Opening Statement to Special Committee on Covid-19 Response

- Jim Breslin, Secretary General, Department of Health

Chairman, Committee Members,

Thank you for your invitation to meet with you today. I would like to extend my best wishes to the Committee, and indeed the new Dáil, in its important work.

Just under 17 weeks ago, on 22nd January, the World Health Organisation (WHO) announced that there was evidence of human-to-human transmission of the novel coronavirus, COVID-19, in Wuhan, China.

Since then, the Department of Health, the HSE, the wider health sector and colleagues across the civil and public service and community and voluntary sectors have put in place an unprecedented response to an unprecedented emergency. I am deeply proud of the way in which people in my own organisation have risen to the challenge, at great personal cost. We must particularly express our deepest gratitude to the staff of our frontline health service who have met this challenge head on with what has been the most supreme determination.

Some Other Developments in COVID-19 Crisis

- 24th January: French health authorities reported Europe's first COVID-19 case.
- 30th January: WHO declared COVID-19 a Public Health Emergency of International Concern. (Ireland's public health emergency response mechanisms had already been activated at that stage and preparedness planning was underway.)
- 20th February: COVID-19 was added to the list of notifiable diseases in Ireland by means of Ministerial regulation.
- 22nd February: quarantine arrangements were introduced in regions in northern Italy.
- 25th February: it was recommended on public health grounds that the Ireland vs Italy rugby match should be cancelled.
- 29th February: Ireland's first COVID-19 case was confirmed. This case was associated with travel to northern Italy.
- 9th March: Government decided to cancel all St. Patrick's Day parades.

- 11th March: tragically Ireland experienced its first COVID-19 related death.
- 12th March: the European Centre for Disease Prevention and Control (ECDC) in its risk assessment said that in a few weeks or even days, it is likely that similar situations to those seen in China and Italy may be seen in other EU countries. ECDC said that the risk of healthcare system capacity being exceeded in the EU in the coming weeks is considered high.
- 16th March: Ireland's National Action Plan in response to COVID-19 was published.
- 12th March: Implementation of major public health restrictions commenced in Ireland when it was announced that schools, colleges and creches would close.
- 15th March: pubs and bars were asked to close.
- 24th March: it was announced that non-essential retail and businesses would close
- 28th March: an order was made for everyone to stay at home unless covered by an exemption such as undertaking essential work or exercising with 2 kilometres of home was introduced.

In the period since we first learned of COVID-19 there have been over 4.7 million cases of COVID-19 confirmed worldwide and at least 315,187 people have died.

In Ireland we have had over 24,100 confirmed cases and 1,543 deaths, each of them deeply mourned.

Nature of the Crisis

All crises come in phases. This public health crisis has a particularly prolonged acute emergency phase. We have made definite progress in getting virus levels back down through stringent public health restrictions. But the social and economic costs of COVID-19 have been huge and will be with us for some time. Yesterday saw the first easing of these measures under the Roadmap for Reopening Society and Business. The bedrock of this progress has been the tremendous commitment on the part of citizens and communities to the behaviours necessary to reduce transmission. The progress is such that we can now collectively take some calculated risks in extending the range of activities it is permitted to undertake. But we need to be aware that we will continue to be in the acute emergency phase of this crisis for some time, with further waves an ever-present danger. This is not a 1, 2 or even a 3-day

storm, after which we move to the recovery phase. The acute phase of this crisis will definitely be measured in months and most probably in years, rather than days.

Health Service Response

Our health service has been tested to the limits but not overwhelmed, as the ECDC and many of us feared.

None of us have seen anything like this before – the scale of the challenge is unprecedented, but so too has been the response.

There has been a focus on moving quickly to utilise all available resources, recognising that our healthcare capacity is challenged even in normal times. For example, we have introduced payments to GPs for telehealth so as to avoid unnecessary visits to surgeries. The HSE has developed 29 community assessment hubs to avoid unnecessary hospitalisations. Private hospital facilities have been secured in preparation for the surge and they are now helping with the non-COVID care that has been displaced from our major public hospitals. The HSE, voluntary hospitals and other health agencies have worked with private nursing homes to support them in preventing or managing infection and continuing to care for our older people.

COVID-19 Testing and Tracing

The health service has also been engaged in a massive effort to scale up our COVID-19 testing capacity. COVID-19 is a new virus. Four months ago there was no test for the virus, much less commercial supply of such tests and the infrastructure necessary to undertake testing at scale.

The HSE has striven each week to increase testing capacity with opening 47 testing centres operational, commissioning COVID-19 testing at 40 additional labs, procuring supplies against a backdrop of global shortages, implementing IT systems to manage referrals and automating processes.

The plane has been in flight while all this necessary work to improve its efficiency and range has been undertaken. The issues which have been encountered have been well documented, but despite these Ireland is positioned towards the top of the international testing league table. Ireland is fourth highest in the EU in terms of tests completed in population terms. To date

over 280,000 tests have been conducted. There is much more work to do, in particular in improving test turnaround times, but this week the HSE is on target to have a testing capacity of 15,000 tests per day with an average turnaround time from swab to result of between 1 and 3 days.

The scale up of contact tracing by the HSE has also taken place. The median turnaround time for giving someone their positive result and commencing contact tracing is just over one day. For over 80 per cent of routine cases initial calls are completed the same day. There are outliers and further improvements are planned and will be necessary to continue to improve turnaround and support any increase in contact tracing requirements associated with the greater circulation of people.

Congregated Settings

Congregated settings are by virtue of their physical nature and the susceptibility of those living there recognised by the WHO and ECDC as involving higher risk of infection. The deaths we have experienced in our long-term care facilities are the most difficult aspect of our experience with COVID-19 so far. The testimony of those who lost loved ones and can't say goodbye in the normal way is truly heart breaking. The international experience involving similar or, in some cases, worse problems than our own has been highlighted by WHO and ECDC who made specific recommendations for this sector in mid to late March. Our commitment to testing and recording of all deaths associated with COVID-19, whether laboratory confirmed or probable, wherever they occur means our figures are much more representative and accurate than in many countries. This information has directed our public health actions. We have also undertaken a comprehensive survey of deaths in long term residential care to ensure that we are fully and transparently capturing the actual position. We are one of the few countries that has undertaken a mass testing programme in long term residential care.

Since the outset of this emergency there has been a high level of alertness to the vulnerability of older people in general and those in long term care in particular. One of the subgroups established under the NPHET has been particularly focussed on measures to protect vulnerable groups and individuals in society. There has been a concerted focus on enhancing measures to protect residents and staff in residential healthcare settings.

Important new national and international information has emerged during the pandemic for these settings. These learnings include the quantum of asymptomatic transmission, the level of the infectiousness nature of the virus, the fact that in Ireland those over 70 years in nursing homes are more likely to contract COVID-19 than those in the general population and the high level of impact on staff absenteeism.

Compliance with infection prevention and control standards forms part of the responsibilities of persons in charge of nursing homes which are registered and inspected by HIQA as regulator of the social care sector. In the context of these responsibilities, the HSE published a series of specific public health and clinical guidance in relation to COVID-19 infection prevention and outbreak control in residential healthcare settings, including guidance on transfers between care facilities on 10th March and guidance on the management of COVID infection in nursing homes on 13th March.

As the disease has progressed a range of enhanced measures for nursing homes have been recommended by NPHET on 31st March and 3rd April for implementation by the sector with the support of the HSE and HIQA. We continue to review international responses to identify any additional actions for implementation. The HSE has established 23 COVID Response Teams to provide support and expert guidance to all long-term care residential settings. HIQA has in place a COVID-19 regulatory assessment framework, in line with the Health Act 2007. In addition, Government has implemented a €72 million Temporary Assistance Payment Scheme for private nursing homes to assist their preparedness and management of COVID-19. This is in addition to the supply of PPE, staff and other supports by the HSE to the sector.

Conclusion

We must be frank in acknowledging that as the crisis is continuing our conclusions must be tentative and preliminary. Because the virus is so new there is much that we still don't know. A proven manual was not available at the outset on how this public health crisis should be managed. We are paying careful attention to international advice and experience. Decisions are being made in real time based upon public health principles, data and our own experience. We are all students seeking to learn. The threat from the virus will be a reality for the foreseeable future and we must all work to protect the space for enquiry and learning if we are to successfully and continually adapt our response.

It is also important to recognise the issues of resilience and sustainability which will arise for staff in the coming months. Winter pressures have merged into the immediate COVID-19 response and now we know that this response will need to be sustained for the foreseeable future. We must find a means of balancing our continued COVID-19 response with attempting to attend to other health and social needs in an infinitely more demanding environment for the delivery of such care.

At the outset epidemiological modelling suggested that with a partially mitigated epidemic by 16th April we could have had 7,800 new cases per day and rising with 2,200 people requiring critical care by 23rd April. The same modelling estimated that we might have had 39,000 deaths by today. Our experience has been much less severe, but every case and every death has been one too many. Thankfully we have also seen the recovery of more than 80 per cent of patients over this period. Our crisis response continues and will require an exceptional and sustained effort for some time. The WHO has advised that the most plausible future scenario in the dynamic of COVID-19 may involve recurring epidemic waves interspersed with periods of low-level transmission.

As we commence lifting restrictions our challenge now is to begin again but using everything we've learned and all of the infrastructure we've built. Our greatest resource – as it has been to date - will be the commitment of citizens and communities to the foundational behaviours around distancing and hand and respiratory hygiene upon which so much depends.

ENDS