DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé hAoine, 17 Iúil 2020

Friday, 17 July 2020

Tháinig an Coiste le chéile ag 9.30 a.m.

The Committee met at 9.30 a.m.

Comhaltaí a bhí i láthair/Members present:

Teachtaí Dála/Deputies	
Colm Burke,	
Holly Cairns,+	
Jennifer Carroll MacNeill,	
Matt Carthy,	
Patrick Costello,*	
David Cullinane,	
Cormac Devlin,*	
Bernard J. Durkan,+	
Joe Flaherty,*	
Kathleen Funchion,+	
Paul McAuliffe,+	
Michael Moynihan,*	
Jennifer Murnane O'Connor,+	
Paul Murphy,+	
Richard O'Donoghue,*	
Fergus O'Dowd,	
Louise O'Reilly,	
Matt Shanahan,	
Róisín Shortall,	
Bríd Smith,	
Duncan Smith,	
Pauline Tully.*	

* In éagmais/In the absence of Deputies Mary Butler, Michael Collins, Pearse Doherty, Stephen Donnelly, Norma Foley and Ossian Smyth.

+ In éagmais le haghaidh cuid den choiste / In the absence for part of the meeting of Deputies Jennifer Carroll MacNeill, John McGuinness, Louise O'Reilly, Róisín Shortall and Bríd Smith.

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

The special committee met in private session until 9.37 a.m.

Impact of Covid-19: People with Disabilities

Chairman: I advise our guests that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence on a particular matter and continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. Witnesses are directed that only evidence connected with the subject matter of these proceedings is to be given and are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

I welcome our witnesses, who are in committee room 2. From the Irish Human Rights and Equality Commission, I welcome Dr. Frank Conaty, acting chief commissioner, and Professor Caroline Fennell, who taught me the law of evidence some time ago and who is a commission member. From the Disability Federation of Ireland, DFI, I welcome Mr. John Dolan, CEO, and Dr. Joanne McCarthy, head of policy, research and advocacy. From Inclusion Ireland, I welcome Mr. Enda Egan, CEO, and Mr. Mark O'Connor, community engagement manager. I invite Mr. Dolan to make his opening remarks and ask that he confine them to five minutes as his statement was circulated to members in advance. We want to leave as much time as possible for questions and answers.

Mr. John Dolan: The DFI has made two submissions, which I note in my opening statement. DFI is about making Ireland a fairer place for people with disabilities. We work to create an Ireland where everyone can thrive and where everyone is equally valued. We do this by supporting people with disabilities and strengthening the disability movement. One key thing that we will always say is that disability is a societal issue. DFI works with Government across all social and economic strands and interests of society.

There are executive summaries of both submissions but I will highlight a couple of points. I refer to the unanimous ratification of the UN Convention on the Rights of Persons with Disabilities by the Dáil in early 2018, along with the commitment in this new programme for Government to establish a joint Oireachtas committee to assist in monitoring and implementing the provisions of the convention. The first of these, the ratification, simply commits Ireland to getting on with the work of implementation. The second is critical and it is important for members to understand that it is a unique instrument. Maybe there is one somewhere, but I do not know of any other parliament, certainly in the EU, that has such an instrument available to it. The UN special rapporteur on the rights of persons with disabilities recently stated that every state's recovery plan must have improvement and protection of the lives of people with disabilities stitched into it and must ensure that people with disabilities can have a life, rather than just being cocooned or put in a parking space while we deal with Covid-19.

Services and supports for people with disabilities were in a bad state before Covid-19 struck. Despite the full recovery of the economy, the capacity to provide services and supports was going in the wrong direction before Covid-19. Poverty was decreasing generally but remained very high among people with disabilities. Services were already facing deficits of more than €40 million, and this year's HSE service plan included a 1% cut which was described as an efficiency measure. All of that was before Covid-19. The funding crisis has been exacerbated.

Organisations have faced huge losses in fundraising and earned income due to Covid-19. Many organisations rely on fundraising. If the cost of delivering services, including additional costs caused by Covid-19, is not fully funded, people with disabilities and their families will continue to bear them as services will be unable to survive.

The demographic trend is going against us. The most potent example of that this week was the Irish Fiscal Advisory Council's findings on dependency ratios. People are living longer, including people with disabilities. Since Covid-19 there have been cuts to services such as personal assistants, schools, day programmes, etc. Therapies and procedures have been stopped. The supports and incomes of people with disabilities, which were always minimal and often precarious, have become intolerably so in the last four months. Families who were always under too much pressure, as members all know, cannot see how they can continue. As society reopens, we must consider a range of issues facing people with disabilities. Support is required to allow those who are medically vulnerable to continue to cocoon. This includes people with a range of conditions such as cystic fibrosis, muscular dystrophy and many others. As workplaces reopen, those individuals are no longer entitled to the Covid-19 pandemic unemployment payment. The advice of the Department of Employment Affairs and Social Protection is that they should access illness benefit but many will not qualify as they are able to work and were in work. People who are categorised as high-risk if they contract Covid-19 must be economically supported in continuing to follow the public health advice.

We also need to reflect on what we have learned so far and be prepared for a second wave of Covid-19. The lockdown took a heavy toll on the mental and physical health of people with disabilities and their family carers. Resilience will not be as high if services are withdrawn. We must also plan to ensure that essential services such as respite, home support and personal assistance are delivered safely. We cannot just cocoon and isolate people. They must be helped to get on with their lives. The fundamentals of the economy are strong. Our capacity to borrow is not in doubt. We must invest now to minimise the damage to the lives and prospects of people with disabilities or two things will happen - people's lives and life years will be diminished and any later investment will only show modest returns.

While health and social protection are critical areas, the same is true for the work of other Departments. The UN Convention on the Rights of Persons with Disabilities provides the agreed objectives. That was accepted unanimously by the Dáil and the Government in the previous term. Its implementation must be at the heart of Ireland's Covid-19 recovery plan. In this regard it would be very useful for the committee to invite the Minister with responsibility for disability to appear before it to explain how the Government intends to stitch the lives and futures of people with disabilities and their families into Ireland's national recovery plan from Covid.

I offer my thanks and appreciation to my colleagues, Dr. Joanne McCarthy and Ms Riona Morris, who did all the legwork.

Chairman: I call Mr. Egan to make his opening remarks and I ask him also to confine them to five minutes. I have just learned that the Seanad Chamber does not have clock whereas there is a clock in the committee room. I ask Mr. Egan to adhere to the five minutes.

Mr. Enda Egan: I thank the Chairman and committee for giving us the invitation to attend this morning. Our submission is broadly based on a recent survey we carried out on the closure of day services and the impact on people with intellectual disabilities and their families. Before I get into that, I wish to point out that Inclusion Ireland is the national organisation represent-

ing 66,000 people in Ireland with an intellectual disability and their families. We work on the basis of a human rights platform and we use the UN Convention on the Rights of Persons with Disabilities as the axis on which we work.

A number of key points for consideration arise from our survey. Some 54% of respondents felt they had little or no contact from their service provider during the period of the Covid-19 pandemic. Regarding the direct impact on people, mental health was the key issue that emerged from the survey, with 38% of families saying they had seen a change in the behaviour of their loved one with an intellectual disability. This behaviour could manifest itself in many ways from an anger outburst to the person retracting. Some 33% of people felt that anxiety had become a major issue for them, and they were far more anxious. Unfortunately, and sadly, 56% of people with an intellectual disability felt that loneliness had become a significant issue for them and felt loneliness was impacting on how they felt and on their general health.

On mental health, it is very important that the new Government policy, Share the Vision, is fully implemented for people with disabilities across the disability spectrum and that they have equal access to such services in their community at their doorstep. This access also involves ensuring adequate communication protocols are in place for people with sight impairment, hearing impairment and speech impairment. It is important that, as stated in Share the Vision, speech and language therapists become a core part of the teams operating at local level. That is very important from an intellectual disability point of view.

In respect of the reopening of services, as the previous speaker pointed out, families at this point are at the absolute edge of their ability to cope with what has transpired during the Covid pandemic period thus far. People are emotionally, mentally and physically at the end of their capacity to cope. I feel another pandemic is about to hit us, which is family carer burnout. That will lead to a revolving door of emergency cases. From speaking to some people, there is evidence of this happening as we speak.

Last week, the HSE issued new guidelines in respect of the reopening of services. We have concerns about some of those guidelines. The key point here is that service providers must move as quickly as possible to reopen services. They must do their absolute utmost and not use the guidelines as a stumbling block for the reopening of services. In the survey, families indicated that some service providers had done very well and some service providers could have done better with the level of resources they have. The reopening of day services is paramount.

Another issue directly related to the Covid-19 pandemic is congregated settings. Based on figures from the beginning of this year, 1,953 people living in congregated settings are not there by choice. It is extremely important that we learn from what has happened during the Covid pandemic. Observance of the rights of people with intellectual disabilities living in congregated settings leaves a lot to be desired. They do not witness the full implementation of human rights. As the previous speaker stated, members have an opportunity to bring the Minister before this committee. There are four Ministers with a brief in the area of disability issues. All four should be brought before the committee to give their views on how they will ensure disability issues do not fall off the radar across the programme for Government. While there are good elements in the programme for Government, we need to ensure they are front-loaded.

Chairman: I ask Mr. Egan to conclude to allow us to hear from other contributors and ensure everyone gets some time.

Mr. Enda Egan: I thank the Chairman.

Chairman: I invite Dr. Conaty, acting chief commissioner of the Irish Human Rights and Equality Commission, to make his introductory remarks. I ask him to confine his contribution to five minutes to allow time for questions and answers.

Dr. Frank Conaty: I thank the Chairman and members of the committee for the invitation to appear with my colleague, Professor Caroline Fennell. The establishment of this committee was a specific recommendation of the Irish Human Rights and Equality Commission to ensure proper democratic oversight of decision-making during the pandemic. It is with particular respect to this work that we address the committee today.

The Irish Human Rights and Equality Commission is Ireland's independent, national human rights institution and national equality body. It was established as a statutory body in 2014 and is accountable directly to the Houses of the Oireachtas. The commission is also the independent monitoring mechanism designated for Ireland under the UN Convention on the Rights of Persons with Disabilities. We are supported in that work by a disability advisory committee composed of a diverse group of people with lived experience of disability.

In addressing the committee today the commission is conscious of our mandate to protect and promote human rights and equality in Ireland in what are truly exceptional times. We are also conscious of members' role as legislators and public representatives to do the same. The committee has heard and will hear from other witnesses today about the direct experiences of people with disabilities during the pandemic and the impact on services and the users of services. We will reiterate aspects that are highlighted by them.

The Irish Human Rights and Equality Commission emphasises for the committee that the impact of the Covid-19 pandemic on people with disabilities should be understood in the context of the rights of people with disabilities and the actions taken or not taken to protect and realise those rights. Under the UNCRPD, to which Ireland and the European Union are party, the State has an obligation to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to respect their inherent dignity. This legal obligation is in addition to the fundamental principle of non-discrimination, including on the basis of disability outlined in Article 21 of the EU Charter of Fundamental Rights and in the EU's equal treatment directives. Article 15 of the Council of Europe's European Social Charter, to which Ireland is a party, guarantees the right of persons with disabilities to independence, social integration and participation in the life of the community. The right to equality is also set out under Article 41 of the Constitution, as well as in statute under the Employment Equality Acts and the Equal Status Acts.

It is clear that Covid-19 has given rise to significant risks of discrimination and the undermining of rights of persons with disabilities, including the rights of older persons, many of whom have disabilities. While Covid-19 is a once in a generation public health crisis, its impact should be seen in the continuum of how people with disabilities continue to be treated in the design and delivery of public policy. The Covid-19 response has exposed inadequacies of Ireland's public policy for people who live in congregated settings, including nursing homes. This includes disruption of supports in services for people with disabilities and for family carers; accessibility of information for people with disabilities; lack of appropriate data that would allow for more responsive decision-making; education and employment for persons with disabilities; and the noted absence of people with disabilities in decision-making that affects them. These issues are detailed in our written submission and we are happy to discuss them further and at length with the committee.

I will highlight one example where it is critical that the human rights and equality implications of public policy are given full consideration. In March, April and May of this year, the Department of Health published guidelines for decision makers in the health service and how access to critical care should be prioritised during the pandemic in the event that demand exceeds availability. The commission has reviewed this guidance and is concerned that there are potentially profound implications for the human rights and equality of people with disabilities, older people and other vulnerable people. We are concerned that those most likely to be impacted by this policy guidance have not been adequately consulted. A consultation process needs to meaningfully consider the human rights and equality obligations of the State and the individual and collective rights of all of our citizens. As a commission, we have communicated our concerns to the Minister for Health. It is our view that the current moment, when the threat of Covid-19 has thankfully receded, represents an opportunity to further consider and develop this important guidance for healthcare workers.

More generally, with regard to the lived experience of people with disabilities, it is important to recognise the progress that has been made. This progress has seen Ireland move from an old charitable medical model of support for people with disabilities towards a rights-based perspective, supporting people to live inclusive, independent lives. It is a fact that the significant gaps and vulnerabilities in existing policy and services have resulted in a disproportionate impact of Covid-19 on people with disabilities. This disproportionate impact is at odds with the sentiment and message of collective solidarity in the face of the pandemic. Unless the law, practice and policy which underpin the rights of people with disabilities are made more resilient, we will continue to see people with disabilities face the same vulnerabilities relating to their rights at times of crisis, including times of economic crisis.

The path to that greater resilience has already been mapped out, as noted by Mr. John Dolan and Mr. Enda Egan, and includes policy and legislation already identified as being needed to bring Ireland into compliance with the UN Convention on the Rights of Persons with Disabilities. To this end, the commission also would add that the implementation of the public sector human rights and equality duty by public bodies and the exercise of their functions would be a significant and positive step towards permanently embedding the rights of people with disabilities in service delivery. It is imperative that we learn the lessons of this crisis and that policy makers ensure that human rights and equality considerations are central in the review and development of policy, the impacts of which are deeply experienced by people with disabilities.

Chairman: I thank Dr. Conaty. I am sorry, members, that it is difficult to hear our witnesses in the committee room. It is the first time that we have sat here in the Seanad Chamber. I ask that our witnesses speak a little louder than they normally would because we apparently cannot do anything to change the sound levels until after this session.

Deputy Cormac Devlin: I welcome the disability organisations and the commission. I thank them for their opening remarks. All the members of the committee have been contacted by families and people with disabilities, especially during the pandemic and in this particular phase. Mr. Egan referred to carer and family burnout. Many of those people have experienced that or are experiencing it at present. Only last week, I raised the roadmap for reopening services with the Minister. I am glad that those guidelines have been published and we are looking at a date in August, which is welcome. However, serious issues still face those services.

I welcome Mr. Dolan back to these Houses. I commend him on the work he did on disability when he was a Member of the Seanad. He referred to the 1% efficiency measure in the HSE service plan. I understand that is due to be reversed but he might highlight that and come back

with a bit more information. He thinks it will be reversed but he might elaborate on that.

Mr. Egan referred to the roadmap and the carer burnout. I also note from the opening statements that 75% of residential settings, where I commend the service providers, saw no outbreak at all during the height of the first phase of Covid-19. However, Mr. Egan also stated that 54% of respondents to the Inclusion Ireland survey had little or no contact from service providers. That is worrying. Many members of the committee have been contacted by affected individuals and their families. Education and day services have been shut down for those vulnerable groups. Could our guests comment on those matters?

Mr. John Dolan: I thank the Deputy for his kind remarks. At least he has the good grace not to be sitting in my old seat.

The Deputy asked about the 1% cut. A sum of €40 million in accumulated deficits across a number of disability organisations was reported to the Joint Committee on Health last year, prior to the crisis. At the start of this year, we were flabbergasted to find that another 1%, or €20 million, was to be taken out of the budget as an efficiency measure. Representatives of the DFI met the then Minister for Health on 20 May last and he indicated quite clearly that the cut was not going to be triggered or operated this year, that it would not be possible to do so. The then Minister asked us for a number of days' grace before we would say anything about it in public. We subsequently wrote to the then Minister on at least two occasions and have still not received a clear response, in black and white, to state simply that the Department is confirming that the proposed cut has been removed. That is where that matter stands and anything that members of the committee can do to get clarity on it would be a great support. That €20 million and other issues indicate that cuts were still being made to services at a time when Ireland was back at full employment and had a healthy economy, prior to Covid-19.

Mr. Enda Egan: The residential services in congregated settings have done quite well during the crisis. I am sad to say that approximately 13 people have passed away in congregated settings across the period of the pandemic. In general, approximately 0.17% of the population in congregated settings contracted Covid-19. The service providers did very well in that respect. Where there were outbreaks, the average number of people involved in those outbreaks in disability services was six, in comparison to 20 in nursing homes.

That leads to the serious issue we cannot remain complacent about, namely, a second wave of Covid-19. The wider issue has already been debated here this morning. If one looks back to 2012, the Government introduced a policy and report, Time to Move on from Congregated Settings: A Strategy for Community Inclusion. At that point, approximately 3,900 people were living in congregated settings, according to figures from the HSE. The average number of people being decongregated since then has been approximately 135 per year. The Government stated in 2012 that all congregated settings were to be decongregated.

Chairman: I must bring in the next speaker if we are to give everybody equal time. Perhaps Mr. Egan could continue his reply in writing. I am sorry but we have a two-hour session and I cannot add to it, unfortunately. I will move on to the next speaker. It is an important issue so I would appreciate it if Mr. Egan would continue his reply in writing. The next speaker is from Sinn Féin. Deputy Tully has ten minutes.

Deputy Pauline Tully: I thank the witnesses for coming and outlining their reports to us, which I have read in detail. Like many of my colleagues in Sinn Féin and Teachtaí Dála across the other political parties, I have been contacted by parents of children with intellectual dis-

abilities. Some of these are adult children and day care services for them have been suspended since March. Many of them have not had any supports for four months, as our witnesses have outlined to us. They have informed us that there have been cases of anger outbursts, of people being withdrawn or frustrated and a lack of routine. An indication has been given that the services may return in August. That is very vague. Has the DFI or Inclusion Ireland been given a date for the return of full services and are they confident that a budget to meet the costs of providing the full services will be available? Costs should not compromise the service. A full service is required. Parents are very much in the dark about this, which is adding to their stress. Many of them have ended up being ill and under medication as well, which is not what we want to see. Many of the people we are talking about are high dependency and there are care packages in place for them but these are not being utilised at the moment. Has either organisation been given something more concrete than just a date in August?

Mr. Mark O'Connor: We understand that the time frame has been left to individual providers. We know from parents contacting us that some service providers have said 7 September, which it will have been almost six months before people are back, which is quite an extended period but this is the timeframe that we have been given by certain providers. It must be noted that the HSE document states very clearly at the outset that there are going to be reduced to supports for people. This obviously has a knock-on effect on family members who may be trying to get back to work or whatever the case may be. The family member with a disability will not receive a full quantum of service. This is very clear in the HSE documentation. Inclusion Ireland has also requested from the Minister that he puts in place a temporary Covid-19 payment so that private providers can secure additional premises to allow for social distancing, and if there are staff required in the short to medium term, to ensure that as many people as possible receive a service.

To be very clear, there have been very some very good examples of new ways of working that are very much in line with the HSE person-focused policy, New Directions. For people with the highest support needs, traditionally folk with severe and profound intellectual disabilities, face-to-face supports from support staff is the only care that will work for then. We ask that the Minister make available additional funding to the HSE, and HSE-funded providers to ensure that as many people as possible can get as much access as possible in a timely manner.

Deputy Pauline Tully: I find it quite disturbing that September is the date and it is being pushed out further. Many restrictions were lifted and services returned on 29 June. Our most vulnerable citizens deserve better than this. This is something I will raise with the Minister.

Congregated settings were also mentioned. According to Inclusion Ireland's report, 1,500 people are living in nursing homes, not even in residential care, who are aged under 65. My colleague Deputy Violet-Anne Wynne from Clare raise the case of Jennifer Hynes who is only 42 and is living in a nursing home in Ennis and has been quite vocal in highlighting her case. There are 1,500 other people also in unsuitable placements because of lack of housing, which is a significant issue. Have the organisations been given any commitment on moving this forward and providing more independent living for people with intellectual disabilities and disabilities in general?

Many older parents are taking care of their child with intellectual disabilities, where the child could be 30, 40, or 50 years of age. Are there any plans relating to independent living for those people, when unfortunately, the day will come when their parents will pass away?

Dr. Joanne McCarthy: I will deal with the nursing homes question.

Mr. Mark O'Connor: On planning, we would have to say "No". When one looks at the HSE's annual service plan, it makes provision for 90 emergency cases this year, whereas in previous years that figure was as high as 180. No funding has been made available to the HSE to provide additional independent living supports for people with disabilities. The Health Research Board calculates the level of need. There are more than 700 people with intellectual disabilities aged over 55 living at home. If one does the maths, their parents have to be in their 80s at least. There are no plans in place to provide for those folks. Dr. McCarthy will give the committee a better insight into the nursing home issues.

Dr. Joanne McCarthy: The issue of nursing homes is an ongoing concern for DFI. As the committee knows, we have been on this issue for almost a decade. We welcome the commitment made in this regard in the programme for Government. As a matter of urgency, we will look to establish real pathways so that people have other options besides needing to go into nursing homes. We had been looking for a specific measure to be put in place and we are awaiting an announcement from the Ombudsman, who is about to make a ruling on this issue. We are hoping that will provide further evidence of the need to put in place a package of payments and supports in order that people have other options.

All of this comes back to the fact that 80% of the money in disability services funds about 30,000 people with disabilities. We are not saying that is a problem but simply showing that this figure illustrates the lack of investment in community-based services, especially personal assistance and home supports. They are the vital services that are needed in the community to support people who are out of nursing homes. They are also the services that are needed to support the resilience of families.

This pandemic has shown that the HSE, like all of us, when faced with a crisis back in February, put in a place a plan that prioritised what services families or individuals needed and then directed those services to them. As we moved through the past six months of the pandemic, many families and individuals who were not at risk presented as not being able to sustain the level of care or supports that were required independent or outside of services. We are talking here about the personal assistance and home support services. When we made a plan for Covid-19, we planned for residential care settings. We did not plan for community-based services. The responsibility and onus then fell on individuals and families and we are feeling the impact of that now. Rare Diseases Ireland did a survey of its members, almost 70% of whom spoke of the mental health impact of Covid-19. The reason was the additional level of responsibility and stress, as well as the caring needs that have been required.

To support Mr. O'Connor's point, we also know of at least 400 families who provide full care to ageing people with intellectual disabilities. Those providing that care are aged over 80. There are real pressure points. We have a lull, as our colleagues from IHREC noted. This is a moment in which we need to reflect on where these pressure points are. We have residential supports in place and we can begin to strengthen them. However, we do not have as clear a pathway to providing community-based supports such as personal assistance home supports and the outreach supports for day services that will be required to sustain families and individuals if we have another surge of Covid-19. These are important questions that merit being put under the spotlight so that we feel confident and families and individuals can be confident that services will be there for them in the community should a second wave occur.

Deputy Pauline Tully: Do I have some time left?

Chairman: The Deputy only has 20 seconds remaining. While there will not be time to

have a question answered now, she may put a question that she wants answered in writing.

Deputy Pauline Tully: I come from an educational background. I was previously a teacher and a special educational needs co-ordinator for a number of years. I know the importance of therapies for students with disabilities or educational needs and I know those students are also suffering as a result of school being closed and the services and therapies not being provided.

Chairman: I thank Deputy Tully. Deputy Carroll MacNeill has ten minutes.

Deputy Jennifer Carroll MacNeill: I thank the witnesses for coming in today and for all the work they have been doing during this period. The secretariat did an excellent report compiling the various written submissions. I thank them for that because it shows the complexity of what we are talking about and how many people with different issues in their lives are impacted. I made some notes as I went through it. When we think about the people we are talking about today and the impact on them, it is people who are deaf, blind, have intellectual disabilities or who require physical therapy or speech and language therapy. It is about the dignity of work and being able, or unable, to participate in work. There are many complexities to it and I know that all the organisations the witnesses represent have faced different challenges. Speaking with MS Ireland, for example, at once stage throughout it, it described the community impact, as the witnesses described, in terms of people not being able to get physical therapy. That is one small example.

If we put aside residential settings for a moment, we have seen the impact on people at home, and the witnesses spoke about the family care burden. From a practical perspective, will the witnesses talk about the sorts of services that have been lost because of the need to cocoon or the need to not have people coming into the house? They might list them out so that we can get a sense of it. It might be a question for the Disability Federation of Ireland, DFI.

Dr. Joanne McCarthy: There is quite an array of service models within the community. There are home support services to help people get up out of bed, and the person goes back to do some light housework. There are also the PA services that support a person out into employment. There are then what we would call much softer community services, which are undervalued but if they are taken out of the system have a significant impact.

Deputy Jennifer Carroll MacNeill: Would Dr. McCarthy mind speaking up a little bit as it is difficult to hear her in this Chamber?

Dr. Joanne McCarthy: Some of those would include peer support services. Many of the neurological organisations would provide peer and family support services. These are very skilled people who come in and out of families at the onset of the neurological condition and travel through that family's life to the pathway of the condition. They are able to provide expert knowledge and support. If we take, for example, motor neurone disease, they might have a family nurse who works with them. They know the trajectory of that condition from diagnosis to, unfortunately, the end point and then on to supporting families out the other side. It is those sort of services. I will use motor neurone disease as an example. We know there are approximately 400 families at any one time in Ireland who are affected by motor neurone disease. It is a ravaging condition that moves very fast. For most people, from diagnosis to end of life is about four years. That organisation works with that family to make sure they have access to the appropriate aids and appliances, information around self-help for the carer, and information around a good quality of life for the person at the different stages. They would have a nurse and also, if I remember rightly, a family support, and they would also provide peer support. All

of those services went online very quickly as best they could but in many cases, and Inclusion Ireland will probably talk about this also, some services can only be delivered face-to-face. All those face-to-face or person-to-person services were withdrawn. While efforts were made to put online services in place, they could not fully replace face-to-face services at any one time. In the lockdown, we were unable to get aids and appliances out to families if a condition changed dramatically very quickly. I am sure they were not able to get aids and appliances to those families. It is that level of community infrastructure that is often not fully appreciated by those outside our sector. We do have day and residential services, and the core service programmes, but it is the softer community services that support the resilience of families and individuals to live with a level of independence in the community that are important. Many of those got lost or had to go online and therefore may not have had the same immediacy as might have been required.

Deputy Jennifer Carroll MacNeill: That is exactly the reason I asked the question. It can be very difficult for outsiders who are not living with a condition or going through that as a family to really understand the importance of the supports that are being provided. I thank Dr. McCarthy for taking the time to do that. With specific regard to motor neurone disease, as has been said, the condition progresses very quickly so six months is an extremely long period to be without services. There can be significant changes within such a period. It is difficult for families to cope with that and remain resilient.

I have a couple of questions on Dr. Conaty's submission. On the second page he states, "The COVID response has exposed inadequacies of Ireland's public policy in relation to" a number of listed areas. On the point he made about "the lack of appropriate data that would allow for more responsive decision-making", will he give an example of what he is talking about?

Dr. Frank Conaty: What we have heard up to this point has cast in poignant relief the fractured nature of policy on, and services provided for, people with disabilities during this crisis. There is a completely inadequate amount of data available on the manner in which the Covid-19 pandemic and the response to it has impacted on people in different groups with different disabilities across a wide spectrum. Without that disaggregated data, it is very difficult to direct appropriate policy responses. It is crucial that this deficit be addressed and that the information be provided. This would allow both the commission and the Oireachtas to do their jobs in respect of oversight. Without the data, difficulties arise.

Deputy Jennifer Carroll MacNeill: I agree. Will Dr. Conaty provide some examples of the types of things about which he is talking?

Dr. Frank Conaty: The impact on people with disabilities across the entire spectrum, including those with physical , sensory and intellectual disabilities, has not been the same. There are many differentiated needs. Therefore, the response to Covid-19 has impacted upon people very differently. We need to understand what those impacts have been. We need data in that regard.

Deputy Jennifer Carroll MacNeill: People who had been attending the Trinity Centre for People with Intellectual Disabilities and who could not finish their courses or internships may have suffered a significant regression with regard to their development and ability to participate. Is that the sort of thing Dr. Conaty means?

Dr. Frank Conaty: It is a good example. Another very good example is adults who have intellectual disabilities who have not had day services since 14 March. The impact on those

adults will again be different for different individuals but we need to understand what those impacts have been. We mentioned regression a few times. That is quite evident. We do not have the data or information to inform a policy response that is directed appropriately.

Deputy Jennifer Carroll MacNeill: In his statement, Dr. Conaty also states, "the Department of Health published guidance for decision-makers in the health service on how access to critical care should be prioritised during the pandemic" and "The Commission has reviewed this guidance, and is concerned that there are potentially profound implications for the human rights and equality of people with disabilities, older people, and other vulnerable people." Will he provide some detail in that regard? What precisely does he mean by it?

Dr. Frank Conaty: The guidance was welcome but it must be recognised that it was brought in during a crisis. There has been no real ability to consult people who may be impacted upon in this regard. We are calling for the voices of people who could be directly affected by the decisions made under these guidelines to be heard and for them to be consulted. It is welcome that the guidelines indicate that decisions should not be made on grounds that discriminate against certain categories but that refers to individual decisions. What about decisions in general? Many aspects of the guidance are welcome but there is a lot of ambiguity and uncertainty with regard to some of it and how it might inform the environment in which decisions will be made. It is such a profound issue that it requires further consultation and development. We have the opportunity to consult and develop further before those guidelines are required. We hope they will not be required but they may be.

Deputy Jennifer Carroll MacNeill: Will Dr. Conaty provide a specific example of such a potentially profound implication?

Dr. Frank Conaty: In the context of how the guidelines refer to the decision environment, as I would term it, the factors that have to be taken into consideration in making decisions on access to critical care can be very wide. I emphasise that the commission is not indicating what the answer should be, but that consultation is required. For example, the guidelines speak to aspects such as life years, quality of life and the application of frailty scores. The manner in which those may be brought into the frame in terms of decision-making meeds to be teased out properly and discussed. We need consultation across those who may be directly impacted. There is no particular guidance or clarity in the guidelines at the moment as to what we actually mean by life years. Are we suggesting that one person's life year is equivalent to another person's life year? None of these discussions are evident from the document. Crucially, we do not see evidence - it may have happened and we would like to see it - of discussing the guidelines in the context of human rights law, international and domestic. We should bring those principles to the fore in the discussion on where these guidelines should go.

Deputy Michael Moynihan: I welcome all the people before the committee. I will put a few things on record first and ask one question afterwards.

The word people with disabilities and their families have used to me since the pandemic struck is that they feel abandoned by the services, particularly people who were using the day centres or adult services. Prior to the pandemic there was a huge crisis. That will be multiplied now in terms of accessing speech and language and other therapies and, indeed, trying to find out whether people want assessment of needs.

This morning's meeting is welcome and we need to have a serious discussion on how people with disabilities are affected by Covid-19. We have seen across all the sectors, quite rightly,

initiatives such as the July stimulus, which is welcome, but we really need to look at how people are affected. Regarding the roadmap for reopening day services and residential services, and there is a sense that while there is a roadmap and there is talk about August, it now looks like it could be September, is there real engagement with the Government and the HSE with these service providers to give them guidance?

In respect of a service provider in my area, St. Joseph's Foundation in Charleville, and the transport issue there, some service users travel 30 to 40 miles from four counties to come to the services in Charleville. That provider has been looking at the transport issue, but what will be the resolution to that? Many families with adults with intellectual disabilities cannot or do not have the wherewithal to provide that transport because the parents are elderly or because they are otherwise not in a position to do so. What will be the solution to the transport issue? Some service users are looking at alternatives. What kind of funding is available for that?

Is there a real sense of urgency that families have been abandoned, especially as we move on in months in the pandemic? The carer support groups within those families are meeting and trying to help each other. I have heard stories from some service providers who have been giving hour-long respite for families so that parents can do simple things like take a shower and so forth, because there are people in their care with profound disabilities. They have been the unheard voice in the calamity that has followed the pandemic.

This morning's meeting is welcome and further engagement must take place. We need to get all the Departments and Ministers in before this committee to ensure all families get a sense that we as a Parliament and this Covid committee are taking on board their concerns and responsibilities as they go forward to make sure everything possible is done to alleviate the crisis for families.

The words "breaking point" have been used a number of times already this morning. Families are at breaking point and they are really looking for some sense of hope, some sense that we understand their plight and some hope and guidance about when the day, residential and shared care services will resume. What is the guidance on the shared care services? When will they resume? There is a sense from the service providers that they are engaging somewhat slowly with the HSE, and the HSE is engaging with the Department, but there is no sense of urgency about it.

Could all Ministers involved come before the committee to deal with these urgent matters? My final question is for Ms McCarthy but all the witnesses might comment on it. Is there an urgency to the HSE's engagement with the service providers at the moment to try to make the best service available to service users and their families through the restoration of adult services, day services, respite services and residential units that have been closed due to the pandemic?

Mr. John Dolan: I might make a few comments on that question, and others may want to come in as well.

The Deputy mentioned people feeling abandoned. Post-Covid was not the first time he or his colleagues heard people talk about feeling abandoned by the State and by public services. It has ratcheted up hugely since the pandemic but things have been in a difficult space for a long number of years and we have not figured out a way. It goes back to a point made by Mr. Conaty about getting the numbers. The numbers are going against us. Babies are being born today who would not have seen the light of day ten years ago. There are more complex needs. People are generally living longer. People with disabilities are, thankfully, living longer. Our

demographic trends are going against us. That is the frustration that policymakers have sometimes when they think they are putting in more money, but they are not putting in enough of that additional money for the greater need that is there. The feeling of abandonment is certainly being very much heightened.

The other issue is about lack of ambition. It is not good enough that people with disabilities do not die from Covid. It is absolutely magnificent that there has not been the kind of attrition we have seen in other areas on that matter for people with disabilities. However, the ambition cannot be that people's lives go into a freezer during the Covid period and we think that is okay; it is not okay. The Deputy asked for a range of Ministers to be brought in and he is absolutely right. Without even mentioning the UNCRPD, that is what it is all about. It is every Minister's job; it is every part of the public service's job to do their part and to do it together. First among equals is Minister for Children and Youth Affairs, Deputy O'Gorman, who is now in a position to be at the core of that and to be the driver of that.

I would like to make one further point and then allow my colleagues to come in.

Chairman: We are over time. Mr. Dolan can do so briefly.

Mr. John Dolan: When Deputy Moynihan referred to the local service provider he talked about one organisation. This is not a criticism of the Deputy, but a pile of invisible organisations are providing soft support to people in his community and every other community. They do not have vans and buses or campuses. That is part of the issue as well.

Chairman: I thank Mr. Dolan. We are very severely constrained in the number of sessions we can have, especially given the broad remit of the committee and the duration of each of those sessions.

If anyone else wishes to respond very briefly to Deputy Moynihan's question I will allow it, but I ask that they speak for no more than half a minute.

Professor Caroline Fennell: I will simply support the notion that the UN convention is at the heart of this. We have the roadmap and we know what needs to be done in legislative and policy terms. The State has that obligation. It is obliged to do so and that costs money. We know what has to be done. It was not done prior to the pandemic. All the pandemic has done is expose the difficulties that are there and the system and its failings as they were prior to that. It needs to be changed. We know how to change it and we need the money to be committed to change it.

Chairman: I refer to Deputy Moynihan's suggestion that we bring in the Minister for Children and Youth Affairs. We do not really know what we will be doing in September. Obviously, anything we propose is subject to the agreement of the Business Committee but it does make sense to bring in the Minister, Deputy O'Gorman, and the Minister for Health to deal with the broader issues of the response to Covid. Once the sectoral committees are up and running, they will be able to bring Ministers before them on specific issues.

I will now move on to the next speaker, Deputy Costello of the Green Party, who has five minutes.

Deputy Patrick Costello: As the witnesses probably know better than me, the at-risk-of-poverty rate among people with disabilities is approximately 46%. There are huge issues regarding a lack of supports for employment, flexible working conditions and cliff-edge social

welfare entitlements. There was mention of a lack of preparedness regarding infection on return to work for people with disabilities already in employment and with health conditions that compromised them. Will the witnesses comment on what employment supports we can put in place in the short term? As a follow-up, are there particular aspects of home-working, which will obviously play a larger part in the lives of the future workforce, as it relates to disability that could be supported by the Government?

Dr. Joanne McCarthy: This is an ongoing issue for us. The subgroup for vulnerable adults has a seat on NPHET and we represent the wider disability sector. Disability organisations have one seat. This is an issue we have been raising there because we need clarity. A number of people who have compromised health conditions, or members of their families who are carers, are seeking confirmation that the pandemic payment will be extended so they can continue to cocoon until such time as there is a vaccine or an alternative is put in place. This is essential because it will force individuals and families to make very difficult decisions as they will not be able to afford to continue to cocoon and will have to go back to work and place themselves and others at risk. For six to eight weeks, we have been looking for NPHET to give clearer guidance on this.

It was stated that people can apply for illness benefit but these people are not sick, they are trying to prevent themselves from being sick. It would also mean a drop of approximately €145 per week for that person. As we know, people with disabilities have the highest at risk of poverty rate within the population. They cannot really afford to take this risk. It is very important that the committee considers this in order to figure out what measures need to be put in place, starting with income and then supports. The other issue is extending the right to work from home where possible so employers are brought on board to support families in being able to make more appropriate decisions. These are two of the main issues on which we have been seeking clear guidance from NPHET on behalf of families and people who are medically vulnerable.

Deputy Patrick Costello: I will pick up on Deputy Carroll MacNeill's point regarding data because I was going to ask similar questions. Another issue in the context of the data, and I am speaking from experience as a social worker, is how practical is it to collect some of this data. I am concerned that it will place an administrative burden on already stretched services and increase the paperwork instead of direct time with people.

Mr. Mark O'Connor: Quite a lot of the data has already been collected. We have been pressing the Department of Health to publish disaggregated figures on instances of Covid-19 in residential services for people with disabilities. It is already reportable to HIQA. The data is there but it is just not being shared.

Dr. Joanne McCarthy: We have been asking through NPHET for data to be gathered on how many people who present at accident and emergency departments have underlying health conditions or disabilities. It is very important and there is a real misconception out there. Most people with disabilities do not live in residential services. They live either independently, with family members or, like the rest of us in our 20s, with their friends. Approximately 8,500 people are in residential services and we have 640,000 people with disabilities. Most of the people with disabilities will never be captured under the data paths set up through NPHET. It is very important that we find ways through which we are currently capturing data whereby we can disaggregate it and capture the impact it is having on those with disabilities.

Deputy Patrick Costello: The congregated settings came up a few times. The Irish Hu-

man Rights and Equality Commission makes reference to the HSE document "Time to Move On From Congregated Settings". That dates back to 2011. I am probably out of time, but can the witness speak briefly on what is needed? I am conscious of the comment that more money is needed but what have been the roadblocks to implementing this HSE policy?

Chairman: We are out of time. Can the witness reply to that question in writing, as we are already over time? Thank you for the pertinent question, Deputy Costello, and I ask the witnesses to reply in writing. The next speaker is Deputy Duncan Smith, who has five minutes. There are no clocks for speakers in the Seanad Chamber so I will l tip the bell after four minutes.

Deputy Duncan Smith: I have a clock with me.

Chairman: I will do it for other members who do not.

Deputy Duncan Smith: I have lost ten seconds. I thank the witnesses for attending the meeting today and for their submissions and statements. My first question is for Mr. Dolan. His submission dated 29 June is very detailed and interesting and I thank him for it. He mentioned that a number of staff from the organisations were redeployed to other Covid-19 related services. How many staff were redeployed to tasks such as contact tracing? Furthermore, is there any indication of when they will return? What impact has their redeployment had on the delivery of front-line services by the organisations?

Mr. John Dolan: Dr. McCarthy is in a far stronger position to answer those questions.

Dr. Joanne McCarthy: Redeployment happened. In fact, there was an earlier question about the challenge of reopening services that we did not get a chance to discuss. When the onset happened initially there was a redeployment of staff from day services to residential services. I presume they were backfilling the 24-7 care that was required in residential services. There is a problem now because people in those residential services will not be resuming full day services. Those day service staff are still supporting the residential services so how does one release those redeployed people back into supporting the reopening of day services? There is an issue there because the same staff cannot be double jobbing. They cannot be bilocated.

There is also an ongoing issue that must be understood. We are moving away, and rightly so, from the concept of day services whereby one goes into a building, one stays there from 9 a.m. to 5 p.m. and then one is picked up and brought home. It is much more person centred. People have individual work plans. Some of them might be working two days a week in the local coffee shop or they might be going to an education and training board and doing some type of further education course. Day services are very different now from the traditional sense, and should increasingly become more different. However, none of those places is open now. People who would normally be using mainstream community-based services, which is the right answer, are now looking to come back into - it is almost a regression - old models of service. This is at a time when we must abide by NPHET guidelines regarding the number who can be in at a single time. How fit for purpose are these buildings which we are trying to empty and which now are filling back up again? It is a complex issue both for the services that are trying to reopen and the families and individuals who are really stretched and need an answer fast.

I know from our representatives and the representatives of other colleagues that these live debates are happening. They are taking place at micro or CHO level where each service provider is engaging, and should be in deep engagement, with its CHO to figure out how it will reopen the service and what level of service can be reopened. At national level there are efforts

to try to give an overarching framework to support that delivery. They are live issues, but we are dealing with very specific challenges within the system.

Finally, and it is awful and vulgar, there is a cost implication. It is going to cost more to deliver the very same level of service, not to mind to expand or respond to the day services and the new additional services that will have to be introduced over the next year. We are told that the services have to deliver within budget. There is additional pandemic-related support for PPE and services; there is not for the fact that it will cost more to deliver even the same level of service. I think there is a realisation that, as crude as the return to the concept of cost is, we have to take it seriously if we are really serious about resolving this issue.

Deputy Duncan Smith: I thank Dr. McCarthy for her comprehensive answer.

In the interest of time, I will finish on a comment. I was interested to see in the submission from DFI that there remains a vast difference between the rights of workers in section 38 agencies and those in section 39 agencies. The new Government will need to remedy this as a matter of urgency.

I thank the witnesses for their submissions and contributions.

Deputy Holly Cairns: The pandemic did not cause the impact of underinvestment in social and healthcare services by the State but it did expose it more. It also showed the incredible resolve and dedication of people with disabilities, their families and volunteers and workers in sports organisations. We know this is a particularly challenging time for people with disabilities and additional health complications. The absence of services for months, the erosion of independence and ongoing uncertainty all take their toll. One of the key lessons is that the State must do more to support our disability sector. It is clear to me from conversations with people who have contacted me and service providers in west Cork, such as Cope Foundation and CoAction, that each story underlines the essential work that is carried out by families, communities and organisations in the area. The State abdicates responsibility for this sector, relying on voluntary organisations and families to provide essential services, and I agree with all the witnesses that this has to change. Each of their submissions highlights the challenges for the sector and individuals concerned and provides guidance on disability inclusive recovery. I wish to focus my questions on this area.

Several of the statements refer to Article 19 of the Convention on the Rights of Persons with Disabilities, which guarantees the right to live independently in the community rather than in institutions. Mr. Egan and Mr. O'Connor rightly call on the Government to make funding available to the HSE to move the remaining people in congregated settings to homes in the community. Could they briefly outline what would be involved in achieving this?

Mr. Mark O'Connor: It depends. We have spoken a little about data, but it depends what number one looks at. The HSE tells us there are approximately 2,000 people in congregated settings, but the folks in HIQA who go out and inspect these places tell us there are approximately 2,900, so there is a significant number of people in these settings. A policy has been in place for almost nine years to move people out. It saddens me to say that up to this point people in these settings have had as good a chance of passing away in a congregated setting as being moved out to a community setting. What we do know, however, and what comes up in HIQA's annual reports, and we have done some research ourselves, as has the National Disability Authority, is that people's lives improve significantly when they move to smaller, community-based settings in line with their own wishes and desires, living in their own homes, such as all of us here do,

being supported to do the ordinary things one does in one's own home and accessing community services. Even HIQA's annual report from this year states that people lead lives that are not in line with human rights and that in larger residential settings there are issues in protecting people, safeguarding and human rights issues.

Dr. Frank Conaty: I wish to emphasise and support what Mr. O'Connor said, but the issue of decongregation has been a persistent and ongoing difficulty for the State for decades, and we have not solved it. We have allowed it to continue through policy deficits. It is not the pandemic that has caused this, but the pandemic is giving rise to greater risks for people in these congregated settings. I will point out just one risk to human rights that will persist if we continue to have people in congregated settings. Since 11 March, people have been in residential settings that have been essentially shut down, and these people have been confined to home without access to family. We might say the position is similar for elderly people cocooning. Many of these people nevertheless need access to family as their immediate advocates. That access has not been available. The fractures in the policy architecture we now see this pandemic showing up have always been there but it is clearly within our gift to address and correct them. The UNCRPD is the pathway to doing that and we need to be real about its application and implementation.

Deputy Holly Cairns: The witnesses have collectively highlighted the shocking estimate of 1,500 people under the age of 65 living in nursing homes. I have unsuccessfully tried to get figures from the HSE for Cork on this matter. All Deputies need to do whatever we can to end the practice of accommodating under-65s with disabilities in nursing homes.

There are multifaceted issues around students with disabilities, which the witnesses also raised in their statements. Families are concerned that any individual or collective progress may be lost when schools and colleges open in the autumn. What priorities should we as Deputies focus on in supporting young people and students with disabilities or additional needs if they return to education?

Chairman: If the witnesses could reply in writing-----

Dr. Frank Conaty: Let me just deal very quickly with the under-65s-----

Chairman: I am sorry but I must ask Dr. McCarthy and Mr. Dolan to reply to Deputy Cairns in writing.

Deputy Holly Cairns: When writing, I ask them to also give us a sense of the types of legislation and policies we need to give immediate effect to the UNCRPD.

Chairman: We would all appreciate answers on those matters, but we will have to get them in writing as I must bring in all the speakers. I call Deputy Paul Murphy.

Deputy Paul Murphy: I thank all those who have given presentations. I will hone on the question of carers. I have been in touch with a number of different carers, including Faye Hayden and Linda Comerford, who are part of the Enough is Enough - Every Voice Counts group. I understand that group is organising a protest next Wednesday at 12.30 p.m. at the Convention Centre to demand the reopening of adult day services. At normal times, it would be accurate to say these people's work is significantly undervalued by the State and it saves the State an estimated €10 billion a year. At this point in time, the situation they face, like those for whom they care, is exacerbated by the absence of services and so on. One carer told me they are screaming and that they are physically and mentally exhausted but they feel nobody is

listening. My question is for Mr. Egan but others may answer as well. I ask him to give us a picture of what the situation is like for carers right now and what needs to be done by the State to address it.

Mr. Enda Egan: The report we just published shows very clearly that people are under immense pressure and that there have been unforeseen behavioural issues for some people with intellectual disabilities because of the Covid-19 shutdown. Some people with intellectual disabilities need consistency in their daily routine and their friends and support workers from within the day services have been taken away from them as a result of the closure of the services. That has brought about a range of different behaviours that families have not seen previously. That, in turn, has put huge pressure on families, many of whom are trying to work from home or provide care for other family members and other siblings in the home environment. This has brought about huge issues for people trying to home educate, as the environment within the home is completely different from that in the school. Many families are experiencing complete physical, mental and emotional burnout from trying to juggle all these issues that Covid has brought about. As Deputies have highlighted, the real concern for people is that they cannot see an end to this. There is no light at the end of the tunnel. For example, we dealt with somebody yesterday whose sibling was getting a service for one hour a week. They have been told that will go up to two hours a week from 8 August. There is no pathway for how that is going to increase, as has been said repeatedly this morning. The pathway document with guidelines on the resumption of day services issued by the HSE last week clearly states that while there is a Covid-19 emergency, services are not going to return to pre-Covid levels. There is no indication as to what levels can be achieved. We all know that we will be living with this situation for some time. There will have to be a national movement of people with intellectual disabilities, everybody with a disability and family carers to ensure that the Government is aware of the pressures those people are under. The Covid-19 pandemic is obviously having an impact on the abilities and rights of people to go out and march and bring their views to the streets. I would not like to see that situation taken advantage of as a result of people not being able to do that.

What needs to happen is that services need to open up very quickly. As has been outlined, some organisations and service providers have done well. Others may have appeared to have used the pandemic as a reason to not provide a service and perhaps to take a very risk-averse view regarding Covid-19. From here on, however, the HSE at national level is adamant that services need to reopen quickly. At the local level of the CHOs, there needs to be clear engagement with service providers because these services have to be got up and running very quickly.

There are issues here, however, as has been stated, regarding providing some funding to maximise capacity and also to take advantage of the situation to put in place the kind of services and methodology in service provision that has been underpinned by the policy, New Directions, which was introduced in 2012 with a four-year plan. There are still major gaps regarding how that plan has been implemented, but there are opportunities now for service providers to implement that New Directions plan properly and to ensure that the person with the disability is right at the centre of the service being provided.

Chairman: I thank Mr. Egan and Deputy Paul Murphy. The next speaker is from the Regional Independent Group. I call Deputy Shanahan. He has five minutes.

Deputy Matt Shanahan: I thank our contributors this morning. Deputy Duncan Smith might have addressed aspects of this issue, but I will return to the topic of section 38 organisations versus section 39 organisations. I visited the Waterford disability services some months ago and there was active recruitment happening at that stage from section 39 organisations

into the HSE. I would like to know from the witnesses if they think that recruitment has now stopped. The Minister or some of his representatives in this committee previously stated that a policy had been instituted that would not see that happen. However, is that recruitment still happening and what is the witnesses' latest understanding regarding the restoration of pay and services for section 39 organisations?

Dr. Joanne McCarthy: There is still a lack of clarity around the restoration of pay. A package was put in place, I think in 2019 but I cannot be certain, where the top 50 funded organisations under section 39 would get a restoration of pay. That left a significant number of organisations that are delivering services that also had pay issues but that have not been addressed. We have asked and, as far as I know, there is still no plan to address the restoration of pay for that part of the section 39 organisations.

The Deputy is dead right. That means that often the organisations deliver very similar or matched or the same model of services through section 39, but those organisations are not able to match the pay of section 38 organisations, which are essentially funded through the public purse and are on the public sector payscales. The brain drain, therefore, continues to happen. A physiotherapist might be working in one organisation and then a vacancy comes up with a section 38 organisation. That person will apply for that post and then leave, because he or she will be doing the same job but for more money in the new job up the road. That whole level of inequity is one of the issues that we know exists.

These are the fundamental issues that are continuing to destabilise services in the disability area. Those issues are also one of the key things identified in the review undertaken by Catherine Day. The independent review group had been established, just before Covid-19 struck. We had our first meetings in October and November in the Department of Health. These are some of the key and tricky issues that have to be addressed. While we talk about this issue in respect of pay, we must not forget how the individual or family will experience the impact of that pay issue. It is that destabilisation of the service. Can a person in a section 39 organisation be confident that the physiotherapist with whom he or she has built a relationship still be in place this time next year? Maybe the physiotherapist will get lured to a section 38 organisation that has the capacity to pay more money.

Deputy Matt Shanahan: My thanks to Dr. McCarthy for that. This is ongoing but I hope it is an area the Government will address between July and September.

I commend the work of all the witnesses, especially the former Senator, Mr. Dolan. I wish to discuss access to disability services and give a shout out for Karl Cretzan in Waterford. He is a cerebral palsy sufferer and he is now over 18 years of age. Although he lives less than half a mile from the Central Remedial Clinic unit on the grounds of University Hospital Waterford, because he is over 18 years of age he can no longer access physiotherapy, occupational therapy or language and speech therapy. He is in the same boat as everyone else who is over 18 years of age. Can the witnesses give us any comfort that these people will be looked at when it comes to future provision of the general services, especially those available in the community but not accessible for these people?

Dr. Joanne McCarthy: There is an ongoing issue with those arbitrary gaps that arise within disability and it happens with those just under 18 years and just over 18 years of age. We now have a comprehensive programme for children for physiotherapy, respite and occupational therapy. However as soon as the person reaches 18 years of age the same programme is not in place. The Disability Federation of Ireland along with colleagues, including Inclusion Ireland

and other umbrella organisations, put in for more funding in the run-up to the last budget and during the election. We were looking for €211 million over five years to fund day adult services such as the services the Deputy is talking about. Again, what is needed is sustained investment and a plan that outlines what we want to achieve for these people with the investment.

It is also important to remember that most of the 640,000 people with a disability are not born with disabilities. They are people like all of us here and they acquire the disability after a brain haemorrhage or car crash. They cannot access these services.

Chairman: I am sorry to interrupt. Please provide any further reply in writing to the Deputy. The next speaker is Deputy O'Donoghue from the Rural Independent Group.

Deputy Richard O'Donoghue: In mid-March, disability day services, including the intellectual disability services, were closed with a small number of exceptions. In May and early June, Inclusion Ireland surveyed the people who use these services and their families to establish the impact of the closure of services. In total, 291 family members answered the survey, as did 55 people with intellectual disability. The impact of the closure of the day service on the mental health of these people cannot be underestimated. A significant number of respondents reported increased loneliness, anxiety, challenging behaviour or anger. One third of those with intellectual disabilities said they had little or no contact with the services.

I will read from some of the responses received. One person referred to an odd text message but nothing else for ten weeks. Another person said he was highly disappointed with the services and the HSE. He felt absolutely forgotten about. He said there was little to offer by way of support for the family who care for him 24-7. Another person said there was no service aside from a ticking telephone call for the relatives. All they got was a telephone call. Another person said he was sent out a pack with a magazine and activities etc., as well as a telephone call.

Prior to the lockdown a total of 123 respondents had access to respite and a further 40 had access to home-based support. Since the lockdown only 15 people have had some respite and 16 people got some home-based support.

Here are more responses from the survey. One person said he got absolutely no respite and no day care since the service closed in March. This has had a tremendous impact of all concerned. His parents are managing him 24-7. The care was given over to them and there was no respite or home support. The carers were totally exhausted with never a minute off. There was no time for other family members who also needed support. There was continuous striving to maintain calmness. It is of vital importance that the Minister for Health makes temporary funding available to ensure that as many people get supported with the greatest amount of time possible upon reopening the services. When the lockdown came I saw that people who had carers coming to their houses had their hours reduced from eight to six, to four, to two. I have seen carers who wanted to go to work told by the caring services they only had a half an hour or an hour to provide the services. Why were carers who were willing to work not allowed to work?

Chairman: Who wishes to respond first?

Mr. Mark O'Connor: In terms of carers not being allowed to work, it is difficult to know. It has varied quite a bit from organisation to organisation. Obviously, there are public health guidelines in place and that severely restricted people in going into other people's houses, especially where there might have been somebody with an underlying condition. That has come through quite a bit in some of the anecdotal evidence that we have not included in the report.

We have what is sometimes referred to as the sandwiched care generation where there might be a younger person with a disability in the house, a family member who has an acquired disability through age in the house and somebody in the middle. We have also got paid carers who come into the family home who are also going home to families where there are underlying conditions. A significant number of staff were redeployed to contract tracing, Covid-19 testing and supporting residential services and that led to much of the deficit in supports going into family homes. I suppose that is guessing at what a lot of it is but that is certainly what has been reported to us.

Deputy Richard O'Donoghue: We have homecare agencies that give support to the elderly and people with disabilities in their houses. They were offering to work and looking for more hours and they were not allowed to work. The people who wanted to work had their hours reduced but their hours were kept to a bare minimum to stop them getting the carer's Covid payment.

Chairman: I am sorry I must ask the Deputy to conclude. If anybody wishes to reply to that point, I would ask him or her to do so in writing.

I will bring in the next Fianna Fáil speaker, Deputy Murnane-O'Connor. In order to get everybody in by 11.30 a.m., I regret I must reduce the remaining slots to four minutes from five.

Deputy Jennifer Murnane O'Connor: First, I thank everyone here today. It is so important that all of us work together for people with disabilities. I particularly want to mention my good friend, John Dolan, who has been a huge advocate for the Disability Federation of Ireland. I sat with John in the Seanad for four years.

I want to talk about preschool children. They are not expected to social distance and I believe they can go in groups, like pods. I am concerned that the HSE has reduced disability funding to organisations by 1%, which on the scale of things is massive. Will there be funding for these preschools when they go back? Is that a concern?

The second matter on which I received several phone calls is that children have not been receiving any therapies - physiotherapy, occupational therapy, OT, speech, psychology - as the HSE is now only operating face-to-face with priority 1 cases. Already, we have had long waiting lists, particularly for network disability team, NDT, autism spectrum disorder, ASD, assessments, with no new appointments being given. This is worrying for the families.

The early intervention service is simply not happening for many as by the time their turn comes around for assessment, therapy or speech or OT, early years have passed. We need to look at significant investments. Maybe I can come back on that one. I would like to support Enough Is Enough and Linda Comerford, who is a carer. In fairness, we need to know when all the services are opening. Given that Ms Comerford is from Kilkenny, I am sure Deputy Funchion will raise it too. We need a roadmap. When I spoke to the Minister of State, Deputy Rabbitte, the other day, I asked her when we could get official dates. We have heard a suggestion that it might happen in August or September. The Minister of State told me she had been speaking to the HSE. She has asked about a web page because she believes it might give more information about the over 1,000 services provided to adults. I feel from dealing with families and listening to their concerns that there is a lack of information. What do the witnesses feel about the new web page that is to be put up by the HSE? Can I have an answer on that?

The other thing I want to ask about is whether there will be enough funding. Is it possible

that when we go back to adult services or preschool services, we will not get the funding that is there? Have any of the different bodies been speaking to the HSE? Can someone come back in on that? Is my time nearly up?

Chairman: There is one minute left so the Deputy may want to leave it for answers.

Mr. Mark O'Connor: This is not a Covid-19 issue, but obviously it has been exacerbated by the pandemic. The HSE's performance report from September 2019 indicates that many people in services were waiting longer than 12 months. That is an extraordinarily long time if one needs therapeutic input. Some 2,830 people were waiting for physiotherapy, 9,296 were waiting for occupational therapy, 1,035 were waiting for speech therapy and 2,636 were waiting for psychology for more than 12 months. I would add on six months in each case since Covid-19 has started.

When one digs deeper into the HSE's performance report one sees that hundreds of people have been waiting more than two years. It is a particular issue in all of the Dublin CHO areas.

Finally, the HSE has to do an assessment of needs within a six-month timeframe. Nationally, 10% are done within six months.

Mr. John Dolan: I will make a couple of comments. First, I thank Deputy Murnane O'Connor for her kind remarks. The Deputy talked about funding for preschool, early intervention and the HSE web page, etc. I will give a quick omnibus response. A lot of these questions-----

Chairman: I am sorry but there is not enough time for an omnibus response. You will have to give it in correspondence.

Mr. John Dolan: A very quick response, sorry.

Chairman: I am sorry, Mr. Dolan. I must try to get in all the speakers to be fair to everybody here. We cannot go over time because of health guidelines. The next speaker is Deputy Funchion, who has eight minutes.

Deputy Kathleen Funchion: I will help the committee by not taking all eight minutes available to me. I know we are under time pressure. I thank the speakers and witnesses for coming in today. I have a number of questions and many of them will be more relevant to the Department this afternoon. I want to ask the witnesses specifically about the adult day services, which were mentioned by Deputy Murnane O'Connor. Do the witnesses have any understanding of when they will reopen and what the guidelines will be? They do not seem to have not received any information or guidelines and it is a huge concern in that sector. Does anybody on the witness list have any information on adult day services?

Mr. Mark O'Connor: The guidelines that have been issued by the HSE do not contain dates on quantum of service within them. The only reference to quantum of service is to say it will be a reduced level. Anecdotally, we have heard back from some people that the service for their family member will begin to ramp up after the August holidays. We have had contact from a few folks saying 7 September seems to be a date a couple of services have given out. Worryingly, a few folks have indicated they are looking at December and January.

Deputy Kathleen Funchion: It is actually shocking to think that some people will have to wait that length of time. We seem to fail people with disabilities or additional needs continu-

ously and consistently. We always seem to talk about the waiting lists, not even with regard to Covid-19 but in general. Everything is a battle. One always seems to have to accept a different standard. It is really frustrating and I cannot imagine what it must be like for people and their families. That brings me to my next question. Is Dr. McCarthy aware if a specific person was ever appointed to NPHET or to tie in with NPHET in any way regarding people with disabilities? It seems to me they have been totally forgotten about. We cannot have absolutely everybody on a committee but it seems this was a very crucial category that was not provided for

Dr. Joanne McCarthy: I represent people with disabilities on NPHET. We represent people with disabilities on the vulnerable subcommittee of NPHET and it has been difficult. It is obviously a big committee with more than 30 members. We have managed-----

Chairman: I ask Dr. McCarthy to speak a little more loudly.

Dr. Joanne McCarthy: I apologise. Disability in the pandemic was not going to be resolved by health alone. The really good thing about the vulnerable subcommittee is that the community Covid response was also sitting and reporting in to that committee. Many people with disabilities and their families were really dependent on the local responses that were happening on an *ad hoc* basis through the community response. Within disability and within the HSE we committed to responding and putting in place as best we could an initial emergency response to the pandemic. Any issues that we as a sector felt we could not get resolved we had the capacity to escalate to NPHET. Having fewer than 16 people with disabilities in residential services pass away as a result of Covid - which was still 16 too many - does speak volumes when one looks at the difference between what happened with us and within nursing homes. It was partially because we had that link.

There are some outstanding issues, the decisions around the wearing of face masks is definitely a problem for the deaf and hard of hearing. That is an ongoing issue that we have with NPHET. Several members of the committee have raised the issue today of how to continue to support medically vulnerable people who are cocooning and that is another issue we have with NPHET. We are still waiting for them to give clearer guidance to our sector on those two outstanding issues.

Deputy Kathleen Funchion: With all due respect to Dr. McCarthy, there are a lot more issues outstanding than those two. I do not think I have spoken to anyone with a disability or their families who have found the response to date acceptable. People have been totally abandoned. PA hours were cut, home helps have not been coming in and, as was clarified earlier, there are no dates for the resumption of some services. It may not be until December or January. This was already a sector so overburdened with waiting lists. From the point of view of children who are dependent on various therapies, so many of them have regressed. That is why it is important that there would have been a link. It is not necessarily a decision for DFI and we can bring it up with the Department later, but this group has been abandoned.

On masks, a number of people have contacted me over the last few days since that announcement was made, particularly about people with autism or sensory issues. If that is not made clear for them and to the public there will be an issue with people asking them why they are not wearing masks. As such it is really important that that is made absolutely clear. Otherwise we are saying to people with disabilities that they must stay inside their houses and not bother ever interacting with anyone. It is really important that that not be the message that goes out.

I have one last point on the UN Convention on the Rights of Persons with Disabilities. We

have not ratified the optional protocol, which we need to do. In the opinion of the witnesses, how would the situation have been different if we had? I think people would have had a bit more power because they would have known they have the right to potentially take a case to the UN.

Professor Caroline Fennell: What often happens is that change comes about because one individual is able to very concretely demonstrate how the State has failed. As such, if the optional protocol had been acceded to by Ireland it might have made a difference in the sense of the ability to demonstrate concretely the impact on an individual. It is unfortunate that has to happen. It often happens in situations that change is brought about because of a very visible example of where the State has failed. It is very clear that the State does not need the protocol to know what has to be done. We know what has to be done. It is really about the issue of delivering on the promise that the State has made with regard to human rights and equality. The equality element speaks to the fact that we really need to have participation by all the citizens. In order for certain people to be able to participate, they need the supports that have been spoken about today to allow them to participate and live a full life where their human rights are respected and they are equal to all citizens of the State. That is what it is about. The Deputy has a point with regard to the protocol and it is something the State should address.

Dr. Joanne McCarthy: I would like to come back in on a point that Deputy Funchion made. I see there is a little bit of time.

Chairman: Very briefly, please.

Dr. Joanne McCarthy: I refer to a very important point which I hope will resonate with the committee. The Deputy talked about the lack of clarity around community supports. One of the main messages we want to leave today is that while NPHET did provide a pathway to understanding and looking in at residential services and the challenges there, in this break before the next wave, if it should come, we really need to provide the same level of clarity on the community supports, personal assistance and in-the-home supports. There is an expectation that NPHET will give that guidance and will invest in those services so that families and individuals are not feeling left abandoned as they are right now. That is really important and I thank the Deputy for raising the point.

Deputy Fergus O'Dowd: I support all the speakers I have heard. We agree absolutely that we are in an appalling and unacceptable situation, not just for the families and their support but also for the people who actually have the disabilities such as autism and all other diagnoses and multiple diagnoses. In many cases these disabilities leave them with a very poor quality of life and the families are also really suffering. A number of parents have been in touch with me. One has a 25 year old daughter who is severely disabled and completely dependent for everything. The mother writes that it is very hard on her body to look after her. Her back is in absolute agony from the physical demand. She is emotionally drained and down in herself at all times. Other parents have more than one child with a disability. They are absolutely frustrated and angry. They are spending all their energy trying to look after their loved ones and it is just not working for them. I refer to a parent of a teenage son who has multiple disabilities and is 15 years old. He is over 6 ft tall and the mother is not able physically to meet his needs but has been refused a residential place for him.

In view of all the points the witnesses have made and that we are making here, how do we ensure there is action? The situation may well be exacerbated by the flu that is on its way and perhaps by a return of the coronavirus. We need a plan. One of the witnesses referred earlier to

everybody getting together. Is there a forum through which we can insist on this to the Minister, the HSE and everybody else, including the bodies and advocates for families? Where is our next step? We can talk here all day but what action are we going to take as a result?

Mr. John Dolan: There is one absolute linchpin focal point that is now available to the Oireachtas, namely, the commitment to establish an Oireachtas joint committee on the implementation and monitoring of the UN convention. We have for the first time a full Minister with responsibility for disability. The Chairman has just picked up on the importance of having that Minister come to the committee and of making sure that the decision the Dáil made two years ago to ratify the convention is put front and centre in all of Ireland's plans. Deputy O'Dowd and I did a lot of work on the transport committee and that is one area. Other areas are housing, employment and education. There are a whole range of them. The Spanish Parliament may also have some kind of mechanism, but I think Ireland is the only Parliament in the EU that now has this opportunity agreed to in the programme for Government. It is really important that it is taken and that this becomes a focal point for all Members of the Oireachtas, all the various interest groups, people with disabilities, their organisations and so on. They must drive it.

Members of the Oireachtas have spoken this morning about issues relating to different Departments. They will all sit on committees of one kind or another. I appeal to them to keep the flag flying in those committees for the inclusion of people with disabilities. The articles of the UN Convention on the Rights of Persons with Disabilities contain very plain language about what must be achieved. This must be kept front and centre in every Oireachtas committee.

Deputy Joe Flaherty: I thank the speakers who are here this morning. We are in no doubt about the challenges facing the disability sector as it seeks to come to terms with the Covid-19 era. Many of the witnesses have eloquently emphasised that those challenges existed before Covid-19. I am particularly concerned about the funding challenge and the timeline for a return to full day care services. We got the roadmap last week and there was some indication of a possible return of services in August. I am concerned by the overtures from the witnesses today to the effect that it could be as late as December or possibly the new year before we see any real meaningful service in that area.

We have several service providers in Longford, including the Phoenix Centre, the National Learning Network and St. Christopher's Services, with which I know Mr. Dolan is very familiar. He came there and spoke at the annual general meeting several years ago. I note 12 of the St. Christopher's Services day care staff members were redeployed to provide cover at residential settings during the Covid-19 pandemic. In order for St. Christopher's Services to expand its day care service to families who are genuinely and badly in need of it, it will have to bring those 12 staff members back from deployment in residential service. The catch, unfortunately, is that those in residential care cannot be left alone.

This comes down to the sums. The annual cost of replacing those 12 staff members will be just under €580,000. If a day care service resumes without additional funding it will be patchy at best and certainly significantly inferior to the service available at St. Christopher's Services before the onset of Covid-19. We have seen €70 million ring-fenced for the childcare sector. It was much needed and it is very welcome. Are the witnesses satisfied with the level of engagement to date on the part of the Department and the HSE on the funding necessary for a resumption of a meaningful day care service as quickly as possible?

Mr. Mark O'Connor: The Department of Health will probably be responsible for funding. The HSE carries out functions for the State but only goes as far as the funding can take it. As I

understand it, the HSE has been told that no additional funding is available for additional staff. That is why at a quite early stage we called on the Minister to restore service to pre-existing levels. If that requires a temporary Covid-19 fund, so be it.

We have spoken about the UN Convention on the Rights of Persons with Disabilities. That envisages people being involved in their everyday communities. There is a HSE policy on this, New Directions. That should give people choice around education, employment and making progress in their lives. It has not been fully implemented. If any new funding is available it should be channelled in the ways called for by New Directions. That does not necessarily mean people having to go to a big centre somewhere. As Dr. McCarthy said earlier, a lot of people work a couple of days a week. They can be supported to go from their homes to their places of employment. If they are accessing an education course in the community, they can be helped to do that from their homes. This does not always have to involve travelling to a big centre. Additional funding is certainly needed to restore the previous levels of service.

Chairman: I thank Deputy Flaherty. Does anyone else wish to comment very briefly on that point? I am sorry the speaking time is so short.

Deputy Colm Burke: I thank all the organisations for the work they have done in very challenging times. With more than 6,000 people in residential settings, it is significant that people were protected so well. I believe only 166 people were identified as having Covid. It is welcome that the number is so small in these very challenging settings. I compliment all the staff working in them.

I wish to focus on the long-term challenges we now have in the disability sector and also with the growing elderly population. I believe the Disability Federation of Ireland represents more than 120 different organisations. About 2,500 section 38 and 39 organisations provide essential services throughout the country in a range of areas. Covid has highlighted the challenges. Is it time for a joint approach and amalgamation of services rather than everyone working in a different pathway?

A number of years ago a multiplicity of unions represented workers. Over a period of time they came together and the unions achieved much more as a result. Should organisations in the disability sector come together rather than acting independently? In the past six years, the number of full-time staff in the HSE has gone from 103,000 to 123,000. That has not happened in the disability sector, meaning that it is getting squeezed in the process. Rather than having so many independent organisations, is it now time for organisations to consider amalgamating, allowing them to provide a far more comprehensive service?

Mr. John Dolan: The Deputy mentioned the unions. I am not up to date with the numbers. At one stage we had as many trade unions as Germany had and that was after efforts in Ireland to get unions to amalgamate. The Deputy asked if that is the right way to go about it. Organisations working hand in glove is the key issue. We all now have something we did not have until recently. The United Nations Convention on the Rights of Persons with Disabilities is the glue that pulls us all together, particularly now that the Government has ratified the convention. Government agencies, Departments and bodies can now say that is the bible we all have to work towards and with which we wholeheartedly agree. That would have a major unifying effect.

Deputy Colm Burke and I both served on the Oireachtas health committee. He will be aware of the number of small, new support groups that emerge when the diagnosis for a condition, a spectrum or whatever becomes possible. Where will they fit in? The Irish Motor Neurone

Disease Association was set up over 30 years ago. Those involved approached two existing organisations at the time and asked to work with them. That was not possible because it would have opened up a whole focus on other organisations doing the same thing.

One of the fundamental rights in Bunreacht na hÉireann is the right to form associations and unions. The issue is how we can get them to work more cohesively together.

Deputy Colm Burke: My point is that there is going be huge growth in the number of people over 65 in the next ten years. It is going to go from 640,000 up to 1 million. The big issue is the challenge about having the numbers of people to provide the support. In the past 12 months when we had full employment, there were great challenges for every organisation to get people to provide the services. That is going to come back. We have to take that into account. Therefore, the disability sector is going to have that challenge.

Mr. John Dolan: It is not just the disability sector that has the challenge, it is the State that has the challenge. I am not being bullish. There have always been amalgamations of organisations over time and organisations have also gone out of operation. The issue is identifying the best way to ensure that the voices of people and families are heard and that they are able to be involved. In all fairness, from my almost 40 years of involvement, doing mergers and acquisitions as would be done in the private sector does not work in public benefit organisations. We went from having ten or 11 health boards to having one. That is the final thing I will say. I thank the Chair.

Chairman: I thank Mr. Dolan and Deputy Colm Burke. I apologise to all of our witnesses for the fact that we had to rush through it. It has been the nature of this committee because we have health guidelines. We need to get our guests out of the committee room they are in now. I thank them very much for coming and answering all of our questions. I thank the Deputies who contributed.

I said we would return to the issue of our report and recommendations on the stimulus package at the end of this meeting. I do not know if we need to go into private session to do so. Do we need to discuss the amendments or are all of them agreed?

Deputy Matt Shanahan: On the amendment that I proposed-----

Chairman: It is included.

Deputy Matt Shanahan: If it attaches to No. 5, not No. 4. It attaches to the one that references credit unions. That is fine.

Chairman: Does the Deputy wish to remove one of them?

Deputy Matt Shanahan: Yes. I put it to both but it should attach to the one in respect of credit unions. I think that is No. 5.

Chairman: Yes.

Deputy Matt Shanahan: That is fine.

Chairman: The other is removed. Other than that, are all the amendments that have been circulated agreed to? Agreed. Is the report, as amended, agreed? Agreed. I thank the staff of the secretariat for all the work that went into this. In particular, I thank Mr. Bryan Coughlan for his work into the early hours of this morning and then a little bit later.

Sitting suspended at 11.40 a.m. and resumed at 12 p.m.

Non-Covid Healthcare Disruption: Waiting Lists and Screening

Chairman: I welcome our witnesses, who are in committee room 2. From the Irish Cancer Society, I welcome Ms Rachel Morrogh, director of advocacy and external affairs, and Mr. Donal Buggy, director of services. From the Irish Medical Organisation, IMO, I welcome back to the committee Ms Susan Clyne, chief executive officer, and welcome Dr. Peadar Gilligan from the IMO's consultant committee and Dr. Denis McCauley, chair of the IMO's GP committee.

I wish to advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If you are directed by the committee to cease giving evidence in relation to a particular matter and you continue to so do, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, you should not criticise nor make charges against any person or persons or entity, by name or in such a way as to make him, her or it identifiable.

I invite Ms Morrogh to make the opening remarks for the Irish Cancer Society. I ask that she confine them to five minutes to allow time for questions and answers.

Ms Rachel Morrogh: I thank the Chair and members of the Special Committee on Covid-19 Response for inviting the Irish Cancer Society here today. We wish to start by formally recording our appreciating for healthcare workers, support staff and anyone working involved in the delivery of healthcare during the pandemic which includes our own staff at the Irish Cancer Society. Their selflessness allowed for the ongoing provision of urgent cancer services in even the exponential phase of the Covid-19 pandemic. This included the Irish Cancer Society's night nursing team who provided nursing care in the home of patients who were at the end of their lives. Our national support line was extended to seven days a week to assist with increased queries from anxious patients and family members. Our volunteer drivers continue to provide transport to people right across the country enabling patients to get to life-saving chemotherapy treatment.

Regarding the impact of Covid on cancer services, a few key points need to be addressed. On 27 March all non-essential surgery, screening and diagnostic procedures were postponed causing huge additional anxiety for patients. The impact of these postponements on cancer outcomes will take years to be fully uncovered. The immediate impact is that it has led to thousands of people not being screened, as well as growing waiting lists for cancer tests and treatment. There is little clarity in sight as to how these will be addressed. It is evident that without immediate action there will be excess and avoidable cancer deaths in the years to come as a result of people getting the care they need later than they should. An illustration of this is that we would expect approximately 450 cancers and 1,600 pre-cancers to have been detected in a typical four-month period if the screening services had been operating as normal. As such, we are very pleased that CervicalCheck has now resumed but disappointed that BowelScreen and BreastCheck may not return until autumn. In addition to screening we are concerned that there are still symptomatic patients who have not sought medical advice and as a result may experience a delayed diagnosis and access to treatment. If action is taken immediately then we

might avoid the most dire predictions becoming a reality. Some of these are included in the submission we made to the committee.

As a first step the HSE must publish a recovery roadmap without delay and the Government needs to fully fund this before budget 2021. The crisis in cancer care pre-existed Covid-19 and the pandemic has just made things worse. Before Covid, targets in the national cancer strategy relating to timely access to diagnostics, surgery, radiotherapy, and the uptake of screening were all being missed. This is a direct consequence of consistent underfunding of a system that has been running to stand still in recent years and which has frequently budgeted in the knowledge that it will not meet demand. As such a return to normal is in fact undesirable for us. We want and need to do so much better. All of us - Government, Oireachtas Members, advocacy organisations and healthcare workers need to ensure that cancer services are fully restored in the short term. We need to take the opportunity to build back a better cancer system focused on the full delivery of the national cancer strategy. Rather than using a challenging environment as a reason not to improve services, we need to use it as the precise reason for building better, more equitable, high quality care that addresses the many needs of cancer patients in Ireland.

Chairman: I thank Ms Morrogh.

I invite Ms. Clyne to make her opening remarks and ask that she also confine them to five minutes to allow for questions and answers.

Ms Susan Clyne: Good afternoon. I thank the committee for the opportunity to address it.

The IMO is the trade union and representative body for all doctors in Ireland who are delivering care to patients across the health services. This includes consultants, public health doctors, community health doctors, GPs and non-consultant hospital doctors, NCHDs. The fundamental problem within our health services is one of capacity and this predates Covid. As a country, we have restricted patient care to match the deficits of our services rather than investing in those services to meet patient need. The Health Service Capacity Report was published in 2018 but little or no progress has been made since. Covid has resulted in extreme pressures on our health services. Our response should not be to limit all other care, but to proactively increase capacity to allow for non-Covid care pathways and create capacity for any Covid surge. To do otherwise will only compound the problem. It is inevitable that patients whose care has been delayed will present with more complex needs as they deteriorate and they will suffer negative health outcomes. Mortality rates will increase. We now have a situation where capacity will be reduced by up to 50% while at the same time there are more than 800,000 people waiting for an outpatient appointment or inpatient care.

We have mounting pressures on our emergency departments throughout the country. Extremely limited referral pathways are available to GPs and there are increased pressures on GP services in situations when patients cannot access secondary care, diagnostics mental health services and other community supports. There is severe overcrowding in our emergency departments with patients languishing on trolleys, elective procedures are routinely cancelled, there are lengthening waiting lists and hospitals are operating at dangerous levels of occupancy. Unfortunately, this year will be worse with the additional impact of Covid-19.

In summary, we have too few beds and we need to plan for an additional 5,000 public acute beds and 300 additional ICU beds. In this context, we must immediately embark on a temporary build programme in tandem with longer-term builds. We have more than 500 vacant consultant posts, and for many years the system has not been capable of attracting sufficient num-

bers of consultants due to inequitable pay policies. General practice and the much needed shift of care to the community must be planned and resourced. There is little additional capacity in general practice at the moment. We must strengthen our public health capacity. We have relied on public health throughout this crisis, but public health is understaffed and undervalued within our system. Care of the vulnerable and elderly in our society requires urgent attention with significantly more resources deployed to allow people to remain at home. We need to continue to invest in prevention with appropriate resourcing of our vaccination programmes and significant investment in diagnostics and treatment pathways to support our screening programmes, and those screening programmes should open as soon as practicably possible. We also need to invest in e-health across all hospitals and community healthcare settings.

Since the commencement of the pandemic, doctors and all other healthcare workers have shown dedication to patients, professionalism and agility in adopting new ways of working. We now appeal to the members of the committee and the new Government to respond in kind to support us and our patients by investing immediately. This is a health crisis and we must respond accordingly and prioritise investment in our health services.

Deputy David Cullinane: I welcome Ms Morrogh and Ms Clyne. I thank them for the kind words expressed about our front-line staff across all our healthcare settings.

As a committee and as Oireachtas Members we have to look at a health catch-up programme that includes acute care across a range of specialties and we are looking at mental health services and older people. Obviously there are challenges for the healthcare system to catch up on delayed care. I will start with cancer screening. Ms Morrogh referred to this in her opening statement when she said that thousands of people had not been screened, that it may take years before we know the full extent of what this will mean for patients, and that some patients may die prematurely if we do not put in place the catch up and if people do not get a diagnosis as quickly as they should. How serious is this matter? Is Ms Morrogh satisfied that enough is being done by the Department of Health and the HSE at this point in time to get the screening services back up and running? That is a starting question.

Ms Rachel Morrogh: The Irish Cancer Society believes it is imperative to get screening services restored, and restored to the way they were before Covid-19. We know the environment is extremely challenging but consider the figures calculated by the Irish Cancer Society. Some 450 cancers have possibly been undetected to date and additional pre-cancers have been undetected. One can start to understand that without our screening programmes Ireland is missing a central plank in its cancer prevention and early detection strategies. If we do not restore the screening programmes to the high quality screening systems that were place before Covid-19 then we risk the general public's health and the chances they have of being diagnosed with cancer early. We know the importance of an early cancer diagnosis. If a person is diagnosed at an early stage then his or her chances of survival are so much better. Ireland is not doing well in cancer survival. Ireland is lower than the OECD average and we need to do much better. This is why the national cancer strategy sets out that blueprint for excellent cancer care, and why we as an organisation, and many other organisations, are extremely disappointed at the lack of momentum and funding behind that strategy. We want the screening programmes to be restored as soon as possible. We are pleased that CervicalCheck is getting under way. For breast and bowel screening, there are people who, unfortunately, have cancer and do not know it. Until those screening programmes are restored, we are not giving them the best chance of detecting that cancer as early as it could be.

Deputy David Cullinane: I thank Ms Morrogh. She said earlier that before Covid, we

already had untimely access to diagnostics and we now have a backlog, which creates more problems and challenges. The HSE will tell us today that it accepts that there is a developing backlog of cases, including in the four main screening programmes, including cancer. It says that this backlog will now have to be cleared in a Covid environment. If Ms Morrogh was talking to the HSE, what is the timeframe? One can say that we will clear the backlog but in reality, how quickly do we need to clear that backlog? From Ms Morrogh's perspective, what timeframe are we looking at?

Ms Rachel Morrogh: We need to clear it quicker than we are. We need to do a capacity review and we have made that recommendation in the submission to the committee. It is important to know what capacity is there. In the case of endoscopy services, capacity has been reduced to between 30% and 50% of pre-Covid levels. Before Covid, there were extremely long waiting times for non-urgent colonoscopies. There is a cancer detection rate within that group. There are currently 19,000 people waiting for a colonoscopy. How are the endoscopy services able to do more, since there is a backlog, with less, due to the capacity issue? We need to consider, while I do not know the answer to this, whether the workforce has been fully restored or if people are still in roles to provide Covid services. We have many different things to consider but we need people to take action today. We are at a crossroads. If we do nothing, we face a dire situation.

Deputy David Cullinane: If we do not take urgent action, the dire situation is that, unfortunately, people will die of cancer prematurely because of a lack of a diagnosis. Is that the case?

Ms Rachel Morrogh: Unfortunately, that is the case. We need people to be diagnosed early. That gives them the best chance of survival. We are worried that some people have not accessed medical services yet. Perhaps they are worried about seeking help in a healthcare environment. We strongly encourage them to phone their general practitioner if they are worried about going in themselves to seek the help that they need. If a person is diagnosed with cancer early, he or she is much more likely to survive it. The likelihood is that if anyone has a sign or symptom of cancer, it is, one hopes, not that disease, but it needs to be checked out.

Deputy David Cullinane: I see that in Ms Morrogh's submission and opening statement she refers to public awareness campaigns to encourage people to get screened and checked, and to have a diagnosis. If the capacity is not there, the screening services are not up and running, and people are contacting the programmes but not hearing back, that will add to their stress. Ms Morrogh is right in saying that we need to have advertising programmes and that people need to be informed and encouraged. If we do that, would Ms Morrogh agree that it is important that the programmes are up and running? Otherwise, it gives people false hope and adds to the stress that they will be under.

The submissions that we have got from both organisations are really high quality, with many good recommendations that this committee should forward to the HSE. The IMO talks about investment in diagnostic and treatment pathways being needed to support the full re-establishment of these life-saving programmes. It is talking about the screening services. Would Ms Clyne from the IMO speak generally about the need to accelerate the reopening of screening services and the importance of it from her perspective?

Ms Susan Clyne: The screening services are important and have been a major health initiative over recent years. The IMO would fully support that. There is a slight difference in the screening services between the women and patients who are called for screening and the encouragement of patients who are developing symptoms outside of screening. Screening is

not a diagnostic tool in and of itself. The message we give to the public should be that anyone who discovers any lumps or bumps about which they are concerned should contact their GP. We need very quick referral pathways from general practice into cancer services in hospitals. The screening programmes are one element of the issue and they are valuable. There is also the issue about the public being almost afraid to attend or concerned that the service they need will be unavailable. It is important that members of the public attend or call their GP when they notice a change in their health. We cannot make everything about Covid-19.

Deputy David Cullinane: That is an important point and I accept it. I just want to put a further two questions to Ms Clyne because we are tight on time. There is an awful lot I would like to ask about, but we are confined by the time limits. Ms Clyne mentioned preparation for the winter flu season and what will happen with the added concern of Covid-19. Those concerns relate to vaccinations and how they are rolled out, as Ms Clyne referred to. I ask her to expand on that.

Ms Clyne has also talked about the need to increase physical capacity in the system. We have also heard from the HSE that the two-metre social distancing rule has meant that capacity is down approximately 25% in acute settings. Is there a need to get additional physical space? Is that what Ms Clyne is calling for and has she made submissions to the Department and HSE in that regard? What type of physical accommodation is Ms Clyne talking about? What would that additional capacity be needed for?

Ms Susan Clyne: There is absolutely a need for additional capacity and there has been for more than ten years. We cannot possibly accept that we are delivering a health service with this reduced capacity. All it will mean is that things get worse, problems will be worse, and people will get sicker. Temporary builds must be the first option. Purchasing or renting space will have to be the second option, while we develop longer term deals or acquisitions. Other than the provision of funding, there is no reason temporary builds cannot proceed. I will ask my colleague, Dr. Gilligan, to speak to the question about the bed situation.

Dr. Peadar Gilligan: As committee members are aware, we have had significant issues with capacity and occupancy in the acute hospital system for many years in Ireland. There are currently 580,000 people on outpatient waiting lists and nearly 250,000 people awaiting various procedures or day case admissions. There was already huge pressure and massive unmet need within the system at a time, before Covid-19, when we were running our acute hospitals at between 97% and 104% occupancy. The public is aware of this because members of the public are waiting for procedures. They are also aware of the fact because of the level of crowding in emergency departments. We can never return to a situation where, when a patient arrives to an emergency department with an emergency condition, he or she is faced with a crowded waiting room, treatment area or resuscitation room. The only way to move away from that situation is by having the required capacity. We were advised in 2018 that a minimum requirement of 2,690 beds needed to be addressed. In the context of the Covid-19 crisis, that minimum requirement has, conservatively, increased to 5,000 beds.

Chairman: Dr. Gilligan can reply further in writing. I thank him very much. Somebody else may wish to ask him about the same point, but I must give way to the next speaker, Deputy Colm Burke of Fine Gael. Is the Deputy taking ten minutes?

Deputy Colm Burke: I am taking ten minutes. I thank our guests for their presentations this morning and the work they have done over the difficult past four months. I especially thank the front-line staff in all our hospitals and community settings.

We are facing new challenges. The hospitals do not have the same capacity because of issues around social distancing and the new processes and procedures that must be followed. I am regularly hearing GPs complain about a lack of access to diagnostic services. Is there any way that we can fast-track and improve that service immediately? People are being referred to outpatient clinics that duplicate a lot of the work that GPs are already doing, but GPs have to refer patients because they cannot get access to diagnostic systems. How can an improvement in that regard be fast-tracked? Since December 2014, the number of people working in the HSE has increased by 20,000. The figure has increased from 103,000 to 123,000 whole-time equivalent staff. If we were to prioritise recruitment in the morning, which areas should be prioritised? When consultants are recruited they also need to have access to beds, operating time and support staff. Where should the priorities be for staff recruitment?

Ms Susan Clyne: I will answer some of the Deputy's questions and pass others on to my colleagues.

The idea of prioritising has been the fundamental problem. We have to accept that our health services do not have enough doctors, nurses and other health professionals working in them. We have to accept that we do not have enough beds. This idea of robbing Peter to pay Paul and making a choice between a consultant and a nurse will not improve the lot of patients. We need significant financing of our health services and we must take this opportunity, as our colleagues in the Irish Cancer Society said. We do not want to go back to the way it was before Covid-19 when it was not good. We want to move on and go back to a system that meets patients' needs and allows people to work in a system and deliver the care they are trained to deliver, rather than running around everywhere trying to source a diagnostic for patients.

On the issue of diagnostics in general practice, I have been looking at budgets from various Governments for many years that show an allocation for diagnostics for general practice, but this budget has yet to materialise. I understand representatives of the HSE who appear before the committee this afternoon will say the HSE is bringing diagnostics to general practice. We would very much welcome that. We would also welcome sitting down with the HSE to see how that will be run. If GPs had quicker access, we would prevent some people from being referred to hospital. People will still need to use hospital services so these services cannot be limited by virtue of capacity. We have to think outside the box and ask how, if this is the limit, we will improve capacity, not just operate within capacity.

I will ask my colleague, Dr. McCauley, who is the chair of the general practice committee and a GP in County Donegal, to talk about the diagnostic flow through from the GP to the secondary care.

Dr. Denis McCauley: I thank Deputy Burke for his question. On the principle of care within the community without referral to the hospital, the clinical evidence is that this approach is effective and also cost-effective. When that care is properly resourced and planned it works.

Last year, the Irish Medical Organisation introduced a deal under which chronic disease will be managed more in the community. We will be able to manage some 80% of the chronic diseases in general practice to a very good standard. The resources, evidence and planning for this are available. This is a template we can use in other areas. As Dr. Clyne has said, 20% of those people will need to be referred on. The concept of care within the community is good for a certain cohort.

There is no doubt that if diagnostics were more freely available to us, we would be able to

attend to a certain number of people and reassure them that everything is fine. We could also be able to identify people who need to go to hospital. There are *ad hoc* systems in place throughout the country where scanning has been made available to GPs. The feedback is that these are responsive, very effective and give reassurance to patients early on that everything is fine. It also gives reassurance to the doctor that the person does not need to be referred. If 100 people with abdominal pain come in, it will be possible to identify and screen out those who need to go to hospital.

Deputy Colm Burke: Does there need to be more structured approach to GPs accessing diagnostics? The big complaint I have is that-----

Dr. Denis McCauley: Yes. Following on from that point, when GPs have access to the *ad hoc* system, where that is available, it is very useful. To make the system effective diagnostics need to be available to all GPs nationally. The word we are hearing is that there will be a system whereby GPs will have more access to diagnostics. If such a system is announced by the HSE, implemented and made available to all GPs, it will be supported by the IMO.

Deputy Colm Burke: Is the IMO satisfied that this can be fast-tracked in order to help?

Dr. Denis McCauley: That is beyond my pay grade. If it is fast-tracked, that would be a positive development but I would have no influence in that. I would only encourage that it is fast-tracked. It is like all systems in that it is in the community and it would be cost-effective management. Therefore, it would ultimately save money and lives, which is what we all want. We primarily want to save lives but if it saves money as a secondary feature, that is excellent.

Deputy Colm Burke: I want go back to the cancer services and how they are coping with the new challenges. What kind of numbers do we need to be able to deal with these new challenges in staffing numbers? Have we looked at what we need in that area and where we can recruit staff from? One of the other issues we have with healthcare is that while everyone is talking about the numbers of people we have in the system, no one is looking at the numbers of people who will be retiring out of the system over the next three to four years, which is also something that needs to be looked at. I am not sure if we have any figures from the HSE on the numbers of people who are retiring out, including nurses, care assistants and consultants.

Ms Susan Clyne: I can quickly respond on the manpower issue and Ms Morrogh will talk specifically about the oncology and cancer manpower services. We know that over 600 GPs are due to retire out of the system in the coming years and there are no supports to help younger GPs to establish themselves. We also know there is a large percentage of consultants who are due to retire. This information is easy to get. The HSE has the data of everybody in the system.

We have failed miserably to attract people to work in the system. That is down to the undervaluing of doctors and other healthcare professional staff within the system and this is known. The healthcare capacity report from 2018 clearly indicates what levels of manpower we need. That is starting from a base of where we have manpower but we are 500 consultants short in the system. That is 20% to 25% of the workforce on any given day that we are short of in the system.

The IMO made a request to the HSE and the Government that specialist registrars, SpRs, who had qualified and finished their training in July of this year would be given a locum post for six months because they cannot travel on to do fellowships. They have not been given those posts. Some are now operating in jobs way below their skill levels and they are not there to

deliver much-needed services to patients.

Deputy Colm Burke: How many SpRs is Ms Clyne talking about?

Ms Susan Clyne: There were 160 SpRs who finished their training two weeks ago.

Deputy Colm Burke: Of that number-----

Ms Susan Clyne: Not one was given a locum consultant post.

Deputy Colm Burke: Of the 160?

Ms Susan Clyne: Yes.

Deputy Colm Burke: Has there been any response from the Department on that matter?

Ms Susan Clyne: We put in a submission and there was no response. Anyone can see on social media that non-consultant hospital doctors, NCHDs, the hospital doctors I am talking about, are working over 24 hours on a shift, which is illegal and in complete breach of their contracts. They are burned out. They have been scrabbling around for jobs at the changeover, moving locations and going to different parts of the country to try to source jobs. Many are working below their training grades.

Deputy Colm Burke: On the SpRs, is it in all categories?

Chairman: The time Deputy Colm Burke takes will be taken from another Fine Gael speaker subsequently.

Deputy Colm Burke: In what areas are the SpRs qualified?

Ms Susan Clyne: All of the specialties and all of the training programmes. I can send the Deputy a listing of the number of SpRs who have qualified in each of the specialties later.

Chairman: I am sorry I had to cut across Deputy Burke but it is difficult to get everybody in.

Deputy Paul McAuliffe: I thank both organisations for attending today. I hope to use some of the responses the witnesses will give in the sessions with the HSE later on. What level of engagement have the Irish Cancer Society and the IMO had with either the HSE or the Department since the pandemic in terms of the restoration, or as has been said, the improvement of services?

Ms Rachel Morrogh: We have been in touch with the Department, the HSE and the National Cancer Control Programme, NCCP, about preparing cancer services for the pandemic since before the first coronavirus case in Ireland. We wanted to ensure that urgent tests and treatment continued throughout the pandemic and that Covid-19 would not be prioritised for all resources at the expense of non-Covid-19 diseases. We were pleased that the urgent tests and treatment continued. We continue to have good engagement with the HSE, the Department and the NCCP. To make any progress, we need to see the HSE continuity plan and we need it to be funded. That is where we will see what is next for cancer services and for the health service generally.

Ms Susan Clyne: In fairness to the HSE and the Department, we engaged with them very quickly at the outset of the pandemic. However, that was more in regard to GP issues. We have

had little or no engagement about the building up of capacity. We are disappointed that some of our manpower requests have not been addressed. In fairness to both the HSE and the Department, the core issue behind most requests from organisations like our own or the Irish Cancer Society is funding.

Deputy Paul McAuliffe: I was going to say "Ms Morrogh", but I am very familiar with her from my days on the rare disease task force so it seems quite strange to address her so formally. Perhaps Rachel would outline the feedback from the cancer support line on the impact on the mental health of patients who have already been diagnosed with cancer. Could she outline some of the experiences she has heard about, albeit anecdotally?

Ms Rachel Morrogh: I thank the Deputy. I will pass that question to my colleague, Mr. Donal Buggy, who is the head of services and has real insight into that.

Mr. Donal Buggy: Upon the shutdown of the country in mid-March, the Irish Cancer Society immediately extended its nurse helpline services to seven days a week with longer hours in the evening. That was intended to address the distress we were hearing on our phone lines on a daily basis. We were also in a position to very quickly start a new remote counselling service to step into the breach where the usual psychology services were not available. That has been a very successful programme. We have linked up with Cancer Care West and the National Cancer Control Programme to provide psychological and psychiatric assistance to those services. That has been really valuable. More than 150,000 patients have used that service to date. As lockdown eases, we are finding that distress is increasing among cancer patients, many of whom continue to cocoon or remain very concerned about the impact of infection on them. We have also had lots of conversations with parents of children with cancer who are extremely concerned about their children contracting Covid-19. They are also very concerned about their children's development, their treatment, and how their families will cope with the challenges of continued isolation. This issue is growing. Rather than a decreasing psychological impact as we move through the phases of reopening, we are seeing increased distress and an increased number of people calling our services to seek psychological help and support. That will continue in the future.

Deputy Paul McAuliffe: To expand on that point, I have been contacted by several people who have rare forms of cancer. They have found the lockdown period very difficult. However, as we emerge from lockdown there is so much uncertainty about how they can safely operate in society and the period for which this will continue is indeterminate. In many ways this is having a more severe impact on their mental health. Does Mr. Buggy believe the Irish Cancer Society is currently able to meet that demand, or are additional programmes or funding needed to cater to mental health needs?

Mr. Donal Buggy: We are able to meet some of the demand, but that does not take the place of a properly funded psycho-oncology service, as envisaged in our national cancer strategy. It sets out what I think is a very comprehensive plan for psycho-oncology services, but again the funding is not in place for that. There are also issues for patients' employment. If they are cocooning because they are at significant risk of infection, how can they engage with their employers in such a way that they can work from home? For many people it is impossible to work from home. We need to do many things to support people who remain in that extremely vulnerable position and who cannot enjoy the freedoms many of the rest of us have enjoyed as we have moved out of lockdown. Mental health and joining that up with the services required for these people needs to be given significant consideration.

Deputy Paul McAuliffe: The submission outlines the need for a clear communications campaign on the signs and symptoms of cancer and to encourage people to attend their health-care professionals on that. Has there been any positive feedback from the HSE on that? Radio and television are full of advertisements on Covid-19. Has any of that pre-booked advertising been considered to target those who may be developing symptoms of cancer?

Ms Rachel Morrogh: We have run a communications campaign, as has the national cancer control programme, to encourage people. The CMO and Paul Reid, the chief executive of the HSE, have talked about the importance of getting people into the diagnostics. It is important that we expand those services, as the IMO has illustrated. Part of that will be physical capacity. We need to reassure people that cancers are still being diagnosed during the Covid pandemic. Anyone with a sign or symptom of cancer really needs to seek medical help.

Deputy Paul McAuliffe: Based on what the Irish Cancer Society has been hearing on the cancer support line, what has been the experience for those patients undergoing radiotherapy or chemotherapy treatment who may have suppressed immune response?

Mr. Donal Buggy: We are getting feedback from our daffodil centre nurses, many of whom have worked directly in the acute cancer services in recent months, that there are challenges with communications and logistics, and ensuring patients can continue to get access to the treatments they need to get better. There has been considerable upheaval with the transfer of services from public hospitals into private hospitals. We have patients whom we bring to chemotherapy treatment through our volunteer driving programme who were getting treated in Tullamore. Very quickly that treatment was delivered in the Hermitage hospital just outside Dublin. There are many challenges for patients even understanding the new logistics of their treatment without even getting into the detail of the challenges associated with how they will navigate the health system.

Deputy Paul McAuliffe: The backlog was discussed earlier. Has the HSE discussed how that backlog may be addressed with either of the organisations? Will it address it purely through the public system, or will it seek short-term capacity from the private system?

Ms Susan Clyne: The CervicalCheck programme, which is back up and running, has always been outsourced mainly to the private system anyway. The HSE has prioritised women for callback based on clinical need. With the new HPV element to that test, the length of time to someone's next callback will be extended, but that is based on clinical evidence and we are quite happy with that.

On the other screening programmes, I do not know how they will address the backlog because we have not engaged on those particular programmes.

Chairman: I thank Ms Clyne and Deputy McAuliffe. The next speaker is Deputy Duncan Smith.

Deputy Duncan Smith: I thank both sets of witnesses for attending. I will address my first question to Ms Clyne. She mentioned preparations for future surges in her submission. All of us are more nervous about future surges now than we were two weeks ago but I have two questions on the expansion of acute bed capacity. First, on the immediate expansion of physical capacity through investment in temporary builds, would that mean new hospitals built in a temporary fashion or the extension of existing hospitals? What does she envisage in that regard? People generally get a little queasy when they hear that something is temporary. I am

thinking of our school system and so on.

Second, is there any role for the use of private hospitals in providing that bed capacity? I note in the ICS submission that one of the aspects of the health response that supported cancer care was the use of private hospitals for cancer care, which the society said worked well and offered continuity of care for some existing public patients, although it may have proved somewhat disruptive to normal schedules. Is there any role for the use of private hospitals in the IMO's suite of recommendations?

Ms Susan Clyne: I will ask my colleague, Dr. Gilligan, to answer the first question about the temporary builds.

On the second question about the use of the private hospitals, we cannot get into this position where we think the private hospitals will save us. If the number of beds available in the private and public hospitals are added, we are still below capacity. The previous Government decided not to renew the contract with the private hospitals. I understand the private hospitals and the Department of Health are in discussions as to how capacity may be used in the event of a Covid-19 surge but we are still getting away from the fundamental problem of capacity. There is a way to move towards that. People may be a little queasy about the idea of temporary builds but temporary is better than no builds. I will ask my colleague, Dr. Gilligan, to elaborate on that.

Dr. Peadar Gilligan: It is fair to say that the acquisition of the private hospitals for a period by the State was absolute recognition of the challenges we have had in capacity. What we in the IMO would like to see, and what every doctor in the country would like to see, is an actual plan to invest in the capacity requirements of the system. Essentially, 5,000 beds would look like a 500-bed hospital. My concern is that, to my knowledge, no plan as yet has been put in place with regard to capital expenditure, despite a 2018 document advising us that significant investment needed to take place. We need the planners, the engineers and the architects of the country to address the requirements to provide that capacity, but we need 5,000 beds. With those beds we also need specialists in the acute hospital system. We need approximately 1,600 more specialists in the system just to bring us close to the OECD specialist *per capita* average. Without those, we cannot provide the timely care that our patients need in a safe way.

Modular builds now are significantly better than they were when I was in school where one could put one's pencil through the walls of the prefabs. They are significantly better now and many countries have invested in those as a temporising measure while putting more significant structures in place. There are tents on nearly every hospital campus in the country. Available capacity within acute hospitals has been looked at whereby areas that historically were not clinical areas have become clinical areas in those hospitals but we need to see that commitment.

Part of the challenge we face is that we want to attract specialists back to Ireland but since October 2012, we have treated them poorly. We have paid them 30% less than existing colleagues. A colleague who took up his appointment after 2012 told me recently that the applause and the thanks were very nice but the reality is that he goes to work and he gets paid 30% less for doing the same job as me. He asked if that was acceptable. I know it is not acceptable. I know that this committee knows it is not acceptable but we need to address that to allow us recruit the specialists we need in our acute hospital system.

Deputy Duncan Smith: I thank Ms Clyne and Dr. Gilligan. I am sure they will accept that, if I ask a question on only one point in their submission, it is because I only have five minutes.

I like to hear full answers and I got a full answer there. It is not to say that I do not agree with or understand the other points raised in the submission. I am out of time. I thank the witnesses for their answers.

Chairman: I thank the Deputy. I again apologise that we must constrain everybody's time. Deputy Shortall will be similarly constrained to five minutes; I apologise.

Deputy Róisín Shortall: It is very difficult to do anything within five minutes.

Chairman: It is.

Deputy Róisín Shortall: What we have heard this morning from the INMO is by no means new. Its representatives were before the committee some weeks ago and told us the same story. There is a lack of bed capacity and a lack of staff. Since then, many of us have raised these issues with the Minister for Health. To be frank, there has been little indication that the scale of the problem has been recognised. These issues have not arisen only in the past few weeks; the INMO has been raising the issue of the lack of capacity in the public health service for years, as have many of us. Covid has exposed the significant weaknesses and inadequacies in our public health service. One has to ask when Government is going to get serious about implementing a public health service that meets the needs of the population.

On an issue members have raised with the Minister, since the witnesses were last before the committee, has the INMO had any further contact from the Department, the Minister or the HSE with regard to the pressing issues of the 500 consultant vacancies and the need for additional rapid-build temporary capacity until such time as we have the capacity that was promised? Has there been any contact at any level or any indication that the INMO and the rest of us are being heard? Are there any grounds for hope that these issues will be addressed soon?

Ms Susan Clyne: There has been a change of government so the officials of the Department and of the HSE have to wait to see what the new Government will decide to do. The short answer is "No", there does not seem to be any plan for significant increases in capacity. We might get 100 or 200 beds but that just will not cut it. It certainly will not cut it this winter.

With regard to consultant vacancies, when we started this campaign we were talking about 100 vacancies. That then increased to 200, then 300. We have yet to be invited to any talks to deal with this crisis in manpower.

Deputy Róisín Shortall: Has there been any discussion with the INMO on the 1,000 Sláintecare consultant contracts promised a number of months ago?

Ms Susan Clyne: There was discussion with us approximately six months ago. As the Deputy will be aware, we have issues in that regard and in respect of the 30% pay cut. We maintain the view that we are more than happy to go into talks with the Government on a new public-only contract but we are not at all satisfied that this will address the recruitment problem. A public-only contract is currently on offer, the type A contract, and we cannot recruit anybody on it. The fundamental problem is the 30% unilateral cut applied in 2012, which bore no reference to a person's qualifications or skills. It was simply a matter of political expediency for the Minister. This has had a devastating effect on the recruitment of consultants in our health service. People feel that it is not the about the money but rather about the psychological impact of feeling one is less valued than a person with whom one is working and who is doing exactly the same job.

Deputy Róisín Shortall: That is a well-made point. I have a question for the ICS delegation. What is the position with regard to people who have undergone cancer treatment and who need screening as part of the follow-up? Are such people being seen for screening? My second question relates to the BreastCheck and bowel screening programmes. What is the reason for the delay? It is very hard to understand it because both services are operated separate to the acute hospitals. Do the witnesses know why those services have not resumed?

Ms Rachel Morrogh: I am afraid I do not know the answer to the Deputy's first question. Now that CervicalCheck has resumed people who need three-month and 12-month screens are being included as a priority group and people entering the service for the first time are being included.

BreastCheck and BowelScreen representatives will come before the committee later and may provide more clarity. Certainly one of the issues is capacity in the hospital system and diagnostics. These are the assessments that people need after they get screened because, as Ms Clyne said, screening is not a diagnostic in itself. If people's access to screening and health care is limited because of capacity issues, this is something the ICS would be very concerned about. We need to address capacity in hospitals to ensure people's diagnoses of cancer are not delayed because of capacity issues. We need to get those screening services resumed as soon as possible.

Deputy Róisín Shortall: Is it the case that screening services are done outside of the mainstream acute hospital services? I am curious to know where is the logjam. Where are the obstacles to resuming these programmes?

Ms Rachel Morrogh: For BowelScreen people must do a faecal immunochemical test, which they do at home, but if this is positive, they need an urgent colonoscopy and this is part of the endoscopy system.

Deputy Róisín Shortall: Does Ms Morrow accept we should at least restart screening so that people at least know and can-----

Ms Rachel Morrogh: Our position is that if people's access to healthcare is limited, and the demand side is limited because of problems on the supply side, it is not acceptable. We need to look at the capacity issues, address them, get them resolved and ensure people are diagnosed with cancer as early as possible.

Deputy Matt Shanahan: I thank our contributors. I reiterate the sentiments of a previous speaker that the submissions are comprehensive. One thing that comes out in almost all of them is frustration, and severe frustration at that. We are all frustrated by what we have heard over recent weeks. We also have significant worries about what September, October and November may bring into the health service.

Mention was made of specialist registrars who were not given temporary fellowships or asked to remain in the service. We could impact on many of the waiting lists if we were to group them under radiology and scopes and increase activity in this area. A significant number of retired surgeons put themselves forward to be available through Be On Call for Ireland. I understand that technically specialist registrars could do some of this radiology and scope work if they were supervised by people with greater experience who have kept up their competencies. Are the witnesses aware of any plans, or have they spoken to the HSE about implementing something like this after hours using operating theatre space, these specialist registrars

and some of the people available through Be On Call for Ireland to increase activity, thereby increasing capacity and impacting on the waiting lists?

Dr. Peadar Gilligan: It is important that we use the resources available to us. People who have completed their specialist registrar training are ready to take up consultant positions. The IMO asked that they be offered temporary consultant positions, pending removal of the international lockdown such that they could travel to undertake further fellowships if they so wished. Essentially, they have completed their training.

Many retired colleagues offered their services to the health service again and it was terrifically courageous of them to do so, particularly given the risk of Covid to older patients. Their help was certainly very gratefully received. However, we need a more permanent solution to this, which is about getting the recruitment very definitely right. The challenge is that if we want to bring in a patient for a procedure, that patient must undergo Covid testing three days before the procedure, such that we have the result back and know the procedure can be safely undertaken and experienced by the individual. We know that patients with Covid who have surgical procedures do less well from those procedures than they would have done if they had not had Covid, for obvious reasons. There are delays in the system as well in respect of the space that patients need, and the processing needs are impacted by that. It is a question of manpower and capacity and, I agree with the Deputy, definitely using the resources that are available to us.

Deputy Matt Shanahan: I have a question about the NTPF. I understand that a large amount of the procurement of the NTPF is based on large groups of procedures probably directed at one or two hospitals. Is there an opportunity in the NTPF to consider smaller bundles directed at more institutions and to use increased service level agreements to ensure we get capacity and continuity into 2021?

Ms Susan Clyne: First, we should be honest and say that we do not believe the NTPF is a long-term solution to the capacity issues in the health service. In fact, it could deprive public health services of much-needed funding. If there is to be an NTPF, and we understand it is to be supercharged with more money, we would prefer to see that spending in the public system, or the public system to be supported to deliver more care. Currently, it is quite complex to do business plans and get funding through. All of that has to be speeded up. Medics, clinicians and their nursing and other colleagues can be innovative and can put forward proposals for funding to get that through. We agree that the NTPF should not just be simply one diagnostic tool based. In fact, the NTPF fund might be better spent if it was spent on an entire episode of care to clear the backlog rather than on a suite of diagnostics and low-complexity, high-volume work.

Deputy Richard O'Donoghue: Mary Fogarty, a nurses' representative, says there is no social distancing taking place in the hospitals. On Monday, 13 July, there were 56 patients on trolleys in one area in the regional hospital with a capacity of 20 patients. This has increased now to 40 patients. Some patients are sitting on chairs. There is no social distance and staff are exposed. The INMO has asked for an internal investigation into full controls for nurses to reduce the risk of spreading infection. Looking at hospitals across the country we see that some of them are struggling with the pandemic and some are not. Perhaps it is time to start examining the management system in some of the hospitals that are not being managed properly. The front-line staff deserve to be protected, but so do the patients. Why is it the case that in certain situations some hospitals are running well and some are not? We must look at how we can assist in this from a structural point of view and at the reason that certain hospitals are coming under that regime. An additional 96 beds were allocated, but staffing at the hospital has depleted by 20%. Is this not something we should examine from a management point of view? This

question is one I asked at a previous meeting of the committee in respect of the meat factories. It is down to the fact that there are management problems in certain areas. If there is no good management, there is no good structure. Every person who goes into the hospital goes there to help, but if the structure in place is not right they cannot help.

Dr. Peadar Gilligan: I share the Deputy's frustration about the crowding of emergency departments because it has been my experience for many years of my career. Things around the country are challenging, and that is because, essentially, unscheduled care is just that. Patients arrive when they feel their problems require urgent assessment. For that reason departments that cannot move those patients who require admission on to the wards will become crowded very quickly indeed. That is reflective of the capacity issue.

In defence of my management colleagues, they have undertaken a Herculean task in the context of Covid. They have reassigned resources and helped in the reallocation of spaces for clinical use and the reallocation of staff to work in various areas. Of course, there are always areas that can be improved on, but our colleagues in management are as clear on this as I am. They do not have the capacity they need to provide the care they wish to provide. Fifty-six patients on trolleys is a situation that should never happen. It happens because patients are not moving through the system quickly enough since there are no beds immediately available for them.

Deputy Bernard Durkan took the Chair.

Deputy Richard O'Donoghue: My second question is: why there is such a high turnover of nurses in certain hospitals compared with others? In certain hospitals around the country there is a massive turnover of nurses who are not staying within the hospital system. Is this not a clear indication that in some of the hospitals there is a breakdown of management or communications to let the nurses do their job properly? They are also frustrated that they cannot carry out their duty of care. We should look from that point of view at how we can help. If there are clusters of areas where there is a high turnover of nurses in hospitals, we should look at that to see why that is. Is it because the nurses are frustrated that they cannot carry out their duty of care?

Dr. Peadar Gilligan: Again, absolutely. I acknowledge there remains huge frustration in the system when people feel that the level of care they would wish to offer they cannot offer because of the constraints of the system. The entire system needs to work towards facilitating the doctor, nurse or healthcare professional in delivering the care he or she wishes to deliver. We have not been in that space, but what Covid has shown us is that when the system pulls together it can achieve amazing things regarding the delivery of safer care. Some 8,000 healthcare professionals in Ireland contracted Covid in the course of the delivery of care to patients, which is a significant number of people who became unwell as a result of the work they do. We have too many multi-bed wards in the hospital system still. We need to move towards more isolation facilities. We have too few critical care beds. We need more of those as well. I share the Deputy's frustration and that of the nursing staff, but we need a system that facilitates us in delivering care.

Acting Chairman (Deputy Bernard J. Durkan): Time is running out.

Deputy Matt Carthy: The submission and the evidence we have heard from the Irish Cancer Society is probably the most concerning that has come before the committee to date because, essentially, the premise of it is that in the efforts to save lives from Covid-19, other

patients' lives have been put at risk. Following on from Ms Morrogh's previous responses, I think she indicated to my colleague, Deputy Cullinane, that if urgent action is not taken, lives will be lost avoidably. Looking at the waiting times as outlined in her submission in respect of access to colonoscopies, for example, there is an indication that 1,000 people have been waiting longer than 28 days and 329 people have been waiting longer than 90 days. Is it a fair assumption to make that lives have already been lost as a result of the restrictive measures put in place in respect of cancer screening services, whether they have been lost or put at risk or will be lost?

Ms Rachel Morrogh: I do not think we are at that point. Cancer takes a while to develop. That is why what we do next will chart the future of the people we mentioned earlier and those 450 cancers that have not been detected yet, or that we would have expected our screening programmes to detect during a four-month period under normal circumstances. We are worried that Covid was layered on top of a system that was not even meeting normal demand. Non-urgent services were postponed for a considerable amount of time because of the need to deal with Covid and we are now facing the choice of whether to fully resource, fund and look at what we need to do across the health services to meet the backlog, as well as the normal demand. The number of cancer cases in Ireland is increasing annually and we need to make choices that will build a sustainable cancer system because, as Deputies outlined, there will most likely be a second wave. What we do now is going to be critical.

Deputy Matt Carthy: I apologise for cutting across Ms Morrogh but the responses required are contained within her submission. Putting measures in place that will save the lives of those who go through the trauma of a cancer diagnosis will be a significant test for the new Government.

I have a brief question for the IMO. It has outlined very effectively some of the deficiencies within our services, but I refer specifically to wards, trolleys and overcrowded waiting rooms. Did the IMO have concerns about fire and health and safety prior to Covid? In November 2019, for example, patients on trolleys were transferred from University Hospital Limerick's emergency department due an unannounced visit from a senior officer from the Limerick Fire & Rescue Service. Is that a broad concern and is it affected by the knowledge of the restrictive measures that will need to be in place during the pandemic?

Dr. Peadar Gilligan: It has been a major concern for us in the IMO and everyone involved in healthcare that crowded environments are more difficult to decant from in the event of an emergency like a fire breaking out. That fire has broken out but it is now called Covid. Crowded situations would allow the spread of this disease. We can never go back to a situation where the UHL emergency department, or any other hospital or emergency department, has crowded wards. We have been saying this for many years, and many Deputies have noted it as well. We now absolutely must have the capacity and bed numbers in place in order that we can safely provide care and safely remove patients from potential risk in the event of an emergency.

Deputy Matt Carthy: I have one very short follow-up question. I come from County Monaghan, which had a very well-developed local hospital from which services were removed. Should those hospitals be utilised and some of those services be restored to ease the pressure on other centres?

Dr. Peadar Gilligan: What we need to do is utilise the system we have to its optimal effect. That does not mean occupying every bed in the system because clearly we cannot do that. We need to have a facility for surge, so we cannot have an occupancy level above 80% in any of our acute hospitals, nor, indeed, in our elective hospitals. The IMO's position is that we need to

move to certain hospitals only providing scheduled care, in order that that scheduled care is not interrupted by the delivery of unplanned or emergency care. That would be a very important initiative and part of that capacity requirement.

Acting Chairman (Deputy Bernard J. Durkan): The next slot is my own. I agree that we have a capacity issue. It has been there for a considerable time and has been growing. We also have a staffing issue and the added complication of people being paid at different levels within the system. That has been a result of issues largely outside the command of most people.

I have some questions. Do the witnesses support the concept of a short, medium and long-term plan? That is Sláintecare, effectively, and the implementation of such a plan is vital now. If we must wait a long time before putting into operation the things we need now, we will be waiting forever. I refer to physical buildings and staffing levels. Which of the witnesses would like to answer?

Ms Susan Clyne: I can answer on behalf of the IMO. We have been supporting short, medium and long-term plans for many years. Unfortunately, the funding has not accompanied those plans. Regardless of whether one is a supporter of Sláintecare, it does not have the funding to accompany those plans. We are stating, however, that there are things we can do in this crisis. We do not need another plan, we need to see action on contingency and building of capacity.

We also need to see action regarding manpower resources in hospitals. We have to state as well that we have been hearing much from the system about shifting care into the community and into general practice. That is good, where it can happen and where it is resourced. We need a great deal of joined-up thinking now to get things moving. Working with colleagues in management, the HSE and the Department of Health, staff showed during this crisis how agile and flexible they were and how they adapted to new ways of working. That was done, however, in the context of a crisis and it was not evaluated as to how it is going to work in the long term and what new supports need to be put in place for that to happen. I ask Dr. McCauley to talk about the shifting of care to the community and how that could happen in the next several months.

Deputy Michael McNamara resumed the Chair.

Dr. Denis McCauley: The shifting of some care to the community is a valid concept. Not all care can be transferred to the community but the care that is transferred has to be planned and it also has to be resourced. I alluded to chronic disease management earlier. That will be a positive development. It only started this year and it has been hindered slightly by the onset of Covid-19, but we have adapted it. We were innovative in adapting it so that we can look after a group of over-70s in a Covid-19 situation.

For this to work, we need to have the required capacity and consultants. General practice is always adaptable, innovative and flexible. However, we need a plan and it needs to be resourced. If care is being transferred just for the sake of it, without it being proven to be useful, that is a bad thing. If it is being done just to save money without any view of the actual benefits, or lack thereof, to the patient, then that is a bad thing.

If, however, certain parts of care can be transferred and if it has been clinically proven that GPs can at least match that care and, as a GP would say, at times even improve that care and if that is feasible and the resources are provided, then general practice will stand up. If the transfer of such care is incoherent, however, and if it is not planned and resourced, it could actually have a detrimental effect. The system is now in flux and the last thing we want is for that flux

to result in a decision to transfer care to the community without all the personnel being in place in the primary care teams, as well as the GPs. It is a laudable concept but it must be effective and it must be resourced.

There was a talk earlier about the flu vaccine. Any raised temperature that occurs in the community now will have an emotional and financial effect. We will not know if a raised temperature is Covid-19 until we test people. The flu is one aspect, however, where we can step up. The previous Minister spoke of vaccinating children. Once again, if that programme is planned properly, and we would like to get the planning done as quickly as possible so we can implement it, this will be a service that will show it can be effective.

Deputy Bernard J. Durkan: I referred to the short, medium and long-term plan because I have been associated with the health services for generations at this stage. It is only in recent times that we heard of the lack of capacity of physical buildings and, obviously, the follow-on in staff. It is only in recent years we were told there were too many beds. Yet, it was obvious to most of us that this was not the case. I welcome the change in the system and the change in emphasis as well as the need for extra capacity. It is obviously a matter for Government to provide that.

The other point I wanted to raise relates to attracting staff and making the health services an attractive place to work. Job satisfaction should be part of the entire system. Will the Irish Medical Organisation identify the issues most urgently needed? What is needed to restore morale and public confidence in the system as well as remove the inequalities within the system?

Ms Susan Clyne: I will answer on behalf of the IMO. I must make the point that for over a decade now the IMO has been highlighting the capacity deficits within the system. This goes back to many previous Governments. In 2008 capacity first began to be reduced. Then it was severely impacted and reduced at the time of the financial crisis. The IMO warned at that time of the negative impact that would have on future generations.

The Deputy asked what we need to do to attract staff into the system. We need to value and respect them. We need to listen to them and allow them to do their jobs in a well-resourced environment. We cannot have two-tier pay systems for medics or doctors. That is a disgrace. The basic principle of equal work for equal pay holds. Yet, we are asking doctors, who are being head-hunted from every part of the globe, to come and work here because we value them so much that we will pay them 30% less than the person they will be working beside. Then we are surprised that they will not come and work here. We are asking our non-consultant hospital doctors, who are currently being asked to work 24-hour or 26-hour shifts, to come back to this health service and work here while claiming that we value them and respect them.

We have an issue with the general practitioner population. Up to 600 GPs are due to retire over the coming years. Retirement is a major issue not only because of the normal issues of retirement but because of Covid-19. Some of these GPs may be at a vulnerable age or have underling health conditions themselves. Yet, we say to our newly-established GPs that we have no supports to help them and we will not help them to set up. We tell them they are on their own.

Government must address the absolute fundamental basic inequalities in the system. Government and the health service must value the staff they wish to recruit. It is not enough to say "thank you very much" occasionally or in a pandemic. That is welcome and it is good to be recognised, but that culture must continue. There has to be a culture of respect, of paying people properly and of listening to them.

Dr. Denis McCauley: One grouping which is important in the context of the pandemic is the public health doctors. Public health doctors have basically been working night and day during this period. All healthcare staff have put their shoulders to the wheel. Public health doctors have been in the background working non-stop to try to ameliorate the effect of the Covid-19 emergency.

Up to 50% of these public health doctors are due to retire. We need to attract public health doctors back into the system. There have been two reports. The last one was the Scally report, which recommended public health doctors be considered for or given consultant status. We have been advocating yearly for this. During the Covid-19 emergency these people have been working night and day, possibly to the detriment of their personal health. We are asking the Deputies to show respect for these people for two reasons. The first is that they deserve consultant speciality status. If they do not get that, we will have great difficulty getting replacements for the 50% of public health people who will retire.

The developed nations that have good public health systems have done better in the pandemic. They do a great deal of extra work, but for a safety valve, for future pandemics and even for the evolution of this pandemic we must have an effective public health service. The fact that public health doctors have not been given consultant status, as recommended over the past decade, is wrong. To add to all that Ms Clyne said, in the context of the public health emergency, public health doctors should be respected with that contact so that we can ensure that service not only remains even static, but develops.

Chairman: I thank Dr. McCauley and Deputy Durkan. I thank the Deputy also for stepping into the Chair.

The next speaker is from Fianna Fáil. The Deputy is coming back in.

Deputy Paul McAuliffe: To come back to the point, Dr. McCauley or Dr. Peadar Gilligan mentioned the issue of the flu vaccination. Obviously, in the fight against Covid, a comprehensive and more widespread flu vaccination programme will be needed. I wonder if both organisations, particularly the IMO but also in terms of cancer patients, might comment on what they would like that vaccination programme to look like and the issues which they may see arise.

Ms Susan Clyne: I understand the HSE will make some proposals to the committee this afternoon in relation to the flu vaccination but it has already been announced that the flu vaccination will now be extended to children between the ages of two and 12.

The IMO had called a number of months ago for Government to look at a total population vaccination programme and to sit down and talk to us about that. What we are concerned about is that we are now coming towards the end of July. We need to sit down and talk about the flu vaccination programme now. Respiratory illnesses will start circulating in early September. We need to have a plan. We need to understand what is going to happen so that GPs can prepare. We have to acknowledge the fact that the days of a full waiting room in general practice are long gone. There are no more walk-in clinics. Everything is by appointment. Therefore, GPs will have to prepare to a certain extent for some vaccination clinics and we need to sit down with the HSE. We are due to meet them next week, but we would have been in favour of a total population vaccination programme delivered in general practice.

Deputy Paul McAuliffe: Can we hear from the cancer society?

Ms Rachel Morrogh: As the Deputy will probably know, cancer patients are considered an

at-risk group. Therefore, they are encouraged to get the flu vaccine every year. Certainly, the Irish Cancer Society will be playing its part in that regard and encouraging cancer patients to get vaccinated.

It is important as well that, while I would expect there to be probably a high uptake among cancer patients, we encourage people at a population level to go and get vaccinated this year. When we think about the impact of flu and seasonal diseases on the treatment of cancer care, and we know that elective surgeries have decreased by 15% during the winter months because of the impact of flu on the hospital system, with the reduced capacity that we are now experiencing as a result of Covid we need to do everything we can to ensure that people will not end up hospitalised and to keep capacity for the urgent cases.

Ms Susan Clyne: If I could make one further point, we must have a strong campaign to give people confidence in vaccinations. We can see from surveys the anti-vax movement is quite strong. It is operating strongly on social media, with much of it around the potential of a Covid vaccine. The system needs to be sending out a very coherent message about the vaccination programmes and the safety of the vaccination programmes.

Deputy Paul McAuliffe: That point that vaccination saves lives needs to be underscored later on with the HSE as well. We have seen social media used positively, but during this pandemic we have also seen it used negatively in terms of misinformation. I support Ms Clyne's comments on the vaccinations.

In terms of the other services the cancer society provides, fund-raising is a huge component, particularly in regard to research. Has the society put a figure on how much it will be down this year as a result of not being able to avail of funding activities or has the society found alternative methods?

Mr. Donal Buggy: The Irish Cancer Society operates largely on fund-raising from the general public, and from corporate supports also. Ninety-eight per cent of the €24 million income of the Irish Cancer Society last year was fundraised. We expect to see a significant deficit this year. Everyone knows our flagship Daffodil Day event which takes place at the end of March every year. Unfortunately, it was not possible to run that event on the streets this year as we normally do. It raises approximately €4 million every year but we were able to pivot and transition that fundraising effort online and raised €2 million. That is half of what we would have expected to raise.

We are working very hard to ensure we can continue to raise the funds needed to support the front-line services we provide. We have always has the support of the public who have been putting their hands in their pockets and supporting us as we have changed our fundraising methods over the past 6 months. We will run a significant deficit in 2020 and expect to also run a deficit in 2021 and 2022. We have reserves in place to address that and ensure the front-line services we have can continue and we can enhance them to address the needs of cancer patients over the next number of years.

Research has been significantly impacted by Covid-19. All clinical trials for cancer in Ireland stopped in February and no new trials have opened since. That has a significant impact on the potential outcome for many cancer patients. It also has a significant impact on the psychological well-being of patients who are not being given access to novel clinical trials or potentially life-saving new treatments.

There are also issues with regard to our research infrastructure. Many of our researchers are on precarious contracts. They have only been able to do a proportion of that work over the past five or six months. Will they be able to extend those research grants? Will they have the funds to be able to continue the research programmes they hoped to deliver?

The society is committed to and will continue to invest in research, particularly, research that is closer to the patient which allows us to really understand the quality of life issues and patient impact issues faced by people who are diagnosed, not just now, but into the future.

Some 65 people today will be told that they have cancer and 25 people will die from cancer today. If we do not invest in research, those numbers will increase. If we do not invest in research in Ireland we will not be able to access the world-class cancer doctors that we need to deliver a world-class cancer system.

Deputy Paul McAuliffe: Mr. Buggy said there will be a significant deficit. Is he prepared to put a figure on that?

Mr. Donal Buggy: I may have to revert to the committee on that. I would rather give an accurate figure. I have a figure in my head but I am not sure it is 100% accurate.

Deputy Paul McAuliffe: I had the great pleasure of launching the volunteer driver service for the ICS last year in Beaumont Hospital. What impact has the pandemic had on recruiting volunteers for that service throughout the country?

Mr. Donal Buggy: One of the first steps we took after the shutdown of the country was to ensure services such as our volunteer driving service could be maintained. We have drivers who are over the age of 70 and who are in the extremely medically vulnerable category. Of the 1,000 volunteers the society had going into the pandemic, approximately half of those temporarily stood down to protect them from the Covid-19 virus.

We were able to develop new online training and recruitment programmes for new volunteer drivers and, thankfully, we were able to take on board more than 100 new volunteers, which allowed us to maintain the level of that service. Approximately 98% of all requests were met over the pandemic period. We were also able to connect with services such as Lifeline Ambulance Service, Order of Malta Ireland and the community and county committees that were set up to ensure any cancer patients looking to access chemotherapy services were able to do so. We are totally indebted to a cohort of magnificent volunteers who, when no one was travelling anywhere in the country, brought cancer patients to and from their appointments.

Deputy Paul McAuliffe: All members would urge people to support the society in meeting both the financial deficit and the deficit of volunteers in order that it might try to continue to support cancer patients. I thank both organisations for being with us.

Chairman: I thank Mr. Buggy and Deputy McAuliffe. Deputy Funchion is next.

Deputy Kathleen Funchion: I want to ask the Irish Cancer Society about cervical screening specifically. I am one of the final speakers so I apologise if this has been raised already. Does the society have any information or figures on how many women are waiting for retests, particularly in the Carlow-Kilkenny region? These would not be initial tests but retests in cases where there were symptoms. Given the delays and everything else caused by Covid, does the society know how long the backlog is for that region specifically? If Ms Morrogh and Mr. Buggy do not have that specific information, maybe they could comment in general on the issue

of the cervical screening and the delays relating thereto?

Ms Rachel Morrogh: I am afraid that we do not have those data. I think that representatives from the screening service will be before the committee this afternoon and they may have the data. If they do not, we can certainly ask them for it through our own channels.

On the resumption of screening, as I said earlier, we do welcome the resumption of CervicalCheck but we are disappointed that BowelScreen and BreastCheck have not resumed. We do not have sight of specific data in respect of backlogs. For the official figures, the screening service may be able to talk to the Deputy about what they are specifically. We have done our own calculations on the number of cancers and pre-cancers that we think have gone undetected during the period that screening has been paused. Regarding cervical cancer, we think that in the past four months approximately 1,000 pre-cancers would not have been detected and in the region of 33 cervical cancers. That is obviously of major concern to us and it underscores the need for screening services to resume as fully as they can as soon as it is safe to do so.

Deputy Kathleen Funchion: I thank Ms Morrogh. My second question is also for the society. This was obviously a very serious situation and everyone must take all the public health advice and measures seriously. However, does the society believe that it was necessary to cut the services to the level that was done? Was there not some safe way of carrying out some of these cancer screenings? Covid is extremely serious but there are so many illnesses, cancer being one, that affect so many people and early diagnosis is key in everything. Was there not a way to carry out some of those screenings? I would like to know the society's opinion on that.

Ms Rachel Morrogh: The advice that was taken by the screening services and by the health services generally was from NPHET. That was the evidence base on which screening was paused. I am afraid that I cannot answer as to whether that was the right decision, but that was NPHET's advice.

Deputy Kathleen Funchion: The only reason I ask is that many women contacted myself - I am sure other people too - about their frustration at seeing certain shops and retail outlets being allowed to open in circumstances where they new they needed a second test and were being told that it was too risky. I am conscious of the irony of that for people who are in that situation and who are worried. Maybe some of the screenings could have resumed earlier than they have. As Ms. Morrogh said, a lot of them have not resumed.

Mr. Donal Buggy: I can perhaps address the Deputy's question. We did not know in March what the pandemic was going to bring to us in the context of the effect it was going to have on hospital capacity. As a result, we supported the decision to pause screening services at that time. Similar decisions were taken right across the European Union. Many countries shut down their screening services. However, many have also resumed services more quickly than we have in Ireland. What we need, or what we are lacking, is that ambition to get those screening services up and running and link them into the hospital capacity that is required to manage patients who have not gone through the screening programme and who need further diagnostics and treatment.

Chairman: Ms Clyne said the IMO called for a total vaccination programme. When did it call for that total vaccination programme and what has been the response to date? I do not mean to limit the possibility to respond to Ms Clyne. It is open to all witnesses.

Ms Susan Clyne: It is in our submission to the committee, and the Irish Medical Organisa-

tion, IMO, has indicated this before. We are not saying that we are looking for a mandatory vaccination programme, we are saying that the HSE should fund a total population vaccine programme. At the moment the HSE funds the vaccine only for at risk groups and for those within the at risk groups even on the general medical services scheme, GMS. The HSE funds the actual, physical vaccine but not the administration of the vaccine. In light of the need to limit respiratory illnesses and flu in the community the IMO has called for the vaccine to be available on a total population basis, but available voluntarily. We would encourage the total population but we do not want to get into the debate on whether it should be mandatory to get the vaccine.

Chairman: Has the IMO received a response on that yet?

Ms Susan Clyne: No. The HSE has indicated it wants to talk to us next week about the winter vaccination programme. We note there has already been an indication announcement that they are looking at expanding the at-risk group to include children aged two to 12 years. We would not believe that this is sufficient.

Chairman: Does the IMO believe it should be free to everybody in the population?

Ms Susan Clyne: Yes. We believe it should be free to everyone in the population and not just the vaccine. A properly delivered vaccine programme within general practice should be free to everyone in the population so we can improve the uptake, maintain records and have a real understanding of where we are with a total population covering.

Chairman: In response to Deputy McAuliffe and to me, Ms Clyne said that it would be administered within general practice. Is the vaccine currently administered by pharmacists?

Ms Susan Clyne: The vaccine can be administered by pharmacists but it is the IMO's view that it is better done through a general practice because the person's health record is more complete and it is a more holistic approach. Very often when people come in for a vaccine there is an opportunistic consultation where other issues are addressed. In the current circumstances it is also safer in general practice.

Chairman: Would Ms Clyne accept that it is safe to have the vaccine administered by pharmacists or does she think there is a particular danger at the moment posed by pharmacists administering the vaccine?

Ms Susan Clyne: No. I do not think we ever said there was a danger caused by pharmacists.

Chairman: So, you do not think it is dangerous for pharmacists to administer it.

Ms Susan Clyne: No. I do not think it is in the best interests of the patient. I believe it is better to have the person's healthcare needs met within general practice.

Chairman: Which would be the priority, that there be a total vaccination programme or that the vaccination programme be administered by general practice?

Ms Susan Clyne: That there be a total vaccination programme. Pharmacists do administer vaccination programmes. The IMO is not saying that they should not. We are calling for a total vaccination programme for the population, which is not a mandatory vaccination programme but a total vaccination programme.

Chairman: I thank Ms Clyne for clarifying that. I am not a medic but I know that certain levels of vaccination are particularly beneficial once a certain, required level is reached such

as the vaccination for mumps and so on. I have a child who was recently vaccinated and I am aware that certain levels are beneficial. Do the witnesses know what level offers a particular benefit?

Dr. Denis McCauley: It depends on the age group. With the flu vaccine, for example, it has been found that if there is lower coverage in children the rate of spread of flu is actually less. A level of 65% is necessary in the older age group to prevent it from spreading quickly. The evidence of the English research shows that if one gets a smaller proportion of children the spread is less. The cover varies depending on which population one looks at. This is the first year they are planning to do it with children and it will be a different mode of administration; I understand it will be a nasal drop. The evidence in England is that the spread is less, but it depends on which population one looks at. When the sea of snot starts in September, while one might feel that children are not particularly sick with the flu, they spread it quite a lot. That is unclear with regard to Covid. It varies with the flu. If one has to administer to fewer children, one gets greater results. Those are the English data. We do not have any comparative data in Ireland.

Chairman: I missed what Dr. McCauley said about something starting in September.

Dr. Denis McCauley: The kids go to school and mix, and there is the issue of social distancing. There is a thing called the winter plan which has started. The crèches are open and a number of childhood infections are beginning to come in. We had essentially no childhood infections at all since March but now with crèches open, we are seeing children with temperatures. Even within the pod system, there will be a certain amount of mixing. With regard to the flu, children are thought to be significant vectors. They are not that symptomatic but do seem to spread it.

Chairman: Is Dr. McCauley referring to children presenting with Covid or children presenting with influenza?

Dr. Denis McCauley: It is a completely separate issue. At present, we are awaiting adjudication from NPHET on whether children need to be tested when they present with a childhood illness, a temperature of 38°C and a cough. I know that there are different data. Data from Israel show that they could spread infections. There is evidence from Finland and Denmark that opening schools did not cause an increase in infections. Those are two diametric facts. The European guidelines on infection control are to be published at the end of August. I cannot answer that question at present.

Ms Susan Clyne: On the subject of vaccinations, while it might be 65% for the flu in that age group, it is different across the population. We would look for everybody to participate in the HPV vaccine for girls and boys in schools. For the childhood vaccination programme, one would need herd immunity of over 85%. We are always pushing for the maximum number of people to be vaccinated to give herd immunity.

Chairman: Do we know what percentage of the population would have to be vaccinated against the flu to achieve herd immunity?

Dr. Denis McCauley: Going by the present system, it has to be above 65% or 70% to be effective. That is going by the Irish situation. The flu vaccine is available to at-risk groups and people over a certain age. That is what is necessary with the Irish dynamic. When one extends it to the whole population, that effective figure could change. As Ms Clyne said, the higher, the better. As I said earlier, any temperature that occurs in the community now will cause a lot of

psychological worry and will cause economic effects. If a child or an adult has a temperature, the need to stay in quarantine at home will have economic effects as well as health effects and psychological effects. The fewer temperatures we have, the better.

Chairman: When does the flu season typically start?

Dr. Denis McCauley: It varies. It came early last year. Generally, it is any time from September to January. The flu came on time in Australia so we imagine it will come in late October, but last year it came early.

Chairman: If we are to achieve herd immunity from the flu by having the required percentage of the population vaccinated, while everybody is stressing that it will be a voluntary vaccination, time is ticking.

Dr. Denis McCauley: That is why we have been advocating for the past two months that we engage with the Government about this, since the then Minister for Health, Deputy Harris, announced that the vaccine would be extended to children between the ages of two and 12. We have been interested to liaise with the Department about the matter and our first engagement will be next Wednesday.

Chairman: After the Minister, Deputy Harris, made that announcement, was there a follow-up consultation with those who would be administering the vaccine?

Ms Susan Clyne: We have had some preliminary discussions with the HSE on the matter. We will meet further with representatives of the HSE next week in the context of the roll-out of the programme. It is important to note that we will always encourage everyone to get the flu vaccine. We encourage employers to make it available to their staff. It is not the case that the vaccine is not beneficial after the end of October. Even while the flu is circulating, vaccinations keep on going.

Chairman: The specific question I asked was, after the Minister, Deputy Harris, announced that he was going to extend the programme, was there a consultation with those who were going to be implementing it?

Ms Susan Clyne: There was not a detailed consultation. We are expecting that to happen.

Chairman: I thank Ms Clyne. Obviously, Covid-19 is a virus with serious consequences in terms of mortality, and even many of those who survive it suffer debilitating and lifelong conditions. The response to Covid-19 has had the effect that some people are not presenting for routine medical procedures and screening programmes have been put into abeyance. That is also going to result in excess mortality. My question might be overly simplistic, but which is going to result in a greater mortality, Covid-19 or the response to it?

Ms Susan Clyne: The excess mortality rate is not that high at the moment. That is something we will only be able to evaluate as the evidence comes in. I am concerned that we are looking at our health services as if this crisis is because of Covid-19. We already had a crisis that Covid-19 has made worse. That is why we must take significant steps in investment at the moment and not more planning. Myriad plans exist for the health sector but we just want some investment based on clinical evidence and patient need.

I do not think we can answer the question about mortality. We are of the view that mortality will increase at a higher level than it would otherwise have done. Mortality is increasing within

our health services because of the capacity issue anyway.

Chairman: How does the Irish return to cancer screening compare internationally? The representative of the IMO may be able to answer that question but I particularly direct it to the representative of the Irish Cancer Society. How does Ireland compare with other western European states with regard to screenings currently being carried out and the plans that are in place for a return of screening programmes? If the comparison is unfavourable, why is that so? What is causing any differential?

Ms Rachel Morrogh: We have tried to find out that information. We have been using our European networks to get good information but it is a bit patchy. We know that screening has resumed in The Netherlands, though on a priority basis. The Netherlands has colon, breast and cervical cancer screening up and running. Its first case of Covid-19 was diagnosed on 27 February. The invitees for screening are being prioritised on the basis that clients who received their initial invitation before 16 March but had their appointment cancelled have been re-invited and will be followed by clients who should have been invited after that date.

The information from Portugal is not entirely clear. In the central and southern regions of Portugal, breast screening has resumed since mid-June and bowel and cervical screening has also returned but we do not know on what dates that happened. In Ireland, we have said previously that we want breast and bowel screening to return as soon as possible. If the reason that cancer screening has not returned is because of the capacity issues then this underscores the point that both organisations have been making today, which is that there needs to be real, substantial and sustainable investment in capacity so that we are able to ensure that people get access to health care and cancer services as soon as they need them. That will ensure that we limit the number of excess deaths and give people a really good opportunity to live a healthy and good quality life.

Chairman: Does Deputy Durkan wish to come back in?

Deputy Bernard J. Durkan: No, I am in the hands of the Chairman.

Chairman: If there is a question that the Deputy wishes to ask, he can ask it otherwise we will-----

Deputy Bernard J. Durkan: I have already raised the question on capacity, the priorities and the manner in which we should set about achieving the necessary capacities. The IMO stated that it had been putting this issue for the last ten years. I have been at health meetings in the last five years where the suggestion that we had an over-capacity in beds came up again and again. I did not believe that at the time.

I wish to put another issue before the witnesses. As our population expands, and it is expanding, and if we recover and hopefully we will fully from the pandemic economically as well as in health terms, the demand will then get bigger again. The question then obviously arises as to whether we are well-placed to provide the level of services required to that greater population. I am not referring to the ageing population to which everybody refers but to the influx of young people who are employed in this country. That has been the pattern for many years and will continue to be the pattern. There are children and family issues as well as older people's issues. I would like to know if that issue is in hand and if those people at the coalface, on the front line, are prepared to push for the necessary facilities there.

Ms Susan Clyne: The Deputy can be assured that all healthcare workers at the front line are

not only prepared to push but have been pushing for a long time for the facilities. The short answer is "No", we are not prepared for an increase in services. We cannot even meet the demand on our services now. Capacity and recruitment are the issues.

At the end of the session I want to make a special appeal that it is absolutely immoral that our public health doctors, who for many years have been advised on foot of a report, as Dr. McAuley said earlier, that they should be treated as consultants, have been the ones who have been asked to manage the country through this pandemic which is not over and yet their issue remains to be resolved. I make a special appeal that this issue be resolved once and for all. Most people do not think about public health from one end of the decade to the next. It is something like this that shows the value and absolute necessity of a well-staffed and valued public health system.

Chairman: I thank Ms Clyne and all of our witnesses for coming in today and for answering all of our questions. I will suspend this meeting until 2.30 p.m. when we will meet with the Department of Health and HSE officials.

Sitting suspended at 2 p.m. and resumed at 2.35 p.m.

Non-Covid Healthcare Disruption: Waiting Lists and Screening (Resumed)

Chairman: We are joined this afternoon by representative from the Department of Health, the HSE and the National Treatment Purchase Fund on the topic of non-Covid-19 healthcare disruption: impacts on waiting lists and screening.

From the Department of Health I welcome Mr. Greg Dempsey, deputy secretary general. From the HSE, I welcome Mr. Liam Woods, national director of acute operations; Mr Damien McCallion, national director emergency management and director general of Co-operation and Working Together, CAWT; Professor Ann O'Doherty, lead clinical director of BreastCheck; Ms Siobhán McArdle, head of operations, primary care and Mr. Eamonn Rogers, national clinical adviser in urology. From the National Treatment Purchase Fund I welcome Mr Liam Sloyan, CEO, and Mr John Horan, chairperson.

I wish to advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If you are directed by the committee to cease giving evidence in relation to a particular matter and you continue to so do, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, you should not criticise nor make charges against any person or persons or entity, by name or in such a way as to make him, her or it identifiable.

I invite Mr. Dempsey to make his opening statement and ask that he please confine them to five minutes to allow time for questions and answers.

Mr. Greg Dempsey: The invitation indicated that it was discretionary as to whether we made opening remarks so we decided that we would not in order to leave more room for questions.

Chairman: That is fine. I thank Mr. Dempsey.

Will Mr. Woods be making any opening remarks?

Mr. Liam Woods: No, Chairman. The only comment I was going to make was to introduce those present from the HSE but you have done so already. The invitation said that based on the submissions we had made to the committee, there was no requirement for an opening statement.

Chairman: There certainly is not. I thank Mr. Woods.

Will Mr. Sloyan be adopting a similar approach?

Mr. Liam Sloyan: We can, Chairman.

Chairman: I thank Mr. Sloyan. On that basis I will open the floor.

The first speaker is Deputy Durkan for Fine Gael.

Deputy Bernard J. Durkan: I am easy Chairman, as always. Will I have five or ten minutes?

Chairman: Deputy Carroll MacNeill is on the list but you do not look very like her. Sorry for the confusion, it was my mistake.

Deputy Bernard J. Durkan: I presume I will have ten minutes.

I welcome our witnesses and am glad to renew our acquaintances, it is not so long since we met in different capacities, in a different time, in a different era.

A few things have come to mind which were raised in the earlier session. They concern the challenges facing the delivery of health services at present. The Irish Medical Organisation, IMO, made a submission earlier. Its representatives were concerned about the incapacity of the health services to deliver, alongside the continued combating of the virus, while at the same time providing for the extra surge and service requirements that will arise as we approach the winter. They are concerned that the incapacities are at two levels, namely, in respect of buildings and ancillary facilities on the one hand and in respect of qualified staff on the other. They also made reference the unattractiveness of work in the Irish health service at the present time, for a variety of reasons.

I would like to hear a response on that point first, if I may.

Mr. Liam Woods: That is a real concern for us. In some of the submissions we have made to the committee the Deputy will see we have identified that there is a challenge. As the committee will be aware, what has happened over the last number of months is that we have seen a significant fall-off in attendance at hospitals. We have seen that recover substantively in the emergency care and emergency flow areas. We saw a significant fall-off in scheduled care. We compensated to some extent in the private system for that three-month period. We are entering into further arrangements with a view to extending that.

The challenge identified is a correct one. The Deputy mentioned facilities and there is a challenge there. We are currently pulling together a lot of proposals to expand capacity physically. That challenge is most apparent in areas like outpatients and emergency departments. Some measures are already in place around that. As part of our winter planning process, which has accelerated this year, we are identifying further requirements. Indeed, the new Minister has instructed us to do so on an urgent basis. From our point of view there is definitely a facilities

challenge.

In terms of staffing, it is correct to say this whole pandemic experience and what it has meant to the health environment and to the wider public has been extremely difficult. That has been the case for staff also. It has really only been through the Herculean efforts of staff we have gotten to where we are. Staff numbers within the overall health system in this period have risen by over 3,200. There has been a significant increase but, of course, there has also been significant absence associated with Covid-19. Growing that staff and growing key service areas, like intensive care, acute beds, community homecare and other supports, is a key priority for us. They are all falling into being considered as part of our winter planning process.

I agree that the challenge will lie more in identifying issues. Our task is to grapple with that and put in place the best arrangements we can now for what the Deputy rightly identifies will be both a potential return of Covid-19, depending upon the trend in the pandemic, and also the emergence of winter.

Deputy Bernard J. Durkan: Have staff levels at consultant level been adequately replaced or replenished?

Mr. Liam Woods: The number of clinical staff and doctors employed has risen significantly. The replacement of consultants is not problematic from an approval point of view but, as the Deputy will be aware, there has been difficulty in recruiting consultants in some areas. It is also quite a lengthy process. We continue to recruit and, in fact, we had a number of doctors return to practice in Ireland to support the pandemic response. We will continue to recruit consultants for the remainder of this year in key areas of service priority.

Deputy Bernard J. Durkan: Concern was expressed about the need to provide cancer care services and screening in the present climate to restore to the required levels the screening and diagnostics needed, and at the same time provide for, perhaps, a second wave with regard to the pandemic. Are sufficient provisions in place to be able to withstand both challenges at the same time?

Mr. Liam Woods: I will ask colleagues to address screening in a moment. Regarding the arrangements for our cancer services within the acute environment in the first wave of the pandemic, rapid access clinics remained open but attendance fell significantly. That can be attributed to the numbers of patients coming forward and referrals from GPs. We also displaced urgent surgery into the private system and actually that worked very well. Mr. Rogers can talk more on that, if required, but that worked very well for first three-month period.

The notion that we have adequate capacity to deal with the Covid-19 surge and the demands of cancer and other urgent elective surgery within the system as it is currently configured is a real challenge. Before we came into the pandemic Sláintecare said there is not sufficient capacity, and that becomes a larger issue now. The Deputy will be aware that at the height of the pandemic we had 2,200 beds closed in the acute system. That was a significant shift, partly associated with public intent around coming into the hospital environment, but also with the shift in staff toward ICU and intensive care. From our point of view, it will be very difficult to respond to both the elective and unscheduled care demand with the surge we know is coming this winter. I will ask colleagues to address screening briefly.

Mr. Damien McCallion: There will be significant challenges in screening. It is important to remember we are only coming through the first phase of the pandemic. The capacity of the

screening and treatment centres will drop from anything between 30% and 70% across the different services through this phase. Clearly, if we have a resurgence, or a number of resurgences, that will bring further challenges. I will ask my colleague, Professor O'Doherty, to describe what some of those challenges are in the context of BreastCheck to give the Deputy some real examples of the practical issues on the ground in the service.

Professor Ann O'Doherty: The most important aspect of any screening programme is to do no harm. We made the difficult decision to suspend screening because many of our women go up to the age of 69. It is a very close contact examination so we suspended screening very reluctantly. That was the right decision at that time. We also had, at the time, approximately 500 women with screen-detected abnormalities so we set about doing that. We are conscious that we have a lot of ground to make up. It is the last thing in the world that I would want to do. I have spent my whole professional life advocating screening and it is the last thing I would want to do.

If we screen 1,000 women, we will pick up seven cancers. If we look after 1,000 women with specifically urgent symptoms we will pick up 100 cancers. We had a situation where we did not have the ability to do everything. The hospitals were being protected for the big surge. It was a challenging time and there was a lot of fear. I want to congratulate all our staff for helping us to deliver the service at all stages during this time. We have been working to look after women with symptoms and that is the priority. We must maximise our efforts. We are in the middle of a pandemic. Our ability to get back to screening normally is limited until we get to a situation where we do not need to have 2 m social distancing. It is not that we do not want to, but that is the reality and we will do everything in our power.

There is, however, a whole area of work. The European Society of Breast Imaging has given us guidelines on what to prioritise in the Covid-19 situation. We have been following exactly that guideline and the lowest priority at the moment is screening healthy women. We have women with a family history who have an 80% lifetime risk of breast cancer. They are in the hospitals and we are screening them at the moment. We are screening women with previous breast cancers. They have a much higher incidence. We are using our resources to the best of our ability in a very challenging environment.

Deputy Bernard J. Durkan: At the present time, it is suggested that considerable numbers of people are awaiting oncology results or tests and could be on a waiting list for some considerable time, which is obviously not a good place to be. It is the same with regard to endoscopy services. To what extent are the witnesses monitoring the requirements there? What actions are they taking, or have they taken already, to address the issues?

Mr. Liam Woods: During the months of the first phase of the pandemic we had a significant problem with endoscopy. The urgent cases, of which there are normally no breaches on a monthly basis, went up to 1,500 breaches in the month of April. That reduced to 1,000 and is now back to 500 so the hospitals are putting a lot of energy into prioritising urgent scopes. The challenge is that in the Covid-19 environment much greater caution is required in terms of undertaking scopes and so the time to complete each scope is greater. There is a productivity issue around that. It ties back to what the Deputy was saying earlier. We also need more facility for scopes and that is something we are working on. We are aware of that. It is recovering somewhat.

The challenge and the international experience is that, unfortunately, it is likely that in total volume terms we will do well to get 70% or 75% of the previous volume. We will have a chal-

lenge there. We are aware of it and we are working at it. I believe the priority scopes, both for bowel screening and by referral, will come back on track over time where we will see difficulties in the routine and surveillance scopes. That is something we will have to work at further.

Deputy Bernard J. Durkan: Am I out of time?

Chairman: Yes, you are but you may come in at the end. There will be a bit of excess time.

Deputy Bernard J. Durkan: I am out of time, not for the first time in my life.

Chairman: The next speaker is from Fianna Fáil. Deputy McAuliffe has ten minutes.

Deputy Paul McAuliffe: I refer to the discussions we had this morning with the Irish Cancer Society and the IMO, particularly the discussion about a national flu vaccination programme. Can the witnesses flesh out some of the plans for that? Is that being done in parallel with the fight against Covid-19, particularly, the roll-out to non-prioritised groups?

Deputy Bernard Durkan took the Chair.

Mr. Liam Woods: Ms. McArdle might deal with this question.

Ms Siobhán McArdle: From a HSE perspective the flu programme forms part of the public health response and is very much part of our winter plan every year. Plans are in development to extend it with particular attention to ensuring there is high uptake in our staff cohort across both community and acute services. We will also extend the programme to higher-risk groups such as people with chronic disease and children to ensure that there is very robust management of flu. That very much ties into our response to the winter plan.

Deputy Paul McAuliffe: Is there a reason the HSE is not approaching the flu vaccination programme with the whole population as the target?

Ms Siobhán McArdle: The implementation falls to the operational part of the HSE but our clinical colleagues are best placed to advise on that. At the moment, the priority is, as I said, the age cohorts that are more vulnerable to the effects of flu and respiratory disease. Also included are people with chronic disease and people with respiratory illnesses such as chronic obstructive pulmonary disease, COPD. We are very much encouraging people who are living with chronic disease, as well as older people and children who are living with chronic disease to engage. We will be guided by our public health colleagues on the breadth of the population that receives the vaccine. Everybody is invited but particular attention is being given to priority populations. We will be working with our GP colleagues, as well as our community pharmacy within the HSE and our support organisations, in terms of occupational health and supporting our staff to deliver and manage flu in that environment.

Deputy Paul McAuliffe: Is the HSE aiming to have the maximum possible roll-out of the flu vaccine to as many people in the population as we possibly can, or are we limiting that ambition to the target groups, just as we might ordinarily do in a normal year?

Ms Siobhán McArdle: It has certainly expanded in the current year. Over the past winter we identified that expanding it this winter would be an advantage in managing in the context of Covid. As such the flu vaccine has been extended to a wider cohort. It is a question we will take back to our colleagues and maybe give the Deputy further information on the extent of the flu vaccine programme for 2020.

Deputy Paul McAuliffe: From some of the clinical advice this morning there is talk that the flu season may reach us in September or thereafter. We have very little time to prepare for that. From both a social and an economic perspective, and speaking as a public representative, there is a benefit to reducing all levels of influenza that we can in order to avoid it being mistaken for Covid-19. Even the slightest symptoms of influenza will lead to people having to self-isolate, to take time off work, and perhaps even entire businesses having to shut down. There is also the idea of false-positive spikes or surges, so the more we can do on the influenza side the better. We need much more detail from the HSE on that at this point.

Ms Siobhán McArdle: We have a flu plan in place and will be encouraging people when that plan is launched to ensure that we have maximum take up of it. We will provide the Deputy on the flu plan outside of this.

Deputy Paul McAuliffe: When the HSE is coming back to me on that it might also look at the issue of pharmacists. I understand flu vaccination can be availed of in the local pharmacy, but that pharmacist is not able to administer the vaccine in a person's home, for example. That is additional capacity that could provide the greater than normal ability to deliver the flu vaccine and I urge the HSE to consider that. I imagine there are other concerns but I urge the HSE to consider this also.

Ms Siobhán McArdle: I agree.

Deputy Paul McAuliffe: Capacity issues were raised this morning as well. The chief one was the idea of the 500 consultant posts. There was also an alarming enough figure that of the 160 specialised registrars, SpRs, who are exiting rotation this year, only one of them has had an informal consultant post. Can the HSE explain what the delay has been in appointing people to those 500 consultant posts?

Mr. Liam Woods: By way of the background facts, the number of consultants has risen by 140 since the start of this year, with a further increase in registrars and interns of nearly 400. We have seen an increase of 526 in medical posts in total in the hospital system since the start of the year. On the question of delay in the recruitment of consultants, there is a process, as I referred to earlier on, that can be a bit lengthy. We are very keen to retain as many of our senior clinical personnel as we can. In fact, in a way, there is an opportunity at this time to do that that might not have existed in previous years, which we are pursuing.

Deputy Paul McAuliffe: Can I clarify the figure of 526? Is that a net increase?

Mr. Liam Woods: Yes, it is. That is a growth in whole-time equivalents. This includes people who may have retired and new appointments and is a net increase.

Deputy Paul McAuliffe: My second question was around the greater access to diagnostics for those at primary care or GP level. Can Mr. Woods talk to that issue, please?

Mr. Liam Woods: Yes I will, and I may ask Ms McArdle to comment too if she wishes. That is a key priority for us. More generally, under the heading of what we can do best to alleviate pressure on the acute system to allow it to do what it needs to do and what it does best, but also to support primary care, the provision of diagnostics to GPs in the community is one target that we are very clearly focused on. From our point of view we are going to market specifically for the purpose of acquiring private diagnostics to support GPs but also to look at the use of public facility. We have recently looked at the access to diagnostics in public hospitals for GPs. As the Deputy would be aware, nearly half of the laboratory work at the moment in

public hospitals is in fact from GP referral source. There is also access to radiology. The key requirement, which in our own dialogues with GPs is very clear, is that the provision of additional diagnostics and of dialogue with consultants and with specialists, is a key ingredient to treating people at or closer to home and not in hospitals. We are very much pursuing this as part of our own winter planning process for this year. Perhaps Dr. Rogers might like to say more about that in his own area.

Dr. Eamonn Rogers: I totally agree. Cancer has to get the optimal care in the right location but we can move certain services that are non-cancer into the community. The national clinical programme in surgery has started looking at this with its models of care, looking at benign conditions that can be managed in the community with shared care initiatives, with general practitioners using nurse-led clinics in the community. These initiatives have actually started and are being piloted at the moment in my own health region. To make this work it involves moving traditional work that comes into hospital which clogs the outpatients. The idea is to reduce footfall in hospitals, which is more important now with Covid-19 risk, and to move this work as much as possible into the community, closer to home. These initiatives are live and also depend, as Mr. Woods said, on getting diagnostics in primary care centres.

Deputy Paul McAuliffe: When Mr. Woods talks about going to market on diagnostics, does he have a number for the diagnostic machines that can be delivered and the types of machines?

Mr. Liam Woods: When I speak about going to market, it is to seek private providers to be in contractual arrangements with us to provide that kind of equipment which is both CT and MRI, as well as potentially ultrasound and X-ray, but the big demand is for CT and MRI for GP referral. That is part of a wider tender that we are doing at the moment with regard to access to private services as part of our ongoing addressing of capacity this winter. It is likely therefore that we will contract entities, it is not specific machines that can provide a service.

Deputy Paul McAuliffe: What level of service or increased level of service will that provide?

Mr. Liam Woods: We already, as Dr. Rogers has said, have a number of pilots under way and we will certainly be looking to support those. We will also be in dialogue with the GP community seeking to support in as much as we can the location of appropriate care in the community. In volume terms, I cannot give the Deputy a number right now but we are seeing this as a significant piece of our winter planning. We are open to acquiring as much diagnostic capacity as we can to meet this demand.

Acting Chairman (Deputy Bernard J. Durkan): We are out of time and we have to move on to the next speaker, Deputy Cullinane.

Deputy David Cullinane: I welcome all of our witnesses. I will start with Mr. Woods. This afternoon, I commended the Irish Cancer Society and the IMO on what were substantial and helpful briefing documents. I also want to commend the HSE because the document it has sent is helpful and expansive. I want to thank the HSE for that first and foremost. Did Mr. Woods hear the committee's exchanges this morning with the IMO and the Irish Cancer Society?

Mr. Liam Woods: No, I did not.

Deputy David Cullinane: Did Mr. Woods read their opening statements or submissions?

Mr. Liam Woods: No, I have not seen those.

Deputy David Cullinane: There was a deep frustration coming from both organisations, which I will go through in a moment. It strikes me that at this point there are three strands to healthcare delivery, namely: dealing with Covid-19 care; dealing with non-Covid-19 care, which is all of the modalities of care from acute care to primary care, mental healthcare and community care settings and so on; and the need for a catch-up programme, which Mr. Woods talked about. Is it fair to say that under current capacity constraints, we will not be able to keep up, never mind catch up, if there is a surge in Covid-19 in the coming weeks?

Mr. Liam Woods: The Deputy rightly identified the fact that there are a number of elements to healthcare delivery that begin to interconnect as we move on. It is fair to say that we face a real capacity challenge, and depending on the trend in Covid-19 data and what happens with this year's flu cycle as winter approaches, we face a capacity constraint. We have a fixed capacity against an as yet unknown demand.

Deputy David Cullinane: My point is that there is a question of how in God's name we will roll out a catch-up programme if we have increased levels of Covid-19 in our acute hospitals, as well as all of the ongoing day-to-day non-Covid-19 care that would have to happen anyway. That brings me to my first question on capacity. The Irish Cancer Society and the IMO, like many other organisations, are calling for temporary accommodation and physical capacity to be made available. Is that something that is being examined by the HSE and the Department and if so, to what extent?

Mr. Liam Woods: Yes, it is. I should say that over the past three months we were already putting in additional capacity, such as the 324 additional acute beds and, critically, the 42 ICU beds.

Deputy David Cullinane: I am asking about additional capacity beyond that again.

Mr. Liam Woods: Beyond that, in terms of looking at modular development on a rapidly accelerated basis across the acute environment, we are also examining proposals as part of this year's winter plan. They are looking at areas such as the displacement of outpatients to create more clinical space. The other capacity issue I should mention is that we will seek to further contract with the private system, which worked well in providing urgent elective care.

Deputy David Cullinane: I want to ask about staffing because that is the physical side of the question covered. That depends on what happens and on the extent of what happens so we will have to see the colour of the money in the context of what that means. On staffing, from a combination of Be on Call for Ireland, the return of retired and overseas staff and locum cover, how many additional staff were brought into the system in full-time equivalent posts to cater for Covid-19?

Mr. Liam Woods: On full-time equivalent posts, we have 3,271 additional posts since the start of the year, the bulk of which would have come on stream since February, which is the period to which the Deputy is referring.

Deputy David Cullinane: Will Mr. Woods provide the committee with a breakdown of those posts in categories? How much does that cost? One of the things we know is that we did not have enough capacity in the public system. Now that we have 3,271 additional staff who have come into the system, they need to be maintained insofar as is possible. Those who need to be kept in their positions should be kept on. What was the cost of those 3,271 posts?

Mr. Liam Woods: I do not have the cost figure in front of me but, on a full-year basis, I

would have to do a sum that multiplies that by an average salary. Maybe I could provide the committee with that figure because it varies by staff type and grade.

Deputy David Cullinane: It would be great if Mr. Woods could provide that figure. I want to move to screening because this morning the representatives from the Irish Cancer Society were concerned more than critical about the screening services and wanting them to be back up and running. They stated that there were potentially 450 cancers that had possibly gone undetected so far. Would Mr. Woods agree with that figure?

Mr. Liam Woods: I might ask my screening colleagues to address that.

Professor Ann O'Doherty: May I explain that? It depends on the length of the interval between when a patient would have been diagnosed and when he or she is diagnosed. That is largely down to the type of cancer and the age of the patient. The European Society of Breast Imaging has written in its introduction that a relatively short delay in screening healthy women of six to 12 weeks has almost very little impact on survival. However, in terms of younger women who present with aggressive symptoms in our symptomatic services, that is where the life years can be gained by treating them very quickly. We must acknowledge that we have lost a lot of ground in-----

Deputy David Cullinane: I am sorry, Professor O'Doherty. My question was in relation to a number. The Irish Cancer Society has put out a number of 450. I am asking if the HSE has a figure that was done on analysis.

Professor Ann O'Doherty: May I explain that? It is impossible to put a number on that in terms of mortality. We could not possibly do that because it depends on the length of the delay. It would require a mathematical statistical analysis-----

Deputy David Cullinane: Professor O'Doherty does not know from where the Irish Cancer Society got its figure.

Professor Ann O'Doherty: I have no idea where it got its figure. I do know that if we were screening, we would be detecting cancers all the time. There is no doubt that we have lost ground but I cannot put a number on it.

Deputy David Cullinane: Mr. Woods or Professor O'Doherty might answer this question. The comprehensive briefing document they provided states that in terms of the four screening programmes, it will take time for screening programmes to build up, but is it fair to say that we do not have time? How quickly are we looking at getting those screening programmes up and running?

Professor Ann O'Doherty: For BreastCheck most of our screening - 70% - is done in a mobile breast screening unit. We normally would have screened 40 women a day in a mobile unit. We now have put a mobile into Beaumont Hospital to help with symptomatic services and we are managing 21 women a day, which is better than we expected. It will have an impact because social distancing has a major impact on our ability to deliver clinical services in all areas. We have a huge challenge, which I am not underestimating and I do not want to give the impression that we can surmount it easily, but we have to put all our efforts and resources into doing so, and we will be doing that.

Deputy David Cullinane: I want to put on record the deep concern expressed by the Irish Cancer Society and many more advocate groups about the need to get screening up and running.

I know Professor O'Doherty accepts that.

Professor Ann O'Doherty: I share that view, yes.

Deputy David Cullinane: I want to put the final question to Mr. Woods. It is regarding capital funding. A reply to a parliamentary question on cardiac care in the south east, and this is only one project, so it will now involve every project, states that a capital plan is being reviewed and revised to take account of the impact of Covid-19. Are we now saying that every capital project is being reviewed, that even ones to which capital money was allocated may not be allocated that money, that we are looking at a full review of the capital project, and that projects that people felt were in the bag and would be delivered may now not be delivered?

Mr. Liam Woods: I am not aware of any project that is not proceeding. The point being made is that the demands on capital, which have been many over the past three to four months, give rise to a need to review. The particular project the Deputy is referring to in the south east is recommenced. Some of these projects are being impacted by the incapacity to work during a time interval, but from our point of view we have not done any review with a view to not proceeding with projects.

Deputy David Cullinane: The HSE is not reviewing individual projects and saying that is in and that is out.

Mr. Liam Woods: No. I think it is a general reference to the fact that we have spent a lot of additional capital on ventilators, other equipment and on buildings in a very short timescale. I commend my State colleagues on the work they did in that regard.

Deputy David Cullinane: I thank Mr. Woods.

Chairman: The next speaker is Deputy Shortall. A number of speakers are not coming today so the Deputy may take ten minutes if she wishes.

Deputy Róisín Shortall: I thank the Chairman. I welcome all our guests. I want to concentrate my questions on the issue of the flu vaccine. Earlier in our session here, and we are all only too well aware of it, there was discussion about the fact that, pre-Covid, we had a very severe shortage of hospital beds. I think we are all aware of that from the capacity review. That situation has been exacerbated greatly through Covid-19. Obviously, there is the whole question of reserving 20% of bed capacity in the event of a second wave. There are also severe constraints imposed as a result of the need for better infection control and distancing within hospitals, which reduces the bed capacity even further. On top of that we are heading into the flu season. There is now the prospect of a perfect storm developing in which our hospitals could be overwhelmed. What is the situation in terms of preparation for the flu season? Recently, I saw the figure for the number of people who were hospitalised last year due to the flu, which was 4,300. That is significantly in excess of the total number of people who were hospitalised as a result of Covid-19. There are real challenges facing us and a real prospect of the hospital services being overwhelmed. What steps are being taken to improve the uptake of the flu vaccine to avoid a fairly severe situation arising in the hospitals? The uptake last year and in previous years was not great. What is the current estimate of the number of vaccines the HSE will have to procure? Last year, I believe the figure was 1.2 million vaccines. We should certainly hope to improve on that if we are to avoid serious problems in the hospitals. What number is the HSE estimating for the demand and what number of vaccines has it ordered and is confident it has secured?

In addition, in recent days the EU Commission urged all member states to launch earlier and broader vaccination campaigns against the flu this year to reduce the risk of simultaneous flu and Covid-19 outbreaks in the autumn and to avoid what the Commission refers to as a cocktail of risks. Is the HSE taking that advice from the EU Commission on board and when does it intend to start that campaign for the uptake of the flu vaccine?

Deputy Michael McNamara resumed the Chair.

Mr. Liam Woods: I will respond and my colleagues can make any further comments. As the Deputy rightly said, the challenge is clear. That we are facing into winter and Covid and, as mentioned earlier, a backlog of demand is putting the health system in a very difficult position. In terms of the uptake rates in hospitals specifically, they have been improving over the past two years but need more focus. The Deputy asked what we are doing. There have been active campaigns, some very successful, on peer-to-peer vaccination within the hospital environment and we will be encouraging and promoting more of that.

Deputy Róisín Shortall: Are those campaigns running at present in terms of hospital staff?

Mr. Liam Woods: No. The Deputy asked when that will start. I do not have a date on which the current year's vaccine is available to us. I will have to refer back to the Deputy on that.

Deputy Róisín Shortall: I meant the campaigns to encourage greater uptake. Have those campaigns started?

Mr. Liam Woods: They will run coterminous with the availability of the vaccine. In the hospital environment specifically, it is very much about having the vaccine and engaging in peer-to-peer vaccination within the sites. At public health level, we have an ongoing engagement with hospitals on flu vaccine uptake, and our public health leads are engaged in that. On the Deputy's specific questions, I will have to refer back to her. I do not have the date for the start of the campaign as it is not within my remit, but I can get it for the Deputy unless Ms McArdle is aware of it.

Ms Siobhán McArdle: The planning for the flu vaccine programme has commenced. That is under the governance of our chief clinical officer. Our colleagues in health and well-being are very much involved in rolling it out on two fronts. One is for the target populations. We work very closely with our GP colleagues. For example, over the past winter there was a focus on ensuring that people in the older population took up the flu vaccine. There was a targeted campaign to advertise the flu vaccine and then we worked directly with our GP colleagues-----

Deputy Róisín Shortall: I am sorry to interrupt, but I am wondering what preparation is being made for this year, given the massive challenges associated with Covid-19.

Ms Siobhán McArdle: The flu vaccine programme-----

Deputy Róisín Shortall: My questions are what the estimated number of vaccines that would be required is and how many vaccines the HSE has secured at this point.

Ms Siobhán McArdle: I do not have that information at present, but we will revert to the committee with it.

Deputy Róisín Shortall: What are the witnesses' views of the adequacy of the number of vaccines the HSE has secured?

Mr. Liam Woods: I will take that. Looking at past practice, would we like to see greater uptake of vaccine? The answer is "Yes", both in the healthcare environment and outside.

Deputy Róisín Shortall: I am not talking about uptake. Obviously, there is a need for greater uptake. My question is whether or not the health system will be ready for the flu season, given the huge challenges that are there as a result of Covid.

Mr. Liam Woods: As Ms McArdle has said, we have an active plan in place. Our public health colleagues and some people specifically leading on vaccine can provide information on that. We do not have that information with us but we do not foresee a problem at this stage with access to vaccine. We will revert with both the detail of the plan and the start date.

Deputy Róisín Shortall: I would really appreciate it if the witnesses could provide the actual figures or the number of vaccines procured.

Mr. Liam Woods: I think Mr. McAllion may have some further information.

Deputy Róisín Shortall: As a result of the advice from the European Commission this week, is it the HSE's intention to start that campaign earlier, as is being advised?

Mr. Liam Woods: As I said, earlier and broader. The answer to both is "Yes".

Deputy Róisín Shortall: What is the date on which the HSE intends to start?

Mr. Liam Woods: It will depend on the availability of vaccine, so I am afraid we will need to revert with that information.

Mr. Damien McCallion: I think I can help. I was trying to come in earlier. As for the vaccine, the number we have this year is 1.4 million, which we believe is sufficient for a 90% uptake among the at-risk groups, which will include healthcare workers. We have also placed an order for the vaccine that is available for children between the ages of two and 12. I will have to confirm that number but it is in the region of 500,000 plus. We can confirm those numbers separately. As Mr. Woods said, it is part of the overall briefing.

Deputy Róisín Shortall: I wish to concentrate on those figures now for a couple of minutes. Last year, I understand, we got 1.2 million vaccines. Mr. McCallion is saying that that is now increasing to 1.4 million. That is only an additional 200,000. Given that there are three vaccines for all children up to the age of 12, and given the need to increase the uptake among healthcare workers in particular but also among the general population, how can Mr. McCallion make out that an additional 200,000 is sufficient?

Mr. Damien McCallion: As I said, in addition, the children's vaccine is over 500,000 as well as the 1.4 million for the adult population. That is believed to be sufficient at the moment to achieve 90% coverage in the at-risk groups, that is, the groups identified as priority, including healthcare workers.

Deputy Róisín Shortall: Does that figure of 1.4 million include the dose for children, which-----

Mr. Damien McCallion: No, that is separate. I am sorry. I may not have explained that well enough. The figure is just under 1.4 million for adults, and those are for the priority groups that have been identified, including healthcare workers, and then over 500,000 for the children's vaccine.

Deputy Róisín Shortall: It does seem quite a small additional number. My concern is that we will not be prepared for the flu season on top of the other constraints that are there.

Mr. Damien McCallion: Sure. From a public health perspective, we can try to give the Deputy more detail on the priority groups Ms McArdle has set out. The number is deemed to be sufficient if we get a 90% uptake, which is high. Obviously, this year in particular we hope we will see high uptake, both in the general population and particularly in our staff groups. I think Ms McArdle and Mr. Woods mentioned earlier that a lot of work has started in respect of our own staff groups. Then the programme for roll-out in the general population and the communications campaign will be aligned with the availability of the vaccine. Perhaps we can get the Deputy more specific dates on that separately.

Deputy Róisín Shortall: I thank Mr. McCallion. Does the HSE actually have the vaccine at this point or has it just placed orders?

Mr. Damien McCallion: I will have to confirm the precise situation in that regard with our public health people. I have just the broader picture of where we are, but we can get the Deputy that information.

Deputy Róisín Shortall: I thank Mr. McCallion. I would appreciate that.

I wish to come back to Mr. Woods. The other big challenge in the hospitals, apart from the inadequate number of beds, is the high number of vacancies among doctors in particular. We were promised a few months ago an additional 1,000 consultant posts and that they would be employed on the basis of what is called a Sláintecare public-only contract. Where are we in preparation for that as regards the legislation for the contract and the discussions with the relevant groups? At what point does Mr. Woods expect to be starting that recruitment campaign?

Mr. Liam Woods: I will ask my colleagues from the Department to respond to that as it is a policy question. We are still working within the current consultant contract framework so the whole-time public consultants we recruit at the moment are type A.

Mr. Greg Dempsey: Unfortunately, I am not overly familiar with the detail of this matter. It is a commitment in the programme for Government and is therefore a priority but I might have to come back to the committee with more details.

Deputy Róisín Shortall: Does Mr. Dempsey know if any work been done on it?

Mr. Greg Dempsey: I have not been briefed on it.

Deputy Róisín Shortall: Is there anybody among the witnesses from the Department who deals with legislation and contract negotiation?

Mr. Greg Dempsey: There is no one here today, unfortunately.

Deputy Róisín Shortall: I would appreciate if we could get an early report on that.

I return to the issue of bed capacity. There have been calls for some time for a proper programme of hospital extension and new hospital provision in order to increase the number of beds available. There also have been calls for an immediate response to the dire shortage through the provision of quick-build temporary facilities. Is any work under way on that at the moment? How soon can we expect an increase in the number of beds, even on a temporary basis?

Mr. Liam Woods: There is work under way on a few sites of which the Deputy may be aware. Clonmel hospital has opened a modular build with 40 beds, which thankfully were available to come on stream early this year. Limerick University Hospital is currently building a further 100 modular beds. As I was saying earlier, as part of our winter planning we are looking at deploying modular technology to put as much capacity as we can on the ground in preparation for winter. There is an active programme and working plan for that at the moment.

Deputy Róisín Shortall: Is Mr. Woods saying he expects to have those beds in place for this winter?

Mr. Liam Woods: We will have some modular facilities for this winter that we do not have today. The timescales for larger-scale modular builds would probably exceed this winter to an 18-month window, but there are some areas where we can make some progress within the interval available.

Chairman: If there is any time at the end I will bring back in Deputy Shortall. I call Deputy Bríd Smith.

Deputy Bríd Smith: Professor O'Doherty said earlier that BreastCheck is using the resources to the best of its abilities. I honestly believe that but the problem here is the lack of resources. She can correct me if I am wrong, but she said she reckons that 450 cancers could have been missed. Is that correct?

Professor Ann O'Doherty: I did not use that figure. That figure was cited by the Irish Cancer Society.

Deputy Bríd Smith: How many cancers does Professor O'Doherty think may have been missed?

Professor Ann O'Doherty: The number depends on the interval between when a woman should have been screened and when she was screened. As I alluded to earlier, the European Society of Breast Imaging has stated that a 12-week wait for screening does not adversely affect a healthy woman. I work in both symptomatic and screening services, and the real problem is ensuring that younger women and women with more aggressive tumours are dealt with. That is what we have to factor in and that is why I cannot give the Deputy an exact figure. We have managed throughout Covid to deal with all the urgent patients in the symptomatic service and that has been a huge challenge. I am not for one minute avoiding the question or saying there will not be an impact. I just cannot put a figure on it. We are very lucky in one way, in that we have a two-yearly screening programme, which was very hard fought for. The UK has a three-yearly screening programme, so women are already waiting 35 and 36 months. We do not have anyone waiting more than three years. We are doing everything we can and we will be back----

Deputy Bríd Smith: I honestly believe that. The problem is the lack of capacity and resources. Professor O'Doherty said that out of every 1,000 checks, one would expect to find about seven cancers. Could she not put a figure on it on that basis?

Professor Ann O'Doherty: It depends. If we look at our screening programme, we should be screening within two years, plus or minus three months. Looking at our backlog, it is 25,000 for that period. Going back to two years plus six months, we have a lower rate. I have the exact figures here. What I am trying to say, however, is that it is impossible to state the numbers because if we get to people quickly enough, then we will not have the adverse effect. I will give the numbers to the Deputy.

Deputy Bríd Smith: If we are not able to pick people quickly enough, we could have more adverse effects than what would be normal.

Professor Ann O'Doherty: What I am trying to say is that we have lost ground in screening and symptomatic services. Our focus has been to save the maximum number of lives possible, which has meant getting the symptomatic women done. Under normal circumstances, we would never have used screening resources to deal with symptomatic women. Even if I was given a huge amount of money tomorrow, the trained staff are just not out there. It takes 14 years to train a radiologist and six years to train a mammographer. We were not expecting Covid-19, so we have lost ground and I cannot pretend that we have not. It is not a resource issue centred on money, however. It is a resource issue regarding personnel.

Deputy Bríd Smith: I want to ask the HSE representatives a question. We are limited with time. The HSE has stated that it has added 3,271 posts. We do not have a breakdown of that figure, but how does that compare with the number of people who applied for positions as a result of Be on Call for Ireland?

Mr. Liam Woods: I can provide a breakdown of that figure to the committee afterwards. Regarding the number from the end of May, however, for the whole-time equivalent increase, that is reflective of any clinically trained person who made himself or herself known to the system and who desired to work in the system during this time. To clarify the Deputy's question further, was she asking me for a percentage?

Deputy Bríd Smith: I was asking for a comparison of that figure with the number of people who applied for positions. I think we all know people, at least one nurse and probably some doctors, who were left waiting around for months after responding to the Be on Call for Ireland campaign but did not get an interview or a post. It was stated earlier that the recruitment process is lengthy and cumbersome. I would like Mr. Woods to comment on that aspect. Why were more professionals not recruited into the system when they were needed and available?

Mr. Liam Woods: I was referring specifically to the recruitment process for consultants, which we have looked at streamlining but it still takes quite some time. The recruitment process more generally has substantively accelerated to bring in those 3,200 posts. In fact, that number of posts would equate to closer to 4,000 people. The system, therefore, has been seeking to take on everybody it could. Where individuals have experienced delays, that may sometimes be because of issues regarding Garda clearance or similar matters. We have certainly sought, however, to accelerate the recruitment process, and the intention in both the hospital and community system overall was to bring on board as many healthcare workers as was achievable to face what was, at that time, an unknown surge level.

Deputy Bríd Smith: Will Mr. Woods comment on what the IMO stated this morning regarding the two-tier consultant contract inhibiting recruitment?

Mr. Liam Woods: We are recruiting into the existing consultant contracts. That comment earlier, which I did not hear, may relate to the post-2012 consultant contract as against the various types of contract that exist. It is not a matter for the HSE, however, but I understand that it is intended that that issue will be addressed as a policy issue. From our perspective, therefore, we are recruiting into the currently available contract types and on the post-2012 pay scales. I suspect that earlier remark was a comment on the post-2012 pay scales, which are a matter for the Government and not the HSE. Having said that, however, I understand that the commitment has been given to review and address that issue.

Deputy Bríd Smith: That is fine. I have a question for the witnesses from the National Treatment Purchase Fund. It was stated that one third of the work of the fund concerns securing public capacity. The problem we have, of course, is that if we continue to rely on the NTPF to solve the waiting lists, we are then effectively building up the private system and not dealing with the capacity issue in the public system. We are therefore continuing to add to a dysfunctional system of public versus private. There is also then the question of the costs. What would the witnesses say about the efficiency and costs of contracting out these needs when they should be in the public system?

Mr. John Horan: To put this is context, and without going back into ancient history, the National Treatment Purchase Fund, NTPF, working with the HSE, the Department and the hospital system, had significantly reduced the waiting lists up to the beginning of this year. In fact, in the early months of this year we had arranged surgery, procedures and scopes for more than 9,000 patients. We had arranged outpatient consultants for 8,500 patients. Then, at the end of March, because of the pandemic, non-critical care or elective care had to be postponed and this definitely had an impact on waiting lists and waiting times. Since June and this month, we have started to commission again.

In terms of where we are doing this work, whether it is private or public, probably the best indicative figure I can give the Deputy is that last year, approximately half our money was spent in public hospitals and the other half in private. We do not have a particular hang-up as to whether it is private or public. It is not an ideological position with us. Our simple view of this is whatever works best. We have worked well with our colleagues, as I say, in the HSE and in the hospital system, to get things done and we think we can help there again once we get out of the enormously difficult situation that we are currently living in.

I will ask my colleague, the chief executive, Mr. Sloyan, whether he wishes to add anything to that.

Mr. Liam Sloyan: I suppose I would just add that there is not a reliance on the NTPF to bring waiting lists down. We work closely with our colleagues in the HSE and the vast majority of treatment of waiting list patients continues to be done by the HSE in public hospitals.

The value of a commissioning system, adding on a relatively small level of extra capacity there, is the flexibility and agility of such a system. It is the case that challenges arise for waiting lists in many different places, many different ways and many different times and a commissioning system can have the flexibility to address the different types of challenges as they might arise. For example, it may be in one public hospital that they require more theatre time and that can be rented in a private hospital to facilitate them. Others may need more staff or funding to provide work at the weekend or in the evening. The NTPF and a commissioning system can look at the different types of problems that have arisen and find a solution to fit a particular problem. I would point out again that the vast majority of waiting list patients are addressed in the public system through the HSE in Ireland.

Deputy Bríd Smith: Surely the NTPF would not exist if we did not have a dysfunctional public care system. There would be no need for a national treatment purchase fund if we had a fully effective national health service instead of the dysfunctional one we have.

Mr. Liam Sloyan: Many health systems internationally have a commissioning element to them. It is not peculiar to Ireland. It recognises the fact that sometimes there are temporary problems that need temporary solutions. In fact, all the time these type of issues arise in waiting

lists and there can be different problems in different years.

Chairman: I thank Mr. Sloyan and Deputy Bríd Smith.

Deputy Matt Shanahan: I thank our guests here today. I stated in the previous module today that the submissions that had been received earlier today largely reflected a great deal of frustration and some of that is coming across in this meeting here too. I would rather concentrate on what we can do rather than on what, potentially maybe, we think we are doing.

I brought up in a previous module the issue of scoping and radiology. I believe there is capacity now in the public system to do increased scoping and radiology later in the afternoon or in the evening because of the capacity constraints during the day. I wonder has the NTPF looked, as I stated earlier, at using some of the specialist registrars, SpRs, using some of the consultants on-site to try and expand hours into the evening. They could go quite late into the evening, maybe to 7 p.m., 8 p.m. or 9 p.m., to do additional procedures.

Mr. Liam Sloyan: We do, across public hospitals. A public hospital may come to us with a plan of the extra cost that it would require in order to do more scopes in the evenings or at weekends and we would agree an arrangement with them and fund them. That is exactly the type of thing that Mr. Horan spoke of when he was speaking about the level of funding that goes into public hospitals through the NTPF.

Deputy Matt Shanahan: With respect, NTPF officials should go to hospital management rather than waiting for hospital managers to come to them. I doubt there is a hospital manager in the country who has time to sit down and consider how the hospital is going to extend services and hours beyond what they are doing at present. Surely it is the remit of the fund to acknowledge it has the purse and the ability to pull people together. The fund should be prepared to implement plans in respect of vacant operating theatres, the availability of cleaning staff, whether there are surgical bed days and bed nights and whether it can provide capacity. That is the remit of the NTPF rather than taking the view it is available to engage with the hospital management.

Mr. John Horan: I can take that particular question. That is very much what happens. This is very much a two-way street. As with other sections in the health service, we now realise that we are going to have to find new and more innovative ways of working. We are going to have to find ways to support patients in this new, changed environment. They include measures such as virtual consultations, diagnostic services and clinical validation. Several areas like these could extend the approach we have taken. We are open to suggestions but we are not behind the door in making suggestions ourselves or in coming forward with ideas. My colleague, the chief executive, is very much at the coalface and brought forward many such ideas long before Covid-19 appeared on our doors. He will be at the forefront again in bringing forward even more innovative solutions in future.

Deputy Matt Shanahan: I am happy to hear that but we need dynamic thinking now. We need people to become far more energised rather than saying simply what they can do. It is a question of what initiatives we have to put on the table and how are we going to move them forward.

Speaking of dynamic initiatives, I will turn my attention to Mr. Woods. I am keen to highlight the situation that Deputy Cullinane alluded to earlier, which is the closure of a catheterization laboratory in Waterford since February. This is adding between 30 and 50 diagnostic cases

to the waiting list every week.

The problem is that essentially the engineers who are required to travel from abroad will not come into the country to observe a two-week isolation period. If we gave them a Covid-19 test and they proved that they were covid-free, they could come in and do the work. I have been asking the HSE in recent weeks to expedite this. To date, nothing has happened. It is not beyond the wit of man to have this done. Will Mr. Woods give categoric approval to put in place Covid-19 testing, communicate with the squires of that laboratory, get these engineers in and get this cath lab up and running please?

Mr. Liam Woods: My understanding is that the project has recommenced. It was not only about the engineers. I will do what-----

Deputy Matt Shanahan: My information differs. I understand the project has not commenced on the ground. I do not know what else has commenced but no other work has commenced there as of yet. That is my information.

Mr. Liam Woods: I will address the core question. I will do everything I feasibly can with the South/South West hospital group to get the project recommenced. I understand from conversations with those involved recently that it is recommencing. If there is any difficulty with that I will certainly communicate with them to ensure it is resolved.

Deputy Matt Shanahan: I wish to highlight to Mr. Woods that I spoke to the former Minister for Health, Deputy Harris, in April on this subject. He agreed with the Department that this was classed as essential work. It is beyond understanding why it has been suspended for so long.

Earlier, Deputy Cullinane mentioned the procurement process for the second cath lab. This has now been extended by another four months without any understanding. We are to have an Office of Government Procurement review of a review of a tender that has now taken 20 months to compile. Will Mr. Woods please use his office to look at this? We had a commitment that building works could start in October. There is no reason they should not. This laboratory is needed. Patients are being added to the list every month. It is absolutely unacceptable that potentially critically ill patients are being denied diagnostic testing because of administration and the ongoing failure to deliver.

Mr. Liam Woods: If it is helpful, I would be happy to provide a further report to the committee. I know there has been a brief report on this but I will certainly provide a further report to the committee on timescales to completion.

Deputy Matt Shanahan: I imagine we would welcome the report, but what I would like to understand is how in 20 months we have only moved a project to design stage and planning permission. That took 20 months when a private laboratory was able to install a functioning cath lab in 12 weeks in the same area.

Mr. Liam Woods: I can comment on the public piece and I will certainly get whatever information that is helpful to the committee to support that.

Deputy Matt Shanahan: One final thing, which was brought up earlier today but not developed to any degree, was the use of e-health solutions as we go forward. A person can walk into a hospital in Switzerland or France, present a card and get all his or her diagnostic tests or medical information pulled up on a screen. When will we get to that situation in Ireland?

Mr. Liam Woods: There has been some very good development in the use of technology. The Deputy is right to say technology is critical to the next number of months in terms of enabling the system to work effectively. That has already happened successfully in the past three or four months using software to connect both GPs and hospitals and GPs and pharmacies. The system in the National Ambulance Service, which is a national call receiving and dispatching system, has worked effectively to support testing and Covid-19 response. We are doing further work at the moment to support integrated working between GPs and consultants specifically with such technologies. Ms McArdle may wish to say more about that in terms of the community work.

Deputy Matt Shanahan: Today, as a member of the Regional Group, I called for Covid-19 testing at all of our airports. We are in great danger of bringing infection into the country with people travelling abroad to hotspots. It is absolutely feasible to do this using both public and private laboratories. I hope the group we are addressing today will bring that message to NPHET. We need to get this implemented as quickly as possibly in our airports and, potentially, our ferry ports before we finish up in October with a complete surge and no ability to treat critically ill patients.

Chairman: I thank the Deputy. His comments are noted.

Deputy Richard O'Donoghue: I brought this up earlier and the witness mentioned that facilities for 100 beds are being built in Limerick at the moment. On 13 July some 56 patients were on trolleys in one area in University Hospital Limerick, UHL, with capacity for 20 patients. This number has increased to 40. Some patients are sitting on chairs with no social distancing and with staff exposed. The Irish Nurses and Midwives Organisation, INMO, has asked for an internal investigation.

We are opening 100 beds in Limerick, which is welcome. If one groups all the hospitals in the country into areas, why have we got such a high turnover of nursing staff and consultants within the hospital system? Do certain hospitals have a high turnover of staff? Are they leaving because of the conditions they are being forced to work in?

Mr. Liam Woods: First, staff turnover varies by type of staff. Consultant staff does not turn over at a very high rate. Nursing staff actually has a higher rate. The Deputy asked about the specific trends. There is definitely a trend from Dublin to the rest of the country, which is visible in both acute and community services. That is often about facilitating a return to a home base.

On the Deputy's comment in terms of Limerick specifically and his observation on trolleys, overall, paradoxically, trolley numbers in the country have been greatly reduced. They are at 86 today and would have been at more than 400 this time last year.

Deputy Richard O'Donoghue: I am asking about Limerick specifically.

Mr. Liam Woods: There are specific challenges presenting in Limerick and one or two other sites. Regarding the query about the infection risk, one will find in many instances what is now counted as a trolley is, in fact, a single area sometimes equivalent to a room with a proper door and walls. The infection risk is being managed. The trolley is being counted in the same way as before but the environment and location is different. At times outpatient space is being used which, of course, is compromising our outpatient capacity.

Deputy Richard O'Donoghue: Some patients are sitting on chairs. That is not a trolley, a

bed or a room with a door. Why are numbers in Limerick always higher? Is it because it covers counties Tipperary, Clare and north Cork and Mr. Woods probably does not have adequate staff to do this?

Mr. Liam Woods: The region has a population of approximately 381,000. It is recognised, and was pre-Covid, that the bed capacity in Limerick is not sufficient to the demand. The additional beds, including the 60-bed block, are intended to partly address that. Hospital capacity on its own will not be successful at that. We need significant additional investment - which is a part of what our winter planning process is about - in community services, general practitioner and GP support services.

Deputy Richard O'Donoghue: The UL hospitals group has offered to help. This has to come from management. Is that not correct? The hospitals have offered to help with the overflow. This has to come from management.

Mr. Liam Woods: Yes.

Deputy Richard O'Donoghue: Let us consider other hospitals and the management of other hospitals throughout the country. I asked this question in the Chamber earlier today. Are there certain areas of certain hospitals where we might have a small problem with management of the systems rather than the hospital itself? Might there be a problem around management and asking for help?

Mr. Liam Woods: In the University Limerick hospitals group there is a strong management focus on addressing the challenge. In fact, this is giving rise to the current investment with strong clinical input, as well as a general managerial input.

Deputy O'Donoghue asked whether the nature of management varies across the country. Of course at some level the answer is "Yes" but from our point of view there are certain key determinants. Let us consider the trend in Limerick over the period of Covid-19. Limerick was probably the only area in the country where there was little fall-off in attendance at the emergency department. This suggests a demand pattern, which Deputy O'Donoghue referred to earlier, in a way, that is putting the hospitals in the UL hospitals group under considerable strain. We have to continue to invest in and develop management throughout the country, but if one looks, one will find real demand and supply issues too. Sláintecare has been clear about that. It varies across the country.

Deputy Richard O'Donoghue: What about the employment of consultants? I said this earlier but not in the Dáil. We have no Ehlers-Danlos syndrome consultant. For two years they have been looking to replace the Ehlers-Danlos syndrome consultant. When will we have one?

I have a second question. Perhaps Mr. Woods can answer both together. It relates to our personal protective equipment if we have another outbreak. I have brought this to the HSE and the Government. There is a company within Limerick that produces PPE. The company is in talks with the HSE about putting a machine into the factory. It would employ 40 extra jobs in Limerick and would be self-contained from a manufacturing point of view for PPE. Not only would it increase jobs but it would mean that we have a constant supply of PPE if there is another pandemic. It would mean the HSE would have PPE on a cost-neutral basis after three years. This has been on the table and has been brought to the Dáil and the HSE. It needs to happen now in case the pandemic happens. It needs to be put in place. It is a common-sense approach. It is all done within the Irish system, including the manufacturing. As all raw materi-

als will be produced on site, we will never have to be without masks again, like we were before.

Mr. Liam Woods: I can revert to the committee with a response on the individual consultant post. I am not aware of the particular post.

Clearly, PPE is a matter of national concern and priority as is the desire that we would have some manufacturing base. While it is not specifically the role of the HSE, I understand that in the context of our industrial development promotion business in the country, it would make a great deal of sense to have domestic supply. We would certainly be interested in that. We do not, as an organisation, engage directly in funding or sponsoring commercial entities, but we have a strong interest in domestic supply in light of our recent history in accessing PPE. I understand dialogue is taking place in other areas nationally. The idea is to look at prioritising that as an area for development. Our procurement function, which has worked with domestic and international suppliers, is keen and will be part of that dialogue. I am not aware of the individual company but I will certainly refer the matter to our procurement people. I imagine they are aware of this.

Chairman: Mr. Woods has said he will provide a written reply to Deputy O'Donoghue. The next speaker is Deputy Colm Burke.

Deputy Colm Burke: I thank all the witnesses present today for taking the time to be here and for the work they have done over the past four months. I will ask four questions because other members want to get in. First, what is the current advice on the wearing of masks to all staff working in hospitals? Are they required to wear masks at all times within the hospital premises? Second, according to the IMO presentation this morning, 160 specialist registrars, SpRs, have completed their training in full and not one of them has been offered a job. Can I get clarification on the reason there has not been engagement to employ them, especially when there are quite a number of vacancies across a range of specialties?

I raised my third question on forward planning three years ago. It concerns the number of consultants who will retire between 1 July 2020 and 1 July 2021. The old process was that jobs were advertised before the person retired. There are more than 3,000 consultants. That figure was increased by more than 1,000 in the past ten years but quite a number of consultants will retire over the next 12 months to two years. Is there forward planning in respect of consultants who are retiring?

My fourth question relates to the need for additional hospital space in Cork. We had the benefit of both the Bons Secours and the Mater private hospitals during the three-month take-over. What is the plan now? Cork University Hospital, CUH, could not deal with the volume of work it had even before the Covid-19 pandemic. The Mercy and the South Infirmary hospitals are under serious pressure. What additional space is being identified as suitable for setting up patient treatment in the Cork area? The consultants in CUH used the Mater private hospital to try to reduce the waiting list for gynaecological services and it worked very effectively. Can that be used in other areas whereby the consultants employed by the HSE would go into those hospitals and transfer people on their public lists with a view to doing particular day care procedures? What progress has been made on those issues?

Mr. Liam Woods: I thank the Deputy. I will take those questions in reverse order. In terms of capacity, we are looking to contract some continuation of access to private facilities both directly and through our working arrangements with the NTPF. We are looking to continue to some extent the kind of work the Deputy is referring to in terms of the private system over

the three months to the end of June. That would support additional work. The South/South West hospital group has separately made proposals which will be incorporated into our winter planning approach relating to additional space that can come on in the short term in modular form across the group. That goes from Waterford over to Kerry, as the Deputy will be aware, but includes Cork. That will be considered in the coming weeks as part of our winter planning.

On the retirement of consultants and the national doctor training programme, we have information on approximate numbers of consultants who will retire at any point in time. I do not have that information here. The Deputy asked for a number up to July 2021. We might be able to return some information to him from the doctor training programme in that regard and perhaps from our HR in terms of a pension retirement view. That information is known. The intent of the Deputy's query was to ask if we can start recruiting prospectively to shorten the gap between a retirement and a new recruitment. That was a recommendation in a report that was done to accelerate consultant recruitment within the HSE by Professor Frank Keane so there is no reason that cannot take place. In fact, I have seen many instances where it does take place.

On the SpRs and the completed training, I understand dialogue has taken place and there is a strong desire to retain as many doctors as possible. I will come back to the committee with further detail but it is our intention to retain as many as possible and work is under way to support such retention.

Deputy Colm Burke: From this morning's session I understand that people who have completed their training in the past two months have not been offered contracts other than for locum work. There is no forward planning with regard to their full-time employment as consultants in any area.

Mr. Liam Woods: I hear the Deputy's comments. I will revert to him with regard to what is actually intended but I know there is a strong intention to retain trained clinical staff to face what the Deputy has rightly referred to as a very significant emerging challenge.

New infection prevention control guidance is about to issue. Once it is finalised, I would be more than happy to provide the committee with a copy. It relates to the wearing of masks within hospital environments. Masks are available for wearing extensively within hospital environments. I believe the Deputy asked whether they are worn in all areas. As I understand it, our latest guidance is that they should be worn in all treatment areas. There may be some areas of the hospital where the risk is not so great and masks may not always be worn in these areas. Substantively, however, they are worn-----

Deputy Colm Burke: Care assistants, cleaning staff, nurses and doctors are not required to wear them when working on a ward.

Mr. Liam Woods: No, staff wear masks in all treatment areas. I was just saying that some areas are not treatment areas.

Deputy Colm Burke: There appears to be some confusion about the requirements in some hospitals. People who are visiting hospitals and wearing masks arrive to find that not all staff are wearing masks. I have got a number of phone calls from different areas of Cork on that matter. Can that be clarified?

Mr. Liam Woods: I will certainly clarify that locally with the group. I will also make the guidance we have on infection prevention and control available to the committee.

Deputy Louise O'Reilly: I thank our witnesses for all of the information they have provided and for their commitments to follow up on some of the information requested. As an aside, I welcome the fact that some Independent Members are now joining Sinn Féin's call for a domestic supply of personal protective equipment to be made available. We were a bit of a lone voice in that regard so it is very nice to have a few people join us.

I have a couple of questions. I have been trying to keep up with what was happening but I had a meeting in the middle of the session so if my questions have already been answered I can check the record. I believe it was Mr. Woods who said that private providers were being sought for diagnostics. What kind of value for money audits are carried out when engaging private providers? Does the HSE check over the last time it did business with a provider and the value for money it achieved? Are there any processes in this regard within the contracts? Is there an automatic review? It is hard to calculate but how can the HSE be sure the private sector provides the kind of value for money people seem to think it does?

Mr. Liam Woods: In terms of value for money, our initial tender will clearly state what we require. That work is going on at the moment. The selection process will be about choosing the most economically advantageous tender response. From a value point of view, the evaluation is initially done at this point. We consider our views of the nature and quality of the service and the price.

Deputy Louise O'Reilly: Is it considered on a per item or per procedure basis or is it about obtaining a certain number of theatre hours or CT scan hours or a certain amount of diagnostic capacity? Is it a matter of a certain amount of money for a certain procedure, with a reduction if a certain amount is bought? I am confused about that. I have been looking at this for a while and it strikes me that not much value for money auditing, if any at all, is carried out. If it is carried out, that is very confusing. Will Mr. Woods talk me through that?

Mr. Liam Woods: I am saying that a tender is being put in place. We will have a decision to make at the beginning. The Deputy is asking what the unit of purchase is, whether clusters of product or so on. In areas such as that of radiology, the contract will most likely be set out by modality. Other areas are MRI and CT and, perhaps, packages. It depends a little on how the market responds.

The Deputy also asked whether we ask what is the value of what we have previously acquired. This is something that will happen in the future with regard to this contract because we have not yet entered into it. From our point of view, we understand this in terms of the clinical outcomes, patients treated and the overall clinical benefit. From our perspective, the future value consideration will be about what work got done, what benefit it brought to patients and whether it supported the provision of GP diagnostics.

Deputy Louise O'Reilly: I am sorry, but when Mr. Woods says things such as that it will depend on how the market responds it does not fill me with a massive amount of confidence. The market responds by making as much money as the market can make and Mr. Woods knows that as well as I do.

The catch-up programme is something I raised with the previous Minister for Health on a number of occasions. We know there has been a lot of missed screening. We know exactly why this is and how necessary it was. Nobody was calling for screening services to be restarted at a stage when they simply could not have been restarted. We understood that. I checked the record before I came here and I never really got a satisfactory answer to the question I had

put to the Minister on a number of occasions. There are a number of issues with regard to the catch-up programme that will be needed. If we take CervicalCheck as one example, we all know what happened when a commitment was given on tests without the capacity in the laboratories having been secured. We saw what happened there. I am sure nobody wants to go back to that. Has additional laboratory capacity been secured to be able to complete the catch-up programme? Has a target been set for the number of missed screenings that will take place before the end of the year? Does the HSE have a longer-term plan for catching up on screening? The figures from the Irish Cancer Society this morning with regard to missed cancers are very worrying. We all fully appreciate why screening could not take place but does the HSE have a catch-up programme in mind and has it secured the additional capacity in the laboratories that will be necessary to be able to deliver on it?

Mr. Damien McCallion: The Deputy has asked about CervicalCheck but she is right that the principles apply across each programme and each programme is quite different with regard to the solutions. CervicalCheck has restarted and a number of priority groups have been identified for the first round. More than 20,000 invitation letters were issued in the first month. The priorities are people on a one-year recall, people who are being recalled in the short term for a repeat test within three months and new women entering the programme for the first time. These are based on clinical risk determined by our clinical advisory group. Approximately 80,000 people will be called back in and they will all be processed between now and the end of the year. We are satisfied that we have the laboratory capacity in place. There are challenges with regard to general practice given the new public health guidelines on Covid, if it were to reoccur. We are monitoring each programme weekly with respect to uptake, what is coming through each programmes and where that leaves us.

There are challenges with regard to the public response. We are trying to put in place communication campaigns to support people coming back into the screening programmes where they have restarted and as they restart. We will have to review this regularly. Each programme is discrete. Earlier, my colleague, Professor O'Doherty, described the challenges BreastCheck faces, which are very different with regard to 2 m physical and social distancing. Each programme will have discrete challenges as we move through them.

CervicalCheck and our diabetic retinopathy screening programme have restarted. We have seen a reasonable uptake of diabetic retinopathy in the first month. It is very early days. CervicalCheck has been slow but it will take some time for it to come back. Pre-Covid, many women took some time from receiving the letter of invitation to taking up an appointment with their GP. There is often a gap in the process. This is something we will have to work through. As was alluded to by other speakers earlier, if we hit further surges or if there is further impact on general practice or clinical hospitals with regard to treatment services, this will also have an effect.

Deputy Louise O'Reilly: The 80,000 women who will receive a test will be additional to the normal 20,000 tests that fall due every month. Presumably they are the women who would have had their smear test in the normal course of events if it was not for Covid. Does the HSE have the laboratory capacity for that? I had suggested an information campaign and I am glad that it was taken up. If they all respond between now and Christmas to that campaign, as we all hope that they do, will we be back to another situation where tests are left for such a long time that there is a danger they might expire? That happened previously. Has the additional laboratory capacity been sourced, notwithstanding that there might be a second wave which would change things? As things stand, has additional laboratory capacity been sourced to be able to do that catch-up?

Mr. Damien McCallion: This is a different set of circumstances from the situation that the Deputy referred to previously regarding cervical screening. We will need to monitor the take-up as we go. We can control some of that take-up and that is what we will try to do, with invitations and so on, to make sure that we align what is happening with invitations, general practice and also colposcopy, because treatment is equally important in ensuring that that space and access to that service is in place.

Deputy Louise O'Reilly: I am not certain that that answers my question but I will move on anyway.

There are 97 people on trolleys today. I have always used the INMO figures that track it and do not want to get into it with Mr. Woods. What is the status of additional capacity in the Arena in Limerick and in City West? I know there was talk earlier about using and creating modular capacity. For the capacity that we have already paid for, is there a plan to utilise the field hospital, as it is being called, in City West, or indeed the additional capacity in Limerick?

Mr. Liam Woods: The facility in Limerick is open and there are patients in the facility. If it is helpful, we can get a report on the volumes there.

Deputy Louise O'Reilly: Is the capacity 100?

Mr. Liam Woods: I believe so. I will confirm that. I will give the Deputy a report on it. There are two dimensions to City West but I think the Deputy is referring to the conference centre which is set up to receive patients, not the hotel. The conference centre will not open to receive patients. The contract with the HSE will end at the end of October. In the short term, we are looking to use the facility for some projects that relate to outpatients. There is a project coming from the Mater relating to glaucoma testing, which we will support in the facility until the end of October.

Deputy Louise O'Reilly: Has anyone ever been in the City West conference centre facility?

Mr. Liam Woods: Yes, I have been there.

Deputy Louise O'Reilly: No, sorry-----

Mr. Liam Woods: Sorry, I lost the Deputy there. Has there been an inpatient in the facility?

Deputy Louise O'Reilly: I am talking about sick people.

Mr. Liam Woods: Apologies. I was okay when I was there. No, it has not admitted patients.

Deputy Louise O'Reilly: How much are we paying for it?

Mr. Liam Woods: I would need our estates colleagues to give me data on that. I will have to send the Deputy a report on that.

Deputy Louise O'Reilly: It has been in the papers, which state that it is approximately €25 million.

Mr. Liam Woods: The price is inclusive of both the hotel and the conference centre, so they would need to be disaggregated.

Deputy Louise O'Reilly: Does the HSE have staff to work at it, if it is to be used? We are paying for it and there are 97 people on trolleys, so I can think of 97 people who might go there.

Mr. Liam Woods: The outpatient and glaucoma initiatives will be staffed by current staff within the hospital environment. Those proposals come with staffing reflected in them.

Deputy Louise O'Reilly: Are they staff already in the system who would be redeployed? Presumably Mr. Woods would be taking staff out of Tallaght if there are people on trolleys in Tallaght, and they would be moving to City West. There are no additional staff.

Mr. Liam Woods: The Deputy has reflected well on our capacity constraints. One of the key challenges is outpatients. It would be staff who are working in those areas but are now being afforded the opportunity to work in a capacity that may have been constrained at some level in the public hospital in which they are working. With regard to glaucoma, the proposal from the Mater foresees that up to 2,000 patients could be seen before the end of October.

Deputy Louise O'Reilly: There will not be any additional staff employed. Student nurses will graduate and presumably they will all get a contract of employment, but there is no additional recruitment or a plan to staff these. To provide staff for these centres will only remove staff who are already working in hospitals.

Mr. Liam Woods: That is correct for these proposals, which are short-term.

Deputy Louise O'Reilly: It is only until October.

Mr. Liam Woods: Yes.

Deputy Louise O'Reilly: Winter is coming.

Deputy Fergus O'Dowd: I welcome our witnesses. I acknowledge the excellent work that has been done by the HSE and its staff, both administratively and medically. They have given huge support to people. The public perception of the HSE has changed significantly as a result of the way in which it has responded to the crisis. Its interventions in places such as Dealgan House nursing home in Dundalk have been hugely important. In terms of the HSE's plan for autumn and an unfortunate but probable return of Covid-19, what relationships has the HSE built with the private nursing homes?

Mr. Liam Woods: On the acute side, the infection prevention control teams and geriatricians within the public system have worked closely with private nursing homes and community colleagues to address the issues that arose. That support remains in place. The Deputy referred to an individual site but there are many instances where support was provided from community and hospital services to private nursing homes. I ask Ms McArdle to comment further.

Ms Siobhán McArdle: Nursing homes or residential care facilities for older persons, both private and public, in each community healthcare organisation area are treated equally in terms of levels of support. As Mr. Woods said, the supports for this cohort include the provision of PPE and advice on prevention and control. In recent weeks, we have been supporting all nursing homes, both private and public, in the provision of Covid-19 testing on a serial basis to ensure we are supporting the staff to remain well and healthy in the context of Covid-19 and to protect the health and well-being of the residents in that setting. We see the approach to all our nursing homes, particularly residents for whom these facilities are their home, as core to the way we deliver our services in the community. We do not really differentiate between them.

They are treated equally in the advice they receive and in the Covid-19 response we are putting in place to ensure safe levels of care.

Deputy Fergus O'Dowd: I welcome those responses. The HSE will spend €1 billion this year on PPE. What is the expected cost of PPE to the private nursing home sector and is the HSE charging the sector for its use of PPE?

Ms Siobhán McArdle: Approximately 30% of the PPE we provide across the health services is provided to nursing homes, both private and public, and that is provided without charge. The HSE provides that free of charge to support the staff to provide safe levels of care in that environment.

Deputy Fergus O'Dowd: The standard is being provided when it is needed but people are paying €50,000 or €60,000 per year for their care in many of these homes. I agree on the medical issue and the need to provide PPE when nursing homes do not have it. However, the HSE should be charging the private nursing home sector for PPE because these homes are certainly charging their residents. I am unhappy that the HSE does not propose to do that. I welcome the HSE's significant engagement with the private nursing home sector.

On 1 January 2020, approximately 8,000 people were on the HSE's waiting list for home care. How many people are on that waiting list today? What are the most recent figures? I ask that in the context of the HSE's note indicating that it is seeking a substantial increase in home support hours in order to fully support patients at home, which I 100% support.

Ms Siobhán McArdle: Home support is a key part of our community provision to keep people well and safe at home and to support enhanced discharge from acute hospitals. I am not sure if I have the figure to hand. We have some waiting lists in some areas but not in every community healthcare organisation area. I will revert to the committee with an update on that but every effort is made to ensure that home support is provided to the highest level of need and to ensure the provision of intensive home care packages where required. These are higher levels of home support to make sure that people who have more complex needs are discharged from hospital quickly.

Deputy Fergus O'Dowd: My experience is the opposite to what Ms McArdle just said. I do not accept that the number relating to the waiting list is not known. I do not mean it is not known to Ms McArdle personally. The waiting list has been growing significantly and the HSE has refused to supply to me the information I sought on the communications between CHO directors and the HSE head director of services for the elderly. There is a lack of transparency in that regard. Before we can understand how the HSE needs to address the future in terms of home care and Covid-19, we need a lot more transparency from the organisation, which I have not got. I have been frustrated at every turn. It concerns me when my constituents who, in many cases, have complex needs are not being made or are being met for only half an hour a day, which is impossible for people. While I welcome the initiative and what Ms McArdle had to say, I ask that she or one of her colleagues would release all of the information I sought. It was refused on the grounds that the communications formed part of the deliberate process of the HSE in the last financial year. I asked that the information be released at the end of that year and I was promised it would be released, but it was not.

It is important to point out that where home care is being provided there is a significant lack of development of Covid measures. I have discussed this with some of the organisations. Home care protects people much better than institutional care. Do the witnesses have figures on

that? They are of huge importance and would support the argument being made. Where does the proposal for a statutory home care package stand in terms of calendar months?

Ms Siobhán McArdle: Home support is a core part of the service we provide in the community to people. In terms of the figures, at the end of April over 1.1 million hours of home support had been provided to people in their own homes across all parts of the country. This is in excess of 41,000 different people receiving home supports. Within that are people with low levels of home support and others with more advanced packages of support. There is a further group of people who receive intensive home care packages, the provision relating to which is in excess of 20 hours per week. Outside of the adult services, we also support home nursing and home care under our paediatric home care package, which is important for families in ensuring that children can transition to home safely and be provided with safe levels of care in that environment.

In terms of the statutory home care package, I am aware that it is under design. There is a lot of work being done by the HSE and our colleagues in the Department of Health in terms of advancing that package. It is a joint initiative. I do not have the details as to where it is at now but I can revert to the Deputy on the matter. My colleagues in the Department have further information.

Deputy Fergus O'Dowd: I thank Ms McArdle for her reply. I am trying to understand how the money is given out through the CHO areas. It seems that in the area I live in, which is CHO 8, people in receipt of home care had to die before there were hours available for allocation to somebody else. This is unacceptable. I understand that the "recycling of hours", which, I understand, is the administrative term for it, was stopped because the CHO had gone over budget. At the start of the year a CHO has a budget. It is important in terms of how it uses that budget that people get the care that they need regardless of where they live or in what month of they year they apply for it. They are two serious and important issues for me.

Mr. Liam Woods: In terms of the waiting list data, the difficulty may relate to the reassignment of staff in the community to more a front-line purpose but I can check that. We should be able to get the waiting list data and make it available to the Deputy. We have no intention to make lists invisible. In fact, the reverse is the case because we need to look clearly at the challenge we are facing.

Ms McArdle addressed the point about legislation, and Mr. Dempsey may have something to say about the statutory basis of home care packages from the point of view of the Department.

At a wider level, in terms of the resources required to respond to Covid-19 - and I understand the Deputy may also be referring to an earlier period - the HSE has spent significant resources to provide care at home, in acute environments and community care settings as best it can over the past number of months. The resources deployed have been well beyond what would have been experienced previously. We are anxious that the committee has the waiting list data and we commit to providing them. Mr. Dempsey may wish to comment on the statutory arrangements that might come into place.

Mr. Greg Dempsey: I thank Mr. Woods, and the Deputy for his question. The development of the statutory scheme is being led by the Department. Work is ongoing but has been delayed somewhat as the Department and the HSE have been responding to the Covid-19 crisis. Its development is slightly behind where we would have liked it to be. I will get a note to the com-

mittee on where we are and our expectations in that regard.

Deputy Fergus O'Dowd: I would welcome a note but that is not much of an answer.

Chairman: Was the Deputy refused access to the waiting list data because they were a part of the deliberative process?

Deputy Fergus O'Dowd: I looked for data for the most recent projected period in 2019 and it was refused to me. I will tell the Chairman the full story.

Chairman: I can hear the full story afterwards. I am anxious that we-----

Deputy Fergus O'Dowd: The key point is that the HSE refused to give me the data even though there was no bar to giving them to me. That is what is wrong with the agency.

Chairman: Mr. Woods has now said he will give the data to the committee.

Deputy Fergus O'Dowd: I will await the data with bated breath.

Chairman: I want to ask a couple of questions and Deputy Shortall wants to come back in. IMO representatives before the committee this morning called for a total vaccination programme. They said that 75% of the population would need to be vaccinated to achieve herd immunity. They explained what they meant by a total vaccination programme. It means that everybody has a vaccination that is free to them, although obviously someone would have to pay for it, namely, the State. They suggested two months ago that such a programme was necessary. Do I understand from what Mr. McCallion said that while there are plans to vaccinate two to 12 year olds and the elderly, there are no plans for a vaccination programme for the general population of people between those ages?

Mr. Damien McCallion: Adult vaccination applies to more than just the elderly. It also includes healthcare workers and other priority groups to which Ms McArdle referred. There are still constraints as to what will be available in the market. Work has been going on for some months and this is not something that kicks in around this time of the year; it starts almost as early as the end of the previous winter. The vaccine is only developed in the southern hemisphere during the winter. We have approximately 1.4 million doses of the vaccine for adults and 500,000 to 600,000 for children. That is the total number of vaccinations available and deals with the priority groups. As I said, it works on the basis of a 90% uptake in the adult population to whom it is made available.

Chairman: Is "No" the hard answer to my question?

Mr. Damien McCallion: Pardon?

Chairman: I have never taken a flu vaccine before but we live in extraordinary times. Can I take it that there are no plans to introduce a vaccination programme for ordinary people who are not healthcare workers, do not have an underlying condition, are not normally recommended to take the flu vaccine and are not children?

Mr. Damien McCallion: Target groups will be prioritised as we go into this winter. It is about targeting those who have the greatest need and are most at risk.

Chairman: I will ask specifically. Are there no plans for a vaccination programme for the general population who are not in the target group?

Mr. Damien McCallion: Other than for those in the categories that Ms McArdle mentioned earlier.

Chairman: Is "No" the answer to my question? There are no plans for a vaccination programme for the general population outside of the-----

Mr. Damien McCallion: That is so for the flu. The flu programme extends to the 1.4 million adults and 500,000 to 600,000 children that I mentioned earlier.

Chairman: I sometimes wonder how it takes two minutes to answer one question. I sometimes wonder whether these meetings are exercises in information provision or obfuscation. I am sorry to say that but it is sometimes difficult to get answers to simple questions. We have been told repeatedly that once the flu season kicks off, whether it will be in September or December this year, there is potential for catastrophe in our hospitals. Would you accept that?

Mr. Liam Woods: I will take that question. Yes, there is a fear that the hospital system could come under very severe pressure.

Chairman: Notwithstanding that, there are no plans to vaccinate the general population.

Mr. Liam Woods: There are two points. First, it is our intention always to answer your questions clearly and concisely.

Chairman: I appreciate that.

Mr. Liam Woods: If we do not have data we are very happy to provide it to you. Second, on the pressure that will come on the acute system, which may be partly influenced by flu and vaccine, there is a requirement for the committee, and I hear it from a number of members, to have a detailed public health briefing on the vaccination programme, its priorities and where we are going with that for this winter. To your wider question, the pressure that will come on the acute system associated with the ongoing known growth in demand for service for emergency care and Covid-19 and, potentially, flu - normally we see a precursor to that being respiratory infection in paediatrics - is a matter of very significant concern. It is a fair reflection to say that the burden the system is facing as we move into this winter is very concerning.

Chairman: Is it hard to get flu vaccine? Is availability of flu vaccine a difficulty that the HSE faces?

Mr. Liam Woods: Our public health person with a specific interest in that would have to answer that question, but we will get that in a proper briefing for you.

Chairman: Mr. McCallion seemed to indicate that there was. Could he elaborate a little? Is it difficult to get flu vaccine in unusually high quantities? I accept that 75% of the population would be three to four times the quantity the HSE would normally buy. Is flu vaccine typically unavailable in that quantity or is there a difficulty in sourcing it?

Mr. Damien McCallion: Yes, there are challenges every year with flu vaccines. Obviously, every country in the world is looking for it at the same time, and those challenges are exacerbated this year with regard to Covid-19.

Chairman: Mr. Woods, you referred to specific challenges and demand patterns in Limerick. Could you elaborate on that? Limerick consistently has the highest numbers of people on trolleys and you mentioned demand patterns in the emergency department there.

Mr. Liam Woods: The bed capacity in Limerick *vis-à-vis* the population was what I referring to at one level. That was assessed and is known to be beneath what was required, which is the additional 100 beds we are referring to. Indeed, earlier developments in Limerick that have supported capacity such as the ICU, the ED, dialysis and the Leben Building have all been directed at growing and improving capacity. Clearly, there has been a demand and supply mismatch and those 100 beds will support addressing that.

However, I also said that hospital beds are not the solution in isolation in the health environment. In fact, excess focus on hospital beds as against community investment will lead to an ineffective situation. From our point of view, we must also focus on investing in community services around Limerick. The community intervention team that is working opposite the hospital there and out into the community is very successful. Supporting that and expanding community initiatives would be very useful. There are initiatives under way in Limerick and across the wider region out into Clare and in Nenagh relating to cataracts that are helping to support the health of the population without bringing patients into Limerick at all, and investing in more of that type of work in our model 2 hospitals in Ennis and Nenagh would be very useful. There are some outreach clinics running in primary care centres from Limerick and we need more of that to support GPs and to bring specialist consultant advice to GPs at local level without having to refer patients to the hospital base.

Chairman: The previous Minister for Health accepted that there was a necessity for more outpatient procedures to be carried out in the model 2 hospitals, and you referred to that in the case of cataracts. Are there any other procedures in which there is an increase of provision in the model 2 hospitals?

Mr. Liam Woods: There are certainly areas of opportunity regarding work that could move. I will ask Dr. Rogers to give some examples, because some good work is going on in Roscommon hospital, for example, and that may be of interest. While it is outside of the University of Limerick region, it is interesting work.

Dr. Eamonn Rogers: This question has been asked several times, and in Roscommon one of the ways of getting capacity is to use the model 2 and model 3 hospitals. Cancer care is complex and must be maintained in the model 4 hospitals. Regarding diagnostics, however, there is a delay in diagnosis and treatment because of Covid-19. In Roscommon hospital, which is a model 2 hospital, over the past 18 months we have been taking blood in the urine - I will use my own area as an example - which has a high rate of cancer detection. It is a see-and-treat model on a walk-in basis in Roscommon. There are no outpatients.

The letter arrives and the patient goes directly to the hospital. Importantly, in these times of Covid-19, there is no waiting in waiting rooms and the patient has an X-ray procedure and a camera procedure on the same day. We have done nearly 700 patients, but I can report on up to 500 patients. We had a cancer detection rate of 10% within 26 days of the letter being received and 70% of patients were reassured on one visit. This is an important area when looking at capacity, and we should use the model 2 and model 3 hospitals much more in this regard. We have evidence and this can be rolled out to other model 2 and 3 three hospitals.

Chairman: I would welcome that. The obvious follow-on question is whether there are similar plans to increase the capacity of the model 2 hospitals in Ennis, St. John's in Limerick and Nenagh hospital. I ask that in the specific context of Limerick being the most consistently overcrowded hospital in the State. If we are going to continue to channel the vast majority of patients from the mid-west region into the most overcrowded hospital during the Covid-19 cri-

sis, that is a catastrophe waiting to happen and the clock is ticking.

Mr. Liam Woods: The answer is "Yes" to the Chair's question. We are considering specific proposals from the UL Group as part of our approach in the coming months and to the winter period. That approach will include things like the integrated care programme for older people, including projects to support older populations who stay at home and out of hospital. That is about investment in staff, including geriatricians, working cross-hospital and in the community. Other proposals involve surgical assessment and radiology. These are due to be considered in the next few weeks as part of our response to winter. There are proposals, therefore, to make more use of Nenagh and Ennis hospitals, and to support Dooradoyle and St. John's.

Chairman: Deputy Shortall would like to come back in.

Deputy Róisín Shortall: I share the Chair's frustration at not being able to get straight answers because earlier I had asked for an assurance that we were able to secure sufficient quantities of the flu vaccine and it is only in the past 15 minutes that Mr. McCallion has spoken of constraints in the market. Will he explain to us exactly what are those constraints? Is it a question of availability or of cost?

I put on the record again my serious concern regarding the HSE planning for only an additional 200,000 vaccines. In the context of the enormous pressures on the hospitals and the greatly reduced capacity, we simply cannot afford to have anything like the same number of people hospitalised this year as a result of the flu as we did last year, which was 4,300 people. We need an assurance at this point that the preparatory work has been done and that adequate quantities of the vaccine have been secured. Will Mr. McCallion explain, therefore, what the market constraints are, please?

Mr. Damien McCallion: There are two different aspects to this issue. Public health advice is what guides the roll out of the vaccination programme for adults and children. We can provide the Deputy with more detail from our public health people regarding how that programme was designed. What I was summarising for the Deputy earlier was that we have enough vaccine for 1.4 million adults and just over 500,000 children. That is the total capacity available and that is based on prioritisation from a public health perspective. It is what guides the public vaccination programme for the flu season and is particularly targeted at groups who are at risk if they are hospitalised. It totally aligns with what the Deputy is describing.

Deputy Róisín Shortall: I ask Mr. McCallion to wind back a little bit and clarify. He referred to the total available doses. Are we operating on the basis of the available total or the required total?

Mr. Damien McCallion: If I may differentiate, the public health advice guides the vaccination and what we purchase.

Deputy Róisín Shortall: Does the figure of 1.4 million vaccines refer to the available total or the required total?

Mr. Damien McCallion: That is what we require for the adult vaccination programme for the winter from a public health perspective.

Deputy Róisín Shortall: Could Mr. McCallion provide the detail on how that figure was calculated, given that it is a relatively small increase on last year's number?

Mr. Damien McCallion: We will get the Deputy a public health paper briefing on the rationale behind the vaccination programme and the numbers involved. All I was reflecting on when speaking to Deputy McNamara was that the market is still competitive.

Deputy Róisín Shortall: I refer to the rationale behind the numbers the HSE is working towards.

Mr. Damien McCallion: We will provide that.

Deputy Róisín Shortall: I ask Mr. McCallion again. Will he explain the market constraints on accessing or procuring the vaccines?

Mr. Damien McCallion: To be clear, I was saying that at the moment there is a global push for the flu vaccine due to Covid-19. That is all I was articulating. Separately from that, my point on public health is that we have clear guidance on the supply for the winter. We have secured 1.4 million doses and more than 500,000 doses for children. We will provide a detailed breakdown of the criteria that were used to draw up those numbers.

Deputy Róisín Shortall: I am sorry. I am asking Mr. McCallion for the third time. Is 1.4 million vaccines the available total or the required total?

Mr. Damien McCallion: That is the figure which public health advice has indicated we need for this winter.

Deputy Róisín Shortall: In that case, why was Mr. McCallion talking about market constraints?

Mr. Damien McCallion: Deputy McNamara asked whether there were challenges in the marketplace in regard to the vaccination. I was merely reflecting that there are challenges in the marketplace because of Covid-19.

Deputy Róisín Shortall: What are those challenges?

Mr. Damien McCallion: Several countries are seeking the vaccine at the same time. That is a common problem.

Deputy Róisín Shortall: Is there a shortage? Do we have a difficulty in securing adequate quantities?

Mr. Damien McCallion: We have defined the needs from the public health perspective and we will respond to the Deputy on that. I am not a public health physician. I am simply describing what we have secured at the moment on that basis. Ms McArdle has described the groups that are part of the flu vaccination programme. Separately, I have described the challenge that exists in the marketplace due to Covid-19, namely, that a large number of countries are looking to secure the vaccination at the same time and extra pressure is created by Covid-19.

Deputy Róisín Shortall: The clear implication of what Mr. McCallion is saying by referencing market constraints is that we cannot procure sufficient quantities and we are limited in the amount we can procure.

Chairman: In fairness, Mr. McCallion is saying that the public health advice that he and the HSE have received is that it is necessary to vaccinate children between the ages of two and 12 as well as other people who are deemed to be at high risk, namely, healthcare workers, the

elderly, people with underlying conditions, etc. He said the necessary percentage equated to 1.5 million doses.

Mr. Damien McCallion: I was describing the uptake. We have accounted for the specific groups and the necessary percentage uptake. Regarding the challenges on the procurement side, I am articulating what we have seen in the market. I can provide the Deputy with a note summarising the distinction between the public health guidance on the vaccine, which we articulated earlier, and the availability of the vaccine in the marketplace.

Deputy Róisín Shortall: I would like more clarity in a written reply.

Chairman: The serious question is whether a vaccination programme beyond what has been described is necessary. I appreciate that this is a clinical-----

Mr. Damien McCallion: It is public health advice. I will not try to describe that.

Deputy Bernard J. Durkan: Given the challenges Mr. McCallion has identified, which will emerge in the next six to 12 months, there is likely to be a cost. Has the HSE made a submission to the Government on the extra challenges and how they might best be met? For example, should the responses to them be funded by grants, loans raised under the European Union's €800 billion coronavirus recovery fund or some other source? What plan exists to deal with the challenges ahead? Do we have a number of options? Has the Department sought Government provision for those options?

Mr. Greg Dempsey: I might have a stab at that. As the Deputy will be aware the Government has already provided over €2 billion to the Revised Estimates for health during the Covid crisis. At that stage we had indicated we would probably need further funding the longer Covid went on, to resume services and so forth. As part of the planning process for winter, that will culminate in a further request which we will then refer to the Department of Public Expenditure and Reform, either as part of the budget process or in advance of that, but probably as part of the budget process.

Chairman: I thank all the witnesses for answering all the questions put today. We have gone slightly over time. I greatly appreciate the time they have taken to answer our questions.

The committee adjourned at 4.41 p.m. until 9 a.m. on Tuesday, 21 July 2020.