

DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé Máirt, 21 Iúil 2020

Tuesday, 21 July 2020

Tháinig an Coiste le chéile ag 10 a.m.

The Committee met at 10 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	
Mick Barry,*	
Richard Boyd Barrett,*	
Colm Burke,	
Jennifer Carroll MacNeill,	
Michael Collins,	
David Cullinane,	
Cormac Devlin,*	
Bernard J. Durkan,*	
Paul McAuliffe,*	
Fergus O'Dowd,	
Louise O'Reilly,	
Matt Shanahan,	
Róisín Shortall,	
Duncan Smith.	

* In éagmais / In the absence of Deputies Colm Brophy, Stephen Donnelly and Bríd Smith.

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

Deputy Jennifer Carroll MacNeill took the Chair.

Business of Special Committee

Acting Chairman (Deputy Jennifer Carroll MacNeill): We have been notified that Deputies Boyd Barrett, Barry, Costello, Durkan, Pádraig O’Sullivan, McAuliffe and Devlin will substitute for their party colleagues today. Are the minutes of the meetings of 7, 10, 14 and 17 July agreed? Agreed. We have received six items of correspondence. Is it agreed that the committee notes these? Agreed.

The committee’s report, “Stimulating Enterprise and the Economy”, was published last Friday. I thank members and the secretariat for their considerable efforts in getting it published. A report on Covid-19 in nursing homes will be circulated to members tomorrow and we will consider it in a Teams meeting on Thursday. An early draft of the report is currently with the working group. We will have two further reports to consider next week. One is on testing and tracing and the other is an interim progress report.

I will chair the first session today. I see we are all wearing our masks. The guidance is that they be worn while in the Chamber except when making contributions. That is fair enough. I am also seated behind a screen.

Covid-19: Infection Rate among Healthcare Workers

Acting Chairman (Deputy Jennifer Carroll MacNeill): I welcome our witnesses in committee room 2. They represent Fórsa, SIPTU and the Irish Nurses and Midwives Organisation.

I advise our witnesses that by virtue of section 17(2)(l) of the Defamation Act 2009 - I have just realised I am wearing my mask while making a contribution - 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 do so, 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.

We will begin with the Fórsa trade union. I call on Ms Keogh to introduce the delegation and to briefly outline the key points of her submission to the committee, which has already been circulated to members.

Ms Catherine Keogh: I am an assistant general secretary in the Fórsa national health office. I am here with Mr. Éamonn Donnelly, our national secretary in the health division. The committee will have received our submission in advance.

The key point for Fórsa is the ripple effect infection rates among healthcare workers has had across the whole health service as we faced into the pandemic. Fórsa represents health and social care professionals including physiotherapists, orthoptists, and speech and language

therapists. Our orthoptists were trained in swab testing and carried out such tests on the front line. Some were then infected with Covid and spent three months off work before returning to front-line testing straight away. We want to talk about the significant effect this had across the health sector, primarily with regard to our own grades but also for all others. A common refrain of the trade union movement is that an injury to one is an injury to all. In healthcare, particularly during a pandemic, an infection for one has an effect on everyone, both in the acute and community settings. Our submission reflects on that and on the rates of infection. I will pass over to my colleague, Mr. Donnelly, who has some opening remarks to make.

Mr. Éamonn Donnelly: In addition to what is in the statement, one of the key points we want to emphasise is that it is not just about the disproportionately large infection rates among healthcare workers, it is about the effect that has across the workforce in the health sector. We hope we will move from a world where we were dealing only with the response to the pandemic into what the HSE calls a co-Covid environment, where we are living with the disease and reopening health services that people need to access. We cannot keep health services shut down forever. What that means is that as community-led health services reopen, the people who have already been working in direct response to the pandemic, and to whom my colleague, Ms Keogh, referred, go back to substantive roles in the community. The example I cite in the statement is of a physiotherapist who will now have to resume treatment with somebody whose mobility has deteriorated alarmingly in the four months since the Covid response started.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Mr. Donnelly. We have his opening statement. I want to try to get to the other speakers and we will come back to Mr. Donnelly.

I thank Mr. King for appearing before us this morning. I ask him to introduce his delegation and make a short comment outlining the key points of his submission to the committee, recognising that we have received it already.

Mr. John King: SIPTU has approximately 43,000 members who work in the health service across a multitude of health service settings. We represent a broad range of workers right across the health service, from porters, attendants, kitchen staff and chefs to professional grades such as ambulance and paramedic staff and staff involved in radiography, nursing and midwifery, as well as a significant number of members in the mental health service.

We made a detailed presentation to the committee, which includes the findings from a survey of our membership. I am joined by Ms Michele Monahan, SIPTU honorary vice president, who is also a front-line worker employed in the HSE. Ms Monahan can give direct evidence to the committee on the effect of the crisis on healthcare workers. While the submission presents the findings, it also makes a number of key recommendations and we look forward to engaging with the committee on them today. They include a comprehensive review on the effects of the totality of the impact of the crisis on healthcare workers affected, but also on the staff who were not affected but were left working in that pressurised environment.

We also believe significant learning is needed on some of the policies and decisions taken to ensure we do not end up in this situation again. I refer, for example, to the decanting of acute patients into nursing homes.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I will stop Mr. King there. I apologise for cutting across him.

Mr. John King: That is fine.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Mr. King. We welcome back Ms Phil Ní Sheaghda. I ask her to introduce her delegation and make a short comment outlining her key points, recognising that we have her submission.

Ms Phil Ní Sheaghda: The INMO's submission today will focus on a matter briefly touched on during the previous discussion on childcare, namely, the high rate of infection among healthcare workers, which currently stands at 34% of all of those who have been infected with Covid-19 in the Republic. Of those, 32% are nurses and midwives. We believe it is time for the Health and Safety Authority, HSA, to be involved and that an examination of the high infection rate among healthcare workers must be examined by the statutory agency tasked with this particular responsibility. It is unfair and disrespectful to healthcare workers when the HSA has not been given the statutory authority to investigate the cause, identify the reasons and make recommendations. We have to do better.

I am accompanied by a staff nurse, Siobhán Murphy, who has been infected with Covid-19. She is currently on week 14 of an absence from work and she has had severe side effects as a result of being infected at work. We know that 80% of all infections within the healthcare setting have been occupationally acquired. We have surveyed our members and we know their biggest concern relates to the fact that, as the committee knows, the pandemic is still within our health service. The idea that they have to face it again with the current level of support absolutely terrifies them. I will hand over to Ms Murphy for one minute to outline her personal circumstances.

Ms Siobhán Murphy: I worked on a Covid-positive ward since 24 March. We were catapulted into this pandemic but we faced it with strength as a team. We are nurses who work 13-hour shifts. We work days, nights and weekends. My experience was of overexposure and burnout due to the challenge we faced already pre-Covid, with understaffing and being overwhelmed with the ever-expanding role of being a staff nurse. As one cannot put a time limit on providing care to a patient, I suppose the exposure to Covid-19 as a nurse was profound. There have been psychological and physical side effects and symptoms that I still experience today. I am still off work at the moment, as are three of my colleagues, while four colleagues required hospital treatment due to contracting Covid-19. A total of 13 out of 20 of my colleagues contracted Covid-19.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Ms Murphy for her attendance today, which we appreciate.

I will move on to contributions from the members. Deputy Devlin of Fianna Fáil is first and he has ten minutes for questions and responses for witnesses. Witnesses should be aware that as it is sometimes difficult to communicate between the two rooms, they might hear the Deputies speak across them but they are only trying to keep things going. I call Deputy Devlin.

Deputy Cormac Devlin: I thank the Acting Chair. I thank the witnesses for their attendance and particularly Ms Murphy for her personal account. Like the public at large, we appreciate all that the witnesses and their members do daily, particularly during this crisis. There were a lot of challenges in advance of Covid and especially during Covid and the witnesses' submissions articulated that very well.

The million-dollar question, particularly if a second wave - God forbid - were to come, is

what could we do differently and how could we do it. I would be interested to hear from the various organisations here. Perhaps the representatives of the INMO would like to answer.

Ms Phil Ní Sheaghda: On what we can do differently, we can ensure that healthcare workers have the same status as every other worker in the Republic. Such a status would mean that if they go to work and become ill because of the job they do, they have the right to have that examined by the statutory agency holding responsibility for any other workplace accident, namely, the Health and Safety Authority, HSA. We urge this committee to ensure that the regulation preventing the HSA from doing just that is altered and the Minister with responsibility puts before the House the regulation changes. It is very simple. It is a statutory instrument and it needs to be done immediately because there is no way an employer in the public or private sector should be the only authority that determines whether it has acted in a correct manner when it comes to its workers' welfare. We do not believe that should be the case. It is not fair to healthcare workers. We appreciate, as we have said publicly previously, the applause and the well-intentioned thanks healthcare workers have received but right now, facing into doing this again, our members are saying they are exhausted and cannot endure this again with the protections that were in place. That needs to be examined by the Health and Safety Authority to ensure that correct protections are put in place.

Deputy Cormac Devlin: I thank Ms Ní Sheaghda. Does any other organisation have recommendations on how we might do things differently?

Mr. Éamonn Donnelly: I agree with what my colleague, Ms Ní Sheaghda, has said on burnout but if we get a second wave it will be very difficult to call on the exact same cohort of people to provide the same response. I wonder about all of the excitement surrounding Be on Call for Ireland when it was announced. That campaign has since been stood down. To my mind, we will not be able to deal with a second wave without the ability to have a fluid migration of the workforce into the health services. We have to be upfront about that. We are in a better place to be able to deal with a second wave due to testing and tracing and so on but, for the reasons my colleague outlined, the workforce in health is pretty much at burnout stage. The HSE needs to be right at the top of the game in ensuring the health services are compliant with the return to work safely protocols. That is not the case and the HSE is behind the pace on that matter.

Mr. John King: I will be brief and will try to avoid being repetitive. I agree with my colleagues on the importance of the statutory agency assuming the required levels of responsibility. The figures speak for themselves. No other sector of employment has suffered the same infection rates as the health sector. The reasons healthcare workers are here is that they work in HSE and healthcare settings. For this reason, the HSE needs to be involved in making sure that all that can be done is done to protect healthcare workers in their employment.

I will make one additional point. As a society, we waited for the pandemic to arrive before we reacted. We have an opportunity, while Covid has abated to the extent that it has, to ensure the policies and procedures we implemented very early on are not repeated because in some cases some of those policies and procedures did not help with the level of infection rates that occurred. We have that opportunity now.

Deputy Cormac Devlin: SIPTU's submission caused a bit of a flurry in advance of this meeting. It was about certain workers presenting for work with potential symptoms in fear of losing overtime or premiums. I find that worrying and I am sure members of the public would as well. How widespread was that?

Mr. John King: We raised this matter extensively with the HSE and the relevant Department when this particular policy decision was taken. To understand the point we are trying to make, we have to go back to the context of what Covid was like in healthcare settings in February and March when we did not have the advanced levels of testing and so on that we have in place now. Staff in the health service, similar to staff in other sectors of the economy, require their total earnings to be able to survive. The point we were making in including this point in the submission was to draw attention to a policy that did not work because it served as a disincentive. It is not a question of determining how many cases there were or what was the prevalence. The fact is that it was a policy that did not work because it acted as a disincentive.

Deputy Cormac Devlin: Obviously if there is a second wave, we need to be very conscious of that. From my perspective, the message should be that anybody who shows symptoms, irrespective of monetary gain, should not present for work. I hope Mr. King, the other witnesses and all members share that view. While financial considerations are a legitimate concern, surely health would override those. I wish Mr. King good luck in SIPTU's discussions with the HSE.

On the discussions between the organisations the witnesses represent and the HSE, I presume they are ongoing in the face of a second wave. Will the witnesses elaborate on that issue?

Ms Phil Ní Sheaghdha: The discussions are ongoing in respect of opening up the health service to Covid and non-Covid services. The problem is that we are still awaiting a funded workforce plan. It is something we have sought and it needs to be put in place. We have guarantees, for example, that both Covid and non-Covid services will have to be provided. We have sought that the workforce reflects that. If I was a nurse in an emergency department tonight, I would be providing either a Covid or non-Covid service. There are not two of me but there are two services. That is for the very reason the Deputy just outlined.

The important point about this virus is that it does not discriminate. Its aim is to infect people so we have to make sure we prevent it from doing that. If that means some members of the workforce having to remain outside it, the health service has to make provision to supplement the remaining workforce. What happened recently is that there was nobody to call on and, therefore, those who were at work were working short-handed. Ms Murphy can attest to that. There were 19 nurses on her ward. Twelve of them got infected and were absent from that ward, but the patient load did not decrease. We know from WHO statistics that infection rates are higher among those who are fatigued. The nurses who remained on that ward were exposed to a higher risk of infection purely because of fatigue. We need a funded workforce plan for nursing and midwifery. Fianna Fáil's pre-Government submission sought to increase the workforce quite substantially. We are eager to have that conversation. We are meeting the Minister this afternoon and will raise that with him, as well as with the HSE. That is the story in the public sector.

In the private sector, the workforce collapsed very quickly because its baseline was insufficient to begin with. We have to look seriously at reintroducing the public provision of care of older persons. We cannot rely on the private sector to the level we have. Some 82% of all care of the older person services is provided by the private sector and the workforce is not sufficient to endure another flu or another wave of Covid-19. It is simply unfair and inhumane to ask it to go back to that level of crazy staffing.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I call Deputy Cullinane.

Deputy David Cullinane: I welcome the witnesses. It is almost impossible to go through

all the submissions in the ten minutes we have. I am sure all other contributors will have the same problem because there is so much that can be said. I thank them for their comprehensive briefing notes and opening statements. I commend all the members of their organisations and the front-line staff across all our healthcare settings on the huge sacrifices that were made and work that was undertaken over the past number of months.

I will start with the INMO. Ms Ní Sheaghdha referred to the international average of Covid-19 rates among healthcare workers. It is 1% in Singapore, 12% in Italy, 15% in Mexico, 22% in Spain, and 32% in this State, which is one of the highest percentages among the countries cited. Can Ms Ní Sheaghdha explain why that rate was so high in Ireland compared to other countries?

Ms Phil Ní Sheaghdha: Those figures have been collated by the International Council of Nurses, which looked at the numbers of healthcare workers infected as a proportion of the overall infection rate in each country. There are some caveats attached to that, for obvious reasons. However, we are satisfied that the figures we have received from the HSE reflect the reality. For example, the most recent figures collated last Friday show that 8,347 healthcare workers have been infected with Covid-19. Of those, the highest single group is nurses, with 2,711 infections. We have experienced that on our wards, and Ms Murphy experienced it personally. There are a number of reasons for the high infection rate. One is that there was a deficit of PPE to begin with, though that has improved and is no longer the issue. The biggest single issue is fatigue and the length of exposure of healthcare workers, such as nurses and midwives, to people with the infection. The longer someone is exposed to somebody with the infection, the more likely that person is to become infected. That has been proven. We have to look at the idea that if we open up a Covid ward with a staff of 19 nurses and 12 of them get infected, we will have no replacements. It simply does not make any sense. It is causing the infection to increase.

Deputy David Cullinane: Ms Ní Sheaghdha also said that 73.25% of respondents in the survey indicated they found difficulty in accessing personal protective equipment. People will find it extraordinary that the number is so high and I am not disputing that it is the case. What time period are we speaking about? What was the critical time period when staff most found it difficult to get personal protective equipment? Has this issue now been fully resolved?

Ms Phil Ní Sheaghdha: There was great difficulty with getting personal protective equipment to begin with, particularly in the private sector. The biggest issue was the wearing of face masks. As the Deputy knows, there was a lot of debate about whether we should wear them. The HSE did not introduce until 22 April a policy that made it mandatory to wear face masks in healthcare settings. I gave evidence before the committee previously, and in our survey nurses give testimony on this point, of nurses being instructed not to wear face masks. This was simply the wrong policy. We knew from international evidence it was incorrect. They were instructed not to wear face masks. One nurse was actually disciplined for wearing a face mask. We now know, thankfully, that face masks contribute to the protection of healthcare workers.

There are various grades of face masks. If I am working in an intensive care unit or an area where I am engaging in aerosol generating procedures, I must have a higher quality face mask. All of this was too late. On 22 April, following the unions in this room requesting and constantly asking the HSE to change its policy, it eventually did so on 22 April. That was very late. Ms Murphy and her colleagues were working on a Covid ward from just after St. Patrick's Day. The point is that personal protective equipment was a big factor. It definitely has improved but we cannot risk the fatigue and exposure again.

Deputy David Cullinane: I might put a number of questions now because I will get caught on time and I want to cover as much ground as I can. I have another question which is specific to Ms Ní Sheaghda and I have a general question for all of the witnesses to come back on, if they can.

My question for Ms Ní Sheaghda is on the survey. It is very distressing to read what happened to front-line workers, it has to be said. We do not have time to go over all of the responses. I will refer to one respondent, who stated returning to work does not mean being 100% recovered and that employers should learn to accommodate staff returning from Covid special leave and support them to get back into shape instead of pushing them even more. Ms Ní Sheaghda said in her opening statement and submission that a long-term process will be required to deal with the psychological impact that all of this has had on nurses and front-line staff, that it is in this phase that many staff will be running on empty and that it is important to be able to respond to the needs of staff and support them. She also said that if a new surge of the virus emerges, the health service must have the workforce to deliver services and adequate supports. Will Ms Ní Sheaghda outline specifically what needs to be done to support front-line workers, whether because of the psychological impact, physical impact or whatever? What practical supports in the here and now will be needed?

I am not sure whether the witnesses saw the sessions we had last week with the HSE, when we spoke about capacity and the obvious fact that we still have to deal with Covid in our acute hospital settings. There may well be a surge but even the levels there at present require a lot of attention from front-line staff. We also have all of the ongoing non-Covid care. We have the programme to catch up on all of the missed care, which is necessary. How will any of this be done with the current capacity? It just cannot be done. Will the witnesses give us their view on what is needed in the short term in terms of beds, staff and other supports, such as physical infrastructure? What is needed in the coming months and the next year in our health service to ensure we can deal with Covid and non-Covid care and have some chance of dealing with the catch-up programme? I know it is a general question but it is an important one with regard to what is needed in the here and now.

My specific question was to Ms Ní Sheaghda on the survey and the more general broader point on capacity is for all of the witnesses if they want to respond to it.

Ms Phil Ní Sheaghda: In the here and now, the respondents to our survey made it very clear that a telephone helpline is not sufficient. They want practical post-traumatic stress support. They describe what they are now enduring as post-traumatic stress. They are saying they are fearful of the ability of their employer to keep them safe. They are also quite determined that they will work and are happy to go to work but they must be protected.

We call on this committee to look to the Health and Safety Authority, which is the statutory body with responsibility to ensure workplaces are safe. We must have that comfort for the people we represent who are to the forefront of keeping citizens safe and making them better. The figures from our intensive care units and the recovery from this pandemic are down to the good work of those healthcare workers who spent their time beside the patients in those beds making sure they recovered. It is really important we do not forget that. Right now, what we need is the assurance that somebody other than the employer is determining that the workplace is safe. That is imperative and this committee has the authority to make that recommendation. We call upon the committee members to do so.

Deputy David Cullinane: I do not have another question; it is just a general question about

the capacity needed in the here and now for all patients.

Ms Michele Monahan: I am a radiography manager so I deal with capacity issues every day. What will happen, as Ms Ní Sheaghda said, is that we will have two pathways. However, we have reopened emergency departments, EDs, which are now at the capacity they were pre-Covid. Pre-Covid we had TrolleyGAR, trolley watch, trolley everything, except one is not allowed to have that any more. What it puts back on the staff is that they work two streams whereby sometimes Covid-19 and non-Covid-19 patients are put through one piece of equipment - one CT scanner one MRI scanner - as fast as possible so no-one is waiting on a trolley and patients are admitted quickly so there is no crossover between Covid-19 and non-Covid-19.

We are not nearly at burnout, we are at burnout. One had to be there and to work through it. As Ms Murphy will attest, nobody can get what one had to go through except to be there. The first thing one learns as a healthcare professional is to leave emotions at the door and do not take patients home with us, but we did. We took every Covid-19 patient home with us because no family members were allowed in to see them. The burnout, stress and fatigue for those who did not get Covid-19 but had to do double shifts, additional call and additional everything needs to be recognised and a response needs to be put in. In one word, what we need to meet the capacity is “More”. We need more staff, more equipment, more space and more everything as otherwise, it is not going to work.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Ms Monahan and Deputy Cullinane. We move on to the Fine Gael party. Deputy Colm Burke has ten minutes.

Deputy Colm Burke: I thank all the speakers this morning for all the submissions they already have made and for the work that has been done over the last four months in particular.

I wish to raise an issue from the HSE report about the breakdown of healthcare workers. One of the concerning figures is of the 8,260 workers - it is now up slightly from 8,260 - some 2,878 of those identified with Covid-19 had underlying clinical conditions. I am extremely concerned that a person working in the HSE with an underlying medical condition then appeared to have been put in the front line. I have evidence of that because a number of people contacted me over the past three to four months where they looked to be assigned to other areas rather than being on the front line and dealing with Covid-19.

Was that issue taken up by any union with the HSE during the course of the last four months, whereby staff with previous medical conditions and who were a high-risk category were required to work on the front line?

Mr. Éamonn Donnelly: I will deal with that because we were involved in the negotiations at that time. The HSE took a very severe position on that issue insofar as they required a consultant’s certification that somebody had a vulnerable condition. If the person did not have a certification from a consultant, he or she was asked to continue as normal or would otherwise not be paid. The practice of ignoring the validation from a GP that a person had an underlying condition seemed to present a significant problem. It is no surprise that a number of workers who were infected had underlying conditions.

Everybody needs to understand that when the outbreak happened in March, we were told that our workers were an army, and a command and control model was put in place to mobilise the workforce to deal with the pandemic on behalf of the citizens of Ireland. That is what happened. However, that cannot be sustained in the long term. We cannot close down community

health again.

The capacity issue is why we need inward migration in the workforce. It is no great surprise that the number of infections comprised workers in a vulnerable category because of the severe stance taken by the HSE in that regard.

Deputy Colm Burke: The figure of 2,878 is quite high. Is Mr. Donnelly aware of whether some of those people had requested not to be assigned to the particular roles they were asked to take on?

Mr. Éamonn Donnelly: There was a prescribed list of what constituted a vulnerable worker. It included heavy-duty stuff such as cancer treatment and so on. Issues such as blood pressure and diabetes were disregarded.

Deputy Colm Burke: I am aware of two or three cases where someone who had been through treatment for cancer had returned to work in the HSE, yet was required to work on the front line. Did the witnesses come across cases of people who had medical conditions and clearly indicated to management that it was inappropriate for them to be on the front line, but management ignored their requests to be assigned to other areas?

Mr. Éamonn Donnelly: It would be wrong to say that management ignored such requests. The policy that was handed down to managers ignored or ruled out such requests.

Deputy Colm Burke: Where did the policy come from? Did it come from HSE management or the Department of Health?

Mr. Éamonn Donnelly: The people who were in charge of the command and control model set down a policy of public health guidance. People from the Department of Health, NPHET and the HSE set down that policy. As far as we are concerned, the policy on vulnerable workers did not go far enough and has resulted in the high number of infections outlined by the Deputy

Deputy Colm Burke: I will move on to the wearing of face masks. I received quite a number of emails at a very early stage from people on the front line who wanted to wear face masks, but it appears that a decision was taken at a local level, by individual medical units, nursing homes or whatever, that masks were not required. Did the witnesses hear from people who had made requests that those in charge of a particular ward, hospital or nursing home ruled against that rather than there being a diktat from a central body such as the HSE?

Ms Phil Ní Sheaghda: I will answer that. The policy of the HSE was quite specific on the wearing of face masks, and it was not broad enough. The policy was quoted to nurses when they sought to wear face masks and the wearing of face masks in the particular setting that they were in contravened the policy. At national level we had to change the policy. As I said, the policy was changed on 22 April to allow the widespread wearing of face masks, something that should have been the case from the beginning.

In respect of the question on underlying health conditions posed by the Deputy, healthcare workers got infected because of the exposure rate. They, no more than any other section of the population, include those with underlying health conditions.

The biggest issue we faced was nurses who were pregnant and attending work. We had a battle to ensure that they were not exposed. Pregnancy was not considered an underlying health condition. Some 34% of all of healthcare worker infections were among nurses. Treating a

pregnant woman with Covid-19 is very difficult and should never even be contemplated. We had a huge problem in trying to get pregnant nurses and midwives redeployed away from the front line. That problem was exacerbated because underlying staffing levels do not support redeployment.

We also had a call from the private sector to redeploy public servants, particularly nurses and midwives, into the private sector when it was short of staff. Personal protective equipment, PPE, was a problem in the private sector and policies and procedures, etc., were unfortunately absent in some cases. The exposure of healthcare workers is the point. It cannot be left to the employers and must be looked at by an agency with the statutory authority to examine it. An employer constantly suggesting reasons something has happened is simply not good enough. We must have stronger and better protections for healthcare workers on a legislative basis. They deserve the same protections as any other worker in this country and should not be treated less favourably.

Deputy Colm Burke: I will move on to consider how we go forward. Over the nearly six years from December 2014 to now, the number of people working full-time in the HSE, whole-time equivalents, has gone from 103,000 to 123,000, which is an increase of 20,000 staff members. That increase obviously applies across all areas, including management, administration, care assistants, nurses and doctors. Where should the priority be in recruitment at this stage? Should it be care assistants and nurses or do we need an increase across all areas of the health sector? A question then arises regarding the kind of numbers should we be planning for over the next three years. We will be unable to introduce the necessary changes overnight but what should we be aiming for over the next three years?

Ms Phil Ní Sheaghdha: The health service has increased in capacity. The busyness of the health service has also increased in comparison to the time when the answer to the most recent recession was to introduce a moratorium on recruitment. Another moratorium was introduced in May of this year and really interfered with the ability of people to stay safe during this pandemic; there is no other way of saying it. There cannot be cutbacks on front-line staff in a service that is delivered by people. We have a shortage now that is estimated at just under 5,000 nurses and midwives. We know that maternity services are lacking. We should have one midwife per 29.5 births but we are close to 37 or 38, at best, in many locations. It is a known fact that we are short of midwives and nurses.

Each of the political parties addressed the matter in its election manifesto. Fianna Fáil said 4,000 extra nurses were needed. Fine Gael said 5,000 were needed. This is known. We know we need more front-line healthcare workers. We need more nurses and must do everything we can to retain those who have come through this pandemic so they do not leave. We also need to recruit more and increase undergraduate places. Some 5,000 school leavers looked to study nursing last year and only 1,700 places are available. That is a quick answer. Undergraduate places should be increased.

Deputy Colm Burke: What kind of numbers are we talking about over the next three years in real terms? How can 5,000 positions be filled over a three-year time period? That is the kind of time period we are talking about.

Ms Phil Ní Sheaghdha: We believe that can be done. There must be a funded workforce plan in place based on science which states that patients do better if there is a skill mix of 80:20 in an acute hospital and 70:30 outside of an acute hospital. That is what the science tells us and the numbers must reflect that. Otherwise, it is stating that it is okay to base our figures on unsafe

levels of care and we do not accept that.

Deputy Duncan Smith: I thank the witnesses for their detailed submissions. There is so much in them that I wish I had more time to deal with them and the committee had more time to interrogate everything that needs to be interrogated. I hope the witnesses will forgive me for picking out a couple of issues from one of the submissions that caught my eye, namely, the quotes from SIPTU members. One of them said that at times there was rationing of PPE and workers were made to feel guilty for asking for it. Another said that it is now very difficult to get access to hand sanitiser and masks. PPE is locked away in the manager's office and if that manager is not in, it runs out. This is quite shocking to hear given the assurances we have been given by the HSE and Government which suggested that this should no longer be an issue in light of the stocks of PPE available to be provided to all front-line and support staff. It seems to still be an issue. Based on that submission, I would be interested if Ms Monahan could give us more detail on her experiences in her work as a radiographer. She touched on this in her first contribution.

Mr. King mentioned at the outset that SIPTU represents a broad spectrum of staff. What has SIPTU learned that would be useful should there be a second wave of Covid?

Ms Michele Monahan: The situation with regard to PPE has evolved. The initial three to four weeks were a nightmare, as has been well documented. With regard to what came from China, the large size would fit a small person so some of us had no hope of getting into it. That was a very significant issue for staff. The issue with hand sanitiser arose because of reliance on a single source. Everything came from one place so, when that one place could no longer supply us, we had no other supplier available to us. The market was oversubscribed because the whole world wanted the same product.

I work in Connolly Hospital where we have a very good team so were not left without anything at any time. We distributed through the wards and became a team. If one area was running low on something one could go somewhere else for it. Everybody worked together. From speaking to my colleagues around the country, I know that this did happen, that things were locked away and that people did have to beg for PPE. That is just not right. The least staff working throughout this pandemic needed was the ability to do their jobs safely. An awful lot of them were denied that. That put them under a lot of pressure and stress. Many did not want to go back to work. People had full-blown panic attacks at work. They felt they could not go to work because radiographers carry out portable X-rays on every Covid patient and people just could not cope with doing that when they might not have PPE.

We really need to learn from all of this. We really need to look after our workers including those who get infected, those who are post-infection and those who are left behind working double and triple shifts and going to places where they do not normally work to pick up the slack while having to learn a new skill set on the job. We need to learn and learn quickly. We need that report and we need statutory backing for everything that happens because we cannot face another pandemic while addressing capacity issues at the same time.

Deputy Duncan Smith: I thank Ms Monahan. I really appreciate her comments but I have less than a minute left. I would appreciate it if Mr. King could answer my other question.

Mr. John King: I will be brief and avoid repetition if I can. I briefly mentioned earlier that society and the health system waited for the crisis to arrive before reacting. We are now in a position where we do not have to allow that to happen again. To give a very broad answer, it

is a matter of our readiness to deal with a second surge when it comes. It is about ensuring that the health service has the capacity and the resources to meet that challenge when it comes. That includes issues such as that of PPE and proper policies and procedures that do not act as disincentives. There must be clear decision-making authority and so on. The point about the role of the Health and Safety Authority has been made so I will not repeat it.

One of the issues with regard to resourcing is that of staffing. This includes safe levels of staffing in all areas. Our submission highlights one matter with a view to highlighting it specifically rather than the story because we must learn from the story. It is then about applying what we have learned. We have thousands of workers who come into health service settings every day of the week to do essential jobs to support the safe delivery of health services. They are not public servants and they do not have the same protections and terms and conditions of employment, such as the likes of death in service benefit, health and safety entitlements and so on. We believe that also needs to be examined if we are talking about a safe delivery of the health system in the future.

Deputy Róisín Shortall: I thank all the witnesses for their presentations but, more importantly, for all of the work they and their members have done over the past four or five very difficult months. I extend my condolences to them on the members whom they lost in the line of duty, and the many members who are still suffering the effects of the Covid infection. The point was made earlier that while thanks are important, there is a heartfelt view shared by the whole country that the way in which to give effect to that in meaningful terms is to introduce protections for workers in both ways.

It is quite remarkable that Covid-19 is not a notifiable disease. That has only come to my attention recently as a result of the campaign being run by the Irish Congress of Trade Unions, ICTU. It is incredible, given the deadly nature of the virus, and the fact that it has had such a devastating impact on healthcare workers in particular, that there has been a reluctance, to say the least, on the designation of Covid as a notifiable disease. I note what has been said about ICTU making an approach to the Tánaiste. It is unfortunate to say the least that the approach has not met with a positive response. It is certainly something we as a committee will take up in producing our report and recommendations. I wish to ask Ms Ní Sheaghda in particular where we are at in the campaign to ensure that Covid is notifiable. Although the Tánaiste has not been encouraging so far, is she engaged in discussions at any level with the Government on this campaign?

Ms Phil Ní Sheaghda: I thank Deputy Shortall. She is correct that the Irish Congress of Trade Unions had requested of the previous Minister, Deputy Humphreys, that the definition of personal injury in regulation 224 would be amended to include an occupational infection of this kind. We also wrote separately on behalf of our members and, as I understand it, a meeting is scheduled for this week with the Irish Congress of Trade Unions and the current Minister, who is the Tánaiste, Deputy Varadkar, to deal with the issue. To date, the response has not included confirmation that the regulation will be amended, which is what is needed.

We also know that in the European Parliament, the definition in the biohazard directive now includes Covid-19 as an occupationally-acquired injury in category 3. As my colleague, Ms Siobhán Murphy, will be able to tell the committee, when one works on wards for 12-hour shifts, one knows all about it when one becomes infected. The long-term effect of this is quite severe. Ms Murphy has now entered her 12th week of being absent from work due to the after-effects of being infected. That cannot be described in any other way except as an occupationally-acquired illness.

Deputy Róisín Shortall: I thank Ms Ní Sheaghda. I note the point she made about staffing levels. Covid has exposed significant failures right across the public services but nowhere more than in the health service. Ms Ní Sheaghda made a point about being significantly understaffed as a result of large numbers of staff being out sick and the need to ensure there is a funded workforce plan. We very much take that on board as a committee.

In the couple of minutes remaining, I have questions for SIPTU and Fórsa. There is an absence of protections for so many of our workers and a large number of healthcare support staff are in precarious, low pay jobs. This is a factor in healthcare assistants, for example, continuing to go to work when they had the virus because of the lack of statutory entitlement to sick pay. What percentage of staff in the areas SIPTU and Fórsa represent do they believe are in that category of precarious workers who do not have the statutory entitlements that many of the rest of us take for granted? Perhaps SIPTU can answer first.

Mr. John King: I thank the Deputy for the question. The reality is that healthcare workers and healthcare assistants who are employed directly by the HSE have a sick pay scheme and receive sick pay benefits under that. That is not the case in the private sector, particularly the private nursing home sector, where they do not have any advanced or reasonable collectively bargained pay, terms and conditions of employment that include sick pay schemes. That is also the case in the contract services sector, which does not deliver direct healthcare but does essential work to ensure healthcare can be delivered safely. This sector includes security, cleaning, private contractors and so on. The vast majority of them does not have a sick pay scheme. In such categories, there are very high percentages that do not have sick pay schemes.

Mr. Éamonn Donnelly: We have had a similar experience with regard to section 39 voluntary agencies representing workers without those type of protections. Within the HSE structure, we do not have experience of that in Fórsa. It is no new thing for healthcare workers to go in when they are sick during non-Covid times. They go to work when they have bad colds and that is normal. On this occasion, we were at great pains to point out to people that, notwithstanding some of the choices one makes to go into work when one has symptoms, they must not present on this occasion. We were at great pains to point that out within the context of the public guidance.

Deputy Róisín Shortall: It is all the more regrettable that when we debated these issues last Wednesday in the Dáil, the motion to put a focus on the vulnerable nature of workers in the health sector in particular was voted down.

Deputy Richard Boyd Barrett: I thank all the contributors and pay tribute to Ms Murphy and all her colleagues for putting themselves in harm's way in very difficult circumstances to protect all of us over recent months. It seems from what the witnesses are telling us that the rhetoric we heard about the wonderful work of healthcare workers has not been matched by supporting front-line workers such as Ms Murphy in the way they should be supported. Listening to the witnesses' contributions, I find it shocking and frightening that they seem to be saying that healthcare workers on the front line are working unsafe hours with unsafe staffing levels and are being put under pressure to go to work even when they have underlying conditions, or for financial reasons. If that persists, we are in deep trouble if there is a second wave, as is likely, in the autumn. Is that a fair assessment of what the witnesses are telling us? I would like to hear from Ms Murphy on this. Does she feel the lessons are being learnt about what happened to her and the experience she has gone through? Are she and her colleagues prepared and, most important, are the HSE giving them the support to be prepared for what is coming in the autumn?

Ms Siobhán Murphy: First, I wish to point out that I am 27 years of age with no medical, previous or underlying health conditions. I unjustifiably contracted Covid-19 in the workplace due to, as was previously said, understaffing, being completely overwhelmed with the role of the nurse, extreme burnout and overexposure to the virus. I believe I was competent in my use of PPE; we had extensive training and education on the ward from infection prevention and control in the hospital on a daily basis, as PPE did change depending on supply.

On being prepared for a second surge, as nurses we are professionals. Speaking from the perspective of my own hospital, I cannot say that any of my colleagues presented to the ward with symptoms of Covid-19. There was a very clear pathway whereby a person isolated, he or she got a swab through occupational health in work, got his or her result and subsequently was off work for 14 days if not longer. In my case, it was for 12 weeks due to symptoms. Going forward, the psychological impact of Covid-19 has been detrimental to me and to my colleagues and I am sure I can speak on behalf of the nurses of Ireland when I say that. Being given a telephone number or an app to access from home for psychological trauma, for post-traumatic stress disorder, PTSD, which was mentioned, is just not sufficient.

We need significant debriefing going forward. Our mortality rate was incredibly high. We as nurses work to save lives but we were fighting a losing battle at the very start of Covid-19 and we do not want to see that again. I personally do not think I can walk into a workplace that is unsafe and that is how I felt at times, even though I was provided with PPE and I was, as I said, competent with it. To me, the workplace was a hazard. I ended up in hospital for a week due to my symptoms, which escalated out of my control and I had to be monitored and investigated as an inpatient in the hospital where I work, where just a week previously I would have been standing as a nurse at the bedside providing care to dying patients who succumbed to Covid-19. It was extremely traumatising and I do not know if any nurse could overcome that with just a number or an app. More needs to be done.

Deputy Richard Boyd Barrett: I wish to thank Ms Siobhán Murphy so much, on behalf of all of us, for what she has done.

Does she believe that lessons have been learned by the HSE and the Government from the rather harrowing experience she has clearly gone through? Does she get any sense that the problems will be addressed? What would making the situation different and better for her entail on the ground as a front-line healthcare worker in the autumn? Is it about more staff, working fewer hours, fewer periods of exposure and more support for the psychological impacts? I have a question for Ms Ní Sheaghdha as well, which must be quick as I am out of time.

Acting Chairman (Deputy Jennifer Carroll MacNeill): The Deputy's time is up.

Deputy Richard Boyd Barrett: Very briefly, what numbers do we need to recruit into the front line to be at safe levels for dealing with Covid and non-Covid healthcare come the autumn?

Ms Siobhán Murphy: To keep it brief, we definitely need increased numbers of staff nurses numbers permanently, not just agency staff that come in for a day here or there. We need to increase the number of nurses who are on a roster. We work seven days a week, 24 hours a day for 365 days a year and if someone falls ill, they have to be replaced. I will hand over to Ms Ní Sheaghdha for the remaining time.

Ms Phil Ní Sheaghdha: The figures we constantly quote are the figures that were in place

before the first recession. We are still working with 1,000 fewer nurses today than we were in 2007 and the health service is much busier. In providing both Covid and non-Covid services, we need a minimum of 5,000 more nurses, including midwives.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Ms Ní Sheaghda. I apologise for cutting across her but we are quite over time.

I thank Ms Murphy for outlining that post-traumatic stress disorder is a very serious clinical psychiatric condition and requires appropriate and urgent supports to try to help people through what can escalate and become a very difficult condition. Appropriate diagnosis at the earliest stage is key. I thank her for outlining her experience so far. That phrase is also used too easily when it is a very specific clinical psychiatric diagnosis. It is very important that those at risk of acquiring it through trauma or developing it in the future get the correct diagnosis and treatment at the earliest stage in order that it does not escalate. I thank Ms Murphy for highlighting that.

I call Deputy Shanahan.

Deputy Matt Shanahan: I thank the witnesses, particularly Ms Murphy and all other front-line nurses. They have done an incredible job. At last Friday's committee meeting, I said that I thought a level of exasperation was quite evident over the course of the day. It has been evident at this committee for a while and is evident again here today. Anyone listening to the evidence and reading the submissions could not but be exasperated. We can all accept that there was a level of unpreparedness because no one knew what was around the corner. What I am concerned with now is what we have learnt and what we are implementing before the winter. I have some background in infection control. Ms Ní Sheaghda said the HSE asked for masks to be worn on 22 April. I asked for them to be mandated in the Dáil on 4 April. There were things we could have been doing regarding PPE. It was also stated that hand sanitiser is only available through one supplier. However, most of the distilleries in the country have been providing alcohol hand sanitiser, so there should be absolutely no reason not to have hand sanitiser in the healthcare sector. I encourage the unions that are present to get in contact with HSE procurement and to talk about these issues. I have worked with a number of companies in Ireland that are having great difficulty in bringing PPE into the supply network because of government procurement. These things must be addressed. I have sat in hospital waiting areas and have looked at staff migrating through hospitals with their scrubs on, going down into community areas and back up to the wards. That must come to a stop, as must allowing public transit through all areas of a hospital. Infection control procedures must be put in place. They are the very first front-line policies, about which the witnesses must speak to the Minister very robustly.

I also previously mentioned temperature testing. Has the INMO any opinion on whether staff should be temperature tested before they start work in the morning, just as they are in other industries?

Ms Phil Ní Sheaghda: There is no doubt that temperature testing has a place but we are more worried about asymptomatic presentations, that is, people who present with no symptoms but who are infectious. We and the other health sector unions have jointly asked the HSE to change its policy of advising staff who are close contacts of a case but have no symptoms to come back to work. We believe that is unsafe. We need swabbing and we need to know the status of workers. In the private sector, there is now mandatory staff swabbing but we do not have such a policy in the public acute hospital system. HSE officials will speak to the committee later and they will say, as they have said to us, that a swab is just a picture in time. However, we believe it is necessary because we know that asymptomatic workers in the private sector are

being picked up as positive, and when they are asymptomatic and positive, they still pass the virus on to others. A temperature is one symptom that can have a number of different causes, but the swabbing of front-line workers must be mandatory in the acute service as well as the private sector.

Deputy Matt Shanahan: I agree with Ms Ní Sheaghda wholeheartedly on that. I also previously brought up the donning and doffing of PPE at this committee and was told the HSE had provided videos on it. I was contacted by a nurse in Cavan hospital many weeks ago who highlighted the issue of donning and doffing of protective clothing and two weeks later, we had one of the highest spikes in the healthcare sector for that very reason. I again ask the witnesses to speak to the HSE about that because these are simple measures to implement. The very first priority is that workers need to be protected. Everybody accepts that. We cannot protect from everything but we can mitigate as far as possible. The INMO should also talk to the HSE about more flexible rotas. Perhaps nurses should only do four hours on and four hours off, with some kind of alternate shift change to reduce the level of fatigue and thereby reduce the rate of infection. I applaud everything the witnesses are doing. I feel sorry for front-line workers who have been caught up in this and I also feel sorry that we are not learning from the mistakes of the past. I hope they will bring these matters to the Minister, as I also intend to do.

Deputy Michael Collins: I thank the witnesses before us today. I will address my initial questions to Ms Ní Sheaghda. How early was testing carried out of residents and staff in care of the elderly facilities? Should it have commenced earlier? Did the failure to carry it out earlier lead to staff and residents being at higher risk?

Ms Phil Ní Sheaghda: I thank the Deputy for the question. The swabbing of staff in the private sector followed the presentation of symptoms. If there were symptomatic presentations then swabbing followed. In the public sector in care of the older person services, it depended very much on the availability of swabbing facilities. For example, Cherry Orchard Hospital has a laboratory on-site and swabbed its staff who presented with symptoms. It had a very good experience of Covid, if we could call it a good experience. In other words, the infection rate was quite low and the transfer of the infection to other staff was kept at a minimum. It also enforced quite strictly the policy of self-isolation for 14 days. Even though the HSE's policy was that close contacts could be derogated to return to work, Cherry Orchard Hospital took decisions not to implement this. I know this because I spoke to one of the assistant directors who felt it was very important not to derogate staff to come back when they did not know their status and had not been swabbed. We have requested this policy to be removed. Today, if a member of the public is a close contact he or she will be advised to stay at home and self-isolate for 14 days. This should be no different for health service workers.

Deputy Michael Collins: We still have situations in community hospitals where the HIQA standards on single bed occupancy have not been met. Did multi-occupancy rooms lead to the spread of Covid-19?

Ms Phil Ní Sheaghda: Our members will say one of the lessons learned is that the isolation of patients whose status is unknown should have been dealt with earlier. This is very difficult to do if one is awaiting swabs and the results are taking a long time to return. This has improved. We certainly have a huge problem with the availability of isolation facilities in acute and long-term care settings. We need more isolation facilities. We know from our figures, which we count on a daily basis, that we have overcrowding at present in our emergency departments. We do not know the status of a lot of the patients when the areas are overcrowded. This is a recipe for disaster.

Deputy Michael Collins: I understand that Ireland has the highest Covid infection rate for health workers in the world and that one in every ten Covid cases reported involves a healthcare worker. Given that more than €1 billion will be spent on PPE in Ireland this year, how is it possible that healthcare workers did not have access to adequate supplies of it?

Ms Phil Ní Sheaghdha: The best evidence of this is from Ms Murphy, who was in that situation. She was fully protected with PPE and still got infected, as did 12 of her colleagues. It is not just about availability. Availability was a real problem at the beginning. That improved, largely because of the work of the trade unions in this room. We sought that face masks should be mandatory for all healthcare workers. That is the point. The point is there are other reasons, and the HSA is the agency that should be examining what those reasons are. The committee can recommend that it now gets on this pitch. We have been asking for it. The Irish Congress of Trade Unions has been asking for it. The workforce is saying this is really serious. This is a hugely infectious pandemic and the agency that is entrusted with workers' welfare and ensuring that workers are safe when they go to work is not on the pitch. That is simply not fair.

Mr. Éamonn Donnelly: I would like to comment on this. During the spike in April, when almost 6,000 cases occurred among health workers, the numbers caused by deficits in PPE were surprisingly low. Most of the transmissions were through the workplace in the work setting, as Ms Ní Sheaghdha said, in a very risky environment. We were speaking about swabbing a few minutes ago. A number of our people who would not be considered front-line workers and stepped into the front line to do swabbing got infected. It is a highly contagious environment but the numbers of infections caused by inadequate PPE, or a lack of PPE, were surprisingly low in that April period. There was a huge problem at the outset and, as Ms Ní Sheaghdha said, the trade unions moved assertively to try to correct that. The totality of the work environment needs to be observed. I would not want anybody to think that if we bulk up on their PPE arrangements this will be okay because it will not. There are a number of factors.

Deputy Paul McAuliffe: A number of questions I identified have already been asked so I will not ask the witnesses to answer them again. It is interesting to look back at some of the contributions and the words used. Ms Murphy used the phrase "catapulted into" and Ms Monahan spoke about the context and what Covid-19 was like. Looking back on the time when this happened, obviously, there are things we could not have changed given the speed at which it came on us. It is, however, exceptionally important we learn those lessons now so any future change in the Covid-19 rate is protected, particularly on masks, which we are all sitting here wearing today. It was not just Ireland but the entire world that got it wrong about masks. We must make sure we do not make that same type of mistake in other areas.

I want to thank all the workers. I am on the record as saying we need to make sure it is more than just thanks. I have no doubt that when Ms Ní Sheaghdha and her colleagues meet the Minister today they will be forceful in terms of the obligation the State has to the workers who have protected us.

I want to turn to the vaccination on influenza. I have said for some time that I am quite concerned we are going to have influenza and Covid-19 at the same time and it will lead to economic difficulties. There will be isolation where it is not needed. Equally, there is an increased risk for patients and healthcare workers. Can the witnesses talk about the availability of the influenza vaccination at this moment for healthcare workers?

Ms Michele Monahan: I work in Connolly Hospital, where one is almost mugged to get it because there are people on every corridor offering it and asking why one has not taken up

the offer. It is readily available in the acute sector for all healthcare workers. I will leave the private sector to Ms Ní Sheaghdha, but certainly in the acute public health sector we are hugely encouraged to take up the flu vaccine.

Mr. Éamonn Donnelly: To complement Ms Monahan's contribution, I was on a call with the HSE last week in which we were informed that while the word "mandatory" might be a little over-assertive, there will be a new vaccination with four dimensions to it rather than the usual three which every healthcare worker will be "expected to avail of". That is encouraging and the trade unions have their part to play there too.

I wonder about the decision to stand down the Citywest facility, where there were 300 beds we went out and had a look at. The construction of that facility was a phenomenal piece of work that showed everybody what could be done. When the numbers were reduced in terms of Covid-19 surely it would have been a way of anticipating a flu surge, for example, from the autumn onwards. I thought it was a strange decision.

Deputy Paul McAuliffe: Given the availability of the flu vaccine, both for healthcare workers and, I understand, target groups - we have identified 1.9 million vaccines - the HSE does not seem to be progressing a population-wide programme with the objective that everyone in the population will have the same level of access that healthcare workers have. That will have an impact on the number of people presenting to emergency wards and will put pressure on healthcare workers. Have the unions given any thought to the impact of that on the already depleted levels of staff?

Ms Phil Ní Sheaghdha: The numbers from last year's flu epidemic indicated that the pressure on ICU beds was significant. We know that those who get very sick with Covid-19 require intensive care beds and that we do not have a surplus of those beds in this country. That indicates that the private hospital facilities must remain available to the public health service. The intensive care beds and units are already staffed and they have ventilators. They must be available.

The flu epidemic has been a feature of every winter and our hospitals have been extraordinarily overcrowded every year right into February. There is no indication that will be any different this year, but what will be different is that we will also have Covid-19. We will have to redouble our efforts to make sure we have the necessary capacity and staff available.

Trade unions, including the INMO, agreed over the past two winters that our members would engage in a peer vaccination programme. That is a policy of the HSE. In other words, if a nurse works in hospital A or B in the public or private sector, he or she can vaccinate his or her peers. Our members now vaccinate their colleagues to ensure the greatest possible uptake of the vaccine when it is available.

Acting Chairman (Deputy Jennifer Carroll MacNeill): The Deputy can have more time if he wishes.

Deputy Paul McAuliffe: No, it is fine.

Deputy Louise O'Reilly: I thank the witnesses, in particular those who have come before us and have been generous with their time. The SIPTU submission states:

There is no doubt that the experience of the pandemic has taught us many lessons. These experiences must form part of our planning for the future. In many cases, services were

unprepared and did not have the essential equipment or training to support and protect healthcare workers in the fight against Covid-19.

My questions are on the basis of that assertion. How much better prepared will we be in the event that there is a second wave, as much as we hope that does not happen? Will we be better prepared? Do we have the requisite number of staff in place? Will the necessary equipment be available? I ask these questions in the context of what was referenced by Ms Ní Sheaghda, namely, the flu.

I am on the record as having said that we have had a succession of Ministers for Health in this State who seem to be surprised when flu breaks out at the exact same time every year. In the context of the potential for an increase in hospital attendances because of the flu and the reduced number of beds that will be available because of physical distancing, is there additional capacity in the system to take up that slack?

Mr. John King: I will take that question. I thank Deputy O'Reilly. The intent of our submission and contribution today is to challenge policymakers and committee members, as legislators, to ensure that we are in a state of readiness. Some of the experiences we continue to have leave a number of unanswered questions. We need to make sure we do not repeat the mistakes of the past.

We do not need to wait for the flu to arrive in order to get ready for it. We know Covid-19 is here and that there is a real likelihood of a second wave. We have touched on the issue of staffing resources. The fact of the matter is that there are not enough staff at any grade. There are real issues there, in particular in the context of dual pathways. There are issues around equipment and so on, and Covid and non-Covid patients arriving into those kind of situations.

Deputy Louise O'Reilly: I will pause Mr. King there for a moment. Have the trade unions been involved in planning for a second wave? In that regard, have they had sight of the additional capacity we all know is needed? Have they had sight of the additional capacity the HSE has sourced? Has it sourced additional capacity? What has been the level of engagement in terms of preparation?

Mr. John King: I have not had sight of that capacity. I am not sure about the level of engagement, even in terms of the contribution made by Ms Ní Sheaghda on the funded workforce plan. The HSE has consistently been behind in dealing with that issue. The issues about staffing and whether we will have the people and equipment to meet the challenges that are going to come are of deep concern. The trade unions engage with the HSE at a senior level on a weekly basis and many of these issues are discussed. The real challenge is to ensure that the correct policy decisions are taken to enable those discussions to deliver meaningful outcomes.

Mr. Éamonn Donnelly: If I may just comment because I have been directly involved in the discussions to which Mr. King has referred. We have not had sight of any plan for a second wave is the explicit answer to the question. I earlier explained one of the reasons for that. When the national emergency struck, there was a command and control model and a mobilisation of the workforce to do something we had never done before. A second wave, if there is one, will come in different circumstances. On the positive side, we will be better equipped from the points of view of tracing and identifying contacts, and we know more about the illness. On the negative side, we have handed back 300 beds and do not have a workforce plan of which we have had sight. People would be wrong to think that it is possible to have a new command and control model that will have the same effect. The difference will be that there have been

delays in cancer diagnostics for a number of months. Therapeutic interventions for vulnerable people have been delayed for a number of months and disability services have closed down for a number of months. The system will be unable to absorb that. We will go into a second wave while having to keep the other services I have mentioned open. It is beyond me how the HSE's Be on Call for Ireland initiative only yielded 125 staff members. That is staggering. It will not be possible to do the job and keep the health services live with an extra 125 people. If the civil and public service model and Be on Call for Ireland initiative are our staffing sources, those staff members need to go to areas of need. The HSE needs to get on top of that.

That is how we should prepare for a second wave. It is high time that preparation was tabled for discussion and not in a command and control manner. We should expect a second wave and expect to be able to deal with it alongside the provision of the rest of the health services.

Ms Catherine Keogh: I might come in on the question. There are two elements that to my mind seem to have been ignored. There is another front line about which people forget, namely, the front line in the community. Home help co-ordinators are represented by Fórsa and SIPTU represents home help workers who go into the home. They were the unsung heroes of the pandemic and kept many people out of acute hospitals. That element of the health service must be a part of any conversation about dealing with a second wave.

I also wish to draw people's attention to structural deficits that exist within the wider health service, including HSE hospitals, voluntary hospitals and section 38 and section 39 institutions providing disability services. As my colleagues have said, we now have a bit of time to plan how to properly approach a second wave. We must look at all those factors. We call on the HSE to do things, and that is important, but my colleagues who are involved in weekly meetings with the HSE know that we also need the voluntary hospitals, which are all independent bodies, to get on board. We need to bear those things in mind.

Deputy Louise O'Reilly: Ms Keogh is right that there must be a whole-of-system approach. Has Ms Ní Sheaghda any observations to make?

Ms Phil Ní Sheaghda: I have, and I thank the Deputy. The important point is that additional beds are needed and must be provided quickly. We are currently involved with a care of older persons service that has gone into liquidation. I do not think that case will be unique but will happen quite regularly, unfortunately. In its service plan last year, the HSE sought to remove 200 beds from care of older persons services. We wrote to the HSE and the Minister for Health objecting to that. We need to increase public service capability to provide care for our older persons. That must be a priority because we know that this virus has a much greater effect on the older population. Our population is aging. We also know that the flu takes a particular toll on our elderly population. For those reasons, we need to be increasing bed numbers in our care of older persons services.

We also need to look at ICU capacity. Three-month contracts were issued to staff to work in the health service during the pandemic and there is a constant requirement to repeat and seek approval for renewal of those contracts. I have two comments to make on that. The first is that these should be directly hired. The second is that if there is any mention of another moratorium on hiring in the health service, we ask all Deputies who are listening to what is being presented today to oppose it.

Deputy Louise O'Reilly: There will certainly be very strong opposition to any suggestion of a recruitment moratorium from the Opposition benches. That is not acceptable. I was

struck by what Ms Murphy said in her opening statement with regard to how she, in particular, and other staff are feeling overburdened, burnt out and overwhelmed. Those are very serious words. I sincerely hope the powers that be in the Department of Health and the HSE listen to those words and take them on board. If we are to face into a second wave, there has to be some acknowledgement of the residual impact of what all of us, but our front-line staff in particular, have just been through.

I will not ask Ms Murphy to comment on her own personal situation but will she outline the residual impact with regard to any annual leave she or her colleagues might have used to take care of kids and what the impact of that will be as we head into a second wave? I also take this opportunity to thank Ms Murphy, Ms Monahan and all other front-line workers. The job they had to do for us was nearly impossible but they did it anyway.

Ms Siobhán Murphy: I have been off on basic-pay sick leave. It is counted as Covid sick leave so it is not taken out of my sick leave allocation for the year. I am, however, on basic pay so I am losing out on allowances for night shifts, weekends and bank holidays. We have had multiple bank holidays. My colleagues who have children have had to take annual leave to look after them at home. Again, they are on basic pay. It is not a choice. If I am sick, I am not going to walk back into the workplace until I am nearly 100% better. I have been told that could be October or November given what I have been through. I know the childcare issue is ongoing. I do not have kids myself but my colleagues do. That is a concern because it means more staff not on the floor because of the lack of childcare facilities. Again, their pay is affected.

Deputy Bernard J. Durkan: Like others, I compliment our witnesses on being here today, the replies they have given, and the tremendous work they have done throughout the Covid crisis. With regard to staffing levels, which has always been a sensitive issue, will Ms Ní Sheaghda comment as to whether she is satisfied that nursing staff levels were increased proportionately when staffing levels throughout the HSE were increased? Did she feel that fewer nurses than other staff were appointed? Perhaps I can get an answer to that question first.

Ms Phil Ní Sheaghda: The increase in the number of staff nurses, the front-line grade, has been quite modest. Some 230 were hired in the past year. We rely very heavily on our student population. We saw that during the pandemic when unqualified students were redeployed and worked as healthcare assistants while fourth-year students worked on the wards. Great thanks are due to them for doing so.

It is not a competition. The health service is short on staff at all grades, although most particularly those grades that work on the front line. We are certainly not satisfied that shortage is being measured properly. For example, staffing levels in services for the care of older persons are determined by cost of care, which is to say what can be afforded rather than what would provide the best outcome for patients. We now have two scientific policies, which have thankfully been adopted as Government policy. These determine scientifically the staffing, including the ratio and mix, required. As I said earlier, in the acute hospital sector, 80% of staff should be nursing staff and 20% healthcare assistants. That kind of staffing results in better outcomes for patients. We are nowhere near that. What the research into that scientific piece of work found is that it actually saves money because it increases attendance, cuts down on burnout and reduces the length of stay of patients because their outcomes are better, as the care gets to them quicker. We know what the answers are. We have the policies. What we need now is to ensure that the Department of Health, the HSE and the Department of Public Expenditure and Reform back it up and that they fund the workforce plans. They have to fund the workforce plans based on science, not availability of resources, because when it is based on availability of resources,

that says to the front-line workers that the health service can only afford X number of us and we should get on with it. We do not accept that and we have never accepted it.

Deputy Bernard J. Durkan: Essentially, my question was to what extent Ms Ní Sheagh-dha was reassured by the increased strength of general nursing staff in the period during which a considerable increase in health staff numbers took place throughout the country. Was she disappointed with the degree to which nursing staff increased or was she pleased that, proportionately, staffing levels in the nursing sector were adequately replenished?

Ms Phil Ní Sheagh-dha: First and foremost, I do not believe that they were increased. We are working with 1,000 fewer nurses than we had in 2007, so they have not increased.

Deputy Bernard J. Durkan: That is not the case.

Ms Phil Ní Sheagh-dha: We also know, for example, in the staff nurse grade, that since last December the increase, if one wants to call it that, was 238. We are still not at the 39,000 we had in 2007. We are more and more reliant on unqualified students to provide services when we know they should not.

Deputy Bernard J. Durkan: Out of the total number of new staff appointed before the moratorium, nursing levels were increased by a proportion. My question was and is whether that was sufficient or if it was lower than required. We believe that it was, but we have not seen the information to back that up.

Ms Phil Ní Sheagh-dha: The HSE's statistics set it out, so the premise that they were increased is incorrect. They were not increased. We are still working with fewer nurses and midwives than we had in 2007, so they have not been increased.

Deputy Bernard J. Durkan: That is not true.

Ms Phil Ní Sheagh-dha: It is.

Deputy Bernard J. Durkan: Deputy Colm Burke has already outlined the total number of extra staff employed by the health services. This is not a criticism of anybody. It is simply an effort to ascertain to what extent the staffing levels of nurses were increased, and whether that was in proportion to the general increase of 20,000 or whatever it was.

Ms Phil Ní Sheagh-dha: Without labouring the point, I have the figures here. The total number of health service staff in January of this year in whole-time equivalents was 119,817. It depends on when one is measuring from. We are measuring from when we had 39,000 nurses. In the nursing category, between January 2019 and January 2020, the difference is 125. That still provides for a total number of nursing staff of 38,205 when we had 39,000 in December 2007, so we have not increased.

Deputy Bernard J. Durkan: I was not asking for a comparison with 2007.

Ms Phil Ní Sheagh-dha: If Deputy Durkan is asking what is the proportionate increase, these are the HSE figures that are on the record: the number of consultants increased during that period by 172 and the number of registrars increased by 183. The biggest increase in the number of nurses was in the student nurse category and there were decreases in other categories. We know, for example, that the increase in the clerical and administrative grades, which my colleagues here represent, was 276. In the higher management grades, it was 309 for the same period that is reported upon. From a nursing point of view, we think that 125 in the staff

nurse category does not come near what is required. It does not even replace those who are on maternity leave. Those who are on maternity leave, for example, make up 3% of the entire workforce because 95% of nurses are women. We know we do not have enough replacements for maternity leave currently. What happens when a nurse is on maternity leave? The remainder work short.

Deputy Bernard J. Durkan: On the concerns expressed about staff in various situations throughout the country being reluctant to report with symptoms on the basis that they might be disadvantaged or that they might have competing needs, does SIPTU have documented evidence to that effect? If so, how widespread was that?

Mr. John King: We do not have documented evidence. We indicated to the HSE and the Department of Public Expenditure and Reform when they introduced that policy that it was wrong and could act as a disincentive. The context, in terms of what was happening in the HSE when that policy was introduced, does not reflect the context today in terms of testing capability and so on. One outcome of that policy and the ease with which people were being sent home and, in many cases, left at home for up to two weeks without being tested if they showed any symptom was that 97% or thereabouts of those sent home were shown not to have any symptoms. In those circumstances, people were financially penalised. The point of telling that particular story in the submission was not to labour that point but to say that policies such as that which serve to act as a disincentive when dealing with an issue like Covid-19 can be counterproductive. For this reason, we argue that such policies should not be in place.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I am struggling with that. It seems to me it would better to be sent home if there was a concern in relation to it. This session has been about concern for infection of healthcare workers.

Deputy Fergus O'Dowd: Fáiltím roimh na finnéithe. Tá jab an-mhaith déanta ag na daoine atá ag obair sa health service an t-am go léir. I have a question about the flu vaccine in preparation for the possibility of an outbreak of flu and the return of Covid-19. Do the witnesses' organisations have a policy on mandatory flu vaccination of all healthcare staff?

Ms Phil Ní Sheaghdha: From the INMO's perspective, we have a policy of promoting the uptake of the vaccine. We have a clear policy on that. The previous Minister for Health, Deputy Harris, sought legal advice, I understand, on the status of a mandatory flu vaccination and we await the publication of that advice because we have not seen it. My understanding is that there is some difficulty with the introduction of mandatory vaccinations and that the legal advice obtained by the Minister set that out. We have not seen it but we have a strong policy of promoting the uptake of flu vaccination. As I said, it is not only that but we have also agreed with the HSE a programme of peer vaccination, which sees our members providing vaccinations to their colleagues in their workplace to ensure the uptake is increased. Dr. Kevin Kelleher has confirmed to us that this approach improved the uptake significantly last year.

Deputy Fergus O'Dowd: What was the uptake last year?

Ms Phil Ní Sheaghdha: It was just over 37% in the grades of nursing and midwifery.

Deputy Fergus O'Dowd: Is that not quite low? I appreciate Ms Ní Sheaghdha's point. I understand the issue of legally challengeable orders and I welcome Ms Ní Sheaghdha's commitment for everyone to get vaccinated.

Ms Phil Ní Sheaghdha: Promotion, yes.

Deputy Fergus O'Dowd: We all need to do more to ensure 100% uptake among those working in a health environment, particularly with vulnerable people and anybody in hospital is vulnerable in one way or another. How can we accelerate uptake, notwithstanding the legal issue Ms Ní Sheaghda raises? I accept her point on legal advice but what can she say on the medical issue?

Ms Phil Ní Sheaghda: There are two things. One is that the statistics we have, and the HSE has accepted this, only reflect those who have been provided with the vaccine in the public sector. As such, we do not know if people go to their GP or get the vaccine elsewhere. It is our view that the figure is much higher than that and if we measure across the healthcare worker grades, public and private, it is higher. The simple point is the flu vaccination is promoted strongly by the INMO and it is our policy to promote it. We have also agreed that to promote uptake our members will participate in ensuring that healthcare staff do not have to travel to get the vaccine and will get it as close to their workplace as possible. That has proven positive.

Deputy Fergus O'Dowd: Research was recently published by the University of Edinburgh on the prevalence of Covid-19 in nursing home environments in particular. It referred to the high footfall of staff, including agency workers, cooks and maintenance engineers, going in and out of the largest homes. This is thought to be a key factor in the infection of elderly residents. I appreciate that Ms Ní Sheaghda represents the nursing profession. Does Ms Ní Sheaghda know if any analysis has been done to show what proportion of the people infected are agency nurses? Is that an important point to make or follow up on?

Ms Phil Ní Sheaghda: There are a number of questions that we have sought answers to from the HSE and that is one of them. We know, for example, that the statistics produced weekly by the Health Protection Surveillance Centre - this only started in the past month because the INMO sought these figures - do not demarcate the numbers beyond the broad categories of "nurse", "healthcare assistant", "doctor", "porter", "other healthcare workers" and "unknown". As such, we have asked for information to allow us to determine where the areas of most risk are. We know now, for example, that 34% of all of the infections are among the nursing grades. We have asked for a breakdown between public and private and also figures on those who are fully equipped with PPE, such as Ms Murphy who worked on a ward with 19 others, all of whom were wearing PPE and 12 of whom contracted Covid-19.

Deputy Fergus O'Dowd: I understand the Ms Ní Sheaghda's point. That is why I raise this research which is, I understand, the first academic research concentrating on the issue. What it found is that in larger care homes - I am not speaking about acute hospitals - the likelihood of infection is 20 times higher than in smaller care homes. As such, my question for Ms Ní Sheaghda is one that concerns me a great deal. It relates to the regulations for care homes and qualified or professional nurses. There is no relationship between the number of dependent or high-dependency residents and the need for professionally qualified nursing staff. That is a serious concern to me. It is unacceptable that there would not be an appropriate and proportionate ratio of high-dependency residents to qualified nursing staff and other qualified persons as well. Does Ms Ní Sheaghda have a view on that?

Ms Phil Ní Sheaghda: We do. It is a very strong view and we have made a number of submissions to Government in respect of it. We need dependency level staffing. We need staffing based on the scientific evidence that determines what is the best outcome for the patient. We have a cost of care model in Ireland. The INMO absolutely rejects it. We also have a real problem with the staffing levels in the private sector where pay rates and collective bargaining for trade unions are not facilitated. We are dealing with many of our members who work in

the private sector who have terms and conditions of employment much different from members in the public sector. They are also trying and struggling to provide the service that is needed because there are not enough of them. It is not unusual to have one nurse for 30 patients. We saw the evidence of that during the pandemic. The ability to provide correct and safe staffing levels does not exist at the moment in the private sector. That is unfortunate. We have called on HIQA to comment on staffing levels on numerous occasions. Right now, we need a Government policy that confirms that staffing levels in the acute sector and in the care of older persons, both public and private, must be based on the dependency levels of the patient. There is a tool for achieving that, which is Government policy. The Government has stated that it will fund it, but we have not seen any evidence in that regard. The funded workforce plan is required and we need engagement with the Departments of Health and Public Expenditure and Reform on it. The Deputy is correct because it needs to be based on science.

Deputy Fergus O'Dowd: I have a relative-in-law who is in a nursing home. He is being looked after extremely well and there is a very good mix of people working there. The problem is that when people are selecting a nursing home, they look for one near where they live and they do not know anything else about it. They go in and sign the contract of care, but there is no mandatory requirement on the nursing home, whether public or private, to say what its staffing levels are or whether there are other ancillary services such as speech therapy, physiotherapy, and so on. One will always find there is a charge of €10 or €20 a week for something that many people cannot avail of because 70% of the people in our nursing homes have dementia. There is a huge lack of transparency about the €60,000 or more that people pay for their care. People say the buildings are fine and they often look lovely, but the quality of care varies significantly.

I welcome Ms Ní Sheaghda's comments and I suggest that if she has other views on the matter that she has not expressed, she should do so and we may include them as recommendations in our report. Until we get that certainty, quality of care and proportionality between qualified staff and medical and nursing need, there will not be proper and adequate care in these institutions.

Ms Phil Ní Sheaghda: We agree wholeheartedly and believe that the private for-profit model is the incorrect one for our older population. We have made submissions to this committee and to the Joint Committee on Health in the previous Dáil on this matter. We raised the 200 beds that were earmarked to be taken out of the public sector last December in the service plan right across the political spectrum, with the HSE and with the Department of Health. The model in this country is to privatise the care of the older person, and that is the wrong model. The State has to provide care for our older population and base the number of nurses, healthcare assistants and other staff on the dependency level of the patient, not the for-profit and the cost of care model, because that model is incorrect.

Deputy Fergus O'Dowd: I totally agree with what Ms Ní Sheaghda is saying. That is the future for good, high-quality healthcare.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank the Deputy. This committee is producing a report on Covid-19 in nursing homes, which will be circulated to members, and we will discuss it in a Microsoft Teams meeting on Thursday. If the witnesses want to make additional contributions on that matter, now is absolutely the time to do so.

I will ask the witnesses a few questions of my own. I return to the issue of preventing people from getting the flu. There is a contradiction in being able to present for work and the risk of Covid-19. What are the witnesses' views on making the flu vaccine mandatory? Ms

Ní Sheaghdha talked about promoting it and she said she thought the real figure was higher than the stated 37%. In what circumstances would a healthcare worker not wish to have the flu vaccine? Is there something that is preventing people from getting it? Is there something we are not aware of that would make it difficult to make it essential, if not mandatory, which has a different regulatory implication?

Ms Phil Ní Sheaghdha: I thank the Acting Chairman for the question. The first issue is whether the health care worker, no more than any other member of society, has an underlying health condition whereby a flu vaccine would be contraindicated.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Will Ms Ní Sheaghdha give an example of this? What underlying conditions?

Ms Phil Ní Sheaghdha: That would depend on the underlying health condition. From our perspective, we are very clear on this. We promote the uptake of the vaccine to the healthcare workers we represent.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Ms Ní Sheaghdha. She did say that. I will be more specific in my question, if she does not mind, to help me with my own understanding. Will Ms Ní Sheaghdha name one or two conditions that are contraindications? Is diabetes a contraindication? Will Ms Ní Sheaghdha name one or two conditions where there is a contraindication with the flu vaccine?

Ms Phil Ní Sheaghdha: My understanding is that it is allergy based and it depends on the particular allergy and on the vaccine produced. As my colleague from Fórsa said earlier, the vaccine this year is slightly different to the vaccine last year. This is a constant matter that people must discuss with their GPs. The point is that my view, and the view of the union representing nurses and midwives, is that healthcare workers, nurses and midwives are encouraged to get the vaccine. It is promoted. They go further than this because they also contribute to the uptake by ensuring other healthcare workers can have the vaccine in their place of work and we provide this to them.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I fully understand and respect that. I am just trying to understand how the list of contraindications is communicated on an annual basis, how clear it is and what those barriers are. I totally respect there are some barriers for some people. Of course, the issue is that a healthcare worker who gets the flu will be deemed, I assume, to be at risk of having Covid-19 given the overlap of the symptoms. We have discussed today the risk of infection of Covid-19 for healthcare workers, and we have also discussed with Mr. King people staying home for various reasons or being required to self-isolate, and there is a clear overlap. What can we do additionally this year to try to ensure people get the flu vaccine?

Ms Phil Ní Sheaghdha: The HSE has done a good job in promoting the vaccine. We would encourage an escalation of this, have it done earlier and more broadly, and educate people about the nature of the vaccine and the type of vaccine it is. There is huge concern among the population, and we hear it every year, about vaccines in general. We do not subscribe to this. Our members who work as public health nurses are on the front line of providing childhood immunisation and meningococcal vaccinations. We promote vaccines. We believe the health service must give correct information and contradict, perhaps, the information out there that is not based on science.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I agree completely with Ms Ní Sheaghda on this.

Mr. John King: I do not want to be repetitive but just to say the responses given by our colleague, Ms Ní Sheaghda, on the work all of the unions do to encourage the uptake of the flu vaccination is also something we promote and advocate in SIPTU.

Acting Chairman (Deputy Jennifer Carroll MacNeill): That is great.

Mr. John King: With regard to the specific question raised by the Acting Chairman on the flu vaccination in the context of a second surge of Covid-19, we intend and hope to have intensive engagement with the HSE on this.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank the witnesses.

To go back to some of the data from the HPSC, it may have been helpful to set out very clearly at the outset that we have all been using the same data from 11 July. Of the 26,076 Covid cases, 8,347, or 32%, were healthcare workers, with 319 hospitalised, 49 admitted to ICU and, very tragically, seven deaths. We are agreed that 30% of the cases were in nursing homes, residential institutions and community hospital long-stay units. We are all working from the same figures. Only 8.6% of cases are linked to an outbreak in a hospital. I wanted to set out these figures. In another submission, we have information that the difference between hospitals and the other settings is likely due to more robust supply chains for PPE in hospitals. I am very sensitive to the presence today of Ms Murphy who, along with her colleagues, was using PPE but contracted Covid-19 at some point. She said that 12 out of 19 of her colleagues contracted it in circumstances where they had been using PPE in a hospital. I want to ask a policy question and perhaps come back to Ms Murphy afterwards. We have separate data which show that 56% of our nursing homes have no cases of Covid-19. Can we talk about those congregated settings or those intensely populated settings? We also have the prisons and the Central Mental Hospital where there have been no cases. Has any of the unions received feedback from members in other settings about how they managed those protection processes better or was it something else?

Ms Phil Ní Sheaghda: I have been in direct contact with the Prison Service. I said at the last presentation to this committee it is to be commended in respect of that fact the prison population was protected to such a degree. That is not an accident. That is a policy where temperatures are taken and where all the precautions prior to attending work are to ensure one is not in any way symptomatic.

In the health service, by contrast, the big issue we had was with the derogation of staff who were asymptomatic but had been notified as close contacts. A person could get a phone call to say he or she is a close contact and should self-isolate for 14 days. That person could then get a call to say we are very short-staffed and he or she must come in. If the person is asked if he or she has a temperature and says “No” they are asked to come back to work. That flies in the face of the public health advice. We have sought the removal of that policy. That policy is still there and no healthcare worker should be derogated by a manager to return to work because they are short-staffed even though they have been a close contact and have not had a test. It is simply wrong.

Acting Chairman (Deputy Jennifer Carroll MacNeill): How long is it taking at the moment for healthcare workers to get results of test? Are they all back at this stage within 24 hours for healthcare workers?

Ms Phil Ní Sheaghda: It is much quicker. It has improved significantly but again, it depends on where one resides and where one has the test. In general terms it is very quick.

Acting Chairman (Deputy Jennifer Carroll MacNeill): Ms Ní Sheaghda mentioned that Cherry Orchard Hospital had a laboratory playing a positive role. Are all the acute hospital laboratories being used in this way? Is there any update on that?

Ms Phil Ní Sheaghda: All of the laboratories facilities are working flat out. My colleagues in SIPTU might be able to give the Deputy a better indication as they represent the laboratory staff.

Mr. John King: In all fairness, that is correct. All of the laboratory facilities are working flat out. As Ms Ní Sheaghda said, and as is evidenced in some of the contributions we received back from our own members, the situation as it is today is much improved from what existed at the outset.

Acting Chairman (Deputy Jennifer Carroll MacNeill): This may be a question better targeted at the HSE at the second session this afternoon but I will elicit an opinion from Ms Ní Sheaghda's own perspective. At this stage, have all the student nurses who will qualify this year been offered full-time positions that are not via agencies? Have other healthcare professionals like physiotherapists, occupational therapists and all those who are coming out of universities this year been offered positions?

Ms Phil Ní Sheaghda: We have an agreement that they will be offered positions but it is still a process that has not been completed. The important thing for the student nurse population is that, from our survey, many of them were traumatised by the experience of going through Covid-19 without supports. We really must make sure they do not leave the profession before they qualify. That is my aim right now. We are trying to get the HSE to understand it must support the student nurses who are in training because 1,700 of them are graduating this year and we need every single one of them to remain in the public health service.

We are short of our colleagues who come and help us every year from the Philippines and India. We have a reduction in the number of registrations which I presented at the last committee. The Nursing and Midwifery Board of Ireland, NMBI, figures show we are quite significantly reduced from this time last year. Every year the health service and private and public sector relies on overseas recruitment to supplement our workforce. We need to make sure that when they qualify our students are protected, supported and have permanent jobs.

Acting Chairman (Deputy Jennifer Carroll MacNeill): We are learning more and more every week and we had Dr. David Nabarro back here some weeks ago talking about the long-term implications of having had and recovered from Covid-19. He has recovered loosely because one of the ongoing features is long-term fatigue. Ms Murphy alluded to that initially and I may come back to it. From a policy perspective, does Ms Ní Sheaghda feel there is a need now to review the work rosters or structures so the 12-hour shift arrangement recognises the ongoing nature of fatigue in this illness?

Ms Phil Ní Sheaghda: What is required are frequent breaks within the roster and that is what the WHO tell us. We need frequent breaks. Ms Murphy is better able to describe this than I am. What is required is that when someone is working and wearing PPE, he or she should be frequently relieved to hydrate and get a break from wearing it. Those committee members who have experienced wearing masks for the first time will understand that it is not very comfortable

and one feels quite restricted. They can imagine what it is like wearing PPE for four hours and then being relieved for a break. The break period is the important point.

Acting Chairman (Deputy Jennifer Carroll MacNeill): As a simple example, I have had to take three breaks from wearing my mask to have some water. I totally respect what Ms Ní Sheaghdha is saying. I will deliberately put policy aside as I come to Ms Murphy. I am last with questions, and that is why I have left what I want to say until the end of this session.

The committee has had 16 public sessions and it is my understanding and that of the secretariat that Ms Murphy is the first person to come before the committee who has survived and recovered from Covid-19. It is remarkable that it has taken this long for us to speak to somebody who has had Covid-19. I thank her for coming before the committee. I do not want to ask her overly personal questions about her experience of the illness, but I recognise that her colleagues, including people she knows well, have had similar experiences.

For the benefit of the committee, the record of the House and those who may be watching and thinking about their movements and interactions with other people, I ask Ms Murphy to give us a sense of her general experience, and that of her colleagues to whom she has spoken, of having the illness.

Ms Siobhán Murphy: I thank the committee for giving me the opportunity to be here today and to share my experience. I am sure what I will say today will resonate with a lot of nurses across the country. I hope I will have made some impact on how we can improve the service if, God forbid, there is a second surge.

We went from being a 31-bed surgical ward to a Covid-positive only ward overnight. Only Covid-positive patients were admitted to our ward. We took on the task of the full multidisciplinary team as it did its remote reviews of patients. We were on the ward, at bedsides, 24 hours a day. It was an honour to care for patients. We love our job; that is why we are there. We bridged communications between patients and families using iPads, something we never had to do previously. The list is extensive; I could go on and on.

I will discuss the biggest change for me and my colleagues who contracted Covid-19. I contracted Covid on 30 April, six weeks after we became a Covid ward. I became a statistic when I tested positive for Covid-19. Initially, I was upset and quite angry, and that was the experience of my colleagues across the board. As I said, I followed hospital protocol and was competent in the use of PPE, but the emotions I initially felt were buried by the physical impact of Covid-19. I was crippled with fatigue, bed bound with headaches and had extreme shortness of breath, which caused great distress as I felt like I was suffocating. Many of my colleagues had the same symptoms.

I could not talk to my family or friends over the phone. I was in complete isolation. I lost my sense of taste and smell. Simple tasks such as washing and dressing or making a snack for myself were unachievable as I was completely debilitated. I presented to the emergency department about a week later because I was deteriorating at home. I was terrified. I have no underlying conditions, as I said, so it was a huge shock for me to be a patient in the emergency department in the hospital that I work in.

I was subsequently admitted for what I thought would be one or two nights' observation, but I was kept in for a week. I had a series of blood tests. I underwent a chest X-ray and a CT scan of my lungs, kidneys and other organs to rule out any damage that can be caused by Covid-19.

As I said, there is no pattern. I was on a heart monitor 24 hours a day for six days because my heart rate increased to 170 bpm. Medical staff told me this was one of the post-viral effects of the illness. I was negative for coronavirus at that stage but still had post-viral effects. The normal heart rate would be 60 to 80 beats per minute. I was on intravenous fluids to rehydrate me and received daily injections to ensure that I did not develop a blood clot which my experience as a nurse tells me can be potentially fatal. That was a worry.

The days and nights were extremely long in isolation. My concentration was massively affected and I was unable to pay any attention to a television that was playing in the background. I was relieved to get home about a week after I was admitted. Recovering in isolation is challenging both physically and mentally, as I have stated. I was unprepared for the psychological impact of contracting and living with Covid-19. It has definitely prolonged my road to recovery but I know I will get there and, hopefully, go back to work with my health at 100%.

For the first time, I experienced acute anxiety and panic attacks. I have ongoing insomnia. I can sleep for eight hours some nights but others I only sleep two to three hours, and I do not know why. I had vivid hallucinations at the start, as did some of my colleagues. That is not spoken about as a side effect. Everybody tends to speak about the physical signs and symptoms but the psychological effects, as I have said, are just as detrimental to recovery.

Twelve weeks on, I still have not returned to my pre-Covid health and still experience some fatigue. I will be fine one day and have to take an afternoon nap the next. Shortness of breath comes and goes. I am awaiting a lung function test to rule out a lasting impact from Covid. I am also very lucky that I have had physiotherapy input. I liaise with the hospital physiotherapy service to regain my strength and that will help to get me back to work eventually.

Acting Chairman (Deputy Jennifer Carroll MacNeill): I thank Ms Murphy for outlining that for us; the committee really appreciates it. It is probably appropriate to leave it there for this session. I again thank Ms Murphy and all the witnesses.

Sitting suspended at 12.22 p.m. and resumed at 12.47 p.m.

Covid-19: Infection Rate among Healthcare Workers (Resumed)

Deputy Michael McNamara took the Chair.

Chairman: I welcome the witnesses from the HSE. I thank Mr. Woods for coming back so soon after being here last week. I also thank his colleagues from the HSE, including those from the Health Protection Surveillance Centre, HPSC.

I advise all witnesses that by virtue of section 17(2)(l) of the Defamation Act 2009, they 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 do so, 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 ask Mr. Woods to introduce his colleagues from the HSE and to briefly outline the key

points of his submission to the committee, which has been circulated to all members.

Mr. Liam Woods: I thank the Chairman. My colleague, Dr. Kelleher, will do that. I note the Chairman's comments about the submission of the statement.

Dr. Kevin Kelleher: I will quickly introduce the people around the table. They are: Mr. Liam Woods, national director of acute hospitals; Dr. Lynda Sisson, chief occupational physician, who works in the HR department as well as carrying out clinical work; Ms Anne Marie Hoey, national director of HR; Dr. John Cuddihy, director of the HPSC; and Dr. Lorraine Doherty, national clinical director for health protection.

As Mr. Woods and the Chairman said, the committee has received our submission, so we will not make any comments on it. I will, however, make a few opening comments. As an organisation, we take very seriously our responsibility to safeguard all our staff and all our patient clientele. That is a fundamental aspect of our role as an organisation. Clearly, the people around this table are intimately involved in that.

We cannot express our gratitude to, and pride in, all the staff in the health system and those who have joined from outside for how they have performed over recent months. They have worked way beyond what anybody could have expected. They have put in days and weeks of immense work in dealing with this problem for the people of Ireland. As members will be aware, we have come out of it fairly well compared with a number of other countries. Our number of cases is proportionately much lower than in other places. Somebody told me today that Idaho in the US, which has a population of 1.5 million, is seeing 1,000 cases a day. At the moment, they are seeing 1,000 cases a day, which would be the equivalent of 3,000 to 4,000 cases a day here. We never went anywhere near that sort of number. We are immensely proud of the ICU nurses, the doctors in emergency departments, the doctor and nurses in primary care and the people who have moved from their jobs to work in other roles as part of the response. They have made immense contributions. Finally, I thank the public health staff, who have been going since very early in January and are still going at this quite hard, and especially our colleagues here in Dublin, which has been the main centre of it, so it has hit hardest on people in Dublin. We are very proud of everybody and we aim, as ever, to try and help them to work in whatever way we can. We are ready to take questions.

Chairman: I thank Dr. Kelleher very much. The first member to speak is Deputy O'Dowd.

Deputy Fergus O'Dowd: I welcome the witnesses. I agree fully with Dr. Kelleher's tribute to his staff and all those who worked to save so many lives. The tragedy is, notwithstanding that, families are deeply suffering and in pain right now.

I have a couple of questions arising from the briefing note we received from Mr. Ray Mitchell in the HSE on testing for contacts of confirmed cases. We are told that 1,314 people did not attend the day zero and day seven tests. They were contacts of confirmed cases. What is the response to that? The figure seems very high to me.

Dr. Kevin Kelleher: I will say a few words and either Dr. Doherty or Dr. Cuddihy will add to it. We recognise that this is a major issue for us. There is a difference between how many people take the test on day zero and day seven. Some of that may be a consequence of the test itself, but it is an issue we need to address. Dr. Doherty has been doing some work in this regard.

Dr. Lorraine Doherty: We had a discussion about this in the HSE just this morning. I thank

Deputy O'Dowd for his question. It is a very important issue. We too are concerned about this because it shows that perhaps people are becoming a bit disengaged with the idea of having a Covid test if they are symptomatic, or if they are a contact, because they understand the implications of having a test on day zero and again on day seven and the need to restrict their movements. In particular, people in the workplace may be reluctant to be tested. What I need to emphasise is that our public messaging is very strong on the need to have a test if a person is symptomatic and also if one is a contact of somebody who is symptomatic.

Deputy Fergus O'Dowd: Of the 2,900 people who were confirmed positive, it is very serious that 1,300 of their contacts did not turn up for their tests. Notwithstanding Dr. Doherty's reply, we need to interrogate the situation more and learn more about the status of those people, if there is an age profile and whether there was a cluster of cases. We need to know more. I do not doubt her intention to find out more but I am most concerned. It is very serious if we not do turn up when we are a contact of a confirmed case. In theory, we could have it and pass it on to many more people. I say that notwithstanding all the good work Dr. Doherty is doing. How does she intend to follow this up? Can she get more data? Should it be a mandatory requirement for a person to turn up for a test if he or she is called? One is protecting other people if one does attend and one is not protecting them if one does not.

Dr. Kevin Kelleher: I agree with what Deputy O'Dowd said and thank him for his support in saying it, because it is very important. We need to look at how we do this. I will hand over to Dr. Doherty to continue.

Dr. Lorraine Doherty: I reassure the committee that we do not take this lightly at all. We make every effort possible to find people who are not answering phones who we have not been able to get to come for the test. The initial contact is made within the contact tracing centres. At least four or five attempts are made to contact people. Where there is an inability to do so, their details are passed to the local public health department, which might have local knowledge on how to find the contacts. We put a lot of time and effort into trying to find them.

Regarding the data, as I said this morning, we have been looking at these data and we intend to do further analysis on them and to look at what factors might be influencing the reluctance to come to testing and whether there is a particular demographic that is not turning up for testing.

Deputy Fergus O'Dowd: It is a very high figure. It is a huge figure and the witnesses need to do more work on it. This may mean the Garda calling, because these people are known with known addresses. The Garda should call and ask them, in the interests of public health, to turn up.

The second question I have relates to the uptake of the flu vaccine, as well as to the certainty of the return of flu and the probable return of Covid-19. From my reading of what the witnesses gave us, the rate of take-up in the HSE is 44%, which is far too low. In other words, if less than half of the workers in acute hospitals and healthcare settings are taking the vaccine, that puts everybody at serious risk, including themselves. What steps does the HSE propose to change that figure significantly?

Dr. Kevin Kelleher: I will speak on the figures and then Dr. Doherty and Dr. Sisson will come in on the healthcare workers.

We have not got the final figures for last year because Covid impeded us from doing it but our understanding is we will be close to 60% of people in the acute sector taking the vaccine.

It is likely that in the long-term care facilities, the figure will be in the high 40s or around 50%. These are significant increases from over the years. Likewise, we know the uptake among the elderly over-65s is 68% and of people in residential care facilities it is around 90%. The figures have been rising over a number of years. We will put a big effort into what needs to happen this year. We have taken major steps to change what we will do in the coming year compared to what we did in previous years in respect of to whom we offer the vaccine and how we do it.

Dr. Lorraine Doherty: I will start with a general comment and then hand over to my colleague, Dr. Sisson. The issue of flu immunisation among healthcare workers is a worldwide challenge. We know that, for some reason, there have been healthcare workers who have been reluctant in the past to avail of the free flu vaccine. I should make clear that enough vaccine has been procured and is available to immunise all our healthcare workers. All healthcare workers receive the offer of influenza vaccine and it is offered in the workplace to facilitate their access. It is an important part of our overall strategy for prevention of infection this winter to make sure that healthcare workers avail of the free flu vaccine. I will pass over to my colleague, Dr. Lynda Sisson, who will update the committee on some of the more specific measures we will take.

Dr. Lynda Sisson: I thank the Deputy. We are actively looking at the flu season coming up and we will start vaccinating on 20 September. I will outline two of the main drivers in increasing flu vaccine, the first of which is to increase the availability of the vaccine. The second concerns increasing the education and communication around it. In terms of increasing availability, we have an enormous peer vaccinator programme in the HSE, which has allowed other nurses in local areas to provide the vaccination to their peers. This year we will include paramedics and pharmacists and we may also include some of the allied health professionals. We will increase the number of peer vaccinators that are available on site to give the vaccine to staff in their local area. In previous years, that has really increased the number of people who have taken up the vaccine. In addition, we are looking to see if we can get healthcare workers vaccinated in their local GPs and pharmacies free of charge and that will hopefully be an option for us in September. Educating healthcare workers is an ongoing thing. We have developed HSe-LanD modules and we have a number of communications. We have a number of areas where we try to break down some of the myths about the flu vaccine and we have been working hard on that. The next step is to start looking at risk-assessing front-line workers and requiring them as part of a risk assessment to partake of the vaccine. That is something that we are exploring at the moment and it is something that has been very successful in increasing flu vaccine uptake in Australia. We may be developing a model on that for this year because, as the committee knows, it will be critical for our healthcare workers to be vaccinated this year, especially-----

Deputy Fergus O'Dowd: I hear everything Dr. Sisson is saying but I am not hearing enough about outcomes. If we have an outbreak of Covid-19 again in the autumn, coupled with the flu, it will be an appalling vista in our hospitals and especially our accident and emergency departments. The HSE perhaps needs to consult with all of us, the Oireachtas, the Government and everybody to ensure that there is a huge campaign. We are going to have to insist that people receive it because if people are working in a hospital environment or with older people they will place them at risk if they do not take the vaccine, notwithstanding exceptions on medical grounds. The HSE needs a much tougher, more resourced and more focused campaign.

Chairman: I have a quick question supplementary to those from Deputy O'Dowd.

Dr. Doherty was saying that the HPSC is looking at those who are not presenting for testing to see if there is any particular demographic. Has it ascertained that there is any such demographic, as of now?

Dr. Lorraine Doherty: We do know that there has been a change in the epidemiology which my colleague Dr. Cuddihy has much more information on. We are now seeing more infections in younger people-----

Chairman: I was referring to people who are not presenting themselves for testing, the people who are not showing up to be tested.

Dr. Lorraine Doherty: I do not have that information Chairman but I am happy to get it for the Chairman and present it at a future meeting.

Chairman: If there is any such information it would be interesting.

Deputy Cullinane has ten minutes.

Deputy David Cullinane: I welcome all of our witnesses and wish them the very best in their work over the next while as they battle with this virus and all of the other health issues that must be tackled.

I wish to begin with Mr. Woods. I do not know if he has read the submissions that the committee received from the healthcare trade unions who were present this morning. The INMO's submission was very extensive and in fact made a lot of good recommendations. One of the things that jumps out of their submission is the very high levels of front-line staff in this State, especially nurses, who contracted Covid-19. It seems to be very high in comparison to Europe and globally as well. Can Mr. Woods explain first of all why so many front-line workers in this State contracted Covid-19 in comparison to other states?

Mr. Liam Woods: We do not get to see the opening statements until after they have been taken at the committee but I look forward to seeing them. I did however hear some of the commentary this morning. Dr. Cuddihy from the HPSC has knowledge in this area and he might address the Deputy's question.

Dr. John Cuddihy: The first thing to say is that in Ireland we have a very broad definition of healthcare worker. It encompasses anyone who works in healthcare, either public and private. In other European countries this is often much more specific, sometimes down to doctors and nurses but in some cases healthcare staff who work in the front line. Second, from the outset of this pandemic in Ireland healthcare workers have been prioritised for testing. Even when availability of testing may not have been as good as it is now, healthcare workers were prioritised so more healthcare workers were tested as a result. Third, even in the course of this pandemic when the number of cases were low, healthcare workers in hospitals and residential care facilities continued to care for patients with Covid-19 so their risk of-----

Deputy David Cullinane: I apologise to Dr. Cuddihy. Notwithstanding that we may not be comparing like with like, he must accept that there were very high levels of infection among healthcare workers in this State. Leaving aside the differences in comparisons, it is very high in European terms. I asked why the rate was so high for front-line workers in Ireland, leaving aside other variations that may not be fair. Even building them in, it is still very high. Why is that?

Dr. John Cuddihy: The Deputy said that the rate is high in comparison with other European countries. I was just explaining that our definitions of healthcare workers are quite different to those of other countries. Similarly, we have very much prioritised healthcare workers in this country. The other factors regarding levels of infection in healthcare workers relate to their risk

of exposure as described even when cases are low, but also the nature of their work. Where they work and where they live may put them in close proximity to other healthcare workers. I will ask Dr. Sisson-----

Deputy David Cullinane: I will ask a follow-up question. We heard very strong testimony from the trade unions this morning. One issue that came across was the directive given to front-line workers not to wear masks. The INMO said that at least one member of staff was disciplined for wearing a mask and that was a huge concern. Why was that decision made and that directive given to nurses and front-line staff not to wear masks in the early stages of the pandemic? Did that decision have an impact on the higher levels of contraction of the virus among healthcare workers?

Dr. Lynda Sisson: I will take that question. We have had an opportunity to look back at the possible causes of transmission for some 2,000 cases. There is no doubt that in the very early stages, undetected cases in the hospitals contributed to huge numbers of infection in healthcare workers. The other thing we have noticed was the inability to practice social distancing, or a lack of awareness around it, in hospitals at the very beginning. Some of our hospitals do not lend themselves to physical distancing.

The decision on masks was made by NPHET and we did not recommend mask-wearing at the very beginning. However, as PPE became more available, mask-wearing was commenced. The differences between the earliest stages and later stages were largely due to the Covid and non-Covid pathways in the hospitals, the earlier detection of cases, the implementation of social distancing and the closing of the canteens. The other issue, to which we alluded earlier, is the change in the culture of healthcare workers coming to work when they were sick. That was one of the big challenges for us because healthcare workers traditionally show up to work with symptoms.

Deputy David Cullinane: Basically, Dr. Sisson is saying that the decision to advise healthcare workers not to wear masks in the early stages was taken by NPHET and not the HSE. Is that what she is saying?

Dr. Lynda Sisson: Yes.

Deputy David Cullinane: Okay. I will move on-----

Dr. Kevin Kelleher: Can I say something on that point?

Deputy David Cullinane: I have many questions to ask and I only have a few minutes.

Dr. Kevin Kelleher: Advice from March clearly indicates that staff should wear masks in the appropriate circumstances as dictated at that time. It very clearly indicated they should wear masks when dealing with people who might have an infectious disease like Covid.

Deputy David Cullinane: The advice changed.

Dr. Kevin Kelleher: No, that was our advice in March.

Deputy David Cullinane: What I am putting to the witnesses is what was said to us this morning by the trade unions that represent those staff. They said that their staff were told not to wear masks and that in a number of incidences, members of staff were disciplined for doing so. We can argue about the timeframes but what we have heard from the previous witness is that a decision was made by NPHET whereby it was not the case that front-line staff should wear

masks. That advice was changed, we all accept that, but I am trying to get an answer as to why that decision was made. That has been dealt with.

I want to move on to the next issue because it is an important one. I ask Mr. Woods to answer this question. A survey was conducted by the INMO of the impact Covid has had on front-line staff. Much of that impact relates to fatigue, while some of them experienced nausea, breathing and respiratory problems and headaches. Mental health was also a huge issue. The term used by the representative from the INMO was “post-traumatic stress”, which is a big challenge for those front-line workers. What practical supports are being considered by the HSE and the Department to support all those front-line workers who went through a huge trauma while trying to deal with this virus? In some cases, they watched people die, saw their colleagues contract the virus and worried about contracting, or did contract, the virus themselves. For those who did contract it, and all of the stresses they are now under, what practical supports is the HSE looking to put in place?

Mr. Liam Woods: I thank the Deputy for the question. I heard Ms Murphy’s evidence this morning as she related her personal story to the committee. This is Dr. Sisson’s area of expertise so I will pass it to her because it is an occupational health matter.

Dr. Lynda Sisson: Levels of psychological supports were in place from the very beginning. We have five levels of support for staff. We have general information and communication, self-help supports and peer supports up to professional supports and, if necessary, escalation to mental health services. These have been in place for staff from the very beginning and they remain in place.

Deputy David Cullinane: If Dr. Sisson and Mr. Woods read the submissions the trade unions made to the committee, they will see they are calling for the HSA to have a much greater role in occupational health issues in healthcare settings. They should examine this and support the recommendations they have made.

My final question for Mr. Woods goes back to a discussion we had earlier this week. All unions were very strong on the need for additional capacity in acute beds, rehabilitative care beds and more physical infrastructure, and retaining the capacity we have. When will the HSE publish a comprehensive plan on increasing overall capacity in our system? We all know we face a major challenge in dealing with Covid care, non-Covid care, all the infection-control measures, public health guidelines and the need for catch-up programmes. We have the winter flu coming at us. We have the potential of an increase in Covid if it happens. It is a perfect storm that requires a plan. Will Mr. Woods explain to us when we will see the bones of this plan that will outline all the additional capacity that will be put in place to make sure we can at least keep up, if not catch up, with all of the missed care?

Mr. Liam Woods: I thank the Deputy. We are preparing our winter plan in the consciousness of Covid. One of the witnesses this morning summed it up very well by saying the system needs more staff, equipment and space. This is precisely what we are looking to optimise as we move into winter. We are also looking at how and where care is provided. With regard to the Deputy’s question on when, there is a process within the HSE that subsequently will involve the Minister. The question of the timing of publication of such a plan is a question that is ahead of us but we are doing it now and we expect we will conclude it within the coming weeks.

Chairman: The next slot is Fianna Fáil and Deputy McAuliffe is going first.

Deputy Paul McAuliffe: By agreement with the Chair, 20 minutes have been allocated but we propose to take-----

Chairman: Yes, that was an error. It will be two ten-minute slots.

Deputy Paul McAuliffe: I propose to take five minutes, as will Deputy Devlin, with the latter ten minutes towards the end.

I want to come back to the testimony Ms Murphy gave this morning. While she was making her own case, she was speaking on behalf of many nurses about the mental health impact and post-traumatic stress of experiencing exceptional circumstances, which, nonetheless, have left many healthcare workers with a trauma. The experience she outlined seemed to indicate the HSE was relying very heavily on very low levels of intervention, including the use of an app and peer support. Will Dr. Sisson elaborate on the supports available? The HSE seems to indicate there is sufficient support but the INMO clearly stated through personal experiences that there is not.

Dr. Lynda Sisson: I thank the Deputy. We have a model of internal and external care for staff counselling in the HSE that is well established. Employees have a choice of going to somebody in their own area or accessing an external service. This service is, as I said, completely free and can range from group to individual interventions. Staff who become unwell can also go to occupational health and, if they need additional mental health services, including specialist mental health services, they can be referred to those services. We have specialist psychiatrists who deal with post-traumatic stress disorder and we have a range of supports from an app to specialist mental health services for staff.

Deputy Paul McAuliffe: Dr. Sisson is saying that every staff member has access to the sort of external debriefing that the INMO said in the previous session was not available.

Dr. Lynda Sisson: Yes.

Deputy Paul McAuliffe: If that is the case, then there is clearly an issue. Those who are representing the workers and the workers themselves do not believe that is available and she is saying that it is. That means there has been a failure to communicate the availability of those services to people. I imagine, given that they are in a state of trauma and are going through a mental health crisis, there is an obligation on the HSE to ensure that communication is correct.

Dr. Kevin Kelleher: We accept that fully and we will take that information back with us. It has to be recognised that two separate things are happening. One is what the Deputy has described, that is, how people have had to cope with the work impact and everything else. Separate to that is the fact that this virus, like all viruses, has its own longer-term impact on people. We have to be careful about trying to make sure that we deal with both of those issues because they are both very important.

All viruses have longer term sequelae that we need to be clear about, and we have to learn about coronavirus and its longer-term sequelae. We are trying to do both of those things at this point. We will take on board what has been said because we want to make sure that staff get access to the appropriate advice. I am not sure I want to keep using the term “post-traumatic syndrome”, but that, along with the longer-term impact of the virus, are the issues facing staff in reality.

Deputy Paul McAuliffe: I thank Dr. Kelleher. As I said earlier, the world was catapulted

into this scenario. There was clearly a lack of preparedness, not by design although there were systematic shortfalls. We struggled to keep up with what was an unexpected pandemic. There will be additional waves. We will not be able to rely on the same response and will have to be more prepared.

The figures for healthcare workers are interesting. The HPSC mentioned 32% of the 8,219 cases. A figure of 48% for phase 2 has been mentioned by Mr. Mark Roe, a postdoctoral researcher in UCD. A figure of 58% for the health service east region has been mentioned in respect of health care workers who have been impacted. I accept there are different definitions. What are we doing at this point to ensure that the level of infection is reduced in any future localised outbreak?

Dr. Kevin Kelleher: We are under time pressure. The overall approach to infection prevention and control includes organisational and individual approaches. It is very much about ensuring that people undertake all of our advice on infection prevention and control and that PPE is used, as appropriate in the circumstances, to protect patients and healthcare workers. That is what we have learned. As a consequence of where we have come from to where we are now, we are beginning to see that it is having some impact, but it needs to be reinforced in all circumstances and that is what we accept we need to do if we have to deal with another wave.

Chairman: I thank Dr. Kelleher and Deputy McAuliffe.

Deputy Cormac Devlin: I thank the witnesses for being here today and answering our questions. I only have five minutes and I will be brief. I hope the responses will also be accurate and brief.

Deputy McAuliffe referred to the testing available to healthcare workers. I am conscious that we need to be prepared for a second wave if it comes. I refer to the supply chain for PPE, in particular the roll-out in the early stages of the first phase of the pandemic to public hospitals and private settings. What assurances can the witnesses give that sufficient stock exists and that PPE will be rolled out to the various community and public health settings?

Dr. Kevin Kelleher: There is very clear advice, led by our national infection prevention control teams, about what PPE is appropriate in what circumstances. As a consequence, we have been seeking to source that PPE. Mr. Woods will take that matter up in more detail.

Mr. Liam Woods: The HSE has built, and is building, significant stock reserves. As the Deputy has referenced, that is sensible as we approach winter and our stock requirements are likely to rise. We have a significant distribution network through our logistics function which is part of procurement. That network is supplying hospitals, communities and other healthcare providers with high volumes of PPE, well beyond anything we have experienced previously.

Our supply chain and its sources are bringing in an adequate supply at the moment. While there is a global market and there have been problems in accessing PPE, right now the HSE is sourcing a sufficient supply. We have good contracts, are building stocks and have good distribution. Of course, we must keep a close watch on that in the coming weeks as we move towards winter.

Deputy Cormac Devlin: I thank Mr. Woods for that. It brings me to my next point, which is the potential loss of step-down and convalescent services that will be acutely needed, particularly in the winter months. These types of services are needed and it is essential that we do not lose them. We need them in order that patients can leave acute hospital settings and conva-

lesce elsewhere. From a public health point of view, having an alternative venue for people to quarantine or have respite is desirable. What interactions does the HSE currently have about securing and maintaining those services?

We heard about the funded workforce plan from union representatives during our first session today. I understand that is currently being discussed. What information can our guests give us about that matter?

Mr. Liam Woods: Can I get specifics from the Deputy on the step-down arrangements to which he is referring?

Deputy Cormac Devlin: Does Mr. Woods mean the question I asked about convalescence?

Mr. Liam Woods: Yes.

Deputy Cormac Devlin: I represent the Dún Laoghaire constituency and there are a number of such settings. Caritas Convalescent Centre, in particular, was in the newspapers last week. While it is a private setting and decisions are made independently of the HSE, it would remiss of the State not to have access to those facilities. We must ensure that no other closures will happen because we will need those settings in the next few months.

Mr. Liam Woods: I agree with the Deputy. I will not address the specific instance he mentioned, but it is our intention to maintain and grow capacity. As the Deputy has said, the step down from acute services is the key to enabling us to have effective flow through the service and there are specific proposals on expanding rehabilitation services to allow for a step-down process for Covid-19 patients. Specific work is going on in that regard.

We are also looking at expansion and have invested in expanding the capacity of community sites in the past couple of months. Our winter planning will also include the provision of as much care as possible at home and effective use of community assessment centres.

The Deputy asked a specific question about the funded workforce plan, which I might ask Ms Hoey from human resources to address.

Ms Anne Marie Hoey: It is fair to say that in recent months, we have grown our workforce through a number of means in response to Covid, including direct recruitment, redeployment, increasing the numbers of staff on part-time hours, rehiring retirees with specific skills and so on. We have also targeted recruitment through specific groups. Student nurses have been employed as healthcare assistants. Medical laboratory scientists have been employed in their sphere, as have radiography graduates.

We have seen an increase in employment over the past number of months. As of the end of June, employment had increased by just over 4,500 staff members. We are continuing various initiatives to address our recruitment requirements as we plan for winter and the Covid environment.

Deputy Róisín Shortall: I thank our visitors for their presentations. My first question goes back to the issue of the flu vaccine. I would like to ask Dr. Sisson a few questions in that regard. I commend the work being done to improve the uptake of the vaccine among healthcare workers. It is really important that we boost this year's figure in comparison with those in recent years. I also note that last week the European Commission advised member states to start their vaccination programmes earlier than normal because of the Covid threat. Has that impacted the

HSE's proposed timescale? That is the first question.

My second question relates to additional orders for vaccines. We heard last Friday that an additional 200,000 vaccines had been ordered. This seems to be quite a small addition given the need to substantially increase uptake. What is Dr. Sisson's view on that?

While I welcome the extension of free vaccination and vaccine availability through GPs, is it intended to extend these measures to pharmacies? Those are my three questions.

Dr. Kevin Kelleher: I thank the Deputy. I will start and then Dr. Sisson will provide further detail. We are ordering close to 2 million vaccines for the coming year. This comprises 1.4 million doses for the groups we usually target, which is an increase on previous years, and an additional 600,000 for the campaign to vaccinate children. This is a crucial part of the overall process.

Deputy Róisín Shortall: My question was whether the HSE is of the view that the order for 200,000 additional vaccines for adults is adequate.

Dr. Kevin Kelleher: Our calculations indicate that approximately 1.4 million to 1.5 million will require the vaccine as per our guidance from the national immunisation advisory committee. This includes those over 65 and those under 65 who have medical conditions. We believe we will have sufficient doses for those people and to cope with the other groups such as healthcare workers. We do not believe we will have a problem vaccinating every healthcare worker if required.

Deputy Róisín Shortall: I hope that is the case.

Dr. Kevin Kelleher: It is. I would be very happy if we got to use every single dose because we never do.

Deputy Róisín Shortall: Will pharmacies provide the vaccine to healthcare workers free of charge?

Dr. Kevin Kelleher: That is being discussed at the moment. The Department of Health and HSE are negotiating with the various organisations involved.

Deputy Róisín Shortall: I will go back to some of the points mentioned earlier. I have two questions for Mr. Woods. On the need for a funded workforce plan, I note the points that have been made about additional staff and so on but a very graphic example was given this morning. At the height of the Covid pandemic, there were 19 nurses working in a particular Covid ward, 12 of whom came down with the virus and went out sick. This placed a great additional burden on the remaining staff. This highlights the inadequate number of staff and facilities in our public health service. Is work to prepare a workforce plan to ensure adequate staffing levels under way? I would also welcome Mr. Woods's comments with regard to the request to make Covid-19 a notifiable disease to the Health and Safety Authority.

Mr. Liam Woods: With regard to staff planning, work is certainly under way in the acute sector. In fact, the INMO referred to it this morning. A safe staffing framework is in place and academic work has been carried out to look at staffing requirements by ward and hospital area. That work will expand to the community area. This means that this year, before the Covid situation arose, we were putting resources in place to increase the number of nurses across the system. There is some work under way. It is a multi-annual programme. Nurse numbers in the

acute area were up by almost 1,600 in June. That includes bringing in students. On the wider point, as was reflected in this morning's dialogue, there is a process under way, which has an academic base. As was referred to, it is based on an 80:20 ratio. That process will expand to other areas of service.

Deputy Róisín Shortall: What is the timescale for the completion of the workforce plan?

Mr. Liam Woods: The work in the acute area is likely to take up to the end of 2021. In the community area, the work is commencing and it is likely to take longer than that. It is very substantive. It is very much unit by unit and ward by ward. Deputy Shortall referred to the rate of staff attrition. No workforce plan will provide for that. We continue to have a very high absence within the health sector associated with Covid.

The community work is commencing now. There is a group in place that is looking at that. Ms Hoey or Dr. Sisson might take the question on notifiable disease.

Dr. Lynda Sisson: As members are aware, Covid is a notifiable disease under the public health legislation. The HSA specifically excludes notifiable disease because it is notifiable under the public health legislation.

Deputy Róisín Shortall: It seems strange, however, that where a health-related disease is contracted within a work scenario in the health sector, it would not be notifiable to the HSA. Surely it would be desirable to have the Health and Safety Authority overseeing the situation.

Dr. Kevin Kelleher: I am sorry, but we are not in control of that. It is an issue for the Health and Safety Authority and its governing body to sort that out.

Deputy Róisín Shortall: I appreciate that. I was just looking for the view of the witnesses on it.

Dr. Kevin Kelleher: We have no view on it at the moment. It is an issue for the Health and Safety Authority and its parent body.

Deputy Róisín Shortall: Okay, I thank Dr. Kelleher.

Deputy Mick Barry: I will start with a couple of questions for Mr. Woods. I would like to come back in afterwards and make some other points in the allotted time.

Why did the HSE not pay staff who went into precautionary self-isolation, as per the roster, and will it do so now, going forward? Does Mr. Woods accept the argument we heard here this morning from workers' representatives that the decision to deduct overtime and premium pay from workers going into precautionary self-isolation created a disincentive and not only increased the prevalence of Covid in the workplaces for which the HSE is responsible, but probably cost lives as well? I would like a comment on that.

Mr. Liam Woods: I will ask Ms Hoey, who is our HR lead, to address that.

Ms Anne Marie Hoey: The public health advice has always been clear in terms of staff self-isolating in the event that they have symptoms and are awaiting testing. In terms of the payment of premiums and overtime, these would not normally be paid when staff are on sick leave. The issue is a broader one for the wider public service and Civil Service. The unions have in fact referred this issue to the Workplace Relations Commission, WRC, and the case is being heard there. We await the outcome of the case, but it comes back to a public pay policy

issue. The Department of Public Expenditure and Reform is the lead Department in that regard.

Deputy Mick Barry: Does Ms Hoey accept that it did in fact increase the prevalence of Covid in the workplace for which the HSE is responsible?

Ms Anne Marie Hoey: SIPTU stated this morning that it potentially impacted on the decision of staff to attend in the workplace. That is not something we are aware is an issue. The public health advice was very clear to staff on their responsibility to isolate if they became unwell.

Deputy Mick Barry: Okay. Am I correct in saying that the HSE would like to see a relaxation of the 2 m rule in hospitals? Do the witnesses accept that any such relaxation could, and probably would, negatively impact on infection rates among health service workers?

Dr. Kevin Kelleher: I will start and then I will ask Dr. Doherty or Dr. Cuddihy to come in as well. We have to look at the evidence about the spread of the disease from a public health perspective and then look at how to run a healthcare system to provide the healthcare that is needed both in a general sense and more particularly when a disease such as Covid is in the system. We have to put those two together. There is a lot of evidence around about how to do it.

The 2 m is primarily a social distancing issue. One does not need to have that in every aspect of healthcare work if there are other means of compensating for it via PPE or doing other things to get past that issue. There can be a mixture of those things. Clearly, we seek to maintain 2 m in areas where there is social contact. There is no need to have 1 m when people are in waiting rooms. They should try, as Deputies in the Chamber and we in the committee room are observing, to keep those 2 m. In other circumstances, 1 m distancing is appropriate. Then one needs to use the infection prevention and control guidance we have, which is general and relates to PPE. Dr. Cuddihy or Dr. Doherty may wish to add to that.

Dr. Lorraine Doherty: I will make a short comment. Dr. Kelleher has covered most of what I wanted to say. I want to make the point that a healthcare environment is a more controlled environment than is one where one might have gatherings of other people in close proximity. We also have very good infection control guidance in place and training in place for healthcare workers and we have PPE available. Those are all mitigating factors in limiting the spread of infection within that environment. When we look at healthcare environments, they are not like social environments. We take advice on infection prevention and control from experts in that field who advise that it is safe to decrease the distance from 2 m to 1 m of separation. We need to take advice from people who have expertise in the field.

Deputy Mick Barry: Would the witnesses support the recategorisation of Covid contracted in a HSE workplace as a workplace injury?

Dr. Kevin Kelleher: I think we have already answered that question. We have not been asked formally and we need to consider it but it is a decision for another Department and the Health and Safety Authority. If they come to us we will give our view at that time. We have not directly considered that at this moment in time.

Deputy Matt Shanahan: I thank our contributors this morning. I refer to an item in the HPSC report regarding sources of transmission, within which is a figure of 11.4% for close contacts confirmed. The figure for travel is down at 1.7%. Have the witnesses looked at that ratio since flights have started to open up in a larger way? Do they know from what time period that data set was taken?

Dr. John Cuddihy: To answer the Deputy's first question, in relation to the more recent data we are seeing an increase in the number of cases associated with travel, both people who have travelled and cases among their contacts when they return here.

Deputy Matt Shanahan: Can I ask Dr. Cuddihy to put a percentage on that with reference to the previous one of 1.7%?

Dr. John Cuddihy: The 1.7% is specifically in healthcare workers. In the general population at present, travel-associated cases in people who have travelled are still in relatively small numbers. We have, however, seen significant transmission, when people return to the country, among their household and other contacts.

Deputy Matt Shanahan: Dr. Cuddihy highlighted that the take up of contacts who had been identified was relaxing quite a bit. Do the witnesses have plans to seek a legal remedy to be implemented to require those on a contacts list to take a Covid test when they are so approached?

Dr. Lorraine Doherty: Obviously, this issue is an area of concern. We need to get more information on this particular cohort who are not appearing for testing and try to understand what the barriers for testing are before we consider any further measures. Decisions about whether to put in place legislation are obviously not for the HSE or the Department of Health. This would have to be considered if it is shown that there is a complete refusal to have testing and that there are no other barriers that we can seek to address.

Deputy Matt Shanahan: The HSE should put some urgency into that.

I mentioned infection-control protocols through the winter in our earlier session. I have witnessed some things that most people would see in hospitals. There are healthcare workers coming down to community areas such as canteens in their scrubs and then going back up to the wards. It may not be happening in Covid wards but it is certainly happening in the general hospitals. It is something that needs attention paid to it. There is also the issue of visitors transiting through the hospitals with no protection over their footwear, which is provided for in other hospitals engaged in infection prevention. The HSE needs to examine these issues and to become far more stringent about the movement of visitors through hospitals to maintain effective infection control. Perhaps this is something the HSE would look at.

This morning I also brought up the issue of doffing and donning PPE, and fatigue. The HSE needs to go back and look at doing more than training videos; it needs to be done in hospitals and time needs to be given to nurses in between shifts to take some time out. Certainly they should be helped with donning and doffing on Covid wards.

I engaged with Mr. Woods at our meeting last Friday and I remind him of the commitments that he gave me then on pressuring the cath lab modification situation at University Hospital Waterford. I hope to hear from him in the coming days with an update on that.

On the issue of specialist registrars, SpRs, who are out of contract, is there any opportunity to give them extended work contracts and to create consultant contracts in the workforce, considering we heard all morning about the complete under-supply of staff?

Mr. Liam Woods: Yes, we are actively working to grow the number of consultants. It is up by 132 since the start of this year but clearly it needs to grow and that is fully acknowledged. We have been recruiting quite extensively within the acute environment since late January-ear-

ly February and we will continue to do so. We are pursuing opportunities relating to consultants and SpRs through our doctor training programme.

Deputy Matt Shanahan: I mentioned the idea of extending diagnostic lists on Friday, considering machine time and people are available who are less busy because of the Covid protocols, and would be able to do additional hours. There is the possibility of bringing in expanded working through use of an instrument from the NTPF. I would appreciate it if Mr. Woods could get back to me regarding the cath lab at University Hospital Waterford.

Mr. Liam Woods: I acknowledge the point about University Hospital Waterford. On extended day and indeed access to diagnostics generally we are, as part of our winter planning, working to facilitate further access to diagnostics for GPs. We are also working with the NTPF to see what we can do to optimally use the equipment we have with the staff resource we have. We have done that over the past couple of winters and it has worked very well so we are seeking to grow that now.

Deputy Matt Shanahan: One final issue I want to highlight is Irish manufacturers who are trying to supply PPE to the HSE. I am aware of two manufacturers who were in very protracted discussions which have gone cold, to a degree, on the HSE's part. These companies have been engaged with by the HSE, they have been brought quite a distance and they spent money to set themselves up to supply the HSE but all of a sudden the executive has gone dark. I would appreciate it if the executive would re-engage with those companies to move everything along. This all part of securing our future PPE pipeline in Ireland.

Mr. Liam Woods: I agree with the Deputy on that approach. It makes eminent sense to have a domestic supply and there is engagement with a number of companies. If the Deputy wants to flag those companies to me separately, I will certainly raise the issue relating to them.

Deputy Matt Shanahan: I appreciate that and thank Mr. Woods.

Chairman: I thank Deputy Shanahan and call Deputy Michael Collins.

Deputy Michael Collins: I thank the witnesses for coming in. When Covid-19 was first identified internationally in late 2019, what steps did the HSE take to procure additional PPE? Was additional PPE ordered internationally? If so can, anyone give me dates and quantities?

Dr. Kevin Kelleher: As soon as it became apparent that we were going to move into this, which was from the last week or so of January, we started doing those sorts of things. I do not have the figures here and now but I can try to get them to the Deputy. At that time, we started seeking to procure whatever equipment we considered appropriate for what we thought was going to come, which included PPE, other equipment and drugs if necessary. We can seek that information but I do not have it right now. We had a meeting in the last week of January and the preparations started virtually from that point.

Deputy Michael Collins: When Covid-19 was first diagnosed internationally, was a risk assessment done by the HSE? Did it identify the at-risk groups, and what steps were taken to safeguard them? On what dates were those actions taken?

Dr. Kevin Kelleher: Both the WHO and the European Centre for Disease Prevention and Control were giving us advice at that time and we were using their advice and debates and discussions about those risks. We were also in contact with colleagues elsewhere in the world and in the UK, so we were aware of those risks, which were brought into the meetings that started at

the end of January within the HSE. NPHE also began meeting at that stage and each of those meetings involved the discussions the Deputy is talking about and looking at what the risks were and what we would face. We very clearly saw the impact Covid was having in China and we took that as our main source of where we might need to go. When it came to Italy, which was the next big change, we took what was occurring there on board as well. Those influenced what we were doing. As the Deputy said, it was a new disease, so our ability to foresee what would happen was not as great as it would be today. We have much better knowledge today. We were making assessments at all those meetings, which were very frequent at two or three times a week, about what we knew, what that meant and how we had to adapt as a consequence.

Deputy Michael Collins: Many people feel that if the HSE had been quicker in responding to Covid, fewer people would be affected and more lives would have been saved. The public has been asking whether the HSE was behind the curve on this. Was it?

Dr. Kevin Kelleher: That is a very difficult question to answer. I think we were on the curve. I do not think we were behind it. We reacted very rapidly to what was happening. We had things in place throughout February and were strenuously trying to make sure we identified cases as quickly as possible. We did that at the end of February and we moved on through that process. It is clear that countries can be easily overwhelmed and one can still see that today. I do not think we have been overwhelmed in any way that is comparable to some other parts of the world. Some parts of the world may have done slightly better but even they are now having difficulties. It is difficult. It is my own personal belief that we reacted as well as we could have at the time. Of course one can do better. We know we could have done better when we look back with the knowledge of today, but we did not have that knowledge at that time.

Deputy Michael Collins: Apart from EKO in Ennis, County Clare, what other Irish companies have been commissioned to produce PPE as an essential element of protecting our health-care workers in the ongoing battle against Covid?

Dr. Kevin Kelleher: We can get that information for the committee. I do not think any of us knows that off the top of our heads.

Deputy Michael Collins: Are healthcare staff better prepared to deal with a second wave of Covid? Based on what we have learned from dealing with this virus, how will the second wave be managed differently?

Dr. Kevin Kelleher: A number of us could answer that question. I think we have learned a lot. We are better prepared and have better resources available to us, both in the knowledge we have gained as an organisation and having staff who now know what needs to be done. We have a lot of guidance, we have PPE in place and we know where we need to go. I will ask Mr. Woods and Dr. Doherty to comment on that as well.

Mr. Liam Woods: We have grown some capacities in the system. We have also grown our equipment base of ventilators and other essential equipment, which is helpful. As Dr. Kelleher said, a range of guidance is available, much of it on the HPSC website. There is training in place and we are growing staff numbers and physical facilities. The challenge will be that of tackling the winter with Covid on top of it, as has been flagged by both members and witnesses at this committee.

Chairman: I call Deputy O'Reilly, who has ten minutes.

Deputy Louise O'Reilly: I will put a ten minute timer on my phone because I do not want

to eat into anyone else's time. I have a number of questions, several of which relate to staffing. We all know, and the witnesses know as well as I do, that low staffing levels contribute to an inability to practise proper infection control. When a place is short-staffed it makes it almost impossible. This morning, we heard from the INMO that nurses are still being issued with three-month contracts. As we face the prospect of a second wave, which we all hope will not arise, I have to ask Mr. Woods about the issue of these three-month contracts versus permanent contracts. Where does he stand on that? Is it the intention of the HSE to issue permanent full-time contracts to people where, let us be honest, there are permanent and full-time vacancies, or is it intended simply to muddle on and plug the gaps with three-month contracts?

Mr. Liam Woods: With regard to full-time vacancies, we intend to offer full-time contracts. There are some contracts that will be for three months because the nurses filling the roles may be students who are recording as healthcare assistants. Retired workers who have returned may have wanted a three-month contract. On the Deputy's core point, we are looking to grow the number of permanent staff and I agree with the Deputy's initial comments.

Deputy Louise O'Reilly: I have been hearing for decades from employers that it is the workers themselves who want the flexibility of precarious work. In my experience, that is not the case. While I respect there may be a small number for whom three-month contracts are sufficient, the vast majority, as articulated by their representatives, want those permanent contracts and it is good to see that commitment. When will these contracts be issued?

Mr. Liam Woods: I would have to understand more about the specific locations throughout the 48 acute sites and the community services. It is the broad intention that permanent available posts will be filled permanently and that this will happen as soon as we can arrange it. It has been happening and there has been significant growth in the whole-time equivalent number in nursing and elsewhere in the employed number in the HSE since the start of the year. It has increased by more than 4,000. Last Friday, I indicated the number was 32,071 and our June data show an increase of more than 4,000. An ever-increasing number of permanent contracts are being offered and staff are coming into place.

Deputy Louise O'Reilly: This morning, we heard from representatives on engagement on planning for a potential second wave. I will not get into the ins and outs of the infection rates but we have had acknowledgement that the infection rates among healthcare workers were unacceptably high and we know staffing has a contribution to make in this regard. I assume the HSE is planning, even if it is not talking to the representatives of healthcare workers, for a second wave. Has it factored in the need for some staff who have accrued annual leave to be able to take it? Some staff will not be able to come to work. Is the workforce plan based on the HSE having full staffing? Has it taken into account the fact there will be reduced numbers of staffing, as there was during the most recent peak?

Mr. Liam Woods: On the wider planning, the calculation of the appropriate number of staff, and nursing staff specifically, is based on a ratio of 80:20. There is work being done on this, as I referred to earlier in answer to Deputy Shortall. It is also based on known patterns pre-Covid of attendance and leave. This work was done but to answer the Deputy's question, the pattern of absence over March, April and May and the likelihood of this recurring are matters we are very aware of and they are part of our planning framework for our winter process. We are very alert to this and very aware of what it might mean.

At the moment, our restriction, in fact, is the total available number of staff to employ in those cohorts. We are doing everything we can, as we have been for some weeks and months,

to attract as many staff as we can into the HSE and voluntary bodies funded by the HSE.

Deputy Louise O'Reilly: The HSE always factors in a certain amount of absenteeism, sick leave, maternity leave, etc. into the workforce plan, winter initiative, winter planning and all the rest. What percentage is it factoring in for this plan in terms of healthcare workers who may be absent as we face into a potential second wave?

Mr. Liam Woods: At the peak of the first wave, nearly 5,000 staff were absent at any one time. While it is difficult to anticipate what the impact of a second wave would be, we hope that with early intervention and the improvements that have taken place in testing and contact tracing we will not experience the same level of surge. We have to plan on the basis that it is still a possibility.

As the Deputy is aware, what happened in the first wave resulted in a significant number of closed beds simultaneously. I understand 2,200 beds were closed. There was also a significant change in the pattern of public attendance at hospitals, which gave rise to a backlog in demand for services that we are now trying to deal with. The Deputy will be very alert to that. From our point of view, we have to plan on the basis that we may see a recurrence at the level we have seen before but we also have to work to avoid that.

Deputy Louise O'Reilly: Absolutely. We heard evidence today from a trade union that staff were so worried about the prospect of losing their premium pay and other allowances that there was a suggestion they may have come to work sick. Is consideration being given to ensuring people are not out of pocket in any way? The witnesses know as well as I do that the basic rate is the basic rate, but many people working within the health service have, given the 24-7 nature of the operation, an entitlement, legally or under collective agreements, to benefits such as additional premiums for unsocial hours worked. Is consideration being given to ensuring money is not a factor when people are considering whether they have to take time off work in order to isolate, etc.?

Mr. Liam Woods: I will ask Ms Hoey to address that from a HR perspective.

Ms Anne Marie Hoey: I thank Deputy O'Reilly. We touched on this issue earlier. The predominant principle, based on public health advice, is that staff should not attend work when they are potentially symptomatic. That has been very clear from the beginning. Our experience is that staff take that responsibility very seriously. In terms of the Deputy's question, overtime payments would not normally be made in a situation where a staff member is on sick leave. The issue that has presented is across-----

Deputy Louise O'Reilly: What payments would be made, if overtime is not being paid? Would the unsociable hours premium, twilight or anything like that normally be stacked into the payment? Is there a flat basic rate?

Ms Anne Marie Hoey: Basic pay can be made up of different elements. Some allowances are part of basic pay, but it has to be taken on a staff category by staff category basis. The issue across the wider civil and public service has, I understand, been referred to the WRC where it is under consideration. It is a public pay policy issue and will be considered and decided on in that context.

Deputy Louise O'Reilly: My final question relates to the HSA. I understand the line Minister responsible is the Tánaiste, Deputy Varadkar. I have raised an issue directly with him. As it currently stands, the HSA does not have a role in inspecting healthcare facilities. Acquiring

Covid in the workplace is not considered to be an occupational injury, notwithstanding the fact that it was acquired as part of a person's occupation. I thought it was a no-brainer, but I have been out of the industrial relations game for some time. To me, if someone acquires an infection as part of his or her work it is an occupational injury. Would the witnesses have a view on that?

Dr. Kevin Kelleher: We have answered that question. Our view is that is, as the Deputy said, a matter for the HSA and-----

Deputy Louise O'Reilly: I am asking if the witnesses have a view as to whether an infection acquired in the workplace should always be considered a workplace injury.

Dr. Kevin Kelleher: We do not have an explicit view at the moment but we will have a view when we are asked. We need to have an internal debate before we can give a view before the committee.

Deputy Louise O'Reilly: Is Dr. Kelleher saying that internal debate is ongoing within the Department, between the Department and the HSE, or with the representatives of workers and all stakeholders?

Dr. Kevin Kelleher: I said that we need to have that debate when we are asked to do so, and we will. We will have that debate and will use our mechanisms to consider how to reply. It is not a decision for us as an organisation.

Deputy Louise O'Reilly: I am asking the HSE to have that debate. Is there someone specific who would need to ask Dr. Kelleher in order to spark that debate? It strikes me as an important debate.

Dr. Kevin Kelleher: We will take up the Deputy's request after this meeting. It will be a part of our process in the next number of days and weeks.

Deputy Louise O'Reilly: It is a fairly urgent matter so it would be much appreciated if it were dealt with in days rather than weeks. Dr. Kelleher might correspond with me to advise at what stage his thinking is. It seems to me that the matter does not require a scientific interpretation. It is simply a fact that an injury acquired as a part of one's work is considered an occupational injury under normal circumstances. I am glad that Dr. Kelleher is going to take up the offer to have the conversation and I would appreciate if he could follow up with me either by phone or in writing.

Dr. Kevin Kelleher: We can certainly do that.

Chairman: I thank Deputy O'Reilly and Dr. Kelleher. The next speaker is Deputy Colm Burke.

Deputy Colm Burke: I thank the witnesses for their attendance.

Chairman: Is Deputy Colm Burke going to take ten minutes? Is he the final Fine Gael speaker?

Deputy Colm Burke: I presume I am.

Chairman: The Deputy has ten minutes and if another Fine Gael Deputy wishes to come in, we have time.

Deputy Colm Burke: I thank the witnesses for their presentations and the work they are doing. I will refer to the report of the profile of Covid-19 cases in healthcare workers in Ireland. On looking at the report, I note that 58.5% of the 88,260 healthcare workers who were identified as positive for Covid were in the HSE east region. While there is a larger number of healthcare workers in that area, in analysing comparable figures was a higher percentage of healthcare workers in the east affected in overall terms, taking into account the total number of healthcare workers in the area? Has any effort been made to identify why that occurred?

Dr. Kevin Kelleher: Dr. Cuddihy will answer the question in more detail but, generally speaking, the virus has been focused in the east of the country regardless of the healthcare system. The virus has been focused on the Dublin and eastern areas.

Dr. John Cuddihy: As Dr. Kelleher has said, the highest incidence per 100,000 population has been in the east. That proportion of incidence in the general population is closely mirrored in healthcare workers. That relates to the number of hospitals, residential care facilities, community services and so on located in the eastern region to serve that higher population.

Deputy Colm Burke: We have seen the breakdown of numbers on nursing homes but is there a similar breakdown for hospitals where there was a higher incidence compared to other hospitals of a similar size throughout the country?

Dr. John Cuddihy: We have not seen that distinction in our data. We have seen significant numbers of healthcare worker infections in residential care facilities and outbreaks in hospitals but the proportions, relative to the populations and numbers of facilities, have been similar across the regions of the country, generally speaking.

Deputy Colm Burke: Has any effort been made to identify where errors were made as a result of which healthcare workers contracted Covid-19? What measures now need to be put in place to make sure there is no reoccurrence? We have a lot of information and data. Have we analysed those data? For instance, some healthcare facilities, including 56% of nursing homes, had no positive cases of Covid, while many others were affected. The case is likewise with hospitals and mental health facilities. Has there been any serious examination carried out to identify why cases occurred in some places while very similar operations in totally different parts of a HSE area saw no outbreaks at all?

Dr. Lorraine Doherty: I thank the Deputy very much for his question. It is very important to try to understand why healthcare workers are becoming infected. Under Dr. Cuddihy and myself, the HPSC has commissioned a study with UCD which will involve an enhanced investigation of more than 400 healthcare worker infections. This is quite an intensive study as it will involve interviewing all of those healthcare workers to determine exactly what their practice was in their particular healthcare setting, what PPE was available, how they were trained to use it, and how they applied the use of PPE and hand hygiene. When the results of this study are available, towards the end of August, they will give us vital information and will help us to identify areas in which we might need to take further action to prevent the infection of healthcare workers and to support them in their practice in preventing infections.

Deputy Colm Burke: Of the 8,260 workers who were diagnosed with Covid, a number were associated with a location in which there had been an outbreak. Some 4,634 contracted Covid independent of an outbreak. Has the source of these 4,634 infections been identified? Page 6 of the report says that 4,634 were not linked to an outbreak.

Dr. John Cuddihy: That is right. The health protection surveillance system looks separately at the infection rates of patients and healthcare workers associated with outbreaks and at the rates of sporadic cases. With regard to those healthcare workers the Deputy mentioned whose cases were not linked to outbreaks, there are a number of likely sources of transmission. These may be related to their work settings or to close contact with a confirmed case either in the workplace or in the community. Some are also related to travel. A proportion relate to community transmission. Despite our intensive contact tracing process and investigations-----

Deputy Colm Burke: Will Dr. Cuddihy give me a more detailed breakdown of that 4,634?

Dr. John Cuddihy: Yes.

Deputy Colm Burke: That would be helpful because it is not in the report.

Dr. John Cuddihy: I can certainly get a breakdown of that figure for the Deputy.

Deputy Colm Burke: I will again raise an issue I raised this morning. It relates to the number of healthcare workers who have been identified as having Covid. Some 2,878 of these had an underlying medical condition. That figure is very high. Where a person had an underlying health problem, were serious efforts made to ensure they were not put at risk? Was a protocol in this regard available to each and every healthcare facility and hospital? Take, for argument's sake, someone who had previously had treatment for cancer and who was now working on a ward where they may be vulnerable to contracting Covid. Was a protocol in place for hospital managers and managers of wards for dealing with such employees?

Dr. Lynda Sisson: Yes, indeed. At the very early stages, we developed a guideline document for pregnant healthcare workers, very high-risk healthcare workers and high-risk healthcare workers. We put that up on the HPSC website. We identified the different risk assessments that are assigned to different people. We divided our workers into those who were working with patients in direct care and those who did not have direct patient care. This was a guideline that identified by name in some cases all of the different underlying diseases that were of concern. We had a whole process in place for those who did have underlying diseases to assist them either in being redeployed, to cocoon if it was appropriate, and to support themselves in terms of the PPE etc. that they would need when working.

Deputy Colm Burke: When was that devised or made available to the people in charge of the various facilities around the country, be it hospitals, healthcare facilities or congregated settings?

Dr. Lynda Sisson: We issued the first guideline in the middle of March and we continue to update it. We now have version 6 online, which was last revised on 26 May. As we learnt about the disease we were able to revise the guidelines throughout that time.

Deputy Colm Burke: Does Dr. Sisson think more could have been done, in the sense that 2,878 people identified with Covid were people with underlying medical conditions?

Dr. Lynda Sisson: Deputy Burke needs to remember that of those 8,000 workers, some were out of the workforce but who identified as healthcare workers. We are aware that some people were out having treatment. They were admitted to hospital and subsequently diagnosed with Covid. They were not all necessarily in the workforce at the time.

Deputy Colm Burke: Do we have a number out of the 2,878 people who were in that cat-

egory?

Dr. Lynda Sisson: I have identified 5,037 healthcare workers in the acute hospital sector, and in the community for the HSE and the voluntaries.

Deputy Colm Burke: We hear various percentages referred to in the context of the 8,000 healthcare workers identified with Covid in this country. There are various figures. What is Dr. Sisson's view of the percentage of the total healthcare workforce? We got a breakdown from her in the report on the profile of Covid-19 cases among healthcare workers and it cuts across all areas from administration to care assistants to nursing staff to doctors. Approximately 135,000 people work in the HSE between full-time staff and part-time staff. Probably another 30,000 work in private nursing home facilities. Reference was made to 8,000 workers, but in real terms, what is the calculation of the percentage of workers who were affected by Covid-19?

Dr. Lynda Sisson: We speak for the public health system but my calculation is just under 5%, about 4%.

Deputy Colm Burke: Is that taking the staff in both the public and private facilities?

Dr. Lynda Sisson: I do not have access to the private figures. That is based on the 135,000 that are currently working in the public sector.

Deputy Colm Burke: Is the 8,000 not made up of people from private nursing homes as well?

Dr. Lynda Sisson: It includes private nursing homes as well.

Deputy Colm Burke: Therefore, if we take the 135,000, plus around 30,000 in the nursing home sector, is Dr. Sisson talking about 8,000 out of that total number?

Dr. Lynda Sisson: Yes, but the 8,000 includes people who are not in the workforce at all, but who do identify as healthcare workers. The number could include a retired GP, for example, or somebody out on maternity leave who identifies as a nurse.

Deputy Colm Burke: Could we get a breakdown of the numbers who were not in the workforce but who are identified as part of the 8,000?

Dr. Lynda Sisson: My calculation is that we have 5,000 out of the 135,000 in the public health sector, which is just under 5%.

Deputy Colm Burke: That identified with Covid.

Dr. Lynda Sisson: Yes, that are currently working in the public sector.

Chairman: To be clear, is Dr. Sisson saying that of the 8,000 who had Covid that were identified as healthcare workers, 5,000 of them were working in the healthcare service at that time?

Dr. Lynda Sisson: In the public healthcare sector.

Chairman: Okay, public as opposed to potentially working in private hospitals.

Dr. Lynda Sisson: Yes.

Deputy Michael Collins: We are aware that the UK and many EU countries put systems in place for the children of healthcare workers to ensure that these very valuable workers could

continue to work. This was largely not the case in Ireland, where no proper childcare facilities were made available to the healthcare workers. Is there a plan in place for children of healthcare workers should we be hit with another wave of Covid infection?

Ms Anne Marie Hoey: The issue of childcare for healthcare workers posed some challenges. The HSE engaged cross-sectorally with Government Departments on supports for healthcare workers. Several options, as we know, were explored. True to public health advice and so on, it was not possible to reach an early resolution. The crèche facilities have now reopened. However, the HSE was as flexible and creative as it could be in facilitating staff to be able to work different shifts, rosters and days. We have a 24-7 service to run so there are many opportunities for us to provide flexible working arrangements for staff to enable them to balance caring responsibilities with the working environment.

Deputy Michael Collins: Is the HSE following the advice of the leader of the Irish Medical Organisation who recommended that the Government stockpile supplies of PPE to protect healthcare workers from the impact of a second wave of Covid-19?

Dr. Kevin Kelleher: That is a debate we are involved in and we need to get clarity around that process. It is a NPHE-Government decision but we are involved in that debate.

Chairman: Does the definition Dr. Sisson just gave reflect what Dr. Cuddihy meant when he said Ireland had a different definition of healthcare workers from other countries? I was struck by that comment earlier.

Dr. John Cuddihy: That is part of it. It is a complex definition. In Ireland, it includes anyone who works in healthcare, both public and private, whereas, as I mentioned, in some other countries it is a narrower definition. It may include just front-line workers or, in some cases, particular categories of workers such as doctors or nurses. In Ireland, it is a very broad definition.

Chairman: Do we know what determines who contracts Covid-19 and who does not contract it? Two people can have the same exposure, and one may contract it while the other may not. Does fatigue and being run down play a role in viruses generally and in this virus, to the extent that we have information about this virus?

Dr. Kevin Kelleher: If I knew the answer to that question, I would be up for the Nobel Prize in physiology or medicine as a consequence, unless my colleagues are up to that. It is one of those complex issues. There are so many different factors that affect people in how they react to a disease. It is not even that they would react the same today as they would react in three weeks' time or they reacted two years ago. It is very different. It is a very complex issue. We can somewhat understand it and that is what we use to try to give our advice on, but we do not understand explicitly why some people contract the virus, except some people have got either natural or acquired immunity as a result of a vaccine for an infectious disease. Does Dr Doherty want to add to that?

Dr. Lorraine Doherty: There are obviously issues in relation to individual susceptibility to acquiring an infection and issues that the environment might precipitate. I think one of the Chairman's comments related to fatigue. A healthcare worker on a ward who is fatigued may not pay as close attention to hand hygiene or PPE. Those are things we are aware of that need to be factored in to the overall planning for staffing in those scenarios. There is a great deal that we still need to learn about this infection. In flu season, we see children as super spreaders of flu

and yet children do not seem to get high levels of Covid. Why is that? We do not know. There are many studies being done on the epidemiology and the modes of transmission and we continue to learn from those. As we learn more about this infection it enables us to identify further control measures. One of the preventative measures that we are hoping to introduce globally in 2021 might be a Covid vaccine. Should a safe and effective vaccine become available in appropriate quantities we can start immunising people for further protection but in the meantime we have to have a very strong focus on our routine infection prevention measures.

Dr. Kevin Kelleher: If I could come back in, this session has discussed the infection rate among healthcare workers. One of the things we are well aware of is that a feature that historically people have been very good at, particularly healthcare workers, is that they come into work. They have such a work commitment that they come in regardless, sometimes, of their own health status. That has always been one of the great features and we know that is how our health service has continued; it has been one of the great things we have witnessed. I have done it in the past and I know that lots of other people have done it. However, in the current circumstances, actually having an infection and having the symptoms of an infection should mean that people do not come in to work. That is a big problem because that is not in the Irish healthcare workers' psyche. Their mindset is that they must come into work because they have patients to look after. How we get past that is a quandary. It is one of the biggest things we have to do.

Clearly a vaccine will make a difference but again we must ensure people take the vaccine. Getting people to understand has been a big issue for us. Members of the committee have heard us say repeatedly every winter that people should not come into work if they start having the signs of flu. I have been saying it for a decade or more. They should stay at home. It is the same here. I am not differentiating between the public and healthcare workers in those circumstances - everybody should stay at home and that goes for the healthcare workers too. It is a big problem for us however because there has been this great element of the Irish healthcare worker's approach that he or she comes in to work when not well enough. Unfortunately we must bridge that significant cultural issue as a consequence. It is a problem for us.

Chairman: Does Dr. Kelleher think that that tendency of Irish healthcare workers to come into work, sick or not, because of the sense of duty they have to their patients has been overly relied on by the HSE in calculating staffing ratios and staffing numbers required?

Dr. Kevin Kelleher: I am not going to answer that directly. When we do those we rely on history and that is reflected in the history. In a sense the Chairman is correct but that is only because we have relied on the history of absenteeism. We do not deliberately say that we know people will come into work as part of that, it is just that we use the history and clearly from what we all now know, we know we have to change. That is a big cultural change. Everybody will then start saying that they have been told that absenteeism rates of 3% to 5% are inappropriate. However, I have said previously that I do not mind an absenteeism rate of 6% or 7% if we are stopping people with infections coming into hospitals to infect other workers in the hospital system or patients. It is a difficult thing to get over.

Chairman: I thank Dr. Kelleher. We have had a number of campaigns in relatively recent years about this. I was previously a TD from 2011 to 2016 and during that time there was a campaign by the younger doctors' division of the IMO, which I think was called "24 No More", and nothing happened. I was contacted by an Irish GP trainee who posted on social media and I think I was tagged in it. She said: "26 hrs later I'm finally finished my shift. Absolutely shattered. Time to get a coffee before I drive home. Sadly many doctors have lost their lives driving home from work following these dangerous shifts." She added: "Would you want an exhausted

doctor managing your loved one in an emergency on the ward? Would it not make more sense to reduce the hours we can work per shift?" Added to the personal danger highlighted by that trainee, there is also an increased danger of slippage in PPE, in that people might not use their PPE properly. How much more do we need? I appreciate that it is a funding issue and ultimately funding is determined by the Dáil rather than anybody in the witnesses' committee room but we have an ongoing crisis with inadequate human resources in our healthcare system, which are presumably caused by inadequate monetary resourcing.

Dr. Kevin Kelleher: I have been a doctor for 40 years and I am ashamed that we still have the same problem today that I faced 40 years ago. It must change dramatically. Ms Hoey will speak a bit more on this but we are very much committed to making sure people work much fewer hours than they often do. As I said, some of that difficulty has to do with people's commitment to do the work. We have to get that difficulty across as we try to rectify those things.

Ms Anne Marie Hoey: I cannot comment on the individual case the Chairman referenced but it is certainly not something we would encourage or condone in the interests of the safety of both the staff and the patients they are managing. We rely on senior clinicians to manage such situations to ensure those long hours do not occur. We are also obliged to adhere to the EU working time directive.

As regards an increase in our medical staffing, we have increased our medical staffing significantly in recent months. In the year to the end of June, we increased the number of doctors in the system by over 1,100.

Chairman: Earlier, Dr. Kelleher mentioned absenteeism during the flu season. Perhaps that rate of absenteeism needs to be greater. Typically, what percentage of the Irish population gets the flu and how many people are hospitalised for it during the flu season?

Dr. Kevin Kelleher: We have different ways of measuring that. One method is the influenza-like illness, ILI, rate, which peaks at around 100 or 120 per 100,000. That means there are 5,000 or 6,000 people with that disease that week. It is quite high. Hospitalisations have risen quite considerably-----

Chairman: Is Dr. Kelleher saying that 5,000 or 6,000 people could have the flu in any given week?

Dr. Kevin Kelleher: That is at the very peak. That rate is an indication but the likelihood is that many more people have it because those are just the ones who have come into the system. Many people do not come into the system with the disease. In our field of public health, we often say that the number could be anything between three, four or ten times higher, depending on the disease. We have been measuring hospitalisations quite well over the last three or four years and last winter, we went up to 7,000 or 8,000 people being admitted with flu. Some of that is because of much better recording but it also indicates a change in patterns. Equally, there are seasons where flu is milder and the numbers are significantly lower. In some years, that rate would barely get above 40 or 50 per 100,000. It differs and it is about impact. It reflects the actual virus that year, how well the vaccine works and a number of other things. As we all know, how we are going to deal with flu is a very important issue for us this coming winter. Does Dr. Doherty want to add anything to that?

Dr. Lorraine Doherty: We cannot really say that all flu seasons are the same. Some years we have a bad flu season and some years a slightly less severe one. We have a very important

flu immunisation programme, which is delivered annually and is to be extended this year to include children aged between two and 12 years old. We have an active process in place for planning for flu this season. We have already established our national flu planning group, which I chair. We are working very closely with our hospital and CHO colleagues, the community and our GPs on preparing for this year's flu season. With regard to the epidemiology of flu this year, there has not been much flu in the southern hemisphere. Often, we try to extrapolate from there what might happen for us in winter. This may be related to the isolation associated with Covid or to other factors. What we can best do is make sure we have robust flu plans in place throughout the health sector and that we have a very robust immunisation campaign.

Chairman: On the issue of a robust immunisation campaign, Mr. McCallion came before the committee last Friday and he told us there is to be a ramping up of the immunisation campaign, and that there will be free immunisation of children aged between two and 12 years. Earlier, Dr. Kelleher mentioned children being super spreaders. In any event, there will be free vaccinations for children aged between two and 12 years, and vaccinations for healthcare workers and those aged over 65. It was a clinical decision based on what was advisable but it seems to have been advised that there was no necessity for a vaccination campaign for the general population. Given that 7,000 or 8,000 people present in any given week, which I am sure creates severe stress and a major burden on our healthcare system, leaving out the stress from Covid, should we be looking at a general vaccination campaign? I do not suggest that it should be compulsory or mandatory but that the State should offer free vaccination to all members of the population in preparation for next winter.

Dr. Lorraine Doherty: The HSE does not set vaccination policy. The vaccination policy is advised by the national immunisation advisory committee, which is an expert committee. It bases its immunisation guidelines and recommendations on the best available evidence and having a targeted approach to protect those most at risk from flu in any one season. Over the years, we have seen an extension of what we call the at-risk groups to include a wider section of the population. We already immunise all of our elderly citizens and this year we are extending flu immunisation to children aged between two and 12 years. Next year, children up to the age of 17 will be included. We continually review policy on immunisation for all infectious diseases. For the flu season, this is done annually to make sure there is no particular risk group. The majority of fit, healthy adults can have a flu infection and not have severe effects or severe sequelae after that infection. This is a live issue that we consider when we review the evidence from each flu season to see whether there is a need for additional immunisation of other groups in the population.

Chairman: Does Dr. Kelleher have a view he would care to proffer on the advantage or otherwise of a generalised vaccination programme?

Dr. Kevin Kelleher: The main change we are making this year is offering the vaccine to children aged between two and 12 years, as Dr. Doherty has spoken about. This is the most significant change we could make. Evidence from elsewhere in the world increasingly states that if we can get uptake of more than 40% or 50% in this age group, it starts to have a significant impact on flu in the overall population. Trying to do this is very important.

The flu vaccine works well for some individuals but it works best at a population herd level. International experience shows it is even better if we get the focus among children. Our colleagues in the North have been doing this for a few years and I believe significant benefits have been shown as a consequence. It is similar in other parts of the UK but the experience in the North has really shown benefits. The most important big change we have made is to focus on

this. If we went through the whole population, we might not have the focus on children, which is the most important thing to do as a consequence. I refer to masks. Dr. Kelleher said the policy or advice changed with regard to the wearing of masks in healthcare settings in March. Is that correct?

Dr. Kevin Kelleher: We heard the point being made in the discussion earlier. We have had policies over a period of time. I wish to point out that our policy produced in mid-March very clearly stated it was appropriate to wear masks in certain clinical situations. That did not stop people from wearing masks.

We have to bear in mind the position we were in at that point as a country. We, like other countries in the world, were dealing with having to access PPE. It was a very different world from where we are today. We had great difficulties. I heard comments about some of the PPE we had. We were striving strenuously to buy appropriate PPE at that stage. We needed to make sure that it was focused in the most appropriate places. We were not telling people not to wear masks. It was clearly appropriate to tell people they needed to use masks as appropriately as possible as per our guidance. That is what we wanted people to do. We wanted to make sure that, as a consequence, PPE was available for staff who were at the highest risk of being exposed.

Chairman: I have to say I am somewhat surprised when I look at the WHO guidance on wearing masks, which is, of course, that masks should be worn in a medical setting, particularly when dealing with persons with Covid-19. Its advice on masks in the general population is still equivocal.

Dr. Kevin Kelleher: As the Chairman said, it is equivocal.

Chairman: We had two members of NPHET before the committee on, I understand, 9 June. Their advice at the time was equivocal, but the advice in Ireland has changed since and masks are now mandatory in a public transport or any confined transport setting and their wearing is advised in indoor settings. Why is the advice of the WHO still so equivocal?

Dr. Kevin Kelleher: It is because the evidence is not as clear as people might think. Some people make out that it is clear; others do not. I am sure that the other witnesses in the room would agree that it is important that we have a multifactorial approach to this. Masks are not a magic bullet. They have to be part of an overall approach, which includes social distancing.

For the public the advice is still that social distancing and respiratory and hand hygiene are the fundamentals. That is what got us through the past four or five months. Wearing masks adds to that, but they are not a magic bullet. General infection prevention and control measures, specifically in healthcare settings and more generally in public settings, are very important messages. They are the things that will keep us going. We need to get people to remember that they still need to socially distance, have respiratory etiquette, ensure they practise hand and environmental hygiene and, as we have said, that they should self-isolate if they have symptoms. That is very important.

I am not denigrating masks. Rather, I am saying that people should not see them as a magic bullet. The real issue is very much that we need to keep up the other messages because the Irish people took them on board very well and that had a major impact.

Chairman: Dr. Kelleher is heading up the expert advisory group on nursing homes.

Dr. Kevin Kelleher: No. It is my namesake, Professor Cecily Kelleher.

Chairman: My apologies.

Dr. Kevin Kelleher: The Chairman has the wrong sex and the wrong person.

Chairman: My apologies. I wanted to ask when the report was likely to be published. I know it is an independent group.

Dr. Kevin Kelleher: Yes.

Chairman: Having clarified that, I thank all of the witnesses for coming before the committee today and answering all of our questions. As nobody else is looking to come in, I will adjourn the meeting. We will meet again in private session on Thursday to consider a report on Covid-19 in nursing homes and the State's response.

The committee adjourned at 2.40 p.m. until 9.30 a.m. on Friday, 24 July 2020.