The effect of the infection rates among HCWs must be examined in a much wider context than the effects placed upon an individual infected worker. The infection of over 8,000 workers means that 7% of the workforce were forced into workplace absence. This comes on top of normal absence rates. So, for direct intervention areas, during a pandemic, resources were decreased by in excess of 10%. However, largescale re-assignment took place on a voluntary basis into areas such as 7 day swabbing, nursing home settings, residential settings. HSCPs undertook training to upskill in areas such as respiratory care in high dependency and ICU settings. Re-assignments also took place to testing centres and community hubs. The effect of this was the ability of the system to somewhat absorb absences caused by HCW infection rates in acute services. This, in turn required huge levels of staff flexibility and rotation, 7 days per week. Such demands can only be met in the short term. Because of what was at stake HCWs across many grades did what was necessary on behalf of Irish Citizens and deserve great merit for their massive contribution to this cause, particularly against the backdrop of having no support on their own personal childcare or care of the elderly needs, despite a government promise given in March when schools and crèche facilities were closed.

It is also worth mentioning the severe demands placed upon senior managers involved in the pandemic response over the past few months. The response could not be carried out without planning and co-ordination. Many of our managers worked 70 hours per week (without additional reward) under immense strain to maintain the level of the COVID-19 response. So the infection rates of HCWs as a by-product placed enormous strains on the system and has left many managers simply burned out. Naturally, clerical and administrative workers were placed under similar strain in their supporting roles.

I will finish by giving a practical working example of a further residual strain placed on HCWs as a result of the high number of infection rates. Many of the day to day health services were, in effect, stood down during the height of the pandemic. Such services are now beginning to re-open. For a physiotherapist or an occupational therapist this means re-engaging with a service user whose mobility, for example, has seriously deteriorated over the past few months because the intervention service had not been available. This, of course, will place an additional strain on the HSCP in a return to ‘normal’ working following on from months of the most extreme pressure caused by the pandemic.

Fórsa welcomes the opportunity to discuss such matters further on 21st July.