled during the height of Covid-19 outbreaks due to the number of staff contracting the infection, and this impacted on the resilience of the nursing homes in dealing with outbreaks. While the HSE provided staff to nursing homes, the Committee notes that it is the responsibility of nursing homes to ensure adequate staffing.

215. The Committee notes evidence from stakeholders that a derogation was provided to managers requesting that staff who were identified as close contacts could attend work if they were asymptomatic. This appears to have been a mistake considering subsequent evidence regarding asymptomatic transmission.

216. The Committee is of the opinion that a delay in issuing a national request to wear facemasks in all healthcare settings unnecessarily exposed healthcare workers to higher levels of infection.

Pay And Conditions

217. The INMO and SIPTU told the Committee that pay and conditions for staff in private nursing homes are set at a level that does not support recruitment and retention of care staff.

218. During the course of its hearings, the Committee heard of "aggressive" recruitment of staff on behalf of the HSE but found little evidence of this. Instead, it believes that staff were more likely to have been attracted to move due to a perception of better working conditions and higher wages in other areas of the healthcare sector.

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[96] SIPTU submission to the Special Committee on Covid-19 Response, 25 June 2020

219. SIPTU notes issues with pay, conditions and provision of adequate training in the private nursing home sector:

> *It is our opinion that these factors did contribute and undermine the private nursing home sector response to the COVID 19 response. To ignore these factors would be wrong. The reality is Government policy has determined the price of care in the Sector. This coupled with soft regulation and no direct oversight by the Department of Health has contributed to the issues experienced by the workforce.*

Healthcare Assistants

220. The Committee supports the assertion that healthcare assistants should have a protected title and formal regulation to ensure safe practice standards are being upheld.

6.5 Safeguarding Of Residents

221. During the course of the Covid-19 pandemic, families contacted HIQA with many concerns about nursing homes and one of the most significant issues was safeguarding and quality of care.[97]

222. The Committee notes that many stakeholders have said there is a need for adult safeguarding legislation and protection of liberty in places of care and legislative recognition for independent advocacy. The Committee understands that the Law Reform Commission is currently undertaking consultation on a legislative framework for safeguarding legislation.

223. Sage Advocacy noted that the current preference of the system is to discharge patients from hospitals into nursing home care, irrespective of their wishes. It states that other options could be explored such as transitional care in community hospital settings or the formation of Community Intervention Teams (CIT) in order to provide robust, responsive and accessible inter-disciplinary teams in the community which can be mobilised if health deteriorates to prevent hospital admission and promote rehabilitation, as well as accepting hospital discharges.[98]

224. Stakeholders such as the Alzheimer Society of Ireland noted the need for inspection procedures which should include new standards to safeguard older people in nursing homes, including those with dementia, in the event of a further pandemic. [99] The Irish Association of Social Workers noted that social workers remain limited in their ability to complete unhindered safeguarding assessment under the current regulations, as they can only intervene if they believe an older person is at risk of harm in certain circumstances. [100]

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[97] Ms Mary Dunnion, Special Committee on Covid-19 Response, 26 May 2020

[98] Sage Advocacy, Submission to the Committee on Covid-19 Response, 17 June 2020

[99] Alzheimer Society of Ireland, Submission to the Special Committee on Covid-19 Response, 25 June 2020

[100] The Irish Association of Social Workers, Submission to the Special Committee on Covid-19 Response, 24 June 2020

6.6 Recommendations

Recommendation 8
The Covid-19 crisis has exposed the potential threats to health and welfare of older people. The Committee recommends that the Department of Health plan for the care older people as part of the implementation of the Sláintecare strategy and to account for demographic trends over the next ten years.

Recommendation 9
The Committee recommends that the Department of Health develops an integrated system of long-term support and care spanning all care situations with a single source of funding. In that regard, the Department should work closely with the Department of Housing to develop models of independent living, supported housing and sheltered housing to cater for the wide range of housing preferences among older people. This strategy should have a specific focus on moving care from congregated settings.

Recommendation 10
The Committee recommends the integration of private nursing homes into the wider framework of public health and social care.

Recommendation 11
The Committee recommends the enactment of legislation underpinning the regulation of and statutory provision and regulation of home care and, in the meantime, that additional funding for home care would be increased to clear the current waiting lists.

Recommendation 12
The Committee recommends that the current regulatory framework for the care of older people be examined by Department of Health.

Recommendation 13
The Committee recommends that the Department of Health and the HSE review the criteria for allocation of patients under the current Fair Deal Scheme, to ensure that, first, patients' needs and care requirements are central to any placement and, second, that all people are not put in an undue risk situation by being placed in a long-term care facility that is not in compliance with HIQA standards on infection control.

Recommendation 14
The Committee recommends that regulations regarding staffing and staff ratios in nursing homes need to be strengthened in order to protect patient health and to prioritise the setting of nurse to patient ratios in line with best practice.

Recommendation 15
The Committee recommends that staffing structures in private nursing homes should be reviewed along with salary structures and terms and conditions of employment with particular reference to access for sick pay and security of employment to ensure appropriate resilience.

Recommendation 16
The Committee recommends that the Department of Health examine the regulation of the role of healthcare assistants.

Recommendation 17
The Committee recommends that there should be no unnecessary delay in implementing legislation on adult safeguarding.

7. Preparations For A Future Pandemic Or Further Infection

225. Preparations are currently underway to manage the ongoing impact of Covid-19 in nursing homes over the next six to 18 months. The Department of Health has established an expert panel which will make recommendations to ensure all protective response measures are planned in light of the ongoing Covid-19 risk and impact for nursing homes over the next six to 18 months.[101]

226. The Secretary General of the Department of Health told the Committee there was no complacency around the issue of a second wave. He said that HIQA has put in place a quality assurance framework regarding preparedness against which it is reviewing nursing homes. He added that the infrastructure, including the multidisciplinary community response teams, has been put in place so that the HSE has support in place. He also noted the stockpiling of PPE and increased testing capability. [102]

227. HIQA has emphasised the importance of testing, improved clinical oversight and governance, including a formal communication pathway for each nursing home with key community hospital specialities, improved contingency arrangements on behalf of HSE and individual providers, adequate training of staff and contingency plans for staff illness, and updated infection control procedures.[103]

228. The Committee has received evidence from stakeholders highlighting the importance of the following measures in the event of another pandemic or further waves of Covid-19 infection:

i. A comprehensive system of testing and tracing among nursing home staff
ii. Improved clinical oversight in nursing homes
iii. The implementation of a framework for Safe Nursing Staffing and Skill Mix in nursing homes
iv. The appropriate provision and stockpiling of PPE and other essential supplies
v. National support standards and guidance for nursing homes staff
vi. An adequately resourced public health institute
vii. The need for an integrated digital strategy across all health and social care services and supporting agencies
viii. Above all, any future pandemic planning must cover the whole care system

[101] Department of Health summary overview paper on nursing homes,

[102] Mr. Jim Breslin, Special Committee on Covid-19 Response, 18 June 2020

[103] HIQA submission to the Special Committee on Covid-19 Response

229. The Committee believes that lessons must be learned from the Covid-19 crisis in nursing homes. In particular, enhanced engagement is critical to ensure residents across all nursing homes are afforded access to best expertise and supports. The above recommendations must be implemented and robust planning for future waves of infection must cover the whole care system.

7.1 Recommendations

Recommendation 18
The Committee recommends that a comprehensive system of testing and tracing among nursing home staff continues along with appropriate stockpiling of PPE and other essential supplies.

Recommendation 19
The Committee recommends that all future pandemic or crisis planning must cover the whole care system.

APPENDIX 1: TERMS OF REFERENCE

(1) Dáil Éireann hereby appoints a Committee, to be known as the Special Committee on Covid-19 Response (hereinafter referred to as 'the Committee'), to consider and take evidence on the State's response to the Covid-19 pandemic;

(2) the membership of the Committee shall not exceed nineteen members, appointed by notice in writing to the Ceann Comhairle as follows:

(*a*) the Government, Fianna Fáil, and Sinn Féin shall each be entitled to appoint four members;

(*b*) the Green Party, the Labour Party, Social Democrats, Solidarity-People Before Profit, the Regional Group, the Rural Independent Group, and the Independent Group shall each be entitled to appoint one member;

(3) the Ceann Comhairle shall announce the names of the members appointed pursuant to paragraph (2) for the information of the Dáil on the first sitting day following their appointment;

(4) the quorum of the Committee shall be seven;

(5) the Committee shall elect one of its members to be Chairman;

(6) it shall be an instruction to the Committee that the taking of oral evidence from any one witness or group of witnesses in a single session shall not exceed 2 hours in each case;

(7) in the absence of a member nominated to serve on the Committee, one substitute may be nominated in accordance with Standing Order 106 for each two-hour session of the Committee: Provided that a substitute may only be nominated by prior written notice to the Clerk to the Committee;

(8) on a proposal by the Committee, the Business Committee shall agree the arrangements for the taking of the Committee's business as part of the Business Committee's weekly report under Standing Order 31, including but not limited to, the agenda for each meeting, the witnesses to be examined, and the format of the meeting, including time limits for presentations and questions; and

(9) subject to paragraphs (6) and (8), the Committee shall have the following powers:

(*a*) power to invite and receive oral and written evidence, oral presentations and written submissions from Ministers and witnesses in accordance with Standing Order 96(1) and (2);

(*b*) power to appoint sub-Committees in accordance with Standing Order 96(4);

(*c*) power to draft recommendations for legislative change and for new legislation in accordance with Standing Order 96(5), and to examine any statutory instrument which it considers relevant to its orders of reference in accordance with Standing Order 96(6) and (7);

(*d*) power to require that a member of the Government or Minister of State shall attend before the Committee to discuss policy, proposed primary or secondary legislation, post enactment reports on legislation, or matters relating to meetings of relevant EU Councils of Ministers

that, in the opinion of the Committee, relates to its orders of reference and for which the member of the Government or Minister of State is officially responsible in accordance with Standing Order 96(8), (9), (10) and (12);

(*e*) power to require that principal officeholders in bodies in the State which are partly or wholly funded by the State or which are established or appointed by members of the Government or by the Oireachtas shall attend meetings of the Select Committee, as appropriate, to discuss issues in relation to Covid- 19 for which they are officially responsible in accordance with Standing Order 96(11) and (13);

(*f*) power to engage the services of persons with specialist or technical knowledge in accordance with Standing Order 96(14); and

(*g*) power to report to the Dáil in accordance with Standing Order 100(1).

Appendix 2: Committee Membership

Deputies:

Colm Brophy (FG)

Colm Burke (FG)

Mary Butler (FF)

Jennifer Carroll MacNeill (FG)

Matt Carthy (SF)

Michael Collins (RI)

David Cullinane (SF)

Pearse Doherty (SF)

Stephen Donnelly (FF)

Norma Foley (FF)

Michael McNamara (I) [Chairman]

Fergus O'Dowd

Louise O'Reilly (SF)

Matt Shanahan (R)

Roisin Shortall (SD)

Brid Smith (SPBP)

Duncan Smith (L)

Ossian Smyth (G)

Notes:

1. Deputies appointed by Order of the Dáil of 7 May 2020
2. Chairman elected at Committee meeting of 12 May 2020

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DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé Máirt, 26 Bealtaine 2020

Tuesday, 26 May 2020

Tháinig an Coiste le chéile ag 11 a.m.

The Committee met at 11 a.m.

Comhaltaí a bhí i láthair/Members present:

Teachtaí Dála/Deputies	
Mick Barry,+	
Colm Brophy,	
Colm Burke,	
Mary Butler,	
Jennifer Carroll MacNeill,	
Matt Carthy,	
Michael Collins,	
Patrick Costello,+	
David Cullinane,	
Pa Daly,+	
Pearse Doherty,	
Stephen Donnelly,	
Norma Foley,	
John McGuinness,	
Catherine Murphy,	
Joe O'Brien,+	
Fergus O'Dowd,	
Louise O'Reilly,	
Ruairí Ó Murchú,+	
Thomas Pringle,+	
Matt Shanahan,	
Róisín Shortall,	
Bríd Smith,	
Duncan Smith,	
Ossian Smyth.	

+ In éagmais le haghaidh cuid den choiste/In the absence for part of the meeting of Deputies David Cullinane, Pearse Doherty, Michael McNamara, Bríd Smith and Ossian Smyth.

Teachta/Deputy Michael McNamara sa Chathaoir/in the Chair.

Business of Special Committee

Chairman: The committee is now in public session. Deputies Ó Murchú, Daly, Catherine Murphy and Barry will be substituting for their party colleagues. There will be a substitute for me in the third session and we will know who that will be in advance of that session. Are the minutes of the meeting on 19 May agreed?

Deputy Colm Brophy: I wish to raise an issue relating to the minutes. Mr. Tom Parlon gave completely misleading information to the committee at one point in his contribution last week. He since corrected that information when he was interviewed last Friday on the "Today with Sarah McInerney" radio programme. It is important that he correct the record of the committee. He was asked specific questions relating to costs by several Deputies and gave information which subsequently received widespread coverage in the media. He now admits that information is wrong. The committee should contact him to ask him to correct the record of the committee. The committee should consider that aspect of the minutes.

Chairman: We will contact Mr. Parlon to see whether he wishes to correct the record. Does the Deputy wish to postpone agreement on the minutes?

Deputy Colm Brophy: I propose that we postpone their agreement until the record is corrected.

Chairman: We will postpone agreeing them until we receive his reply, which we can consider.

Deputy John McGuinness: The following day or the day after that, I raised the matter with the Minister for Finance, Deputy Donohoe, and asked him to provide an analysis of the issue commented on by Mr. Parlon. It would be worthwhile for the committee to receive that analysis as it would indicate the viewpoint of the Department and might be more accurate. If Mr. Parlon has withdrawn his statement, we need to clarify the position.

Chairman: It is agreed that we will write to him and invite him to address his remarks during the session. We can then consider the minutes in that light.

Senator Colm Burke: On a different issue, at the meeting last week reference was made to one third of all healthcare workers having tested positive. That statement was subsequently reported on by an RTÉ news programme. If one extrapolates from that reference, approximately 45,000 healthcare workers would have tested positive, which is incorrect. What ought to have been stated is that one third of those who have tested positive are healthcare workers. It is important that the incorrect statement be corrected. In fairness to the news presenter who reported on it, she was only following up on what was stated before the committee. It is important that we correct that statement. One third of those who have tested positive are healthcare workers. There are more than 130,000 workers between the HSE, private nursing homes and disability facilities, so 7,500 positive tests means less than 6% of them have tested positive. It is important that that message be conveyed rather than incorrect information.

Chairman: I take the Deputy's point. We will postpone agreement on the minutes and discuss the matter at the meeting of the working group on Friday. Anyone who wishes to contribute can do so then.

Deputy John McGuinness: Last week, we asked witnesses to provide the committee with

correspondence on matters such as-----

Chairman: We have not moved to correspondence but the Deputy can continue.

Deputy John McGuinness: Last week, we asked for correspondence on how the National Public Health Emergency Team, NPHET, was established and between the various organisations about testing and other matters. Will we get that correspondence or are we waiting for the witnesses to decide on sending it to us?

Chairman: As the Deputy knows, we have written requesting correspondence and we have received voluminous correspondence from some of the parties that were here-----

Deputy John McGuinness: But not this-----

Chairman: -----last week and less from some of the others. The letters we sent are included in the correspondence, as have any replies received. There will be follow-up, of course.

Deputy John McGuinness: That is fine.

Chairman: Is it agreed to take the 31 items of correspondence received as noted? Agreed. I am informed that some correspondence was received late last night. I appreciate that Deputy McGuinness may not find that satisfactory but I am putting it on record.

Deputy John McGuinness: Some of the correspondence and statements arrive far too late.

Chairman: Yes.

Deputy John McGuinness: Members do not get a chance to read all the stuff the committee is getting. We should get it earlier.

Chairman: The 31 items of correspondence received have been noted and members have received written submissions for today's meeting. We received a large volume of correspondence at 9.30 a.m. regarding issues raised last week concerning nursing homes.

Deputy David Cullinane: I will make a quick point on that. I requested last week that we have that meeting at this hearing. We were asked by the secretariat to follow up with items arising from the hearings regarding follow-up documentation. That was supplied but, again, we got the information an hour and a half before today's meeting. It is a large amount of information and members must now trawl through hundreds of pages. It is not a coincidence that it landed at 9.30 a.m. We need to be much sharper and more robust with the Health Service Executive, HSE, and the Department of Health. We need the information we are looking for well in advance of our sittings to allow us to do our jobs. That should be noted for our future work.

Chairman: I thank Deputy Cullinane. I move on to the work programme. Following a meeting of the working group last Friday, it was agreed that any of the following members may take the Chair whenever required to do so by virtue of the absence of the Chairman, Deputies Butler, Carroll MacNeill and Cullinane. Is that agreed? Agreed. Deputy Butler will chair today's third session.

The following meetings have been agreed in principle by the committee. Next week, we will deal with the use of private hospitals in the first two sessions and travel restrictions in the third session. On 9 June, we will take oral medical evidence on issues related to minimising the risk of a second wave while reopening the economy. We will also have two sessions on

supports for businesses. The working group will meet again on Friday when it will consider a draft programme that will take us to mid-July. The output of that meeting will be submitted to next week's session for approval. Is that agreed?

Deputy John McGuinness: I am disappointed that an earlier date has not been scheduled to discuss the issue of private hospitals.

Chairman: I noted the Deputy's position on that, which was relayed to the working group.

Deputy John McGuinness: We should review that decision if this committee is to be meaningful because the issue is current.

Chairman: There was a consensus. The Deputy put forward his views and Deputy Shanahan was of a similar view. I am afraid, however, that the consensus-----

Deputy John McGuinness: We are closing the gate when the horse is gone. That is about the size of it. We should reconsider this and I ask the working group to reflect on it.

Deputy Matt Shanahan: Is it worth taking a motion on a reconsideration?

Chairman: No, but we can discuss it in the working group. We have witnesses waiting outside to give evidence. We have invited them here and I would like to move on to hearing from them. We can discuss these matters further in the working group on Friday, which Deputy Shanahan is welcome to join, as is Deputy McGuinness. I know Deputy Shanahan had some technical difficulties last Friday.

Deputy Matt Shanahan: That is fine.

Chairman: The last point to note is that arising from the proposals the committee has received and members should consider, the secretariat is preparing composite proposals. Is it agreed that those already prepared will be forwarded to members to give them an opportunity to propose changes by close of business tomorrow? Agreed.

Our request for a fourth session has not yet been considered by the Business Committee. It has not yet made a decision.

We move on to other business. I call Deputy Shortall.

Deputy Róisín Shortall: Will the Chair clarify what is the procedure for opening statements? How long do witnesses have?

Chairman: It is five minutes.

Deputy Róisín Shortall: That is fine.

Chairman: It is five minutes per member as well to make a statement, ask questions and obtain answers.

Deputy Róisín Shortall: I thank the Chairman.

Congregated Settings: Nursing Homes

Chairman: I now invite our witnesses, Mr. Tadhg Daly, chief executive officer, Nursing Homes Ireland, and Mr. Mervyn Taylor, executive director, Sage Advocacy, to join us. I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence in relation to a particular matter and continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and consideration at all times in accordance with the witness protocol.

I now invite Mr. Daly to make his opening statement and ask that he limit it to five minutes. As we received the opening statement in advance, it has been circulated.

Mr. Tadhg Daly: I thank the Chairman and committee members for the opportunity to address them today. I am joined by my colleague, Ms Anne Costello, nursing committee director, Nursing Homes Ireland. The work of this committee will represent one of the most important analysis of a national emergency that will forever be ingrained in our country's history. I wish it well in its work in the weeks ahead.

Nursing homes are traditionally very positive settings and homes of inspiration and happiness to the communities within them. They are a home from home. Covid-19 has brought huge levels of upset, sadness and worry in through their doors. I now take this opportunity to call upon us to commemorate forever all those who, tragically, lost their lives in our nursing homes and in our country because of this cruel virus. We should take the opportunity to laud the considerable sacrifices of nursing home residents. The loss of a loved one's personal touch and, for many, the loss of friends has caused huge upset and worry for thousands of our most special residents. Under very pressurised circumstances, our staff have made extra time to sit with residents and have prioritised the use of technology to connect residents with loved ones, often taking time outside of working hours to fulfil such work.

We applaud the staff in our nursing homes, HSE, private and voluntary. These 40,000 people are on the Covid front line. They have made sacrifices willingly, and with great commitment they continue to provide person-centred care, comfort and support. I thank the staff in the nursing homes for the care and support provided to residents over the weeks and months, with much of it provided to residents with Covid-19. The recent months have presented a stressful and demanding time, and these people ensured residents received excellent care in the most challenging of circumstances.

Covid-19 has presented a tragedy for nursing home residents, but it should not be lost on us that four out of every five nursing home residents who contracted Covid-19 recovered from the virus. This is testament to the tremendous dedication and professionalism of the staff under extremely strenuous circumstances. There needs to be a greater appreciation that care of the

older person is complex. Nurses in our nursing homes have very specific clinical expertise and a broad knowledge base founded on the science and art of the person-centred gerontological care model.

During the first three months of the year more than 2,500 people entered nursing home care under the fair deal scheme. Every month, 1,000 people transfer from our acute hospitals into private and voluntary nursing homes. During this national emergency, 7% of Covid cases entailed transfer of residents to hospital. As an easily transmittable virus, we knew in early January and February it could take the lives of nursing home residents in our communities. Preliminary research indicates up to 40% of transmission is passed by asymptomatic persons. The mass testing of residents has seen asymptomatic residents and staff test positive. Nursing homes have huge levels of experience in managing the outbreak of flu and norovirus every winter and have extensive experience, both clinical and practical, in implementing infection prevention control measures, but a global pandemic is on a different scale entirely.

We were exasperated in early stages and felt the sector required a very specific plan. We knew Covid-19 had a disproportionate impact on older people. The planning and focus was almost exclusively on our acute hospitals. We were aware people in our nursing homes would be among the most susceptible to the virus and a national strategy and response was required. The challenges of personal protective equipment, PPE, testing, aggressive recruitment of nursing home staff and discharges from acute hospitals are well versed at this stage. Our decision to restrict visitors on Friday, 6 March was informed by our nursing committee, comprising clinical experts, and it was not taken lightly. It was taken on a Friday because we were conscious of the many visitors who may have come to nursing homes that weekend.

Key State organisations left the nursing home sector and its residents isolated in those early days, and the dismay will live forever with us. However, we welcome the lead of the Minister for Health, Deputy Harris, in eventually bringing senior officials from his Department and the Health Service Executive, HSE, around the table to support the sector and our residents in coping with Covid-19. The evidence from Ireland and internationally is no individual element of the health service can manage the global Covid-19 pandemic alone. The supports provided by HSE community services are appreciated and have delivered valued resourcing supports to residents.

Covid-19 continues to live with us. We give early welcome to the Minister's commitment to establish a nursing home expert panel to support good planning and safeguards to protect people who call a nursing home their home. However, one significant voice is absent, that representing nurses from our nursing homes, who continue to operate very much on the front line.

Members of the Oireachtas will be aware that Nursing Homes Ireland has outlined annually a request that the Government should lead in establishing a forum on long-term care. That call has gone unheeded for almost a decade but today we reiterate that call. We wish to move forward but Covid-19 now lives among us. We are actively engaged with the Minister, Deputy Harris, his officials and colleagues in the HSE and the Health Protection Surveillance Centre, HPSC, in presenting measures that can ease visitor restrictions in our nursing homes. Clear policy is required and there is a requirement to balance delicately health, safety and risk to life against the mental well-being and happiness of residents. Social connection for nursing home residents is critical.

Lessons can be learned from closer engagement brought upon us by Covid-19. There is now a requirement for a better and more integrated working relationship between the State and

the entire nursing home sector. The core focus must be on meeting the complex health and social care needs of nursing home residents. As a society, we will be stronger working together.

Mr. Mervyn Taylor: I thank the committee for this opportunity to appear before it. The mission of Sage Advocacy is to promote, protect and defend the rights and dignity of vulnerable adults, older people and healthcare patients. We support and advocate for people independently of family, service provider or systems interests. We have made a detailed submission to the committee, so in these opening remarks I want to focus on where we go from here. We see little value in shroud waving and comparing deaths in one nursing home with another. As Mother Jones famously stated, "Pray for the dead and fight like hell for the living."

I will first give some sense of what it has been like from the perspectives of residents, relatives and staff. "You have no idea how awful it is – it's horrific." These were the words of a member of staff in a nursing home that experienced a serious outbreak and many deaths. The impact of an outbreak has been frightening for many residents, and for those with dementia, the arrival of people in full PPE was terrifying. Serious shortages of staff meant that there was little, if any, time to provide support to residents in facilities where many died. For families with relatives who were extremely ill or dying, the inability to visit or even to talk to their loved one by phone was a source of considerable distress and frustration.

Approximately 20% of older people need some form of support and care, of which less than 5% will live in a nursing home at any one time. Nursing home care is not long-term care. The average length of stay is just over two years. In 2016, Sage Advocacy, along with other NGOs, organised a forum on long-term care for older people. The unanimity of opinion at that forum was summed up in a question. Why, despite decades of policy reports and recommendations to Government, is there still a systemic bias towards care in congregated settings and no formal legislative basis for support and care in the community? The report of the forum spoke of the need to develop a vision for long-term support and care which is as compelling as that of the hospice movement at its best.

At the core of this issue is the fragmented nature of social care for older people. This is not just about what did or did not happen in March and April. Home support services, such as they are, are not provided on a statutory basis or regulated and have no clear vision, other than the level of home care packages that can be provided in any one year.

Care in nursing homes is provided on a statutory basis and is regulated, but has an overly complex and ultimately dangerous architecture. The National Treatment Purchase Fund, NTPF, buys care from private providers without proper consideration of the range of needs. The HSE administers the scheme but - this is critical - the contract is between the older person and the nursing home. HIQA sets the standards, but has no role in setting the price, and inspects, but has no powers to investigate complaints. Crucially, as Sage Advocacy's February report on medical care in nursing homes pointed out, there is no clear framework for the provision of medical care to the most vulnerable of our older people, nor are there ratios set for the level of suitably skilled nursing staff.

Over recent decades the State's approach to the residential care of older adults has been one of retreat in favour of private providers, with the remaining public facilities providing care mainly to the more frail with complex care needs, sometimes in famine era buildings. Elements within the HSE, working with NGOs, put forward proposals for a change to a teaghleach or smaller-scale household model, but they were not supported. The State, having outsourced the service, practised social distancing while the public, notwithstanding the good service provided

by many facilities, is increasingly questioning the morality of private investment in human vulnerability. Simply stated, we are talking of vulnerable people in a vulnerable sector.

Our detailed recommendations are set out in our submission. The five I would highlight are: an integrated system of long-term support and care spanning all care situations with a single source of funding; the integration of private nursing homes into the wider framework of public health and social care; clear guidelines on the skills and level of nursing staff and medical care required in congregated care settings related to the needs of residents; a wider range of service and ownership models for homecare and care in congregated settings; and legislation for adult safeguarding and the protection of liberty in places of care and legislative recognition for independent advocacy.

The Covid-19 public health emergency has shown some of the great strengths of Irish society. It has also shown weaknesses. We have a two-tier healthcare system and a two-tier siloed approach to the long-term care and support of older people which is biased towards congregated settings. We owe it to ourselves, and to those who have sacrificed so much, to do better. Let us shed a tier and set about building Sláintecare, a single-tier national health service with an integrated system of social care focused on home and a much wider range of options between home and nursing homes. I thank the Chairman.

Chairman: I thank Mr. Taylor. I would now like to call on Deputy Louise O'Reilly, who is speaking for ten minutes.

Deputy Louise O'Reilly: I thank the witnesses for being here today and offer my sympathies to the families of those who have been bereaved and those resident or working in the nursing home sector.

I have some questions for Mr. Daly relating to his statement and correspondence we received today. It strikes me that the nursing home sector showed a degree of foresight and planning and tried to flag issues at a very early stage. The hundreds of pieces of correspondence we received at 9.30 a.m. today indicate that, as Mr. Daly said in his opening statement, a national strategy and response was required. The correspondence and letters from March show that Mr. Daly was begging for assistance and PPE and that, to use his words, he was pleading with the State to stop the aggressive recruitment of staff from the nursing home sector. In short, it appears that nursing homes were flooded with patients and starved of staff, and yet there was no plan. Does Mr. Daly have any idea why no plan was forthcoming, when all of the international experience would tell us that there was a need for one? We know now that more than half of the deaths that have occurred have occurred in the nursing home sector. Why was there no plan?

Mr. Tadhg Daly: That is a question for someone else. The point we have been continuously making is that given the vulnerability of the age profile and the complexity of care of older persons, there should have been a national plan. From where I sit, what I have seen is an overt focus on the acute hospital sector to the exclusion of community care in general. Clearly, the discharge of large numbers of patients from the acute hospitals was an attempt to ensure the hospitals were ready. We heard that a good deal in terms of ensuring the hospitals were prepared. In fact, the surge that was predicted or expected in the hospitals materialised in the nursing home sector.

Deputy Louise O'Reilly: To prepare the hospital sector, large numbers of patients were discharged but they were discharged to the nursing home sector with no plan.

Mr. Tadhg Daly: From a nursing home point of view, it is important to state that the nursing home sector is a part of a well-functioning health service. In peacetime - in normal times, as it were - there would be regular transfers of people from acute hospitals. Our concern was that there was no plan. In fact, the issue of testing was critical in hindsight. The fact that residents who had come from acute hospitals were not tested prior to admission to the nursing home was-----

Deputy Louise O'Reilly: At the time those responsible were preparing the acute hospitals, they were transferring large numbers of patients from those hospitals to the nursing home sector. These patients were to become residents but they were not tested. Was any protocol given to nursing homes? Were nursing homes instructed that these people had to isolate for 14 days? Did those discharging people check in advance that nursing homes had single room accommodation or were people simply discharged to create space?

Mr. Tadhg Daly: The policy was evolving from public health on an ongoing basis, to be fair to public health, but clearly they were categorised as low risk in most cases. On the basis of the correspondence that I have seen from the acute hospitals, nursing homes would have taken those precautions in terms of isolation, where possible.

Deputy Louise O'Reilly: Nursing homes were not instructed to - that is my point.

Mr. Tadhg Daly: No. The current guidance says that a person coming from an acute hospital should be in isolation for a period of 14 days. That was not public health policy at the time, but it would have been practised in most nursing homes. This was compounded by the fact that if nursing homes had large numbers of asymptomatic residents, then we could have staff members caring for residents who subsequently tested positive. These staff members would also have been caring for other residents within a particular nursing home.

Deputy Louise O'Reilly: I am looking at correspondence sent by Mr. Daly on 10 March. He requested that all discharges would undergo a full risk assessment, a full medical assessment and be tested for Covid-19. I have been told by the Minister for Health as well that the protocol dictates that a patient discharged must have two negative tests prior to transfer. That did not happen in March. Am I right?

Mr. Tadhg Daly: No, it did not happen.

Deputy Louise O'Reilly: At the same time, staff were being aggressively recruited, to use the term Mr. Daly used. He called on the HSE to "desist from targeting the recruitment of staff from the private nursing home sector". These staff were being recruited by the HSE to go to the acute hospital sector at the same time as large numbers of patients were being transferred out. Is that right?

Mr. Tadhg Daly: Yes.

Deputy Louise O'Reilly: Nursing homes were losing staff at the same time as they were being asked to take on additional patients.

Mr. Tadhg Daly: We were.

Deputy Louise O'Reilly: None of these patients was tested. The medical assessment and risk assessment that nursing homes had looked for were not taking place in March.

Mr. Tadhg Daly: Some risk assessment was done but the testing was not done in line with

what we would have felt. In recent times we have seen the European Centre for Disease Prevention and Control state that a more rigorous programme of testing would have been appropriate.

Deputy Louise O'Reilly: I am looking at correspondence from Mr. Daly. Chairman, I want to point out again, on the record, that we received a huge volume of correspondence at 9.30 this morning. It is not helpful. It is more helpful for us in doing our work if we get it in good time. I am looking at correspondence from Mr. Daly dated 17 March sent to the Department. Mr. Daly stated:

> We require a commitment to constant two-way dialogue as we strive to protect the nation. In such regard I am following up again with regard to critical issues.

At the time we were looking at what was happening internationally. We could see what was happening in Italy and other countries where the surge was happening not only in the hospitals but in the nursing home sector as well. We knew that there was an acute issue in the nursing home sector. Yet, Mr. Daly was writing and requesting that there would be a constant two-way dialogue.

Is it fair to say he was right but was not getting much back in response? That is what seems to be in the correspondence: a lot of letters from Mr. Daly but not a huge amount by way of detailed correspondence-----

Mr. Tadhg Daly: Our first communication to the Department was in February. As to what we suggested at that time, I had come across some evidence from my colleagues in Scotland that we should replicate some of the advice and guidance there. That took some time to take hold. It is fair to say we had a good engagement with officials, but clearly we were also exasperated by the fact that we had not met the Minister at that stage. The meeting was, I think, at the end of March.

Deputy Louise O'Reilly: The first meeting was at the end of March, but how many times had Mr. Daly requested that meeting? We know that Nursing Homes Ireland issued a press release on 25 March, and we know from the correspondence that Mr. Daly made a large number of requests, but that meeting did not happen until the end of March.

Mr. Tadhg Daly: Yes, 30 March, but it is fair to say there has been very good engagement from the Minister, Deputy Harris, and officials since then.

Deputy Louise O'Reilly: That is fair enough.

Regarding the number of discharges made at the very beginning, is it Mr. Daly's opinion that it is possible that in some instances the virus may have come into nursing homes via those discharges because of the lack of risk assessment, the lack of medical assessment and the failure to test prior to transfer?

Mr. Tadhg Daly: I am not a public health expert or a virologist-----

Deputy Louise O'Reilly: I am only asking for Mr. Daly's opinion.

Mr. Tadhg Daly: -----but clearly the virus was very easily transmissible and, given what we know now about the levels of community transmission probably as early as February, yes, I would say that was a contributory factor.

Deputy Louise O'Reilly: Mr. Daly says in his submission to us:

Key State organisations left the nursing home sector and its residents isolated in those early days. The dismay will live forever with us.

I will come to Mr. Taylor as well on this, but could Mr. Daly briefly describe the impact of having to deal in this environment not just with the deaths that happen but also with caring for those patients? I refer to the impact that this has had on the residents and the staff and the fact that so many opportunities were missed. The staff and the residents were on the front line without as much as the comfort of their families, who were waiting outside.

Mr. Tadhg Daly: For the period of early March it was very distressing. I was getting calls from members and dealing with staff and with families. As I said in my statement, our first priority should be the residents because they have had a difficult period with no visitors. They have also lost friends and what they see as their family. It was therefore very difficult and we were exasperated by the lack of engagement, as we saw it at that time.

Deputy Louise O'Reilly: I like the Mother Jones quote to which Mr. Taylor referred, "Pray for the dead and fight like hell for the living." It is very important. He described the impact on the residents and the staff and the relatives of the staff: "You have no idea how awful it is - it's horrific." As to what was happening at the time, what feedback was Sage Advocacy getting from residents and their families, specifically relating to that period when, as Mr. Daly has described, nursing homes were being flooded with patients but starved of staff at the same time?

Mr. Mervyn Taylor: Sage Advocacy is an external organisation. It works with individuals and families, sometimes where a person lacks capacity, or their representatives. We do not have an operational role in the nursing homes. The Deputy will appreciate that because of the restrictions, it was very difficult to get contact. We did nevertheless have a lot of contact with some relatives in some cases but also with staff. In many cases we were acting almost like a sounding board for some people who are under an awful lot of pressure in the nursing homes. One of the key issues was that there is a belief that the hospitals were suddenly emptied out all into nursing homes. I would like to see the data on the transfers from the acute hospitals to the nursing homes because I think they are mixed. That is my very strong impression. I know there were some nursing homes that took in people and other nursing homes that closed down, restricted visiting and said they would not take anybody from acute hospitals-----

Deputy Louise O'Reilly: As is their right.

Mr. Mervyn Taylor: -----as is their right, one might argue.

Chairman: I thank Mr. Taylor. I am sorry to cut across him but we are quite curtailed by time because we cannot be here for more than two hours at a time.

Deputy Fergus O'Dowd: I welcome Mr. Daly, who is here on behalf of Nursing Homes Ireland, and Sage Advocacy. I pay tribute to all those who work in nursing homes, who give so willingly and so well of their time, their effort and their personal commitment.

Chairman: I thank Mr. Taylor and Deputy Shanahan. The sad fact that so many people have died in nursing homes is a tragedy for all of us. We must find not only accountability, but also the facts. Is it true that Mr. Daly first met the HSE's CEO in mid-February?

Mr. Tadhg Daly: We met on 19 February, but there-----

Deputy Fergus O'Dowd: That is okay. I just-----

Mr. Tadhg Daly: -----was no engagement on Covid-----

Deputy Fergus O'Dowd: Nursing Home Ireland's engagement with the Department began in late February. Is that correct?

Mr. Tadhg Daly: We wrote to the Department on 28 February.

Deputy Fergus O'Dowd: There are 400 items of correspondence between Nursing Homes Ireland and the Department of Health. Is that correct?

Mr. Tadhg Daly: I did not realise the number was so vast.

Deputy Fergus O'Dowd: It is. On 17 March, did Mr. Daly thank the Department of Health for regular and ongoing communications in the current unprecedented environment? Did Nursing Homes Ireland assure the Department of its support and state that they would work together? On 18 March, Nursing Homes Ireland wrote to the Department and thanked officials for their continued collaboration, stating that together they would have the commitment to ensure the care of 25,000 residents in private and voluntary nursing homes was addressed. Nursing Homes Ireland also wrote that it appreciated the round-the-clock engagement and availability in that regard.

Mr. Tadhg Daly: Yes.

Deputy Fergus O'Dowd: On 19 March, Nursing Homes Ireland had a conference call with the Minister. On 20 March, it had a conference call with the Department of Health. On 24 March, Nursing Homes Ireland was looking for financial assistance. On 26 March, the Minister confirmed that to it and, on 29 March, there was a meeting. On 4 April, the temporary financial assistance scheme was launched. Correspondence shows that no one from NPHET asked Nursing Homes Ireland not to tell families where the cases or clusters were. Are all of these facts correct?

Mr. Tadhg Daly: No, they are not. The Deputy mentioned a number of items. We would have ongoing engagement with officials throughout the year. There are 25,000 people residing in our members' nursing homes, so we view it as an important role for the organisation to engage with officials throughout the year.

Deputy Fergus O'Dowd: Of course.

Mr. Tadhg Daly: My approach is to work collaboratively with people.

Deputy Fergus O'Dowd: Okay. Chairman, I-----

Mr. Tadhg Daly: Regarding dates, the Deputy mentioned a conference call on 19 March with the Minister, but the first meeting with the Minister was on 30 March.

Deputy Fergus O'Dowd: The conference call I talked about was on 19 March. Did a conference call take place?

Mr. Tadhg Daly: With the Minister, no.

Deputy Fergus O'Dowd: My information is that it did.

Mr. Tadhg Daly: No. Our first-----

Deputy Fergus O'Dowd: The main point I want to make to Mr. Daly-----

Chairman: In fairness, if the Deputy asks Mr. Daly a question, he has to be allowed to answer.

Deputy Fergus O'Dowd: Of course.

Mr. Tadhg Daly: The first meeting with the Minister was on Monday, 30 March.

Chairman: Thank you.

Deputy Fergus O'Dowd: So Mr. Daly is saying that this conference call did not take place. Fair enough.

Mr. Tadhg Daly: A conference call may have happened, but we did not have a conference call with the Minister. I would have to check my-----

Deputy Fergus O'Dowd: I believe Nursing Homes Ireland did have a conference call, but my main point is that Mr. Daly's statement, "Key State organisations left the nursing home sector and its residents isolated in those early days", is patently and obviously untrue.

My second point relates to Nursing Homes Ireland's directors. It has 12, all of whom are business people. I looked at their accounts and there are wealthy companies represented among those directors, who are very fine people in every respect. Some €23.3 million was the profit of eight of those directors in the last accounting year. I cannot get the accounts of the other directors because they are part of other companies. Is it fair to say that the nursing homes sector is a privately funded organisation and has a great deal of money to pay for, for example, PPE, testing, staff accommodation and extra staff in this crisis?

Mr. Tadhg Daly: Yes. The sector takes its responsibilities seriously. The issue with PPE is well rehearsed. The normal supply of PPE was unavailable to the sector. Most of the PPE being garnered for the country was being directed towards the HSE and the HSE alone. It was not an issue of finances, but of accessibility.

Deputy Fergus O'Dowd: But Mr. Daly's-----

Mr. Tadhg Daly: Likewise, testing was being done nationally by the HSE.

Deputy Fergus O'Dowd: What funds did nursing homes spend in addition to normal funding to get PPE and pay for testing, extra staff and staff accommodation?

Mr. Tadhg Daly: It runs into millions of euro. I can get those figures for the committee.

Deputy Fergus O'Dowd: Please. I thank Mr. Daly.

Mr. Tadhg Daly: I had a call with the Minister yesterday. Under the temporary financial assistance scheme to date, €8.7 million has been drawn down. That spending was probably incurred in April.

Deputy Fergus O'Dowd: That was Government money refunded to nursing homes.

Mr. Tadhg Daly: No. It is State money to support our fellow citizens.

Deputy Fergus O'Dowd: Yes, but my point is-----

Mr. Tadhg Daly: It is a support that-----

Deputy Fergus O'Dowd: -----that Mr. Daly asserted that nursing homes were not supported. I am saying that the facts point to the opposite.

Mr. Tadhg Daly: If I could, Chairman, please. The State scheme was announced on 4 April. The first money was only drawn down last week.

Deputy Fergus O'Dowd: But who paid? Nursing homes were recompensed.

Mr. Tadhg Daly: No.

Deputy Fergus O'Dowd: I am not saying it is a bad thing. It got the money back that it spent. To say that its members were left isolated is not a fact.

Mr. Daly's organisation is the one that all the private nursing homes come back to. In the last report published on his organisation's nursing homes, how many of the 581 homes were fully compliant fully with HIQA regulations?

Mr. Tadhg Daly: I do not have those figures.

Deputy Fergus O'Dowd: I have.

Mr. Tadhg Daly: There is another important qualification there. These are public, private, and voluntary nursing homes, which will also include-----

Deputy Fergus O'Dowd: I am aware of that. The fact is that only 123 of the 581 nursing homes - public, private and not-for-profit - were fully compliant. Of those, there was a failure rate of 32% under governance and management, there was a residents' rights failure rate of 23%, for risk management it was 22%, and for infection control it was 18%. When that report was published, what was Mr. Daly's response?

Mr. Tadhg Daly: I said two things. One was that the HIQA report for 2018 highlighted the high levels of compliance. HIQA is an independent body and it did highlight in its opening statement the high levels of compliance in the sector. The other thing I said was that the issue about compliance and inspection was what happens after the inspection. The inspection may highlight an issue where there is what could be seen as an area for improvement. All of the nursing homes, public private and voluntary, would then receive an action plan. The question then is to follow up on the action plan. If HIQA was unhappy, it could take corrective action.

Deputy Fergus O'Dowd: Mr. Daly is right that the report highlighted that the compliance rates were very high, but what did the report actually say? It said that the compliance rate had gone down from 27% in 2017 to 23%. Mr. Daly represents an organisation whose members in the last published data have reduced compliance with infection control, and reduced compliance under all of these points-----

Mr. Tadhg Daly: That includes the HSE homes.

Deputy Fergus O'Dowd: It includes everybody. I am not saying it does not.

Mr. Tadhg Daly: That is an important distinction.

Deputy Fergus O'Dowd: Mr. Daly is making the point that the State, the HSE, the Minister or the Department did not assist his members. I believe that they did and I also believe that

his organisation could have done much more for its members and it did not do that. The key point which we all want to ensure from here on is that Mr. Daly's organisation's members are compliant in every respect. There is only one nursing home-----

Chairman: I remind the Deputy that our terms of reference are the State's response to Covid-19.

Deputy Fergus O'Dowd: If I can make this point, Chairman, and I am sorry if you do not like me saying this, but I am going to say-----

Chairman: I have no problem but I am required to keep to the terms of reference and I have pointed this out to members previously.

Deputy Fergus O'Dowd: -----this louder, and as loud as I can. It is exceptionally clear and it is something that I have said all of my life: the care of older people in nursing homes is not acceptable. The nursing home private sector is not compliant in the main, right across the sector. It comprises very wealthy companies which complain that the taxpayer is not doing enough for them. I wish to state exceptionally clearly that we need a total change in the way we look at the care of older people. We need the home care packages mentioned by Mr.Taylor, in the smaller units referred to, and to look after people with dementia. We need to stop this game of blaming everybody and to accept the fact that we are not doing enough and have never done enough. Unless things change now, we are going to go down the same road.

I respect Mr. Daly, whom I have met a number of times, but I want to make it exceptionally clear that it is not good enough that this system would continue, and the tragedies that have unfolded in many homes because of the deaths of loved ones. We have seen it every day on the television when it comes on about those poor people who have passed away. I knew many of them and I am saddened, and I know that the families are saddened by this. It is a scandal that this happened.

I point to a report in *The Guardian* about a British Parliament hearing. There is not one death certificate in all of Hong Kong for a person in a nursing home who had Covid-19 because not one of them there died. I just get so angry at this.

We need to move forward together but we must establish the facts. The truth is the truth and the truth will out. We have to change radically everything to do with older people.

Chairman: Mr. Daly indicated he wished to reply.

Mr. Tadhg Daly: Yes, on a few points, please. The nursing home sector is arguably the most highly regulated part of the health service. HIQA will be appearing before the committee in the afternoon. Not alone does HIQA have the authority but it also has the responsibility, if it sees standards that are not acceptable, to close a home. That responsibility rests with HIQA.

I have met many Members of this House over the last while. We hold an Oireachtas open day every year and we have met many Members at that. I spent eight or ten weeks last year coming in to meet Members one-to-one on the issue of a continuum of care. We need to develop a suite of care services for the older population and Nursing Homes Ireland members are doing it already in many cases and we will not be found wanting in our responsibilities.

Deputy Mary Butler: I thank our witnesses for giving up their time and for coming in today. This awful pandemic has borne down heaviest on older people, particularly on those in

nursing, residential and care homes. We have to be cognisant of the fact that 62% of all deaths that have happened so far have been in those settings and that 93% of all who have lost their lives so far are in the over 65 age bracket.

I have listened to the last speaker with interest and I want to bring the discussion back to the fact that there were failings over the last two months. We all realise that and it is important that we delve into it. It is also very important that we accept that four out of every five people in nursing homes who got Covid-19 recovered and I would like to thank the 40,000 staff in nursing, care and residential homes who have gone far beyond the call of duty.

I undertook a survey between 7 April and 8 April, in which I contacted 80 nursing homes in the south of the country. The results I got from them at that time bear out exactly what Mr. Daly said in his opening statement about the insufficient testing of residents and staff, a massive shortfall of PPE and an aggressive recruitment of nursing home staff. I want to point out that when I conducted that survey, at a time when I was being contacted by nursing homes all over Ireland as Fianna Fáil spokesperson for older people, 50% of the nursing homes that came back to me - and I got a 25% sample - had insufficient staff. That bears out what Mr. Daly said about staffing. On PPE, 30% of the nursing homes that came back to me had sufficient PPE. This was between 8 April and 9 April when we were entering the surge. However, 60% of the nursing homes that came back to me had no PPE and 10% had a three-day supply at that time. That testifies to the fact that nursing homes, whether they were public or private and whether they were care homes or facilities for people with additional needs, it made no difference. They did not have the staff during the Covid-19 pandemic and there was a shortage of PPE. I will stand over that assertion and I have all the emails to back it up.

Mr. Daly said that Nursing Homes Ireland sought detailed Covid-19 advice from the HSE in a letter on 28 February. I accept that it was 30 March before Nursing Homes Ireland met the Minister and his officials. After Nursing Homes Ireland requested dedicated guidance for residential care settings, when did it receive that advice?

Mr. Tadhg Daly: I will have to check the specific date but in the middle of March Nursing Homes Ireland and the HSE, through the national clinical programme for older persons, developed guidance specific to residential care settings but it took a number of weeks.

Deputy Mary Butler: Would it be fair to say that Nursing Homes Ireland was initially disappointed? From the initial request on 28 February to 30 March, would it be fair to say that for Mr. Daly, as chairperson of Nursing Homes Ireland, which represents approximately 485 nursing homes in the sector, it was disappointing that it took four weeks for officials to meet with Nursing Homes Ireland?

Mr. Tadhg Daly: It is important to put on the record that we were engaged quite regularly with officials in the Department. Many matters were being escalated and we were hearing that NPHET was discussing certain matters but we felt it was important that the voice of the nursing home sector and the frustration that was felt by our members was heard at an official level. We were disappointed that it took almost a month before we got to meet with the Minister. I appreciate that he was busy in many other areas but I would highlight that given the vulnerability of older people, we felt this issue should have been higher on the agenda.

Deputy Mary Butler: Does Mr. Daly believe that NPHET realised the gravity and urgency of the situation facing nursing homes in the early stages? I know there were many calls, including from my colleague, Deputy Donnelly, for nursing homes to be represented on the NPHET

taskforce. Does Mr. Daly believe it realised the urgency at the initial stage because we had all seen the pictures from Italy and Spain where older people were left in nursing homes without care?

Mr. Tadhg Daly: No, I do not, unfortunately. There was NPHET itself, a vulnerable persons subgroup and a nursing homes group. As an organisation and a sector, we had no representation on any of those three committees. That, to me, was more than disappointing. It was unacceptable in my mind.

Deputy Mary Butler: I have another question on staffing issues during March and April. Mr. Daly mentioned in his opening statement that there was "aggressive recruitment of nursing home staff initially by the HSE". I have heard that from different nursing homes I spoke to. Can Mr. Daly expand on that? Was the recruitment above and beyond a general advertising campaign or did the HSE directly head hunt staff from nursing homes?

Mr. Tadhg Daly: Yes. We had written to the director general of the HSE and to the Minister. There were three letters on that occasion, on 9 March, outlining our concerns around that issue. What happened was people were on panels in some cases. There was also, we would suggest, a targeting of people who were working in the sector. We would have made the point that denuded one element of the health service to support another element, which was counterproductive. We would have asked for a moratorium on recruitment. This happens on an ongoing basis and people transfer for whatever reason. However, in the teeth of the global pandemic, we felt it was appropriate to ask the HSE to do that. It did not agree to do that at the time but there has been some improvements in that respect over the past number of weeks.

Deputy Mary Butler: Now that we seem to have passed the peak, has the situation in regard to staffing in nursing homes improved? Are the nursing homes for whom Mr. Daly can speak preparing for a second surge?

Mr. Tadhg Daly: There are two things. Yes, the last number of weeks have been encouraging. Obviously, yesterday's announcement that there were no deaths was very encouraging for all of us, as a society. Things have definitely improved but we cannot afford to be complacent at all. I am aware there is some talk within NPHET and among others about a potential second wave. That is where the expert group the Minister has established is important because it will, hopefully, do what did not happen, maybe, back in February and March, and provide a roadmap for Ireland Inc. for public, private and voluntary nursing homes.

Deputy Mary Butler: Mr. Daly, in his opening statement, spoke about the National Treatment Purchase Fund, the authority responsible for the commissioning of nursing home care. We all understand how it works but Mr. Daly said it fell silent as homes incurred considerable and responsible costs to manage the pandemic. I accept the Minister came on board with a package. I also accept the fact that any expenses incurred in March were not allowed and it was only the expenses incurred after 1 April. It is only fair to be clear about this matter. Many nursing homes incurred a lot of expenses in March that they could not recoup. What did Mr. Daly mean when he said it "fell silent" as homes incurred considerable expenses?

Mr. Tadhg Daly: The Deputy highlighted two issues. It is fair to acknowledge that on 4 April that was announced. We were very disappointed it was not backdated to 1 March, as the Deputy said. There are two issues here. There is an element of that scheme which talks about outbreak assistance, so there is extra funding, which is very positive, for those that had an outbreak. We would argue as well that those who spent considerable moneys to keep a nurs-

ing home Covid-free, in some respects, are not being recognised by the fact that the additional funding, in part C of that particular scheme, is only for those who had an outbreak. We were disappointed with the level of engagement by the National Treatment Purchase Fund at a very early stage.

Deputy Mary Butler: I will wrap up my questions to Mr. Daly before moving on to question Mr. Taylor. We will never know how Covid got into nursing homes, hospitals, homes and communities. We can only surmise. During the first three months of the year more than 2,500 people entered nursing home care under the fair deal scheme. Every month 1,000 people transfer from acute hospitals into private and voluntary nursing homes. I accept that Mr. Daly may be unable to answer my next questions. How many people transferred in March after restrictions were imposed? How many of these patients from the acute sector were tested before going into the nursing homes? The crux of the issue is that these patients may have had Covid without realising it and may have, involuntarily, brought it into the nursing homes.

Mr. Tadhg Daly: I have some figures, but I do not have them in front of me, in terms of the number of transfers. The other question is more difficult to answer, in terms of the number of people who were tested.

Deputy Mary Butler: Yes.

Mr. Tadhg Daly: To my knowledge, from dealing with members, very few were tested. If they were asymptomatic, it was not deemed necessary to take a test.

Deputy Mary Butler: I have a question for Mr. Taylor. I thank him for all the work he does advocating for older people. I have met him previously. Was he contacted by very many families, sons and daughters of people in nursing homes who are very concerned about their parents at this time? Unfortunately they have not been in a position to visit. I know nursing homes have done an awful lot of good work with FaceTime, phones and all that. Could Mr. Taylor explain the level of contact he has had from people who are worried?

Mr. Mervyn Taylor: It was considerable. I said on "Drive Time" before that one of my abiding memories of this crisis has been a sense of phones not being answered when a place went into crisis. It is important to say that in Deputy Butler's own area, in the south east, they got away relatively lightly. It was the north-east quadrant from Dublin across to Mullingar and up to Cavan that was very badly hit. In that area, there were nights one would put one's head in one's hands. There were people who were despairing. They could not get through because the staffing situation was so difficult. The nursing homes were really stuck for staff. Some places were down to absolute skeleton staff until the cavalry came. The fact of the matter is that they needed support. People were literally worn out. I think of one woman in particular who had a dying husband and a son who had lived in the same nursing home and had gone into a hospital and died. People were literally worn out and we were almost trying to pick up the phone calls for them because they were running out of energy. That is one of the key things. It sounds like it has nothing to do with clinical care but one of the most important things was the lack of ability to answer the phones. To think of a nursing home with 50 people in it, that is at least 50 families all trying to get through, and there is nobody able to answer the phone. All sorts of stories were magnified; that is one of the problems. It is about trying to separate fact from fiction in these situations. We heard of places where there were all sorts of allegations about numbers of deaths which were subsequently not true.

Chairman: I would ask Deputies to, please, leave time for answers. If we continually go

over time, the speakers at the end will not get to speak. I call Deputy Ossian Smyth of the Green Party.

Deputy Ossian Smyth: I thank Mr. Daly and Mr. Taylor for coming in. I want to ask Mr. Daly about the distribution of PPE. I understand it was chaotic for a while and nobody was getting anything. Now I believe we are at a stage where some people are over-supplied and some are under-supplied. That is the experience of my colleague, Councillor Róisín Garvey in Clare, who tells me she went around with a supply of PPE and found that some nursing homes did not want it and some were desperate. Is that Mr. Daly's experience with his members?

Mr. Tadhg Daly: Yes. In the early stages, as the Deputy said, it was quite chaotic. Everybody was scrambling to ensure that they had enough supply. We made a suggestion in the early stage that every nursing home should have a three-day supply in-house so they could deal with either a confirmed case or, more important, a suspected case. We also felt that among our members, if we had a three-day supply people could share, maybe, in a given location.

Deputy Ossian Smyth: Have the infection control rules that are apparently needed affected the operation of the nursing homes at the moment? We talk about congregated settings. Typically, people are sitting in sitting rooms, watching TV, sharing rooms on occasion or whatever. Nursing Homes Ireland has received guidance from the Department of Health on how they should operate from the infection control point of view. Does that mean that fewer people can fit in a nursing home? How is it affecting Nursing Homes Ireland members?

Mr. Tadhg Daly: That is the next question in terms of this expert group. It is looking at how we can plan for the next six to 18 months. Over the last while we have seen that people are practising cocooning, in effect. In the private and voluntary sector, the vast majority would be in single en-suite rooms. Unfortunately, as regards the social connectedness piece, people very often are staying in their rooms.

Deputy Ossian Smyth: Are there very few new entrants to the nursing homes? Is it the case that people are not being admitted any more?

Mr. Tadhg Daly: It is mixed, to be honest. In some homes where there has not been a Covid outbreak and where an acute hospital is still discharging and they have taken the appropriate steps in terms of risk and testing, it is appropriate that a person would be transferred. In those cases, a person would be isolated for 14 days.

Deputy Ossian Smyth: I think it is fair to say that many people, even before the pandemic, would have preferred to stay in their home than go to a nursing home. They might have had a fear but now that fear is much greater and it is among families as well. Government policy is to move more towards home care and having a statutory home care package and away from relying on the fair deal scheme alone. This combination of fewer people fitting in a nursing home because of infection control rooms, fewer people wanting to enter them and the State supporting more home care would seem to add up to much less demand for nursing home spaces. I do not know whether this is how Mr. Daly sees it. If this does happen, will it lead to nursing homes either closing or having higher fees to stay in a nursing home with fewer people in it?

Mr. Tadhg Daly: The Deputy has raised a couple of points. Clearly, what we need to develop as a society is a continuum of care for older people. We always get caught up in the silos of home care, acute care, and housing with supports. We need to develop a continuum of care. There is a legitimate question on what we term the future viability of some homes, in particular

smaller homes. We are very concerned about this with regard to maintaining service continuity. We have an ageing population and an increasing ageing demographic. It is also important to say the age profile of nursing homes is primarily over 80 and over 85.

Deputy Ossian Smyth: Mr. Taylor mentioned that the average length of stay in a nursing home is two years. I am sorry to ask this but does this equate to life expectancy?

Mr. Mervyn Taylor: In general terms, yes.

Deputy Ossian Smyth: If fewer people go to nursing homes and more home care is taking place, does Mr. Taylor expect that future nursing home stays will be shorter? Hospices have the shortest expected length of stay. Will future nursing home stays be shorter, for example, for one year? Will Mr. Taylor describe what fits into the gap between home care and nursing homes?

Mr. Mervyn Taylor: We need a continuum. Mr. Daly and I have been on the same platform regarding a continuum of care for a number of years. It is everything from home care, split housing and boarding out to supportive housing, mutual and housing co-operatives and housing with supports. There is a need for nursing home care but it is also how we try to envisage it for the future. We must bear in mind there is a wide range of nursing homes. I looked at the recent lists and 49% of nursing homes have fewer than 50 residents. This has its own issues. We want people to live in smaller more homely places but the fact is the trend is towards larger places. How do we get the balance right? It can only come with the continuum the Deputy is describing.

Deputy Duncan Smith: We need the documents from NPHET, the HSE and the Department which we requested.

Chairman: They have been requested and that request will be reiterated.

Deputy Duncan Smith: We will send an email later.

I thank Mr. Daly and Mr. Taylor for coming before the committee. I will direct my first question to Mr. Daly. It has been pretty clear that, in his words during media appearances yesterday evening and this morning and in his opening statement, he has been shifting responsibility to the HSE. Is there anything he would have done differently with regard to his organisation earlier this year? Is there anything he would look back on and say he should have done this or that?

Mr. Tadhg Daly: Let me be clear that I am not shifting responsibility. We take our responsibility very seriously. I am highlighting the facts, which are that there were gaps in terms of the supports. It is not about supports for the private, public or voluntary sector; it is about supports for older people. Many of the measures we took on infection control, sourcing personal protective equipment, isolation within nursing homes and nursing homes being prepared with contingency planning could be improved but that is for another day. At this point, nothing stands out, to be honest, with regard to whether we would do things differently.

Deputy Duncan Smith: Is Mr. Daly satisfied with the larger corporate members of Nursing Homes Ireland? I know it also has members from the voluntary sector and small and medium enterprises. Nursing Homes Ireland's large corporate members have considerable experience of dealing with the HSE through the National Treatment Purchase Fund. The individuals involved are self-starters who have a lot of contacts, although they may not necessarily be living or domiciled here. Is Mr. Daly satisfied with their efforts?

Mr. Tadhg Daly: The virus is indiscriminate. It does not pick a public home or a private home, a large home or a small home. The efforts of all of the sector, public, private and voluntary, have been to try to suppress the virus. At this point, I do not have any concern but ultimately that is a matter for HIQA as the independent inspectorate.

Deputy Duncan Smith: Yes, and HIQA will appear before the committee next. I agree the virus is indiscriminate but we are grappling with early figures that would indicate it more heavily affected the private than the HSE homes. We need to tease that out more.

Mr. Tadhg Daly: I do not think that stands up to scrutiny.

Deputy Duncan Smith: As a committee, we will be scrutinising that, but we are dealing with facts and data as we get them.

On the staff shortages, it is widely reported that the average pay in the sector is approximately €12 per hour for health assistants. Does Mr. Daly think this has had an impact on the staffing levels and the ability to attract staff? Nursing Homes Ireland has had its own recruitment campaign since 17 March, which would indicate this has not been successful. Mr. Daly said the HSE has been aggressive in its recruitment campaign but does he think the Nursing Homes Ireland structure in terms of pay for health staff has been a factor in this?

Mr. Tadhg Daly: Clearly, the sector is, as I said earlier, the most highly regulated, if taken from a standards point of view, but it is also regulated from a price point of view. The National Treatment Purchase Fund sets the fees and the fees, in turn, dictate the pay scales within the sector. We would love nothing better in the morning than to be on the same rates as the HSE but the State is not providing that level, despite the fact the fair deal is supposed to be a level playing field.

Deputy Duncan Smith: An awful lot of figures are being thrown around in regard to the industry and, as was said, everything from the voluntary right through to large corporates are involved. Given there has been an issue in terms of being prepared for this across the State, would Mr. Daly consider the setting up of a pandemic or crisis fund within the nursing homes sector, which he represents? I am referring to a sort of sinking fund into the future for those that can pay, and they would pay in so there would be a fund that could be drawn upon if there is a second or further wave of this crisis. This would mean that for those few weeks that were spent with the HSE, getting responses and not getting responses, it would not have to be such an issue because there would be that reserve, which would come from the nursing homes' own resources.

Mr. Tadhg Daly: Possibly, but the issue was not finance at all. The issue was PPE generally, as it just was not available. Members were sourcing it, they were buying it overseas and buying it locally. Finance was not the issue - let us be absolutely clear on that. The issue was that it was a scarce commodity in an international market and the source of supply had dried up, not just for nursing homes but for all elements of the health service.

Deputy Duncan Smith: Money must be an issue because there is now a €72 million support package and the nursing homes have drawn down €8.7 million. Money is an issue.

Mr. Tadhg Daly: The point I am making is that it was not an issue in terms of our preparedness because people had spent, and I can get some of the figures for the Deputy in terms of what members had spent in March. The point Deputy Butler made was that the scheme is from 1 April whereas, in fact, members would have spent quite considerable sums in March which are

potentially not recoupable under the temporary financial assistance scheme.

Deputy Duncan Smith: I thank Mr. Daly.

Deputy Róisín Shortall: I thank both witnesses for their presentations. Any examination of what has happened in the nursing homes must be viewed in a policy context. There is no doubt bereaved families and Irish society generally are paying a very high price for what I would regard as a confluence of policy failures in the care of older people which have been graphically and tragically exposed over recent months. It is important that we bear in mind what those policy failures are. The first is the two-tier health service. The second is in regard to social care being treated as the poor relation of the health service. The third is the fact that nursing homes are regarded as a good investment opportunity, as opposed to a central element of the healthcare service, and that the incentivisation of investment in nursing homes has led to the unrelenting privatisation of the sector. The fourth is the fact that older people themselves are incentivised to access nursing home care because of the lack of statutory entitlement to home care, in spite of the fact that home care is what older people want and is in the best interests of their health needs. The fifth area that has been absolutely exposed is the light-touch regulation of this entire sector.

I recognise that Deputy O'Dowd had to leave. I would make the point to Deputy O'Dowd and other Government Deputies that those points have to be made loudly as well and must be heard clearly. We are wasting our time examining this whole area unless we recognise that policy context and those policy failures.

I have a number of questions for Mr. Daly. The first relates to the staff ratios in operation across the sector. What ratios apply in respect of nurses to residents and healthcare assistants to residents, and what is the policy in respect of casual staff?

Mr. Tadhg Daly: There are two things. One is that no ratios are set by the regulator-----

Deputy Róisín Shortall: I asked what Mr. Daly operates in his sector.

Mr. Tadhg Daly: We do not operate. We are not the regulator. Ultimately, members-----

Deputy Róisín Shortall: No, I asked about what Mr. Daly and his members operate.

Mr. Tadhg Daly: It depends.

Deputy Róisín Shortall: What ratios does Mr. Daly work to?

Mr. Tadhg Daly: As per the regulations, it depends on the layout of the building and the dependency levels of residents. It varies across the sector depending on the complexity of care required and the layout.

Deputy Róisín Shortall: Does Mr. Daly have recommended ratios for his members?

Mr. Tadhg Daly: We did. In 2009, when HIQA began, we submitted a paper at the time calling for ratios. That was not taken on board.

Deputy Róisín Shortall: I accept the point Mr. Daly makes on different situations, but he must have an overall ratio in respect of nurses to residents.

Mr. Tadhg Daly: No, what one has in each nursing home is what one would call a person in charge, that is, a director of nursing who would then make that call in terms of both the numbers

and skill set. The skill set is important as well. It is about numbers and skill mix in terms of nurses versus senior clinicians versus care assistants. It varies right across the sector.

Deputy Róisín Shortall: So Mr. Daly does not recommend any particular ratios as regards nurses.

Mr. Tadhg Daly: The regulator does not permit-----

Deputy Róisín Shortall: No. I asked if Mr. Daly does.

Mr. Tadhg Daly: No, the regulator does not permit us to do that. We would love to have them. If we had ratios in the morning, then we could go back to our friends in the NTPF and say it is a cost associated with it. We would argue, in fact, that the greyness around it at times is being used against the sector.

Deputy Róisín Shortall: Presumably, Mr. Daly can set his own policies for his sector. I find it hard to believe that he would be precluded from having safe ratios as regards nurses to residents.

I will list the other questions I have for him and perhaps he could answer them together. What is the policy in Mr. Daly's sector on staff moving between nursing homes? How much of the €72 million support fund has been drawn down to date, and what have his members been using that support money for in the main?

I refer to the transfer of patients from acute hospitals, which we know should have happened anyway. We should not have large numbers of older people in acute hospitals when they do not need to be there. Mr. Daly identified this as the source of the virus in nursing homes. The CMO disputes that. Does Mr. Daly have data to support his contention?

Mr. Tadhg Daly: The Deputy raised three points. One was on the policy of the sector on moving staff between centres. A number of our nursing homes, particularly in rural Ireland, would have a steady state of staff. In urban areas, more so, there would be some movement of staff between centres. However, there would also be movement of physiotherapists and speech and language therapists, and of other professionals coming in and out of nursing homes. There is no absolute policy one way or the other.

On the €72 million, as of last Friday, €8.7 million has been drawn down and the majority of that has been spent on PPE and staffing.

On the issue of the transfer of residents, I am not saying it was the sole determinant. However, I am saying it was a significant contributory factor because, as we know now, there was much greater community transmission of the virus.

Deputy Róisín Shortall: What is Mr. Daly's data to support that contention?

Mr. Tadhg Daly: What we saw was that the residents were not tested and-----

Deputy Róisín Shortall: That is not data.

Mr. Tadhg Daly: -----40% were asymptomatic, so following the mass testing there was a significant increase in the number of positive cases in nursing homes.

Deputy Róisín Shortall: It is a substantial claim to make and Mr. Daly's members would know the point at which his patients or residents were transferred to hospitals.

Chairman: Deputy Shortall, I apologise, I must stop you.

Deputy Róisín Shortall: What data does Mr. Daly have to support what he is claiming?

Mr. Tadhg Daly: We have the number of transfers from hospitals without testing, and we now know 40% of people were asymptomatic.

Chairman: Thank you very much, Mr. Daly.

Deputy Róisín Shortall: They are not the same people-----

Mr. Tadhg Daly: Yes, they are.

Chairman: Thank you, Deputy Shortall.

Deputy Róisín Shortall: Some 40% of people-----

Mr. Tadhg Daly: I am not saying that, I am saying-----

Chairman: I am afraid cannot give Deputy Shortall time from somebody else.

Mr. Tadhg Daly: I am happy to come back to the Deputy on the specifics.

Chairman: By correspondence, if necessary. Thank you, it is appreciated.

I call Deputy Barry.

Deputy Mick Barry: I will start with a brief question for Mr. Taylor, requiring a brief reply. In his statement referring to outbreaks in nursing homes, he said that staff shortages in some cases led to risk-taking with staff in some facilities having to continue to work while ill and in other cases encouraging people back from isolation. Can Mr. Taylor stand over that statement or back it up?

Mr. Mervyn Taylor: What we report is what we hear. These were statements made to us by staff who were isolating and who were feeling under great pressure to come back. One has to bear in mind that there were extreme shortages-----

Deputy Mick Barry: I understand that. They were referred to in the passage I quoted.

Mr. Mervyn Taylor: Hard decisions had to be made.

Deputy Mick Barry: Mr. Taylor is saying that was direct evidence given to him by staff.

My next question, also for a brief reply, is for Mr. Daly. I will read from the statement again: "Staff shortages in some cases led to risk taking with staff in some facilities having to continue to work while ill and in other cases encouraging people back from isolation." Does Mr. Daly think that is correct and could he comment briefly on it?

Mr. Tadhg Daly: I do not believe that it is widespread for several reasons. First, all nursing homes follow the public health advice. Second, in the case of an outbreak, public health are in the building every day. Third, there was a change in policy around the term "essential workers" on foot of some recommendations from the deputy chief medical officer.

Deputy Mick Barry: It was not widespread but it certainly happened.

Mr. Tadhg Daly: I do not believe so.

Deputy Mick Barry: How many people work in the private nursing home sector? Roughly speaking, how many of those would be covered by a sick pay scheme?

Mr. Tadhg Daly: About 30,000 people work directly in the sector. As to the number covered by a scheme, I would have to check for the Deputy. Some would be covered and some would not be covered.

Deputy Mick Barry: Would perhaps 25,000 be covered and 5,000 not be covered or would the reverse be the case perhaps? I am not looking for an exact figure from Mr. Daly but a rough idea.

Mr. Tadhg Daly: I would have to do a survey of our members because each member is independent and members run their nursing homes independently of NHI.

Deputy Mick Barry: Does Mr. Daly not even have a rough idea of the number of workers who may be covered by a sick pay scheme?

Mr. Tadhg Daly: I do not, to be honest, but I can get the figure for the Deputy.

Deputy Mick Barry: I find it slightly incredible that Mr. Daly is not aware of even the rough figure. This is a key issue because if a person working in the private nursing home sector wakes up in the morning with a sore throat or a temperature, there may be something going on. If that person has take-home wages of less than €350 per week, there is an economic incentive or an economic pressure on him or her to go into work and take a risk. Does Mr. Daly agree with that analysis?

Mr. Tadhg Daly: No, because I place my trust in the staff of the sector, who care deeply for the residents they care for. They would not take that risk because we have had a heightened risk of Covid in the past number of months. I would not accept that at all.

Deputy Mick Barry: To be clear, I too place my trust in the staff who have been on the front line and have done heroic work. However, it is not credible to argue that if workers were to suffer losses in pay, in some cases significant losses, this would not be a pressure point, at the very least, to take a risk in this situation. Does Mr. Daly not even accept that it is a pressure point?

Mr. Tadhg Daly: It is a big risk. I would say that nobody is prepared to take it given what we know now about the issue of Covid.

Deputy Mick Barry: I lost 20 seconds at the start of my contribution as a result of the carry-over from the previous slot. I will conclude, however, by referring to the passionate speech made by Deputy O'Dowd in which he referred to the private nursing home sector putting profit before health and safety. The Deputy has since left the meeting but I point out to the remaining Government members that the reason for that is that we have gone from having a nursing home sector that was majority publicly owned 35 years ago to one which is overwhelmingly privately owned. The reason for that change was that a policy of privatisation backed up by massive tax breaks was pursued by Governments led by both Fianna Fáil and Fine Gael. There was, therefore, more than a touch of hypocrisy in the bit of outrage we saw earlier.

Chairman: I call Deputy Shanahan from the Regional Group of Independents.

Deputy Matt Shanahan: I thank the witnesses for attending today. On the temporary financial assistance payment, I understand the capitation payment is based on the number of public residents as opposed to private ones. Is that correct?

Mr. Tadhg Daly: That was changed last week following our engagement with the Minister. It is a positive move.

Deputy Matt Shanahan: I would much prefer to concentrate on where we are going as opposed to where we have been. On the facilitation of isolation protocols in nursing homes now, is there an ability for the nursing home sector to be recompensed for that?

Mr. Tadhg Daly: "No" is the short answer. Unfortunately, at the moment, if one does an isolation area and one does not take in new residents, it is a disincentive.

Deputy Matt Shanahan: On Deputy O'Dowd's comments earlier, I met some of NHI's members in March. As somebody who has been involved in trying to help the HSE to source PPE through contacts that I have, I am well aware of the cost of PPE and of what was being paid by some of NHI's members and the difficulties getting it. I do not think Deputy O'Dowd was quite clear in highlighting the fact that NHI members are not being paid for those purchases made back in early March. That needs to be put on the record because at the moment the record reflects that is not the case when, in fact, NHI members have not been paid.

I wish to ask Mr. Daly about recruitment. Would Mr. Daly say it was a difficulty for the sector that the HSE was actively targeting healthcare personnel for recruitment, and that they were coming from some of the homes of NHI members?

Mr. Tadhg Daly: Yes, that was very challenging in the early period because losing any staff member even in ordinary times is challenging, particularly nursing staff. Nursing staff are a scarce commodity worldwide, so that put extra pressure on the sector. We asked for a moratorium on recruitment for the period of the pandemic at least.

Deputy Matt Shanahan: I questioned the Minister on all of those subjects in the Dáil on 23 April, so I am glad that there has been some movement.

On future testing regimes of staff and patients, the ECDC is calling for weekly tests. Is Mr. Daly engaging with the Department at the moment on how this might be achieved?

Mr. Tadhg Daly: Yes, we have had twice weekly meetings with the Minister, which is very positive. That needs to be acknowledged, and we have met with officials in the Department. We have produced a paper, which we submitted last week. I understand that NPHET is meeting this Thursday. We concur with the ECDC's recommendation.

Deputy Matt Shanahan: Some private hospitals are implementing their own PCR testing and they can turn around tests potentially in less than half an hour. Is this something that NHI might look at trying to facilitate for its members, both public and private?

Mr. Tadhg Daly: Absolutely. The challenge for us now is to navigate our way out of this particular pandemic and ensure the safety and welfare of both residents and staff. Any measures that we can take as an organisation will be taken.

Deputy Matt Shanahan: On the isolation of residents at present, we know that four out of five residents who have come into contact with Covid have survived. We assume the science is not exact, but we know people have antibodies for a period. Is it possible that we could look at

antibody testing to try to identify those nursing home patients and allow them to have access to their family and relatives, rather than continuing to be locked down?

Mr. Tadhg Daly: On the issue of easing visitor restrictions, we have submitted a paper to NPHET on that and I believe that is for discussion on Thursday. We have come through a very difficult period and I concur with the Deputy that we need to look at solutions so that we can move to the next phase because clearly the visitor restrictions are having an impact on residents.

Deputy Matt Shanahan: On Mr. Daly's comments regarding the integrated model of care into the future and the clear guidelines for skills, everybody here would support that. We accept there are strictures imposed on the NHI by NTPF in terms of the overall burden of moneys there to assist that.

Mr. Taylor mentioned advocacy for those in residential care being framed in legislation. In 30 seconds, could he give a quick outline of how he sees that being developed?

Mr. Mervyn Taylor: I will do so very quickly, as I am aware of the time strictures. Legislation has been anticipated for safeguarding adults and the Law Reform Commission has a consultation going on regarding how such a framework might best occur. We believe that is a mechanism for framing legal recognition of independent advocacy. There is also a need for legislation on protection of liberty of people in congregated care settings because that is a serious issue. People have been transferred from acute hospitals to nursing homes on temporary transition funding. The question is: will they have a choice of staying there or getting the package they need to support them to go home? Legislation can come either way.

Chairman: I thank Mr. Taylor and Deputy Shanahan.

Deputy Michael Collins: I welcome Mr. Daly and Mr. Taylor who are giving evidence today. It has been a very difficult time, especially for those who have lost loved ones in nursing homes. I pay tribute to the staff in nursing homes who have worked incredibly hard. I know of their hard work because I contacted many nursing homes in west Cork, such as Cramers Court in Belgooly, CareChoice Clonakilty, Bushmount Nursing Home, Skibbereen Residential Care Centre, Fairfield Nursing Home in Drimoleague and Deerpark House Nursing Home in Bantry. Each of them has gone through a difficult time. Thankfully, the number of cases of Covid in west Cork has been very low, which is a blessing in its own right. However, there are questions that need to be asked and I must address them as quickly as possible in the time I have. Most of them will be for Mr. Daly.

Was a strategy in place to test patients who were moved from hospitals to nursing homes in order to free up acute hospital beds? If there was such a strategy, what percentage of those patients were tested and moved only on the basis of a negative result?

Mr. Tadhg Daly: In early March, there was no such strategy. We received communication from the acute hospitals and the HSE community healthcare organisations that the patients were deemed to be low risk, had not been in contact with Covid and would be transferred. There was no definitive strategy at that point.

Deputy Michael Collins: Is there a tracking system in place to identify nursing home staff who are working in more than one nursing home?

Mr. Tadhg Daly: There is. All our members are logging that information on a daily basis with the HSE, HIQA and the public health authorities. The information is held centrally.

Deputy Michael Collins: Mr. Paul Reid stated that the mass testing of nursing home residents and staff at facilities is complete. Is there a plan to ensure the safety of residents in every residential nursing home?

Mr. Tadhg Daly: The mass testing is complete. As another Deputy noted, the question is what we will do next and whether there will be a targeted testing approach. I do not believe that the HSE is planning mass testing. It is clear that there must be a roadmap for testing in order to ensure that nursing homes can take patients from acute hospitals and reopen to visitors.

Deputy Michael Collins: Do nursing homes plan to test and monitor the variables within those settings, such as the testing of staff on a weekly basis, at least? From what I can gather, it currently takes two weeks for residents to be tested and ten days for staff to be tested. Is Mr. Daly aware that Animal Health Laboratories in Bandon, west Cork, is turning around Covid-19 tests in a day? If he is not, will he get Nursing Homes Ireland to avail of this incredible service such that testing can be carried out in our own backyard rather than samples being flown to Germany and all over the world?

Mr. Tadhg Daly: On testing, matters have improved greatly, to be fair to the HSE. Turnaround time has been reduced to approximately three days. We will be guided by the recommendations of the public health authorities in respect of the next wave of testing. We understand that will be announced before the end of the week.

Deputy Michael Collins: Is Nursing Homes Ireland aware of the laboratory in Bandon?

Mr. Tadhg Daly: I am not aware of it. What we have been dealing with is a national response. Ultimately, the HSE is running the testing programme. We have asked that testing kits be made available to staff in nursing homes in order that they can take swabs themselves, which would be far quicker than having to wait for the National Ambulance Service to so do.

Deputy Michael Collins: That leads me on to my next question. I and many professionals believe doctors and nurses should be allowed to take swabs, which could result in being able to get next-day results. Is Nursing Homes Ireland working towards that?

Mr. Tadhg Daly: Absolutely.

Deputy Michael Collins: Has the HSE given any indication that it will allow that to happen?

Mr. Tadhg Daly: It is happening in some centres, which is very positive because it leads to a quick turnaround and it means that the resident is swabbed by a person he or she knows well. It can be very comforting for a resident to have a person who he or she knows doing the swab rather than an external person.

Deputy Michael Collins: As already stated, everybody wants there to be quick results. It seems to me that it is taking between ten and 12 days to get tests completed. If it takes another three to five, six or seven days to get the results, it defeats the whole purpose. My point is that we need to look to local laboratories to carry out these tests. I urge Mr. Daly to consider using such laboratories.

Chairman: I ask that Mr. Daly reply to the Deputy in writing on the matter.

Mr. Tadhg Daly: I will revert to the Deputy directly on that point.

Chairman: I call Deputy Cullinane. Is he taking five minutes or ten?

Deputy David Cullinane: I am taking ten minutes. I welcome our witnesses and commend them on their service and work in representing their members - Mr. Daly in particular -and patients. I also commend them on dealing with a very difficult situation where, as I am sure they know, staff were across different departments as well.

I will talk Mr. Daly through his opening statement in a few minutes. He will understand, however, that at the previous session we asked for all correspondence between NHI and the Department of Health. We got that today at 9.30 a.m. We have not had time to go through all that correspondence in detail, but I have isolated some items, which I want to go through because they illustrate exactly what is in Mr. Daly's opening statement.

I will start with No. 32. I will not name the individuals involved, but Mr. Daly wrote to a senior official in the Department on 16 March setting out his concerns. I know there was prior correspondence, but on that date, he emailed this individual seeking a commitment to a dialogue. He referred to critical issues he had raised previously referred to considerable anxiety, access to PPE and issues concerning essential workers, and he suggested that a working group should be established to co-ordinate activities in the home care setting. Does he recall that?

Mr. Tadhg Daly: I do.

Deputy David Cullinane: Two days later, on 18 March, Mr. Daly again followed up with more questions in respect of the provision of PPE, oxygen and required supplies, which he stated was very challenging, to say the least. He also referred to exhaustion of stocks, stated that residents and staff were awaiting testing and that was a difficulty. He also stated that "Delays occurring can present cataclysmic consequences." In that correspondence, Mr. Daly again sought an urgent meeting regarding outstanding issues. Does he remember that?

Mr. Tadhg Daly: I do indeed.

Deputy David Cullinane: Did Mr. Daly get that urgent meeting?

Mr. Tadhg Daly: I think we met within two days with officials.

Deputy David Cullinane: Was that with officials in the Department of Health or with the Minister? Did Mr. Daly seek a meeting with the Minister?

Mr. Tadhg Daly: We did seek a meeting with the Minister. The first meeting with the Minister was on 30 March.

Deputy David Cullinane: When did Mr. Daly first seek a meeting with the Minister?

Mr. Tadhg Daly: I would have to check my date properly.

Deputy David Cullinane: Was it weeks prior to that?

Mr. Tadhg Daly: That is correct. Our first correspondence was at the end of February and-----

Deputy David Cullinane: I thank Mr. Daly.

Mr. Tadhg Daly: -----we were engaging right throughout March.

Deputy David Cullinane: There was a constant pattern here of looking for meetings, flagging issues and raising yellow and red flags. I will go to correspondence No. 42. This was sent directly to the Minister for Health. It was an urgent request for a meeting and a conference call. That was on 19 March, and there was no response to that until the end of March. Is that correct?

Mr. Tadhg Daly: That is correct.

Deputy David Cullinane: In No. 43, Mr. Daly again raised concerns in respect of a number of issues. I refer to a letter he wrote to the Minister in which he states:" I am writing to you to request an urgent meeting or conference call to discuss important issues." Mr. Daly then set out all the issues again. He continued by respectfully requesting immediate engagement to ensure the NHI could continue to provide high quality. That was on 19 March. It was not until the end of March that there was a meeting. Is that correct?

Mr. Tadhg Daly: That is correct.

Deputy David Cullinane: No. 46 is also correspondence from Mr. Daly, where he noted that the Department had established a working group on the nursing homes sector but the said that the decision to establish a group and exclude NHI "beggars belief, given that the sector provides care in a home". Mr. Daly, therefore, had outlined that issue right through the process. He wanted a working group in place, but his group had been left out of the process. Is that correct?

Mr. Tadhg Daly: Yes, there were two subgroups of NPHET. One was the vulnerable persons subgroup and a nursing home subgroup was established as well. That was the one to which I was referring. There was a specific nursing home group and we did not have a seat at that table. That was unacceptable.

Deputy David Cullinane: It seems to me, reading all the correspondence, that this was Mr. Daly's organisation was crying out for help, almost daily, and not getting the appropriate responses. Is that a fair assessment?

Mr. Tadhg Daly: We had good engagement with officials, but what we were hearing was that matters were being escalated. It was not until we met the Minister at the end of March that matters took off.

Deputy David Cullinane: In Mr. Daly's opening statement, he stated he was "exasperated". That is a very strong word.

Mr. Tadhg Daly: It was very challenging, because I was dealing with members and families ringing me daily. There was a lot of frustration and anxiety in the sector.

Deputy David Cullinane: Mr. Daly referred to the sector needing a specific plan. That did not come until the end of March. Is that fair to say?

Mr. Tadhg Daly: Or even early April.

Deputy David Cullinane: Mr. Daly also stated it was obvious that Covid-19 would have a disproportionate effect on older people and that the focus was almost completely on acute hospitals. A national strategy was required but it took a long time in terms of all of the correspondence to get that national strategy. Is that a fair point?

Mr. Tadhg Daly: Yes. Our point was that the focus was almost exclusively on the acute hospitals and preparing for the surge in the acute hospitals, whereas the surge materialised in

the nursing home sector.

Deputy David Cullinane: Mr. Daly reiterated in his opening statement that there was insufficient testing of residents and staff, that there was a mass shortfall of PPE and that providers had suppliers that they would utilise to source such equipment but they were informed of a global shortage. I noted in some of the correspondence, which we are only now getting an opportunity to comb through, that some nursing homes were forced to use painters' overalls and supplies from a local school and a vet as personal protective equipment. Does Mr. Daly find it profoundly shocking that that is the situation that staff and managers in the institutions were left in? The sector was crying out for help day in and day out, week in and week out during that timeframe and nursing homes and the staff were forced to used painters' overalls and supplies.

Mr. Tadhg Daly: In regard to the issues around PPE, there was a national shortage. The HSE was doing its best at the time but we would have felt that some of the PPE should have been directed towards the nursing home sector given the vulnerability, age profile and complexity of residential care.

Deputy David Cullinane: Mr. Daly took a decision early on. I appreciate that we can look back with the benefit of hindsight but in early March Nursing Homes Ireland took a decision to impose restrictions in regard to visitation. Is it not the case that NPHET met a week later and took a different approach? Mr. Daly mentioned in his opening statement that NPHET publicly challenged the decision that his organisation took.

Mr. Tadhg Daly: As I said in my opening statement, all through the first week of March our nursing committee was meeting on a regular basis. My colleague-----

Deputy David Cullinane: Mr. Daly used the words "publicly challenged". In other words, the outworking of the press statement that was issued at the time as a consequence of that meeting was that it publicly challenged the decision that his organisation made, which was to keep people safe.

Mr. Tadhg Daly: Yes, and it did pose some challenges because we had people telephoning us saying that they had heard there was no requirement for visitor restrictions and that they wanted to gain access to homes. That was a particularly difficult week for the staff in our homes.

Deputy David Cullinane: Mr. Daly further mentioned in his opening statement that the National Treatment Purchase Fund, which is the authority responsible for the commissioning of nursing home care, fell silent as homes incurred considerable and responsible costs. The statement that the NTPF "fell silent" is a very strong one. In what area did it fall silent?

Mr. Tadhg Daly: All through March people were making significant preparations and spending considerable amounts of money to source PPE and additional staff, isolation areas and so on. Given the role of the National Treatment Purchase Fund in terms of funding under the fair deal scheme, we would have expected it to reach out and engage with the sector in terms of what those costs would look like.

Deputy David Cullinane: Mr. Daly also said - this is one of the most telling contributions of his opening statement - that key State organisations left the nursing home sector and its residents isolated in those early days and "the dismay will live forever with us." That is a very strong statement. It strikes me that Mr. Daly was very disappointed and angry with the State actors that they did not respond. Despite all of the telephone calls, emails and other correspondence and the yellow and red flags being raised, the organisation and its members and residents

of nursing homes were not given the human and financial resources that they required because there was an absence of a plan. Would that be a fair assessment of what Mr. Daly was getting at in that sentence of his opening statement?

Mr. Tadhg Daly: When I was preparing my opening statement I was thinking back on the early period during March when we were getting many calls from members and families and how exasperated they were. I was trying to reflect in my opening statement the challenge that we all went through at that particular time.

Deputy David Cullinane: What about Deputy O'Dowd's assertion? He gave a very robust defence of the Department. When Mr. Breslin was here last week I put questions to him on some of these issues and he said that there was guidance and a plan throughout February and March, contradicting much of what is stated in all of the correspondence and Mr. Daly's opening statement. How does Mr. Daly respond to the questions that were put to him by Deputy O'Dowd and to the head of the Department downplaying the issues that he has raised throughout all of the correspondence and in his opening statement today?

Mr. Tadhg Daly: The correspondence speaks for itself. We had very good engagement with officials. I deal with officials in the Department on an ongoing basis. My natural *modus operandi* is to work with people.

Deputy David Cullinane: Did Mr. Daly feel let down?

Mr. Tadhg Daly: It is not about me.

Deputy David Cullinane: No, but on behalf of his members did he feel let down? This is about patients in nursing homes.

Mr. Tadhg Daly: Yes, this is about residents. Absolutely.

Deputy David Cullinane: Does Mr. Daly feel those patients were let down?

Mr. Tadhg Daly: I do. As a society, we did not pay enough attention to the care needs of those in residential care.

Chairman: Is Deputy Carroll MacNeill taking five or ten minutes?

Deputy Jennifer Carroll MacNeill: If I take five minutes, will Deputy McGuinness come after me?

Chairman: There are ten minutes for Fine Gael and ten minutes for Fianna Fáil.

Deputy Jennifer Carroll MacNeill: Grand. If I take five minutes, my colleague can also take five minutes.

Chairman: Yes.

Deputy Jennifer Carroll MacNeill: I thank the witnesses for attending. I acknowledge the phenomenal and committed work of individuals in the sector who have worked really hard. I have stayed in touch with those in my area and last week we raised the issue of testing and tracing. I will be raising a significant matter that arises with respect to insurance but Mr. Daly is representing Nursing Homes Ireland, a representative body of for-profit and private nursing homes. Deputy O'Dowd has, over the course of his career, expressed concerns about how older people are cared for. The purpose of this committee is to assess the State response, and as Mr.

Daly indicated, it is one of the most important analyses that may be conducted. It is in that vein that I wish to interrogate some of the matters raised by Mr. Daly.

The most important statement made by Mr. Daly, both here and in the media over the past couple of days, is that the sector felt isolated in early March, that this was distressing and that there was a lack of engagement. I will go through this as we now have the benefit of the correspondence between the Department and Nursing Homes Ireland. I apologise if this is dull but it is important to be careful.

Going back to the beginning of the year, there were two items of correspondence, with one relating to insurance and a second concerning a former Deputy, Mr. Jim Daly, who was not running for re-election. The correspondence of 28 February related to a call of thanks with respect to guidance on Covid-19. From 28 February onwards, there was very significant engagement on a daily and often multiple times daily. This was at assistant secretary level with Dr. Kathleen MacLellan. It is important because of what the witness said to go through some of the correspondence and I will give Mr. Daly the opportunity to respond at the end. Correspondence from the Department on 2 March states: "Thank you for your email. We continue to ensure members are appropriately informed.". The reply from Dr. MacLellan states: "Tadhg, many thanks for keeping me updated." I imagine some in the media will go through this correspondence but it is important for the committee's purpose for it to be done. On 4 March Dr. MacLellan wrote:

> Tadhg,
>
> ... Yes I can confirm that there [are] a number of subgroups being established under NPHET. I will be chairing the Vulnerable People subgroup

Dr. MacLellan is the assistant secretary in the social care division and she indicates that she is chairing that subgroup and is the primary point of correspondence with Nursing Homes Ireland. Is that correct?

Mr. Tadhg Daly: That is correct.

Deputy Jennifer Carroll MacNeill: Was Nursing Homes Ireland disappointed with the level of engagement on the part of Dr. MacLellan?

Mr. Tadhg Daly: We were not disappointed with the level of engagement. The issue was with the national plan that was coming. I was hearing that matters were being escalated. Looking at the correspondence, one can see we were being told the matters we were raising were being escalated to the working group.

Deputy Jennifer Carroll MacNeill: On 5 March, Dr. MacLellan indicated: "There is a Department briefing ...and I have asked that you are invited - I hope to see you there." The reply from Mr. Daly states:

> Thank you Kathleen,
>
> I acknowledge commitment to ensure that residents and staff in the private and voluntary nursing home sector are encompassed in all Government planning.

There is some correspondence back and forth. On 5 March, Mr. Daly states:

> Thank you for [the] invitation to [the] stakeholder briefing in the Department tomorrow.

I can confirm that a number of our members participated in a conference call with Dr. Siobhán Kennelly [in the] HSE this afternoon ... I would appreciate a quick [update].

The correspondence continues and I do not want to take the committee's time by going through this in detail that is too great. On 10 March, however, there is a letter from the Secretary General of the Department of Health, which states:

I refer to your letter of 9 March.

As part of preparedness planning for Covid-19 we are examining a range of work force issues and I have asked relevant officials to look [at that]

This is in early March, when Mr. Daly indicates that his organisation felt isolated. There is correspondence on 10 March at 7 p.m. and 8 p.m. The correspondence continues, indicating that guidance was issued on 10 March and Mr. Daly thanks Dr. MacLellan for the correspondence indicating that guidance was issued. How is it precisely that Nursing Homes Ireland felt isolated? All this correspondence is from a period between 2 March and 10 March. Was it the particular engagement of the Minister that Mr. Daly sought?

Mr. Tadhg Daly: It was not that I felt isolated at all. It was the sector I represent which felt isolated. My emails reflect my approach to working collaboratively with people, and what I was looking for was guidance, advice and an escalation of matters. On the issue the Deputy referred to in terms of the Secretary General responding, he stated that it was escalated to other officials in the Department. I still have not had a response in respect of that particular matter.

Deputy Jennifer Carroll MacNeill: Correspondence dated 13 March states: "Dear Kathleen ... Thank you again. We wish to acknowledge your engagement ... We are committed ... and thank you for your participation." I appreciate that there is back and forth and clarity in respect of PPE and that that was an issue. I appreciate that testing was an issue. I appreciate that these were issues, collectively and nationally, not just for the sector but also for the State. Mr. Daly said he felt isolated. It is a really important statement. When he engaged with Deputy Cullinane, he stated that he sought a meeting with the Minister on 19 March. To correct the record, he had a conference call with Department officials on 20 March. Is that correct?

Mr. Tadhg Daly: That was a conference call with the working group and it took place on the basis of an outbreak. That was a working group of which our organisation was not a member.

Deputy Jennifer Carroll MacNeill: Okay.

Chairman: Deputy Carroll MacNeill has used the five minutes.

Deputy Jennifer Carroll MacNeill: Okay. That is no problem.

Chairman: Other members will not have time. I am sorry. I cannot make time. Is Deputy McGuinness speaking for five or ten minutes?

Deputy John McGuinness: I will speak for five minutes.

Chairman: Okay.

Deputy John McGuinness: From reading the correspondence we received today and having listened to Mr. Daly's replies to various questions from members, it is clear that this is a huge scandal. As a country, we will reflect on what has happened with great sadness and shame.

How best can we deal with all of the correspondence Mr. Daly has submitted to the committee and been asked about today?

Separate from this committee, is it the case that we now need a general inquiry at some stage into what happened so that we can understand clearly and have the time to tease out the step-by-step failings that have occurred? Whether it is the Minister, the Department or whoever, we are talking about the care of the elderly and a significant number of deaths that may or may not have been avoided. Does Mr. Daly see the need for a more substantial inquiry into all of this?

Mr. Tadhg Daly: It is important, in terms of the State's response, that the committee does its work first. That would inform the next steps. Similarly, the expert group that has been appointed by the Minister has an important job to do. I would not like to prejudge what is going to come out of those two groups but, clearly, there are lessons to be learned. The challenge for us, as a society, is to ensure that we continue to develop high-quality care-----

Deputy John McGuinness: That is putting it mildly. What happened here is a complete failure of policy and a disregard for the care of older people. There are significant lessons to be learned from this, but the fact is that there is conflict, in the context of some of the issues raised, between Mr. Daly and the Department of Health, NPHET and so on. That conflict needs to be resolved. As policymakers, we need to be clear about where the failures occurred and also about the evidence Mr. Daly has for some of his statements. I would want to be clear on the direction nursing homes will take for the future because it is, without doubt, a shame on all of us that this happened and that there was not the type of response that there should have been from those who were central to delivering such a response in respect of the queries that were made. Mr. Daly is the one who is highlighting all of this and saying it.

Mr. Tadhg Daly: Absolutely.

Deputy John McGuinness: He should not dress it up.

Mr. Tadhg Daly: The point I am making is that there was a very ambitious and necessary plan for acute hospitals. It is clear that that happened. Our position is that it did not happen for community care. That is a failure to my mind.

Deputy John McGuinness: Did nursing homes withhold information from family members in respect of care and the issues the sector faced?

Mr. Tadhg Daly: No, the issue there was-----

Deputy John McGuinness: If Mr. Daly says no, that is fine. Did the nursing homes prevent the testing of staff within the homes? Was there a question around that? Did nursing homes try to avoid the testing of staff at some stage? Did some of them?

Mr. Tadhg Daly: No. We were calling for testing.

Deputy John McGuinness: Can Mr. Daly check that out?

Mr. Tadhg Daly: I can. We were calling for testing. We called for robust elements of testing.

Deputy John McGuinness: Is it not another scandal where the information required by families to make informed decisions about the care of their loved ones in these nursing homes was withheld from them?

Mr. Tadhg Daly: That did not happen. On 1 March, when the first case broke out, the National Public Health Emergency Team issued a statement saying that all of the information would be handled centrally. In the early stages, what we said to members was that speculation about the number of cases and clusters was unhelpful; the same point Mr. Taylor made earlier. I have made the point-----

Deputy John McGuinness: So nursing homes withheld the information.

Mr. Tadhg Daly: No. Two calls would happen in what I would term ordinary times. One would be to the ambulance, potentially, if someone fell, and the other to the family. I am absolutely 100% confident, and can stand over the fact, that families of those who had residence in nursing homes were kept informed at all stages. There were challenges in terms of staffing, no doubt, in terms of answering all the queries.

Deputy John McGuinness: What are the current guidelines?

Mr. Tadhg Daly: The current guidelines are the same as they have been for the past nine weeks. Basically, the family should be informed at all stages. That has always been the case.

Deputy Colm Burke: My thanks to Mr. Taylor and Mr. Daly for coming to the committee this morning and for their contributions.

I want to go back to the issue of the roll-out of swabs being taken by staff. Is it not now a priority that every nursing home would have a person assigned to be able to do that on an ongoing basis? Is there now a discussion with the HSE for that to be put in place and for it to be done within a particular timescale? Surely, we could set a timescale of the next 14 days for that to be in place in every nursing home throughout the country. Is that physically possible at this stage?

Mr. Tadhg Daly: Yes, absolutely, and that would be our request. As I understand it, a paper is going to the National Public Health Emergency Team on Thursday on that basis.

Deputy Colm Burke: Does Mr. Daly expect a time period for that to be put in place?

Mr. Tadhg Daly: The only information I have is from the European Centre for Disease Prevention and Control, which says it should happen on a weekly basis.

Deputy Colm Burke: Could we actually have every nursing home being able to take the swabs? Can we have that structure in place within 14 days?

Mr. Tadhg Daly: Yes, absolutely.

Deputy Colm Burke: Would Nursing Homes Ireland look for that kind of period?

Mr. Tadhg Daly: Yes, absolutely. Many of our members are doing it already.

Deputy Colm Burke: Many people have raised the issue about staff pay in nursing homes. Approximately €1 billion per annum is being assigned for the fair deal scheme. What proportion of that goes to the private nursing home sector?

Mr. Tadhg Daly: I do not have the figure in front of me but I think one third of the budget goes on two fifths of the residents. The significant proportion of the €980 million is actually spent in the public system.

Deputy Colm Burke: In other words, per patient there is less coming to the private sector.

Is that correct?

Mr. Tadhg Daly: Yes, the discrepancy is something of the order of a national average of approximately 62% per resident per week more in the public system than in the private system.

Deputy Colm Burke: Does that mean a 62% additional cost in the public sector per patient?

Mr. Tadhg Daly: That is correct. That is per resident per week.

Deputy Colm Burke: In real terms - in money terms - what is 62%? Is it €200, €300 or €400 per week?

Mr. Tadhg Daly: It is an average of approximately €500 per week. It is something in the order of €980 on average per week in the private sector as against €1,400 or €1,500 in the public system. Perhaps I can get those figures for the committee as well, afterwards.

Deputy Colm Burke: There will be an additional cost because of personal protective equipment and all of the other costs associated with Covid-19. What additional cost does Mr. Daly believe will now be incurred per patient?

Mr. Tadhg Daly: At this stage of the game, it is very early in terms of putting a figure on that. Clearly, however, the announcement by the Minister of a temporary additional scheme was welcome. That was for three months. It is supposed to end at the end of June. The next question is what happens after the three months. We raised that with the Minister yesterday. That will be part of what I hope is our constructive engagement with the Minister and officials as we go through this.

Deputy Colm Burke: In any event, there will now be an additional cost.

Mr. Tadhg Daly: I have no doubt. Yes, absolutely.

Deputy Colm Burke: I want to go back on the issue of deaths in nursing homes. Life expectancy in this country has increased by seven years since 2000. In other words, people are living seven years longer now compared with the year 2000. Nursing homes have made a contribution to that increase in life expectancy. On average, how many deaths are there in all the nursing homes across the country per month? Have we a figure for that?

Mr. Tadhg Daly: The HSE would be in a better position than me to comment, but the figure from the fair deal scheme is something in the order of 7,000 to 7,500 people annually, so perhaps about 600 people per month. This goes back to the point Mr. Taylor made about the complexity of care and the reduced length of stay in nursing homes.

Deputy Colm Burke: Has there been at any stage, outside of Covid, a sudden increase in deaths in the nursing home sector?

Mr. Tadhg Daly: In February 2018, as I recall, there was a particularly bad flu and, I think, more than 1,000 deaths.

Deputy Colm Burke: That was a jump of 400 in one month alone.

Mr. Tadhg Daly: I do not know the exact figures, but yes, there was an increase in that month, as I recall.

Deputy Colm Burke: Finally, I wish to ask about the forum, which is an issue I raised in the Seanad. Who should be on the forum that Nursing Homes Ireland believes should be set up? Mr. Taylor might also come in on that.

Mr. Tadhg Daly: Our position on the forum has been on the record for a long number of years. We feel it should be Department-led because that is the whole policy. Going back to the remarks many of the speakers have made, it should be about policy. The forum should include the likes of HIQA, the HSE, Nursing Homes Ireland and, critically, representatives of older persons themselves.

Chairman: Mr. Taylor has ten seconds; otherwise, I ask him to reply with correspondence.

Mr. Mervyn Taylor: Roughly 24% of people die in nursing homes.

Chairman: The question is who should be on the forum. Otherwise, I will have to ask Mr. Taylor to reply with correspondence.

Mr. Mervyn Taylor: We had a forum in 2016. The issue is implementing the policies that have been talked about for the past 30 years.

Deputy Stephen Donnelly: I thank Mr. Taylor and Mr. Daly for coming and for their work in the past few months advocating on behalf of older people and residents and staff within the nursing homes. What has happened is tragic and heartbreaking. It has happened in a lot of other countries, although notably there are countries that managed to act decisively and early and avoid the outbreaks we have seen in our nursing homes. Both Mr. Daly and Mr. Taylor have laid out that older people lack a voice generally in policymaking and that nursing homes - really, we are talking about the residents and the staff when we talk about nursing homes - have also lacked a voice in this crisis. The Government's Covid action plan for mid-March refers to nursing homes only once as somewhere to send hospital patients. The plan makes no reference to any supports or risks that need to be examined for nursing homes. Mr. Daly has said that the first time he managed to get a meeting with the Minister was 30 March, when we were well into the crisis in the nursing homes. The first time the National Public Health Emergency Team even mentioned nursing homes in its minutes was in the minutes for its 12th meeting on 10 March. Its recommendation was that the restrictions that the nursing homes themselves had put in place should be relaxed. The National Public Health Emergency Team therefore held two positions in the same week: one, that schools should all close, and two, that nursing homes should be more open, which I find absolutely extraordinary. Would representation on the National Public Health Emergency Team and closer contact with senior officials and Cabinet have made a difference? The Minister's position, which he has outlined repeatedly to me, is that HIQA, the regulator, represents nursing homes at the table. Do the witnesses believe HIQA can represent nursing homes at the table? Critically, looking forward, do the witnesses believe that nursing home residents and staff and older people have a sufficient voice now, be it on the National Public Health Emergency Team, in senior policy settings, in senior HSE areas or at a senior political level, in order that we can properly prepare for the potential second wave which may come and make sure we do not see these outbreaks and tragic deaths occur again in our nursing homes, and indeed for older people in other settings?

Mr. Tadhg Daly: Regarding representation, yes, I believe having a voice for the sector, whether a nurse working on the front line, staff working in the sector or indeed older people themselves, on NPHET would have made a difference because it would have raised the issues on the agenda. The Deputy pointed out that the first discussion was on 12 March. I contend that

having a voice for the sector and older persons on NPHET would have been important.

HIQA is the independent regulator for public, private and voluntary settings. It is on NPHET, but so is the HSE, which is a provider of care through its own public facilities. Clearly, the private and voluntary sectors were not represented on NPHET. HIQA can speak for itself this afternoon, but its role is more about regulation than representing the voice of the sector.

Regarding the Deputy's third point, I have spoken to many parliamentarians over a long number of years about the voice of older people. In my role, I represent the providers of care, but-----

Deputy Stephen Donnelly: In the interests of time, I will ask a specific question. The Minister and I have discussed the matter repeatedly in this Chamber. The answer he keeps giving me is that nursing homes and their residents and staff do not need any representation because they now have regular access to him. We are still in the middle of this crisis and are planning for a second wave. Does Mr. Daly believe that nursing homes have sufficient voice at the right political, administrative and official levels?

Mr. Tadhg Daly: To be fair to the Minister, we meet him twice weekly. That is important and encouraging. He is very engaged and all the points we raise are being addressed. However, I would still argue that a voice for the sector needs to be on NPHET.

Deputy Stephen Donnelly: I thank Mr. Daly. Does Mr. Taylor believe that, in dealing with this crisis, older people now have sufficient voice in the various fora they need to have it - politically, administratively and in the State sector?

Mr. Mervyn Taylor: No. There is little time available in the meeting, but the simple fact is that, more than any talk of forums or public inquiries, we need integration of the private nursing home sector into the wider framework of health and social care. There has to be some link on clinical governance and nursing support across each of the six new HSE regions planned under Sláintecare. There was a constructional problem with private nursing homes, in that they were literally outsourced and forgotten about. I am clear on that.

Regarding a voice, I look forward to legislation that will legitimise the role of independent advocates. I remember private nursing homes throwing our staff out and not allowing them to contact residents. That is a rare occasion, but it has happened. When we talk about a voice, we need to talk about a right for independent advocacy and recognising that practice in law.

Chairman: I thank Mr. Taylor and Deputy Donnelly. I have a couple of questions for the witnesses before they leave. Earlier in the meeting, there was a dispute concerning a teleconference. We have found a reference to it in what the Department of Health provided at 9.30 a.m., but the document is heavily redacted. Unfortunately, Mr. Daly is the only participant in it that we can identify.

Mr. Tadhg Daly: Okay.

Chairman: I appreciate that Nursing Homes Ireland has far fewer resources than the Department, but does it have records of meetings, emails and other correspondence with the Department of Health? If so, could it provide them to the committee?

Mr. Tadhg Daly: Yes. I was not aware of the volume of correspondence that had already been provided, but I am happy to supply whatever is required.

Chairman: Whatever correspondence Nursing Homes Ireland has. I do not wish to overburden it because I appreciate-----

Mr. Tadhg Daly: We do not have the same resources.

Chairman: I understand.

Mr. Tadhg Daly: I am happy to talk to the secretariat about what will be made available, but as far as I am concerned, anything that is on the record is available to the committee.

Chairman: I am sure that there are good reasons for the heavy redaction by the Department of Health and that it will provide them. We will ask for those reasons.

The Care Quality Commission is the United Kingdom's equivalent of HIQA. It required that every care facility identify a clinical lead by 15 May. In Ireland, some HSE facilities have a medical officer who is responsible for the care of all staff and some do not. In many HSE and private facilities, there are many people under the care of many different GPs and there is no one person responsible for the care of everyone. Would a similar approach to the UK's be beneficial in Ireland if a clinical lead had to be appointed for every care facility?

Mr. Tadhg Daly: Absolutely. We have made that point. We felt it was a missed opportunity in the revision of the General Medical Services, GMS, contract last year. We are on the record in outlining that there should be a requirement for a specific GMS contract for residents in nursing homes.

The only other point, Chairman, is that the current standards speak of the resident retaining the right to his or her own GP.

Chairman: In addition, perhaps.

Mr. Tadhg Daly: Well, yes. That may be.

Chairman: Or is that instead of?

Mr. Tadhg Daly: No, currently the position - which is the point being made by the Chairman- is that many GPs are in and out of care facilities because of the right to retain one's own general practitioner. It is important to put on the record that general practice is a great support for their patients who are our residents.

Chairman: Was there something that Mr. Taylor specifically wanted to come in on?

Mr. Mervyn Taylor: In February of this year we published a discussion document, Delivering Quality Medical Care in Irish Nursing Homes. One of the things that led us to develop this work, in which we collaborated with Nursing Home Ireland and the Irish College of General Practitioners, ICGP, was our concern that it was unclear what the clinical leadership is in nursing homes, particularly in private nursing homes. Some residents are being charged €25 and others €40 a week for a GP service when the fact of the matter is that they should be entitled to this anyway because of their age. In some places there would be a very good structure while in others it would be very difficult for GPs to come in. I want to quote very briefly from this report:

> The point was made that nursing home staff may not have the exposure, experience and training available in acute hospitals. It was also suggested that skills sets of nurses working

in nursing homes may have gone down in recent years with a concomitant fear of making decisions in potentially crisis situations.

The difficulty here is that if a nurse needs support and there is not strong clinical support, then there is a real weakness in the system, and there has to be clinical leadership.

Mr. Tadhg Daly: It is important to put on the record that the nurses in the nursing home sector are very well qualified and caring professionals with deep gerontological experience. They do have the support of GPs but they are very able and have great experience.

Chairman: Mr. Daly had an introductory meeting with Mr. Paul Reid, the CEO of the HSE, on 19 February. Was Covid-19 a concern at that time or did it emerge later?

Mr. Tadhg Daly: No, it was not discussed. In fact, as we were getting up to leave, we were talking about matters overseas. It was not an agenda item at all.

Chairman: Thank you very much for your help and for answering my questions as well as those of the committee. We look forward to receiving the documentation. I am sorry it is probably extensive but we will accept as much as Nursing Homes Ireland can provide.

Mr. Tadhg Daly: I will be happy to talk to the secretariat to clarify which departments are involved.

Sitting suspended at 1.08 p.m. and resumed at 2 p.m.

Congregated Settings: Nursing Homes (Resumed)

Chairman: I welcome Mr. Phelim Quinn, CEO of HIQA and Ms Mary Dunnion, chief inspector of social services and director of regulation at HIQA. I thank them for joining us in the Dáil Chamber. We are joined from committee room 1 by three representatives from the HSE: Mr. David Walsh, national director of community operations; Ms Sandra Tuohy, assistant national director of older persons services and Dr. Siobhan Kennelly, national clinical advisory group lead older persons.

I advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence in relation to a particular matter and continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such plans. While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and consideration at all times. If they believe that they are not being so treated I ask them to bring it to the attention of the committee.

We are not taking an opening statement from the HSE as last week we received a statement from Mr. Paul Reid, CEO of the HSE. I invite Mr. Quinn to make his opening statement and ask that he limit it to five minutes. As we received the opening statement in advance, it has been circulated to members.

Mr. Phelim Quinn: I welcome the opportunity to address the Special Committee on Covid-19 Response. I am joined by my colleague, Mary Dunnion, chief inspector of social services and director of regulation.

Before I start, on behalf of HIQA, we wish to convey our sympathies to the families of those who have died in nursing homes and across the country during this pandemic.

HIQA, through the office of the chief inspector, registers and inspects 584 nursing homes accommodating approximately 30,000 residents. From the onset of this public health emergency, HIQA has endeavoured to make an effective contribution to the national response through our interactions with the Department of Health, the HSE, providers, residents and relatives. While routine inspections were not initially possible, HIQA has a process in place whereby all centres are formally contacted by an inspector on a regular basis to assess how they are managing in the provision of safe services to vulnerable service users. In addition, the chief inspector issued eight regulatory notices with the aim of reducing the regulatory burden on providers.

Inspections required to register new centres or facilitate increasing capacity have been expedited within days. HIQA has provided information to the Department of Health and the HSE on those centres with a history of poor compliance with key regulations, as those services were at increased risk of Covid-19 outbreaks.

Formal processes are in place whereby HIQA escalates actual or potential risk to the HSE's crisis management teams. On a weekly basis, the chief inspector and her leadership team meet the HSE to formally discuss ongoing issues and to escalate risk within the sector.

To support the public health response, HIQA provided the HSE with key information such as the locations of nursing homes, the number of residential beds and staffing levels. Furthermore, the HSE and the Department of Health availed of HIQA's online notification system to ensure the timely distribution of information to all nursing homes.

Currently, 80% of nursing homes are operated by private providers. Although funded through the nursing homes support scheme, the HSE did not know this sector. As a consequence, the infrastructure required by the HSE to support the private sector was under-resourced and became increasingly challenged. In addition, the current model of private residential care for older persons has no formal clinical governance links with the HSE. Importantly, this means there is no national clinical oversight of the care being delivered to some of our most vulnerable citizens.

Many nursing homes and disability centres were adequately prepared and managed to contain Covid-19 outbreaks. However, the private nursing home sector faced unique challenges. For example: timely testing and results; access to sustainable levels of PPE, oxygen and subcutaneous fluids; and baseline staff numbers, including senior nursing expertise in infection prevention and control.

In recognition of the difficulties faced by the providers of residential services, HIQA initiated a number of interventions from 5 March. These included the escalation to the HSE and the Department of Health of risks and trends requiring a more co-ordinated national response. On 18 March, HIQA made a formal offer to assist the HSE in liaising with designated centres.

This was in recognition of the fact that there was no established relationship between the HSE and the private sector.

Every day HIQA collates data on the number of designated centres with suspected and confirmed cases of Covid-19, as well as the numbers of unexpected deaths in designated centres. Since the end of March, this information has been supplied on a daily basis to the Department of Health initially, and then to the HSE and the HPSC.

From 1 April, HIQA requested a formal escalation pathway for a more strategic co-ordinated approach to the supply of PPE, resident and staff testing and results, a longer-term approach to staffing and infection control advice.

To provide support and assistance to providers and staff, HIQA established an infection prevention and control hub on 6 April. HIQA continues to review information received from members of the public, care staff and family members. It must be acknowledged that the creation of crisis management teams in each CHO area and the resources provided by the HSE at the community level played a significant part in supporting the private sector, and importantly, in protecting residents. COVID-19 has presented significant challenges to the current models of care in place for our older citizens. Since our establishment, HIQA has endeavoured to influence policy in the area of older persons' services based on our experience of the sector.

HIQA believes that the quality and safety of our health and social care services would be greatly improved by a review of the current regulatory framework and the introduction of an accountability framework, to include a commissioning model. As part of an accountability framework, HIQA believes that a system of care management could be introduced across the HSE's community service areas. Such a model would closely align with the principles and goals articulated within Sláintecare, as the key aim of the system is to support people in, or as close to their own homes as possible. These care plans are based on a multidisciplinary assessment and would enable a sustained shift away from institutional models towards a more person-centred system whereby care is provided in the home. I thank the members for their attention this afternoon. We look forward to answering any questions they may have.

Chairman: I thank Mr. Quinn for limiting his opening statement to five minutes. I call Deputy O'Dowd.

Deputy Fergus O'Dowd: I extend my deepest sympathies to the families of all the people who have passed away in our nursing homes and in our society as a result of Covid-19. I recognise absolutely the hurt and pain people have, particularly when loved ones pass away in a nursing home. They do not get to see them or say goodbye. It is an appalling vista which is brought about by the nature of the virus itself. I also acknowledge the tremendous work of all our health service people, workers in nursing homes, care assistants, cleaners and people who help out in every way. These people do fantastic work, often for very poor wages and without proper recognition.

I have met Mr. Quinn and communicated with him. I have appealed some of his decisions to the Information Commissioner in the past, in an effort to get transparency around the care of people in nursing homes. I wrote to him on Tuesday, 24 March seeking an entitlement which I believe the people had at the time and still have, namely, a categoric assurance from HIQA that all nursing homes and care homes are fully compliant in infection control. The reason I wrote the letter was the HIQA report to which I referred earlier, which indicated that, at the time, only 123 of the 581 nursing homes subject to HIQA inspection met in full all of the regulations. I

did not get that commitment from Mr. Quinn. While I note what he is saying here today, as I understand it, he has to be accountable. The office of the HIQA chief inspector has statutory responsibility for the registration and inspection of nursing homes and other residential services for children and adults with disabilities. As part of its remit, HIQA can inspect nursing homes and make binding decisions relative to the safety and quality of care provided to residents following inspection. That is the statutory power HIQA has. I note Mr. Quinn's call for additional powers, with which I do not disagree. Why was Mr. Quinn not able to give that categoric assurance to me and, more importantly, to all of the residents that all of the homes they were living in were fully compliant in infection control? Clearly, we both know they were not. That is my first question.

Mr. Phelim Quinn: If it is okay with the Deputy, I will pass to my colleague, Ms Mary Dunnion, chief inspector. To be clear, in my response to the Deputy I suppose what I was trying to articulate was the fact that as part of the general response to Covid-19, a multi-agency response was required in terms of getting that sort of assurance for this pandemic.

Deputy Fergus O'Dowd: Sure.

Mr. Phelim Quinn: In respect of the some of the figures the Deputy has mentioned, which were contained within our 2018 overview report, I will pass to my colleague, Ms Dunnion, to give the Deputy some update.

Deputy Fergus O'Dowd: With respect, I have no problem with that but right now, the question is to the chief executive, not to the chief inspector. If Mr. Quinn wants to pass it, that is fine, but I think he should answer it.

Mr. Phelim Quinn: The chief inspector of social services is a statutory post-holder directly responsible to the Houses of the Oireachtas. It is for that reason that I wanted her to provide the members with some direct information on the statutory role that she provides. As a regulator of health and social care services we cannot give absolute assurance. It is our responsibility to provide assessments of compliance with regulations and standards and report on these, and to take subsequent action to ensure compliance is achieved through the enforcement contained in the legislation. I really would like to take the opportunity, if possible, to pass to my colleague to give the Deputy some further details.

Deputy Fergus O'Dowd: I will respond to that reply afterwards.

Ms Mary Dunnion: I thank Deputy O'Dowd. In 2019, which are probably the more up-to-date figures, 238 inspections included regulation 27, which is the one particular to infection control. Of these 238 inspections, 20 cases were not compliant and a significant number were only substantially compliant. There are several reasons for this. The national standards for community centres called for a national integrated approach to infection control and antimicrobial stewardship. To date, this is not in place. On the rare occurrences when outbreaks of winter vomiting and influenza occur these procedures are effective but the national standards are not able to deal with the case of a pandemic.

One of the big issues that makes centres not compliant is the premises. In this context, there is a statutory instrument that gives nursing homes until January 2021 to become compliant. Until they reach this level of compliance they cannot be compliant with the standards of infection control.

Deputy Fergus O'Dowd: For clarity, what was the percentage that was not compliant?

Ms Mary Dunnion: Of the 238 inspected, 20 were fully not compliant with infection control standards.

Deputy Fergus O'Dowd: In fact, this is a higher percentage than the previous year because it was 18% and now it is more than 20%.

Ms Mary Dunnion: No, 20 of the 238 cases.

Deputy Fergus O'Dowd: I apologise. I have not seen the figures. I am glad Ms Dunnion has given them to me.

There is a particular problem when nursing homes are inspected and major or minor non-compliance is found and I will use a particular nursing home as an example but I will not name it. This particular nursing home was inspected in March 2019 and the report was published in July 2019 but the follow up inspection was not until December 2019 and that report was published in March 2020. There was a year between the first inspection with negative outcomes and the report of the follow up inspection which, in this case, appeared to show compliance. Without going into the details, this nursing home was non-compliant with regard to health and social care, safeguarding and safety, residents' rights and dignity and suitable staffing. Its complaints procedure is compliant. Notwithstanding all of the powers HIQA has, the process of inspection and follow-up does not seem to be working as quickly as it ought to be. I appreciate that follow-up is part of the process but it is not fast enough or good enough.

There is no change in the figures we have. The majority of nursing homes are not compliant. In this crisis HIQA is statutorily accountable. I do not suggest it is passing the buck to anybody else, and I agree it includes other agencies, but ultimately the buck stop with it. As an inspectorate, does HIQA require more staff? The witnesses can correct me if I am wrong but the figure in its most recent report was that 76% of nursing homes were inspected last year as opposed to 100%. If HIQA does not have enough staff to investigate, look at, help and support private and public nursing homes it cannot do its job. Does HIQA need more powers? It seems that non-compliance can drag on and on. I do not agree there is a difference between major and minor infractions. By definition, a nursing home should be 100% compliant. Does HIQA need more powers to ensure this happens? A huge part of this is not just finding what are the issues but training and making available to public and private nursing homes the professional capacity to upskill all of their staff. It is good enough finding fault in one sense but if people do not upskill an inspector cannot be there 24-7.

We have had a serious problem with a private nursing home in Dundalk where there has been an awful lot of sadness and upset at the terrible outcome for so many people in a very short space of time. It seems there was a situation whereby out of a total of 24 professional staff, particularly nurses, only six were available to maintain that nursing home because of illness and absence for other reasons. Given that we are in this sort of crisis, not just nationally but internationally, does HIQA, in the context of its investigations, have the power to seek information from the nursing home, from the HSE and from others in order to get to the bottom of what happened and give closure to the families in Dundalk that are so distressed?

Mr. Phelim Quinn: I will reply, in the first instance, to the Deputy's question on powers. In recent years, we have sought a review of the regulations. The regulations that currently obtain were developed, in the main, in 2009 and, subsequently, in 2013 and are worthy of review to keep pace with current models of care.

Before passing over to Ms Dunnion, I must stand that, in the context of the training of staff, at the beginning of our corporate planning period last year, we changed the emphasis of some of the work we have been doing regarding standards development. We have been looking at the development of training and guideline materials to assist the implementation of standards within health and care settings. For example, we have developed a training module in regard to infection prevention and control in the community standards and we are also in the process of developing a training and guideline module for human rights-based approaches to care across the nursing home sector.

Chairman: I ask our guests to be brief because we are over time.

Ms Mary Dunnion: We have enforcement powers but they are sometimes difficult to enforce. By way of example, three nursing homes which were taken to court over the past two years pursued two judicial reviews. We currently have legal cases pending on regulatory decisions I have made in the context of registration. We have the powers to seek the information the Deputy mentioned. We have begun the process for the nursing home he mentioned and, in fact, I am there tomorrow for an on-site inspection.

Chairman: Were those judicial reviews successful or unsuccessful?

Ms Mary Dunnion: They were unsuccessful for those that made them and successful for us.

Deputy Ruairí Ó Murchú: I would also like to express my sympathies to the families who have lost loved ones, particularly in nursing homes, and to the staff who cared for them. It is incredibly distressing.

I would like to continue the questioning in regard to Dealgan House Nursing Home. It would be fair to say that Mr. Tadhg Daly of Nursing Homes Ireland spoke about what he saw as a major failing in regard to the testing of residents, the shortfall of PPE and the aggressive recruitment of nursing staff. I would also say that maybe plans were not in place for a situation such as an outbreak of Covid-19 in Dealgan House-----

Chairman: I am not sure it is appropriate to refer to a particular nursing home.

Deputy Ruairí Ó Murchú: I have a number of questions which are quite general but if I could have specific answers regarding Dealgan House, it would be helpful. Mr. Daly also spoke about the discharges from acute hospitals and he put it down squarely to difficulties across nursing homes in general. With regard to Dealgan House Nursing Home, there were obviously a huge number of issues and it is an absolute tragedy. I would like to know at what point HIQA became aware and how it escalated the issue. I would also like to know how the HSE first became aware and how it escalated the issue, given that it obviously reached a point where the RCSI hospitals group was appointed in or around 17 April. I would like to have those answers first.

Mr. Phelim Quinn: If the Deputy does not mind, my colleague is dealing directly with the situation in respect of that nursing home and the ongoing investigation.

Ms Mary Dunnion: The way we organise our work is that a number of nursing homes will always have a designated inspector and, as a result, we were very aware of the issues in the particular nursing home. They were escalated in a formal way through the CHO area and through the HSE.

Deputy Ruairí Ó Murchú: Can Ms Dunnion give me a timeline for that?

Ms Mary Dunnion: I have not got the exact timeline but I can certainly provide it to the Deputy. It was immediate, however, because we have a daily escalation pathway. We are familiar with the situation and our review of it has begun. We have completed meeting the relatives of families there, and as I mentioned to Deputy O'Dowd, as of tomorrow we will be inspecting in the area we are discussing.

Deputy Ruairí Ó Murchú: All of that is welcome. I spoke to a number of families and they are glad to have that interaction.

It went from HIQA to the HSE. Can anybody give me an answer to who made the decision, and why, for the RCSI hospitals group to take over operational control?

Mr. Phelim Quinn: Our colleagues within the HSE might be able to help.

Mr. David Walsh: To the best of my knowledge, the first two suspect cases in Dealgan House Nursing Home became known on 31 March and the confirmation of diagnosis was on 4 April. From that time, Midlands Louth Meath community healthcare organisation, CHO, was involved with the nursing home and subsequently on or around 17 March the RCSI hospitals group made a decision to become more centrally involved. In the interim period, however, a number of supports had been given, including staff supports from both the acute hospital and community setting as well as personal protection equipment, PPE, infection control advice.

Deputy Ruairí Ó Murchú: So the HSE became aware from on or around 4 April?

Mr. David Walsh: We became aware of the first suspect cases on 31 March.

Deputy Ruairí Ó Murchú: When Mr. Walsh talks about involvement from on or around 4 April or early April, what did that consist of?

Mr. David Walsh: It consisted of staffing, assistance with PPE - I think the first delivery was overnight between 4 April and 5 April - and assistance with items such as oxygen and other advice. Midands Louth Meath CHO, or CHO 8, was involved from-----

Deputy Ruairí Ó Murchú: That is okay. When was the decision made to take over operational control? Will Mr. Walsh give me the reason, while accepting there were huge problems in the place?

Mr. David Walsh: My knowledge is that, on or around 17 April - I can be corrected on that - the senior staff in the RCSI hospitals group became so concerned that they decided, by agreement with the nursing home, that it was appropriate to put in a bigger team and management team to assist them through the process.

Deputy Ruairí Ó Murchú: So it was the staff Mr. Walsh put in on the ground who made the decision?

Mr. David Walsh: It was based on that knowledge, yes.

Deputy Ruairí Ó Murchú: From the start of March to the start of April, how many patients from acute hospital facilities were transferred to Dealgan House Nursing Home? This is one of the problems that Nursing Homes Ireland has put out as being a possibility. It has also put out that the HSE guidelines on visitors could have been a problem.

Mr. David Walsh: I do not have that specific information but I am happy to follow up on it for the Deputy.

Deputy Ruairí Ó Murchú: That is absolutely fine. At this time, I am glad to see that HIQA is carrying out an inspection and is talking to families. I hope that will arrest any difficulties and highlight any issues that will be built into wider operational protocols across the board so we do not have another Dealgan House scenario. I would like some clarity on whether, when that report is finished, it will be furnished to families beforehand. Beyond that, when will a decision be made on operational control? Would the RCSI consider handing back control before this report is published? Whatever conditions and mistakes are found in the report, they must be rectified and we must ensure we have plans into the future.

Ms Mary Dunnion: In the context of this particular nursing home, the registered provider is the responsible entity. That is the position as it stands. We publish all reports. We will always link in with those that we have dealt with in the relevant context. The registered provider, as the legal entity for the particular nursing home, will have the right of reply on all reports. The report will have to go through a due process procedure. Once that is finished, it will be published aligned to all the reports that we publish.

Deputy Ruairí Ó Murchú: Is it correct that there are additional nursing staff in Dealgan House nursing home and that infection control specialists and nursing managers have also been involved? Will that remain the case? I understand that the position is to be reviewed at the end of May, although I know that certain staff working in Dealgan House were slightly afraid that this may happen at an earlier stage. I would like some clarity on what conditions have to be met. We must also ensure that we have best practice and plans to maintain best practice.

Ms Mary Dunnion: I do not know the position because we will not be on site until tomorrow. We will be measuring against the nationally mandated regulations with which the registered provider must ensure compliance. If it is not compliant, it must have a plan to achieve compliance.

Deputy Ruairí Ó Murchú: Alright.

Mr. David Walsh: If I could add to that, my understanding is that, as of today, there are no staff from either the RCSI hospitals group or the midlands, Louth, Meath CHO actively participating in a shift in Dealgan House. However, Dealgan House is still availing of advice and guidance from the RCSI hospitals group.

Deputy Ruairí Ó Murchú: In that case, is it correct that an element of oversight will be maintained? If so, for how long will it be maintained?

Mr. David Walsh: Through the area crisis management team process, there is a system of contact between the HSE and every nursing home, public, private or voluntary. That system remains in place for the duration of the pandemic.

Deputy Ruairí Ó Murchú: The big thing is to ensure that we arrest all the problems and ensure they do not arise. I would also like to ensure that a contact infrastructure is in place so that when people believe a situation like this is about to arise, that information gets to the HSE and HIQA as quickly as possible. Is such infrastructure in place? How should staff, family members or others act in such circumstances?

Mr. David Walsh: There is ongoing engagement and a system. In the midlands, Louth,

Meath CHO specific contact points are available for every nursing home. Should people have concerns, they can contact their local CHO as well as the regulator obviously.

Ms Mary Dunnion: In addition, there is a concerns line in place for all residents, families and staff to contact HIQA. As the Deputy mentioned, some have availed of this.

Deputy John McGuinness: What is the HSE's response to the various concerns raised by the two witnesses this morning? How many inspectors does HIQA have? Why is there a designated inspector for individual nursing homes? Would it not be better to have random inspections? Did HIQA receive any complaints from nursing home staff, families of residents or individuals with knowledge of nursing homes and the care of the elderly at this particular stage in Covid-19? If so, what was its reaction to them?

In his opening statement this morning, Mr. Taylor stated there was little knowledge of the nursing home sector in the HSE. However, it is the HSE and the nursing homes support scheme that gather all the information on each individual client in these homes. There is, therefore, a lot of information circulating within the system and that seems to have been ignored. Those are my first questions.

Ms Mary Dunnion: I thank the Deputy.

Ms Mary Dunnion: I thank the Deputy. There are 24 inspectors for the 580 nursing homes. We have a concerns line and since 1 March we had 28 concerns in March, 176 in April and 88 thus far in May.

Deputy John McGuinness: Can Ms Dunnion repeat that?

Ms Mary Dunnion: From 1 March we had 28 concerns in March, 176 in April and 88 thus far in May.

Deputy John McGuinness: Where are these coming from?

Ms Mary Dunnion: The concerns come from staff, families and residents themselves. Predominantly, the issues staff have brought to our attention are the availability of PPE, testing and results, and infection control advice and procedures. Families have raised significant issues around safeguarding; quality of care; communications; the impact of visiting restrictions; social isolation for their families; obviously and very sadly; and the death of residents. Some families expressed concerns about the fact that we were inspecting. Residents have contacted us and predominantly the areas residents have brought to our attention concerns the issue of isolation and not seeing their families and the loneliness associated with that. They also had some concerns around their food within the particular nursing homes.

We follow up on all of the information we receive. Since 1 March we have conducted nearly 200 inspections across the nursing home sector and, as I said, some risk inspections are ongoing. All these concerns are followed through. Everybody gets to speak-----

Deputy John McGuinness: What was the finding? Were all these concerns upheld?

Ms Mary Dunnion: No, not all of them.

Deputy John McGuinness: How many of these concerns were upheld?

Ms Mary Dunnion: I would not be able to give the Deputy the number of concerns that

were upheld because the majority of them centred around the fact that families were unable to see their family members within a nursing home. That was significant and such was our concern that two weeks ago we wrote to the Health Protection Surveillance Centre to see if we could get public health guidance on how nursing home owners may be able to open their doors in a controlled manner with public health precautions so families could see their loved ones in nursing homes. That decision has yet to be made.

Deputy John McGuinness: There is less than a minute left but will the HSE comment on this morning's statements from witnesses?

Mr. David Walsh: I might ask Dr. Kennelly to talk about the discharge issue.

Dr. Siobhán Kennelly: A number of statements were made by Mr. Daly, particularly on the issue of acute discharges and how they were managed over the period of the pandemic. It is important to understand that national guidance was being issued from the earliest possible point. Much of that national guidance reflected the fact that we were learning about the pandemic as it evolved. There is no handbook to much of this, as many of the Deputies will understand.

Deputy John McGuinness: If I can just interrupt-----

Dr. Siobhán Kennelly: Essentially, the initial guidance issued on 10 March-----

Deputy John McGuinness: Does Dr. Kennelly broadly dispute-----

Dr. Siobhán Kennelly: -----referred to protocols around how those would be safely managed. In all cases where testing was needed, it was directed. That was based on our knowledge of the clinical course of the presentation of Covid-19 in older people at that time. There were also strong recommendations made in respect of facilities where residents might have had contact with patients in acute hospitals, that those facilities were able to isolate those patients and provide the appropriate level of IPC support. That was all out there from the earliest possible stage.

Deputy John McGuinness: Can my question be answered when we get the sound sorted?

Chairman: In fairness to Deputy McGuinness, he had a question which Dr. Kennelly did not hear because there are sound problems. Could the Deputy repeat it?

Deputy John McGuinness: Does Dr. Kennelly dispute the statements made by both witnesses this morning or does she accept some of the criticism and charges made in those statements?

Dr. Siobhán Kennelly: I refute it. As a matter of public record, I can show the Deputy evidence of the correspondence that myself and officials in the HSE issued through the system, in line with the public health advice and with colleagues from Infection Prevention and Control. It is very important to understand that we are in a very fast-moving situation when we are trying to address these issues. We were aware of the fact that we had approximately 670 delayed discharges in acute hospitals at that time. One of the biggest concerns for me, both as a clinician and as a geriatrician who is very involved in the care of these patients, was that in the event of an anticipated surge in these acute hospitals, many of those who had finished their acute episodes of care would be at very high risk in terms of contracting Covid. Everything we did and all the guidance we issued - including the very comprehensive guidance that was issued again on 17 March regarding how patients would be cared for in nursing homes, regardless of

whether they were in public or private facilities - was on the basis of the information we had and our understanding of the pandemic. In addition, there was a balancing of the risk for individual residents and how that risk would be managed by clinicians in acute hospitals and in long-term care settings.

Chairman: I ask Dr. Kennelly to send that guidance to the committee.

Deputy John McGuinness: I think the members should move to the committee room.

Chairman: It might cause a public health risk if we were all to crowd into a committee room. We are limited in terms of what we can do and how we do it.

Deputy McGuinness queried the appropriateness of inspectors being allocated to certain care institutions and asked whether it should be done on a random basis. What is Ms Dunnion's view in that regard?

Ms Mary Dunnion: I understand why people might wonder about that. The issue is that some inspectors may have responsibility for 30 nursing homes, although that rotates over a period and is not a fixed allocation. As nursing homes and disability centres are scattered throughout the country, sometimes the location determines which inspector can be assigned.

Deputy Patrick Costello: I wish to offer my condolences to those who have lost loved ones and to people living in nursing homes who have lost their friends, especially in light of our normal cultural ways of mourning loss being so difficult to achieve.

It is a great privilege for me to be here to ask questions of our guests. As a social worker, I am usually the one on the receiving end of interrogation by HIQA. It is nice that, for once, the tables are turned. Mr. Quinn stated that there is no clinical governance linked to the HSE for private nursing homes. I ask him to deal with the clinical governance for private nursing homes. Are there minimum staffing levels, staff-resident ratios and so on? How are such matters decided? What clinical governance exists, apart from HIQA enforcing standards?

Mr. Phelim Quinn: In local clinical governance, a number of nursing homes have a system whereby they link in with GPs, have assigned GPs or, in some instances, have medical officers who take responsibility for clinical governance arrangements. Obviously, individual residents who may have been referred into gerontology or other forms of services have specific links in that way. The key issue I outlined in my opening statement is the fact that there is no specific national structure or control in the context of the clinical oversight of the care of people who have been admitted to nursing homes as a result of multidisciplinary or other assessments. That absence is problematic as matters stand.

On minimum staffing levels, I will defer to Ms Dunnion in her role as chief inspector of social services. Issues in that regard were raised in the session this morning.

Ms Mary Dunnion: The regulations are weak when it comes to staffing. HIQA would very much welcome those regulations being looked at and would be happy to work on and contribute to that discussion. The regulations are very weak. It was stated during the session this morning that HIQA does not allow ratio staffing. That is totally untrue. The staffing levels are determined by the legal entity, namely, the provider of the nursing home, be it private or statutory. In a clinical context, staffing levels are not weighted as highly in a nursing home. By way of example, the legislation describes "a person in charge of a nursing home", whereas a director of nursing with gerontology would be a much stronger description. There are significant oppor-

tunities to look in that context at staffing and we can see the challenges staffing brought during this pandemic.

Deputy Patrick Costello: Is there a difference in the requirements between statutory, HSE-run nursing homes and private nursing homes regarding staffing or are the weak regulations affecting both?

Ms Mary Dunnion: The staffing levels depend on the registered provider. We identify a significant shortage of staff if we see it, but it is totally dependent on the provider. Statutory nursing homes and private nursing homes will decide their own staffing levels, and I believe the regulations are poor in that context.

Deputy Patrick Costello: I thank Ms Dunnion. A question that is perhaps more relevant for the witnesses from the HSE concerns how infection control is going to change how nursing homes operate. We are all trying to cope with social distancing, including down to the other side of Leinster House here. Fewer people are going to be in nursing homes as a result of social distancing. How will the system cope, on the statutory side in particular, with those changes and that impact? Is there concern about a reduction in admissions to nursing homes and the knock-on effects? If that happens, there will be a major loss of income from falling numbers. How does the HSE see the nursing home sector in general managing to cope with that? If the private sector is under more pressure, will that in turn put more pressure on statutory and community services?

Mr. David Walsh: I am conscious of the time. Deputy Costello is correct that capacity, in any setting, whether acute or long-term care, will be different in future, depending on the premises. There is an issue, and we need to rethink our model of care to address those issues because there is no short-term way of increasing bed stock or otherwise increasing capacity. We need to examine the model and see how we make it function in future. I am sorry, but I think we are out of time on that issue.

Chairman: I call Deputy Duncan Smith of the Labour Party.

Deputy Duncan Smith: I would like to pick up on HSE clinical oversight. There is obvious concern about the lack of HSE clinical oversight of nursing homes. HIQA has been the regulator for more than a decade now. After many visits to and engagements with nursing homes, did it at any point write to the Department of Health or the HSE prior to spring 2020 regarding that oversight model? If so, when was that and what were the details of that correspondence?

Mr. Phelim Quinn: In the course of recent years, we have written to the Department of Health on many occasions regarding the regulatory framework and the way that framework impacts on the sector. One of the key issues, for example, even concerning the advent of Sláintecare and planning for a statutory home care scheme, is that we have submitted several regulatory models to the Department of Health. They try to account for the older persons care pathway to ensure the regulatory framework spans that pathway and is not specific to individual care settings. I believe issues such as clinical governance could be addressed in that.

Deputy Duncan Smith: Has any response been received? Was there any kind of encouragement from the Department regarding taking this up or has HIQA been stonewalled?

Mr. Phelim Quinn: I would not call it stonewalling. There has been engagement with the Department on things such as the statutory home case scheme. That scheme, however, appears to continue to be in development as a separate scheme. Our recommendation, however, based

on our own experience within the sector, is that there should be more of a regulatory framework that spans the entirety of older persons services.

Deputy Duncan Smith: That is fine. I want to be clear on whether HIQA has physically visited any of those nursing homes in which there have been outbreaks. We know the inspectors need to use PPE etc., but have they gone in person to where there have been outbreaks?

Mr. Phelim Quinn: Again, I will ask my colleague to answer that. Most of what we have done up to this point has been based on information that we have also been exchanging with our colleagues across the four UK jurisdictions and across Europe. The pattern of inspection that we have engaged in has been very much informed by the engagement that we have had. My colleague will provide detail for the committee on the types of inspections that we have done to date and on the fact that we have reserved the right to do what we term risk-based inspection throughout the pandemic.

Ms Mary Dunnion: To date, we have not gone where there has been a Covid outbreak. However, that situation is changing because we are moving now into risk-based inspections under the guidelines of the national public health guidance. As I said, we have conducted a number of inspections since March but these have been, generally speaking, in the context of either opening new centres, changing so that there can be increased capacity if that is feasible and correct in line with the regulations and around contingency planning, particularly in the nursing homes that did not have an outbreak because we identified the risks. We learned, as did everybody else. That has been a good exercise with the nursing home providers. The feedback has been very positive in the context of that. We begin risk-based inspections now.

Deputy Duncan Smith: That will happen in places where there are outbreaks.

Ms Mary Dunnion: Yes.

Deputy Duncan Smith: That is good to know. In terms of the gerontological expertise within the leadership of HIQA, I understand none of the 15 Covid-19 health technology assessment guidance focuses on older people in nursing homes. What is the expertise for the nursing home area within the leadership of HIQA in terms of this crisis?

Mr. Phelim Quinn: There would be no specific medical gerontology expertise within HIQA. However, all HIQA staff are recruited with specific expertise across a range of specific services, which includes gerontology. This could be staff from a nursing and social care background or allied health professionals background.

Deputy Duncan Smith: Is that being addressed now? Has HIQA acknowledged that this lack of expertise should have been addressed previously and is it now rectifying the situation?

Mr. Phelim Quinn: It is not something specific because the other key issue as well is people with an aptitude for the role of a regulator. The Deputy mentioned as an example the evidence summaries that have been developed by our health technology assessment directorate. It must be noted that our health technology assessment directorate works on the basis of engagement with experts and expert advisory panels, which include gerontologists. All that work is informed by medical and other relevant scientists and expertise.

Deputy Duncan Smith: I thank Mr. Quinn and Ms Dunnion for their responses.

Deputy Róisín Shortall: I thank the witness for the presentation. I made a point earlier

that I think is worth repeating, namely, we are viewing all of this in the context of an extremely weak and irresponsible policy context. If anything, we should learn from this experience that this virus has exposed huge weaknesses in how we provide social care in this country.

I was struck by the comment in Mr. Quinn's opening statement that 80% of nursing homes are operated by private providers and that although they are funded largely through fair deal, the HSE did not know this sector. It is a damning statement of our national health service that in regard to up to 30,000 very vulnerable patients resident in nursing homes, the HSE did not know this sector and it needed to get information from HIQA. Mr. Quinn went on to speak about the current model of private residential care having no formal clinical governance links with the HSE, which is really extraordinary. There is no national clinical oversight of care for what is probably the most vulnerable group of patients in this country. That is damning.

I have some questions in regard to HIQA's action in this regard. It is clear HIQA had serious concerns about the lack of clinical oversight for this large number of patients. What did it do with those concerns? With whom were they raised? Apart from commenting on them in reports, with whom did HIQA raise them and on how many occasions did it raise them with the HSE, the Department or Ministers? What was the reaction when it did so?

Mr. Phelim Quinn: I agree with the Deputy that the circumstances of Covid-19 have exposed a significant number of weaknesses in the system. This is one of them. It is quite interesting that, as part of the solution and in the context of the work being done jointly by ourselves and the HSE in the endeavour to support the work of private nursing homes subsequent to the pandemic, we have seen greater co-ordination of care and a greater understanding of where care takes place within the sector. As already stated, on a number of occasions we have raised issues that we have had regarding the current regulatory framework. We have written papers and submitted them to the Department, which in the main is the policymaker in this instance.

Deputy Róisín Shortall: On how many occasions would that have been done?

Mr. Phelim Quinn: There have been a number of occasions and, as an example, we have certainly repeated or resubmitted the paper on the regulatory framework relating to the older persons' continuum on a number of occasions. In the advent of the development of the Sláintecare project office, we had discussions with the director.

Deputy Róisín Shortall: Did the authority receive responses to those?

Mr. Phelim Quinn: No, we have not received specific responses. Part of the engagement is ongoing. For example, the discussions relating to this have formed part of the basis of our discussions with respect to the statutory home care scheme.

Deputy Róisín Shortall: What about before that or the advent of Sláintecare?

Mr. Phelim Quinn: From memory, unless my colleague would reply differently, I do not remember a specific reply.

Deputy Róisín Shortall: There has been no response from the Department of Health to concerns about the lack of clinical oversight in the nursing home sector.

Mr. Phelim Quinn: No.

Deputy Róisín Shortall: That is quite extraordinary. I thank Mr. Quinn for his answer. My second question relates to infection control. The authority does many annual inspections

in respect of infection control and there are many concerns about that. At what point did the authority raise concerns about particular nursing homes that had fared poorly in inspections relating to infection control in the context of the virus?

Ms Mary Dunnion: We publish all of our reports; they are in the public domain. At the onset of this particular pandemic, we identified premises that would be challenged in the context of managing Covid-19 outbreaks. Our findings would have been communicated to the Department of Health and the HSE. We are talking about February and March.

Deputy Róisín Shortall: A list of nursing homes that would have been in the high-risk category would have been submitted.

Ms Mary Dunnion: Yes. We went further than that. We took a look at particular types of nursing homes that would have been at risk in the event of a Covid-19 outbreak. We would have determined these to be single, stand-alone providers and limited companies, as well as those with regulatory non-compliance not only with infection control but with governance and management, risk management and staff training.

Deputy Róisín Shortall: To clarify, was a list submitted-----

Ms Mary Dunnion: Yes.

Deputy Róisín Shortall: -----or were these types? Was it a list of nursing homes about which there were concerns? Was there a response to that list?

Ms Mary Dunnion: It was just an acknowledgement.

Deputy Róisín Shortall: Was it from the Department or the HSE?

Ms Mary Dunnion: It was from the Department.

Deputy Bríd Smith: We are seeing a serious attempt to pass the parcel today on the part of all the witnesses. It is not a failure of any one body - Nursing Homes Ireland, HIQA, the HSE or the Department - but at its heart it is a gigantic political failure to act in the interests of our elderly people. Since the late 1980s we have been privatising the care of the elderly. It was described by the Ombudsman in a 2010 report as a creeping move towards privatisation that has now become a gallop. We have a reversal of what we had in the 1980s today, with 80% of nursing homes in the private sector and 20% in the public sector. There should be no attempt by anybody to say "It is not me, it is them or it is not them, it is me". All are to blame here.

I point out to the HSE and HIQA that this is very similar to the Ruth Morrissey case in the context of CervicalCheck. The court was very clear in that instances when it stated that one cannot argue that because a service or care is subcontracted, responsibility can be passed on. Both HIQA and the HSE accept that patients are referred to private nursing homes. Responsibility for what has happened here cannot be avoided. I have a couple of questions for the HSE. I understand Mr. Walsh is a member of NPHET. Is that correct? We went through the minutes of NPHET, a committee which has been meeting since early January, and the first mention of care of the elderly was in early March. Can Mr. Walsh tell me when he decided that this was an issue for NPHET?

Mr. David Walsh: I can confirm that I joined NPHET for the first time on 10 March. My knowledge of proceedings starts at that point in time.

Deputy Bríd Smith: Was Mr. Walsh brought on to NPHET specifically for this issue?

Mr. David Walsh: I was brought on as senior operational manager within the HSE. My understanding is that at the time there was a decision to broaden the membership of NPHET to incorporate a broader perspective. I am not sure who else came on board at that time, but I and-----

Deputy Bríd Smith: That is fine. I will run out of time.

Mr. David Walsh: Okay.

Deputy Bríd Smith: It is clear that prior to Mr. Walsh coming on to the committee there is no mention of care of the elderly in the NPHET minutes. Despite this being a global phenomenon, it seems to have gone under the radar.

In the first three months of this year, 2,500 people were transferred from acute hospital settings into nursing homes under the fair deal scheme. Can Mr. Walsh tell me how many of those people were tested for Covid-19 before they were transferred?

Mr. David Walsh: I cannot. I do not have that detail.

Deputy Bríd Smith: Could he get that detail for us? I find it surprising that he does not know how many patients were moved from acute hospitals to nursing homes, having been or not been tested.

Mr. David Walsh: There are a couple of questions within that, including when testing first became available. I am happy to follow up on that for the Deputy.

Deputy Bríd Smith: I thank Mr. Walsh. My next questions are to HIQA. In its statement, HIQA said it told the HSE about specific homes. What specific homes did it warn the HSE about? Did it warn the HSE about specific homes and what action did the HSE take on foot of that? The statement also said that HIQA told the HSE where the homes were. Does that mean HIQA told it where all of the homes all over the country were located? If it did, did it highlight what particular homes it felt might struggle more than others based on its previous inspections, especially the 18% or so of homes that failed inspections?

Chairman: I ask that particular institutions not be named, if possible.

Mr. Phelim Quinn: That is fine. The first part of the Deputy's question referred to particular homes. We dealt with those homes that had made contact with us and were struggling to cope with the virus within those homes. At that point, we referred specific issues to the HSE for support.

The location of homes gets to the heart of what I said earlier. The HSE is not necessarily familiar with the entirety of the sector. We supplied it with information on locations, the numbers of residents and staff etc. in those homes.

I want to reference the point made by my colleague earlier. She had provided to the Department a list of high risk homes.

Chairman: I understand Ms Sandra Tuohy, assistant national director for older persons services, wants to answer Deputy Smith's question. Is that correct? I was told by the secretariat that Ms Tuohy wished to speak. If I am incorrect in that, we can move on.

Deputy Bríd Smith: Can I ask one final question?

Chairman: You are out of time.

Deputy Bríd Smith: I lost seconds because of the Chairman's intervention.

Chairman: The reason I intervened was that you asked the witnesses to name particular people. You are in the Chamber longer than I am.

Deputy Bríd Smith: I am not asking for names. I want one short message from the HSE. Is it now testing staff before they take up roles in nursing homes?

Mr. David Walsh: I did not hear the start of the question. I am sorry.

Deputy Bríd Smith: Until 12 March, the HSE was not testing staff in nursing homes. Then, the testing started after we raised the issue here in the Dáil. Is the HSE now, this day, currently, testing staff who enter nursing homes to take up a job?

Mr. David Walsh: I will ask Dr. Kennelly to answer that.

Dr. Siobhán Kennelly: One of the opportunities here is to highlight the limited role that kind of testing approach actually has. Unfortunately, the way it actually is with Covid-19 testing is that a person can test negative for it today and be positive for it tomorrow. We have learned hugely through the risk of-----

Chairman: Please be brief in your answer, Dr. Kennelly. We may get an answer in more detail by way of correspondence.

Dr. Siobhán Kennelly: We have learned hugely about the disease in the course of the pandemic. We know that asymptomatic transmission-----

Chairman: I do not know whether it is a sound problem or a more general communication problem. Please be very brief and maybe provide a more detailed answer by way of correspondence.

Deputy Bríd Smith: It is a "Yes" or "No" answer.

Dr. Siobhán Kennelly: That is fine. I would simply say it cannot be a blanket "Yes" or "No" answer because actually testing does not work that way.

Chairman: Thank you, Dr. Kennelly. If you wish to provide more information by way of correspondence, that is fine.

Dr. Siobhán Kennelly: I would be happy to do so.

Chairman: I apologise for bringing witnesses in and not giving them more time to answer. We simply do not have more than two hours.

The Regional Group is next and Deputy Shanahan has five minutes.

Deputy Matt Shanahan: I am unsure who these areas might relate to. They are possibly for HIQA or the HSE. Maybe a written answer for one or two of them might suffice.

My first question relates to nursing homes and personal protective equipment availability. I understand gowns are still a particular issue for several nursing homes. There also appears to

be confusion regarding the use of PPE in certain sections and nursing homes, especially over where and when it should be used. This is informally coming back from some nursing homes managers. Have the authorities issued any guidance aside from what came out earlier on in the engagement?

I have a question on staffing, especially in respect of healthcare staff who are deemed vulnerable or at risk. Again, there appears to be confusion in terms of those who are vulnerable. They are basically told to isolate at home. Others who have been exposed to Covid-19 patients are at risk. Maybe this needs to be clarified nationally to nursing home managers.

I brought up another issue in the Dáil some weeks ago. It still has not been addressed by the HSE. Why are senior nurse managers in nursing homes not allowed to take swab tests and present them to the local care setting? I know in Waterford at present we have been successfully using the University Hospital Waterford south east regional pathology laboratory. We are turning around swab tests in less than 24 hours. It seems we have to send out National Ambulance Service personnel to take swabs. Why are we doing that when we have qualified people in-house to do it? Maybe someone could answer that.

The HSE has supplied accommodation relief for healthcare workers who are living together. This was not extended to nursing home personnel. They have to meet these challenges themselves. Does either the HSE or HIQA have thoughts on that?

I want to ask HIQA about nursing home inspections. My understanding is that the authority has been engaged in desktop reviews for quite a period and that authority staff have visited the facilities. I believe any further reviews should be done by way of desktop review. We should not have inspectors coming in or transiting in and out of nursing homes unless the authority has a specific concern backed up by a complaint.

In one of the opening statements, a HIQA inspector stated that significant facilities are the point of failure, in other words, the infrastructure on-site. Has HIQA any plans to support policy to allow some mandating of capital by Government to allow these systems to be rectified? I presume we are talking about private homes that are not in a fit state and that were never meant for the number of patients they are now carrying.

Is there an opportunity to look at the early de-isolation of patients? I am referring to those who have proven antibodies. Surely, we can find a way to recognise these patients and allow them to have access and go back to their family members.

Has HIQA any specific opinion on the failure of the Minister for Health to appoint someone from the nursing home sector to the expert review panel?

Chairman: I would ask that any questions not answered in a minute and a half be answered by way of correspondence.

Mr. Phelim Quinn: My colleague will take some of those questions.

Ms Mary Dunnion: The Deputy asked about HIQA inspections, and he is quite correct. We have had a combination of site and desktop inspections. Going forward, they will be risk-based inspections where there is a risk to quality or safety. That is under public health advice.

We will be very pleased to work with the expert review panel and submit any information that we have and that it requires. I think the other questions are particular to the HSE.

Mr. David Walsh: According to the last figure I heard, 29% of the accommodation uptake was from staff in private nursing homes, so that facility is still very much available right across the sector. No differentiation is made. I ask Dr. Kennelly to talk about the testing processes.

Dr. Siobhán Kennelly: I agree with Deputy Shanahan on this. A number of CHOs have put in place training in order that the nursing homes can run that testing. Part of that is about then being able to get the tests to the relevant laboratories. A national testing pathway is being put in place through NPHET and the HSE. That will be available to us in due course in terms of how testing will be upscaled.

The other question the Deputy asked was about the possibility and the role of antibody testing in a nursing home population. Unfortunately, we have very little evidence that antibody testing will play a huge role, particularly in that population, in residents' ability to mount immune responses, so we cannot say with any assurance that that would be the appropriate way to go. We are, however, with HIQA and others, very conscious of the role of visits, which a number of Deputies have highlighted, so that guidance is being reviewed and will go through NPHET - I hope on Thursday, as mentioned - in order that we will be able to start opening up visiting in our nursing homes again.

Deputy Michael Collins: I welcome our guests. I have a number of questions, starting with HIQA. I understand that for new builds of nursing homes and community hospitals, 80% of resident accommodation must consist of single rooms and there must be no more than four residents per multi-occupancy bedroom. Is this correct?

Ms Mary Dunnion: Yes, there are national standards. There is, however, a statutory instrument which allows both private and public nursing homes an opportunity until January 2021 to become compliant with these standards, and that is ongoing.

Deputy Michael Collins: The question concerns older nursing homes and community hospitals. I know that a number of them are meeting the 80% single occupancy requirement. Quite a lot of them in my constituency of Cork South-West have been brought up to top standard. For others that are working towards the standards, when is the cut-off date for meeting the standards?

Ms Mary Dunnion: It is expected, on the basis of the statutory instrument, that these physical infrastructure issues are to be addressed on or before 1 January 2021.

Deputy Michael Collins: Am I correct in stating that the original date to meet the HIQA 80% single occupancy standard was in 2016?

Ms Mary Dunnion: That is correct.

Deputy Michael Collins: That was changed or extended to a later date. Is that the case?

Ms Mary Dunnion: Yes. There was a statutory instrument which allowed the timeframe for that to be achieved.

Deputy Michael Collins: In view of Covid-19, does Ms Dunnion think this was a wise decision?

Ms Mary Dunnion: It is an ongoing challenge for providers. We feel very strongly about it and have taken many regulatory decisions based on the amount of space available for each resident. This has been challenged by providers, and the statutory instrument allows them that

opportunity until January 2021. We believe, however, that it is very important, not only for infection control but for residents' rights to personal possessions and freedom of space, to be able to have visitors and that privacy. We see that as an essential component of a person's life in a nursing home.

Deputy Michael Collins: One of the reports is from a hospital in west Cork where former nursing home residents are residing. I will just quote from some of the report and I will not mention the hospital. The report states:

> - The use of multi-occupancy rooms for up to seven residents did not support the receipt of personal care and communication in a manner that protected privacy and dignity.
>
> [...]
>
> One resident had complained that sharing a five bedded room with one en-suite bathroom was difficult. Residents in a six bedded room had taken over the bed spaces of vacant beds to store some of their personal items as they did not have enough space by their own beds.

Why were these community hospitals not brought up to standard? I have spoken to the staff in this hospital. The stress they have been working under has been phenomenal.

They have been let down by the Government, the HSE and someone here because the standards should have been complied with in 2016, as with other community hospitals. They were not complied with, though, which has sadly led to Covid deaths. I am not saying that this is the specific reason, but it very much looks from HIQA's report like there was an issue and standards were not met. They still have not been met and it has cost lives. Why were the standards not applied across these hospitals by the first deadline of 2016?

Ms Mary Dunnion: Regulation is an instrument of policy. In this context, I concur with the Deputy. It is of great regret to us that residents are not having a lived experience in nursing homes that allows them the privacy, dignity and rights to which they are entitled.

Deputy Michael Collins: I have a question for the HSE in the short time available to me. Does it plan to test and monitor the variables within these settings, including the testing of staff on at least a weekly basis with an efficient turnaround of results?

Mr. David Walsh: I might add that the HSE is in the middle of a major capital plan to address some of the issues the Deputy discussed. We will have to assess what the impact is of the current stalling of that because of the pandemic.

Regarding the premises as they currently operate, there are questions as to what their capacity will be in future. Each CHO, linking with its public health colleagues, will follow public health advice in terms of how testing should be conducted within those units.

Deputy Michael Collins: Will the HSE allow doctors and nurses to carry out Covid-19 tests and local labs, some of which provide same-day results, to analyse them instead of flying them out to Germany?

Mr. David Walsh: A national strategy on testing in the medium term is to be reviewed and completed in the next few days. The testing that takes place will be guided by it. I understand that this matter will be considered by NPHET over the next number of days.

Chairman: Next is Sinn Féin. For how long is Deputy Doherty speaking?

Deputy Pearse Doherty: Ten minutes. I will begin by expressing my sympathy and condolences to everyone who has lost someone during this pandemic as well as to all of those working on the front line in our nursing homes and the organisations that our guests represent who are trying to suppress the pandemic in our communities.

As of yesterday, there were 1,606 confirmed deaths as a result of Covid-19. Thankfully, none was reported yesterday. Long may that continue. My first question is for HIQA. How many of those----

Chairman: I am sorry, Deputy, but this is entirely my fault. Before the Deputy asks his question, I should say that I have realised that I have taken Deputies in the wrong order. The next speaker is actually from Fine Gael. My apologies.

Deputy Pearse Doherty: That is fine.

Deputy Colm Burke: Deputy Doherty has already started.

Chairman: Okay. Deputy Doherty can proceed.

Deputy Pearse Doherty: Of the 1,606 individuals who lost their lives, how many were residents of nursing homes?

Ms Mary Dunnion: Under legislation, every provider has to issue a notification of an unexpected death. We receive those notifications every day. In 2019, 150 unexpected deaths were reported. In 2020, 1,029 unexpected deaths have been reported as of this morning. This does not mean that all of those deaths are related to Covid-19, but they are classed as unexpected. The validation of those figures will be done by the Health Protection Surveillance Centre, HPSC.

Deputy Pearse Doherty: There are reports. For example, we knew on 6 May that 740 of the deaths, or 54%, were in nursing home settings. Is Ms Dunnion saying that HIQA does not know how many of the 1,606 were residents of nursing homes?

Ms Mary Dunnion: No. These are all residents of nursing homes.

Deputy Pearse Doherty: I am sorry, but I meant Covid-related.

Ms Mary Dunnion: We do not know the verification of whether that was the cause of death. What a provider must report to us is what is classified as an unexpected death. The relationship between the 2019 and 2020 figures and centres with Covid are the data that we share with the Department of Health, the HSE and the HPSC. The validation of the actual end figure rests with the Health Protection Surveillance Centre.

Deputy Pearse Doherty: The only accurate data I can find that has been published goes back to 6 May, which was that 740 of the Covid-19-related deaths at that time were from nursing home settings.

Ms Mary Dunnion: I am unclear as to the source of those figures but the validated figures are from the Health Protection Surveillance Centre.

Deputy Pearse Doherty: Can the HSE shine any light on this?

Mr. David Walsh: I am quite happy to follow up and get an updated figure for the Deputy. I do not have one in front of me.

Deputy Pearse Doherty: Are there any figures on the proportion of deaths of residents of nursing homes in the private sector and in the public sector? I put this to HIQA because in its opening statement it mentioned, in particular, the challenges of the private sector. Was there a more acute issue in the private sector than in the public sector or was it balanced?

Ms Mary Dunnion: I do not have the figures but we will be able to supply those to the Deputy. To reiterate, these are classified as "unexpected deaths". Validation that they are related to Covid-19 is not part of the information that we hold in HIQA but I can give the Deputy the breakdown of unexpected deaths from private to statutory centres. We will forward that information to him.

Mr. Phelim Quinn: If I may interject here, a more up to date figure could probably be produced by HPSC given that we have been made aware that 52.4% of deaths so far have been within the long-term residential care sector. There probably would be a bit of work to be done but the HPSC could provide that.

Deputy Pearse Doherty: HIQA has in the past given the Department of Health and the HSE a list of centres that would have been in breach of regulations, training, etc., in different HIQA inspections. Has HIQA monitored whether there has been an increased number of deaths in those centres that it listed or has it left it to the Department?

Mr. Phelim Quinn: No, but I think what we probably could do is provide some form of correlation on this. That would be quite an exercise. In the first instance, our rationale for providing the list for what we believed were centres that were more at risk was to enable a swifter response from the support services.

Deputy Pearse Doherty: Is HIQA aware of any member of staff who was not allowed to isolate having been in contact with somebody who was Covid-19 positive at the early stages or of staff members who were being asked to return to work, despite the fact they may have been symptomatic?

Ms Mary Dunnion: No, we have no information of that sort.

Deputy Pearse Doherty: Can I ask the HSE that same question?

Mr. David Walsh: The public health advice on people with symptoms has always been clear. I was aware of a query in regard to one nursing home but that was clarified and the person was not allowed back to work. I am not aware of any other instances but I will be happy to follow up on any information the Deputy may have that that is occurring.

Deputy Pearse Doherty: We will pass on that information afterwards.

On the appeals made by Nursing Homes Ireland on PPE, testing and guidance, what did the HSE do about all of those emails being sent to the HSE, which it was copied into time and again? Did the HSE take any action on the nursing home sector? Specifically, given the number of deaths and the great trauma and heartbreak that has occurred within those settings, does it believe now, with the benefit of hindsight, that any of those deaths could have been prevented? If so, what type of actions could have been taken, which were possible and should have been taken in the early months of February and March?

Mr. David Walsh: The HSE has engaged on Covid-19 with Nursing Homes Ireland since January of this year. I will ask Ms Sandra Tuohy to go into the detail of that.

Specifically, on PPE, the HSE was very clear from the outset that it would not differentiate between public, private and voluntary settings. I am aware that units, whether public or private, wanted more PPE. We are all clear that the overall increase in demand for PPE required us to prioritise the distribution of same to those premises that were affected by either suspected or confirmed outbreaks. To date, the HSE has supplied in or around €27 million worth of PPE to private nursing homes since the beginning of March.

Deputy Pearse Doherty: Nursing Homes Ireland was repeatedly calling for guidance on patient transfer. On 10 March the HSE issued guidance to Nursing Homes Ireland and it responded to the HSE to basically say that it was not good enough, it wanted testing of patients before they were transferred and it wanted PPE. Does the HSE now believe it was a mistake to transfer patients into nursing home settings without being tested first?

Mr. David Walsh: I will ask Dr. Kennelly to address that question because guidance was given and that guidance is still in place.

Deputy Pearse Doherty: The guidance did not include testing. Are the witnesses saying it still does not include testing?

Dr. Siobhán Kennelly: No.

Deputy Pearse Doherty: If a patient is transferred to a nursing home, is any testing carried out before the patient is transferred?

Dr. Siobhán Kennelly: That is incorrect. The protocols that are in place and that have been developed in conjunction with colleagues in public health and infection prevention control speak to the role of testing in the specific patient scenarios. The Deputy has to remember that in early March we were still in a situation where many of our hospitals did not have Covid-19 and many of the people who were being transferred out would not have had any exposure to Covid-19. In those instances, it was appropriate not to test patients but all transfers were given a caveat that where there were any suspected symptoms, patients were not to be transferred and they were to be tested first. In addition, all facilities were to have appropriate isolation facilities to be able to manage and monitor patients with appropriate precautions from an infection control point of view for a 14-day period when that transfer was made.

Deputy Pearse Doherty: Nursing Homes Ireland made the point on asymptomatic individuals who had Covid-19 in the 40% range and in the emails it sent it detailed that it wanted all patients tested before transfer. Does Dr. Kennelly believe that was a mistake?

Dr. Siobhán Kennelly: We did not have information on what asymptomatic transmission looked like in Covid-19 until well into later March. One of the things that is important to highlight in terms of some of the response is that we were also beginning to learn that presentations of Covid-19 in older people were quite atypical. They did not fit the case definition that would have been put out in terms of cough, fever and shortness of breath-----

Deputy Pearse Doherty: With respect, we are short on time. The guests from Nursing Homes Ireland told us in the earlier session that it was looking at international experience. Was it the case that Nursing Homes Ireland was way ahead of where the HSE was? It wanted the testing because it was looking at asymptomatic patients. The HSE refused that point blank time

and again. It was looking for PPE that was not coming. Most importantly, it instigated visitor restrictions that NPHET - including members from the HSE - overturned. Was it not the case that Nursing Homes Ireland was ahead, that the HSE and the Department of Health were unfortunately behind the curve with the restrictions and supports that were needed and that as a result of this virus, we have unfortunately seen a huge loss of life within these settings?

Mr. David Walsh: The facts show that there has been an unprecedented level of support to private nursing homes since the commencement of this process, including the standing up of nine area crisis management teams and 23 Covid-19 response teams to provide direct support and input into the private sector-----

Deputy Pearse Doherty: The facts show that Nursing Homes Ireland was ahead of the curve.

Chairman: I thank Mr. Walsh and Deputy Doherty. The Deputy has made his point. I call Deputy Colm Burke.

Deputy Colm Burke: I thank the witnesses for coming here today and for being available to answer the questions we are putting to them. On the 584 centres that HIQA inspect, my understanding is that 80% of those are private and the other 20% are public. Of the 20% that is public, are they community hospitals and mental health facilities? Perhaps we could get a breakdown of how that is made up and the numbers relating to both private and public.

On the list of facilities given to the Department, may we have a breakdown of what numbers were public and what were private? Perhaps the witnesses might even outline that to us now at this stage.

Mr. David Walsh: I will ask my colleague.

Ms Mary Dunnion: There are 580 nursing homes of which 114 are statutory ones. There are 31,000 residents in total, and 5,708 are in HSE-funded centres. When we talk about this sector, it is all nursing homes, as determined in the Health Act. They are called designated centres for older persons.

In the context of the escalations, yes, there was a percentage which were statutory, a lot of those based on the premises. On the risks that were there should there have been a Covid outbreak, I would not be in a position to give that information at this moment but we can certainly furnish the ratio between private and public.

Deputy Colm Burke: A list of public and private nursing homes was given to the Department. Can we have the breakdown of public and private?

Ms Mary Dunnion: Yes, we can furnish that information.

Deputy Colm Burke: I want to ask about the HSE and congregated settings. We had a number of incidents and deaths in a number of facilities like Portlaoise, Phoenix Park and the community hospital in west Cork. I have spoken to people who worked in those facilities. For instance, I know that there were no changing facilities for staff in some of those facilities and there were six patients per ward. Surely these facilities were identified as high risk at a very early stage. What action was taken to deal with the situation when they were identified as high risk?

Mr. David Walsh: The Deputy is correct in that. There have been 76 outbreaks in mental

health facilities as well as a very significant number in older persons and disability settings. Without prejudice to the numbers that HIQA may provide afterwards, there were 90 premises on the HSE older persons side that required either full replacement or remedial works to meet the standard around the maximum of four to a room. The infection control guidance and advice that applies to every setting applied to each of those premises as well. As part of the area crisis management team process, each CHO was required to implement those measures right across those settings.

Deputy Colm Burke: Remedial works, in some cases, were not taken until after people had died in the facilities. Does Mr. Walsh agree with that?

Mr. David Walsh: I am not sure what the Deputy means by remedial works. In fact, as part of the capital programme, there is a very significant amount of pretty serious capital work yet to be done before the overall standard is met. Certainly, services worked within the limitations of their physical infrastructure to meet the standards and implement the infection control guidance with assistance from local departments of public health and from their consultant colleagues from hospitals.

Deputy Colm Burke: With the ones identified as very high risk, I know that no action was taken with at least two of them, even though they would have been high risk because there were at least six patients per ward. No action was taken until it was identified that patients were positive.

Mr. David Walsh: I am not sure what the Deputy means by "no action."

Deputy Colm Burke: I am talking about in one case, for instance, a simple one of changing facilities for staff.

Mr. David Walsh: I am not aware of that.

Senator Colm Burke: I am aware of it.

Mr. David Walsh: I am happy to follow up on it.

Senator Colm Burke: I understand that in more than one place, no remedial action was taken until after people were identified as positive and in some cases until after people had died in the particular facility.

Mr. David Walsh: As I said, the Deputy has information that I do not have. I am happy to follow up on it for him.

Senator Colm Burke: I thank Mr. Walsh.

Deputy Stephen Donnelly: I thank our witnesses for attending today. It seems clear given the scale of clusters, outbreaks and fatalities in nursing homes that opportunities were missed to support the nursing homes and prevent contagion into them. Various vectors into the nursing homes have been discussed today, including staff being discharged from hospitals, for example. I believe one of the reasons is that nursing homes and older people have had no voice in the room where the decisions are being taken, which is the National Public Health Emergency Team. I have put this to the Minister for Health repeatedly in the Dáil and he has repeatedly told me that nursing homes do have a voice and HIQA is their voice. The Minister's formal position is that HIQA is the voice of nursing homes on NPHET. We have a limited number of minutes from NPHET meetings but on 30 January, the second meeting, HIQA was present and

nursing homes were not discussed. On 4 February, the third meeting, HIQA was present and nursing homes were not discussed. At the fourth meeting on 11 February, HIQA was present and nursing homes were not discussed. At the fifth meeting on 18 February, HIQA was present and nursing homes were not discussed. On the eighth meeting on 25 February, HIQA was present and nursing homes were not discussed. At the ninth meeting on 3 March, HIQA was present and nursing homes were not discussed. At the 12th meeting, on 10 March, HIQA was present and nursing homes were discussed. The action that was agreed was that the unilateral restriction of visiting to nursing homes was not required at that time. At the same meeting, NPHET agreed that we needed to look seriously at closing all of the schools in the country because the outbreak had become so severe. Within 36 hours, it made that recommendation and the Taoiseach implemented it two and a half days later. If HIQA has been the voice of nursing homes on NPHET, and given that it has clearly been at all of the meetings, why did it never raise the crisis that was emerging in nursing homes? When the crisis was finally raised, why did HIQA stand over a decision that visitor restrictions were unnecessary which the nursing homes had put in place themselves because they were aware that there was a crisis?

Mr. Phelim Quinn: The Deputy is quite correct in that HIQA was invited onto NPHET quite early on. There was no specific reference at that point to HIQA being the voice of nursing homes. HIQA is an organisation with a very wide remit. It has a remit for the regulation of health and social care services in Ireland, which includes our healthcare services, adult social care services, children's services, health technology assessment and standards development. It was from that perspective that it was my understanding that HIQA was being invited onto NPHET. I would appreciate that there has not been reference within the minutes in respect of nursing homes. However, I am also aware that on 4 March there was a specific sub-group of NPHET set up to look at vulnerable people, which would have included the nursing home sector. Colleagues from HIQA were at that point nominated onto that group. I believe it is from that point as well that HIQA played a very significant role in providing information, data and a number of other sources that dealt with the way in which we were looking at nursing homes, perceiving the problems within the nursing home sector and also how we at that point started to support that sector.

Deputy Stephen Donnelly: Given that HIQA has said the HSE has stated it does not understand the private nursing home sector, it is fair to think the Department of Health does not either as it is a further step removed. The only people on the National Public Health Emergency Team are civil servants from the Department of Health, HSE officials, a few virologists and HIQA. HIQA representatives were the only people in the room at all of those meetings who had any understanding of what was going on in nursing homes. Why did it take so long to raise the issues? When it was raised on 10 March why did HIQA stand over a decision not only not to protect the nursing homes but to open them up again?

Mr. Phelim Quinn: It is my belief the specific decision taken on 10 March was taken on the basis of the disease profile in Ireland at that particular time and the associated public health advice. We in HIQA are not public health experts and we followed and accepted the public health advice at that particular time. I appreciate the public health advice changed two days later when the disease profile also started to escalate in the country. At that point, NPHET decided to restrict visiting.

Deputy Stephen Donnelly: Does Mr. Quinn accept it was HIQA's role to raise the crisis with the public health officials on NPHET so they could react? This was part of why it was there.

Mr. Phelim Quinn: I believe that role was there but at that particular time the issue of visiting was based on public health advice.

Deputy Mary Butler: My first question is for the HSE. Mistakes are made in a time of crisis. The most important role of the committee and all of the stakeholders is that we learn to be better prepared in case we have a second wave, which is highly probable. In his opening statement this morning, Mr. Daly of Nursing Homes Ireland referred to aggressive recruitment of nursing home staff initially by the HSE. Is it true that the HSE actively head hunted staff from nursing homes? Was this not unfair and counter-productive?

Mr. David Walsh: I discussed with Mr. Tadhg Daly, I cannot remember the exact dates but early in the process, the issue of recruitment. I assured him of a couple of things. The first was that the national director of human resources wrote to each CHO and hospital group asking them not to recruit actively from the private nursing home sector. The second was regarding the Be On Call For Ireland panel. The national director of human resources made it clear within the HSE that nobody working in a healthcare setting in the country, including in private nursing homes, should be recruited through that process but that it should be used to bring in new people.

Deputy Mary Butler: Unfortunately it still happened and I believe Nursing Homes Ireland requested a moratorium regarding staff. I know the HSE cannot prevent a staff member moving to another job but at this time of an unprecedented pandemic it had a huge effect on the ability of nursing homes to be properly staffed during the peak of the crisis.

Mr. David Walsh: I know that in a number of cases arrangements were made, even though contracts had been signed, to leave people with their current employers for a period of time. I know there have been a couple of cases where people did move, and that is regrettable, but in the main private nursing homes are not a target for recruitment by the HSE. Obviously there are people on panels, and Mr. Daly said so this morning, and there is movement between the sectors at all times, but certainly the message I have given out, as has the national director for human resources, is that we do not want to undermine in any way the provision of healthcare in any other part of the system.

Deputy Mary Butler: Does Mr. Walsh accept that patients being transferred in March and April from acute hospital settings to nursing homes should have been tested for Covid-19? Does he accept this non-testing would have contributed to higher mortality?

Mr. David Walsh: I will ask Dr. Kennelly to address that.

Dr. Siobhán Kennelly: I thank Deputy Butler. With regard to the staffing issue, it is not in anybody's interest for one sector to deprive another sector of staffing. Clearly, there are going to be major issues to be addressed as a result of this in terms of governance and resilience in general within the private nursing home sector, in particular a need for them to reflect on their own staffing issues and possibly the issues that arise in terms of short-term contracts and the security they themselves can give to those staff.

To move on to the Deputy's question with regard to the transfers, again, the big learning has been around the fact that asymptomatic transmission was not a feature of WHO or ECDC guidance until 18 March and the guidance we had been issuing around the end of February and in early March did not reflect that. In fact, if we look at the WHO guidance, it indicated "possible" asymptomatic transmission, so everybody was still rigorously applying a case definition

that was based on people having symptoms. When these patients were moved, they were not tested on the basis they did not have symptoms.

The other key piece was that if staff coming in from the community to work in these care settings did not have symptoms, they were not being tested either. We have learned a lot from the mass testing exercise in that regard. Clearly, the guidance we will be issuing to revisit that will look substantially different on the basis of the learning we have had in terms of that testing piece.

I would like to reiterate it is not the case that testing gives a definitive result where Covid is concerned. People can be Covid-negative today and Covid-positive tomorrow. That is the nature of the condition itself, particularly in the pre-symptomatic phase. It is also the case that we know that about 20% of patients who test as negative or not detected for Covid may actually develop symptoms in the following 14-day period. For that reason, all of these transfers were advised to be isolated and monitored for a 14-day period because these are our best safeguards.

Deputy Mary Butler: I want to reiterate the second part of the question. Does Dr. Kennelly accept that this non-testing, even after 18 March, would have contributed to higher mortality in nursing homes?

Dr. Siobhán Kennelly: It is very hard to say that, with all due respect. We have looked at the international evidence. The first published report that really reflected the high prevalence of asymptomatic transmission, particularly in congregated settings, was on 27 March in the *New England Journal of Medicine*. That is how quickly things have been evolving in this pandemic. We know we had testing of asymptomatic residents in our mass testing exercise, which took place on 14 April. It is very difficult to say because we do not know what the mortality looks like in terms of patients who have tested positive but who were asymptomatic. Clearly, we are going to have to look at the staff testing protocols, how that is to be done on a regular basis and how that situation gets managed from here. That is what the national testing strategy is going to inform in the coming weeks.

Deputy Norma Foley: At the outset, I want to convey my sympathies to the families of all those who have passed away in the nursing home setting at this time, and to acknowledge the trauma for families and, equally, for nursing home staff.

The focus today is very much on Covid-19 and how that has hit the nursing homes but, in the interests of balance, it is important to acknowledge that many nursing homes remained free of Covid. Equally, with regard to the nursing homes that were hit by Covid-19, it was not just peculiar or particular to nursing homes and it is what we are living with currently. There needs to be balance in the whole discussion.

Deputy Butler put it superbly when she acknowledged that in any crisis situation, the measure will be what we learn from it. In that respect, I would like to point to the fact there was quite an amount of confusion and lack of clarity at the outset as to how things were operating within the nursing homes. Nursing homes were told that patients were to remain in nursing homes and not be transferred to hospitals yet, at the same time, patients were being discharged from hospitals and brought to nursing home settings without testing. All of that confusion did not help the situation. Equally, it is my understanding that on 14 April the HSE informed HIQA that due to difficulties in sourcing PPE it would not be possible to provide the three day baseline for PPE, as promised, and PPE would be directed to those areas termed greatest risk. On that particular date, 14 April, the number of clusters in nursing homes had risen to 158. There

was a litany of confusion and lack of clarity but going forward, and I have discussed this with a number of nursing homes in my own constituency, is there an ongoing commitment from the HSE to provide PPE or is there a cut-off date?

Mr. David Walsh: The HSE is committed to providing PPE and as the CEO said, probably at this committee last week, we are looking at a probable total commitment over a 12 month period of in excess of €1 billion across all sectors. To date across private nursing homes, the HSE has provided in or around €27 million worth of PPE and millions of items. At this time there is no suggestion whatsoever that is going to cease. If anything, as more need is identified, it is met. That being said, in discussions with Nursing Homes Ireland we have encouraged it to continue to explore its own sources because more is better. Until such time as we can not only meet demand but begin to accumulate stock to provide a buffer, I do not think any of us will be satisfied on the overall position regarding PPE.

Deputy Norma Foley: I welcome that. A point raised with me by a number of nursing homes is the current position where if a patient has to be transferred to a hospital for a minor procedure - it may well be an X-ray, a cardiac issue or a pacemaker or a defibrillator check - on return to the nursing home, even though he or she might have only been on the hospital campus for an hour or two, he or she is expected to go into 14 day isolation. That adds considerable trauma for the individual, families, and the nursing home. Nursing homes are now making the decision on what is most urgent so that people might or might not attend hospital. Is there a better way of doing things going forward? Is it possible services may be made available at nursing home sites rather than people having to go to hospital? Is there an opportunity for learning there?

Dr. Siobhán Kennelly: As we speak, guidance around all of that is being revisited to give clarity. As somebody who has been working in the sector for a number of years, I am well aware of how people are trying to balance those risks. We are trying to issue guidance on what care can be delivered, when, and by whom in as responsive a way as possible. It is important to reiterate that.

On those short-term visits the Deputy is talking about, the feeling is that anything that can be done in a short period does not require isolation afterwards. Again, it is important that people understand the role that asymptomatic transmission and the potential for asymptomatic transmission play in this. Clearly, people who need overnight or more prolonged stays will require isolation on transfer back. That will all be addressed. It is important to note everything that is happening is being monitored on a close basis by our colleagues. Massive issues have been highlighted by the Deputy's colleagues with regard to the discussion around governance and resilience, and how they are going to be managed out in terms of the ongoing risk of transmission and ongoing risk to nursing homes. As a clinician, I am alive to it, as are most people here, and unless there is a systemic address of some of the issues that have been highlighted throughout the discussion they will continue to pose a challenge.

Deputy Norma Foley: The turnaround for testing of staff in nursing homes has proven quite problematic as well. I want to raise that with the witnesses.

Mr. David Walsh: I can answer that. When we started large-scale testing in nursing homes turnaround times were not where they needed to be. That has improved week on week, and there is still some improvement to be got. The GP referrals are now working very well. We need the same turnaround for nursing home testing and any employment-related testing.

Chairman: I have a couple of questions before we finish. The witnesses from HIQA spoke about national clinical oversight. The Care Quality Commission, CQC, HIQA's equivalent in the United Kingdom, required that a clinical lead be identified by each care facility by 15 May because the situation in the UK at the time was the same as the situation still is here, wherein a number of different GPs were going in and out of care facilities treating different patients without clinical oversight in the care institution. Is that something HIQA would like to see happen here and, if so, would it require legislative change? I ask that question given the committee's remit.

Mr. Phelim Quinn: I am not specifically aware of that particular recommendation by the CQC-----

Chairman: It was not a recommendation; it was a legal requirement.

Mr. Phelim Quinn: That would certainly be worthy of exploration in the current context. Given that Covid-19 will be with us for quite some time, that would be a useful step.

Chairman: Is "worthy of exploration" as far as Mr. Quinn will go?

Mr. Phelim Quinn: Yes. I would not want to bounce into something that is unexplored at the minute and how it would actually work in the context of nursing homes. Clinical oversight would certainly be extremely useful, however.

Chairman: Does Ms Dunning have any view on the matter?

Ms Mary Dunnion: Yes. An expert group has been brought together by the Minister and we are waiting to see what its interim arrangements will be. There is a longer-term issue around policy on the care of older people and the alternative pathways that might be there for them. That issue is really worthy of exploration. It would be timely for the legislation and regulations to be reviewed and considered by the Oireachtas.

Chairman: The issue of rooms with more than one person was raised. I appreciate that this is not ideal and it is certainly not suitable in these times. Beyond that, however, there are patients who do not want to be in single rooms. I appreciate that it may not be possible to facilitate that now but hopefully it will be possible at some point after we return to normality. I expect there will be patients, including one person who was very close to me until earlier this year, who are adamant that they do not want to share a room and be isolated. I wondered if HIQA, in laying out standards, considers this. People should not be forced to share a room but perhaps they should be able to do so. Does HIQA have a view on that?

Ms Mary Dunnion: Yes, we are very conscious of this issue. We view a nursing home as somebody's home. The residents have made a decision to live there and, as a consequence, it is important that it is designed to meet their requirements. To address the Chairman's point, the important question is what will be the future of the sector. There are many different types of steps which would be really important. One step would be to recognise that some residents do not require the same level of care as others and that, therefore, there would be different types of facilities. We are more than delighted to share a paper we have done that looks at the regulation of services as opposed to the premises, which is all about rooms, facilities and so on.

Chairman: Dr. Kennelly pointed out the frailties of the testing system insofar as one could test negative one day and positive the next. We need to be wary of that. Those who test positive are isolated for 14 days if they are in hospital or in a care facility. Are they tested again at

the end of the 14-day period?

Dr. Siobhán Kennelly: Until recently people were regularly tested at the end of the 14-day period, and that is still going on. One of the issues that we have come to understand in the course of this is that some patients who have been hospitalised have been persistently testing positive beyond the 14 days. What we understand better now than might have been the case even some weeks ago is that the positive status one gets at 14 days probably has very little of what we would call active virus in it, so the potential for infectivity is low. The guidance has been amended to say that if one tests positive at the end of the 14-day period, one is recommended for a further isolation period of seven days. There is no further testing after that period. That came through the national expert advisory group on Covid-19 that meets on a frequent basis to assess this evidence as it comes through. On people who want to transfer and who may have been positive at the end of the 14-day period, they are still safe to transfer as long as they can be accommodated in single room accommodation for that seven-day period. We believe the risk of transmission to be very low at that point.

Chairman: If there is random testing in the population, how does one know whether it is somebody testing positive at the beginning of the 14-day period, at the middle of this period or at the end of it?

Dr. Siobhán Kennelly: It will depend very much on whether somebody had symptoms. I am not a virologist or an infectious disease expert and some of these questions might be better directed to such an expert but essentially patients knowing when they may or may not have had symptoms will influence when we might know when the 14-day period started. In general, it is taken from the date of the first test result that is positive. In the absence of symptoms, the 14-day period is completed from then on.

Chairman: I thank Dr. Kennelly for answering my questions and all of the witnesses for answering all of the questions of committee members.

Sitting suspended at 4 p.m. and resumed at 4.30 p.m.

Deputy Mary Butler took the Chair.

Congregated Settings: Direct Provision Centres

Acting Chairman (Deputy Mary Butler): We are joined from committee room 1 by officials from the Department of Justice and Equality to deal with the response to the Covid outbreak in direct provision centres. I welcome Ms Oonagh Buckley, deputy Secretary General, civil justice and equality, Mr. Michael Kirrane, assistant secretary and head of immigration service delivery, and Mr. Mark Wilson, principal officer, international protection accommodation services. We are also joined by the following representatives from the HSE: Ms Siobhan McArdle, head of operations, primary care; Dr. Kevin Kelleher, assistant national director, strategic planning and transformation, public health and child health; and Mr. T.J. Dunford, head of service, primary care operations.

I advise our guests that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They

are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. While we expect witnesses to answer questions asked by the committee clearly and with candour, they can and should expect to be treated fairly and with respect and consideration at all times, in accordance with the witness protocol.

I invite Ms Buckley to make her opening remarks. I remind members that they will have five to ten minutes for questions and responses from the witnesses. I ask Ms Buckley to keep her opening remarks to five minutes.

Ms Oonagh Buckley: I thank the Acting Chairman and the committee for inviting us to participate in this session to specifically look at how the Department, operating alongside relevant officials from the HSE, has worked to reduce the risk to residents in our centres and address any instance of infection that occurred. As committee members will be aware, the Department has been working to try to address the weaknesses in how we accommodate and provide services to applicants for international protection, while at the same time trying to manage a significant increase in the number applying for protection and seeking accommodation. In addition, fewer people with permission to be in the State have left our centres due to problems with sourcing housing in the wider community. Consequently, we have been reliant on centres that have been working at almost 100% capacity for the last couple of years, augmented by a series of hotels and bed and breakfasts which provided emergency accommodation. Some of that accommodation consisted of rooms in hotels that continued with their normal commercial business.

When faced with the pandemic, and conscious of the heightened challenges all congregated settings have in that context, particularly centres like ours where people leave every day to work, study and engage with the local community, our key priority was, and continues to be, to ensure the safety and well-being of our residents, centre staff and the wider communities in which they live and work. This has motivated every action we have taken during the pandemic.

Our centres are following the guidelines prepared by the HSE's Health Protection Surveillance Centre, HPSC, for residential settings with vulnerable residents. I acknowledge the support the HSE has provided to us, in particular its national social inclusion office. Working together, we continue to develop the appropriate policies and responses for the benefit of our residents.

Congregated or residential settings pose specific challenges during this pandemic, but this is not unique to direct provision settings. Shared accommodation is common in homeless and disability services, student accommodation and private rented accommodation. Given that reality, the HSE's advice on all congregated settings is that during the Covid-19 crisis, non-family members sharing a room in centres are considered to be a household. This means they should implement social distancing measures from other households, that is, residents in other rooms, and they should self-isolate if they are displaying symptoms or if directed to do so by the HSE.

One of our first objectives was to work to cocoon our most vulnerable residents. The Department could readily identify older residents and, in fact, we worked to put in place solutions for residents over the age of 65, rather than 70. As we do not hold medical information about our residents, those considered especially vulnerable to this virus on medical grounds and identified to us by the HSE have also been cocooned for their protection.

We then sought to address issues around providing isolation facilities, given the inevitabil-

ity that in a pandemic our residents, interacting as they do daily with the communities around them, might contract the virus. We therefore required facilities for self-isolation, both on-site and off-site. Centre managers were instructed to provide up to three rooms on-site. Given the occupancy pressures in the centres, there was also a need for off-site facilities where residents could be cared for until it was safe for them to return to their centre. We identified four suitable premises in Dublin, Cork, Limerick and Dundalk, with capacity for 299 people and, in conjunction with local HSE officials, put in place the necessary supports for isolating residents. Each of these facilities has a non-profit organisation on-site providing psychosocial supports to residents and being supported by HSE healthcare professionals.

We also knew we had to reduce the density of residents living in our centres. In recent months, therefore, we have procured more than 1,550 permanent and temporary new direct provision beds. We relocated more than 600 of our residents, about 7% of our total population, in the period from mid-March to early April to support social and physical distancing in centres and enable cocooning measures to be put in place for the most vulnerable. This, I know, has caused no little controversy as we moved residents with much less notice than normal, and with fewer of the interactions with local communities that have become part of better engagement with communities as we try to work to ensure decent accommodation for our residents. By doing this, we have brought the maximum occupancy in any room to not more than three single people in any centre. In addition, we limited the numbers of single persons sharing a room to two for the new locations we have opened in response to the pandemic.

We have worked hard to try to ensure that residents in our centres, and the management and staff, have the tools and knowledge to help prevent outbreaks or reduce their impacts if they occur. Residents in all centres have been made aware of the need to practise social and physical distancing, good hand hygiene, coughing and sneezing etiquette, etc. Translations of public health advice have been provided to all centres and we are communicating with residents and centre managers via regular newsletters, which are also available on our website

www.accommodationcentres.ie. The newsletters have provided practical information on implementing social and physical distancing and promoted shared learning and best practice across our network of centres. Visitors have not been permitted in our centres since 19 March. I thank the managers and staff of those centres who, given the needs of the pandemic, have continued to act and perform types of work they never thought they would be asked to do. They are front-line workers of another type and I thank them.

To help residents with their personal needs for support, a telephone support service for residents, run by the Jesuit Refugee Service, has recently been launched and Department officials have also begun virtual clinics to engage more directly with residents. Managers have been asked to increase the standard and frequency of cleaning throughout the centres, paying particular attention to communal areas. A regular supply of hand sanitiser is provided by the Department and distributed by it. Other PPE is also distributed as required and in line with HPSC guidelines on its appropriate use in residential settings. Centre managers have put in place measures to stagger meal times and visits to communal laundries and so on. Where a person is symptomatic and awaiting test results, additional protocols are applied, including around meals and cleaning.

In partnership with the HSE and Safetynet, we have put in place a national clinical telephone service to provide public health advice to support centre management and their staff. It is also being used to advise, support and work with locations where vulnerable groups are present, relating to the implementation of Covid-19 guidelines and measures.

Committee members will be aware of the efforts the Ministers for Justice and Equality, most recently the Minister, Deputy Flanagan and Minister of State, Deputy Stanton, have made over recent years to try to improve the direct provision system, in particular driven by and building on the recommendations made by Mr. Justice McMahon in his report in 2015. At this stage, approximately one quarter of residents have own-door accommodation and approximately half have access to kitchens and food shops so they can live and cook independently. Thousands have access to the labour market. Dozens of our residents are also acting as carers at this time.

New national standards for accommodation providers were published last August and are due to come into force at the beginning of next year. While the process of reform has increased, the Ministers and the officials of the Department here today fully acknowledge that further improvements are required and will continue to act to try to achieve this. An expert group chaired by Dr. Catherine Day is establishing best practice in other European states in the provision of services, including accommodation to international protection applicants, and it is looking at longer term trends and solutions. An interdepartmental group was established to ensure that all Departments are proactively delivering on their responsibilities to international protection applicants and the short-to-medium term options which could be implemented to improve the system. Its report is ready to be submitted to a new Government. Despite the crisis conditions imposed by the pandemic, the work of these two groups is advancing at pace.

My colleagues and I are happy to answer any questions members may have.

Acting Chairman (Deputy Mary Butler): I remind members that they have ten minutes, inclusive of responses from the witnesses.

Deputy Norma Foley: I acknowledge the excellent work of the many organisations and Departments represented here today, and I do so unequivocally. Equally, there is much that could and should have been done better, which, when not done as it should be in terms of best practice, can have a catastrophic impact. I wish to raise this afternoon the catastrophic impact on the lives and quality of life of the residents of the Skellig Star centre and the wider community of Cahersiveen due largely to what I would regard as very poor practice. It is my intention to proceed by posing three short questions. I would appreciate it if those questions could be answered, following which I will continue my line of questioning.

I seek clarification on the following questions. First, did the HSE, as suggested by the Minister for Justice and Equality, fail to inform the Department of Justice and Equality of a positive diagnosis of Covid-19 at the Dublin hotel accommodation base of a large group of asylum seekers? A yes or no answer will suffice. Second, knowing of the positive Covid-19 case, why did the HSE not authorise testing of the group before they were sent to Kerry? Third, will the representatives present explain who made the decision to overrule the legitimate concerns and misgivings of HSE Cork-Kerry about moving a large group of people during a pandemic to a place which Cork-Kerry HSE deemed to be utterly inappropriate given its poor services of primary care available in the area?

Ms Siobhán McArdle: On the first question regarding informing the Department of Justice of Equality, I will pass that question to my colleague, Dr. Kelleher, because it relates to public health guidance in regard to the informing around public health outbreaks.

Dr. Kevin Kelleher: When instances happen, wherever they happen around a case being identified, the individual case is spoken to as to who would likely be their contacts. That is what happens in these circumstances. It is my understanding that the first case arose approximately

12 to 14 days after the person involved was moved. It is unlikely that was as a consequence of what happened in the hotel. Even so, as a consequence of the investigations carried out by the public health people in the hotel, there was no need to speak to people outside the group that was concerned because of the way they lived together at that time.

Ms Siobhán McArdle: The second question relates to authorisation or information related to testing. The testing programme for Covid-19 towards the end of March related to people who presented with symptoms of the virus. At that point, people were advised to contact their GPs. They continue to be advised to do so and their GPs will discuss their clinical symptoms and refer them for a Covid-19 test. With regarding to mass testing, which is a proposal in this instance, I will pass the question to Dr. Kelleher as it is a public health query.

Dr. Kevin Kelleher: The public health people concerned will assess the position at that point and make a decision about who - including what groups - needs to be tested. That is what happened. At that point, the totally appropriate decision in the circumstances was made.

Deputy Norma Foley: I absolutely dispute the fact that residents of the hotel accommodation in Dublin were not impacted by the positive diagnosis. Equally, I am still not clear who overruled the HSE in Cork and Kerry and its misgivings. I will move on, however.

I note from the submission by the HSE head of primary care that the HSE is of the view that the first case of suspected Covid-19 in the Skellig Star occurred on 30 March. That date puzzles me because I have verifiable evidence of a written communication from the Skellig Star to the Department of Justice and Equality on 24 March confirming a suspected case of Covid-19. The resident concerned was placed in isolation on 20 March, one day after arrival in Cahersiveen. Two points arise. If the Department of Justice and Equality knew of a suspected case on 24 March, why was the HSE not aware of it until 30 March, almost a week later? The timeline might not be of importance to either the HSE or the Department of Justice and Equality but it is very important to the residents of the Skellig Star and the community of Cahersiveen. This timeline confirms unequivocally that Covid-19 was transported by bus on 18 March and 19 March to the Skellig Star and the community of Cahersiveen. I say this without apportioning any blame whatsoever to the residents of the Skellig Star. Rather, I apportion absolute culpability to the HSE and the Department of Justice and Equality for not conducting the necessary Covid-19 testing prior to those people leaving Dublin. To my mind, at the very least this was a grave oversight and at worst an unequivocal dereliction of duty of care to all concerned.

I also raise a point concerning oversight of the Skellig Star as it currently operates. As has been made clear in previous discussions, the HSE has indicated that it advises, recommends or suggests appropriate public health measures but that it is up to the operator to implement those recommendations. The Department of Justice and Equality has delegated operations on the ground to a private operator in return, no doubt, for a substantial fee. The key question I wish to pose is who, among the organisations whose representations are assembled here, including the HSE and the Department of Justice and Equality, has oversight of what the operator is doing on the ground? Is it the HSE, the Department of Justice and Equality or neither body?

Are the witnesses aware the operator did not appear at the Skellig Star until 26 March, eight days after residents first arrived? Is that oversight? Untrained staff were left in charge, resulting in chaotic scenes when residents arrived on 18 March. There was no social distancing, no beds were available and sufficient rooms had not been prepared. I could raise a number of specific points regarding daily oversight at the Skellig Star but time does not allow. I will, therefore, mention just one. Are the Department of Justice and Equality and the HSE aware that

no professional deep cleansing of the Skellig Star has ever taken place, from 18 March to this very day, 26 May? That is despite 25 confirmed cases of Covid-19. How is it being cleaned? I will tell the committee how it is being cleaned. Mr. Price Stardrops, a white vinegar spray Mr. Price advertises as being cheaper than all the rest at €1.49 a bottle, is what is being using throughout this entire pandemic to clean and disinfect the Skellig Star Hotel. Is that best practice? Is that acceptable? Is that good enough, given that there have been 25 positive cases in the Skellig Star?

I have asked for an independent inspection of the Skellig Star building. The Minister, Deputy Flanagan, refused on the grounds of the health and safety of workers carrying out the inspections. Yet, the HSA can investigate more than 400 meat plants and construction sites can be investigated for proper adherence to social distancing measures. The quality of life and health and welfare of the residents living 24-7 in an infected and unsuitable building cannot be provided for, yet all these other inspections can take place. It is utterly shambolic and unacceptable. I ask the Department to do the honourable thing, that is, carry out inspections and close the building. I would appreciate any answers in the time that is left.

Ms Oonagh Buckley: If the Deputy has verifiable evidence of a report to the Department on 24 March, we would like to see it because we have not been able to establish any evidence of knowledge in the Department prior to 30 March when a centre manager reported to our daily helpline that he had one case of a person self-isolating. That is the first report we have been able to find, but if Deputy Foley has verifiable evidence of something earlier, she should please share it with us and we can then check our systems.

We have to go by HSE advice on testing and our colleagues from the HSE have already explained the protocols around testing. As to the view of Deputy Foley that there is culpability around a lack of testing, I cannot concur with that because there are protocols around how testing should happen.

With regard to oversight of the service provider, the Department of Justice and Equality is the responsible Department for direct provision centres. They are our residents and are people for whom we have the ultimate responsibility. Normally we would have a protocol of three unannounced inspections of every centre every year. That is what we aim for. It has been difficult to achieve given the number of centres we are now running. In the context of the pandemic, we have to consider our staff and their health and safety.

As it happens, the Deputy may not be aware that a member of staff was present on the night the centre was opened. In fact, she stayed in the centre to see that everything was right. The Deputy will be aware that there were a number of teething problems as the centre opened because it was opened quickly and there was no time to spend four to six weeks, which is the norm, making sure everything was working correctly. The staff member who stayed made sure that the centre was as proposed, that people settled into it, that heating was provided in each room because, as the Deputy knows, the boiler had problems in the intervening period, and that the necessary arrangements were in place for the centre.

I understand what the Deputy is saying about the centre's staff who almost certainly came from a previous employer, as is the law. We also encourage centre managers to employ locally because that provides good jobs to communities. We have been very consistent. We opened the centre much faster than normal. We did not have the time to do what we normally do in these circumstances. The centre manager did not have the time. We have been in daily contact with the centre manager over the past six to eight weeks. I speak to the Minister every day about

the Skellig Star in Cahersiveen. We have regular interactions with the staff and are constantly looking at what they are doing. We are happy that the centre is now being run very effectively and well. There are good facilities in the centre and we are happy it is working well for the residents that remain in the centre at this time.

Acting Chairman (Deputy Mary Butler): We have to move on. The next speaker for the Sinn Féin slot is Deputy Pa Daly who is taking ten minutes.

Deputy Pa Daly: First of all, I thank all the witnesses for coming in to answer our questions. I will address the first question to Ms Buckley. Ms Buckley mentioned the national standards published in August of last year. One of the first themes in the national standards relates to how there must be a responsive workforce and how recruitment of staff should be able to deliver safe and effective services for both children and adults. Ms Buckley mentioned that the 15 staff in the centre had to learn new skills. Had any of them any experience whatsoever in working in a direct provision centre beforehand? Had any of them partaken of the Tusla course? Had any of them even been Garda vetted? Is it true that two of the managers actually left in the first four weeks after the centre opened on 19 March?

Ms Oonagh Buckley: What I can say now is that all staff have now completed the Tusla course and all staff have now been Garda vetted. I want to come back to the question of the timeframe for that.

The Deputy asked about the opening sessions. There was some change in the management. I believe one person resigned in the first week or so. The centre manager in place now is a very experienced centre manager who ran a direct provision centre for many years. Considerable experience has been put into the direct provision at this point.

Now I will come back to the Garda vetting. It was brought to our attention on Wednesday last that there may have been staff on site who had not been Garda vetted. We immediately reached out to the Garda vetting unit. The unit indicated to us that there were concerns about the way in which the Garda vetting had been done and the fact that there were some staff on site who had not been Garda vetted. This is a very serious thing. It is obviously the employer's obligation to ensure Garda vetting is done. It is also part of our governance structures and we have to ensure that it is done. I can now say that, with the co-operation of the Garda vetting unit, all staff who need to be Garda vetted have been Garda vetted as of Monday. However, it was an unacceptable thing that happened and it was something that-----

Deputy Pa Daly: At the time that it was opened had any of them been Garda vetted? Had any of them done the course? Had any of them any experience in working in a direct provision centre?

Ms Oonagh Buckley: At the time it opened, a number of them had been Garda vetted but not for that location. As to their experience of working in a direct provision centre, I would not know that off the top of my head. I will have to come back to the committee with that information.

Deputy Pa Daly: Ms Buckley mentioned that it was important for the Department to ensure the safety and well-being of all residents. That includes in respect of the accommodation provided. Under the theme of national standards, which Ms Buckley also mentioned, the document states that the planning and design of accommodation should be informed by the needs of residents. This includes the need for own-door accommodation and accommodation which

is homely, accessible and furnished. Moreover, privacy, dignity and safety should be protected and promoted. Is it not the case that none of the rooms provided were own-door? There was no own-door accommodation. The rooms in the former hotel did not even have a kettle. Sharing of bedrooms had to be undertaken by approximately 60 of the residents who went there first. Social distancing in this hotel was completely absent because the residents had to share the laundry, lifts, corridors and dining facilities. Is that not the case?

Ms Oonagh Buckley: First, Deputy Daly is quite right to say that the standards were published last August. They come into force on 1 January next year, as I said. They are standards that we will be working actively to go towards. It would be very much our preference that, instead of having one quarter of our residents in own-door accommodation, we would have 100% of our residents in own-door accommodation. We are quite a long way from that as of yet, and in those circumstances people have to share facilities. They have to share laundries and bathrooms in many cases. Many of our single residents have to share with strangers. That is the state of play and it was the state of play when we opened the Skellig Star Hotel. The same standards that would apply in many of our centres apply in the Skellig Star.

Deputy Pa Daly: I think the Skellig Star was first reviewed or surveyed, or whatever the phrase is, by someone from the Department of Justice and Equality in August or September of last year. Presumably, that person was aware of the minimum standards and may have been aware of the joint committee's report, which stated that the Department of Justice and Equality should avoid isolated locations with few public transport services, amenities or employment, should avoid emergency accommodation and should have child-friendly spaces for recreation of children. The report also stated that there should be specialised training for staff on residents who may have suffered trauma, sexual abuse or domestic abuse in the past. Was any of this taken into account by the person who went down to look at this premises in September of last year?

Ms Oonagh Buckley: The official working for me who carried out the inspection on 18 September examined the premises in the context of a framework for procurement against which we work and which has certain minimum standards. With respect, we have to go with what is offered to us under the current model of acquisition and procurement of accommodation for direct provision. As I keep repeating, we are not happy with the current model and we would like to move away from it but we are not there yet.

Deputy Pa Daly: The new standards had been in place a month before that person went down to Cahersiveen, so was it a survey, or what exactly was the purpose-----

Ms Oonagh Buckley: He inspects the premises for suitability against our procurement framework, that is, whether it meets the size standards for rooms and so on. If we had filled the Skellig Star to its maximum capacity against our standards, it could have accommodated between 150 and 160 people. We never put that many people down there. I think that at the maximum the number of people was 103.

Deputy Pa Daly: Regarding the size of rooms and so on, the Department is still using - I ask Ms Buckley to correct me if I am wrong - the McMahon report, which uses a definition from the Housing Act 1966 as the minimum space required for a bedroom, which is 4.65 sq. m. That is about the size of a double bed. Is that standard, referred to in the publication which came out last August, still the one the Department will use into the future?

Ms Oonagh Buckley: That standard is what we currently measure against when properties

are offered to us. The new standards, when they come into force next year, will be higher. In the meantime, we have taken the voluntary decision to reduce the number of people we have sharing any room, regardless of size, to a maximum of three. In fact, in many of our centres we now have a maximum of two strangers sharing a room. Obviously, family units continue to share.

Deputy Pa Daly: When the outbreak occurred in Cahersiveen, an offer was put to the PRO, who contacts the local elected representatives, of other accommodation in a holiday village in the county. That would have been own-door accommodation. Two of the cottages were actually offered for free. In an effort to take some families out of the Skellig Star, an offer was made. That was turned down by the Department. Is that correct and, if so, could Ms Buckley indicate why it was turned down?

Ms Oonagh Buckley: That is correct. We had a number of reasons for that, but one of the principal reasons is that direct provision is not just a bed for the night. A lot of services, a lot of food and a lot of other issues have to be provided. We are very pleased that somebody was willing to offer us accommodation. We would much prefer if people offered us accommodation that we could rent under the HAP system and if we could move our nearest 1,000 people with permission to remain into that accommodation. If that gentleman were willing to rent us his accommodation on a HAP basis, we would be very happy to try to see whether we could accommodate some of the people with permission to remain in the State who need housing. We would be very keen to get them out of their current accommodation. If we could move those 1,000 people into the wider community, we would then be in a position to stop our use of so much emergency accommodation.

Deputy Pa Daly: I thank Ms Buckley for that. Did any further inspection take place between September and March, after the initial inspection? When exactly was the decision made to move to Cahersiveen and who made it? What criteria were used? Who decided which people to pick? There is a feeling in Cahersiveen that women and families were brought down there just to appease the local residents in case they had any fears that there would be single men in the area. Is that correct?

Ms Oonagh Buckley: To answer the questions in order, the decision was taken that we needed to take people out of these hotels where there was commercial business going on because at that time, as the Deputy will recall, the big risk was that the virus would come in with foreign travellers from abroad. While we had residents who were staying in the same accommodation as people travelling from abroad, we felt that was our biggest risk. We needed to concentrate all of our residents in centres where we were the sole occupant and could apply a greater degree of control over people coming in and out of the centres. As to who took the decision, I did.

Deputy Pa Daly: Ms Buckley did.

Ms Oonagh Buckley: We signed the contract on 16 March. The decision was taken the previous week that we would have to move people. Having signed the contract on 16 March, we moved the first residents on 18 March. When I say that happened much more quickly than normal, I am not exaggerating. As the committee knows, we would normally take some weeks to engage with the local community and we would probably be able to shape the residents that needed to travel and so forth. In this case, however, we had to move populations from five different locations, four of which were in Dublin, to a number of areas. Cahersiveen was only one.

Deputy Pa Daly: Finally, given that the-----

Acting Chairman (Deputy Mary Butler): I am sorry, Deputy, but we have to move on. I have allowed an extra minute.

Deputy Pa Daly: Okay.

Acting Chairman (Deputy Mary Butler): The next slot is Fine Gael's. I call Deputy Carroll MacNeill, who has ten minutes.

Deputy Jennifer Carroll MacNeill: I thank Ms Buckley and the HSE staff for attending. I will ask Ms Buckley a couple of brief questions to clarify some figures. How many centres are there operating now and how many were operating previously?

Ms Oonagh Buckley: It is a movable feast. We closed one centre over the weekend for the same reason we stopped using it earlier in the season. Currently, we have residents in 84 locations. That number includes 47 direct provision centres - I will have to take the figures out, as they change regularly - and 33 emergency accommodation facilities. We have four self-isolating facilities and we are using five other facilities for density reduction. There are 84 centres in total at present.

Deputy Jennifer Carroll MacNeill: Will Ms Buckley confirm the total number of residents there, including those who have permission to reside?

Ms Oonagh Buckley: We have just short of 1,000, something like 988, people with permission to reside. There would be more but for the fact that we have had to reduce our-----

Deputy Jennifer Carroll MacNeill: I know, but I am asking for the total number, including those with permission to reside.

Ms Oonagh Buckley: We have 7,700 residents who are in the asylum process or post it and a further 250 who are refugees and who live in what are called EROCs, or emergency reception and orientation centres. We are treating them identically to direct provision centres for now.

Deputy Jennifer Carroll MacNeill: The Department relocated approximately 600 of that number.

Ms Oonagh Buckley: We relocated approximately 600 of that number over the course of two and a half weeks.

Deputy Jennifer Carroll MacNeill: That is fine. The committee has a report from the HPSC on outbreaks in vulnerable population settings. It states that 14 outbreaks in direct provision centres were notified, with 175 cases linked to those outbreaks. Is that the Department's information? Is that the total number of cases in direct provision centres or are there more and the 175 are just linked to those outbreaks?

Ms Oonagh Buckley: Unfortunately, I cannot verify those figures. They are not the Department of Justice and Equality's figures.

Deputy Jennifer Carroll MacNeill: Perhaps someone from the HSE could verify them.

Ms Oonagh Buckley: They are different from what we know. I might have to pass that question to my colleagues in the HSE.

Deputy Jennifer Carroll MacNeill: In the interests of time, could someone from the HSE answer, please? According to the HPSC's report, 175 cases are linked to the 14 clusters. Is that the universe of cases in direct provision centres or is it just the number of cases linked to the outbreaks, is there a different number and, if so, what is that number?

Dr. Kevin Kelleher: It is almost certainly close to the total. It would be uncommon for there not to be an outbreak once there was a case and we would know about it. The number mentioned relates explicitly to the 14 outbreaks. I doubt if there are many more than that, but I cannot say explicitly because of the way the information comes. In particular, it would be difficult to say in respect of people living in some of the other accommodation that Ms Buckley mentioned and that would not be as easily identifiable to us as direct provision services. The figure cited is explicitly what we know about at the moment.

Deputy Jennifer Carroll MacNeill: It is a little troubling that we do not have a figure for the number of people who have been identified as having Covid-19 in these centres. Shall I take it that this is the correct number? Does Dr. Kelleher wish to clarify for the committee later?

Dr. Kevin Kelleher: I can revert and let the committee know whether that is not so, but I would imagine it is very close.

Deputy Jennifer Carroll MacNeill: According to the report, 13 of those people were hospitalised and there were no intensive care admissions or deaths. Is that consistent with the HSE's information?

Dr. Kevin Kelleher: Yes, it is. It is important to note that these figures include both residents and staff. In outbreaks such as this, the figures identify and include both residents and staff.

Deputy Jennifer Carroll MacNeill: Can Dr. Kelleher provide to the committee by way of correspondence the number of residents who have-----

Dr. Kevin Kelleher: If that comes out clearly from the data, we will provide that.

Deputy Jennifer Carroll MacNeill: I thank Dr. Kelleher.

On some of the information provided, the Irish Refugee Council did a survey on how people had experienced this pandemic. There are a number of interesting findings. Some 83% of respondents said that they did not have access to information about the pandemic. I appreciate in certain circumstances that there would be language issues or other communication barriers. I note from Ms Buckley's comments the level of effort that she has put in to communicating about the pandemic. If those figures are correct, it seems, according to this information that it has not gone okay. Can Ms Buckley give some information on the particular efforts she has made in communicating the public health advice to people in these environments, please?

Ms Oonagh Buckley: I thank the Deputy for her question. From the get-go we knew that communicating with centre managers and the centre residents was going to be one of the biggest challenges we would have. We established a new team drawn from staff across the Department who volunteered for this work, and set up a system where firstly we rang every centre manager on a daily basis. We asked how things were progressing, and if there were things that they needed, for example PPE, or whatever. We were receiving direct information from centre managers.

We also started centre newsletters initially for centre managers, which were issued twice or three times a week. We then started doing one for centre residents which went out at least once a week, but sometimes more frequently than that. That provides a great deal of information, often in many languages, for the centre residents. We have multiple languages and people with multiple levels of capacity in languages in our centres, which is something we are very conscious of. We therefore tend to try to have as many communications as possible published in the major languages. I am sure we do not reach everybody every time. We will continue to do this and to keep pushing information into our centres.

One of the recent innovations which we asked centre managers to set up was for WhatsApp broadcasts for all of their residents. Broadcast is a more secure way of sending information out; it can be sent directly into the phones of residents as it comes through, which is done through constant efforts, reminding and reiteration. We also try to ensure that centre managers themselves are putting up appropriate signage, etc. We continue to do that on a daily basis.

Deputy Jennifer Carroll MacNeill: That sounds very much like it is coming from the Department. Can Ms Buckley help me understand the relationship as to lead responsibility between the Department of Justice and Equality and the HSE especially at the early stages as to the provision of this guidance? How has that relationship worked? Can both of our witnesses please comment briefly on any lessons learned from that experience?

Ms Oonagh Buckley: We have been very reliant on the HSE and it has done a great amount of work with us and for us in helping us manage the population. As Dr. Kelleher has said, that has thankfully led to a situation where we have not had a single serious case of Covid-19 in our centres so far and long may that remain the case.

One of the lessons that we have learned is that before the pandemic, health services were provided to residents of the centres in the same way as they were provided to all the citizens of this country. Asylum seekers get a medical card and access GP services in that way. We are reliant on national advice from the national social inclusion office. That system is perfectly adequate for normal health needs of residents in normal times, possibly with the exception of mental health, but as our population is reasonably young and healthy, it is probably not enough at this time. I have written to the HSE, and to a colleague of Ms McArdle's, requesting that it review the types of supports that it offers to vulnerable persons, including to direct provision centres, at this time, whether on a national or regional basis. That is certainly a lesson that we have learned.

Deputy Jennifer Carroll MacNeill: In the interests of time, is that correspondence that can be shared with the committee, from the point of view of transparency?

Ms Oonagh Buckley: I will be happy to share my letter to which I have not received a reply as yet, which I am sure is under preparation at this time.

Deputy Jennifer Carroll MacNeill: Is there anything that the HSE would like to say on the lessons learned in the relationship and how things have been?

Ms Siobhán McArdle: Even prior to the onset of the Covid-19 pandemic, there has been a very robust and integrated engagement between the HSE and the International Protection Accommodation Service, IPAS, under the governance of the Department of Justice and Equality. They have been working closely together to provide health guidance and supports to new arrivals into the country as well as providing public health information and linking people into

the health supports in their communities, wherever those communities may be. In response to the Covid-19 pandemic, or even in advance of that, there has been an increased level of meetings held and measures taken at national and local levels. At a local level, in each community healthcare organisation our social inclusion services work within primary care services to ensure that every resident in direct provision receives all the information required to support his or her health outcome. At a practical level, that means engaging people with their GP services in the wide range of primary care centres-----

Deputy Jennifer Carroll MacNeill: I thank Ms McArdle. I only have about 30 seconds left and I want to ask the Department one more question. I am terribly sorry to interrupt. As I understand it, there have not been new cases presenting to Ireland at the rate there had been. What steps is the Department taking to use what might be described as a lull or a pause in new applications to try to expedite the processing of existing applications or has the Department been hampered in that way because of the courts being limited in their sittings?

Ms Oonagh Buckley: In point of fact, 773 people presented seeking international protection over the course of the first few months of this year. The numbers have fallen off in the last month or so but we were still getting a steady stream of people applying for international protection and seeking to access the accommodation services up until the middle of April. As soon as any travel restrictions are lifted, that flow will happen again. We have consistently allowed people to apply for asylum and we have never stopped that. However, we have had to restrict a lot of access to our buildings. Unfortunately, the Department's systems are largely paper-based and that has very much restricted our capacity to take decisions. We are actively planning for a resumption of that work, which should allow us to resume taking decisions, particularly positive decisions that we hope will allow people the opportunity to move on with their lives.

Deputy Joe O'Brien: I want to ask Ms McArdle of the HSE a question to start. Ms McArdle mentioned that she worked closely with IPAS. Did she know or was she notified in advance of the transfer of direct provision residents by IPAS to new locations where they would be sharing with strangers?

Ms Siobhán McArdle: On the opening of the centre in Cahersiveen, as my colleagues in the Department of Justice and Equality stated, we were also informed of the opening on March 16. That information was provided to the HSE national social inclusion office as well as to the local community healthcare organisation. At that point, the community healthcare organisation, particularly its social inclusion services, would have had multiple engagements in the following days to ensure that access to health services was put in place for all the new residents. Given that the opening of the centre was happening at the time of the Covid-19 pandemic, our national social inclusion office - the membership of which includes a number of public health specialists - would also have provided guidance from a public health point of view. That would have supported our colleagues in terms of-----

Deputy Joe O'Brien: Was the building checked for suitability by the HSE in advance of the people arriving?

Ms Siobhán McArdle: No it would not have been checked by the HSE. That would not be part of the normal protocol. Advice was given around public health guidance and around access to health supports but it would not be usual practice for the HSE to inspect a building.

Deputy Joe O'Brien: It is a pandemic and there are issues around social distancing. It is not normal practice but I am suggesting that perhaps it should have been done. Can Ms

McArdle clarify how many people in direct provision centres have been tested and how many have not been tested as of today or what are the HSE's most recent figures?

Ms Siobhán McArdle: We will have to come back to the Deputy on that.

Deputy Joe O'Brien: The HSE does not know.

Ms Siobhán McArdle: No, we would not have that level of detail. We can say that any person, as with any member of the population, who presented with symptoms that are suggestive of Covid-19 would have been encouraged and supported to access his or her GP or a GP service to ensure he or she was referred to-----

Deputy Joe O'Brien: These are congregated settings, however, and we are specifically talking about them because people are vulnerable in congregated settings and Ms McArdle is telling me the HSE does not know how many people in this congregated setting have been tested.

Dr. Kevin Kelleher: I have some figures. So far, we have tested 1,734 people. In our direct numbers there is another 959 and so far there have been just over 350 cases. So the positivity rate is somewhere around 6% to 8%.

Deputy Joe O'Brien: That sounds like a quarter of people have been tested.

Dr. Kevin Kelleher: I cannot-----

Deputy Joe O'Brien: I shall leave it at that and suggest that everyone in these congregated settings should be tested.

I have a question for the representatives of the Department of Justice and Equality. The ongoing public health advice provided by the HSE, and in its statement provided to us in advance today, single-room occupancy was mentioned three times, if not four times, as the public health advice. Why did the Department not follow the public health advice? Earlier it was mentioned that the Department has to go by HSE advice on testing. Why not the HSE advice on distancing?

Ms Oonagh Buckley: The HPSC advice does not mandate single-room occupancy. Certainly, I have not seen any such advice nor has any been given to me.

Deputy Joe O'Brien: We have a document today that refers, in three or four different places, to single-room occupancy except for families. The ongoing public advice provided by the HSE is what that is saying.

Ms Oonagh Buckley: I have not seen that document, Deputy. He would have to share it with me. I am not aware of any document that mandates single-room occupancy.

Deputy Joe O'Brien: It does not mandate but recommends; it is public health advice, I think. How many new households were created? When I say households I mean people who did not know each other in advance. How many new households were created, since the beginning of the pandemic, by moving people either within or between new or already established centres? How many new households do we have, if Ms Buckley understands my question?

Ms Oonagh Buckley: I do, Deputy. I will have to come back to him on that because it would involve us doing a calculation on how many cases we moved of existing cohorts of

people and put them together where they were, so that would not be the creation of a new household. I would have to check how many times we put single people, who had not shared rooms together before, into new rooms. I will see if we can work that out and get back to the Deputy with the figure.

Deputy Joe O'Brien: That is a crucial point. These are people who did not know each other and are strangers. They are put into a room where they have no other choice but to share with a stranger and obviously the risk level is very high. I would appreciate if Ms Buckley could tell us how many households have been newly created and put into a more vulnerable situation.

Acting Chairman (Deputy Mary Butler): We will now move on to the Labour Party's slot; Deputy Duncan Smith that he has five minutes.

Deputy Duncan Smith: I direct my first question to Ms Buckley. The direct provision system is what I consider to be an inhumane and difficult system in which people must survive. Ms Buckley mentioned that she will be back in terms of some regular business and try to process applications for citizenship. If we are on a downward trend for Covid-19, and hopefully we are, there are fears of a second wave and a flu outbreak in the winter. Have Ms Buckley or any senior officials in her Department considered a fast-tracking approach for citizenship or a citizenship amnesty for asylum seekers in this period? Such a scheme would empower asylum seekers to move into the community, access payments, access the housing assistance payment, to make their way and contribute to Irish life and not spend another winter living in direct provision.

Ms Oonagh Buckley: There are a couple of issues. Permission to remain or the grant of refugee status does not actually give one citizenship. There is a further requirement of residency that takes a number of years. I assume the Deputy is talking about permission to remain in the broader sense.

As I mentioned earlier, we have nearly 1,000 people with permission to remain who remain in our centres. We would like them very much to be accommodated in the wider community because that would free up a lot of space in our centres for the people for whom we have to provide accommodation.

We have certainly been asked by the Minister and the Government to examine the case of undocumented workers and to look at people in the wider community who may not have a current status. We have not been asked to fasttrack things. We have not needed to be asked because we are constantly working on trying to improve the speed with which we take decisions on whether people are granted permission to remain or not. We have not been asked to change the criteria on the basis of which we make those decisions.

Deputy Duncan Smith: Would Ms Buckley be minded to recommend to the Minister to change any criteria at this time in light of what has happened during this outbreak? Would she be sending any memos to the Minister on the basis of her experiences in the past few weeks?

Ms Oonagh Buckley: That is the sort of policy decision a Government would have to take, and probably an incoming Government. They would be the sort of decisions that the caretaker Government would find difficult to achieve. If I was asked to prepare such a proposal, I could certainly look at that. Obviously, we have some sterling examples of people who have worked very hard in places such as care settings who live within our centres, many of whom have permission to remain, as it happens, but some of whom do not. There would be, perhaps, ways of

adjusting some of our more individual considerations that could allow us to do that if we were so asked by a Government.

Deputy Duncan Smith: My next question is for the HSE and follows on from Deputy Joe O'Brien's questions on testing. We have had 1,734 tests so far. What are the criteria as regards further tests? Is it just people who have developed symptoms or who have asked to be tested because of that, or is there a protocol for further systematic testing in direct provision centres? Are there concerns that people in the direct provision system are afraid to speak up and say they have symptoms for fear that they may be moved away from their support services and networks in their specific centres? Are there any actions to counter that?

Dr. Kevin Kelleher: My maths was not good enough when I was answering earlier. So far, I have got a record of us performing just shy of 2,700 tests, of which 180 were positive. There were ten places tested where no case was identified, which gets us close to 1,000 tests. It shows a very different picture across the system. There were some places with nobody positive at all. Our current position is that we would take it on board primarily as a consequence of symptoms of an individual who shows signs of Covid-19. We would then investigate that with a clinician as a consequence and decide how to progress it. One would hope that the first person would be asked to be properly isolated such that they would then reduce the risk of passing on to anybody else and the person they were sharing a room with, if that was so, would then be asked to isolate as well and restrict their movements.

Deputy Duncan Smith: In a word, there is no recurrent, consistent testing of people in direct provision.

Dr. Kevin Kelleher: At the moment, our advice is that there is no need to carry out repeat testing, particularly because, as a consequence of the process, we have just gone through a whole host of different residential facilities and shown up very few cases.

Acting Chairman (Deputy Mary Butler): We will move on to the Social Democrats slot. I call Deputy Catherine Murphy.

Deputy Catherine Murphy: We know that the first time the Minister found out about there being a positive Covid case in advance of the move was when my office contacted the Department. The reason we were given was that it was to de-risk, as we heard earlier. When did the HSE know there was a positive case in the Swords hotel?

Dr. Kevin Kelleher: We knew there was a case in the Swords hotel, if the Deputy is referring to the Travelodge-----

Deputy Catherine Murphy: Yes.

Dr. Kevin Kelleher: We knew about that slightly earlier that month.

Deputy Catherine Murphy: Why would that not have been communicated to the Department of Justice and Equality?

Dr. Kevin Kelleher: We deal with the individual case as it is and the information we had was such that the group, the individual and the group they were part of, had contact internally and with nobody else by the criteria we have, which are very well known, around the contacts we talk about.

Deputy Catherine Murphy: I was given subsequent information and I raised the matter

in the Dáil a couple of weeks ago, although I still have not received a reply. There was a large group from a hostel in north Dublin moved into the Swords hotel very soon after the move by the other group to Cahersiveen. Will Ms Buckley confirm or deny this was the case and that another group was moved into the Swords hotel?

Ms Oonagh Buckley: Once the Swords hotel was no longer accommodating other residents we started to use it again to accommodate people, particularly new arrivals. However, towards the end of last week we became aware that the particular hotel was starting its economic business again and was taking in paying customers. In the circumstances we felt the same risk issues arose so we have ceased our use of that hotel and have moved all of the residents to other facilities in Dublin.

Deputy Catherine Murphy: Is Ms Buckley aware that within days of the exchange happening between Cahersiveen and the new group arriving from north Dublin into that hotel that a number of hotel staff members ended up with a positive Covid diagnosis?

Ms Oonagh Buckley: The first we became aware of anything about positive cases in the Travelodge in Swords was when we received the letter from the Deputy's office. We then contacted hotel management to find out what was going on and it was they who told us what happened, as the Minister has said to the Deputy. I will have to check what was said to us about the staff. Obviously, that is the personal information of staff. I can come back to the Deputy as to whether we were told staff members had been infected.

Deputy Catherine Murphy: Were other guests in the hotel when the new group was moved in following the move of the first group to Cahersiveen?

Ms Oonagh Buckley: Again, I will have to check that for the Deputy and I am happy to come back and do so.

Deputy Catherine Murphy: I have been trying to get this information for the past few weeks.

Ms Oonagh Buckley: We will try to establish it for the Deputy.

Deputy Catherine Murphy: It needs to be closed off.

What is the chain of command in terms of notification between the HSE and the Department of Justice and Equality where scenarios such as these present themselves?

Ms Oonagh Buckley: Perhaps Mr. Wilson is best placed to speak about how we go about notifying people. I presume the Deputy is talking about opening centres. Is that correct?

Deputy Catherine Murphy: Yes, and moving people in situations such as in this case where the HSE was aware of a Covid case but the Department of Justice and Equality was not told. Where is the chain of command? Who made this decision?

Mr. Mark Wilson: A decision to move applicants is made by IPAS. We consider the competing pressures and risks attached to where we have people and move them as we have to. It is an ongoing system that has a large number of new arrivals and, therefore, there must be movement within the system for the system to operate. As was explained earlier, when we open a new centre there is a requirement that we wait until the contract is signed before we can communicate it to our colleagues not only in the HSE but also in the Department of Education and Skills-----

Deputy Catherine Murphy: I was really trying to deal with issues in this Covid environment. Who in the HSE is responsible for communicating in a situation where there is a Covid positive case in a hotel? Who was responsible for notifying the Department of Justice and Equality in this situation, where it was known that it was also a direct provision centre?

Mr. Mark Wilson: The environment has been evolving over the past two months. What would happen with that matter now is that the public health section would make contact with the Department of Justice and Equality and convene an outbreak control team meeting. That public health-led process would ensure proper communication is maintained throughout the outbreak. In respect of movements in the second week of March, the environment was very different. We were responding very quickly. That was within the second week of activity ratcheting up in terms of concerns. If the Deputy recalls, there was the potential for a wave of 25,000 cases by the end of that month. Decisions had to be made. IPAS and I liaised with the national social inclusion office. We considered the issues attached to whether to make a decision to move-----

Deputy Catherine Murphy: Really, a line would have done. I did not need a big long reply that really did not answer my question. It does not appear very clear what the line of communication is. Could somebody communicate with me in writing to tell me what the line of communication is in a situation where there is a Covid positive case? Who has responsibility to notify the Department of Justice and Equality with regard to a direct provision centre? Perhaps that could be followed up with me in writing.

Deputy Bríd Smith: All members have been sent the submission from the Movement of Asylum Seekers in Ireland that contains many photographs of the interiors of direct provision centres. As soon as I saw how cramped and crowded and on top of each other people were, it reminded me of playing house as a kid, with bricks and stones and lumps of planks, and of pushing everything together so we could all lie down together and have a mess. That is no way to treat human beings but the evidence for it in the context of Covid is quite shocking.

The reality is that the HSE has given advice for all congregated settings to the effect that, during Covid, non-family members sharing a room are considered to be a household. We have a particular difficulty with this in direct provision because of the overcrowding to which I have just referred but also because, much of the time, people who are sharing rooms do not speak the same language, are not of the same religion and do not get to know each other. Do the witnesses agree with that advice? If they do not agree with it in the context of direct provision, have they ever objected to it, sought clarification on it or looked for it to be changed?

Ms Oonagh Buckley: It is not our place to disagree with that advice, and it is the advice we are working under. It reflects the fact that, in congregated settings of this type, and direct provision is only one, there are particular difficulties in applying social distancing in that context. These guidelines take account of that, which is what they have to do because there are settings like this, such as direct provision, disability services and homelessness services, across a broad range of the areas where people who are not members of one family are sharing rooms. The advice has to take account of that and we have to try to apply best practice around that. Ireland is not unique in this regard. The EU guidance on this matter reflects almost entirely what we have done in terms of trying to ensure best practice. However, acknowledging the fact-----

Deputy Bríd Smith: That is fine. The point I want to make is that if it is not their job to query that advice, it is their job to look after the occupants of direct provision. I am of the view that those two things are contradictory. The Minister recently stated on radio that they are in his care and if anyone works for the Minister, surely their care should matter to those who look

after them.

On 12 March, the Taoiseach stated that gatherings of 100 or more people indoors should be cancelled. The provision of services in the canteen at Knockalisheen direct provision centre, where over 200 asylum seekers receive their meals, was not cancelled. Distancing in areas such as communal toilets and showers in Kinsale Road, Great Western House, the Glenvera Hotel, Hazel Lodge, Clare Lodge, Cahersiveen and other locations was not possible and did not happen.

The residents in Cahersiveen received a letter, which I presume came from the Department, although the witnesses might clarify that. It stated that, unfortunately, there had been two new confirmed cases in the past week and that this was clear evidence that some residents were not following the public health recommendations, thereby causing further infection. It also stated that the period of advised restrictions on movement would need to be extended for a further 14 days and that because social distancing was not being followed by everybody, the period of recommended self-isolation was to be extended. Translating this into layman's terms, it means that the residents of these areas who cannot self-isolate or socially distance correctly are being blamed for their own plight. Will the witnesses comment?

Ms Siobhán McArdle: That letter was part of a suite of communication that was provided in the centre. It was prepared on the basis of both public health guidance and knowledge of how the centre was operating. However, I would counter that the authors did not wish to apportion blame to any of the residents and that it was merely a reminder of the importance of adhering to the public health guidance. I have to say also that it was supported by on-site supports. There is a HSE support community health care worker to attend on-site seven days a week, who provides and supports residents in terms of interpreting the public health advice and, where queries arise, engaging with centre management to support residents in adhering to that public health guidance. It was by way of providing additional communication and to explain to residents why the period of extension was happening.

Deputy Bríd Smith: The letter stated there is clear evidence that some residents are not following the public health recommendations and because social distancing is not being followed by everybody, the lockdown has to be extended for 14 further days. That sounds like they are being blamed for their own plight. I repeat to the witnesses that these centres are totally inadequate for the purposes of self-isolation and social distancing, particularly during this crisis. If anything, it has exposed the horrors and inhumanity of direct provision in a sharp way. Who is the author of that letter to the residents?

Dr. Kevin Kelleher: There was at that time an outbreak control team meeting every two days. It came out as a consequence of one of those meetings and the committee involved.

Deputy Bríd Smith: Did the committee write this and order it to be sent to the residents in Cahersiveen?

Dr. Kevin Kelleher: I would imagine it was written by a member of the committee, which agreed to it, and it was then sent out as a consequence of the meeting. One could read it either way, that it was directed to the residents or to the management. It stated what was required to try to control the outbreak at that time.

Deputy Bríd Smith: It stated that it was a notice to all residents of the Skellig Star accommodation centre.

Dr. Kevin Kelleher: That is correct and solutions then followed much more as a consequence, as the Deputy heard. The Department helped to move people as a consequence. The system took it on board and the Department and managers of the unit were involved in those meetings.

Deputy Bríd Smith: The evidence shows everybody should be moved out of that direct provision centre and alternatives provided. That would be the solution to this horrendous mess and the inhumane conditions these people are being forced to live under, and God knows for how long more. None of us knows when this pandemic is going to subside or become a thing of history.

Acting Chairman (Deputy Mary Butler): Thank you, Deputy Smith, we must move on. I call Deputy Shanahan from the Regional Group.

Deputy Matt Shanahan: It is fair to say many inadequacies in our public health policy are being shown up by Covid-19. The direct provision situation is at the top end of things that must be addressed. I will ask a number of questions and the respondents can come back at the end.

I have two questions for the Department of Justice and Equality. The witness said at the start that all staff have been Garda vetted and Tusla-approved. What training has been undertaken, if any, in terms of understanding the requirements of infection control? Ms McArdle said there are people on site but there is a significant issue around communication and translation, particularly in terms of having something in writing, which I ask the witnesses to look at.

Given what we now know, has the Department or the HSE looked at doing a review or analysis of the asylum process and the length of time it takes for applications to be considered? A "Yes" or "No" answer will suffice. The rate of refusal last year was approximately 67%. The question that first comes to mind is why we have people waiting so long to get an application approved or otherwise. This would seem to feed into the numbers.

In terms of the HSE and isolation rooms for suspect cases, do the witnesses know how these are being dealt with and if isolation is being observed? The evidence is that it is not.

I refer to communal spaces in direct provision centres. Has anybody thought to come up with a rota system so people are not in the same room at the same time using washing and eating facilities? Maybe that is happening, but will somebody give me some information on that?

Approximately 800 applications to the asylum process last year were from people of African descent. A good deal of medical data is building up to say this group of people may be more at risk to the severe outcomes of Covid-19. Has the Department made any efforts to prioritise them and ensure they are first to be removed in the case of a outbreak?

Ms Oonagh Buckley: The Deputy's first question was around the training requirements for infection control. We have done quite a degree of training, supported by the HSE. In fact, a very useful webinar was done, which all centre managers were strongly encouraged to watch and participate in.

As we said to the committee, there is a telephone line, which we are paying for and is provided by a group called Safetynet, which both takes their queries around safety issues and health issues and proactively works with the centres to try to improve their safety. In addition the HSE sent an infection control nurse into the specific centre in Cahersiveen. The nurse went through a very detailed checklist of what could be done in terms of managing infection control,

particularly in the context of an outbreak. That checklist, which was extremely helpful, was then promulgated to other centres as necessary to help them with infection control. It is worth bearing in mind that the people who run our centres are, in the main, hotel or accommodation managers, and they have never had to do this before. We are having to learn what they need to know and are providing it to them as best we can, over time.

With regard to translations and comments, we translate a lot for the residents as well so they know about the basic things, about cough etiquette and so on. These are the things that we have started to learn and practice by rote, although I noticed I coughed into my hand earlier which I probably should not have done.

Mr. Kirrane may wish to come in on the issue of processing.

Mr. Michael Kirrane: We have been looking at the processing of cases for the past number of months to see how we can speed that up. Our average processing before the pandemic was 15 months for a first-instance decision. We want to get that down to nine months, and indeed to get it below that. We have had our challenges with the pandemic because we cannot carry out face-to-face interviews as part of the process, which we must do as it is a legal requirement. We are looking at how we can get back and start that process as quickly as possible through the use of video-conferencing and a series of other measures.

In the longer term, the Catherine Day advisory group has been established. One of its terms of reference is specifically to look at how to further speed up processing cases and to look at best practice across Europe in relation to doing that. It is currently undertaking its work and is expected to report in the autumn. It is in all of our interest to speed up the processing of cases because by doing so, it would mean that people would be in the direct provision system for a shorter period, and those who are given a positive decision could get on with their lives and move out of the facility as quickly as possible.

Ms Oonagh Buckley: On the isolation rooms, off-site isolation rooms are supported by a section 39 agency that provides the necessary supports. That was done by arrangement with each of the CHO areas. With the on-site isolation rooms it is a little more difficult to say, but they are only ever a temporary solution while a person is waiting for a test result. If he or she is confirmed positive, or is in close contact with others, he or she is taken to one of the off-site self-isolation facilities.

There are rotas for all the shared rooms and facilities, and we strongly encourage centre management to put that in place, and continue to encourage them to do so. It is far and away the best way to manage this within what is a closely-confined setting where people have to share laundry facilities, eating areas, and so forth.

With regard to people of African descent, we have cocooned everybody identified to us as either in the first or second category of health vulnerability. Those were identified to us by the HSE. We have to go by what it tells us because we do not hold people's health information. We have not been given any additional advice around people of African descent, but obviously if that becomes part of the evolving knowledge the HSE passes onto us, we would do whatever it asked us to in that regard.

Acting Chairman (Deputy Mary Butler): I thank Ms Buckley. I call Deputy Michael Collins for the Rural Independent Group.

Deputy Michael Collins: People in direct provision centres in this country have been

treated appallingly. This is something I have said before, and I say it again today. Our Government has failed these people, and the people of the communities in which people in direct provision live. As I said a few months ago, this is a box-ticking exercise by the Government. It was trying to show Europe and the world how it was willing to take people in under direct provision, but not telling the world what conditions these people would be living in. All too often we have seen ten beds in one room. Is this the norm for many in direct provision? In March approximately 110 people in several direct provision centres, including a number of children and heavily pregnant women, were given scant notice and ordered to move to Cahersiveen in County Kerry, without testing in advance, in order to avoid overcrowding and the development of Covid-19 clusters. They were forced to leave the lives they had started in Ireland behind. On 18 March, there was an outbreak of the coronavirus in the centre. In mid-April, the development of a Covid-19 cluster ensued, resulting in 24 cases to date. Since mid-April, all remaining residents have undergone the ordeal of a 24-7 voluntary but strongly advised confinement in the 56-bedroom centre, with restricted access to its limited outdoor area. They have also endured 14-day isolation periods in their small bedrooms, sometimes in recently infected rooms, some sharing with strangers and others as entire families. Together, we are now presented with a horrible new dilemma which only the witnesses and their colleagues have the power to resolve.

Was there a testing strategy in place to test people who were moved from one direct provision centre to another? If there was such a strategy in place, what percentage of the people in direct provision were tested and moved only on the basis of a negative result?

Dr. Kevin Kelleher: To my knowledge, there was no such strategy. The moves were arranged by the Department of Justice and Equality. However, if we understood there to be an issue in a centre, the testing would then be developed as a consequence of what we knew about what was happening in the centre. As the committee heard, if a case or contacts were identified, they would be moved out of those centres as quickly as possible to separate isolation facilities. The testing depends on the circumstances, the conditions, the numbers, etc., in those centres.

Deputy Michael Collins: Why was there no testing strategy? Will there be a testing strategy put in place going forward?

Dr. Kevin Kelleher: It is an important issue. We only have a very short period of time and this is likely to be a very long answer. The Deputy has to understand testing in these circumstances. The test we use only tells us that the person is positive or not detected at that moment in time. It does not mean the person is negative for the next week. The person could be tested the next day and be positive at that point. A test is not the answer. The answer is about how we take on board the whole process. We have given advice from the very beginning of this process around this area. Our first advice was put up on our HPSC website in early March. It was revised in April. It states very clearly how to deal with this issue, both in terms of trying to prevent it and when there are outbreaks. There is further advice on our website about dealing with outbreaks. The committee has heard some of those details. We have sought to put in, where necessary, additional staff like the infection protection control nurse, having a community worker on sites on a daily basis and things of that nature.

We seek to work with our colleagues in the Department of Justice and Equality to try to reduce the burden of people with Covid in these facilities as much as possible but it is difficult because of the circumstances. Along with them, we are trying to put in place systems that do that. They are basically the same things we ask everybody in the country to do. It is not that different at all. It is about good hygiene, good respiratory etiquette and social distancing.

Ms Oonagh Buckley: The Department of Justice and Equality would have an issue if the HSE sought uniquely to start testing asylum seekers when that was not required of other citizens in similar circumstances or other nationalities. We would have a very grave difficulty if asylum seekers were singled out for testing ahead of any other group in society. They are only tested when the HSE needs them to be tested. That has to remain the case.

Deputy Michael Collins: I asked the same question today of the witness from Nursing Homes Ireland. I asked if there was testing in place when patients were moved from a nursing home or hospital to another nursing home. I am not singling out any sector. It is important when people are moving from one care provision facility to another, regardless of what it is, that Covid testing would be done.

With the potential for a further wave, what planning is under way to ensure people resident in direct provision centres will be permitted to follow clear social distancing guidelines?

Ms Oonagh Buckley: We are very conscious of the fact this is a very long-term situation. It is a marathon and not a sprint. We are starting to plan at this point for how we can ensure that we can maintain the lower level of density in our centres that we have achieved at this point. We are starting to plan the use of self-isolation facilities, how we use them and what we need to retain in that space. That is particularly challenging because several of the hotels we are using have indicated they will return to commercial business when the economy reopens. Hotels will not be as readily available and, as such, we must plan very carefully around how we might do that. That is a specific issue within the broader challenge of trying to improve the quality of the accommodation we provide on a general basis. We are working very hard at so doing. We await the recommendations of the group headed by Catherine Day which are likely to come through in September and should set us on a track in respect of where we go more generally in providing appropriate accommodation options for people who come to Ireland and apply for international protection.

Deputy Thomas Pringle: Have all healthcare workers been moved out of direct provision? If not, why not? They are vitally important.

Ms Buckley noted in her opening statement that the Jesuit Refugee Service, JRS, had launched a support service for residents of centres. How long has it been in place? How many calls has it received? How much feedback has the Department received on it? I know from experience that the Department will not accept complaints from anybody other than residents. In that light, why was that service introduced?

On testing and the HSE, the Department stated that there are approximately 8,700 residents in the asylum system. The HSE has tested 1,734 of them. Why have all residents not been tested? What is the difference between hostels for asylum seekers and nursing homes, where there has been blanket testing of all residents and staff? Why has that not been rolled out for asylum seekers?

Ms Oonagh Buckley: The Deputy's first question regarded whether all healthcare workers have moved out. The short answer is that through our labour market access records we were able to identify 160 people who we thought were working in a care setting and might need solutions to be provided for them. We proactively tried to contact each of those healthcare workers. In fact, we asked a particular NGO to help us do so, which it readily did. Unfortunately, there was a relatively low take-up of the accommodation offers by the healthcare workers. Between 10% and 20% of them indicated a willingness to accept such an offer. There are many reasons

for that, such as that they have family in the direct provision centre and do not wish to leave them or they are perfectly happy in the direct provision centre. Many people are quite happy where they are. The accommodation on offer from the employer or the HSE may not have been of the right kind or they were not happy with it. The choices open to us were to evict them from our centres or tell them they must give up their job in healthcare, neither or which we were willing to do. As such, all we can do is to continue to recommend to people that they take up the offer. We are continuing to do so, but it is not mandatory for people to take up the offer.

On the JRS support line, we got it up and running on Thursday. We had been working on it for a couple of weeks. In the first two days, we received 11 calls. Ten of those issues had been resolved by the time we got a report yesterday morning. The line is up and running and it is a very useful way for people who need to raise an issue, for whatever reason, to so do. We continue to ask people who have a problem to, please, tell us about it first because we can fix it. If they raise a problem about their centre, that information will never travel across into the International Protection Office. It will have no effect whatsoever on one's application for asylum or permission to remain.

Deputy Thomas Pringle: With respect, residents do not believe that.

Ms Oonagh Buckley: I acknowledge that people are frightened.

Deputy Thomas Pringle: They wish to-----

Ms Oonagh Buckley: The JRS line is a way of trying to ensure they have a neutral place to go to raise concerns and we will happily deal with that. Many NGOs take these queries and refer them to us. We have received a few dozen NGO-related queries to our helplines recently.

Deputy Thomas Pringle: Departmental officials have refused to take complaints when I have raised issues with them.

Ms Oonagh Buckley: I am surprised to hear that. If the Deputy wishes to raise anything specific, he can refer it directly to me. We are open to Deputies raising specific issues as well. We prefer to hear about them ourselves first because, as I said, that means we can try to do something proactively before a matter gets out on Twitter and all those other things that happen. On blanket testing, I will pass over to my colleagues.

Dr. Kevin Kelleher: I spoke about this earlier and we have clear evidence. We got positive results as a consequence of some testing we did when we learned of outbreaks in some centres. We actually performed that type of mass testing in nine or ten centres. No cases were identified when we screened all the residents. That coincided with the information we were getting from elsewhere from mass testing. Outside areas with known outbreaks, testing produced very few, if any, positive cases. We are now very clear, therefore, that mass testing is not the appropriate way to go. It is far better to look at this issue in the context of testing known cases and being very strict and quick with that. That is what we are doing now as a consequence and we always do it very rapidly. Our testing is down to the point where results are available and back in 36 to 48 hours, at the longest.

Deputy Thomas Pringle: If a nursing home turned up negative following a test, would that be a signal for another test?

Dr. Kevin Kelleher: Throughout that process, when we moved into areas where there had been no cases, it showed very few, if any, cases whatsoever. Again, in the testing carried out

in nine or ten direct provision centres, totally outside any hint of problems, none of them had a positive case.

Deputy Thomas Pringle: The issue in congregated settings does not apply to asylum seekers but it does to residents of nursing homes.

Acting Chairman (Deputy Mary Butler): I thank Deputy Pringle and the witnesses. We have to move on. I want to be fair to everyone. We move to the Fianna Fáil slot again. I call Deputy Donnelly, who has five minutes.

Deputy Stephen Donnelly: I thank our guests for their contributions. I will focus on the current level of provision and the safeguards in place. Regarding vulnerable people, I note from Ms Buckley's opening statement that has been deemed to be those over 65 years old rather than 70. Taking those vulnerable to Covid-19, therefore, as those people over 65 and those with underlying conditions, what is the current state of play? Do all those people have their own rooms and all the necessary safeguards around them to protect themselves from contracting the virus?

Ms Oonagh Buckley: Yes. We were lucky, in one respect, that the number of those aged over 65 years is low, somewhere short of 70. A further three dozen or so people with high health vulnerabilities were identified to us in recent weeks by the HSE. We have put solutions in place for all those people. In some cases, those solutions do not involve them having their own space. In at least one case, two ladies I am aware of asked to stay together because they are friends. Several members of our older population are also part of family groups, want to stay with their family network and are in a household in that way. Appropriate solutions, that the HSE is okay with, have been found for all that population, but it is, thankfully, quite small.

Deputy Stephen Donnelly: That is good to hear. There was also a situation where people sharing rooms but not in the same family were deemed to be of the same household. They were asked not to interact with other households. In reality, however, there are shared bathrooms in some cases, as well as shared cooking facilities and communal areas. How is that being done in practice in light of the very tight spaces many of these men, women and children are living in?

Ms Oonagh Buckley: Many of the practical steps concern good hygiene control. It involves rostering people and having rotas in place. In many cases, food is being delivered directly to bedrooms. It involves putting in place a series of measures, depending on the individual capacity of the centre and the individual issues arising in that centre, needed to try to-----

Deputy Stephen Donnelly: I specifically ask about cooking. Ms Buckley mentioned rosters. For the rest of us in Ireland there is no question that families would share each other's space in kitchens once it was properly cleaned afterwards. Is it the case that families, households or groups in rooms have to use the same cooking facilities, although it might be at different times of the day?

Ms Oonagh Buckley: That would be the effect, as long as there is reasonable hygiene control. In some cases, however, the HSE has advised us and we have had to close the communal cooking facilities, which is of course a step backwards in the independent living of residents. We have had to go back to direct provision of food in the centres for that reason.

Deputy Stephen Donnelly: I thank Ms Buckley. The current public health advice for wearing masks is that people in indoor settings and reasonably close contact with others - in shops, for example - should consider wearing such masks. This does not necessarily mean medical masks but even cloth masks. Do the residents who want such masks have access to

sufficient face coverings to comply with that public health advice in direct provision centres?

Ms Oonagh Buckley: We have a very large supply of masks available and we will not be found wanting if people look for masks from us. We effectively have a weekly delivery of PPE to every centre. I am not sure what the current advice is on the use of masks in congregated settings. I might have to call on a colleague from the HSE to give that information or perhaps we can get the advice to the Deputy.

Deputy Stephen Donnelly: I thank Ms Buckley for the response. The follow-up question is whether any resident who wants a mask can have one.

Ms Oonagh Buckley: We certainly have enough masks. We would have to go on the best advice available to us as to whether people should wear them in those circumstances. That is why I want to come back to the Deputy on the current state of play with regard to the advice. As he knows, there is great concern within the HSE that people would not use medical grade gear inappropriately, and there may be some circumstances, as I understand it, where it may cause problems.

Deputy Stephen Donnelly: I appreciate that but the residents in direct provision are in a unique position as they are in close proximity with other people not in their household in indoor settings. They have no choice about that. If it is not the case, the Department might look at this but I hope any resident who wants a mask would have access to one. My understanding of the current public health advice is that should be the case.

I ask about the children in direct provision. They no longer have access to school and they are living in impossible positions that I imagine will scar them very deeply for years to come. For the children who cannot go to school, have other educational supports been provided such as tutoring in centres, remote schooling or safe spaces where they can do their studies? Have any other psychological supports been provided for the children? I imagine many of them are very scared right now.

Mr. Mark Wilson: The responsibility for the provision of education rests with the schools and we have direct links with the Tusla education support service and the Department of Education and Skills in respect of the various categories on which we are focusing and where some support might be needed. For example, there were 32 children doing their leaving certificate this year and we had to give some definite thinking to how we would work with those at an earlier stage of the development of the pandemic. We also have children transitioning from sixth class to first year and we have a small number who came into our system but have yet to be linked with schools. Those particular children are targeted by relevant educational welfare officers and arrangements have been put in place to support them.

We have also been linking with colleagues in the Department of Rural and Community Development around library drops as a support for children. All centres are obliged to have Wi-Fi and all rooms have televisions, which can assist children in linking with programmes such as the RTÉ "Home School Hub".

Deputy Stephen Donnelly: Do they have access to laptops?

Mr. Mark Wilson: We did a survey through our call centre in the Department on the level of demand for additional tablets or laptops and we are not getting indications there is a high level of that demand. We are in a position to respond to that if it is brought to our attention. Equally, there is a scheme, through the Department of Education and Skills, for that purpose.

Deputy Stephen Donnelly: I thank the Acting Chair for her indulgence. I happen to be homeschooling three children who are all at different levels in primary school. Between Aladdin, Seesaw, ClassDojo, Google Drive and email, it would be very difficult to do it without access to a PC or a laptop. Mr. Wilson might make sure that children who are in school are facilitated in terms of online learning because many schools are using it to teach children.

Acting Chairman (Deputy Mary Butler): We move back to Sinn Féin. Deputy Carthy has ten minutes.

Deputy Matt Carthy: I thank the witnesses for attending and for their information. I recognise that this is an incredibly stressful time for all of them, particularly those who are working on these issues on a daily basis. I should put on the record my bias because I have monitored the situation with direct provision for a number of years and I am of the view that it is an abhorrent system which needs to be changed. It serves neither those who are seeking international protection nor the local communities in which they are often placed well.

I want to get some very quick background information. There are 84 locations in which people seeking international protection are currently housed. How many people in total currently live in those 84 centres?

Ms Oonagh Buckley: We have just short of 8,000 people technically accommodated, although I should note that many people have sourced their own accommodation during this time. Approximately 10% of our population have-----

Deputy Matt Carthy: Approximately 8,000 people. How many of them are in what the Department would call emergency accommodation? Ms Buckley stated that there are 33 emergency centres.

Ms Oonagh Buckley: I will have to get the exact number of those located in emergency accommodation for the Deputy. We will have to come back on that.

Deputy Matt Carthy: For context, how much has been paid so far this year to private companies in the context of housing those 8,000 people?

Ms Oonagh Buckley: Again, I will have to give the Deputy the exact figure. I have seen figures from a month or so ago. What I can say-----

Deputy Matt Carthy: How much was paid in the month of April?

Ms Oonagh Buckley: I will have to come back to the Deputy on the exact figure. I would not want to give him a figure that was incorrect. What I can tell him is that we are well ahead of our estimate in terms of spending at this point. We are likely to greatly exceed our estimate for direct provision this year.

Deputy Matt Carthy: As in overspending or underspending?

Ms Oonagh Buckley: Overspending.

Deputy Matt Carthy: Overspending. Okay. Dr. Kelleher can correct me if I am wrong but he indicated that there were 180 positive cases across ten centres housing people seeking international protection. Is that correct?

Dr. Kevin Kelleher: That was the figure for outbreaks. There would possibly be more in-

dividual cases, as the Deputy has heard, where people are not in overt direct provision centres. It would not be as easy to-----

Deputy Matt Carthy: Perhaps between the HSE and Department we could get an exact figure in respect of the 84 centres. Can the Department state how many deep cleans have been carried out in the 84 centres?

Ms Oonagh Buckley: I am not quite sure what the Deputy means by deep cleaning, but I am not aware of deep cleaning being a requirement of the advices we have been given to date in respect of those centres.

Deputy Matt Carthy: Okay. None is the answer. I refer to risk assessment, a matter Deputy Daly did not have time to discuss. Was a risk assessment carried out by the HSE or the Department prior to 16 or 18 March when residents were moved to Cahersiveen? Have risk assessments been carried out in all centres in respect of the Covid-19 outbreak and what it might mean?

Ms Oonagh Buckley: In terms of the very fast moving situation in the first two weeks of March, I do not think we could formally state that a risk assessment was carried out in terms of a piece of paper with a matrix and all of that. However, we knew we had risks in the system and we had to act to address them. At the same time we were asking centres to follow a protocol. I might ask Mr. Wilson to come in here because we are working on a more elaborate risk framework which will allow us to put in more supports around various centres based on a model provided by the Mental Health Commission. Does Mr. Wilson want to come in on that?

Mr. Mark Wilson: Early on in the second week of March we asked centres to consider several issues that were pertinent to the developing problem, including their routines around cleaning and developing self-isolation capability at local level. That was followed up with a request for contingency planning to be put in place that allowed for feedback in respect of the individual centres.

In the next two weeks, in co-operation with our colleagues in the national social inclusion office, we will be undertaking a further assessment of each of the 85 centres or locations to be able to identify where particular locations may need assistance in strengthening arrangements. As Ms Buckley has said, this is being built on the Mental Health Commission model-----

Deputy Matt Carthy: I am sorry to cut across Mr. Wilson. Is it correct to say that the principle of the risk assessment is self-assessment by the management of each centre as opposed to an independent risk assessment being carried out by the HSE or another body?

Mr. Mark Wilson: We will pull together information that we have available to us plus self-reported information from the centre. We will be considering on-site follow up to that in addition to the information provided and gained.

Deputy Matt Carthy: Let us take, for example, the centre at Cahersiveen or any new centres or location that the Department of Justice and Equality is examining. Before anyone is moved to a centre, is there a process by which there is an assessment carried out with a view to Covid-19?

Mr. Mark Wilson: We have not moved people of late because of the requirement to keep people in their existing locations. We have a current conversation with our colleagues in social inclusion-----

Deputy Matt Carthy: Could the Department officials answer the question in respect of Cahersiveen? Before people were moved to Cahersiveen was a risk assessment carried out with a view specifically to Covid-19?

Mr. Mark Wilson: At that point in time that was not considered necessary or not asked of us.

Deputy Matt Carthy: I note that some 25 men from Cahersiveen - I could be wrong on the figure - were moved to Cork and then four were moved to other locations. Were tests carried out on the individuals moved prior to transfer?

Dr. Kevin Kelleher: I do not know. We would have to come back on that.

Mr. Mark Wilson: Those moved from Cahersiveen to Cork were moving to self-isolation facilities so they would be isolated for the period when they required intervention. Only on the basis of public health advice-----

Deputy Matt Carthy: Only people who had already tested positive were being moved. Is that correct?

Mr. Mark Wilson: Yes.

Deputy Matt Carthy: Are other transfers taking place? I gather from Ms Buckley's earlier response that there are some limited transfers taking place. Is there a practice of tests being carried out before the transfers take place?

Ms Oonagh Buckley: I will come in on that. In general, the transfers taking place at the moment involve individuals who have tested positive. They have been moved to an isolation facility and have completed their period of isolation. Either they need to be transferred back to where they came from or transferred on to another centre. The other group of people who are moving into our system are the people who are still arriving and applying for international protection on a daily basis. We are working with our colleagues in the HSE to try to introduce an effective quarantine system for them for a couple of weeks. Then we need to move them on to other centres. The system is a live system. There are constantly people flowing into it and fewer people flowing out of it. We have to keep the system moving. We are in constant engagement with our colleagues, especially in the national social inclusion office, as to how we can continue to maintain the system safely.

Deputy Matt Carthy: Is there a practice of when people are moving from one place to another, especially if they are moving into a new centre, that they have either gone through a period of quarantine or been tested prior to being located in one of those centres?

Ms Oonagh Buckley: There is no practice of specifically testing asylum seekers unless it is required based on health reasons. As I said earlier, the Department of Justice and Equality would object most strongly to any suggestion that there should be a practice of randomly testing asylum seekers as a unique group compared with the rest of the population.

Deputy Matt Carthy: I want to clarify that I was not suggesting it would be random. I am suggesting that if somebody is to move into a congregated setting, perhaps it should be examined whether he or she has been tested beforehand. I heard what Ms Buckley said about the Department's objections to asylum seekers being treated differently. I would argue that asylum seekers are being treated very differently in many respects. On that note, I wish to ask

for specific numbers, starting with the number of residents currently sharing bedrooms with non-family members.

Ms Oonagh Buckley: There are approximately 1,700 persons sharing bedrooms.

Deputy Matt Carthy: How many non-family members share toilet facilities with one another?

Ms Oonagh Buckley: Substantially more persons.

Deputy Matt Carthy: Does Ms Buckley not have a number?

Ms Oonagh Buckley: In effect, one could say that anybody who is not in own-door accommodation, which is about a quarter of our population, is almost certainly sharing either cooking or toilet facilities.

Deputy Matt Carthy: Would the latter include shower and washing facilities?

Ms Oonagh Buckley: That is a requirement of our centres.

Deputy Matt Carthy: Does Ms Buckley get that there would be a problem there in the event of an outbreak of Covid-19?

Ms Oonagh Buckley: As I said in my opening statement, we know there are weaknesses in this system. We would like to improve it but we are trying to manage our system in the middle of a pandemic. We are trying to manage as best we can with a system that we know is not fit for purpose and needs to change.

Deputy Matt Carthy: I would argue that it needs to do more than change. It needs to be radically reformed because it is broken. Again, that is not a reflection on the people with whom Ms Buckley works, who are doing hard work under very difficult circumstances.

Ms Buckley referred a number of times to the Catherine Day report and the analysis that has been carried out. Can she tell me offhand whether that will examine a systemic review - in other words, looking towards moving away from the private sector towards public provision of housing for these very vulnerable people?

Ms Oonagh Buckley: That is the precise purpose of the group.

Acting Chairman (Deputy Mary Butler): That answer will have to be furnished in writing because we are up against the clock.

Deputy Colm Burke: I thank all the witnesses for coming in and all the people working in the direct provision centres and in their administration.

Ms Buckley referred to about 8,000 residents currently in direct provision. In how many cases are decisions on applications pending? Of those cases, how many judicial review procedures are in place? Can we have an idea of those figures?

Ms Oonagh Buckley: I will have to come back to the Deputy on the judicial review figures because our judicial review figures comprise things such as citizenship and EU treaty rights. They would not necessarily comprise people in the international protection process only. I have the figure for the number of people in the international protection process here somewhere, so if the Deputy wishes to ask his next question, I will have the figure identified before he-----

Deputy Colm Burke: My next question is about people who have a particular medical problem such that they are required to attend hospital regularly for medical review. Is there a process in place for moving them to safer accommodation? If so, are there many people in respect of whom the Department has had to use that process in order to be sure? I raise this question because where the virus has been identified in a particular centre, these people will move back and forth from a hospital to the centre. What kind of numbers are we talking about there? Is there a process in place for dealing with that?

Ms Oonagh Buckley: We cocooned the people who were identified to us by the HSE as being vulnerable. If there is an outbreak in a centre, it is generally the case that the HSE tells us we cannot move anybody into that centre. That is the normal process in those circumstances, for obvious reasons. We certainly would not move medically vulnerable people into such conditions. I am not entirely sure I followed the other aspects of-----

Deputy Colm Burke: If in a centre there are people with a particular medical condition other than coronavirus, is there a process in place for moving them into a safer location in order that they are not at risk, particularly given that they are likely to be attending hospital for medical review?

Ms Oonagh Buckley: My apologies, yes. In the normal course, if somebody is identified to us, particularly by his or her GP, as requiring specific provision, for example, access to hospitals, there is a standard process that we always use in those circumstances. In a normal year we have many people requiring special medical facilities. They might have HIV, for example. We make special provision for them in terms of accommodation.

As promised, I have found the figure the Deputy was looking for. At the end of April there were 5,694 applications for international protection on hand in the international protection office.

Deputy Colm Burke: What kind of numbers are we talking about in the case of those with particular medical conditions outside of coronavirus?

Ms Oonagh Buckley: This question refers to people with specific vulnerabilities. We will have to come back to the Deputy. I will have to be careful about the information. Obviously it will have to be very generic, because obviously we cannot really-----

Senator Colm Burke: I fully accept that.

Ms Oonagh Buckley: The other point I need to make is that we do not hold individuals' health records. If we are asked to provide facilities for somebody, we certainly endeavour to do so. Perhaps the best thing I can come back to the Deputy with is we can let him know and give him the figure for how many people we have been asked to make special health provision for, say in the past year. That is not a problem.

Senator Colm Burke: In the case where a person is pregnant and is attending hospital clinics, what is the accommodation provision for such a person, in particular in a specific place where coronavirus has been identified?

Ms Oonagh Buckley: I will ask Mr. Wilson to talk about the issue relating to pregnant women. In the event of somebody giving birth, we had an instance of this in Cahersiveen, and they were not and would never have been returned to the centre in Cahersiveen. Provision was made for them at another centre in that community health area. Mr. Wilson will speak with

regard to pregnant women and checks.

Mr. Mark Wilson: Health care in direct provision is provided through the primary care system. Residents are linked in with their GP. Where requirements are identified locally with the centre manager, the resident will look to resolve the problem. If it cannot be resolved at that level, it will come up to ourselves. We will link with our HSE colleagues to find a suitable solution to the problem that is presenting, be that pregnancy or any other health condition.

Senator Colm Burke: Ms Buckley referred to the case in Cahersiveen. My understanding is that that person was not moved, in fact, attended clinics for care and was returned to the centre.

Ms Oonagh Buckley: She was not moved prior to the baby being born, but once the baby was born, she was accommodated elsewhere in our network.

Senator Colm Burke: But she was attending a hospital from the centre.

Ms Oonagh Buckley: She was, indeed, because that is the care model that is provided to people in the system who are pregnant.

Senator Colm Burke: Looking to the future and having had to deal with that situation in Cahersiveen, does Ms Buckley think that a better plan can be put in place? On each occasion this person attended for maternity care, she went back down to the centre, and each time she went back, it was clearly identified that she was not positive. Is there a better way?

Ms Oonagh Buckley: We will certainly have to take that away and think about it. We will have to operate under health advice as well. The Deputy has to understand that there is countervailing piece, which is that once there is an outbreak in a centre, we are not supposed to move people from the centre. There is an issue about how we find a balance in such situations.

Senator Colm Burke: I accept that this is a very specific kind of situation that will arise. Do we now need to look at this from a long-term point of view, so that there is a plan in place to deal with it?

Dr. Kevin Kelleher: May I come in? The HSE is at the moment looking at how we will have to provide all our services into the future of this pandemic. It is one of our key tasks at the moment to see how we can provide services such as the Deputy is talking about - maternity services - which actually have carried on the whole time throughout this, as clearly they need to. We are looking to how we provide services such as these in a world where Covid-19 will exist. It may or may not be known if people have Covid-19, and therefore we have to provide the services in those ways. We are seeking to do this in many very innovative ways. Increasingly, some of this will happen via telephone and video etc. to facilitate a lot of this and to ensure people are not being exposed, either when coming into our facilities or when they are already in our facilities. We are looking at that now and members will have heard our CEO and others talk about this in recent weeks. One of our key tasks is to see how we can provide all of our services in this period. The Deputy is talking about a specific issue, which we have carried on with throughout this period, and our maternity services have been very involved in looking at how they had to deal with these circumstances.

Acting Chairman (Deputy Mary Butler): Does Deputy Burke mind ceding his last minute? I want to get the last speaker in and time is pressing. Would you mind?

Deputy Colm Burke: You gave your colleague an extra two and a half minutes on top of the designated five minutes.

Acting Chairman (Deputy Mary Butler): The answers are coming from a different room. It is difficult.

Senator Colm Burke: I know, but your colleague was given an extra two and a half minutes. I have a final question around the number of people who are still in centres even though asylum has been granted to them. This question may have been answered already but do we have a number for those people?

Ms Oonagh Buckley: It is just over 980.

Senator Colm Burke: Are efforts being made to move them out and to provide suitable alternative accommodation?

Ms Oonagh Buckley: Yes. Those efforts have continued throughout the pandemic and even during the lockdown. Eighty people moved out of our centres as part of that assisted process during the month of April, which was great. We need to do more of that and we are working strongly with two NGOs that helped that process. We have a co-located official from the local authority services and the Dublin Region Homeless Executive who helps us with housing assistance payment, HAP, applications and so on, and we are very keen for as many of those households as possible to move out of our centres as quickly as possible because that relieves a huge amount of pressure on us elsewhere.

Deputy John McGuinness: The transcript of these three sessions today should be sent to all of the negotiators and leaders of the parties forming the next Government because we have heard about the failure of public policy in so many areas today. The officials present can account within that policy but this House has failed in the care of the elderly, the respect shown to them and the care they deserve at this time in their lives. We also failed with the disability sector and the section 39 organisations, which were mentioned earlier. We did not touch on those in depth at all. However, when I asked a question of the HSE about the funding for section 39 organisations, that question has still not been answered and those section 39 organisations that provide services in group settings and houses do not have the funding to meet today's public health requirements. I am being told that by a number of different organisations and we are letting them down in this House if we do not insist on getting the appropriate answers from the HSE and every other body that is associated with this.

On direct provision, what we are again experiencing is the failure of a policy that has been implemented by successive Governments for the past 20 years because we have deliberately ignored the most vulnerable in society. These people who come to our shores are vulnerable. For a long time, Members of this House have been highlighting in Second Stage debates of legislation the faults and failures in the care of the elderly, the disability sector and the direct provision facilities. The finger clearly points at us here.

I am not asking the witnesses to comment on the following issue that has arisen but they can do so if they want. So many different Departments and Government agencies that are involved in this deal with their business almost in silos. They do not connect with each other as successfully as they should. There is a clear effort being made by many concerned to deflect, obfuscate, ignore the double standards that exist and move on.

For example, in today's hearing the Chairman or Acting Chairman read out before every

session that one shall not refer to an individual in such a way as to make her or him identifiable. Witnesses are asked to refrain from that. Today, we heard the centres being named where Covid had been identified. That is in the direct provision setting but when it came to the care of the elderly the Department was asked not to do that. There are double standards that cannot be ignored and we have to deal with them. Ms Buckley, when the Department offers or awards a contract, what oversight kicks in from there on to ensure that the rights of the people in these settings are protected? We constantly refer to public health standards and advice but I think we should be guided about what we would want to do in the name of humanity and compassion rather than just tick a box. How does the Department oversee the contracts that are offered? Does the Department have inspectors? Does it report back? What does it do with breaches and so on?

Ms Oonagh Buckley: In normal times we aim to have three unannounced inspections of each of our centres and those go through the detail of what is required of the centres. Any flaws or faults that are found are immediately referred to the centre manager and asked to be addressed directly. There is a follow-up visit, if needed.

In terms of governance of the rights of the people, the Deputy will be aware that under the McMahon report of 2015 centre residents were given access to the Ombudsman and the Ombudsman for Children. The Ombudsman now conducts a very proactive campaign of visits to centres. Indeed, he published his report in the last few weeks. He deals very proactively with complaints that come in. As well as the capacity to complain to us which, as one of the Deputy's colleagues has already said, some people do not like to do there are many routes now to try to ensure that centres are effectively managed.

Deputy John McGuinness: In the context of those who manage the centres, how many of those managers or holders of the contract got in touch with the Department or the HSE in the lead into the Covid-19 crisis to say "hang on a second, we cannot deal with this"? Did alarm bells ring for the Department? Were the centre managers central to those inquiries?

Ms Oonagh Buckley: Our alarm bells were ringing all right but they rang in our own heads. It was not that centre mangers were telling us they were going to have concerns.

Deputy John McGuinness: Did they?

Ms Oonagh Buckley: It was us saying to centre managers that we needed them to start planning for this. We had our first planning meeting for Covid-19 on 6 March and we have worked might and main 24-7 ever since to manage the situation. It was very much us proactively working with centre managers to get them to look at the situation that they needed. As the Deputy will have heard, we now have daily phone calls with them. We deal very proactively with their concerns and manage that through a specialised helpdesk that we put in place.

Deputy John McGuinness: Did the managers come to the Department with their concerns arising with what they might have had to do, in terms of planning for Covid-19, or did the Department have to pursue them? Were they proactive on behalf of their residents in the centres that they owned and managed?

Ms Oonagh Buckley: There was a differing approach depending on the centre manager. It would probably have been us who first contacted all of the centres saying,

"we need you to start planning for this". The centre managers have responded differently, depending on their different capabilities. One of our key tasks now, applying a risk framework,

is to look at those centres that need additional supports from us and to proactively offer them. Since we put in place the call centre and so forth, centre managers are actively encouraged to come to us or come to the safety net line with any concerns that they have, which they do. They ask us for PPE and things that they need or tell us about their concerns about, for example, people wanting to return to the centres. We have a very strong interaction with them now.

Deputy John McGuinness: How many people did the Department move out of the centres to either isolate or because it was beyond the number that could be coped with in the context of Covid-19? How many people were moved out of the various centres and what was the extra cost involved?

Acting Chairman (Deputy Mary Butler): I must wrap up the debate and suggest that Ms Buckley answers the final question in writing.

Ms Oonagh Buckley: That is no problem.

Deputy John McGuinness: Ms Buckley may have the number.

Ms Oonagh Buckley: We moved more than 600 or 7% of our population to help with capacity thinning.

Acting Chairman (Deputy Mary Butler): I thank all our witnesses for their attendance and for the information provided for today's meeting. Is it agreed to request the Clerk to seek any follow-up information and carry out any agreed actions arising from this meeting? Agreed.

The committee adjourned at 6.40 p.m. until 11 a.m. on Tuesday, 2 June 2020.