DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 28 Deireadh Fómhair 2020

Wednesday, 28 October 2020

Tháinig an Comhchoiste le chéile ag 11.30 a.m.

The Joint Committee met at 11.30 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Colm Burke,	Martin Conway,
Cathal Crowe,	Annie Hoey,
David Cullinane,	Seán Kyne.
Bernard J. Durkan,	
Gino Kenny,	
John Lahart,	
Róisín Shortall.	

I láthair / In attendance: Deputy Denis Naughten.

Teachta / Deputy Seán Crowe sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: As this week's meeting was unscheduled, we will leave our minutes and correspondence until the next meeting. Does any member wish to raise any other matters before I introduce our guests?

Deputy David Cullinane: I wish to raise two issues, the first of which relates to the contract for Viapro and whether procurement rules were followed. If they were not, which seems to be the case judging by the public statement from the HSE, can we write to the HSE to establish why they were not and whether there is a requirement for the HSE to have checks and balances to ensure the quality and safety of products? I acknowledge that responsibility rests primarily with the Department of Agriculture, Food and the Marine but this is €9 million of defective products. People have questions about procurement, which is ongoing with the HSE. There is not a week when the Committee of Public Accounts is not made aware of a lack of compliance with procurement rules at the HSE. This issue, however, is quite serious. Can we further ask the HSE what steps it is taking to recoup the moneys? We spent €9 million on products that are not fit for purpose. How will the State get the money back?

The other issue relates to the establishment of the CervicalCheck tribunal. I am aware that meetings were held on Saturday and Monday with representatives of the 221+ group. A commitment was given to that group that the tribunal would be paused, yet the statutory instrument, if I am reading it correctly, was signed on Friday night. The members of the group are outraged and very concerned. In fact, Vicky Phelan used the word "betrayed", which is a strong word but, obviously, that is how she feels. We need to get to the bottom of this. The Minister for Health will appear before the committee next week. Can we put him on notice that this is an issue we want to be addressed? He nonetheless needs to address it before the meeting. This is an issue of public concern and the Minister has a duty to set the record straight. We might also ask him, given that he signed the statutory instrument, whether he can revoke it. I assume he can, which he should do if that is what the group wants. I ask that we write to the Minister specifically on that. Through the medium of this meeting and previously through social media platforms, I have called on him to clarify his position immediately . That is important for the group in question.

Chairman: Is that agreed?

Senator Martin Conway: I might add one point about the Minister's appearance next week. I believe he will make an announcement concerning the criteria for medical card qualification, an issue on which John Wall has been very vocal. I wish to put the Minister on notice that if he is to appear before the committee next week, he might share the detail with us ahead of time or, if he is not in a position to do so, to deal with the issue as part of his opening statement.

Deputy David Cullinane: We asked to write to the Minister to seek the clinical advisory group report, which relates to that specific issue. We have not yet received that report and I do not think there has been a response. I understand the Minister met one of the people involved on the campaigning side but he needs also to brief the Oireachtas and the committee.

Chairman: Is that agreed? Agreed.

Covid-19 Contact Tracing: HSE

Chairman: I welcome our guests to the meeting. They will all present remotely by video link and provide us with an update on contact tracing for Covid-19. I welcome from the HSE, Ms Niamh O'Beirne, national lead for testing and tracing, Dr. Kevin Kelleher, assistant national director of public health and child health, and Mr. Damien McCallion, national director of emergency management and director general of co-operation and working together, CAWT.

Before we hear our guests' opening statement, I point out there is uncertainty as to whether parliamentary privilege will apply to witnesses giving evidence from a location outside the parliamentary precincts of Leinster House. The constitutional protection afforded to witnesses presenting in person in Leinster House may not extend to those presenting remotely. No clear guidance can be given on whether, or the extent to which, the evidence given is covered by a statutory nature. Therefore, if witnesses are directed by the Chair to cease giving evidence on a particular matter, they should respect that direction.

I invite Ms O'Beirne to make her opening statement.

Ms Niamh O'Beirne: I thank the Chairman and the members of the committee for the invitation to attend the meeting to discuss testing and tracing. Joining me today are Dr. Kevin Kelleher, assistant national director of public health, and Mr. Damien McCallion, national director of emergency management.

Since the onset of the Covid-19 pandemic, the HSE has worked tirelessly to build a robust testing and tracing infrastructure. It is important to acknowledge the extent of what has been achieved. To date, we have established a system that has enabled us to complete more than 1.54 million tests, identify 58,000 detected cases and complete more than one quarter of a million contact tracing calls. Last week, we processed more than 115,000 tests, exceeding the capacity set out by 15%.

We all know that caution is required when making international comparisons, but as for how our testing numbers compare against those of our European neighbours, as reported by the European Centre for Disease Prevention and Control, ECDC, we are ranked second among countries with a population of more than 2 million of the 28 European countries that the ECDC reports on. We are outranked only by Denmark. In addition, many countries do not test close contacts as a routine, such as the UK, the Netherlands and most recently Belgium, while some countries such as Germany, specifically in the Berlin region, Switzerland and the Netherlands have requested people to trace their own close contacts.

We remain agile in our approach when responding to the Covid-19 pandemic and have driven continual improvement within our systems and processes. We have focused on turnaround times and, during the current peak in the pandemic, we have been achieving 95% of swabbing appointments on the same day or the next day, and more than 95% of results in less than 48 hours from the swabbing appointment, two thirds of which occur within 36 hours. These metrics compare very well against those of our European colleagues. Italy, France, Spain, the Netherlands and Denmark all work with 48 hours or less as a target from swabbing to result. We are meeting all testing demand and are still working within our testing capacity.

Since the beginning of this pandemic, we have built up capacity at our testing centres and acute hospitals. These services are stood up by healthcare professionals, community swabbers, the National Ambulance Service and Defence Forces personnel. To ensure we have the required staff, we have engaged in a recruitment campaign for swabbers, contact tracers and public health doctors. We continually assess the needs in the community and identify areas

where improved access to local testing is needed. In recent weeks, this has included a large-scale testing centre in Croke Park, a testing centre in Galway city and an additional pop-up centre in Cork city. Capacity at our laboratories has also been increased, so that today we can process more than 120,000 tests per week, with our logistics team working to forecast demand accurately each week.

We have set up and are continuing to deliver numerous serial testing programmes. This has included more than 291,000 tests for staff in residential care facilities, food production facilities and both residents and staff of direct provision centres. These programmes have been set up in response to these settings being noted as at higher risk and their residents among the most vulnerable in our society. We are one of the few countries to conduct and maintain serial testing throughout peak testing demand.

As well as caring for these high-risk groups, we have an enhanced pathway for schoolgoing children and staff in school settings, ensuring that once we are aware of a detected case associated with a school setting, it is managed by our public health departments and turned around in the most optimal time, recognising the high importance of keeping schools open. There is a constant need to balance the demands between individuals feeling unwell in the community, outbreaks in congregated settings and testing in higher risk settings through serial testing programmes.

We have worked and will continue to work to ensure that our testing and contact tracing system is robust and performant. However, the increase in demand and the number of detected cases in our community in October has challenged our systems, particularly our contact tracing service. The rapid rise in the number of cases in early October exceeded the capacity of our contact tracing system as it was set up. For context, six weeks ago we were making 8,500 calls a week but this increased last week to 38,000 and we struggled with this capacity.

In response to this, and in a continuing effort to maintain effective turnaround times for contact tracing for the population at large, we asked a limited number of people, 1,971, who received a positive result from 16 October to 18 October to notify their own close contacts and organise tests through their GPs. This decision was taken to ensure that every person received information as quickly as possible, allowing them to be aware of their status and to take actions to care for themselves and to protect others from infection. While clearly this was not ideal and we appreciate the impact on those affected, it was deemed the only viable option in order to deal with the most recent cases quickly and reset our system. We apologise to the 1,971 people impacted and this week we will call everybody we missed to check that they have been able to identify their contacts and advise them to be tested. Since Friday, 23 October, our contact tracing system has been back on track and achieving its metric of all close contacts being contacted within 24 hours of the notification of the positive case.

In order to ensure we will be able to address future demand, the HSE is continuing to recruit additional contact tracers. More than 800 people have gone through our interview process, 274 new staff have been taken on board and a further 90 will join by the end of this week. We will continue to bring in an additional 60 to 70 every week. We plan to recruit 800 and then see if we need more.

As this pandemic develops, we continue to respond as effectively as possible while designing and implementing a long-term, sustainable test and trace operating model. The Covid-19 disease does not follow any plan. It is unpredictable and continues to challenge us all individually and equally challenge our testing and tracing service. We continue to do our utmost in our

response, ensuring sufficient testing capacity and optimal turnaround times, all in the interests of public health.

Chairman: I thank the witnesses. They are all very welcome. They know the format of these meetings. The various political groupings ask questions. They have ten minutes each in the first round. They are supposed to get their replies within those ten minutes, within reason. The first group comprises Senators Kyne and Conway.

Senator Martin Conway: The witnesses are very welcome to the committee. It is only fair that it should be put on the record that, on the whole, the HSE is doing a difficult job but it is well recognised among the public that the job is being done very well. Ms O'Beirne and her team deserve to be commended on that. I wish to put a number of questions to the witnesses.

In Ms O'Beirne's opening statement she spoke about the split between clinical expertise in the contact tracing structure and level 2, as she described it. It is supposed to be a 40:60 split. Is that split being achieved? If so, are the clinical people all from the HSE or have any of them at this stage been recruited outside of the public health system?

I would be interested to know how the HSE's customer service engagement is going. The HSE is obviously calling quite a number of people - I would think five on average for each positive case. How are the public responding? I get it that someone might be very upset to receive a call from one of the HSE's contact tracing people. What is the proportion of, say, difficult or aggressive engagements? Do the witnesses feel contact tracers are getting overwhelming co-operation or just average co-operation? As far as Ms O'Beirne's team's experience with this is concerned, do the witnesses feel there is buy-in from the people getting these calls pointing out that they have been identified as close contacts?

Those are my first questions. I will come back in later.

Senator Seán Kyne: I thank Ms O'Beirne and her team. As for the clinical side of things, I understand from an individual I know who does contact tracing for the HSE that the call one's are the calls to tell people they are positive. Is it absolutely necessary for those calls to be made by a person with clinical experience? I understand that part of the reason there were delays during the surge is that the HSE did not have enough clinical staff or staff with a clinical background. Is it a clinical or a science background? What are the specifics in that regard? Is such a background an absolute requirement? Why is it necessary? Is it because someone may have a difficult question about Covid? Could such a person be transferred over to somebody else? Would that not speed up the process?

The second area I wish to speak about is the testing. Are all speech and language therapists, occupational therapists and HSE dentists back in their old roles or are they still carrying out testing? Is there a timeline for those very important service providers to be back in their front-line positions? One of the main complaints I have received about the whole test and trace system is that front-line staff are being taken away from their important work to carry out this work. I understand that at the start, when the HSE was under pressure, it may have been necessary to have all hands on deck and get people who were available, but speech and language therapists, occupational therapists and dentists are hugely important in their own right in the work they should be doing, and they should be back at their work.

Senator Martin Conway: I have a few further questions. Regarding the surveillance, I know that when the crash point happened recently enough, the HSE reduced the number of

questions it asked when contacting people. I am curious to know whether the HSE has gone back to normal in that regard.

How effective do the witnesses find the app? Has the HSE done any quality tracking of it? Is it synchronising as the HSE would like in terms of the physical contacts it is given? Then there is the question of the app automatically activating.

Finally, the witnesses might give us a breakdown of what the testing has cost the taxpayer so far.

Chairman: Whoever wishes to respond may go ahead. The witnesses have about five minutes to answer those ten questions, so I wish them the best of luck.

Ms Niamh O'Beirne: So far we have recruited 274 people, about 25% of whom have been clinical staff. Overall, as we mentioned in our briefing note, we need about 40% of the team to be clinical to balance the teams that are non-clinical. To respond to the question why they are clinical, our tracers speak to people about their illness and talk to them about their self-isolation and restricted movement, and it is very important that people understand what they need to do. In addition, patients can be quite anxious when they receive the news, as Senator Conway mentioned, so it takes some time to talk them through what they need to do and to spend time with them gathering their close contacts and their information. Our recruitment is ongoing and we keep the balance as we recruit to make sure we have enough on both sides, clinical and non-clinical.

We were asked a question about our experience with people on the phone and how they react. Our tracers sometimes have difficult phone calls with people, particularly those who are close contacts. They find being told very difficult because it means they need to restrict their movements for 14 days and also need to do tests. Unlike a standard call centre call, these calls can take quite a long time and are really important. A tracer could spend up to an hour trying to convince people to go for a test but they would generally be in the minority. The vast majority of people are receptive to our tracers and would follow the public health advice and attend their test. We have seen a much higher number of people turning up for their day one tests, more than 92% at the moment, and the day zero test is up in the 60s, which is much higher than it was in the summer.

The Senator also asked about reducing the questions. As of this week, we are still operating on a reduced level of questions. We will bring this back so over the next six weeks we will start to increase the number of questions we ask to increase the amount of retrospective tracing we do. That will become very important when we have low levels of the disease. Dr. Kelleher may wish to add something on that point.

Dr. Kevin Kelleher: We are gaining the information that helps us to a degree. Of course it would be better to have the full thing but we had to balance that with the need to ensure we contacted people as well. It was a balance between the two and we struck an appropriate balance at that time.

I have done a number of the calls, not routinely but occasionally, and on the whole the vast majority of people are very engaged and understand what is going on and participate but occasionally some people find it very difficult. I have not had any really difficult ones but some people have had some extremely difficult calls and that is a problem and a difficulty. They are trying to help and yet they are getting a fair degree of abuse. I have been in the centre when that

has happened and one can see the person on our side of the call visibly wilting as a consequence of the call. It is a difficult thing throughout this issue.

The app is a tool. It is not anything other than a tool and it is to help us in our way of dealing with this. My colleagues in public health use the information they get from the app to help them to control what is going on in the circumstances. It becomes more important when it is involved in things like outside events, such as sporting events or things of that nature, and in schools. We use it in those circumstances as a tool to make our assessment. It is not an absolute statement of anything. The reality is one could leave one's phone in one's jacket in a room with people walking in and out of the room. Even though one might not be in the room, one would still get contacted, so we must bear these things in mind. The app is there and it is very effective. As always, we would absolutely suggest that more people should use the app and use it regularly. The more people we can get using it, and using it regularly, the bigger the difference it will make because it gives a mindset to people about what they need to be doing, in that they are thinking about things as a result.

Mr. McCallion could take the question about the cost which I think is the only one we have left.

Ms Niamh O'Beirne: Would Mr. McCallion like to come in?

Mr. Damien McCallion: This is the point about the community people going back to duties, I think, rather than cost.

Ms Niamh O'Beirne: At the moment we have 984 staff who are deployed to testing, swabbing itself and tracing. Around 118 are in contact tracing and the remainder are supporting the community swabbing sites. As we recruit people into both centres we will bring staff back into their normal community roles. Contact tracing has, as we said, recruited just under 280 staff so far and by next week there will be more than 350, so over time we will start to bring staff back to their normal roles. We have reduced their roles within contact tracing already and as we faced the increases over the past number of weeks, we did not take more staff from front-line work. We used staff from HR and environmental health to support us but we did not move back to the community staff. Similarly with swabbing, they will also reduce as we bring in more community swabbers in the coming days and weeks.

Senator Martin Conway: What about the cost?

Chairman: Mr. McCallion is going to answer that now.

Mr. Damien McCallion: Which aspect of the cost is the Senator referring to?

Ms Niamh O'Beirne: The cost to date.

Mr. Damien McCallion: I am sorry. The total cost of the spend on testing and tracing was of the order of €163 million at the end of August. That is split up between swabbing, labs and contact tracing which would have been a small cost to date but which will obviously increase as we bring more people in on a permanent basis. As such, many of our costs involved reallocating people, people being seconded in or, as one of the members mentioned, in the initial response to the crisis, the reassignment of people from other duties, whereas now as we bring more people in on a full-time basis that cost will rise. That is the expenditure this year to date in relation to the testing and tracing pathway.

Deputy David Cullinane: I thank all those who are operating on the front line in testing and tracing in whatever capacity they serve. Whatever deficiencies, or lack of capacity in, the system are certainly is not down to them. It is a very difficult and challenging job so I take this opportunity to commend all those who are involved in that.

I want to unpack some of the numbers and, as I do so, I would say to Ms O'Beirne that I want precise answers to the questions because it is numbers I am looking for. We have the context in both the opening statement and the briefing note given by the HSE. When the briefing note from the HSE states that 581 staff are currently available to work on routine contact tracing, is that figure of 581 made up of people who are directly employed and still reassigned? Does that 581 include the 274 new staff who have been onboarded, as it is called, as part of the recruitment target of 800?

Ms Niamh O'Beirne: Yes, the 581 includes 274 staff who have come as new hires. It also includes 214 staff from the HSE and 93 who have come to support from other public sector bodies.

Dr. Kevin Kelleher: On top of that, all the staff in the public health departments around the country are also involved in contact tracing. It is not just the staff Ms O'Beirne has detailed there but also the 300 to 400 staff in the public health departments around the country. Both groups are involved in contact tracing.

Deputy David Cullinane: This is why we need to be very clear on the number. If there are other people involved in tracing, the HSE officials should tell us and put it in the briefing notes they give us. The note states: "We currently have a total of 581 staff available to work on routine contact tracing." Therefore it is confirmed that 274 of those are people who have been recently recruited and 214 are HSE. Does it also include the 160 environmental health officers or are they separate?

Ms Niamh O'Beirne: It includes the environmental health officers.

Deputy David Cullinane: It does. How many people were directly employed so far, taking out those who were-----

Ms Niamh O'Beirne: Some 274.

Deputy David Cullinane: Some 274 in total were directly employed. If it is 581 at the moment, what does Ms O'Beirne expect the total number to be at the end of the year?

Ms Niamh O'Beirne: We are aiming for 800 at the moment but the 214 redeployed from the HSE will go back into their jobs so we need to recruit to replace them and then to recruit in addition to them so at the moment 800 is the number.

Deputy David Cullinane: The number is 800. When we are told 800 will be recruited, does that include the 580 who are already there? How many will be recruited between now and the end of the year?

Ms Niamh O'Beirne: The 800 includes 274 who are there at the moment. People who have come from other public sector bodies and the HSE will revert to their normal roles. Therefore, we need to move from 274 to 800 and we are going to do that at a rate of 60 to 70 per week.

Deputy David Cullinane: Does that then mean those who were seconded or were reassigned will go back? Is Ms O'Beirne telling me that at the moment, when it states 581 staff are

available, the 581 will become 800 by the end of the year, in simple terms? Is that what she is saying?

Ms Niamh O'Beirne: Yes, the 581 will become 800.

Deputy David Cullinane: Okay. Why was that not done over the summer months? In her opening statement Ms O'Beirne had to apologise to 1,961 people. There was much commentary on whether the system was fit for purpose and whether we had used the summer months wisely. We are now being told that 60 or 70 staff will be recruited per week. Why only 60 or 70? Why can that not be accelerated? Leaving that aside though, why was this not done in the summer? If we had all of those staff in place, it may well have been the case that the system may not have collapsed and the HSE would not have to come before the committee today to apologise to those people. Why is recruitment only happening now? Why were all of the additional staff who could have been employed during the summer months not put in place?

Does the HSE not accept that we are in the middle of a second wave? The numbers are the highest they have been at any point in time. They went down a little bit in recent days. Over the past week we have seen cases in excess of 1,200 a day, the highest at any point in the pandemic. Yet, we only have 581 people available for contact tracing, a figure that will increase to 800. Why was recruitment not done during the summer months? It is an obvious question that people will ask.

Ms Niamh O'Beirne: Over the summer months, the staff that have been deployed to contact tracing came from universities and different parts of the HSE and Defence Forces, Revenue and the public service. Those staff then returned to their roles. There was a significant decline in cases. In June and July, they had all returned and left us with a small number of staff.

Deputy David Cullinane: That is not an answer my question. The HSE planned to have 800 by the end of the year. In my view, it should have at least 800 today but it does not. Whether staff left for whatever reason is irrelevant from my perspective. The HSE has to plan and make sure that we have a tracing regime that is fit for purpose. If there will be 800 by the end of the year, why do we not have 800 today? Why were staff not recruited during the summer months when we needed them as a second wave came? We are in the middle of it now and we only have 591. It is an obvious and direct question. Why were the additional staff that were needed not hired earlier? Why has the recruitment process only started over the past number of weeks?

Ms Niamh O'Beirne: We began the recruitment process in August. Role descriptions had to be developed, approved and put out. They went out over August with the bigger campaign beginning in September. We received 2,500 applications. We had to go through them, interview people and then go through standard compliance checking. That is what has been going on over the past number of weeks and months to bring in the staff we have had.

It is not ideal that we did not have enough staff for the number of cases of the virus in the country. In early October, cases increased from 544 to 1,000 overnight. We missed all of the numbers in between. There was a jump. We moved from 8,500 calls six weeks ago to nearly 40,000 calls. We had met demand, but it exceeded the capacity we had at that time. We will continue to recruit and are working very hard on that. Training and onboarding has to be done in a managed and quality assured way and everything requires clinical cover.

Deputy David Cullinane: I need to come back in and say a number of things. I will put my questions when I finish my point.

It is immaterial how many cases there were during the summer months because we know that lockdowns are used to reduce the numbers. The time is then used to build up defences so that when the number of cases increases we have very robust testing and tracing that can then be used to hunt down and stay ahead of the virus. That did not happen because we do not have the capacity today. There are 581 today and the HSE hopes to have 800 by the end of the year. Ms O'Beirne said that is not ideal. That is an understatement in terms of how people will see it, especially the 1,900 people that the HSE had to apologise to.

I have practical questions on how this impacts people. An elderly patient who is due for a scope in Bantry Hospital in County Cork contacted me. He was told he had to go for a Covid test and had to travel to Cork city, a two-hour round trip. Yet, there is a testing centre 4 km from him his home. Why is this happening? There are any number of examples where people had to travel far beyond where they live when there are testing centres close to them.

I received an email from a HSE official which confirmed to me that teachers and SNAs are being told to disable the Covid app when they go to work. Are the witnesses aware of that? Can they confirm whether and why it happens?

Ms Niamh O'Beirne: I will pass the question on schools to Dr. Kelleher.

Dr. Kevin Kelleher: I understand that happened in one particular instance. I am not sure it happened elsewhere. As we said, there is an issue about how the app can be used in congregated settings.

Deputy David Cullinane: That does not answer my question. It was not one issue. The email I received stated that the directive being given to SNAs and teachers from the HSE was that they should disable the app when they go to school and work. We are encouraging people to use the app. I use it every single day. I assume we want teachers and SNAs to use it. We need a more detailed explanation on that because it is a serious issue.

Dr. Kevin Kelleher: I have no problem with giving the Deputy a more detailed explanation on that. If he forwards the question to us, we will come back to him with a more detailed response.

Deputy David Cullinane: What about the person who had to travel from Bantry to Cork city?

Mr. Damien McCallion: I will take that question. In general, hospitals will try to accommodate people locally as best they can. That is an individual case and hospitals will link in with patients directly. Most hospital also work with patients in terms of transport for procedures or pre-admission tests, if required. I will be happy to follow up on the specifics behind the case in Cork University Hospital. Each hospital makes those decisions locally in terms of patients and travel arrangements for testing. If the Deputy wants to forward me the details of the case I can take it up with the hospital directly.

Deputy David Cullinane: Okay. I thank the witnesses.

Deputy John Lahart: I thank the HSE team for, by and large, rising to the huge challenge. I include in that everybody involved in testing and tracing, Óglaigh na hÉireann, which transports the tests, and everybody on the front line.

On my way in, I listened to Dr. David Nabarro on the radio. We now have five weeks left

at level 5. How does the HSE propose to use that time to prepare for the next phase? What has it learned from the last phase?

I keep referencing the Spanish flu in terms of precedents. I do not think we should forget about it. There was a second wave in October and November and a third surge in March and April. We may predict that. It would be terrific if it did not happen, but that was the pattern 100 years ago.

What have the witnesses learned over the past number of months? Are 800 contact tracers sufficient to deal with the ongoing requirements for testing and tracing? Will that number be sufficient to deal with a potential third surge?

Ms Niamh O'Beirne: I thank the Deputy. The topic most on our minds at the moment is the importance of staying ahead of the virus. Overall, in terms of testing and tracing we are looking to gain a workforce of 3,000 or 4,000 between swabbing, laboratories and contact tracing. As part of that, we have to build up the swabbing sites of which there are 37 at the moment.

In addition, we are working with the National Ambulance Service to build mobile sites that move at a fast pace and open up quickly. They can do 300 or 400 tests at one time. We have definitely learnt about the importance of pop-up sites. We can open sites really quickly when there is particular demand in a small area. That is something we will have a permanent infrastructure around and a response to in terms of adding additional swabbing capacity where we need to.

Deputy John Lahart: Does Ms O'Beirne think that 800 will be sufficient?

Ms Niamh O'Beirne: The figure of 800 relates only to contact tracing. On that part of the pathway, we will go to 800 and then examine whether we need to increase that number to 1,000. Based on international metrics, for size of our population it is estimated 750 will be required. We believe that number will manage.

We need to bring forward a few other things with that, such as our technology roadmap to allow close contacts to organise their own tests. That will be available within the next few weeks and will be important. We also need to plan for how we manage the calls and deal with people on the phone in terms of the time we can spend with them.

Deputy John Lahart: Will the duties of the 800 contact tracers when they are employed exclusively focus on tracing? Do they have any other duties?

Ms Niamh O'Beirne: They do not have any other duties. They join each of our contact tracing centres. After their training they are deployed purely to contact tracing.

Deputy John Lahart: I do not think that we used the period when the virus had been suppressed successfully. That is just an observation I am making and I do not need the witnesses to go into it. However, I am very concerned that we use the current period really well to prepare for and anticipate a third surge. I assume the witnesses are likewise anticipating a third wave of infections.

My next question relates to the tracking system. The level of testing now taking place is very impressive by any standards and the witnesses have my congratulations on that. I thank them for bringing it up to that scale. I understand that the HSE is employing people specifically to do the tracing work. Tracking contacts and ensuring they isolate is a very important part of

the response to Covid. Will the witnesses comment on that?

Dr. Kevin Kelleher: The Deputy is quite right that we must make use of the period between, potentially, more than two or three waves, depending on how things go and whatever interventions may be available. The clear issue in this regard is to do with the level of socialisation. As we can see, the number of contacts rose when we moved out of tighter restrictions. We got it down to two or three but it then went up again as time moved on. That is the crucial issue and the one thing that will always hit us in the context of capacity. If we get to the point where we are back to the sorts of numbers we can cope with, which would be individuals having only three or four contacts each, then we would be in a good position. However, if the contacts go up above five, six or ten, as they have done, that is when we have real problems and there are suddenly a massive number of calls to be made to contacts. We have to look at how we go about keeping that number down into the future. We can look at some of the measures that are being used elsewhere. As Ms O'Beirne said, it could involve making use of technology which is being used in similar situations around the world. We are trying to get to that point. The big issue is that we need to make sure people understand the importance of adhering to certain rules. The main thing they should do - this is the general message for people, as well as the specific message we are looking to put out - is to reduce social contacts, particularly when they know they are ill.

Deputy John Lahart: I am not sure whether Dr. Kelleher can hear me properly and I do not meant to sound abrupt. I am sorry if I seem rude, which is not my intention, but we are very restricted as to time. The HSE has a five-week window to get this right. Rather than giving a long narrative, will Dr. Kelleher say whether he thinks we will be in a place, in five weeks' time, to improve the tracking part of the process?

Dr. Kevin Kelleher: We are seeking to get the elements of that put in place. We are doing a number of studies at the moment looking at the numbers and how we can improve the process. We may have to do it electronically and we may be able to do some calls as well. We will seek to do that as we move on and get through those numbers. The Deputy is right that this aspect is very important.

Deputy John Lahart: That is why I am asking about it.

Dr. Kevin Kelleher: Some countries have moved to a situation where they have people being visited by the state police and things of that nature. That is a move we have not reached and which not many countries will reach. We must make sure people are observing the self-isolation requirement.

Deputy John Lahart: The witnesses might keep the committee abreast of developments in this regard because it is a really important aspect of the effort to contain the virus.

I have a brief question in regard to air travel. I do not think the airlines and airport authorities ever anticipated that the HSE or public health unit would cover the cost of operating, or take responsibility for operating, testing and tracing measures in an airport context. I assume, based on the experience elsewhere in Europe, that this would be done privately and added on to the price of an airline ticket. Do the witnesses have any views on the matter?

Mr. Damien McCallion: We are working closely with the Department of Health, the Department of Transport and the Irish Aviation Authority to see what sort of testing system might be put in place in airports. On one level, this is a policy decision. Deputy Lahart is probably

aware of the EU paper that has been published setting out proposals in this area. We are working to ensure that whatever capacity is put into place in this sector does not impact on the overall public health provision. That is a key consideration. We will work closely with the Departments and aviation bodies to ensure that does not happen. We believe a good outcome is possible given the co-operation we have had.

Second, we are looking at alternative testing methods as part of the work we are doing with NPHET. That will take a little time and some of the early evidence shows there is still much to do. We can see that from what is happening in most countries in Europe. The polymerase chain reaction, PCR, test remains the standard method. The airports are looking to offer that type of testing in line with some of the changes that are coming from the EU. We are working with the relevant Departments in that regard. Again, it is important to state that the messaging is vital in terms of ensuring that people are aware of the crucial importance of observing the public health advice. Members may be aware of the recent case where a couple who returned from a trip abroad were responsible for a chain of infections that impacted more than 50 people. We are working very closely with the Departments and airport authorities in this area.

Deputy John Lahart: I appreciate that effort and I particularly appreciate that any measures will not impose an undue burden on the public health system. I thank the witnesses for their answers and apologise for bamboozling them with questions. My final question is to ask them if they can characterise the nature of some of the difficult calls that have had to be dealt with by tracers.

Dr. Kevin Kelleher: We find that people are often very unhappy to be told that they are a contact. It is a surprise and not what they wish to hear, particularly because of the implications of the requirement for 14 days of restricted movements. There is a small cohort of parents who are refusing to have their children tested and who get very angry at any suggestion that such testing should be undertaken as a consequence of the tracking process. I have been involved in these things for the past 30 years and it is very difficult to judge who is going to react badly until one gets into the call. Sometimes people will come back on a subsequent call and be very annoyed about things. They might ask why we telephoned them instead of writing to them and so on. It is a very difficult process because it involves dealing with human nature and people have to just try to see their way through it.

As Ms O'Beirne said, the staff in our centres are doing exceptionally well and are spending a lot longer on calls than is absolutely necessary trying to help people to get through the process. Equally, trying to get people to be open and honest with us about who their contacts are takes time. It is not an easy process but people are making those efforts. All we are asking is that people understand that we are just trying to do our job in the centres and trying to help people to control this disease. It is not as if we are doing any of this out of any type of malice. It is quite the opposite. The process is difficult but we will make every effort to accommodate and work with people in those circumstances.

Deputy Róisín Shortall: I thank the witnesses for their attendance. I want to move on from the issue of staffing to the performance of the system, specifically its effectiveness or otherwise in driving down the level of the virus. What is the current estimated turnaround time from development of symptoms to referral for a test?

Dr. Kevin Kelleher: There is an element to factor in around the time between when the individual develops symptoms and when he or she makes the decision to contact a clinician.

Deputy Róisín Shortall: I am asking what the estimated median time is for that.

Dr. Kevin Kelleher: We do not have data on the time from when individuals start to say they feel unwell and when they contact a clinician.

Ms Niamh O'Beirne: We track from the moment of the GP referral to getting a swabbing appointment. At the moment, that time is, on average, 24 hours. Some 91% of people will have a test within 24 hours from when they go to their GP to request it.

Dr. Kevin Kelleher: I have contact with a core team of GPs once a week and I will raise that question during the next call to see if I can get that information for the Deputy. On the whole, it seems the process is fairly quick in most cases because the system is very easy for people to use.

Deputy Róisín Shortall: What is a reasonable estimate of that time lag?

Dr. Kevin Kelleher: I would think it is much less than 24 hours and may be 12. I honestly do not think it is much longer than that. However, there is clearly an issue around individuals hiding. Unfortunately, we know that a significant number of people do not report that they have symptoms and carry on with life. That is a separate matter. On the whole, the period for the majority is 12 hours, no more than 24.

Deputy Róisín Shortall: Another figure, more like two or three days, has been suggested because people think Covid is a cold and take paracetamol and so on. Dr. Kelleher's figure, 24 hours, about which I am not sure, is a day. We are aware that the turnaround time from referral to a result is 2.2 days. The most recent turnaround time from a result to tracing in the HSE's report for the past week is 3.8 days. That gives a total of seven days from symptoms to contacts being traced. All the indications are that the optimum time from symptoms to 80% of contacts being traced is four days. On that basis, the performance falls very far short of what is required to ensure a testing and tracing system is effective. I would like the witnesses' view on that. Do they accept a period of four days is the optimum turnaround time from end to end?

Ms Niamh O'Beirne: I will pick up on the metrics side and I will ask Dr. Kelleher to address the period of four days. The most recent metrics for the past couple of days indicate that in the community setting, which is where symptomatic people go to their general practitioner and have close contacts identified, the median end-to-end turnaround time for a negative result, or a "not detected" result, is two days. The average is 2.4 days. For a "detected" case, the median period is 2.3 days, and the average, or mean, is 2.8 days. That is a for a complete end-to-end process, from the beginning of referral to the end of contact tracing. The median figure for contact tracing in the past number of days is back down to one day. That is the international metric and goal we have been seeking to achieve. We are aware that in the most difficult week, the period rose above three days but it is now back to one day. That is where we would really like to keep the contact tracing figure. We have 91% of referrals in less than 24 hours, when one wants an appointment. Some 95% of people have their swab result back in less than 48 hours, and all tracing is done in less than a day. On the four days-----

Deputy Róisín Shortall: I am sorry but all I can do is work on the basis of the figures on the HSE website. The most recent figures indicate that 3.8 days is the median time for tracing: "All contact tracing is completed within 3.8 days (median) – including all complex cases". I am just going by the figures the HSE is publishing on its own website. The dashboard indicates the period from referral to the communication of a result is 2.2 days. Ms O'Beirne is referring to an additional day for referral, which makes it seven days.

Ms Niamh O'Beirne: To be fair, the tracing figure of 3.8 days refers just to one week. Over the entire period, we generally kept it to one day. It is currently back at one day.

Dr. Kevin Kelleher: May I come in on that point?

Deputy Róisín Shortall: Just a moment. I am concerned about the current situation. I am working on the basis of the figures provided on the HSE's website for this current week. According to those figures, the turnaround time from symptoms to the tracing of 80% of contacts is seven days. Do the witnesses accept the figure of four days is the optimum turnaround time for a testing and tracing system to be effective? Could I have a "Yes" or a "No"?

Ms Niamh O'Beirne: First, we do not accept the seven days on the basis of the most recent data we have. On the question on four days, does Dr. Kelleher wish to contribute?

Dr. Kevin Kelleher: Yes, that would be-----

Deputy Róisín Shortall: It is a "Yes" or "No" question. Do the witnesses accept that four days is the optimum turnaround time from symptoms to the tracing of 80% of contacts? The research indicates this is what is required for tracing to be effective. Does Ms O'Beirne accept that?

Dr. Kevin Kelleher: First of all, I have not seen that research-----

Deputy Róisín Shortall: Does Ms O'Beirne accept that?

Dr. Kevin Kelleher: -----so if the Deputy lets me have it, I will be happy to make a more detailed comment as a consequence. Part of it is out of our control. We can control what we can control at the end of the day.

Could I say something else? One of the points that is very important-----

Deputy Róisín Shortall: If Dr. Kelleher does not mind-----

Dr. Kevin Kelleher: -----is that we clearly say to everybody that once they start to have symptoms, they should-----

Deputy Róisín Shortall: Dr. Kelleher is eating into my time.

Dr. Kevin Kelleher: That is the fundamental issue here.

Deputy Róisín Shortall: Could the Chairman ask him to stop?

Chairman: Could Dr. Kelleher let the Deputy back in? I do not know whether he can hear what is going on. The Deputy has seven minutes for both questions and answers. She has tried to make a couple of interventions. I ask her to proceed.

Deputy Róisín Shortall: I thank the Chairman. I have asked direct questions and sought direct answers, and I would appreciate it if they could be given.

On 17 August, the HSE said it was developing a new testing and tracing model. What is the position on that now? Is there a new model?

Ms Niamh O'Beirne: Yes. As part of that new model, we looked across the different parts of the pathway. We set up the new pop-ups with the National Ambulance Service. We have also been increasing the testing capacity. We have increased it to 120,000.

Deputy Róisín Shortall: Can Ms O'Beirne send us a note?

Ms Niamh O'Beirne: We are seeking to increase it further. We have also introduced new technology.

Deputy Róisín Shortall: Can Ms O'Beirne send us a note on what the new model is exactly?

Ms Niamh O'Beirne: Yes.

Deputy Róisín Shortall: Ms O'Beirne referred to pop-up testing facilities. Mr. Reid was before us a number of weeks ago and asked about a pop-up centre in the part of Dublin that has the highest rate by far, Ballymun–Finglas, and the difficulties associated with accessing testing centres that are some distance from people's homes. When can we expect to have a pop-up centre in Ballymun–Finglas?

Ms Niamh O'Beirne: We revise our pop-up centres regularly. We put one into Dublin city, Cork city and Galway city recently to support testing. We respond immediately to the demand in particular areas where we believe testing is required. At the moment, there are 37 centres.

Deputy Róisín Shortall: I suggest that the area in Dublin with the highest rate by far should be a priority for the HSE. We were given an undertaking in that regard. I would appreciate it, therefore, if the witnesses could send me a note on when they propose to follow through on that undertaking to provide a pop-up centre in the Ballymun–Finglas area.

Can we have a schedule of staffing? Many have referred to the fact that valuable time and opportunities were lost during the summer months. We now have five weeks to get the testing and tracing system in place and operating properly. Can the witnesses send us a schedule for the period between now and 1 December, when I hope the level 5 restrictions will be lifted? Where does the HSE expect to be on 1 December in respect of both testing and tracing? How many existing staff and other staff will be available on 1 December in each of the services? Can the witnesses identify what element of these staff will be drawn from other front-line services? Can the witnesses provide that detail for us? I am not asking for it now. I am looking for basic detail, in the form of a table or schedule of staffing, so we will know where we can expect to be on 1 December, when I hope we will be in a much better place than we are now.

Chairman: Can that be done?

Ms Niamh O'Beirne: Yes, it can.

Deputy Gino Kenny: I thank all the speakers for their contributions. I have a number of questions. The second has largely been answered. The first is on testing and tracing in schools. Obviously, the imperative over the past couple of months has been to keep schools open for everybody involved. In the State's primary and post-primary schools, there are 939,000 pupils and 66,000 staff, including teachers. That is nearly 1 million people in the educational system, primary and post-primary. As of 19 October, only 10,000 tests have been done in the school system. That equates to 1% of the school population. Are the witnesses absolutely confident in tracking and tracing in our schools at this time?

Dr. Kevin Kelleher: When we are told of a case that involves either a child in school or it is clearly a member of staff at a school, the public health department immediately starts to assess with the individual or parents what is happening. If necessary, and more often than not, they

get in touch with the school to review the position within the school, doing what is now called a public health risk assessment to see what is necessary as a consequence of that case.

In some circumstances, because of what has happened, nothing needs to be done as the individual has not been in the school for the period in which he or she might have been infectious. If something needs to be done, a review is done within the school of which people need to be identified and asked to restrict movements and be tested as a consequence. That assessment is done with the school based on what happened in the school in those circumstances. It often concentrates on the class that the individual was in or teaching or working with, and the consequence of working in that class. Sometimes, this involves members of non-teaching staff who have virtually no contact with children or other members of staff.

The figure of 10,000-plus comprises the people who have been identified as being at risk as a consequence of those assessments. It will carry on and we will keep doing it. We are still doing things, even in the half-term, and we will start again in full flurry, I imagine, as schools start again next week. We are doing this as effectively as possible in order to maintain schools being open so children can get their education.

Deputy Gino Kenny: Will the witness quantify from that number of staff and pupils how many have tested positive, particularly since September?

Dr. Kevin Kelleher: Figures indicate that number, overall, is somewhere between 2.5% and 3%, depending on the part of the schooling system we are talking about, specifically the primary, secondary or special education area.

Ms Niamh O'Beirne: As a result of risk assessments, we have tested in 757 schools and completed 18,390 tests, identifying an additional 538 detected cases. That covers childcare facilities, post-primary, primary and special education.

Deputy Gino Kenny: Deputy Shortall touched on this but there was a really good article in *The Irish Times* today by Dr. David Joyce and Professor Eilish McAuliffe. They wrote about the SQ80, which I had never heard of before. It describes 80% end-to-end turnaround from symptom development to testing being carried out and contact tracing being completed. They argue that testing and tracing can be put right in six weeks. The science behind it makes sense, although some of it goes over people's heads. How confident are the witnesses and the HSE that the SQ80 can be done in four days? In response to Deputy Shortall, the witnesses have said it is probably more than four days. It is logistically difficult but Dr. Joyce and Professor McAuliffe argue it must be done or else the process is not fit for purpose.

Ms Niamh O'Beirne: Our current metrics for a detected case indicate we can go from one end of the process to the other - from our tracking that is the moment of referral through to the end of contact tracing - in an average of 2.8 days. Based on the article, the symptoms piece must be added. From the communications perspective, the HSE is doing much work to continue to encourage people to come forward for tests as quickly as possible to GPs. The tests are free and in many cases there is same-day testing, or it may go to the early part of the following day. A test can be done quite fast, which is important, and achieving a completion rate of 91% in less than 24 hours within that overall metric is important, as is producing the result from laboratories. Even through the peak we are delivering results in less than two days from the swabbing appointment.

It is continuous work in communications to ensure people come forward as quickly as pos-

sible and we work with GPs to support out-of-hours referrals as well, which is happening over the weekends and into the evenings. This is to ensure that any time people are sick, whether on a Monday morning or Saturday evening, it is possible for them to contact a doctor and get themselves referred for a test in any of our sites that open 12 hours per day, seven days per week, to facilitate that.

Dr. Kevin Kelleher: To be clear on that point, this is totally free for anybody. The Government has in place an agreement with general practice that even if people are not in the general medical services, GMS, scheme, this is a totally free process. The call and testing is totally free for the individual, regardless of GMS status. Everybody can call up and there is no barrier whatever. As the members quite rightly say, the big issue here is getting people to recognise this and come forward. That is part of the public campaign and we have heard Dr. Holohan speaking about it, as well as the rest of us. It is a very important matter. The second part is trying to get people away from social contact once they have symptoms. It is one of the most important parts of this process.

Chairman: There is clearly a contradiction in what the witnesses are saying and what is on the website. Deputy Shortall has a quick point.

Deputy Róisín Shortall: Ms O'Beirne states that end-to-end testing and tracing is 2.8 days currently. The website states something very different. It states that from referral to result of test, it is 2.2 days, and for completion of tracing it is another 3.8 days. That gives a total of six days plus one day from symptom to referral, meaning it is seven days. Will the witness point us to the place we can find figures supporting her claim of 2.8 days for end-to-end testing and tracing?

Ms Niamh O'Beirne: Yes, I took them from my dashboard this morning. My figures refer to the past three days so I will ensure the website is updated to reflect the most recent figures. I apologise for that.

Mr. Damien McCallion: Sometimes the website covers different periods as well, so we will revert directly with a clarification. Sometimes, for example, it is a seven-day period while in other cases it is a rolling three-day period or a previous day. We can see those on a more real-time basis.

Chairman: Deputies Colm Burke and Durkan will share the next slot.

Deputy Bernard J. Durkan: I went first the last time.

Deputy Colm Burke: I thank all the witnesses for the work they are doing, as well as all the staff involved with tracking and tracing. I will ask a couple of questions on different topics. Will Dr. Kelleher deal again with how people are contacted and the response tracers get? In the past week, all of us, as public representatives, have received fairly nasty emails on various matters. For example, I got one stating "I hope you die screaming" and another stating "You are nothing but scum, I hope you burn in hell". What kind of reaction are staff getting? Are they getting abusive reactions when they are contacted? Is the case I am referring to an extreme one?

I raised an issue ten days ago about texting when people come in from abroad. They fill out the locator form and get a text in the first day stating they must isolate for 14 days. They then get a further text on the second day asking if they are in the location they said they would be. If one replies "Yes", one gets a different text. Then one gets a third text some time later which gives the impression that one does not have to comply with the 14-day requirement for

self-isolation.

No one has confirmed to me who is sending out these texts. The text itself does not state who sent it. The Department of Transport has said it is not involved, as has the HSE and the Department of Foreign Affairs. We are now coming up to the Christmas period. It must be ensured that whatever texts go out that it is clearly identified from where they are coming. Has this issue been resolved? No one has confirmed to me that it has.

Rapid turnaround antigen testing has been rolled out in some countries, particularly in schools. Where does that stand here? People with vitamin deficiencies seem to have a greater risk of contracting Covid, as well as finding it more difficult to deal with it. Does the HSE intend to have a campaign to highlight this issue to ensure people can respond accordingly?

Dr. Kevin Kelleher: I empathise with the Deputy if he is receiving such communications. It is unpleasant. Once or twice in my career I have been targeted in that way and it is not pleasant.

Regarding our staff, we have not quite got to that level, except on some of the social media which is not as personalised. They deal with it and there are support systems in place to assist them. It is a difficult issue. It is not uncommon in health care that people react in a bad way because they have been given bad news. It is part of our training to deal with it. That is why we spoke earlier about the need to have clinicians around. They are far more able to deal with it than some non-clinicians would be in those circumstances. They are always around to support an individual and are on call if necessary.

There has been research going on around the world on vitamin deficiency. It is not, however, as definitive, as people seem to think. One issue which it is revealing is that, like with all diseases, if one is not in the best of health when one gets a disease, one will suffer worse from it. A deficiency of certain vitamins, such as vitamin D, may have an impact. We need more research on this.

Having said that, Ireland has a problem with vitamin D deficiency *per se* because of circumstances such as skin colour, lack of sun, etc. It is an issue and there is a campaign trying to improve that.

Mr. Damien McCallion: On the texting issue, it comes through from a joint agreement between the Departments of Health and Transport. The HSE is not directly involved in it. On the potential perception that, after the third text, people might not have to fulfil their full quarantine arrangements, I am not familiar with the details of the text. I will come back to the Deputy on that.

Deputy Colm Burke: I can actually send on the texts received by a person who came in from abroad. I got copies of them. There is nothing in the text as to which Department or agency is sending them which is a big mistake.

Mr. Damien McCallion: I will take that back and ensure both where the text is coming from and the perception that someone could cease quarantining is addressed. The latter point is subject to review at EU level.

We have been monitoring the antigen testing for some time. On the specificity and sensitivity of such tests, the performance of some of the early ones produced in the market has so far been poor. In recent months, we have seen some improvement in the tests offered.

HIQA has just undertaken a health technology assessment of alternative testing to PCR. It has asked the HSE to validate it in different sectors. In simple terms, antigen tests, even the strongest ones, perform better in areas where there are symptomatic cases. We have a high number of cases and we are currently verifying it in an outbreak setting. In other words, if one has an outbreak, can it be used quickly to pull people out when PCR will take 24 hours to 48 hours to return? It could be a useful tool in that regard.

I would be cautious, however, in the sense that the performance characteristics of many of the tests are poor. On the back of HIQA's report, which was out last week, we have set up a group to look at the various settings to assess the performance of the test and how it could be used in conjunction with PCR. There is a strong view that it will not replace the PCR test, the gold standard across Europe. The WHO and the ECDC, European Centre for Disease Prevention and Control, have given strict guidance on its potential use.

Based on HIQA's report, we are validating it and we have a process under way on that. We are working with the different sectors to see where it might have a value. A small number of tests we believe would hit the appropriate level of performance that we could utilise. We have our hands on one of those and we are negotiating on the other two for the purpose of this validation process. We must run those through and see how they perform.

The clear recommendation from HIQA and the WHO is that it has to be run through a validation in one's own country in particular settings. The claimed performance could vary wildly depending on the setting in which one tries it. We have a team working on that currently. It is one we are actively watching but it is too early to commit to its potential.

The WHO gave sanction for it to be used as an alternative in some developing countries which would not have access to PCR. There are clear issues with the numbers one would miss. If PCR is available, then it remains the standard to limit best the spread of the disease.

Dr. Kevin Kelleher: It is important that people-----

Chairman: We have run out of time.

Dr. Kevin Kelleher: -----understand that a negative test is not an indication that one is free. It is one of the most important things we need to make sure people understand. Having these quick tests does not mean one no longer has to self-restrict. If one has the symptoms or has been a close contact, it does not obviate from the need to carry on restricting one's movements as a consequence. It is an important issue. It makes no difference whatsoever. We need people to understand that. The test is not a magic bullet which gives someone freedom at all. It is actually just an indication. One is still bound by the public health advice to restrict one's movement for whatever period it is, depending on the circumstances.

Senator Annie Hoey: I thank the witnesses for answering all the questions.

Have the witnesses a timeline for the research HIQA is doing on antigen testing? Will the public hear any of the results from that? It is a topic in which people are interested. I know it is not the be-all and end-all but it has captured some of the public imagination. Have the witnesses a timeline on it and will antigen testing end up being used?

There have been reports this morning about contact tracing staff being asked to bring in their own laptops. While it has been reported they are not using it for any data, is this shortage of equipment having an impact on the work of the contact tracers? Are they sharing equipment?

Are they able to do the work to the best of their ability? If there is a shortage of equipment, what needs to be done to remedy it? We have talked a lot about the phone calls. I am interested in performance management. We have heard that calls were taking up to an hour. Is there a focus on the quality of calls and on output rather than quantity? Are contact tracers trying to fly through as many calls as they can or is the emphasis on quality and trying to ensure that people have the information. What are the targets and how is that managed?

Is there any support for contact tracing staff who are on those difficult calls and experience abusive situations? It is very difficult for staff. I hope this is not too common. Is there someone they can talk to to decompress? How is that managed?

Mr. Damien McCallion: On the antigen testing, I would not set a time on it. I might not have explained it clearly. HIQA provided a report on alternative testing, of which antigen was just one. That report is in the public domain. It made several observations but the bottom line was a request that the HSE undertake validation in different settings. It is clear that antigen testing is not particularly strong and there is no evidence base relating to asymptomatic settings, which is the area where most people have caught it, in the public imagination. It is important that we do that validation. Prior to the HIQA report, we had already commenced the process on antigen testing. HIQA engaged with us through that process, as with NPHET. A lot of the early tests are very poor, there is no point in saying otherwise. We have identified a number that we believe have stronger performance characteristics that are worth validating. That is one reason until now there has been very limited progress in that area, not only in Ireland but elsewhere. That is why countries are starting to look at how it can be deployed alongside the PCR testing. As we move through validation in those areas we will start to see if those results give the basis for deployment.

I am optimistic about some sectors, and it would be invaluable for outbreaks such as in a home or setting when something is needed that can get people out quickly to prevent the spread of disease, where the PCR could take days. It is early days and the group still has to do the work and run formal validations across the various settings where we might deploy it. It is one on which we are actively working rather than monitoring when the tests were poorer earlier in the year. We are much more confident now that it is worth looking at in more depth, which is what we are doing based on HIQA's advice. The WHO has given strong advice on where it should and should not be used and where the validation in a country needs to be done to assess the role it should have.

Ms Niamh O'Beirne: I will address the questions on the quality of calls and the time spent on the phone. At different points in the disease, we spend different amounts of time on the phone with individuals. We did call people to discuss having a positive result. It is a very difficult call for people to receive that news and understand how they should isolate and manage their illness. Following that, there is another call with them to talk about their close contacts. From a quality perspective, it is important to spend time with people trying to understand that and elicit information from them. We make another call to close contacts which may be quite fast. The person may already be aware if they are a family member or close contact, so they accept that and we arrange the test. We do not tell people we call who the index case is, so in other calls there might be a lot of questions and we spend some time with them to encourage them to go for a test. We do not have metrics where we tell our staff how many calls per hour they need to do. We do training with them to understand that it is mostly about quality. Having said that, we know how many calls we need to do. We made 38,000 calls last week. We must make sure that enough staff are on at varying points in the disease to be able to spend time with

people on the phone and give them all the information they need for us to be able to contact their close contacts and get them organised for a test to reduce transmission.

Dr. Kevin Kelleher: Prior to Covid about 95% to 97% of all positive results would have been delivered to the person concerned either by the GP or their hospital clinician. We in public health would only have been involved after that had happened. The vast majority of what people call "call ones" normally would have been done by a clinician who would have told a patient that they had X or Y and told them that they would get a call from public health as a consequence. We have had to change that relationship entirely since Covid so that now we tell them, not through their clinician who normally is their GP or hospital consultant, but by someone in one of our centres. That is a big change.

Clinicians are available at all times in the centres supporting contact tracers around how they deal with the calls and so on. Someone will be available to one of the callers, so if they are not clinicians themselves or if they are clinicians who are not doctors, doctors are often available to get in touch and talk through an issue. A level of support is always available and it can be escalated up the system.

Psychological support systems are also in place for members of staff who feel they have hit a wall in what is going on and they need support. That is very clearly available to anyone. People have needed that and we have sought to support people around those issues.

Deputy Cathal Crowe: Most of my questions are for Ms O'Beirne as lead of contact tracing in the HSE. I have just come from the Committee on Transport and Communications Networks where we were briefed by Aer Lingus and Ryanair on the great need to move to rapid antigen testing at airports to get aeroplanes back in the sky and return aviation to some semblance of normality. They will be briefed by others in the aviation sector later. To date just over 250,000 people out of a population of 4.9 million in Ireland have been contact traced through the HSE's facilities.

Last year 38 million passengers came into Ireland. Aviation is operating at 90% below its previous level. If airports move to this model of testing, does Ireland have the public health capacity to facilitate that process or should it be done privately?

Ms Niamh O'Beirne: There are different elements to that. The testing itself, that is, swabbing and laboratory processing, can be done by private partners, but the contact tracing would remain within the public system. Under the infectious diseases Act, the laboratories need to refer all positive cases to a public health department. High numbers of tests from travellers coming into the country would impact us where there were positive cases. Were someone to test positive and be in Ireland, we are responsible for contact tracing the individual.

Deputy Cathal Crowe: I am thinking of the straw that broke the camel's back. How much more capacity is available for contact tracing? The system is already hugely burdened. Could it take on potentially millions more? Does the public system have the potential capacity to take that on?

Ms Niamh O'Beirne: Like everything, contact tracing needs to build capacity. Were the numbers of international travellers to return to levels like 38 million, dealing with that would be extensive. We have worked closely with the Departments of Transport and Health on what they do and so that their decisions have the least impact on the HSE and the work we are trying to do in controlling the disease.

Deputy Cathal Crowe: If we move to that model of testing passengers and international travel recommences, what would happen when someone arrived in Ireland who was asymptomatic and had tested negative for Covid but was positive a couple of days after arriving? We could end up with a kind of Cheltenham in reverse or an influx of people the weekend of an international match. Do we have any arrangements in place or planned for contact tracing to be possible with international partners if we have an influx of people for a sporting event or similar? Do we have any capacity to take that on beyond our borders and beyond Northern Ireland as well?

Dr. Kevin Kelleher: That already exists. We already have and are part of a number of arrangements within both the EU and the WHO to deal with that, so we already have in place systems that allow us, if somebody flies into Ireland now and has been off the flight for two or three days, to identify that he or she is positive. We can go back with the airlines and others to identify potentially the people who might be at risk and then deal with that in those ways. We are doing that at the moment for about four or five flights per day. We are quite active on it. It is part of the system-----

Deputy Cathal Crowe: That is good to know. I am happy with Dr. Kelleher's answer.

A number of school principals have contacted me. I was a schoolteacher until February. Where a school has a confirmed Covid case, the principal is obliged to get in contact immediately with the HSE, and the HSE then takes on a communications co-ordinating role. That sounds ideal, and this was designed initially in order that the principal would not be burdened with the huge task of doing a little contact tracing and speaking to classes and parents. All of that is fine, but in reality it is taking in some instances 24 hours or longer for that whole communications chain to come full circle. Meanwhile, the school principal is in the staff room facing down colleagues, knowing that there has been a Covid case in the school. There are colleagues going home to elderly parents. Children in the class could be unwell. Within what kind of timeframes is the HSE doing the school communication turnaround? The principals I have talked to and the Irish Primary Principals Network find it grossly inadequate and it is really putting pressure on the principals. They are going around basically gagged for a 24-hour period knowing there is a heightened risk in their school but also knowing they cannot speak about it to others in their staff and school community.

Dr. Kevin Kelleher: We aim to speak to the principal, as a consequence of our being told of an individual, be it a child or a member of staff, on the day concerned as quickly as possible, having discussed it with the individual and all the parents concerned. Likewise, we aim to be able to speak to the principal on the day he or she gets in touch with us. We are in daily communication with colleagues in the Department of Education. I get involved in weekly meetings with the education stakeholders on this. We are trying to enhance the systems we have in place over this half-term period-----

Deputy Cathal Crowe: I thank Dr. Kelleher for that. Finally, what software does the HSE put on the contact tracers' laptops to ensure they are compliant with the GDPR and other relevant data regulations? They go home in the evening and use the same laptops for Facebook and other forms of personal use. What software does the HSE put on the laptops brought from home to the contact tracing points? What software does it give employees to ensure compliance with data regulations?

Ms Niamh O'Beirne: We provide laptops to our staff to do tracing. The application we use is all cloud-based, so nothing is held on the laptop itself. The contact tracer accesses our Mi-

crosoft Dynamics CRM system, which is where all the data are held on who to call. The issue that was mentioned in the newspapers today relates solely to one facility and to a small number of people who were asked to bring a personal laptop just for training. They will not be rostered to do contact tracing until their HSE laptops have arrived.

Deputy Bernard J. Durkan: I have just a couple of questions. Over recent months, there were obvious signs of an escalation in the incidence of the virus throughout the country. What system did the HSE have to identify the cause of the escalation? To what extent was the HSE in liaison with local communities or similar to identify, first of all, the main cause? I know there has been a return to schools and a return to business. That is one thing but, for example, I and many others were contacted by countless people who brought to our attention wide-scale non-adherence to the basic advice given. In order to combat the virus, did the HSE consider any means or methods to address the staff requirements for combating large numbers of the public ignoring the need to wear masks, observe social distancing and hand hygiene and virtually everything else? There were countless instances in many towns and villages throughout the country that would illustrate large numbers of people ignoring all the regulations, including going on holiday to some of the places that are known virus black spots and returning to the community. What methodology was used to monitor that kind of activity in order to be able to prepare the HSE for the monitoring and the testing and tracing that would ultimately follow?

Dr. Kevin Kelleher: The question the Deputy is asking is debated regularly at NPHET meetings, where NPHET is the focal point for that advice to the Government. NPHET has consistently made the points the Deputy has made. He will have heard the Chief Medical Officer, the deputy chief medical officer, our chief clinical officer here and other people talk repeatedly about asking people to do those things. There are also issues, generally speaking, for the Government about how those regulations are governed. The HSE is not directly involved in that but we have been speaking to people about how we do it. As Deputy Durkan says, we have rightly been looking to see how we can deal with some of those issues. We have pinpointed some of those events. We have had discussions with organisations about this. We are in regular discussions with other parts of government about these areas - I am involved with some, others are involved in others - trying to ensure that this is done. It is interesting to note that we have seen a significant improvement on what happens in some of the industries we have been involved in. The biggest issue, as the Deputy quite rightly says, is non-observance in general and in parts of society not following what we are asking people to do. It is very difficult because that is the behavioural change we are trying to get in place to cope with the disease until we have some method of dealing with it that does not involve the significant behavioural changes we are asking for at the moment.

Deputy Bernard J. Durkan: Would Dr. Kelleher care to comment on what has been suggested to me to the effect that if people in general, all sectors of our society, had observed to the spirit and the letter the regulations that were in place, it would have been possible to avoid the level 5 restrictions we are under now?

Dr. Kevin Kelleher: I think that is a distinct possibility. There is also a probability that we would have witnessed a wave regardless because that is the nature of the disease and how infectious diseases of this nature occur. They go up and down in waves regardless. The severity could possibly have arisen regardless. We can see as a consequence of the imposition of level 5 now and level 3 previously that people's behaviour has altered and is making a change. I totally agree with the Deputy. It very much reflects what we in public health have been saying quite strongly, as has the HSE as an organisation and the Government.

Ms Niamh O'Beirne: We must continue our media and public campaign for people to observe the requirements and to encourage them in order that people's understanding is increased and the message is kept out there. That is very important.

Dr. Kevin Kelleher: We have already shown that the number of contacts per case has declined in the past few weeks from the peak of cases three or four weeks ago. We have seen that number decline to three, I believe.

Ms Niamh O'Beirne: Yes, it is just over three.

Dr. Kevin Kelleher: That shows that people have taken on board the need to restrict their activities. When the number has decreased to two or three, it basically reflects household contacts.

Deputy Bernard J. Durkan: In the event of a recurrence of the events of the past four or five weeks, does Dr. Kelleher feel confident that the HSE has the ability to respond in time to minimise the impact of another surge?

Dr. Kevin Kelleher: That is what we are planning to do. The committee has heard from Ms O'Beirne about what we are doing to set up a system that will be able to cope. Like all things, it will depend on other considerations. If there are 1,000 cases a day and each of those has ten or 12 contacts, the numbers become massive and different things are required. We are looking at doing those things, but I hope that people have now seen the impact of what has happened and will reflect this knowledge in their behaviour. The real issue is moving on after whatever period this goes on for and what people do in the next stage. How things move on will be the key issue.

Deputy Bernard J. Durkan: I feel we will be revisiting this subject. I would like to congratulate all the front-line staff and thank them for their efforts. As I said previously in the House, it seems contradictory for staff to put their health and their lives at risk by working around the clock in some cases while other people in society ignore simple regulations that could make their jobs a lot easier.

Chairman: My apologies for not bringing in the Independent Deputy. I thought he was substituting for Senator Frances Black.

Deputy Denis Naughten: I will go through my questions and then ask the witnesses to respond. I accept that we are in a very difficult situation at the moment. We are seeing 1,000 cases a day, each one of which has numerous contacts. Let us take a step back to last month before this recent surge. A report, entitled COVID-19 Testing and Tracing: Roadmap to enhance capacity and turnaround, was published to great fanfare on 14 May. One of the risks highlighted in the report was rapid scaling up of volumes of activity. That was always a risk. As a mitigating measure, the report recommended stress-testing current operations to provide resilience. That was published on 14 May, long before the summer and the recent surge.

We heard in evidence this morning that the warning bells started ringing during the August bank holiday weekend. On 23 September, I raised the specific issue of contact tracing with the Minister for Defence on the floor of the House. He stated that the Defence Forces were waiting for a phone call from the HSE. That was seven weeks after the warning bells had started to ring. The documentation provided to us this morning states that the HSE has engaged with numerous public bodies, which have offered their support as part of the contact tracing effort. It also makes it clear that the HSE received offers of support from other bodies rather than seeking support itself. From the August bank holiday weekend on, which agencies and Departments that

had previously provided contact tracers were contacted? Were any of the contact tracers who had been trained up for the first wave of infection offered temporary, part-time or out-of-hours contracts under which they could work in the evenings or on the weekends? Those contact tracers had built up the system's capacity.

I received an email at 12 noon today regarding a parliamentary question I tabled at the beginning of the month. The email was dated last Thursday, 22 October, and was from Ms O'Beirne. I had asked about the number of HSE staff that have been deployed to contact tracing. The figures provided to me this morning indicate that 430 health and social care professionals were employed as contact tracers and testers last month. Can someone explain to me why occupational therapists and physical therapists were involved in contact tracing and testing last month when there was no surge? Why had efforts not been made to fill those positions with alternative staff before the surge? If that had been done, those 450 staff members could have been recalled to deal with the present surge. It seems that all the HSE staff currently involved in contact tracing are qualified medical professionals. Are any administrative staff involved in contact tracing?

Ms O'Beirne stated in her evidence that the number of HSE staff involved in contact tracing will decrease as other staff are brought on stream. I have been told by the CEO of the HSE and in replies to parliamentary questions that this will only happen after the full complement of 800 staff is recruited. Based on this morning's evidence, it will be the week before Christmas before all of those staff are recruited. This means that none of the HSE staff will return to their old posts until the new year. Ms O'Beirne went on to say that once the 800 staff are recruited, a decision will be made on whether the number should increase to 1,000. Can she clarify whether those staff members will be redeployed in advance of Christmas week? Alternatively, will we have to wait until the 800 staff have been recruited, as was indicated in parliamentary replies I have received?

Ms Niamh O'Beirne: The Deputy's first question was about the support we have received from other public bodies. Since August, when we began to increase our staff numbers again, UCD was the first university with which we engaged for support. The Revenue Commissioners also provided us with support, as did the Defence Forces through the Army bands. We received support from our colleagues throughout the public service. Those who had previously been involved, including university staff and employees who were working in front-line positions, did not return to contact tracing specifically. The HSE staff members involved in contact tracing today include approximately 25 allied health professionals. Some environmental health officers, who are also front-line staff, and human resources staff are supporting our contact tracing effort. Those staff will return to their normal roles as we start to build up capacity through our new recruits. Earlier I mentioned a figure of 274; that is the number of new recruits who are dedicated to contact tracing. Another 80 or 90 are coming this week, which will bring the number to 350 next week. We need to increase that number to have a dedicated workforce that is not required to do other things as part of its normal work.

Staff members are also involved in swabbing, which is a separate part of the process. That part of the pathway has approximately 800 staff drawn from different professions throughout the HSE, particularly clinical staff. That number will decrease as we hire more community swabbers in the coming weeks. Our ultimate aim is a dedicated and stable testing and tracing workforce that is independent of front-line services and the HSE's other administrative and healthcare services. That was part of our overall organisational design for testing and tracing.

Deputy Denis Naughten: I am not happy with that response. The reply I received today

contradicts it. We have been told that 866 staff were employed in this role in September. We are now hearing that there are 24 today. There is utter confusion.

Ms Niamh O'Beirne: If I may explain, the 866 are in swabbing, not contact tracing. It is a separate part of the process. However, it is true that 866 staff from the CHOs have been deployed solely to swabbing. The contact tracing effort has a different staff complement.

Deputy Denis Naughten: The parliamentary question related specifically to contact tracing. The HSE is now saying that it misled the Dáil in relation to the parliamentary reply it furnished to me rather than misleading me here this morning. This is part of the difficulty we have had. We are getting information out of two sides of the HSE's mouth in relation to what is going on here. I had this conversation privately with Dr. Kelleher, in that we cannot get clarity regarding the numbers involved here. The HSE is saying that there are almost 900 staff, 430 of which are allied health professionals such as occupational therapists, physiotherapists and speech therapists, carrying out swabbing today while nurses who have applied through Be on Call for Ireland who are capable and qualified to do this have not been taken on to fulfil the swabbing role. Instead, we have the speech therapists, the occupational therapists and physiotherapists carrying out this role. That is completely unacceptable.

Chairman: Can we have a quick response? I will move on to the next member.

Ms Niamh O'Beirne: In response to that, the campaign of recruitment for swabbers began in September. Three and a half thousand applicants came through on that and the first 200 of those are in place. We continue to recruit them at a rate of 90 to 100 per week. They need training. They are non-clinical staff trained into those roles. They need training and they need clinical oversight in all the centres across the country. Just like contact tracing, with the swabbing side we need to continue to recruit so that we have adequate staff who are independent of the community health services.

Chairman: The frustration for the committee and many of the Members of the Houses arises because we could understand, maybe earlier on in the pandemic, that the HSE was securing staff from different elements within it but in key areas, such as the CHO 7 area which Deputy Durkan and I cover, the team for children of school age with special needs has almost collapsed. In speech and language therapy, prior to the pandemic one waited possibly up to two years for an assessment and possibly another two years to get supports. Those waiting times have extended further because many of the staff have been seconded to track and trace and to other jobs. I suppose that is where the frustration arises. In the earlier days, it made sense but those people clearly need to be back in the services for which they are trained. If possible, bring on those who responded to Be on Call for Ireland. It was a great idea but it did not seem to be taken up. There are others, we believe, who could be doing the job rather than those trained professionals who are clearly needed in other areas of the HSE.

Ms Niamh O'Beirne: Absolutely. We agree. That is the process that we are going through in interviewing people who have applied for the roles and moving to appoint them to the roles as quickly as we can.

Chairman: Ms O'Beirne will come back to us with those figures at some stage, as was asked earlier on. There are only two more members looking to come in. Perhaps they would ask a question each.

Senator Martin Conway: I have two quick questions. First, in terms of the cancellations

of tests, what figures have the witnesses on scheduled tests that were cancelled? Were the people who cancelled the tests followed up on to reschedule the tests? What percentage of those tested positive for Covid? It would seem, if a test was cancelled or people did not show up for a test and it was rescheduled, that one is talking about another 24 to 48 hours. If they were not self-isolating, we are looking at a dangerous situation. The second question-----

Chairman: The Senator has one question, sorry.

Senator Martin Conway: I just wanted to ask about private testing. Have the witnesses any figures on private testing and are the statistics from the private testing feeding into their overall figures?

Deputy Colm Burke: I raised concerns earlier this week about people travelling to Northern Ireland for medical procedures. They are travelling for anything up to six hours by bus, and many of them are elderly. It is relation to cataract operations. Maybe Mr. McCallion might deal with this issue. My understanding is that there is a delay, certainly, in the south-south-west area, in getting appointments to be assessed. Can we fast track that process by using the National Treatment Purchase Fund to refer people for consultations and then put them on the list for cataract procedures? In the South Infirmary, there are only 133 cases waiting to be dealt with. Some 90 of them are waiting less than three months. The problem is that people are not getting on the list because they are not being assessed. Can we deal with that issue at this stage? Finally, would Mr. McCallion accept that travelling to Northern Ireland at this stage is a little unsafe and that people need to be advised of that?

Mr. Damien McCallion: On private testing, I can answer that fairly quickly. Private laboratories that undertake PCR testing are obliged to report those to public health and to the Health Protection Surveillance Centre, HPSC. Positive results for PCR will come through in the HPSC figures that are reported regularly. We get results as well from private hospitals. Those numbers feed into our own system but, as I say, there is a legislative requirement under the infectious disease legislation for private laboratories. We would be in contact with those we know on a regular basis to make sure that is happening in a timely manner for all the reasons the members have set out.

I will have to revert to the Deputy on the point about the specifics of the cataract procedures. While I am familiar with the fact that people travel South to North, and, indeed, North to South, in terms of my other role, all I would say on its safety or otherwise is that people clearly should observe whatever the public health regulations are in the two jurisdictions at any point in time in terms of travel. There are also people who, by nature of the jobs in healthcare or other settings, need to travel across the Border on a regular basis. People should adhere to the regulations in the two jurisdictions at any point in time. Equally, I recognise that there are significant numbers of people who travel across the Border every day and who, within those regulations, are entitled to do so. That would include access to healthcare but also healthcare staff. The numbers who travel across are big. On the specific matter, maybe I could come back to Deputy Colm Burke. If the Deputy can forward me some details, I can pick up the particular point about cataracts. That is a broader issue than Covid and maybe we can link it to the acute hospitals.

Ms Niamh O'Beirne: I might pick up the question Senator Conway asked about the do-not-attend rate. The do-not-attend rate for the past number of days is at 15%. We contact those individuals and offer them another test date. We would not keep figures - we do not have the metrics - for those who had their test redone as to whether Covid was detected or not detected. However, we have seen an improvement in the do-not-attend rate and people adhering to their

appointment time. Certainly, we have seen an improvement in the day seven testing also, which has risen to more than 90% over the past number of months.

Senator Martin Conway: Can I put it another way? Of the 15% who do not attend, how many are successfully rescheduled?

Ms Niamh O'Beirne: I will get that figure for Senator Conway. I do not have it to hand.

Chairman: I thank all the witnesses for their helpful engagement this morning. Apologies if they were cut off at certain times. It is the nature of how we are trying to conduct these meetings. I hope we can continue this conversation. I look forward to some of the written answers and to meeting the witnesses again in person.

At the next meeting on Wednesday, 4 November, the committee will meet with the Minister for Health, Deputy Donnelly, to get an update on tackling Covid-19 and a briefing on plans for his Department in achieving its budget 2021 target.

The joint committee adjourned at 1.29 p.m. until 11.30 a.m. on Wednesday, 4 November 2020.