DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Máirt, 9 Márta 2021

Tuesday, 9 March 2021

Tháinig an Comhchoiste le chéile ag 9.45 a.m.

The Joint Committee met at 9.45 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.	

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

Business of Joint Committee

Chairman: We have one item of committee business to be addressed before I call on our witnesses to present to the committee.

Can I take it that the draft minutes of both the public and private committee meetings on Tuesday, 2 March, are agreed and there are no matters arising? Agreed.

Covid-19 Public Health Measures: Update from Health Service Executive

Chairman: I welcome the witnesses from the HSE who will present to us virtually and provide us with an update on Covid-19-related public health issues, with particular reference to the arrangements for an extended vaccine roll-out and the operation of testing and tracing.

Maidin mhaith. Cuirim fáilte roimh gach duine go dtí an cruinniú sláinte. I welcome Mr. Paul Reid, chief executive officer, Dr. Colm Henry, chief clinical officer, Dr. Lorraine Doherty, national clinical director for health protection, Mr. Damien McCallion, national lead for Covid-19 vaccinations and Ms Niamh O'Beirne, national lead for testing and tracing.

Before we hear the opening statements, I point out to the witnesses that there is uncertainty as to whether parliamentary privilege applies to evidence given from a location outside the parliamentary precincts of Leinster House. Therefore, if witnesses are directed by me to cease giving evidence in relation to a particular matter, they must respect that direction.

I call Mr. Reid to make his opening remarks and he has five minutes.

Mr. Paul Reid: I thank the Chairman and members of the committee for the invitation to update the committee on the HSE's public health measures to respond to Covid-19.

I am accompanied by my colleagues, Dr. Colm Henry, chief clinical officer, Ms Niamh O'Beirne, national lead for test and trace, Dr. Lorraine Doherty, national clinical lead for health protection and Mr. Damien McCallion, national lead for Covid-19 vaccinations.

I will make a brief opening statement on the current situation with Covid-19 and current and future developments with test and trace, as well as an overview of the roll-out of the vaccination programme.

Thankfully, all major indicators of the disease are now trending downwards although we remain alert to the impact of new variants of Covid-19. Up to 7 March, a total of 223,219 cases and 4,422 deaths due to Covid-19 have been recorded in Ireland. Our 14-day incidence rate is now 172.3 per 100,000, down from almost 1,500 in the middle of January.

We are still actively managing 358 outbreaks in acute hospitals and long-term residential care settings, although the number of new outbreaks is falling. As of today, I will give the updated numbers from my script, we now have 397 people with Covid-19 in hospital and 101 people receiving ICU care. While falling, these numbers are still very high in the context of our experience with this disease and in comparison with other health conditions. This has an ongoing impact on our acute and community services which are simultaneously responding to usual seasonal pressures and maintaining as many services as possible, accounting for social distancing measures and infection prevention and control, IPC, requirements.

Thankfully, our winter plan initiatives, such as GP access to diagnostics and additional home care hours, are successfully mitigating demand on hospital services. We are restarting paused services on an incremental basis and hope to be in a position to restart all services shortly. However, it must be understood that our staff are still in the midst of responding to the unprecedented Covid-19 surge, from which the recovery will be much more gradual than the escalation.

On testing and tracing, the third Covid-19 surge placed unprecedented pressure on our test and trace system, with an increase in demand that has been well-documented. Referrals for testing peaked at 28,000 per day in late December 2020. Extensive operational planning and demand modelling was undertaken in advance of this period which allowed the agile deployment of many levers and service reconfigurations to cope with prolonged demand. The decision to reduce close contact testing allowed all testing resources to be directed to finding new cases from symptomatic individuals. Close contact testing resumed on 29 January. Retrospective contact tracing is occurring and will increase as case numbers reduce to under 600 consistently. While testing volumes remain high, current metrics across the test and trace system show that we are operating within target performance levels. The HSE antigen working group is validating a range of antigen assays, including in acute hospitals, the meat processing sector, community testing sites and outbreak settings. Antigen testing is now available to all acute hospitals and is being used by three National Ambulance Service mobile teams on a pilot basis. These will be used as a tool alongside our extensive PCR rapid and batch testing systems.

On vaccinations, since the roll-out of the vaccination programme began on 29 December 2020, significant achievements have been made by the HSE. As of 5 March, 363,601 first-dose vaccines and 149,721 second-dose vaccines - a total of 513,322 - have been administered. We will get updated figures this morning. I am delighted to report that residents in long-term residential care facilities, front-line healthcare workers, and people over 85 years of age have largely received their first dose, and in many cases, their second dose.

We are continually adjusting our integrated operational plans to align with the updated allocation sequencing and confirmation of supply schedules. Despite many challenges, the HSE has adhered to the Government's principle of ensuring all available vaccine supply is administered. We are currently among the top five countries in the EU for vaccine roll-out.

Clinical oversight and guidance are at the centre of directing the roll-out of the vaccination programme to ensure vaccines can be administered safely, efficiently and effectively. We continue to build the appropriate capacity to administer 250,000 vaccines per week, subject to supply. Our ongoing planning and roll-out includes operating models for GPs, pharmacies and vaccination centres, alongside the corresponding ICT, infrastructure and recruitment mobilisation. Some 37 HSE vaccination centres have been agreed and the required infrastructure is being finalised, with self-referral processes planned. To date, over 2,000 recruitment applications have been received and an additional 9,702 healthcare professionals have completed Covid-19 vaccination training.

In conclusion, we are coming out of a very challenging period, although we are not out of the woods yet. While we know it has been extremely difficult for everyone, we are asking the public to stick with us over the coming weeks and continue to follow the public health guidance to help suppress the spread of the virus. The virus and its impact on society remain largely unpredictable and, as such, the need for proactive monitoring and agile planning has always been a feature of our response, and will continue to be so.

Chairman: As members are also attending the meeting virtually from their offices, they cannot see the clock to monitor speaking time. I will advise them when they have one minute remaining, if I can interject. I ask members to stick to their time in order to facilitate the participation of all members. I thank the witnesses for their attendance this morning. The first questioner is Senator Kyne.

Senator Seán Kyne: I thank Mr. Reid and his team for attending the committee this morning. I acknowledge the work being done by all of our front-line workers in hospital settings, vaccination centres and GP surgeries.

I have a number of questions. The first two will hopefully only require short replies, so I might start with them. Have all GPs nationwide received at least their first batch of vaccines that were issued up to last week? Second, last week at the meeting of the committee, I raised with the Minister for Health the case of patients in hospital settings who have not received the first dose of the vaccine, as the policy of the HSE was that vaccinations should take place in the community only. Can Mr. Reid confirm that this policy has now changed and that hospital patients over the age of 70 will now receive the first dose in hospital?

Mr. Paul Reid: I will be brief in my responses. On the question in respect of GPs, we are engaged with a total of over 1,300 practices throughout the country. The vast majority of them have received and, indeed, administered first doses to 72,500 people in this age population. The remaining supplies will be sent this week to 30 GP surgeries which are not in a position to buddy up for various understandable reasons. They cover a population of between 500 and 750 in total. That group will be vaccinated this week. The surgeries will receive their supplies during the course of the week. Our contact centre has been contacting them from last Friday and contact will be made to confirm deliveries for the rest of this week.

On the Senator's second point, he is quite right that there are other people in that age population that need to be vaccinated during the course of this week. That group includes people who are housebound. An arrangement has been put in place in agreement with GPs and the Irish Medical Organisation, IMO, for them to be vaccinated by the National Ambulance Service. Third, arrangements are being put in place to vaccinate those who are hospitalised in one of our acute hospitals. It is a tricky issue because there may be some patients who are in hospital for a very short period, so arrangements need to be made in respect of where they will receive their second dose. However, our leaning now is that if people are in hospital, they will be vaccinated there and will most likely also receive their second dose in hospital.

Deputy Seán Kyne: I welcome the change in policy from last week when the Minister attended the committee. It is certainly welcome in respect of those who are resident in our hospitals.

In April, it is hoped that we will receive around 250,000 doses per week. That is the estimate, all being well, and it amounts to 1 million doses for the month. We want those doses to be administered. I ask Mr. Reid to talk us through procedurally how this number of vaccines will be administered in our vaccination centres, GP surgeries, pharmacies and even dental surgeries. For example, will it be first come, first served in the relevant age groups or will people be individually invited to receive the vaccine or book online? What sort of logistics does the HSE have planned for that?

My second question concerns interns and the intern doctor cohort. There are currently around 1,100 interns working in the HSE. From 12 July 2021, this number will drop to 750.

In effect, the health service will be cutting about 250 junior doctor posts, arguably at a time of huge demand for resources. To put it into context, in University Hospital Galway, intern numbers will fall from 86 to 71; in Portiuncula Hospital, they will fall from 15 to 11; and in Mayo University Hospital, they will fall from 16 to 11. Last year, the previous Minister for Health, Deputy Harris, offered all eligible graduates of Irish medical schools an internship role with the HSE. Considering that there is an even larger budget this year, why is that policy not being continued?

Mr. Paul Reid: I will take the first two questions, before asking my colleague, Dr. Colm Henry, to respond to the Senator's third question. I am conscious of the time limit, so I will be brief.

I will briefly walk the committee through the logistics and the sequencing of the delivery of 250,000 vaccines per week in April, as referred to by the Senator. Put simply, there are plans in place for 37 vaccination centres to open immediately across the country. There will be a total of approximately 800 booths across those vaccination centres. The centres will range in size and will have the capacity to complete different levels of vaccination throughout the country. Some will have 50 booths, some will have between 30 and 50, some will have between one and 20 and others will have between 20 and 30. They will be of various sizes and scale. The centres with 50 booths will administer approximately 5,000 vaccinations per day, with the figure reducing to 3,000, 2,000 or 1,000 based on scale and size. The resourcing plans for the centres are ongoing. There are three different strands to it. There are now almost 10,000 vaccinators on our register of trained vaccinators throughout the country, being a combination of HSE staff, other healthcare staff and professionals. Our GPs and pharmacists are key as well and they will obviously be part of the vaccination programme. Separate to that, the local community healthcare organisations, CHOs, and hospital groups have initiated their own recruitment campaigns and have progressed very well with recruitment for their vaccination centres. Separate to that again, we have advertised through a national campaign and we have close to 2,200 applicants today, almost 1,100 of whom have already been screened. All have very strong qualifications and many are already Garda vetted and ready to go. That is the resourcing model approach to the vaccination centres.

Vaccination centres will operate on a 12-hour day basis. That does not mean that vaccinators will be working and on their feet for 12 hours. Rather, they will be working on a rotational shift basis. We have determined the resourcing requirement to be approximately 25 staff for every ten booths. Obviously, there will be a requirement for ten vaccinators for ten booths but other administrative staff will also be needed. We have seen six of these vaccination centres in operation throughout the country, including in Galway, Sligo and Dublin, which has given us a real indication of how they work and the processes involved. That is the resourcing model for the vaccination centres.

In terms of how people will be sequenced to come in to the centres, on a national level we are working towards the national prioritisation programme set out by the national immunisation advisory committee, NIAC, and the sequencing agreed by Government. The group we are working on at the moment is quite a challenging one. Cohort 4 comprises those with medical conditions that put them at high or very high risk. We are working through the process of determining the best locations for them to have their vaccinations. We envisage it will be a combination of hospitals, vaccination centres and GP surgeries. As we move into the wider population in April, the vaccination sequencing will be supported by an ICT portal. As we move into the next category of prioritisation, we will be advising the relevant people to register on the portal

and they will be assigned an appropriate location for their vaccine. Ultimately, as we move into those larger groups in April, it will be a combination of GP surgeries, pharmacies and vaccination centres in their entirety. That is a very quick overview of the situation with regard to the centres, the sequencing, the who and the when. I will ask my colleague, Dr. Henry, to respond to the Senator's question on medical interns.

Dr. Colm Henry: I thank the Senator for his question. Normally there are 734 intern posts created as part of our structured intern training scheme which feeds into our basic specialist training, higher specialist training and so on. Last year, as a once-off, we offered in excess of 1,100 posts because of the prevailing conditions. We were in the middle of the first surge. The interns started early, on 25 May, rather than in early July and that overlap was particularly welcomed by the intern networks and the junior doctors themselves. It was always understood that this was a once-off situation.

The figure is set at 734 because that number of places corresponds to other important interdependent numbers, one of which is the number of CAO applicants for medicine and the number of training places available for doctors who come off the intern year, which is a year they must complete before they get full registration. Basic specialty training comes after intern year, then higher specialist training and, ultimately, consultant posts. What we are trying to do is create more posts at senior level so there is proper medical manpower planning and a corresponding number of interns produced by our medical schools.

On the issue of the numbers and any future expansion, work is ongoing in the HSE by the national doctors training and planning unit on the modernisation of the intern year project, involving all of the 734 posts. One stream of this project involves looking at the numbers of posts, the number of training positions for people after they come off intern schemes and how they will ultimately lead to GP or consultant posts as part of proper, all-round manpower planning. I hope that answers the question but I am happy to respond to any issues the Senator may have.

Senator Seán Kyne: I thank Dr. Henry for that. We are still in the midst of a pandemic and, in that context, is it right to reduce the numbers this year considering we have an increased budget? Should we not continue at least for this year? I understand from discussions this morning that the number of CAO applicants for healthcare and medical courses has increased.

Dr. Colm Henry: There are always more applications than there are posts available. Last year we offered, as a once-off, in excess of 1,100 posts. A significant number of final year medical students turned them down and ultimately we ended up with 992 interns. The feedback we received is that the aspect that was of greatest value was the overlap between those interns starting early and those who were already in position. We heard earlier about the falling numbers of Covid cases in hospital and the roll-out of the vaccination programme, which has seen a significant fall in hospital-acquired Covid and in infection among healthcare workers. It seems we will not be in the same position in terms of need this July as we were in July of last year.

Mr. Paul Reid: Can I just add one piece to that? On the wider point of the pandemic and recruitment, the Senator is correct. We made a good case to the Government through the Department on resourcing. In the year to the end of 2020, our total resourcing was up by 7,500. This includes doctors, consultants, nurses and medics. This is a very significant increase in resourcing which will carry forward into this year. This year's budget facilitates an incremental increase in resourcing, based on last year, of 16,500 for the year. That is a process we are working through in terms of recruitment across various channels. There are very targeted recruit-

ment campaigns being conducted across all of our medical professional workforce.

Chairman: I have to move on, but before I call Deputy Cullinane, I ask Mr. Reid to elaborate on the vaccination programme and ambulances calling to the doors of the elderly. I am sure many people will be worried if they see an ambulance at the door of an elderly neighbour so I ask Mr. Reid to explain what is going to happen.

Mr. Paul Reid: We are very conscious of what the Chairman has just said in terms of the shock effect of ambulances. We have worked hard to ascertain the best way to get to housebound patients of GPs and there is no doubt the best approach is through our National Ambulance Service. Obviously, we do not want this to be a surprise for people, so our teams will make contact in advance, which they already do for swabbing. National Ambulance Service personnel are well trained and take a professional approach to giving advance notice. It is the most appropriate way to reach housebound people. As I said previously, the Pfizer BioNTech and Moderna mRNA vaccines are very complex vaccines. In terms of reaching those who are housebound, this is the best approach, involving very well-trained paramedics.

Deputy David Cullinane: I welcome Mr. Reid. We have very limited time so I want to ask as many questions as possible in the ten minutes available to me. I will start by thanking again all of those on the front line who are doing a wonderful job in our health services, in testing and tracing and in the roll-out of the vaccine. I appreciate that a lot of good work is being done by a lot of people in the HSE and I want to put that on the record.

On the vaccine roll-out, who has overall responsibility for or command of the supply and logistical issues? Who is the person in the HSE that has day-to-day, overall responsibility in those areas?

Mr. Paul Reid: I thank the Deputy for his comments about front-line workers, which are really appreciated. On supply issues, engagement with various suppliers across Europe is done through the Department. It is Department led and ultimately, the responsibility of the Minister. Supply lines are a function of the engagement between the Department and the various suppliers. Obviously, we in the HSE are engaged in signing contracts etc., but supply lines are the responsibility of departmental officials through the Minister.

Deputy David Cullinane: Who, at a senior level, is in contact with the pharmaceutical companies? We know we have had several interruptions in supply. It was reported in today's edition of *The Irish Times* that there was a target of 1.7 million doses by the end of March. We were told it was 1.4 million earlier this year when others appeared before this committee. It dropped down to 1.2 million because of an interruption in supply from Astra Zeneca. Questions are being asked and I hope Mr. Reid will have the answers today for us. How many times have we seen an interruption on the supply side? How many times have been told we are getting X number of vaccines and we end up getting Y which is a lesser amount? Does Mr. Reid have that information for us this morning? How many times have we seen those levels of interruptions?

Mr. Paul Reid: I will answer the questions on the supply lines as reported this morning. I believe 1.7 million related to what might potentially be delivered from the advance purchase agreements. Ultimately the Deputy is right. It became clear to us the second forecast figure of 1.4 million was what was likely to come through. The further figure is very much out there. Our expectation is that there would be over 1.2 million, about 1.24 million, of expected delivery for this quarter. Based on what we have experienced recently, we have certainly said a few times-----

Deputy David Cullinane: I have very limited time. We have seen several interruptions on the supply side. A number of times Astra Zeneca has left us short, as did Moderna last week. How many times has that happened? Are we still on course to reach that target or because of those interruptions, will we now not reach that target of 1.2 million by the end of March?

Mr. Paul Reid: With respect, I was trying to give that figure down to exactly what we expect now for this quarter. In answer to the Deputy's question we had expected 1.2 million for this quarter. Realistically we see that probably drifting into the first week of April. Some 175,000 of them were to be delivered on the last day or so. Realistically it will be around 1.1 million, probably going to 1.2 million in the first week of April. With changes to supply, changes to prioritisation, changes to sequencing and changes in vaccine types to be utilised, we have probably changed our operating plan 15 to 17 times in total. How many of those have been down to supply issues? On a regular basis from the start of this we have had to adjust to whatever the issue is, be it a supply chain issue or otherwise. The delivery of it has not impacted to the end of the quarter from an efficiency or an operational perspective. The delivery of it, if it is to be impacted, will be impacted by supply.

Deputy David Cullinane: All we want is factual information. I ask Mr. Reid to provide the committee with a note on how frequently there has been an interruption in supply. This should outline, for example, that on a particular date we were due to receive X number of doses from a particular company and then we received Y which was a lesser amount or more as the case may be. We should be given that information so that at least we have the facts as to how frequently we have been left short. I am concerned that the target will now reduce to 1.1 million. It was 1.7 million initially; it dropped down to 1.4 million; it was then 1.2 million; and it is now 1.1 million. Obviously, that erodes confidence in the overall roll-out if we are having problems on the supply side. If Mr. Reid could provide that detailed note to us, it would be useful.

Who is responsible for the logistical side of getting the vaccines from A to B? Who has operational responsibility for that area?

Mr. Paul Reid: I hope the Deputy appreciates that I try to give him all the facts and figures we have on how frequently the plan has changed. We are quite happy, through the high-level task force and the Department, to get him a note on supply issues, which have probably changed four times in the past three weeks.

Logistical issues overall are the responsibility of the HSE in conjunction with our supply-chain cold-storage operator. That would be the manner in which we arrange the distribution to, in the previous weeks, GPs, or to the acute hospital systems. Through ourselves, our supply-chain cold-storage operator-----

Deputy David Cullinane: Who has overall responsibility for getting the vaccines from A to B? This is not just anecdotal; it is factual and has been reported by many GPs. Some did not get their vaccines on time. Some got their vaccines without proper equipment. I know one GP who received a box of leaflets as opposed to a box of vaccines and they had patients waiting to be inoculated. We have had reports of these types of incidents and we still have not been given the data on how frequently there has been a problem on the delivery side.

Mr. Reid spoke earlier about those who have been unable to buddy up. The Minister also gave us that information. That is not what we are looking for. We want to know how many times there has been a problem on the delivery side for GPs. Given that we are experiencing problems when we are administering the vaccine for the very small number of those aged

over 85 - we are told we will see it ratchet up very significantly to 250,000 a week from April onwards - it is our responsibility to ask why these problems have happened. Who has overall responsibility for getting the vaccines from A to B? On how many occasions did GPs who were due to receive their vaccines not receive them on time, or receive them and may not have had the proper equipment?

Mr. Paul Reid: As the Deputy knows, we fully respect his role and responsibility in terms of transparency in challenging us. That goes unsaid. We have been very upfront. We have never said it is anecdotal evidence. We went on the record publicly last week to acknowledge that there have been issues in the third week of this delivery programme. I will briefly give some context of the three weeks. In the first week of this programme, in 255 practices with 500 GPs, 14,500 vaccinations went quite well across the board. That information comes from the IMO and the ICGP. In the second week almost 54,000 people were vaccinated in 500 practices containing over 900 GPs. In the third week, the Deputy is absolutely correct, we have been working with 542 practices for the delivery of approximately 37,000 vaccines. We did experience problems with a number of practices. That involved some practices not receiving the required amount, some practices not receiving their vaccines on the day they were expecting it-----

Deputy David Cullinane: My question is: do we have a number? I hear what Mr. Reid is saying about some practices. It would be important for us to have that number so that we have a sense of the scale of the problem that emerged. We need to learn lessons as we ratchet up the roll-out. We all want this to be a success. When problems arise, we need to fix the problems which is why I am asking who has overall responsibility for ensuring the data are presented to us and more importantly for ensuring that the vaccines get from A to B and that if there are problems those problems are resolved. I still do not know who has responsibility for logistics in the HSE. Who has day-to-day responsibility?

Mr. Paul Reid: I said it from the very start. We, the HSE, have responsibility.

Deputy David Cullinane: Who in the HSE?

Mr. Paul Reid: Our overall project manager dedicated to this is Damien McCallion. We have a dedicated supply chain SRO, who is Seán Breslin. We have a dedicated SRO for logistics. It is a joint SRO programme involving Seán Breslin and Dr. Lucy Jessop. That is the structure we have on that.

Coming back to numbers, again I am trying to give the Deputy every bit of information I have available today. We will certainly follow it up with the rest. I will give some numbers for that third week. Initially we needed to get to 65 practices in this week, involving 750 patients out of the total of 72,500. Between 25 and 40 practices had a range of impacts relating to consumables, as the Deputy said, or reduced supplies across the country. On those two figures, 65 GPs which reduced to 30 for this week for buddying up and delayed deliveries to those and between 25 and 50, I am happy to get the Deputy a further summary.

Deputy David Cullinane: I have two very quick questions finally. We have heard from Britain that there may be a need for a booster shot in the autumn. Does that need to be considered in this State also? I welcome that we have now started into category 4 and that those with underlying medical conditions will start to get their vaccines. It is important that we get that right. Do we have a central register of people with chronic illnesses and, if not, will that impact our ability to roll out vaccinations to that cohort of people as quickly as possible? Will consultants have to go through their systems manually to identify those patients and then feed

that information to the HSE? We are again seeing problems with IT systems and the lack of a proper registration system and databases.

Will Mr. Reid confirm whether we have a central register of people with chronic illnesses? If we do not, will that present challenges in identifying the cohort of people with underlying conditions who we all want to see get their vaccines as quickly as possible? I ask about that in addition to the issue of the booster jab. Given we have now seen that may have to be done in some other European countries, is that being considered in this State as well?

Mr. Paul Reid: I ask my colleague, Dr. Colm Henry, to address those questions.

Dr. Colm Henry: I will try to be as quick as possible with the Deputy's time. On the first issue, it must be borne in mind that in the UK a decision was made to extend the interval between the first and second doses of the vaccine and that may have informed any decision made to administer a booster dose. In addition, HIQA has surveyed the question of immunity, whether natural or vaccine-induced, and there is evidence of persistent antibodies up to six months, with some waning thereafter. The question of a booster dose is one that is outstanding for all countries internationally and it has not been answered yet. We may well be looking at annual booster doses, depending on what the evidence shows in time.

The Deputy is right that there is not a single national disease registry for the whole range of conditions described by NIAC in its letter. It is easier to identify patients with certain conditions. For example, the national renal office has a good idea of the number of people on dialysis, those who have received organ transplantation and those in the end stages of renal failure through the network of nephrologists. Similarly, in the area of cancer the oncology network will have a fairly good idea of the types of patients described in the NIAC document. However, for other conditions there is no such registry and that will require us to mine into the information in hospitals and general practices.

Deputy David Cullinane: I ask the Chair if it might be possible to get a detailed note from the HSE on some of the issues I raised. I appreciate the responses from Mr. Reid, but it is important for us to have as much data as possible on the inoculation process and on where problems have arisen with GPs not getting vaccines, consumables and syringes on time and associated delays. I would like to have those data and not just from some GPs. We must know in percentage terms and in specific numbers how frequently these problems occurred so that we can learn lessons. I am concerned that perhaps that information is not being recorded, which would be even more of a problem. If it is being recorded, it can be presented to us. I ask that the information be presented to the committee in writing in due course.

Deputy John Lahart: I thank the chief executive officer, Mr. Reid, and his team for their public service. I can imagine that there is pressure and more pressure from the beginning of every day to the end. For our part, I express an appreciation of how Mr. Reid, his team and the wider HSE organisation have operated in this pressurised environment. There is no indication that pressure is going to let up. I have a question on the figures. How many people approximately are there in long-term residential care in Ireland?

Mr. Paul Reid: I thank the Deputy for his comments. I can give him two figures. The number of residents and staff in long-term nursing homes is just over 75,000 people in total. On the number of vaccinations in long-term care facilities, which my colleague, Mr. Damien McCallion, can clarify, it is more than 90,000 people, including residents and staff. That includes nursing homes, as well as mental health, disability and other older care settings.

Deputy John Lahart: That is enough for me. Mr. Reid might also be able to answer this genuine question on the figures for me. The number of people referred to in Mr. Reid's previous answer is a huge jump. The census in 2016 estimated that there were just over 32,000 people aged 65 years old and over in what are called communal establishments, of which almost 23,000 were in nursing homes and the remaining 10,000 people were in other communal establishments. Has there been a jump in the figure from about 22,000 in 2016, and a total of 32,000 at that time, to the figure given by Mr. Reid of 75,000 people?

Mr. Paul Reid: I am sorry if I confused the Deputy. I gave him figures for residents and staff in each of those locations.

Deputy John Lahart: Okay, so the figure then is about-----

Mr. Paul Reid: There is a staff to resident ratio of 1:1, or even more, in nursing homes.

Dr. Colm Henry: I might just come in here. The figure given by the Deputy is correct if we look at nursing homes and community hospitals which provide long-term care. These are public units as opposed to private nursing homes. The breakdown given by the Deputy is therefore approximately correct. Bearing in mind the particular risk for older people in congregated settings, whatever setting that might be, we went beyond the literal interpretation of the residential care settings in this vaccination programme for people in category 1 and included any areas where older people were present in congregated settings, including mental health facilities. The risk for people in those facilities was as great as for people included within a strict definition of those in category 1. The approximate figures given by Deputy are therefore correct because there are private nursing homes and also community hospitals and long-term residential care facilities in the public sector, which comprise a minority of the provision of care for older people in congregated settings.

Deputy John Lahart: It might be helpful if-----

Mr. Paul Reid: My colleague, Damien McCallion, is on the call and he may want to comment further on this topic.

Mr. Damien McCallion: To reinforce Dr. Henry's point, the total number of people vaccinated in that cohort is 92,000 and that included a wide range of settings beyond nursing homes. It also included the staff as well as residents, and that has brought the number up to this total. We have that breakdown if the Deputy would like to receive it.

Deputy John Lahart: Yes, it would be helpful if that breakdown could be supplied. There have been reports about the vaccination programme, and this process has been frustrating for everybody, with peaks and troughs. Mr. Reid will appreciate that several anticipated game changers to date have fallen short. The latest good news story relates to an anticipated game changer, namely, the Johnson & Johnson one-shot vaccine and its potential. There was an anticipated supply of about 50 million doses of that vaccine in the United States, but in the short term I think that figure has fallen to 10 million doses because of issues encountered by the subcontractor who produces the vials for the vaccine. It is not an issue with the production of the vaccine but with the production of the vials. The expectation being talked about now in the US is of 10 million doses being available in the short term. What news has there been from Johnson & Johnson? The European Medicines Agency, EMA, still has to approve this vaccine. The population accepts that from now until early or mid-April, there will be issues with supply that are beyond the control of the HSE. I think the public accepts that but from mid-April,

there is an anticipation of what has been termed an "abundant" supply. How are things looking generally from the perspective of such abundance?

Mr. Paul Reid: The Deputy has called the situation as it is. We do not see that there will be an abundance of vaccine supply from Johnson & Johnson. Our second quarter projections indicate approximately 3.8 million vaccine doses being available from four suppliers, assuming the EMA approves the Johnson & Johnson vaccine. The assumption is that the Johnson & Johnson vaccine will make up about 600,000 doses of the total, and that will primarily-----

Deputy John Lahart: Over what period?

Mr. Paul Reid: That will be over quarter 2 but primarily back-ended. There will be smaller numbers in mid-April and then there will be greater supply in the following two months, primarily from Johnson & Johnson.

To answer the Deputy's question in the round, our first quarter has been an experience of high levels of frustration with supply issues from the HSE's perspective. The supply from Pfizer has been more stable, although we did have one change to that supply line as well, while the supply from Moderna of late has been unstable, as has certainly been the supply from AstraZeneca. We welcome the country manager being appointed by AstraZeneca. It has been a very frustrating quarter, overall, in terms of supply lines. That has been an EU-wide issue.

We expect, and would assume, based on what is happening worldwide, to have a higher level of predictability in the second quarter. The Johnson & Johnson one is a smaller element of our expected commitments. Having said that, there may be other vaccine supplies that will come on board. There may be other current suppliers who will strengthen their capacity for the next quarter. The next quarter will see some swings and roundabouts between suppliers and some other suppliers coming on board.

Deputy John Lahart: It is to be hoped there will be 600,000 Johnson & Johnson vaccines supplied in quarter 2.

Mr. Paul Reid: Yes, and the benefit of that-----

Deputy John Lahart: It is a single jab.

Mr. Paul Reid: Yes. It is important for some vulnerable groups which can use it quite well.

Deputy John Lahart: Okay. It is fair to say that the public is waiting for an abundant supply in quarter 2. Is Mr. Reid beginning to cast doubts on that? What does he think would be the total supply for quarter 2 if everybody delivered what they say they will?

Mr. Paul Reid: The committed supply that we have, if we include quarter 1, would bring us from between 1.1 million to 1.2 million deliveries to 3.8 million deliveries. We see a stronger delivery in quarter 2. This an EU-wide and worldwide issue.

I will make a few brief comments on the public's perspective. We totally understand the frustration of the public. I want to provide some reassurance. As we get supply, we are administering it in a very efficient manner. On average, 95% of the supply is administered within a week and sometimes it is administered within three days. For example, last Friday week we were due an AstraZeneca supply of 64,000 vaccines. We are operating at such an efficient level at the moment - I do not say this as self praise for the HSE - that we are administering vaccines very quickly. What happened on that Friday meant that on Saturday and Sunday we did not

have the projected volume to deliver over the weekend. My point is that impacted us immediately. We are operating at a higher level than most EU countries in terms of administration.

Deputy John Lahart: I wish the HSE well with the supply. I refer to antigen testing in meat plants. Mr. Reid said in a recent interview that there was some testing - not antigen testing - going on in meat plants. Could he develop and quantify that and say a bit more about antigen testing?

Mr. Paul Reid: I will ask Ms Niamh O'Beirne to comment.

Ms Niamh O'Beirne: We have done testing in meat plants for many months. We have carried out over 100,000 tests. We go to each meat plant once a month for PCR testing. We did a validation study for antigen tests with over 7,500 tests in meat plants, in conjunction with the Department of Agriculture, Food and the Marine. At this juncture, we are working with the Department which wishes to supply food businesses with antigen tests for twice weekly testing. Our agreement with the Department is that under its governance it will do that and continue to support the PCR testing run through the HSE. There is a combination of antigen and PCR testing.

Deputy John Lahart: Has the HSE visited every meat plant?

Ms Niamh O'Beirne: We visit 85 plants once a month.

Deputy John Lahart: Out of how many?

Ms Niamh O'Beirne: All of our meat plants are covered within that. There are other businesses on the list.

Deputy John Lahart: If I have heard Ms O'Beirne correctly, the HSE has visited every meat plant once a month at this stage and twice weekly testing is coming on stream in terms of antigen testing.

Dr. Lorraine Doherty: That is correct.

Deputy John Lahart: Does Dr. Doherty know when that might commence?

Mr. Paul Reid: Dr. Doherty is leading this programme.

Dr. Lorraine Doherty: I thank the Deputy for his question. I and a colleague have chaired a group which is examining the validation of antigen tests in a range of settings in the country, one of which is meat plants. We have worked with the Department of Agriculture, Food and the Marine. We have now validated one test that can be used in that setting. What we must understand about rapid antigen testing is that it is not rapid and it is quite resource intensive. Twice weekly testing in meat plants would require a dedicated resource. Alongside that, the performance of these tests is not that good for asymptomatic people when the prevalence of infection starts to fall as is happening now. We are keeping our overall approach with regard to antigen testing in the sector under review.

Mr. Paul Reid: In case my colleagues did not cover it, the positivity rate of serial testing in meat plants was about 0.6%-----

Dr. Lorraine Doherty: In the latest round.

Mr. Paul Reid: -----in the latest round of testing.

Deputy Róisín Shortall: I welcome Mr. Reid and thank him for his presentation. I thank him and his colleagues for their ongoing work. I have a number of questions which will require short answers.

I refer to data generally. I appeal to Mr. Reid to provide more figures on a regular basis. It is difficult because every week health spokespersons need to ask the Minister for information, and we repeat the requests here. I will preface my remarks by saying that everybody understands that there are supply issues and the supply is volatile, but it is important that we get data on the factual situation. I am talking about the actual number of deliveries that have arrived here. I am not looking for forecasts or projections, but rather the actual figures.

We now have daily figures for the number of vaccines. We have sought daily figures for the number of vaccines that arrive in this country. The Minister agreed last week that there would be weekly updates on the number of vaccines that arrive in this country. I want to check with Mr. Reid whether those weekly figures will be available on the data hub and that we will not have to plead for them to be made available? They should be published daily, or at least weekly as a start. I ask Mr. Reid to clarify that will be the case.

My next question relates to Moderna. The official figures as of the end of February state 40,800 doses of Moderna have arrived in this country. As of 28 February, the official figures state that 8,630 doses were administered. What is the reason for the very substantial gap between the number of vaccines that have arrived and the number administered?

On messaging and what the HSE is intending to do, it is important that it is a bit more specific because my concern is that people's expectations are being raised by the kind of general messaging that is going on. For example, three weeks ago it was announced that all those aged over 70 would receive the vaccine and that that task was starting. It was not made clear to people that there were sub-categories within that. We are now just getting to the point of finishing the over-85 cohort. It will be a few weeks before people in their early 70s are vaccinated. It would be better if we were told the HSE was starting with those aged over 85 and then moving onto those aged between 80 and 85. It would give people some idea of when they could expect to get their vaccines.

The point applies to cohort 4, people at very high risk. My understanding is that there are about 160,000 people in that category. It has been stated that this week 10,000 will be vaccinated. It will be some time before everybody in that category is done. The message should be clearer in regard to the period of time involved in vaccinating that cohort.

I have a question on the plan for the mass vaccination programme. At the moment the average daily number of vaccines being administered is 12,500. If we are to use the full expected supply for the second quarter, that will have to be ramped up to about 40,000 per day, which is a massive increase. Mr. Reid gave various figures earlier in response to the first questioner. Does the HSE intend to publish the plan for the mass vaccination programme? We know there are 37 centres, and have talked about 10,000 people being trained and 2,200 being recruited. When will we actually see the plan? When is it intended to publish it?

My final question relates to tracing. What percentage of people are being back-traced seven or 14 days to find out where the virus is being transmitted?

Mr. Paul Reid: I thank the Deputy for her questions and comments. On the first issue of data and data availability and what the Minister committed to, I will pick up this issue with the

high-level task force which has the data. We are working towards deliveries that we get. On the production of data, I am more than happy to work with the task force to provide whatever the Minister committed to.

On data overall, the Deputy will note as we progress that one of the work streams has been specifically focused on reporting and data to utilise the data that we have.

Deputy Róisín Shortall: It would be good to share that data. As a standard, it should be uploaded to the data hub every week. I would like to see that done daily, but at least weekly.

Mr. Paul Reid: I am trying to share with the Deputy the data that we foresee becoming available. We will see more data on the individual cohorts vaccinated, the percentage of the cohorts vaccinated and, as we progress, on effectiveness. We have a particular workstream in that regard but it is not finalised just yet. I reassure the Deputy that we now putting all of the data into a single data lake. All of the data that we have from testing and tracing and the vaccination programme are being recorded in the same data lake and so we will be in a stronger position to produce more data as we go along.

The Deputy's second question was in regard to an update on the Moderna vaccine, the delivery schedule and the difference between the gap. I will make two points. I am working off the top of my head but I think the last delivery up to last week was about 42,500. Of that, 1,800 were used for GPs for the initial vaccination programme, which equates to 3,600 in terms of two doses. A further 12,500 were immediately distributed to GPs to help them with some of the more difficult clients they had to get to. They will be utilising that supply. The difference between the Moderna vaccine and the others is that we have to keep a one-for-one distribution in the fridge in our central cold chain storage. For every one we distribute for vaccination, we have to keep a second. That is based on supplier recommendations and guidelines. It is different because of the buffer in any given week. By way of description, a buffer in any given week is a combination of the Pfizer-BioNtech supply that we propose to use for vaccination the following week and whatever distribution we have given out in total for Moderna to be vaccinated. It is slightly different; it is an extra requirement to be held back.

Deputy Róisín Shortall: I appreciate that but the figures as of the end of February show that less than one-quarter of the Moderna supply had been administered. That should be 50% rather than 25%.

Mr. Paul Reid: The difference being that 12,500 were distributed to GPs, which is the equivalent of 25,000 because a further 12,500 has to be kept back. A further 6,000 were distributed last week to GPs and that requires another 6,000 to be held back in the fridge. The Moderna vaccines will be administered through GPs, working through the 80 to 84 year olds.

On the question around messaging for the over 70 and 85 year olds, the Deputy is correct that we are aiming to get through first vaccination of all of the over 70s before the middle of April, with the second vaccination to be completed before the middle of May. We have started doing that on an incremental basis. I fully accept what the Deputy says in terms of expectation. We have gone out fairly regularly and announced what group we were doing next and what numbers were in each group. The figure for the 85 to 90 age group was 72,500. The figure for the group we are progressing through now, which is the 80 to 84 year olds, is 90,000. We know there are 72,500 in the 85 plus age group and we have probably done over 96,000 of those aged 70 and over. GPs are administering some vaccines to the 80 to 85 year olds this week, as they did for some in the previous week, but in the case of a person in the 80 to 84 year old category

whose husband, wife or partner is, for example, 87 years old where there are potential extra doses available they have the facility to vaccinate in parallel. As we move through the other cohorts, that will happen as well. I take on board the Deputy's comments.

On the question regarding cohort 4, before I ask my colleague, Dr. Henry, to respond, I would like to make two brief points. The advice from the national immunisation advisory committee remains that age is the priority for vaccination. We should continue with our vaccination programme until we get through all of those aged 70 years and over. Cohort 4 is in sequencing after we get to all of those. However, we are very conscious of the medically vulnerable and we are anxious to get to them as soon as we can. The 10,000 figure is just to start the process this week, while we are analysing the data on which Dr. Henry will elaborate for the Deputy.

Deputy Róisín Shortall: Can Mr. Reid give a rough estimate of when cohort 4 might be vaccinated?

Chairman: The Deputy has gone over time. I ask her to allow Mr. Reid and Dr. Henry to respond to her questions as I need to move on.

Mr. Paul Reid: On the 40,000, I am happy to go through it again but the response is similar to the response to the initial question in regard to mobilisation. I am happy to come back to it when Dr. Henry and Ms O'Beirne have responded to the questions on the percentage of people and the testing.

Dr. Colm Henry: As the Deputy says, this group, who are at very high risk of serious illness, hospitalisation or death, comprises approximately 160,000 and multiple different disease cohorts. I have spoken to Professor Karina Butler about this on many occasions. They are all of approximate equal risk and so in terms of risk we do not propose to create any internal hierarchy among this group. What we are doing initially is vaccinating those we can get to quickest. In parallel with this, we are working up lists of the accessible patients with cancer, kidney disease and those on immunosuppressant medication. These are the patients we can get to more quickly than others who are more disparate throughout community and hospital services. In response to the Deputy's question, we expect this to go right through the month of March based on the anticipated numbers, while at the time same ensuring we identify everybody who is intended to be covered from within a group described by NIAC.

Deputy Róisín Shortall: Dr. Henry says it will continue through the month of March for 160,000 people. That is ambitious.

Dr. Colm Henry: It is. I believe the project will go beyond that because there will be patients coming on to these lists, particularly patients with cancer and renal disease. As people, unfortunately, are acquiring these diseases all of the time, I expect it will be an ongoing project even when we cover the majority of these patients. Our aim is to get the substantive majority of them vaccinated throughout the month of March, but the Deputy is correct that this process may continue into the month of April. We must ensure that we cover as many as possible or as are intended according to the NIAC list, which are not always easy to source because they are not accessible within any one registry or specialty.

Mr. Paul Reid: I would like to make a final comment following on from what Dr. Henry said. Identification of this cohort will continue throughout March. It is a matter of supply. We also have to use our supply to vaccinate those aged 70 years and over. It is not simply a case of identifying them; it is a supply issue as well.

Ms Niamh O'Beirne: On the question regarding source investigation, in roughly 80% of cases the source is known. This is shown in current data. As we are now steadily under 600 new cases per day, we intend to introduce a new call for routine cases to go back to the individual with some further questions.

Deputy Róisín Shortall: Is there back-tracing with cases in relation to seven or 14 days?

Ms Niamh O'Beirne: The public health departments do that. We have started that in Cork, where there has been a review of seven days and reduced the number in relation to community transmission as they found when speaking to cases that more of them were contacts of confirmed cases. It is being rolled out as capacity allows. As we get lower in the case numbers, we will do it on a routine basis across all of the 20% of cases that are currently in community transmission.

Mr. Paul Reid: With the permission of the Chairman, Dr. Lorraine Doherty will provide some extra information, particularly on variants in respect of which we go back further and generally.

Dr. Lorraine Doherty: I will give a brief update on variants. We are closely monitoring these in the country now. To date, we have identified 15 cases of the South African variant and three cases of the Brazilian variant.

When we identify a variant of concern - these are defined by World Health Organization classifications - we undertake an enhanced process of contact management. The case itself has to isolate for 14 days. We test it twice. Such cases are very strictly isolating. We test their contacts and the contacts of contacts are actively followed up and have to isolate. Therefore, there is a much enhanced process of contact management around these cases and an enhanced data set collected because, most importantly, we need to try to identify the source of transmission for these infections and whether or not they are travel related. That is an accepted process that is in place across the country now in all public health departments and we bring a weekly report to NPHET on the variants of concern that we are investigating.

Deputy Róisín Shortall: Can that report be made public?

Chairman: I need to move on to the next questioner. We are way over the time. Deputy Gino Kenny is next.

Deputy Gino Kenny: I thank the HSE delegation for its statement this morning. I have two questions.

The first question is in regard to workplace transmissions. SIPTU made a statement last week that serial testing in meat processing plants has been reduced in recent times. My experience with the Health and Safety Authority, HSA, in regard to workplace manifestations has been, to say the least, quite haphazard. I understand the HSE's remit does not cover the HSA. How is the HSE co-ordinating communication and the strategy of crushing the virus in workplace manifestations because it has been a serious issue from day one? The witnesses might answer that question about the strategy of the HSA and the HSE.

Ms Niamh O'Beirne: I will take the first part of that question and clarify an earlier point. We go into 85 plants every week to do serial testing where we have very strong support from the employers and staff to show up for monthly PCR testing. We go to meat plants with more than 50 staff. That has been going on now for a number of months and we have not amended that

programme as of yet. It tends to be enhanced by additional antigen testing going on a number of times per week and those supplies of antigen testing have been handed to the Department of Agriculture, Food and the Marine for onward dissemination.

Dr. Lorraine Doherty: Deputy Gino Kenny will be aware that there have been a lot of outbreaks associated with both meat plants and other industries, such as the construction industry and the food industry. We recognised this quite early on last year and we established a national standing oversight committee to work with the industry and the HSE in regard to these outbreaks. A number of approaches were taken to developing new communications materials and new guidance for the sector. Alongside that, we have an active surveillance programme for infections across all of these sectors. Each of our public health departments plays a key role in working with the individual premises when they have cases, in terms of doing a public health risk assessment, determining the need for any additional control measures, following up of contacts, appropriate isolation of cases and, most importantly, constant reinforcement of the prevention messages that need to be applied in the workplace quite rigorously, and that message has to be consistently reiterated and communicated to staff and management in these facilities.

Deputy Gino Kenny: My second question is in regard to the administration of the vaccine. I refer to the rate of hourly pay to those who are administering the vaccine. According to what I have in front of me, GPs administering the vaccine will get €120 per hour, pharmacists will get €70 per hour, nurses will get €25 per hour and student nurses on placements in vaccination centres administering the vaccine will get nothing. That seems unfair. Could somebody explain why there is such a disparity between healthcare professionals getting, at one end of the scale, €120, and somebody as a student nurse getting nothing?

Mr. Paul Reid: I thank the Deputy for his question and I am happy to address it. First of all, the matter of pay and pay policy is a matter for Government and the Department which ultimately determine the pay policy for the vaccination programme and pay policy overall. From our perspective, the different pay arrangements are acknowledgement of various different agreements and different professions. In the context of GPs and, similarly, in terms of some pharmacists as well, one is in essence dealing with sole traders. As one goes into different grades, there is a standardised grade agreed at the departmental level around the vaccination programme that we are recruiting for at present which is in the range between €35,000 and €50,000. That arrangement is in place. The point on scale will determine, based on experience, etc. It is a function of various different pay arrangements and agreements with various different professional grades associated with it.

Deputy Gino Kenny: My last question is in regard to the interns or trainee doctors. I understand 300 will be let go. Senator Kyne touched on that at the beginning. Many people probably do not understand how interns in the Irish public health service who are badly needed are in essence now being let go. It does not make sense, particularly as we need as many doctors now as possible in the pandemic. Could somebody comment on the situation around the interns?

Dr. Colm Henry: I thank the Deputy. I want to acknowledge the huge role that interns and junior doctors have played in the pandemic. In the three surges in the past year, they were true front-line workers and they contributed hugely to our response in the hospital system. Interns are trainee doctors in the sense they have got their medical degree and they complete this year under the supervision of a network of medical schools in the hospital system with a designated trainer before they get full registration when they qualify and then go on to training schemes, be it in general practice or in hospitals. We cannot look at the numbers of interns we create

in isolation. We are moving from a system where we know we have too many non-training hospital doctors. We want to move to a system where we have training opportunities for these interns so that the numbers who come through the intern year could then access what is basic specialty training, BST, then higher specialist training and then, in good manpower planning, can progress in their careers to become either general practitioners, public health or hospital-based consultants. In looking at the number, it is not just a question of dealing in isolation with what is right or good for one group of a workforce alone. It is how it integrates with other training requirements as they go on.

As I say, we are reviewing the quality and the configuration of the existing intern posts affiliated to the six medical schools and part of this will be looking at the number and seeing if we can increase the number in line with increased training opportunities. On that point, last year we increased the number of training places, not only the intern places, in response to the crisis and we created additional fellowship posts to enable our trainees, not only interns or senior house officers, SHOs, as specialist registrars, to stay in Ireland beyond being an intern here. We created additional training posts in public health, general practice, anaesthesia and other critical core specialties in response to the crisis and, as I said, additional fellowship posts which allowed them to complete higher specialist training here too.

Deputy Gino Kenny: I thank Dr. Henry.

Senator Martin Conway: I, too, commend the HSE and the team - Mr. Reid, Dr. Henry and others - on their clear communication. They are readily available and that is important in terms of retaining public confidence.

In terms of the vaccine programme, we all know that there are issues. There were always going to be challenges and difficulties. However, I would like to focus on the healthcare portal. I would like some facts and figures. How many healthcare staff are now registered on the portal? How many have got vaccines and how many are waiting to get vaccines? I understand staff in the blood board in the mid-west, for example, in County Clare, have got their appointments for vaccinations but in Limerick, they have not. The HSE might just give us some quick figures on that.

Mr. Paul Reid: I might refer the Senator to my colleague, Mr. McCallion, for up-to-date figures, particularly for healthcare workers registered and vaccinated, because we have it online.

Mr. Damien McCallion: We are at cohort two of healthcare workers. The estimated size of the cohort is approximately 200,000. As of Sunday, we had 174,000 on dose one and 84,000 on dose two. We have seen an increase in registrations from the private sector in the past week. That is a good thing and we anticipate that will run on for another week based on those numbers as well so we would expect to exceed the cohort size. The Senator will appreciate that is just an estimate for the private system While we have a good handle on the public system the private system is still there. People are being pulled off the portal by the local vaccination centres on a prioritised basis; that is how the function works. However, with the numbers at the moment, as I said, close to-----

Senator Martin Conway: Regarding the Irish Blood Transfusion Service nationally, these are people who are out taking donations of blood to keep the structure going. Are many of them still waiting to be vaccinated?

Mr. Damien McCallion: I cannot give the Senator a detailed number on that. However, front-line workers, predominantly, are picked up in this cohort so if they are in that, we could look at the blood bank to see the numbers but I do not have them to hand.

Senator Martin Conway: Returning to Mr. Reid, at the very start of the vaccination programme, there was a lot of need in the mid-west. University of Limerick, UL, Hospitals Group was only issued with something like 3,400 doses of the vaccine whereas the south west group, for example, received 19,000. Is there any explanation for such a difference? It was definitely perceived as unfair. This was at the very start so the cohort consisted of healthcare workers, essentially.

Mr. Paul Reid: I think the Senator is going back to the very first weekend or week. There was huge angst at that stage over who got what. To explain, two things were happening that week. One was that we had received our first deliveries. From 26 December we were distributing them across hospital groups. Some hospital groups were mobilising, getting ready and getting their vaccinators ready and we had planned the deployment to them in that first week in January. The South/Southwest Hospital Group started with an initial phase on that weekend, for us and with us, and the group vaccinated, in fairness to it, was not just its own healthcare staff but GP communities as well. There was just a very short period where one would have seen that disproportionate number but it was not just the South/Southwest Hospital Group doing its own teams; it was vaccinating some other healthcare workers as well. Then the following week when University Hospital Limerick was up and running, that balanced itself out.

Senator Martin Conway: My concern is when this is ramped up, fairness and equity of access is going to be a big issue. Has the HSE processes in place to make sure there is a fair distribution of vaccines to the 40 centres? Has it advanced plans in that regard so we do not hear that certain parts of the country are getting inoculated far quicker and to a far greater extent than others?

Mr. Paul Reid: The Senator is right. The strongest feedback coming from any surveys is that from the public's perspective, fairness is the top factor they are concerned about. As we distribute, the portal, as Mr. McCallion touched on, is the key mechanism for us to have uploaded the next groups of people we are vaccinating, whether it is in this case healthcare workers or others and that is the way we are arranging it. It is similar with GPs. For example, this week we know the supply level we have does not meed the immediate requirement of GPs and we know that upfront just based on supply. We are distributing based on equity and proportion this week for GPs as they move into the 80 to 84 age group. That will be a continuing principle.

Senator Martin Conway: One sees stories like that of Sneem last week and while it is great for the people of that town, it gets everyone else's back up. I am very much supportive of the work of the HSE. It is doing as good a job as it can under the circumstances but we must ensure those type of situations do not happen. I presume there are not too many Sneems around the country.

Mr. Damien McCallion: I will come in there. With regard to GPs, it is, as Mr. Reid said, based on demand and then there is a principle of equity. There are some practical issues with the vaccines in terms of numbers that must be given in that there is a minimum. In some instances that results in some of the smaller practices perhaps getting a slightly larger number and hence being able to do a larger number of patients. However, it is very much balanced on demand and then the principle of equity across the distribution to GPs and that model will continue into the mass vaccination centres as well.

Senator Martin Conway: My final question is on group 4. I get the debate about carers looking to be vaccinated and understand why that cannot happen but we need much clearer timelines and information for the people in group 4. People also need to know how they are going to be contacted because at the moment they do not know whether it is going to be by their GP or the healthcare setting or the service they are part of. What plans has the HSE to get further clarity on group 4, which is starting this week?

Mr. Paul Reid: Dr. Henry might respond to that question.

Dr. Colm Henry: As I said earlier in reply to Deputy Shortall, we are in the first instance vaccinating those who are most easily identifiable. The Senator is correct that people are out there wondering whether they are on the list or whether they are eligible. We will contact patients, either through hospital networks or primary care networks, as we go through this quite complex group of patients with specific clinical criteria. That messaging is going out. We have spoken to some of the advocacy societies, including the Irish Kidney Association, Irish Cancer Society and clinical groupings. For anyone listening today and through our communications we will make it clear we will contact people either through hospital networks or through their GPs.

Senator Martin Conway: I thank Dr. Henry.

Senator Annie Hoey: I thank the HSE representatives for everything they have said. I have three questions. GPs to whom I have spoken in the past week have been a bit frustrated with some poor communications. When they called the dedicated call centre, they were speaking to people who did not have the information they needed to hand. This included information such as whether their order had been received or when exactly it would arrive. Has this system changed? The HSE will appreciate that there needs to be clear communication on vaccine delivery when dealing with older, less mobile patients. I am, therefore, wondering has there been a change in communications processes or whether anything has been done on that.

Mr. Paul Reid: I am not sure if the Senator heard what was said earlier on so I will try to be very brief. While acknowledging some of the issues that emerged last week, in fairness, relative to the almost 1,350 practices we have been working with over the three weeks, it was a smaller number of GPs who had issues but I acknowledge they have had them.

To respond to the Senator's specific question, the particular changes we have put in place include a new support centre we have put in place for GPs. As part of that, GPs from 1,350 practices will have dedicated account managers or relationship managers. Separately, we have put in a new communications process whereby there will be a weekly bulletin going out to GPs that will clarify the availability of supplies for the following week. This week, for example, communications went out to GPs on Saturday night to set out that the available quantity of vaccines next week would be 37,000. Based on all the numbers they returned to us of the 80 to 84 year-old groupings, we feel it is about 15% less than they may have listed because that is the supply we have for that week. I, therefore, expect it is giving them greater clarity in terms of planning for those vaccinations. Again, this is on the principle of equity in distribution.

There are new support centres, new weekly communications and new relationship managers. We have had three weeks of that programme, we have vaccinated more than 96,000 people who are mostly over the age of 80 and we have worked with 1,350 practices. The vast majority of those have gone according to plan but there were issues last week, which we have addressed and will continuously monitor.

Senator Annie Hoey: I thank Mr. Reid. I have two quick questions arising from a GP with whom I spoke. The GP in question expressed worries about the pace of the roll-out. I understand that issues completely outside of our guests' control mean that the vaccination programme is going at a slower place than we hoped. The GP is worried that the virus will mutate to a point where the vulnerable people who have already been vaccinated will have to be vaccinated again relatively quickly because of the slow speed of the roll-out. I am not a specialist in this area and my questions are a result of the person to whom I was talking. That person said that the whole point is to get as many people vaccinated as quickly as possible to slow down mutations. Does Mr. Reid have any comment to make on that? Will there be any impact because of the slow rate here? Is the person who spoke to me expressing unfounded concerns?

Mr. Paul Reid: I made the point earlier that the issue of delivering the vaccine in an efficient way is a key priority for all of us. We would rate highly in European terms for our administration of vaccines per hundred thousand of population based on the level of supply. We also rate highly on the distribution and administration of those vaccines. Some 95% or more of any vaccines we get in a given week are administered within that week and, in some cases, within three days. That is at a high level.

The approach we have taken to vaccinating, based on medical guidance from the national immunisation advisory committee, NIAC, has been specifically to address the most vulnerable. If one takes, for example, long-term care facilities or nursing homes, practically all of the residents and staff of nursing homes have received both doses of the vaccine, with the exception of a tiny few with a level of sickness that means we will have to go back to them. The vast majority of residents of long-term care facilities, more than 90,000 people, will have received their first doses of the vaccine by the end of this week. That is a highly vulnerable group in terms of impacts that include death and mortality.

The situation is similar for addressing front-line healthcare workers who are also highly vulnerable. We are vaccinating the over-70s who are living in the community. We are seeing a benefit from the approach we are taking. We are, thankfully, seeing reductions in mortality, infection rates in nursing homes, outbreaks in healthcare settings, the levels of sickness among the elderly population and the levels of sickness and absences from work through Covid infection among our healthcare workers. Transmission levels have collapsed in the past four to six weeks as a result of the vaccination programme. We are seeing strong benefits to date from the programme based on the prioritisation approach. It is the right approach.

To return to the nub of the Senator's question, the pace of the roll-out will be a function of supply, which is currently the constraining factor when we consider how much quicker we might go. That is part of our mobilisation plan for April onwards.

Senator Annie Hoey: Does Mr. Reid have no concerns that the pace of the vaccine roll-out will have a knock-on impact, as the GP told me? I am not a specialist in this area.

Mr. Paul Reid: I will ask Dr. Colm Henry to come in.

Dr. Colm Henry: Real-world experience in other countries, such as a report that came from Scotland, shows positive evidence. Scotland has a high level of the B117 mutation, which is also now the predominant mutation in this country. That report showed reduced hospitalisation with serious illness after the administration of the first doses of the Pfizer BioNTech and AstraZeneca vaccines, including among older cohorts. There is, of course, concern that immune evasion may happen if certain mutations get a stronger footing. The mutations that are shared

among some of the variants may render the vaccine less effective. However, based on two of the vaccines that have been tested, namely, Johnson & Johnson and Novavax, we see reduced but still strong efficacy. The vaccines still have a particularly strong impact on reducing serious illness and hospitalisation. While there may be a reduced effect, it does not mean there is no effect and it seems so far that, even with mutations, the more serious manifestations of the illness are prevented.

Mr. Paul Reid: I will add a couple of things because it is important that we continuously reassure the public and build their confidence at every opportunity. I will stand back from it all and give the Senator some facts. Transmission, mortality, sickness and hospitalisation levels are down. The numbers in intensive care units, ICUs, are, thankfully, down. We know that those reductions are also a function of what is happening in the community. Hospital-acquired infections are significantly down. Serial testing in nursing homes show an infection rate that is now down to 0.2%. That is a function of both reduced community transmission and the vaccination programme. The percentage of cases of Covid in healthcare workers in the first week of this year was at 16%. That figure is now down to approximately 4%. There were more than 3,600 Covid cases among healthcare workers in the first week of the year and that is significantly down to approximately 300 cases or fewer. Those are positive impacts of the approach we are taking.

Senator Annie Hoey: Do I have time for one quick question about the numbers?

Chairman: Go ahead.

Senator Annie Hoey: I want to follow up on the issue of the intern programmes being cut by 350 places. Dr. Henry said that a number of additional posts and fellowships have been created. What is the difference in those numbers? While 350 posts have been cut, what is the increase in other posts? In order to figure out the difference, we can subtract that number from 350 so we know how many intern places have, effectively, been cut.

Dr. Colm Henry: I gave those figures earlier. The normal number of places is 734. As a once-off, positions were offered to 1,100 medical students who were qualifying last year, a significant number of whom turned down the offer, so the final number who took up a position was 992. In the intervening period, we have increased the number of trainees and the opportunities for interns who have finished their intern year to stay in Ireland and get a training scheme, particularly in some of the core specialties. We have also created a number of fellowships for higher training. We introduced an overlap last year because people who qualified began work on 25 May, rather than in July, and we plan to maintain that overlap this year. As I said earlier in response to questions from another committee member, we cannot look at the number of interns in isolation from the availability of training places for them to proceed to after they have completed their intern year.

Deputy Bernard J. Durkan: I welcome the information given to the committee by Mr. Reid and his colleagues. I congratulate them all, particularly those on the front line, on the dramatic reduction in the incidence of the virus and the brilliant fight against the disease, very often while facing criticism from many quarters. It is like working in a goldfish bowl and everybody has an answer. Those at the centre have to do the work and I congratulate everybody involved. It has been a tremendous example of what can be done.

From here on in, the crucial issue will be the extent to which vaccines remain available to this country. Can we be assured that it will not be necessary for our guests to review their pro-

jections? When expectations are reviewed downwards, it is disappointing to the general public, although understandable. Such a review may be caused by a lack of supply and that does not resonate all that well with the public.

Mr. Paul Reid: I thank the Deputy for his opening comments. He mentioned fighting against the disease overall. We in the HSE would also like to reflect on why we are seeing positive benefits of the vaccine and its impact. There are still strong levels of concern about the positivity rate, the level of transmission and the impact of the B117 strain on transmission rates. Approximately 27% of close contacts of an infected person are testing positive and, in the case of a household, that figure is close to 35%. I want to make sure that we do justice to the fact that we are still living with a real threat at the moment. On the supply issue, I want to reassure all Deputies and Senators that I am aware the Department and Government officials are doing everything possible. Interventions at EU level at the early stage by the officials and An Taoiseach did address some of the impacts we thought were going to come at us. I know they are working quite hard and relentlessly every day on the supply. We fully appreciate what the Deputy has said and that as we have to readjust, particularly with the readjustments downwards, there is a huge level of frustration because everybody wants the vaccine and wants it quickly.

As I said earlier, we expect the reliability of delivery to strengthen in the coming weeks, especially as we head towards April. Potentially, as other vaccines come on board and on stream that should help us too. We acknowledge that this quarter has been a difficult period.

Deputy Bernard J. Durkan: Can the HSE do anything about the doubt over the constant supply? Is there anything we can do about that? Can the Government, for example, negotiate with alternative suppliers? This is, apparently, being done in other cases. Could we see what might happen there? Confidence in the system is hugely important from the HSE's point of view and that of the general public. If we cannot rely on a constant supply what can we do to try to do that?

Mr. Paul Reid: To answer the question again, and I may have said it to one of the Deputy's colleagues, from a policy perspective it is for Department officials to advise the Minister and the Government on policy. That would be the route for any change to policy. Having said that, when the EU process for the advance purchase agreements that we have all signed up to comes through, it will give us a pipeline of almost €18 million of vaccines across a range of suppliers. The issue of stability of those suppliers, however, and the timing of those supplies has definitely been a feature of the first quarter. Should the Government decide to change its approach and work through a different process, that would be a policy decision for the Government. The EU process overall, while not specifically related to this issue, has served Ireland very well, and has served the HSE very well, with drugs, medical devices, drug supplies, availability and price. The decision such as the Deputy has asked about is a policy matter for the Government.

Deputy Bernard J. Durkan: One of the things that comes to mind is that the general public will say "Well, okay, what are we doing if we have an insecure supply and how do we counter that?" How do we make our feelings known to the suppliers? How tight is the contract? How binding is the contract? Can we have the contract reviewed or can we have it reviewed to our advantage? The supply is essential to the success of the vaccination campaign.

Mr. Paul Reid: The Deputy is making very strong and clear points, which I cannot disagree with. I reassure the Deputy that at every stage where we become aware of or gain any foresight into supply line issues they are taken up by Department officials quite directly through EU levels and directly with suppliers through the high-level task force. We have ongoing regular

engagement with suppliers directly. I can reassure members that any time we have raised issues at a Government level there have been escalations with senior Ministers and the Taoiseach at EU level to strengthen the levels of predictability and reliability. It is a function of what is happening worldwide and certainly what is happening in the EU on the supply level.

Deputy Bernard J. Durkan: Before I move on to the next question, which relates to a different aspect, there seems to be no arbitrator for what should be done in the event of a supplier saying it cannot deliver. That completely changes the HSE's own predictions for the roll-out of the vaccine. A number of instances of that nature will, ultimately, undermine public confidence in the system that Mr. Reid is working so hard to promote. How vigorously do we deal with the suppliers who cannot supply with regard to contacts and so on? Do we pursue vigorously enough to be able to convince them that it is not such a good idea?

Mr. Paul Reid: The direct engagements happen between Department officials at supplier level and at EU level, sometimes with the high-level task force. I can reassure the Deputy that in the context of AstraZeneca, delivery of which has been significantly impacted in the past couple of weeks, a very strong level of engagement happens regularly. Thankfully, it has recently put in place a country manager to manage the Irish relationship, which we welcome. In fairness to the likes of Pfizer BioNTech we have had stable supplies from it and it has a dedicated company and country manager here who, by coincidence, happens to be named Paul Reid also. We engage with them directly and regularly. That supply level has been stable, with one exception earlier on and we would hope to see that continue.

On the Deputy's question about the contract and arbitration, contract negotiations happen at an EU level. Again, this is something the Government has escalated. I am aware that the Taoiseach has raised the issue regularly at EU Council meetings, up to and including quite recently. These are matters on which the Government will intervene.

Deputy Bernard J. Durkan: I thank Mr. Reid. I ask the Chairman not to forget to remind me when I am running out of time.

Chairman: The Deputy has run out of time but he can have one last question.

Deputy Bernard J. Durkan: My last question relates to GP practices. I have come across some cases where the supply issued all right but some of the attendant documentation did not, such as the relevant GP reference numbers, especially where GPs have public and private practices. Has this been addressed? Can it be addressed to be more efficient to get the fastest possible kick-off in every case?

Mr. Paul Reid: I will restate some of my comments that across all of the 1,350 GP practices we have worked quite extensively with, the first two weeks went extremely well with the suppliers, the deliverables and the consumables. In the third week, which was last week, across a smaller number of GP practices we fully acknowledge that there were issues not just in the smaller practices but also in the bigger practices. We have put in place a whole range of supports to address that. There is more engagement directly to the contact centre with more weekly bulletins to go out to them. There is more clarity on what they can expect and on what days. Where issues have emerged when consumables do not arrive in a timely fashion we are addressing this also. There have been a number of issues but overall, of the 90,000 people who have been vaccinated in the over-80s and over-70s age groups across 1,350 GP practices, it has gone really well. We acknowledge there were issues last week across a number of practices. We have put in a whole set of arrangements to strengthen that process and we will move on.

Deputy Bernard J. Durkan: I thank Mr. Reid.

Chairman: Before Mr. Reid moves on from the vaccine issues, has there been any discussion around producing these vaccines in Ireland? Some other European countries have gone down that road.

Mr. Paul Reid: I am aware that there has been some assessment to see if it would be possible or feasible, primarily through IDA Ireland. I do not believe it is possible, from what we know and understand right now. From my previous role in local authorities I am aware that the requirements for pharmaceutical companies are quite specific around capacity and equipment to develop different vaccines. Vaccines and drug development can take some time to recalibrate. I understand there has been some engagement to see the feasibility but it is not our strongest possibility.

Deputy Cathal Crowe: I confirm at the outset that I am in the precincts of Leinster House.

I have a number of questions for Mr. Reid. I am sure that Mr. Reid has had many questions this morning from Deputies and Senators around the State about vaccine roll-out. In Clare we have seen strident improvements. A lot of people have been vaccinated since. There are fabulous examples, such as Sixmilebridge last weekend, where the local GP was out with representatives from the GAA club. They were funnelling people through, vaccinating them and getting them home safely. We have had other examples in parts of west Clare where vaccines are only arriving today. Certainly the cogs in the system are well oiled in some places but there are instances where it has been dropped.

At a recent meeting of the committee I highlighted there had been missing links with regard to HSE staff. The mental health nurses at Ennis General Hospital had not been vaccinated but administrative staff were being vaccinated. In some cases, it has gone beyond vaccinating cohort 2. I was told something yesterday that I wish to substantiate with the witnesses. Is it true that HSE staff working from home and not on the front line are being vaccinated along with their front-line colleagues? I ask Mr Reid to verify this or dismiss it.

Mr. Paul Reid: I thank the Deputy. I would like to stand back for a second and come to the question. Overall, the prioritisation and the sequencing in the vaccination programme have gone really well. There have been exceptions and some were reported in the first few weeks. It is very frustrating for us, and me, when exceptions happen and somebody is vaccinated out of sequence because it causes a lot of angst. I do not support any occasion where such things happen. We do have flexibility in the system, and we have given guidance through the chief clinical officer where vaccination programmes are being carried out. These are very precious vaccines, particularly the mRNA vaccines, with regard to logistics, supply and being utilised within the time limit. We have provided flexibility within the system to have a back-up list in case there are extra doses in vials to ensure not one dose is wasted. There are some legitimate reasons where people have gone through the process and other people have been vaccinated, who would eventually come forward in cohort prioritisation. It is also frustrating for us where it happens out of sequence.

Deputy Cathal Crowe: May I ask whether staff working remotely are within the same prioritisation? Will Mr. Reid confirm this?

Mr. Paul Reid: If staff are within the definition of front-line healthcare workers. I am not aware of the specific instance referenced by Deputy Crowe with regard to people working from

home. If the indications are that they would be needed for certain activities as front-line workers then they would be legitimately vaccinated.

Deputy Cathal Crowe: Okay.

Mr. Paul Reid: It should not be a process of vaccinating somebody who is not a priority.

Deputy Cathal Crowe: I want to ask about something that has been a feature in the mid-west region in recent weeks. The new 60 bed block in University Hospital Limerick has opened and it is great to see it. It is alleviating some of the pressure in the hospital. A key issue raised with me by patients and some staff is that there is no discharge co-ordinator in the new block. During peak Covid when patients are well enough to go home or leave the hospital environment they may need support from public health nurses and their local health centre but there is no discharge co-ordinator to put such a plan in place. People are being moved home from a hospital environment in a taxi, car or sometimes an ambulance with no plan in place. Mr. Reid may not have the answer today but I implore him, as the helmsman of the HSE, to ensure this key appointment is made to ensure it works smoothly. Is Mr. Reid aware of this issue? He may not be but I ask him to respond briefly.

Mr. Paul Reid: I am not aware of the specific case, as the Deputy will appreciate, but I will say a couple of things. The Deputy is right that University Hospital Limerick has had well-deserved investment in extra beds and blocks, which has proven beneficial. With regard to the hospital, and overall, the investment plan we had for winter incorporated some of the issues raised by the Deputy. We had a significant investment plan of €600 million. This may not have always been seen or understood, or perhaps we did not communicate it, but if we look at what happened throughout the hospital system over winter we saw reduced numbers of emergency department admissions and attendances of probably 10% versus last year. However, we also saw an average of a 72% to 75% reduction in trolleys. It is not just about reduced numbers. It has been about improved flow through. Some of this flow through has specifically been related to the issues the Deputy has just addressed. We can discharge quicker to a key location identified in advance. This has improved the flow through overall. It has not happened in some cases, we have had-----

Deputy Cathal Crowe: I appreciate that. I do not expect Mr. Reid to know every nook and cranny as he leads a huge operation. After this meeting I ask him to look, with his senior staff, at appointing a discharge co-ordinator. It is the final piece in the jigsaw of making the facility a success.

With regard to intern doctors, I know it is a ministerial decision ultimately but last year there was a pilot scheme whereby the HSE service was bolstered by contracts offered to intern doctors. In County Clare and the mid-west region, several dozen doctors were added to the system allowing for better care at ward level. A campaign is under way and many of us are being lobbied. Will Mr. Reid comment on the benefits of the pilot scheme, which is mooted to be discontinued? Did it help the hospitals in offering a level of care in recent months by having newly qualified doctors contracted to the hospitals?

Mr. Paul Reid: I will ask my colleague, Dr. Henry, to answer this.

Dr. Colm Henry: What the Deputy is referring to is the additional interns brought on earlier last year. What we did last year was addressed by some of the Deputy's colleagues earlier. Normally, the number of interns in the training system, which is operated in conjunction with

the six medical schools responsible for overseeing the training, is approximately 730. Last year, we offered places to all graduates and of those 1,100 graduates, 992 took up the offer. This was a once-off exercise last year, in view of the position we were in with the surge. It was not part of the overall medical workforce planning, which involves not just the intern year but creating training places for them afterwards, up to higher specialty training and progression to general practice, hospital consultants or public health. It was never the intention to maintain this beyond last year.

We are reviewing the current configuration of intern training, the quality of the training and the number of 734, which we will revert to this year. We are maintaining the overlap we had last year, whereby the newly qualified medical students began work following early final medical exams on 25 May. This was much earlier than the usual second week of July. We hope to have an overlap of one to two weeks this year as it was particularly beneficial last year. It is not the current plan to maintain the numbers at 1,100. We offered places to 1,100 and a significant proportion turned them down and left the country to go elsewhere.

Deputy Colm Burke: I thank Mr. Reid and the other witnesses for their work in dealing with the Covid-19 pandemic. I will make a comment and I do not want a response on it. It is about cohort 4. It is important to outline to people, with regard to the cohort with underlying medical conditions, whether dialysis or chemotherapy treatment, that vaccination will not be delivered immediately to them but that it will be done over a period of time. I have received a huge number of calls over the past week from people looking for clarification. It would be helpful if it was clearly set out that this is a four or five week programme and that it will not happen overnight. This is important.

I want to go back to the issue of interns because it has been raised by a number of speakers. There is a lot of misinformation and I need clarification. Last year, 1,100 were taken on. My understanding is that up to 60% of interns leave after one year in Ireland. Perhaps we might get some clarification on this. What percentage of interns left in 2017, 2018 and 2019? If we take 60% of 1,100 it would leave us with 440 people. If we take 60% of 734 it would leave us with 294 people. To me, it does not make sense to now reduce the number of interns because there is going to be quite a big exodus once people are able to travel and the pandemic is under control worldwide. I am not sure whether we are doing long-term planning very well. If one looks at all the hospitals across the country outside of Dublin, Cork, Limerick and Galway, the vast majority of junior doctors are non-EU qualified. Please explain how we are going to deal with that issue. Why are we so reliant on doctors from as far away as Pakistan, Nigeria and the Sudan coming into Ireland? Now, when we have an opportunity to deal with the issue, we have walked away from it again.

Dr. Colm Henry: To refer back to comments made by the Deputy's colleagues, it is not just a feature of the intern year. Intern year is a particular year, that occurs immediately after qualification, during which junior doctors work until they get full registration thus enabling them to progress to training schemes. The reason people may leave after their intern year may be precisely for that reason, the need to access training schemes. Consequently, expanding the number of interns without planning for an expansion in the number of training schemes has the effect of kicking the problem down the road. Part of manpower training, which I assure the Deputy is very actively taking place, is reducing our dependency on non-training doctors by converting those posts into training posts. As part of our response, in July 2021 we created 106 additional places and many of them from existing non-training posts. The reasons people may leave is to get training posts in other jurisdictions. Our challenge is to reduce our reliance

on non-training posts, which are not good for assistance and certainly not good for the doctors concerned.

Deputy Colm Burke: On the challenges facing the health service, for hospitals located outside of the main centres of Dublin, Cork, Limerick and Galway, it is difficult to fill a huge number of posts, whether they be registrars, senior registrars or senior house officers, SHOs, because the number of people coming in from outside of the European Union now is decreasing as well. We are also finding it difficult to fill consultant posts in smaller hospitals and do not even have any applicants for a lot of those posts. Where is the long-term planning? How will this issue be dealt with over the next three to four years? I ask because I do not believe that we are dealing with this matter.

Dr. Colm Henry: I can assure the Deputy that there is long-term planning to reduce our dependency on non-training posts because they are not good for doctors and do not place people on training schemes to a specific end point where they would become consultants, having fulfilled the criteria for a training scheme, or GPs, public health specialists or whatever it may be. Repeating a situation where we create additional non-training posts in hospitals just increases our dependency on these posts. Our manpower planning is focused on increasing the number of training posts and converting these non-training posts into training posts by creating an additional number of consultant posts and an additional number of higher specialist trainees in order that we do not have a-----

Deputy Colm Burke: Does Dr. Henry accept that it is challenging to fulfil consultant posts, SHO posts and registrar posts because we do not have enough people?

Dr. Colm Henry: We have always had a challenge filling non-training posts. Yes, we have a challenge filling particular consultant posts in model 3 hospitals throughout the country, and this has been the subject of two programmes of work that we have engaged with in national doctors training and planning on reducing the number of consultants who are not on the specialist register, as well as on reducing our dependency on non-training doctors. It is part of our manpower planning to reduce our dependency on both those cohorts.

Mr. Paul Reid: On strategic planning, last year there was a net increase in consultant posts of approximately 210 for incremental increase, last year, of consultant positions. This coming year, we have a recruitment plan to recruit 350 consultants, if I am correct. We have a strategic workforce plan and part of it is well funded for this year and into next year as well. To restate what Dr. Colm Henry has said, this is not easy. It is not easy recruiting consultants and it is very difficult recruiting consultants and doctors for model 3 hospitals.

Deputy Colm Burke: I have raised the issue of surveying people who are leaving the health service on a number of occasions. Today, we received a letter from Ray Mitchell saying that there is no national scheme to conduct a detailed survey of the people who are leaving the service, be they administration staff, nursing staff, care assistants and doctors. As some very good people are leaving, why not set up a structured survey of those who have decided to leave the HSE in order that we can learn and improve how the HSE manages people?

Mr. Paul Reid: To answer, there are a couple of approaches to this. One, at a local community healthcare organisation, CHO, level and acute hospital level, there are exit engagements, discussions and surveys with staff in terms of what information they can capture as to the reason for exiting or leaving. The reasons can range and we do have some information on that. There is not one national system database. The Deputy will be aware that many of our issues in the

health system are legacy issues around single integrated systems to integrate that information. We are looking at how we can get that knowledge back from the local services and the local system.

Deputy Colm Burke: Can we plan for that now to help the health service retain very good people? It we did that we could analyse the issues, for example, in a hospital, in an administration section of the HSE or any section. It would be great to learn from why people have arrived at their decision to leave and move on to either other countries or other services within the State.

Mr. Paul Reid: There are a range of engagement studies in which we engage to give us some extra knowledge of it, albeit not specifically always in terms of exits. We have regular engagement surveys with members of staff where they can reflect back to us the mood or certain issues. Staff surveys happen very regularly and is an ongoing process. We also conducted, during Covid, an engagement survey with staff members to understand, from their perspective, what it was like, what worked, what frustrations they felt, what we did good and what we did not so good. As a result we have significant knowledge and data on staff, as well as, at local level, on exits. We do not have one single-----

Deputy Colm Burke: I received a very detailed email from a public health consultant who is now in Australia and he worked in Tallaght before. Where are we with the issue of public health doctors not being treated as consultants? Will the issue be resolved within the next six months?

Mr. Paul Reid: The whole issue of public health consultants and consultants' pay and contracts is the subject of an industrial relations process, which is managed and currently ongoing between the Department of Health, the Department of Public Expenditure and Reform, the HSE and the Irish Medical Organisation, IMO. That is an ongoing industrial process at the moment.

Deputy Colm Burke: I will send Mr. Reid the email because it is very good and shows that we have lost a very good person to another jurisdiction.

Mr. Paul Reid: We have lost some good people over many years. I have no doubt our intention is to try to attract them and win them back.

Chairman: Has there been a discussion with pharmacists and dentists on their involvement in vaccine roll-out? When will they be involved?

Mr. Paul Reid: The dentists and optometrists were just the subject of a recent statutory instrument, SI, amendment and change to regulations in order that they can become part of the vaccination programme. Pharmacy is ongoing. Vaccinations are taking place for pharmacists. They will be part of the solution whether it is vaccinating in some pharmacies or in vaccination centres. The vaccination process is ongoing. That would be some of the numbers that my colleague, Mr. Damien McCallion, would have said on the vaccination programme for healthcare workers. We have seen an increase in the last couple of weeks and will see an increase next week, which is largely around some of those workforces coming through.

Chairman: When the State is in crisis due to fires, floods and weather outrages, the State relies on the Defence Forces. They are front-line workers many of whom are involved in the roll out of the vaccine and so on. The rest of that cohort is comprised of 6,500 personnel, which is a fairly small group but they are a key component for dealing with crisis situations. When do we expect to see them involved? Mr. Reid might not have an answer here today. In talking about any cohort or group, that is certainly one we should be looking at as a whole. God knows

what we are facing in the future, and it is one of those important groups that is badly paid.

Mr. Paul Reid: First, I acknowledge the massive work done by the Defence Forces with the HSE since the start of the pandemic in contact tracing, swabbing centres, nursing home support and in vaccination centres throughout the country. The Defence Forces have been there for us at every level of need and continue to be there. I thank them very publicly. I work very closely with the Chief of Staff, Mark Mellett.

From a technical or prioritisation perspective, in essence, they fall into key workers, which is a later group. NIAC is now looking at putting some of those groupings ahead. Legitimate cases are being made by many in the workforce, including the Garda, those in education, teachers, etc. That is a process NIAC will look at for the prioritisation of that cohort coming forward.

Chairman: I again thank the witnesses for their contribution here today. I know there has been a lot of focus on things that have not gone quite right but we do appreciate all the work Mr. Reid and his colleagues are involved in. We appreciate when things do go right and we want to see things running as smoothly as possible. I wish him and all his colleagues well in the future.

That concludes our business today. The committee will meet again in public session at 9.30 a.m. on Tuesday, 23 March when we will get a briefing on nursing home regulation and the plans for the development of a new model of care for older people, with representatives from the Department of Health and HIQA presenting to the committee. Go raibh míle maith agaibh. Stay safe.

Mr. Paul Reid: Thank you, Chair.

The joint committee adjourned at 11.52 a.m. until 9.30 a.m. on Tuesday, 23 March 2021.