DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé Máirt, 19 Bealtaine 2020

Tuesday, 19 May 2020

Tháinig an Comhchoiste le chéile ag 11 a.m.

The Joint Committee met at 11 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	
Richard Boyd Barrett,+	
Colm Brophy,	
Colm Burke,	
Jennifer Carroll MacNeill,	
Matt Carthy,	
Michael Collins,	
David Cullinane,	
Pearse Doherty,	
Stephen Donnelly,	
Francis Noel Duffy,+	
Norma Foley,	
John McGuinness,	
Jennifer Murnane O'Connor,+	
Paul Murphy,+	
Fergus O'Dowd,	
Louise O'Reilly,	
Matt Shanahan,	
Róisín Shortall,	
Duncan Smith,	
Ossian Smyth.+	

+ In éagmais le haghaidh cuid den choiste / In the absence for part of the meeting of Deputies Bríd Smith, Ossian Smyth and Mary Butler.

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

Business of Special Committee

Chairman: The committee is now in public session. There are a number of substitutes today. Deputy Jennifer Murnane O'Connor is substituting for Deputy Butler for the third session, while Deputy Richard Boyd Barrett is substituting for Deputy Bríd Smith for the first and second sessions and Deputy Paul Murphy is substituting for her for the third session.

We have a few housekeeping matters which I propose to deal with now, in a very cursory manner if possible. If we cannot agree on them, we will have to go into private session. I am loath to spend much time in private session as the witnesses who have come here to speak to us have a lot on their plates. The first matter is the minutes. Has everyone seen the minutes and are there any issues arising from them that we need to discuss in private session? No. Are the minutes agreed? Agreed.

The correspondence has been circulated. Can I take it that that is noted? Agreed.

I propose to push the election of a Vice Chairman back to this evening when we can meet in private session remotely from our offices using Microsoft Teams. I ask any Members who want to participate in that meeting to make sure they are able to use Microsoft Teams and that they have the technical capability to do so. Oireachtas IT staff are available to help with that.

Deputy Róisín Shortall: What time is the Chairman proposing to have that meeting?

Chairman: Once the third session is completed.

Deputy Duncan Smith: Will we be allowed a few minutes to get back to our offices?

Chairman: Yes; it would not be immediately. We will give a reasonable break if people want to grab a sandwich or something. Rather than taking up time with this matter now, I propose that we discuss it this evening. Is that agreed? Agreed.

I have liaised extensively with members of the committee and groupings regarding speaking slots. It is proposed to give every member of the committee five minutes in which to make a statement, ask a question and receive answers. Members can give their speaking time to someone else, subject to the proviso that people can speak for a maximum of ten minutes at a time. I propose to proceed on that basis for today. We can discuss it again this evening but I do not want to-----

Deputy Fergus O'Dowd: Can the Chairman explain that again?

Chairman: Every single member of the committee has five minutes, so everyone is equal-----

Deputy Fergus O'Dowd: That is for the first session but there is a second session as well, so we have ten minutes between the two sessions.

Chairman: No. The Deputy will have five minutes to speak in this session. If others wish to give him their five minutes or *vice versa* they can do so, subject to the proviso that nobody speaks for more than ten minutes at a time.

Deputy Fergus O'Dowd: I do not have an issue with that in theory but as the witnesses will not be present in the way we initially expected, one may want to spend more time with one witness than five minutes will allow. That is the only problem I see.

Chairman: I appreciate that but if the first speakers-----

Deputy Fergus O'Dowd: I am just making the point.

Chairman: -----are taking more than five minutes, those who have a slot later will not be reached and that would be quite unfair. We need to make sure every member of the committee has an equal opportunity.

Deputy Fergus O'Dowd: The point I am making is that the limitation we have is the two-hour session.

Chairman: I understand. The issue is-----

Deputy Fergus O'Dowd: I just want to make one point. I appreciate that the Chairman understands all this but I want to articulate it clearly. I will have questions, not necessarily today, which will exceed five minutes because I expected to have ten minutes with the witnesses. That is the point I want to make, but I am not objecting today.

Chairman: I appreciate that. If the Deputy would like more than five minutes today, he might speak to his colleagues and somebody might give him an additional five minutes.

Deputy Fergus O'Dowd: I just want to make the point that, as I understood it, the Chairman's initial proposal was that we would all have ten minutes.

Chairman: That was based on having a double session which is not possible now, based on advice.

Deputy Fergus O'Dowd: The problem is that the same witnesses will not be there.

Chairman: That is right.

Deputy Fergus O'Dowd: I have made the point and we will take it from there.

Chairman: I appreciate that the time limits which are required of us are going to make it difficult. We are going to have to be concise, make as few statements as possible and try to elicit information rather than making statements.

Deputy Fergus O'Dowd: I do not disagree.

Deputy Pearse Doherty: I was a minute late to the meeting. Was the Chairman dealing with the issue of the election of a Vice Chairman in private session?

Chairman: We are still in public session.

Deputy Pearse Doherty: We are in public session.

Chairman: Yes.

Deputy Pearse Doherty: Did the Chairman mention the postponement of the election of a Vice Chairman until the end of the business of the committee?

Chairman: Yes.

Deputy Pearse Doherty: Can I ask, with the indulgence of the Chairman, if that could be postponed until the start of the meeting next week?

Chairman: Does anybody oppose that? No. That is a good idea.

We have the physical capability to take witnesses from committee room 1. Committee members would sit in the Dáil Chamber whereas the witnesses would be in committee room 1. I am aware of the risk that people might have to go into self-isolation. I consulted with as many committee members as I could this morning, although I did not have a mobile number for one or two of them. I am minded to allow the witnesses to sit in committee room 1 and committee members will ask them questions by video link. That would minimise their exposure. We are a relatively small group but there are 19 committee members here, plus staff from the secretariat. That is a relatively large group of people to be consistently in the company of for up to a two-hour period. If committee members agree with that, we will take witnesses by video link from committee room 1. If there are objections, we can go into private session and discuss the matter.

Deputy Fergus O'Dowd: I think we need to go into private session.

The committee went into private session at 11.08 a.m. and resumed in public session at 11.26 a.m.

Briefing by Department of Health Officials

Chairman: To recap, witnesses can give evidence from committee room 1 if they prefer not to be in the Chamber. Mr. Jim Breslin has said he does not have a preference. I thank him for coming before us today.

I wish to advise the witnesses that by virtue of section 17(2)(*l*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If you are directed by the committee to cease giving evidence in relation to a particular matter and continue to do so, you are entitled thereafter only to a qualified privilege in respect of your evidence. You are directed that only evidence connected with the subject matter of these proceedings is to be given and you are asked to respect the parliamentary practice to the effect that, where possible, you should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly. I will do my utmost to ensure that they are so treated, as, I am sure, will all committee members. I ask witnesses to bring any concerns witnesses have with regard to their treatment to the attention of the committee and they will be fully considered in accordance with the witness protocol.

Mr. Breslin can make his opening statement, followed by Dr. Tony Holohan. I remind members that every member is being afforded five minutes, and they can be given a further five minutes by a colleague who is further down the speaking list, subject to the proviso that members may have a maximum slot of ten minutes at any time to make statements and ask questions and, most important, leave time for receiving answers. I also ask witnesses to limit their opening statements to five minutes. We have received their statements and I thank them for taking the time to prepare and send them in advance. I now ask Mr. Breslin to give an opening statement.

Mr. Jim Breslin: Do I remain seated?

Chairman: Sorry. Finally, I would ask everybody to remain seated throughout. People are free to leave and I would encourage people to leave and come back to avail of their slot so that there are as few people as possible in the Chamber because the more contact we have with people, the more risk there is of spreading Covid-19 or, indeed, any other infectious disease. I would ask that people sit while addressing colleagues or witnesses and asking questions, and that they speak through the Chair.

Mr. Jim Breslin: I thank the Chairman. I am outside my usual habitat.

I thank the Chairman and committee members for their invitation to meet with the committee today. I extend my best wishes to the committee, and, indeed, the new Dáil, in its important work.

Just under 17 weeks ago, on 22 January, the World Health Organization, WHO, announced that there was evidence of human-to-human transmission of the novel coronavirus, Covid-19, in Wuhan, China. Since then, the Department of Health, the HSE, the wider health sector and colleagues across the civil and public service and community and voluntary sectors have put in place an unprecedented response to an unprecedented emergency. I am deeply proud of the way in which people in my own organisation have risen to the challenge, at great personal cost. We must particularly express our deepest gratitude to the staff of our front-line health service who have met this challenge head-on with what has been the most supreme determination.

In the period since we first learned of Covid-19, there have been more than 4.7 million cases confirmed worldwide and at least 315,000 people have died. In Ireland we have had more than 24,200 confirmed cases - that is the figure as of last night - and unfortunately, 1,547 deaths have been notified, each of them deeply mourned.

All crises come in phases. This public health crisis has a particularly prolonged acute phase. We have made definite progress in getting virus levels back down through stringent public health restrictions but the social and economic costs of Covid-19 have been huge and will be with us for some time. Yesterday saw the first easing of these measures under the roadmap. The bedrock of this progress has been the tremendous commitment on the part of citizens and communities to the behaviours necessary to reduce transmission. The progress is such that we can now collectively take some calculated risks in extending the range of activities it is permitted to undertake but we need to be aware that we will continue to be in the acute emergency phase of this crisis for some time, with further waves an ever-present danger. This is not a one, two or even three-day storm, after which we move to the recovery phase. The acute phase of this crisis will definitely be measured in months and, most probably, years rather than days.

Our health service has been tested to the limits but not overwhelmed, as the European Centre for Disease Prevention and Control, ECDC, and many of us feared. None of us has seen anything like this before – the scale of the challenge is unprecedented but so, too, has been the response. There has been a focus on moving quickly to utilise all available resources, recognising that our healthcare capacity is challenged even in normal times. For example, we have introduced payments to GPs for telehealth so as to avoid unnecessary visits to surgeries. The HSE has developed 29 community assessment hubs to avoid unnecessary hospitalisations. Private hospital facilities have been secured in preparation for the surge and they are now helping with the non-Covid care that has been displaced from our major public hospitals. The HSE, voluntary hospitals and other health agencies have worked with private nursing homes to support them in preventing or managing infection and continuing to care for our older people.

The health service has also been engaged in a massive effort to scale up our Covid-19 testing capacity. Covid-19 is a new virus. Four months ago there was no test for the virus, much less commercial supply of such tests and the infrastructure necessary to undertake testing at scale. The HSE has striven each week to increase testing capacity with the opening of 47 testing centres, commissioning 40 additional labs for the testing of Covid-19, and procuring supplies against a backdrop of global shortages, and also implementing IT systems to manage referrals and automating processes.

The plane has been in flight while all this necessary work to improve its efficiency and range has been undertaken. The issues that have been encountered along the way are well documented but, despite these, Ireland is positioned towards the top of the international testing league table. Ireland is fourth highest in the EU in terms of tests completed in population terms. To date, more than 280,000 tests have been conducted. There is much more work to do, in particular, in improving test turnaround times, but this week the HSE is on target to have a testing capacity of 15,000 tests per day with an average turnaround time from swab to result of between one and three days.

The scale up of contact tracing by the HSE has also taken place. The median turnaround time for giving someone a positive result and commencing contact tracing is just over one day. There are outliers, and further improvements are planned and will be necessary to continue to improve turnaround and support any increase in contact tracing requirements associated with the greater circulation of people.

Congregated settings, by virtue of their physical nature and the susceptibility of those living there, are recognised by the World Health Organization, WHO, and the European Centre for Disease Prevention and Control, ECDC, as involving higher risk of infection. The deaths we have experienced in our long-term care facilities are the most difficult aspect of our experience with Covid-19 so far. The testimony of those who lost loved ones and cannot say goodbye in the normal way is truly heartbreaking. The international experience involving similar or in some cases worse problems than our own has been highlighted by WHO and ECDC, which made specific recommendations for this sector in the latter half of March. Our commitment to testing and recording of all deaths, wherever they occur, means our figures are much more representative and accurate than in many countries. We have also undertaken a comprehensive survey of deaths in long-term residential care to ensure that we are fully and transparently capturing the actual position. Since the outset of this emergency there has been a high level of alertness to the vulnerability of older people in general and those in long term-care in particular.

Important new and international information has emerged-----

Chairman: I am sorry to interrupt, but I would ask Mr. Breslin to conclude so that we have enough time for questions.

Mr. Jim Breslin: We must be frank in acknowledging that the crisis is continuing and our conclusions must be tentative and preliminary. Because the virus is so new, there is much that we still do not know. A proven blueprint was not available at the outset on how this public health crisis would be managed. We are paying careful attention to international advice and experience. Decisions are being made in real time. The threat from the virus will be a reality for the foreseeable future and we must all protect the space for inquiry and learning.

Chairman: I thank Mr. Breslin. I must ask him to conclude. We have his opening statement and we appreciate that he sent it to us in advance. I ask Dr. Holohan to give an opening

statement and to limit it to five minutes, if possible.

Dr. Tony Holohan: I would like to thank the Chairman and the members of the committee for the invitation to appear today. I want to wish the committee well with the important work it is undertaking on behalf of the Oireachtas. The committee has indicated that its members wish to focus on three specific issues today. I am happy to offer a full briefing at any stage on the response to this whole pandemic on behalf of the National Public Health Emergency Team, NPHET, as I believe such an understanding will be critical to supporting the committee in its work.

I welcome the opportunity to explain our response. Maintaining open, clear communications with the public has been a central tenet of the health service's response to the Covid-19 pandemic, and to this end we have held 52 press conferences to date, among other things. Since Covid-19 emerged in China in December 2019, it has spread widely and rapidly around the world, as members have heard. As of today there have been more than 4.5 million cases worldwide, with 24,200 of these in Ireland. Sadly, 1,547 people in Ireland have lost their lives. We are acutely conscious of the grief that people have experienced over the past three months. I would like to take this opportunity to express my deepest condolences to all those who have lost loved ones.

We first heard reports of a novel coronavirus infection during the second week in January. Immediately, senior public health people in this country began to confer, monitor and collaborate with colleagues internationally. It became clear from an early stage that this would become a significant challenge for the world. It is equally true that the world's experience with this virus is still unfolding, with tragic consequences for many countries, irrespective of levels of preparedness, wealth or development.

While we had high levels of preparedness arising from our experience with pandemic influenza and other public health challenges, it was quickly clear to us that this virus was very different. The ease of its transmission and its severity, particularly for those who are vulnerable, combined with the fact that there is no natural immunity to this virus, no medicines available for its specific treatment and no vaccines, has presented an unprecedented global public health challenge.

To that end, on 30 January the WHO declared a public health emergency of international concern. The NPHET, which has been at the centre of our public health response, held its first meeting on 27 January 2020 and has held 31 meetings to date. Its role has been to provide clear advice to members of the public on how to protect themselves, their families and their communities, and when necessary to provide advice to the Government through the Minister for Health regarding wider societal public health measures.

By the middle of March it became evident that unprecedented action was needed to prevent the spread of infection, high rates of hospitalisation and intensive care unit admissions and significant mortality. Our collective actions have suppressed this infection, protected the health of people in this country and undoubtedly saved lives.

The cornerstone of the response in this country has been based on a public health evaluation of risk and public health-informed recommendations to Government as to what measures can be taken at each point to minimise the impact of this disease. However, there is no certainty that we can keep this virus suppressed. The advice of NPHET is that we now ease restrictions in a phased risk-based manner, while maintaining close vigilance of the spread and impact of

this virus to ensure that we can safely recommence work, social engagement, education and the day-to-day operation of the health service.

NPHET will continue to advise the Government, through the Minister for Health, to ensure that the decisions the Government takes are informed by public health considerations, while recognising that the Government will also need to take into account wider economic, social and other considerations as part of the phased unwinding of restrictions.

Chairman: I thank Dr. Holohan for being so precise.

Deputy Stephen Donnelly: I welcome Mr. Breslin and Dr. Holohan to the Chamber and thank them both for the work they have been doing. I know they have been working flat out for several months and it is greatly appreciated. I wish them the very best with their ongoing efforts. As Mr. Breslin said, we are still very much in the emergency or acute phase.

We have ten minutes. I have five questions and I might ask both witnesses those questions, which should give them time to answer and if there is sufficient time we can go back and forth. I will start with testing and tracing. At last week's briefing, the health spokespersons from the HSE said that the median turnaround time from referral to getting a result back was five days. We heard from the Minister in the Chamber last week that the target time is three days, which still feels quite long. Mr. Breslin stated that in some instances this is now down to between one and three days. What is the current position and what is the target? Is it that we want to get a 24-hour turnaround across the board or for high-risk groups like healthcare workers, elderly people and so forth?

The second question I have is on the impact on the health system. Before the Covid virus arrived, the health system was struggling. The Covid virus has been catastrophic for healthcare facilities and ongoing work, but just as worrying are the medium-term impacts. Mr. Breslin said we could be dealing with this for months and potentially years. My understanding is that HSE hospitals used to have a bed occupancy rate of 95% but in the Covid world it will have to be no more than 80% in order that we can guard against a surge. Doctors have told me that the number of patients that can be operated on in a given theatre list is down by about half because of all the Covid hygiene and cleaning requirements. I believe it was discussed here last week, and other consultants have stated, that the number of patients that can now be seen by any given doctor and his or her team in an outpatient clinic session could be down by between 30% and 50%. On top of that, Paul Reid said an additional €1 billion would probably be required for PPE on an ongoing basis. Has an analysis been done on how diminished the HSE's healthcare capacity will be, how long is it believed that will be the case and what can be done about this extremely challenging situation?

My third question relates to private hospitals. The reason for taking over these hospitals made a lot of sense and it was a brave thing to do. We all saw the awful scenes from Italy and other places where patients who were critically ill were being treated in car parks. Clearly, the situation is not working at the moment. There seems to be a 30% occupancy rate and figures being collected by doctors suggest it has fallen since last week. Many of the operating theatres and diagnostic machines are not working as they could. About half the private consultants have signed up. It seems, at the same time, that we will use public healthcare money to treat private patients in private hospitals. This is money that would usually be provided by the insurance companies. The intention is noble on all sides in that we are trying to procure more healthcare capacity for public patients at this time, but it is clearly not working in terms of using the health-care assets we have, nor in terms of public money. We are told the National Treatment Purchase

Fund, NTPF, has identified about 5,000 public patients who could be treated in private hospitals, whereas €50 million in the pre-Covid world procured approximately 21,000 procedures. I know a review is under way but, given that we are spending €115 million or more a month and that the assets are clearly not being used while men, women and children around the country are suffering, deteriorating and, in some cases, may lose their lives or be permanently damaged because this capacity is not being used, is it now time to quickly decide to cancel the contract while retaining an option for surge capacity in the future and to redeploy the money involved to the NTPF? This would mean that insurance companies would continue to pay for the private patients to be treated in private hospitals and that we could supercharge the NTPF, allowing us to make serious inroads into public patient waiting lists.

Chairman: The Deputy has used almost five minutes. If he wishes to get two answers to each of these questions, it is a matter for himself as to how to proceed.

Deputy Stephen Donnelly: I will ask one more quick question, although the answer might be a bit long. What is the medium to longer-term strategy? Some people are saying we need to crush the curve as was done in Australia and New Zealand, allowing these countries to open up more widely. South Korea has taken a different approach that consists of very comprehensive testing, tracing and isolation. Sweden took a different approach, which was broadly to stay open. It has approximately the same fatality rate as Ireland. Has a strategy been decided on? Where is the thinking with regard to how we are going to deal with this over months and, as Mr. Breslin has pointed out, possibly years?

Chairman: Does the Deputy wish both witnesses to answer each question?

Deputy Stephen Donnelly: I am satisfied with whatever way the witnesses want to answer.

Mr. Jim Breslin: On testing, the Deputy mentioned that it was taking five days last week. The target, which I believe we will achieve, is to reduce this to three days for 70% of all tests. There will be further improvements in this regard. One such improvement is to text people whose results are negative. This automation will speed things up. We want to continue to improve in this area. The system was patched together but it now needs to be redesigned end to end. The HSE is doing this and is working on its information systems and processing systems to get testing as close to real time as possible.

With regard to the impact on health services, on 5 May, NPHET advised that we could restart non-essential care within the health services. We are in the process of ramping up and planning for that in what will be a very different environment. It will undoubtedly take longer to do many procedures. To take endoscopy as an example, a single endoscopy is usually very quick to do. One will now have to put PPE on, do the procedure, take the PPE off again, decontaminate the area, and then bring someone back in. It will take longer and will cost more so there is a good chance we will end up doing less over this period. The way to buffer that is with innovation such as using technology, including telehealth and so on. The healthcare environment, however, will be very challenged for the foreseeable future.

On private hospitals, it is relevant that non-essential care was not taking place in either public or private hospitals up until the start of this month. We are, therefore, also in a ramping-up phase in private hospitals. A good deal more than half of consultants have signed up. We have made good progress in recent days. The Deputy is right however. Before the end of this month we need to stand back and review the situation in its entirety. One of the mandates we had in conducting negotiations was to prevent a situation in which, during the course of a pandemic,

private patients could be in private hospitals because they had private health insurance while their care was paid for by the taxpayer. This would have undercut solidarity in our national effort. That was the motivation behind the arrangements we have put in place. It is important to acknowledge that a further wave or surge could happen at any stage and, in that case, we would need that capacity. The health system is not well-endowed with capacity.

I may return to the question of the medium to longer-term strategy as answering would eat into Dr. Holohan's time.

Dr. Tony Holohan: In the interests of time, I will not supplement Mr. Breslin's answers too much but I will say that testing and tracing should not be seen in isolation; it should be seen as part of a set of public health advice. Individual members of the public can help shorten the time to diagnosis by coming earlier. In addition to the enhancements that have been made to testing and tracing, we are advising individuals who are experiencing cold and flu-like symptoms not to put off the phone call to the doctor to see how they are until tomorrow but to make contact early. That gives us a greater chance, as do the improvements Mr. Breslin has outlined.

I could speak about the overall strategy at some length but I am conscious of the committee's time. Comparisons have been made to a number of different countries. With regard to New Zealand, western Europe has been the epicentre of this infection; New Zealand is on the other side of the world. It is 2,500 miles from the nearest landmass. It is not part of a political, economic legal, social, cultural union with a number of other countries, like Ireland is. Direct comparisons - I am not suggesting the Deputy is making them - that others have made are not entirely valid. The spread of infection to that part of the world was a much later event and much smaller. They did take decisive action as I believe we did in this country. However, we were very close to the epicentre of this infection in a way that New Zealand simply is not.

Regarding Sweden, much has been said about mortality. I do not want to point unduly at comparisons between different countries, but we have to be sure we are counting the same things. We think in terms of direct comparisons. Admissions to intensive care are probably a more reliable measure of the burden of infection. Sweden has had a much bigger challenge than this country on that measure. When I checked yesterday it had almost 400 people in intensive care. If we adjusted for population that would be the equivalent of almost 200 people in intensive care here; we have 50.

Chairman: I thank the Deputy and witnesses for staying in the time allocated.

Deputy Louise O'Reilly: I thank both witnesses for their evidence and for being here. We know how busy they are, and I thank them for giving us their time. I propose to do as was done previously. I will ask my questions and if we have time for an interaction, that is fine.

Yesterday we began the reopening of the economy. I am conscious that 100,000 construction workers are going back to work, which will pose a challenge for them in their workplaces and for their families when they go home. It will also pose a broader public health challenge. We are aware that specific guidelines for the operation of construction sites are in place. Later we will have a conversation with people about how they will be enforced. Is there a specific plan to test and trace those people who are now going back to work? I am sure the witnesses will agree testing and tracing are much easier when the country is on pause or shut down. Now as the economy begins to reopen, is a specific plan in place to cater for the numbers of people who will now be moving around and who previously had not been doing that?

We note the specific plan in place for construction workers. Is there similar guidance and advice for transport workers, postal workers and other people who will now be going to work and will have more work to do. Transport workers will be bringing people to and from work. It has struck me that - maybe it is necessarily so - some of the measures have been reactive rather than proactive. I would have thought the officials would have used the time on pause to make preparations for reopening the economy. I ask the witnesses to outline those specific preparations, in line with protecting the health, safety and welfare of those workers who will be returning to work out of necessity in the coming days. Indeed, some were back at work yesterday.

With regard to healthcare workers, the latest figure I had heard was an infection rate of around 25% to 30% among our healthcare workers. That is very concerning and I am sure the witnesses are also very concerned about that. I ask them to comment on how they think that happened, because it is not in line. I have heard members of the Government and others make comparisons between us and South Korea and other countries. We can make all the comparisons we like, but as far as I am aware nowhere else is that figure as high. I ask the witnesses to comment on how it got so high among our healthcare workers and what specific measures are in place. Is it due to the chronic understaffing we had as we came into this? Is that a factor?

I will not go over the reported tensions between the Department and the HSE. All those have been well ventilated in the public domain. I refer to reports following publication of the letter that there would be twice-weekly phone calls between the CMO, the head of the HSE and the Secretary General. Are those phone calls happening? Are the witnesses finding them useful? Are they minuted and if so, can they be published so we can all be up-to-date on it?

I have a question on nursing homes. According to the Minister for Health, on 19 February Paul Reid met the director of Nursing Homes Ireland. What actions were taken? It strikes me that some time was lost and that the measures put in place in the nursing home sector were, as I have previously described, reactive rather than proactive. It would seem the opportunity existed on 19 February. Were the witnesses aware of that meeting, were they briefed and what specific actions were taken as a direct result?

Mr. Jim Breslin: I will take a couple of those questions and then ask Dr. Holohan to come in. On NPHET and the interaction with the HSE and what was put in place following the request from the HSE, we had a teleconference with the HSE chair, myself, the Minister, the Chief Medical Officer and the CEO of the HSE. We have agreed to have a regular weekly teleconference, which is minuted, where we go through all of the issues as a collective. It has been very beneficial over the period. The interactions are not just daily, they are almost hourly in between that, but as a centre piece where everybody comes together it is proving-----

Deputy Louise O'Reilly: Have those been published?

Mr. Jim Breslin: They have not been published yet but they are publishable.

Deputy Louise O'Reilly: Okay. If they could be provided to the committee that would be good.

Mr. Jim Breslin: On nursing homes, the Deputy asked about the meeting with the HSE CEO. The CEO will be before the committee later, but I understand that people touched base on the kind of preparations that the HSE was putting in place and Nursing Homes Ireland on its preparations and they agreed to keep in touch and provide the support to each other over the period. I can speak at more length about nursing homes generally but that is the position on the

specific question.

I will ask Dr. Holohan to comment more.

Dr. Tony Holohan: On workers, we have done a lot of work with other Departments and the Health and Safety Authority, HSA, will be before the committee in the afternoon to provide an update on that work to ensure our public health advice is incorporated into the work that it does and support of and oversight of work and workplaces.

Any decision on testing and its role in a particular occupational setting will be taken on a public health assessment at a point in time if that is something that is valuable and worth doing. It will not necessarily be the case that particular occupational groups will be subject to a sweep of testing unless there is a public health rationale, and that might arise. That will be assessed on an ongoing basis over the course of the disease.

On healthcare workers, we have had a challenge. We have been honest and open about that. The figure is slightly over 30% - it is 31.5% as of yesterday - which is a high percentage. It should be borne in mind that we have prioritised healthcare workers for testing and, unlike many countries, we have completed a significant testing programme in residential care facilities. The staff in those settings were both tested and identified as positives and will be part of that figure. We have been proactive on this but there is no question that it has been a challenge. It reflects the fact that healthcare workers are in the front line. They are at risk of picking up this infection by virtue of the work they do. There is also the challenge that healthcare workers, when they are infected, are a source of potential infection both for the people they serve and the communities in which they live and are part of. That is a particular challenge and continuing cause for concern to address that. There has been a substantial fall in the rate of infection among healthcare workers so while the number is high, the incidence has been dropping significantly in recent weeks.

Deputy Louise O'Reilly: Does that include people working for private companies in the healthcare sector, specifically, contract cleaners, contract caterers, agency nurses, and agency healthcare assistants and carers?

Dr. Tony Holohan: All individuals who are healthcare workers who are identified as being at the front line, yes.

Deputy Louise O'Reilly: That would include contract cleaners?

Dr. Tony Holohan: Yes and it would include people in the community such as primary care staff, GPs, and anyone who is-----

Deputy Louise O'Reilly: They are very easily identifiable as healthcare workers. I am talking about people who are on contract working in hospitals for private entities: are they also included in those figures?

Dr. Tony Holohan: All healthcare workers, yes, at the front line.

Deputy Louise O'Reilly: That is not my understanding but I am happy to receive that information.

Dr. Tony Holohan: I am conscious of time. I could say a lot about nursing homes. Yes, the approach has been both reactive and proactive. Reactive is a necessary part of the response. It is the whole purpose of an epidemic response. We must react to an unfolding situation. What

we decide to do today might, by virtue of what we know tomorrow, turn out to be something we need to supplement or change. That is the nature of a public health reaction.

The first confirmed case in this country was on 29 February. The advice that came a couple of days later from the European Centre for Disease Prevention and Control, ECDC, said there was no strong evidence of transmission of infection preceding symptom onset. That was the advice after we had had our first case. We know that is no longer true. That is the advice we were acting on at that point in time, and I can go through-----

Deputy Louise O'Reilly: I understand that. I have one last question as I am conscious of time. All the advice I have read indicates that 72 hours should be the time for testing and contact tracing. How close to that are we? Is Dr. Holohan confident that as well as the capacity to swab, there is capacity to contact trace and follow up, specifically in the context of workers returning to work this week?

Dr. Tony Holohan: I think we can be confident of that. A huge amount of work has been done in the HSE, and I know its witnesses will be able to add much more detail. I am conscious of the time. The turnaround times have improved very significantly and the improvement in those has not finished. I believe that some of the innovations that have been introduced in that contact tracing, testing and sampling regime in this country are without precedent internationally. Now, people who are subject to testing get negative test results by text. With our positivity rate at the moment at 3%-----

Deputy Louise O'Reilly: I am talking about-----

Dr. Tony Holohan: -----97% of people are getting a result in that way. There was a challenge in getting negative results back to individuals, and that has been removed. There are other arrangements in terms of a telephone line arrangement for GPs. Where there is a challenge in getting a result to a patient, they can make same-day contact in regard to that.

Deputy Louise O'Reilly: It is still not 72 hours.

Dr. Tony Holohan: The majority of contact tracing is happening within 24 hours.

Chairman: I call Deputy O'Dowd who has five minutes.

Deputy Fergus O'Dowd: I propose to use two and half minutes. I have one question and I ask the witnesses to respond as they wish. First, I congratulate them on their excellent professionalism, their work and their credibility. I want to tell all the health workers who have given so much to all of us, and all the essential workers in the country, how much we respect them for what they have done.

I want to ask a question about all of those people who, sadly, have passed away in our nursing homes. I know it is not just in Ireland that this is happening but all over the world. If we want to benchmark the state of our nursing homes, public and private, the most recently published data, which are from August 2019, show there were 31,000 residents in 581 homes. Only 123 of those 581 homes were fully compliant with the HIQA regulations. Compliance was down from 27% in 2017 to 23% in 2018. Compliance with regulation 27, which deals specifically with infection control, was inspected by HIQA in only 215 of those 581 homes in 2018. Of those, 37 were found to be non-compliant. As such, non-compliance in providing very basic protection for residents in terms of infection control stood at 18%.

The HIQA report also found rates of non-compliance in the areas of governance management, fire precautions, residents' rights, risk management, and training and staff development of 32%, 34%, 27%, 22% and 19%, respectively. Were the witnesses aware of this or did HIQA advise them of it? What benchmark were they were given for the fight they had to fight, given that their hands were clearly tied by virtue of the fact that this was a new virus the world had never seen before? As they acknowledge, we knew that nursing homes were the most vulnerable. We knew from the evidence that this would be the case. My question is very clear. Can the witnesses give an absolute and categorical assurance to me now that all nursing homes, public and private, in this State are fully compliant in terms of infection control?

Chairman: Who does the Deputy wish to answer that question?

Mr. Jim Breslin: I am happy to kick off. I thank the Deputy for the congratulations. What we have been engaged in is providing advice on an overall framework. All of the progress made has been made by the Irish people. There is no one actor in this. There has been cross-party support for it. Every sector has given support to it but, ultimately, it is down to the behaviour change that we have made and that we will have to sustain into the future.

In regard to nursing homes, undoubtedly, anybody who has observed, as I have, nursing homes over an extended period will have seen the development of that sector. The Deputy mentioned the regulation of the sector by HIQA and the introduction of new standards and infection control guidance, which are particularly relevant in this situation. We have infection control standards in place. I believe the current version of the standards is from 2018. That would be very consciously part of the responsibilities of the people in charge of those nursing homes, whether these are private or public. HIQA plays a very important role in reinforcing that responsibility. It has done so throughout the Covid-19 crisis. It is currently engaged in an assessment process on Covid-19. However, right from the start HIQA reached out and issued guidance and notices to providers about their responsibilities.

That is not to say that this is easy. The CMO can talk on that but this is a much more infectious virus than the typical flu that we experience and is much more severe in its impact and yet it is hard to keep flu out of a nursing home during the winter period.

Much work has gone into this sector. I will not say that all of it has been perfectly executed nor will I say that there has not been learning in this. There has been a great deal of learning. The CMO has talked about the fact that the WHO and the European Centre for Disease Prevention and Control, ECDC, have updated their guidance on this. There is no doubt that this is and continues to be an absolute focus of the overall public health effort as is the importance of ensuring that everybody who is running a nursing home is very clear on what his or her responsibilities are, on what good practice is, and has the support to do that in every instance. That will be to the fore as to how we continue to manage the virus.

Chairman: I thank Mr. Breslin and now call Deputy Ossian Smyth.

Deputy Ossian Smyth: I will start with Mr. Breslin. I want to ask about people who have cancer, people with chronic illnesses and people in pain who up to now have been attending private hospitals for non-elective and very necessary procedures. Their procedures were simply eliminated, or their appointments disappeared. Understandably, we needed, or thought we needed, the hospitals for the surge. What is going to happen to those people? When are they going to get treatment or are any of them getting treatment at the moment or is there an alternative path for them? People have been coming to me to say that they have no idea when this

is going to happen. Is there a date when we will be returning to treating at least non-elective patients who require treatment? I presume that some of these people will die and that this will be seen in the mortality statistics at the end of the year.

Our hospital system is often at 100% capacity, not just our emergency departments but our acute hospitals also. In the future we will have reduced capacity. Due to social distancing we will be down to 60% to 70%. How are we going to cope in that situation? It seems that we need the excess capacity from the private hospitals but we need to obtain it in a different way. Deputy Donnelly referred to this. Is there a way that we can use a less crude method done than just sequestering the entire empty private hospital? Can we obtain the procedures that we need to meet that extra capacity that will be required?

Mr. Jim Breslin: I thank the Deputy for his question. On the activity that is currently under way in private hospitals, I wish to place on the record that 6,646 inpatient discharges have taken place. There have been 21,350 day cases, which might include chemotherapy, 26,386 diagnostic procedures, and 15,862 outpatient procedures. I expect all of those figures to increase as we go through this.

Deputy Ossian Smyth: What period do these deparmental figures refer to?

Mr. Jim Breslin: Those figures are up to last week. One of the factors is that the whole health service was restricted in what it was doing because of the presence of the virus to the extent that it was within our community. That did affect private hospitals. We concluded the heads of terms of agreement with the private hospitals but there were protracted discussions with private hospital consultants. We have more than 280 private hospital consultants on board. More are finalising their position with us, which is the majority of the cohort. The private hospitals are happy with the sign up that they have at this stage and that it can work within their hospitals and that we have the manpower to do so.

On the continuity of care issues that the Deputy has referred to, that is dependent on the consultant under whose care the person is being treated. If that consultant signs up to the arrangements, all of his or her patients move across with him or her at the very point in treatment that they are at. They do not go back to the start of the queue or back to a GP. They stay with that consultant based on the point that they are at on the care spectrum. The one distinction is that they do not pay a fee to that hospital consultant nor does the health insurer. The reason is that we are going to pay a salary to the hospital consultant so he or she cannot be paid twice.

Deputy Ossian Smyth: How many consultants have signed up to this deal at this stage?

Mr. Jim Breslin: More than 280 consultants have signed up. In the event that they do not sign up, arrangements are in place with the patient to decide if he or she wants to stay with that private hospital consultant. The patient might stay with him or her in his or her outpatient rooms, if that is the type of care the patient is receiving, or the patient may wish to move across. If patient moves across, he or she moves either to another private hospital consultant who has signed up, or to a consultant assigned from within the public system.

I refer to the point about how much activity that there can be in this period. We are organising and re-organising all of the activity, so many things that were happening in public hospitals have now moved lock, stock, and barrel into private hospitals. We want to keep it away from an area that might have Covid, and run it in the private hospital, and run it in a facility that is purpose-built for that. The private hospital facility makes an important contribution to how

we meet healthcare needs at this stage. What we will have to review is the extent to which we continue with that. The point that I wish to make, and I made it earlier, is that the mandate that we started from was not to have a dual system of public funds going into a private hospital and then fee income coming in at the same time. We may change that, but the question that presents in that situation is whether there are different incentives for treating private patients in that situation.

Deputy Ossian Smyth: If 280 consultants have signed up, how many consultants have not?

Mr. Jim Breslin: There are about 450. Some consultants have very sessional commitments as they are retired. We think there are about 450, and there is a good chunk who are in the process of signing up, on top of the 280.

Deputy Ossian Smyth: I thank Mr. Breslin.

Chairman: Deputy Duncan Smith of the Labour Party has five minutes.

Deputy Duncan Smith: I would like to direct most of my questions to the CMO. I wish to go back and forth on the questions as the answers should not take too long. I would like to thank the CMO and the Secretary General for all their work, and for the leadership that they have shown over the last number of months.

What was the CMO's thought process in terms of announcing the capacity for 100,000 tests per week on 17 April, given that it is a month later and, according to the Secretary General's statement, we are on the cusp of meeting that target? The statement from the CEO of the HSE, who is coming to the next session, states that we are at that target today. I am still uncertain as to whether we have that capacity now. Either way we are close, but what was the CMO's thought process in stating that without first consulting with the HSE?

Dr. Tony Holohan: We are at that capacity now. We think that is the scale that we need for the various different categories, and I can explain what it is composed of. That number was arrived at as a result of the work that we did at the National Public Health Emergency Team, which is attended not only by people from the Department and a range of other organisations, but also by the senior leadership of the HSE. They are all party to our discussions. Our collective assessment was that was what we believed that we needed. That was the target that we set out to achieve, and it has now been achieved. However, it is not the only target that is important. The key target from our point of view is the turnaround, namely the length of time it takes to get a piece of information back to a patient, or in respect of a patient to a public health team to allow the necessary processes of contact tracing, or indeed clinical management if it is a patient who is unwell and where clinical management is needed for them. That is the critical thing.

Deputy Duncan Smith: I appreciate that.

Dr. Tony Holohan: I refer to what we might find as we go on and as this pandemic unfolds. I should make the committee aware, as it may or may not be aware, that this morning the ECDC published Surveillance of Covid-19 at long-term residential care facilities in the EU-EEA. It is hot off the presses this morning. It is recommending testing in respect of staff of long-term residential facilities at the rate of something like once a week.

Deputy Duncan Smith: I am not disputing the amount that is needed.

Dr. Tony Holohan: I am not suggesting that the Deputy is. There is a fixation generally on

the number of 100,000. In fact, it may need to be fluid. We might find that we need more testing. We know that we are not using that volume of testing at the moment. We have more than sufficient capacity right now. However, needs will change.

Deputy Duncan Smith: That fixation was probably set by the statement on 17 April, but I am happy that we are at that capacity----

Dr. Tony Holohan: That has been the target for a month.

Deputy Duncan Smith: With all due respect to the CMO, I have two minutes left. How many members were at NPHET's first meeting and how many were at its 31st meeting, which I believe was the most recent one? How are the recommendations from NPHET communicated to the national crisis management team in the HSE? Is it in a report, or is it in the minutes of the meetings? If so, I ask if they can be published? I think that we are seven meetings behind now, or maybe more, for which the minutes have not been published. How are members of NPHET appointed? Is there a specific protocol that the Minister has to sign off on? Who is the key decision-maker for appointing people to NPHET?

Dr. Tony Holohan: The Deputy asked a series of questions and to be honest, I have not internalised every single one of them. I have not come prepared with the specific pieces of information so I cannot tell him exactly how many people were present. However, the number was probably in the order of ten or a dozen. NPHET has grown over the period according to our needs. That is the nature of that particular team. We have used it on many occasions in the past as a structure to guide our response. Its composition, size, scale and expertise depend on what our needs are at a point in time. We have, therefore, brought on or co-opted people at various points along the way.

On the minutes, which the Deputy asked about, I do not think he is up to date. We have caught up in terms of the minutes, even in the past number of days. It is important, however, to understand the process that we use. I was asked how we capture decisions and conclusions. What we do, before the conclusion of each meeting, is agree on the conclusions and actions that form the basis of the advice that goes either to the Minister, and through the Minister to the Government, or to the HSE and its CEO. We agree that text in the meeting. The final part of each meeting is reaching agreement on that and it then frames the body of the letter. We do not wait until a set of minutes has been finalised before acting because we need to be in a position to act quickly. That is the whole nature of the exercise.

Deputy Duncan Smith: That is encouraging.

Dr. Tony Holohan: The administrative task of publishing the minutes has lagged a little behind and we are trying to catch up on that. We have had 31 or 32 meetings, with an average duration of between three and four hours. In some weeks, we have had three or four meetings, some of them until late into the night or the early hours of the morning. The challenge of keeping up to date with all of the administrative tasks associated with that is significant but it has not delayed our decision-making or our advice to Government.

Deputy Duncan Smith: If the committee could see that correspondence, it would be much appreciated.

Deputy Róisín Shortall: I thank Dr. Holohan for his ongoing work. I have three questions for him. They concern the basis and rationale for decision-making and the need to be much more transparent about decision-making, not least to keep the public and everybody else with

him. We are quite different from other countries in that we do not release much of the data, make the data open source or explain as we go along. For example, when the decision was taken to open schools in Denmark, a full risk assessment was done and the outcome published, so everybody knew that the R-nought number was likely to go up a small bit, as it did before coming back down again. Everybody bought in to the decision to reopen Danish schools. I am not specifically talking about schools but the need for very robust risk assessment and to be very open and transparent about it. What expertise and tools are available to NPHET to risk assess all of the major decisions that are being made?

The R-nought number currently stands at around 0.5. That is very hard to understand given the profile of the people who have been tested in recent times. In the main, they are people who had a lot of contacts and therefore, presumably, there was a lot of transmission. On what is the R-nought number based? Is it based on a theoretical model and, if so, can the model be published?

Dr. Holohan has talked a great deal about the need to understand the behaviour of the virus. What is his current estimate of the prevalence of the virus in the community? It is very hard to understand that. Last night, the figure for new cases was 88. It is fantastic that it has fallen so low. If 88 cases represent a 3% positive testing rate, the total number of people whose results we got yesterday was less than 3,000. That figure does not sit logically with the approach of needing to do 15,000 tests per day. How does Dr. Holohan explain what appears to be a disconnect there?

Dr. Tony Holohan: I will take the questions in reverse order, if that is okay. We are not testing at the scale of 15,000 a day at the moment. We know that. One of the things we wanted to bring forward and that we would have been discussing this morning in the National Public Health Emergency Team, but that meeting is not taking place, is the question of what would be next in our priorities regarding testing and where we would direct that capacity. In broad terms, the 3% positivity rate reflects what we think is happening in the community, but there are other categories of testing that we will have to prioritise into the future in the healthcare environment, for example, in hospital settings, although it will not just be hospital settings. As we increase, it is hoped, the amount of non-Covid-19 care we provide, testing both patients and staff will become a feature-----

Deputy Róisín Shortall: Yes, but it is based on less than 3,000 tested yesterday.

Dr. Tony Holohan: Yes, that is correct. There is also something of a weekend effect in that.

Deputy Róisín Shortall: Okay.

Dr. Tony Holohan: If I can add to that, one of the things that will help in our understanding of the community transmission, and I accept the point the Deputy is making, will be the decision we have taken to introduce this week, with the easing of restrictions, the testing of close contacts of cases, which many other countries are not doing. That will add significantly to our understanding of community transmission and asymptomatic transmission and give us a much greater response, as it were, in terms of our handling of that.

Regarding the R-nought, it is based on the summation of three models and-----

Deputy Róisín Shortall: Will Dr. Holohan publish that model?

Dr. Tony Holohan: -----it is due to be published. I would have to check with the chair but

my understanding is that the work is going through a peer review process at the moment. I cannot honestly tell the Deputy right now what the timeline is in that regard but the intention is to publish that.

Deputy Róisín Shortall: It is important and-----

Dr. Tony Holohan: Absolutely, I agree entirely.

Deputy Róisín Shortall: -----I wonder why it has not been done.

Dr. Tony Holohan: With regard to the expertise, we have a range of different expertise at the NPHET in respect of our public health assessments. There is a range of epidemiological and mathematical modelling expertise, public health, geriatrics, psychiatry and a range of other supporting specialties.

Deputy Róisín Shortall: Again, would Dr. Holohan commit to publishing those risk assessments for the big decisions taken, for example, in respect of the construction industry, schools or whatever? It is important that we are aware of the basis.

Dr. Tony Holohan: Regarding those assessments, let us say an assessment relating to a school setting, some of that work in some of those circumstances will be done by the relevant sector. We give public health advice and we support other sectors in the decisions they have to make on the actions they need to take, internalising our public health advice into the way they organise the-----

Deputy Róisín Shortall: Would Dr. Holohan favour publication of those risk assessments?

Dr. Tony Holohan: Any of the material we have available to us, which is our public health consideration, we frame it in the minutes and publish. I have no difficulty in making that available.

Chairman: You said the assessment is being peer reviewed and you cannot tell us now what the timeline is. Can you let us know by correspondence what the timeline is likely to be?

Dr. Tony Holohan: I just wish to check with Professor Philip Nolan, who is chair of the group. He is leading that work. I just do not know that piece of information at the moment.

Chairman: You can provide it by correspondence.

Dr. Tony Holohan: I know the intention is to publish that model.

Chairman: You can let us know, roughly, what the timeline is anticipated to be.

Dr. Tony Holohan: Yes, I will find that out and let you know.

Chairman: I call Deputy Boyd Barrett.

Deputy Richard Boyd Barrett: I thank Mr. Breslin and Dr. Holohan for all the work they have done. Nobody has doubts about that. Dr. Holohan said he has a concern about health workers. The infection rate among healthcare workers is very high - Dr. Holohan said it is 31%. Why is it so much higher among Irish healthcare workers than it is in other jurisdictions? It is one of the highest. Why is that the case? What advice did the HSE get on healthcare workers? I have been asking about this since the second week of March. According to the NPHET minutes the team got advice twice from the expert advisory group, on 7 March and 10 March,

relating to healthcare workers. On 16 March I asked what those advices were and I still have not received an answer. I have asked repeatedly to see the advice, recommendations and minutes from the expert advisory group. This is terribly important given the high level of infection among our healthcare workers.

To bring Dr. Holohan up to speed on the position, and I do not understand this, an agency nurse who was recruited by a Dublin hospital two weeks ago has tested positive for the coronavirus in recent days. She was not tested when entering that hospital, where there are many elderly people. I do not understand this. I would like to see the advice that was given by the expert advisory group in March about healthcare workers and I would like an explanation on why we have such a high infection rate among healthcare workers. How on earth can we have a situation where healthcare workers are coming in to work with vulnerable people two months into this crisis when we know there is a problem with healthcare workers' infection rate and that they are not being tested before they start work with elderly people? We then discover it two weeks later. Are healthcare workers who go to visit the elderly in their homes being tested before they do that work? Are there regular tests of healthcare workers when they are working to make sure they are not infected? I would appreciate answers to those questions. Could we please see the advice and minutes of the expert advisory group, for which I have been asking for two months?

Dr. Tony Holohan: Yes. I will engage with the chair of the expert advisory group group about when the minutes and advice can be provided. We have, for the most part, acted on all the advice the expert advisory group has given to NPHET. I see no difficulty in making that available to the Deputy. There is new guidance from the European Centre for Disease Prevention and Control, ECDC, from this morning about the question of testing. We will look at what that means for testing here, as will other countries. I cannot answer about the specifics of why an individual nurse is not tested, as the Deputy will appreciate.

We have had a significant programme of testing throughout the residential and community sector, including in nursing homes. Staff and patients in all settings have been tested. A public health-led set of decisions has determined who gets tested and when. The team at the Health Protection Surveillance Centre, HSPC, which is doing that work is continuing to assess how we should appropriately prioritise testing with regard to public health. The next meeting of NPHET was due to be this morning, and will consider the question of prioritisation, with regard to the next categories that we think are important for testing. What does the ongoing programme of testing for people who work or reside in long-term residential care facilities need to be? It will address people in exactly the categories about which the Deputy is asking.

Deputy Richard Boyd Barrett: We are signed up to the European project on convalescent blood plasma therapy. I asked weeks ago for a report on how that is going. The results are promising. I understand there are apheresis machines for the extraction of blood plasma in St. James's Hospital and that 500 people who have recovered from Covid-19 have offered to make donations, but those machines are not being used to extract that blood plasma. I would like to know what is happening there.

Dr. Tony Holohan: I was not aware the Deputy would ask that specific question so I do not have a specific answer, but we will get it for the Deputy and correspond with him on it.

Deputy Matt Shanahan: I thank the witnesses for their attendance. I have some questions for Mr. Breslin and I ask him to leave time for the Chief Medical Officer for the last couple of answers. Who is responsible for managing positive tests and the negative tests? Deputy

Naughten brought in information during the week about meat factories. We have had contact occurring with management in meat factories but not directly with the patients, to say that patients had tested positive. On the other hand, negative test results have taken more than two weeks to come back. There are significant issues which Mr. Breslin might address.

Some 45% of our population has private health insurance and is, at present, excluded from accessing general consultants' work and any opportunity to have treatment. Mr. Breslin said that a significant number of doctors have signed up to the type A contract. How many surgeons have signed up to the type A contract? It is my understanding that in private hospitals, where much elective work is done, that if there is no surgeon to do it, there is not much point in having the other consultants on board. Some €115 million is going out per month to secure the hospital contract. I see in data from 18 May that only 30% of beds in private hospitals are taken up. Many of these are long-stay patients from public hospitals who have been moved out. The National Treatment Purchase Fund's annual budget is between €30 million and €50 million per year, and we are spending €115 million. I would like see that contract revised.

On University Hospital Waterford, UHW, I want to put something on the record which is not quite Covid-related but is as a fact of it. We had a diagnostic cardiac lab facility on site there since September 2017. This was moved off the premises in recent weeks, however, as the contract was not extended. We are now back to one cardiac cath lab in the south east for 500,000 people. We have a hospital with 160 beds-----

Chairman: Is this related to the Covid response?

Deputy Matt Shanahan: Yes, I understand. I just will make the point if I may. We have 160 beds in the hospital but we have only three patients in there for Covid. I would ask the witnesses to reflect on that.

Can I ask the Chief Medical Officer if there is any update on hydroxychloroquine? Is there any update on the idea of using vitamin supplements, particularly vitamin D, and zinc supplements for the elderly? Does Dr. Holohan believe antibody testing can be used at any point in the future?

With respect to Waterford having the lowest incidence of Covid in the country, why can the regions not be allowed to open in advance of the major population centres?

Chairman: I remind the witnesses that they are only asked to answer questions on Covid.

Mr. Jim Breslin: On the positive test - the Chief Medical Officer will confirm this - the procedure is contact tracing would take place with the individual. I cannot understand the issue that has arisen with an employer getting a result in the absence-----

Deputy Matt Shanahan: It has been communicated to the Department.

Mr. Jim Breslin: -----of an individual. The policy is that it will go back to the individual who has been the subject of the test. As Dr. Holohan has referred to, there have been delays with negative tests. A negative test is the one less concerning to the contact tracer. As Dr. Holohan has outlined, we have now automated that, so that will flow very readily. Up to 97% of cases will go back with a text message.

On the private hospitals, I would not agree that 45% of people have been excluded. The private hospitals are open to the whole community at this stage. It is a clinical judgment as to

who gets admitted. That will not be decided on somebody's insurance. That equally means, if somebody is insured and it is clinically necessary for them to be admitted, then they are eligible for admission.

On the number of surgeons, I do not have the exact number. However, I would not expect the type of huge bias that the Deputy is inferring. Surgeons need hospitals. In order to practise, they would want to have access to private hospitals. There are some other specialties which do not need hospitals as much. They can do much of their work in an outpatient setting. They may be less represented in the numbers which signed up. We have not experienced a major problem in terms of surgeons different from other doctors. We have had some delay in everybody signing up but not specific to surgeons.

I was not going to comment on the cath lab but I do know the full extent of the concern, the issues and all the work that has gone in both by the HSE and nationally.

Dr. Tony Holohan: To be clear, we have had some reports of employers receiving results in respect of individual patients. That is a breach of confidentiality.

Chairman: We are over time. The other questions can be answered by correspondence. I am sorry I have to be ruthless with time to ensure everybody gets a fair crack of the whip.

I call Deputy Michael Collins for the Rural Independent Group.

Deputy Michael Collins: I thank both gentlemen for being here before us today. It is important for questions that the public has and for which we need to have answers.

On testing, many samples have been sent to Germany at a massive cost. I understand a new plane was required to fly them in and out of the country. I have spoken to labs here about testing that could have been done in Ireland. Animal Health Laboratories Limited is testing for Covid-19. Tests go into the lab in the morning and the results come back in the evening. This company felt that if it had a few more resources, it could have done anything up to 5,000 plus tests a week. While it has been considered by private hospitals, it has not been considered by the HSE. Why did we go to the massive expense of flying our samples to Germany, waiting up to three weeks? I have had cancer patients contacting me who cannot have cancer treatment because they are waiting three weeks for results. We find out that this kind of test could have been done in Ireland and created jobs locally. It could be looked at going forward. I am not trying to point fingers here because the witnesses have done some tremendous work and I do not want to be seen to be critical in any way. However, that is the point that I would really appreciate an answer on. The HSE has taken over the 19 private hospitals at a cost of €115 million per month. It is completely understandable that a deal had to be done initially to secure capacity in respect of Covid-19. No one knew where this would go initially and the HSE had to do so, but the light switch for medical care for all other patients has been turned off. There are now 2.2 million citizens with private healthcare who will have had no option but to join the public waiting list as of 30 April. The National Treatment Purchase Fund, NTPF, recorded 770,000 people in hospitals and clinics. Other countries have had to do something similar and they have reverted. I am asking the same thing. Are we considering the gradual reopening of private hospitals to people with private health insurance? It is important and there is fierce worry out there that people with serious health issues need to be seen. They are paying for private healthcare but that is not available at the present.

Did the HSE, in its consultations, remove elderly and sick people from hospitals and put

them into nursing homes and community hospitals without testing them? There are other questions but I would prefer to have those answered.

Mr. Jim Breslin: On the German lab, I can say it is not more expensive than Irish labs, including some of those that we have introduced more recently. The number of labs that are now testing in the National Virus Reference Laboratory, NVRL, has gone from one to 41, so we have taken account of capacity where we have been able to find it. With reference to lengths of time, a backlog of tests went to Germany and therefore by the time those people got their result there was a delay. However, the results coming back from Germany are very much within the next day, so there is not that length of time. The HSE will always look commercially at where best to do this and have regard to the turnaround time. That will be a dynamic situation which we will keep under review as we go along. We have added significant private sector labs in Ireland. One of our biggest labs now is a private sector lab, so there is an openness in the HSE to try to secure turnaround and cost effectiveness, but also the quality that we need, which would be foremost.

I have said what I have said on private hospitals. I do not envisage that people will have to go right back to the start of a waiting list. That is not what the policy says. There will be a review before the end of the month. We will take everything into account, but one of those things will be the World Health Organization's advice that the most likely scenario here is for recurring waves. The idea that we had our experience and now we can move on is absolutely not the case. We could be subject to a further wave, in which case we would be back to looking at a modest amount of ICU capacity within our public health service and wondering if we will be able to cope in that situation. There are strong arguments for using all of the capacity that we have nationally and for reviewing it on that basis.

Chairman: All labs and testing are contracted directly with the HSE rather than with the Department, is that correct?

Mr. Jim Breslin: Yes.

Chairman: Deputy Collins has 15 seconds.

Deputy Michael Collins: I appreciate the answers. Another question I have is on the many home helps who got personal protective equipment, PPE, very late in the day. It was a serious worry to them.

Mr. Jim Breslin: We have good relationships with the home help sector. It has played a very important role. There is a relationship with the local community health office in terms of PPE. It has also been flexible and has gone in and worked in nursing homes in the most critical phase.

Chairman: Thank you, Mr. Breslin.

Mr. Jim Breslin: One of the things going forward will be to try to get that service back up and running. It is important that we have a home help service into the future to try to cope.

Chairman: The next Fianna Fáil speaker is Deputy McGuinness who has five minutes.

Deputy John McGuinness: Have the witnesses examined the role of carers in the home and how they are being supported in all of this? The section 39 organisations, which provide services for the mentally and physically challenged clients, were caught for cash and funding

before this happened. Has funding been released to those organisations to ensure that they can expand the role that they have, and indeed, support what is now required because of Covid-19?

In terms of reopening the economy, have the witnesses looked at France and its red and blue counties and numbers, urban and rural, in terms of a response to either one? It seems to be a plan worth looking at.

The private hospital deal of €115 million a month has been mentioned. Is it actually €115 million a month, or has it gone over that? If so, why? Are the consultants involved in the hospitals being compensated for the loss of their business plans, in terms of the rooms they rent, lease or have purchased and the staff they employ? Where have all those staff gone? Are they being compensated? Is there an overall plan for the use of private hospitals - a solid plan to which people can refer? As of last week there was not.

The loss of three months of normal service in these private hospitals is projected to cause 1,800 extra deaths from cancer this year. Is Mr. Breslin familiar with these figures? That amounts to 20 extra people a day dying from cancer. I would like clarification around all the services offered to them. How many patients in private hospitals had their appointments cancelled over the past week?

As regards the deal itself, would it not have been a better idea to have a contingency for capacity that would be made available should it be needed? There was only a handful of patients in some hospitals at the beginning of this particular with the Private Hospitals Association. Scopes have been cancelled in public hospitals, and there is now a backlog of more than 4,000. What is being done about that?

Chairman: Deputy McGuinness should leave time for Mr. Breslin to answer the questions.

Mr. Jim Breslin: We have to go back in time as regards the private hospitals. As we moved towards the end of March, we were beginning to experience some of what we had seen in Italy and France, and based on the trajectory of admissions into ICUs in public hospitals, they were going to rapidly fill up. We would have exceeded our ICU capacity within a week. That was the focus of the arrangement we put in place. We needed immediate access to those facilities. We will obviously review that as we go forward, but as I said earlier, we could find ourselves back in that situation quite readily. The other thing I should stress is that during that period, non-Covid care fell off across all healthcare services and sectors, in both public and private hospitals. We saw it in emergency departments-----

Deputy John McGuinness: I am sorry to interrupt, but I am watching my time. I asked specifically about the contract, the consultants and their business plans. What is the position on that?

Mr. Jim Breslin: The consultants received a type A contract and are remunerated for that. In some instances where there is a business case in which their outpatient rooms would need to be used for the delivery of public care, paid for by the public purse, the HSE has been given the authority to enter into arrangements as long as there is value for money. That does not underwrite all the business losses that somebody suffered. Whole sectors of the economy are experiencing such losses and there are arrangements in place to address that separate from the health service.

Deputy John McGuinness: Can Mr. Breslin deal with the other questions I asked regarding the cancellation of private appointments and the funding for section 39 organisations?

Mr. Jim Breslin: This afternoon, the HSE will outline the very close working relation it has with section 39 organisations. Arrangements have been put in place on a case-by-case basis where they have been affected by Covid. They may be taking on extra duties or may have incurred extra costs and the HSE has a process for that. The Government has put in place a scheme for charities in general as well.

Deputy John McGuinness: Could I ask that some of the questions that were not answered, which are particularly relevant to consultants and the operation of their business, be answered in writing?

Chairman: Mr. Breslin-----

Mr. Jim Breslin: I think I covered all the consulting questions but there are one or two-----

Deputy John McGuinness: Mr. Breslin has not done so. He was very flippant about the consultants, their business plans and how they are going to be written off.

Chairman: Is Mr. Breslin happy to answer the questions? We can recap them if necessary after the meeting.

Mr. Jim Breslin: Surely.

Chairman: I thank Mr. Breslin. We can go back over the debate to see what was asked. We are over time. I appreciate that Deputy Cullinane is taking Deputy Carthy's time but I ask him to limit his contribution to seven minutes.

Deputy Colm Brophy: There has been a second speaker from Fianna Fáil. Does the sequence not mean that a Fine Gael speaker is due to ask questions now?

Chairman: The next speaker is from Sinn Féin and Fine Gael will follow. Somebody in Sinn Féin gave up time, unlike Fine Gael. I ask Deputy Cullinane to limit his contribution to seven minutes because, otherwise, other people will not get to speak at all.

Deputy David Cullinane: We will not quarrel in public; we can deal with that matter later. I will proceed.

I welcome the two witnesses and thank them and the teams behind them for their work. I send my best wishes to those teams and commend them for the work they have done. I will put my questions distinctly and I know that our witnesses are experienced and will respond equally distinctly. This is our first opportunity to look back, although it is also important to look forward, which I will do when I talk about testing and tracing. There are questions that need to be put about nursing homes and congregated settings. I will firstly put questions to Dr. Holohan.

My understanding is that when Nursing Homes Ireland first responded to the Covid-19 crisis on 4 March, it imposed nationwide visiting restrictions on private facilities. Is that correct?

Dr. Tony Holohan: I cannot confirm that it was 4 March but it was in the early days of the month.

Deputy David Cullinane: It was in the early days of March.

Dr. Tony Holohan: I have no reason to dispute that it happened on 4 March.

Deputy David Cullinane: On 10 March, on Dr. Holohan's advice, the blanket restrictions

were lifted and that advice was given to nursing homes. Is that correct?

Dr. Tony Holohan: It was not given to nursing homes. It was a broader piece of advice, given in public, that related not only to nursing homes but a range of different actions that were happening over the course of that week. That was the advice we gave in public. We talked about it at the meeting of our National Public Health Emergency Team on that date as it related to nursing homes because we had a substantial concern that there was a lot of unilateral action taking place over the course of that week. A lot of organisations were taking their own decisions about what public health actions they needed to take, not informed by our advice. Our clear concern was to ensure that all of the organisations in the country were operating in step with our advice. That was, ultimately, what happened when the advice that we gave to the Government was implemented on 12 March.

Deputy David Cullinane: On 10 March, the advice was that there should not be restrictions because they were too restrictive. Is Dr. Holohan saying that advice was given in broad terms?

Dr. Tony Holohan: That is not correct and I have been quoted as having spoken in those terms. If the Deputy checks our press release at that time, we said that visitor restrictions in respect of nursing homes "are not necessary at this moment in time". That is a totally different thing to the way it has been interpreted by many people as saying-----

Deputy David Cullinane: Was advice given to nursing homes? Was there any communication between Dr. Holohan's office and Nursing Homes Ireland on any of that?

Dr. Tony Holohan: No. There would have been engagement between Nursing Homes Ireland, the Department and the Minister to which I was not a party.

Deputy David Cullinane: There is disagreement as to whether that was an instruction or advice from Dr. Holohan, however it was presented in the public domain.

Dr. Tony Holohan: It was public advice.

Deputy David Cullinane: Dr. Holohan may have a particular view of it. I think it was three days later, on 13 March, that the visiting ban was imposed, or reimposed. Is that correct?

Dr. Tony Holohan: On 12 March, we made a series of pieces of advice around school closures and a range of measures across society which included a recommendation that visits to nursing homes and healthcare facilities would cease. It was a change in our assessment of the disease on 11 March that led us to that point. Up to that point, we did not think that we should introduce such arrangements because we understood that these were restrictions on people visiting their loved ones in places where they live.

I should point out that, in terms of cross-country comparisons that we have done, when considering the length of time between a country reporting its first case and implementing visitor restrictions in the way that we did on that occasion, we were the quickest country in the world. No country-----

Deputy David Cullinane: How many clusters of infection do we now have in nursing homes? How many clusters have been identified in nursing homes and residential settings? It is in the hundreds, is it not?

Dr. Tony Holohan: It is over 200 at this moment.

Deputy David Cullinane: We can all accept that is very high.

Dr. Tony Holohan: It is, but it does not-----

Chairman: Deputy Cullinane should allow the witness to answer questions.

Dr. Tony Holohan: That figure does not relate to visitor restrictions. We know that the point at which visitor restrictions were recommended by us, which was on 12 March, there were no reported clusters. No country made a such a recommendation, relative to the path of infection, earlier than we did. That is in comparison with a range of countries. I do not want to waste the time of the committee but I have that data here.

Deputy David Cullinane: Dr. Holohan can forward that information.

Dr. Tony Holohan: It shows comparisons with New Zealand, Australia-----

Deputy David Cullinane: I want to put a follow-up question to Mr. Breslin.

Dr. Tony Holohan: -----Canada and a range of countries across Europe. They all took a substantially longer time to implement that. We did that before the advice came from the WHO and European Centre for Disease Control and Prevention to introduce those recommendations.

Deputy David Cullinane: I thank Dr. Holohan.

Dr. Tony Holohan: We were very responsive to the disease.

Deputy David Cullinane: I want to put a question to Mr. Breslin. There was correspondence between NHI and his Department around that time. We have heard from the NHI that it sought meetings with the Minister or officials. If there was correspondence between the NHI, Mr. Breslin's office and the Minister, what was the nature of that? Can he share that correspondence with us? The NHI will come before the committee next week. My understanding is that it raised concerns about the lack of an overall comprehensive plan for nursing homes. As we all now know, there has a been a high incidence of Covid-19 in nursing homes. What was the nature of the correspondence at that early stage in March that took place between the Department and NHI?

Mr. Jim Breslin: I am happy to share the correspondence. There is a great dealing of ticktacking with NHI, as the representatives of the sector, across a range of issues. During this period, that range of issues was connected with Covid. It related to specific issues and also their seeking engagement and representation on various structures. At the time, NHI sought representation on subgroups in NPHET that had been set up. Some of those subgroups had been doing the work of designing financial support schemes for the sector, so we did not consider that that was the appropriate course. NPHET is an expert group, and has HIQA on it as the representative of the regulator of the sector.

Deputy David Cullinane: Is it not also true that it had appealed for specific guidance on what to do in nursing homes and how they should respond to this crisis, predicted that nursing homes would experience severe staff shortages, and raised concerns about PPE?

Mr. Jim Breslin: There has been a huge amount of guidance issued to residential-----

Deputy David Cullinane: At the time, they were not clear about the position because they were looking for specific guidelines.

Mr. Jim Breslin: As I referenced earlier, there is already infection control guidance for the sector from HIQA. The HPSC issued guidance in early March, setting out how to manage Covid-19 both to prevent it and if there was an infection in a nursing home. Guidance, which is continually updated, has been issued to the sector. As the Deputy will no doubt hear from the HSE later today, a huge range of supports have been put in place to try to help the sector. The sector is a mix of publically operated and privately owned facilities. It is not line managed in its entirety by the HSE; much of it is outside the HSE.

Deputy David Cullinane: I ask that all correspondence related to NHI, the Department, Dr. Holohan's office and the HSE be forwarded to this committee in advance of next week's sitting if that is possible.

Chairman: Is that possible?

Mr. Jim Breslin: Yes.

Chairman: Deputy Colm Brophy has five minutes.

Deputy Colm Brophy: I thank the Chairman. I endorse the comments of my colleague. I thank Mr. Breslin and the Chief Medical Officer for their service. I want to address the Department specifically in my first question.

Allowing for Mr. Breslin's opening statement and the preceding media coverage of it, we are facing into a crisis that may last for years rather than months. I want to comment on one particular aspect regarding the private hospitals and private health insurance. Is it effectively irrelevant for people to have private health insurance now? If one takes the position outlined by Mr. Breslin, which is that the Department wishes to retain private hospitals under its control for the duration of the risk of the Covid-19 pandemic, which by his statement will be years, then effectively there is no private healthcare in Ireland and for most people that means an end to private health insurance. There is no logic in paying for private health insurance. Indeed, there is even a questionable logic in continuing to pay for this year's private health insurance.

Mr. Breslin said that someone who is in the system will obviously maintain his or her place in the system. Am I correct in understanding that for somebody with a new complaint there is now no such thing as private healthcare? Does that position have Government or departmental endorsement? Are we happy with a process whereby we say to people who paid tens of thousands of euro over their lives for private health insurance in this country that the money was, in effect, wasted?

Mr. Jim Breslin: The Deputy has extrapolated. What I set in place was the policy that motivated the putting in place of the arrangement. The arrangement is in place for three months. The HSE has the option to extend that for a fourth month and, by agreement with the private hospitals, by a fifth month. That is the arrangement that is in place. We are now coming up to the end of month two when we will do a review, which will decide what we do after month three. We will have to take-----

Deputy Colm Brophy: In answer to colleagues' questions, Mr. Breslin twice said that, because of the risk of a surge capacity, the HSE needed to maintain that capacity. Let me take his answer through to its logical conclusion. If the HSE needs to maintain the surge capacity and there is no vaccine or treatment, while the pandemic risk remains the same in terms of surge, am I correct that means we permanently have to maintain that capacity?

Mr. Jim Breslin: I would not reduce it down to an either-or option. There will likely be different options at which you could look at where we are and what the future might hold. It is not simply: do you continue with the deal that you did the last time or do you not do the deal? You could look at different options within that.

Deputy Colm Brophy: Can Mr. Breslin reassure people that he is not envisaging a situation which effectively amounts to the abolition of private health insurance?

Mr. Jim Breslin: The health insurers have given a rebate on insurance for the period.

Deputy Colm Brophy: For a short period. Effectively, if we keep the hospital system the way it is, it is a rebate. I want to conclude-----

Mr. Jim Breslin: It is by agreement. The State did not impose this.

Deputy Colm Brophy: I appreciate it is by agreement but their subscribers, who were paying their hard-earned money into private health insurance for many years, have also got views on this.

I refer to a secondary area. I apologise for having to be so blunt but I have a second question that is primarily for the Chief Medical Officer on advice in the area. When we were initially on this committee, we were told we could be broad-ranging in our questions to him. I accept it is not in the core area.

I want to specifically ask about the underpinning medical advice to the 14-day quarantine on entering the country that has come into play. As long as that remains in place Ireland is an effective lockdown zone as regards reopening for tourism, the commercial life of the leisure industry, etc. It has significant implications. It seems to many a displaced point that one has Northern Ireland with an open border with people going back and forth as we all want but people are landing in Dublin Airport faced with a 14-day lockdown, which effectively will kill our tourist industry. What is the medical advice that underpins the advice to Government on that?

Dr. Tony Holohan: It is public health advice. It relates to our assessment in relation to the potential incubation period of this virus. There is pretty much international consensus on 14 days. Few countries are at variance with that particular measure. It is to try and ensure that we limit travel from overseas and have people coming in who do not spend a period of time. The reason it does not exist for travel on the island is that our assessment is that, in broad terms, the island is behaving as one from a disease point of view. In Northern Ireland, the incidence is broadly similar.

Deputy Colm Brophy: I accept that. While it is valid now, has Dr. Holohan any idea of when that will be lifted or when it will be considered?

Dr. Tony Holohan: I could not give a commitment in relation to that. In general, which, I know, will not answer the question, no measure that we have recommended of this kind will be in place for any longer than we believe it is necessary. It is simply too early to make an assessment, given - even on the island of Great Britain and in many other European countries let alone the United States and the rest of the world - the state of infection of how long we need to have that in place.

Chairman: I am conscious that both Sinn Féin and Fianna Fáil have had more speaking time than Fine Gael. I will not be able to get to Deputy Foley but I ask Deputy Colm Burke to

limit his contribution to two minutes. I am sorry that Fine Gael has had less time in this session. It will be borne in mind.

Senator Colm Burke: There are a number of points I wanted to raise but I will touch only on one that relates to congregated settings within the HSE. I was in contact with someone who was, in fact, affected by Covid-19 and works in a facility where a number of people died. The person highlighted the simple fact that there were no changing facilities within the facility for staff when they came into work in the morning. A number of people died. Within a few days, all of what the staff were looking for was put in place. I am wondering at the very start of this process whether an audit was done to see which congregated settings were in danger. For instance, in the setting to which I refer, there were six psychiatric patients per ward. Once the virus got in there, it was high risk. I am wondering was there a list of those places made. We have a number of HSE facilities where there have been more than ten deaths. Was a list made? It would appear from the evidence I have that no action was taken to deal with a crisis in those facilities.

Chairman: I thank the Deputy and apologise for curtailing the speaking time. We must learn from our mistakes.

Deputy Colm Burke: Can we make up from it in the next session?

Chairman: We will certainly try to. I do not want to take the time.

Mr. Jim Breslin: Guidance was issued to all those sectors. As stated earlier, each is unique in terms of its local infrastructure. In many cases we have multi-annual capital programmes in place to improve the infrastructure. This means that what one person in a particular centre will have to do will be different from what someone is doing in another. As the regulators, HIQA and the Mental Health Commission have risk-rated individual settings and kept in touch with the HSE where they have concerns. That process is continuing.

Deputy Colm Burke: Nothing has been learned from this. I was speaking to a staff member in the past few days. While certain new procedures have been put in place, they have now disappeared again. For instance, each member of staff was given a scrub suit to put on when he or she came in. There are none available now when staff members come into work. Nothing has been learned from the process. This needs to be challenged.

Mr. Jim Breslin: From what the Deputy says, that centre is regulated by HIQA or the Mental Health Commission. The HSE, HIQA and the Mental Health Commission will be very interested in those issues if they are of concern.

Chairman: I thank Mr. Breslin. To conclude, I have two questions. We have a road map made up of phases which may be brought forward or may take longer than we anticipate. Have we outlined objective criteria that will allow us to move from one phase to the next? I refer to the transmission rate, ICU capacity, etc. Is it possible to publish those criteria? These questions are for Dr. Holohan. What is the position regarding transmission rates throughout the country? Have we managed to limit sustained human transmission to certain areas?

Dr. Tony Holohan: In broad terms, we have effectively extinguished it from the community in general, right across the country. Much of the caseload that is now being reported is seen in the context of particular settings. We are still seeing some positive numbers in residential care facilities, though the number has reduced very substantially, and in some occupational settings. That is not to say that there are not some cases, but we have effectively extinguished it, which was the strategy from the very start. We have to start with suppressing this infection across

the community before we have a chance of protecting nursing homes or other specific settings.

On the specific question around criteria and measures, the actual threshold may change from time to time. How we view, say, a figure of 30 people in an intensive care unit at a certain point will depend on whether the number on the previous day was 29 or three. As such, the particular number very much depends on the context. We have a series of criteria that are set out in the Government's Roadmap for Reopening Society and Business. These refer to the disease and a range of other metrics concerning testing, contact tracing, health service capacity and the broad impact of the measures on the health and well-being of the public. All of these are taken into account in the staged recommendations and advice to the Government around easing restrictions.

Mr. Jim Breslin: I had one point to add.

Chairman: I am afraid I need to get us out of here. Can I take from what Dr. Holohan said about transmission that we no longer have sustained human transmission in all areas of the country?

Dr. Tony Holohan: No. That is an absolute statement. I could not say that in absolute terms. We have effectively brought it down to a very low level. We do not have sustained widespread community transmission. We know that because we are not seeing a caseload which would reflect that, in spite of the fact that we have very substantial testing capacity in place. We are testing large numbers of people relative to the number of positive cases that are being identified. We can be assured about that.

Chairman: I thank Mr. Breslin for his forbearance.

Mr. Jim Breslin: I wish to add that in addition to the advice on criteria that Dr. Holohan has referred to, the Government published public health advice, an economic assessment and a social assessment on Friday. We pass the advice to the Government, which pulls in multiple perspectives to make a decision.

Chairman: I was interested in the medical criteria that will enable us to move forward or prevent us from doing so. I thank the witnesses and committee members, especially Deputy Foley. I apologise to Deputy Foley and to Fine Gael. That will be borne in mind during the next session. We need to learn not to take so much time in private session

Deputy Colm Brophy: We will need a couple of minutes in private session at the start of the next hearing because the way the timing has worked out is unsatisfactory. I appreciate the Chairman's efforts, but it is absolutely unsatisfactory.

Chairman: I accept that it is unsatisfactory.

Deputy Colm Brophy: One party enjoyed 17 minutes of questioning. That cannot be allowed to happen.

Chairman: Deputy Brophy's party got 12. I appreciate that. I thank the witnesses very much.

Sitting suspended at 1.05 p.m. and resumed at 2 p.m.

Business of Special Committee

Chairman: As with the previous session I am loath to go into private session because it eats into the time we have available for witnesses. We will stay in public session unless members force me into private session. There are a couple of housekeeping matters that need to be agreed and they can be done quickly.

I proposed to meet this evening via Microsoft Teams but it is not logistically possible, so we will put that back to tomorrow if nobody disagrees with that. However, we must do it tomorrow because our recommendations have to go to the Business Committee. Is that agreed?

Deputy John McGuinness: Do we have it arranged for tomorrow?

Chairman: Yes.

Deputy John McGuinness: Will the Microsoft Teams technology be in place?

Chairman: Yes, Teams is in place. Anybody who has a Microsoft device that is provided by the Houses or is compatible with it, and that the Houses accept as being compatible, will be able to access it, but some people have iPads, which creates a difficulty.

Deputy Mary Butler: Are we in public session now?

Chairman: Yes. We also need to agree about next week's sitting, which is on congregated settings, focusing on nursing homes. Do we also wish to cover direct provision next week or will we consider it separately at a future date?

Deputy Louise O'Reilly: I think we should consider it with the other congregated settings. I think it would be better if we could do that.

Chairman: I am inclined to agree with that, unless somebody else disagrees.

Deputy Colm Brophy: May I just ask one question in that regard in light of today? If we bundle the two together, will it be two hours or four hours? Will we have the same witness issues? Will it be two separate sessions?

Chairman: Given what we have learned from this morning, we will always have different sessions rather than double sessions. I do not see how we could accommodate double sessions.

Deputy Colm Brophy: Could we focus on the nursing homes in the first session next week and deal with direct provision and congregated settings in the second session?

Chairman: Yes. We would deal with that in the second session. We have the facility to hold three sessions.

Deputy Mary Butler: We agreed last Tuesday that we would give two sessions to the issue of nursing homes because it has been so significant. Some 62% of all deaths have occurred in residential settings. We agreed last Tuesday that we would have two sessions.

Chairman: We can have two sessions on nursing homes and one on direct provision if the committee agrees to that. Rather than eating into our time now I would like to discuss it tomorrow. Perhaps we should push this discussion back until tomorrow. Is that agreed? Agreed. We will have to agree that tomorrow. There is another issue with regard to access to Microsoft Teams for parliamentary assistants and so on. We can discuss that tomorrow. Is there anything further?

Deputy Colm Brophy: In light of the end of the last session, how corrective will we be with timing in this afternoon's session? There was a discrepancy of more than five minutes between the time given to our party grouping and that given to another grouping. We have to have balance. That was very unfortunate.

Chairman: I acknowledge there was a discrepancy, albeit of five minutes rather than of more than five minutes. Sinn Féin had 17 minutes, Fianna Fáil had 15 minutes and Fine Gael had only 12 minutes. I will seek to remedy that this afternoon.

Briefing by HSE Officials

Chairman: I understand we are joined from committee room 1 by our witnesses. Is that correct?

Mr. Paul Reid: Yes. Paul Reid, CEO of the HSE, here.

Chairman: We are joined by Mr. Paul Reid, CEO of the HSE; Ms. Anne O'Connor, also of the HSE, who is responsible for testing and tracing; and Dr. Colm Henry, chief clinical officer of the HSE. I thank them all for attending. There are three witnesses but we can only accommodate a maximum of two in the Chamber. The witnesses are therefore giving their evidence from committee room 1, where they can be sufficiently separated.

I wish to advise the witnesses that by virtue of section 17(2)(*i*) of the Defamation Act 2009, witnesses are protected by absolute privilege in respect of their evidence to this committee. If they are directed by the committee to cease giving evidence in relation to a particular matter and continue to do so, they are entitled thereafter only to a qualified privilege in respect of that 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 or entity by name or in such a way as to make him, her or it identifiable. Members are reminded of the provisions in Standing Order 186 that the committee should also refrain from inquiring into the merits of a policy or policies of the Government or a Minister of the Government or the merits of the objectives of such policies. While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly and with respect and consideration at all times in accordance with the witness protocol of the Houses.

I remind members that they have five-minute slots. If a member wishes to give another member his or her slot, members may speak for that time as well, subject to a maximum of ten minutes for any member. I will do my best to keep members informed of time. Without any further ado, we can begin the three witnesses' opening statements. I thank them all for the statements they have provided in advance. I appreciate that they are busy and thank them for taking the time to provide those statements. I ask that each witness limit his or her opening statement to five minutes to allow the maximum amount of time for questions and answers.

Mr. Paul Reid: To respect members' time, we have just one opening statement. I will touch on some aspects of it but not maybe all of it. It is all on the record, obviously placed before the committee. I am grateful for the invitation to appear before the Special Committee on Covid-19. I am joined by my colleagues, Ms Anne O'Connor, chief operations officer for the HSE, and Dr Colm Henry, our chief clinical officer.

I am aware that the special committee wishes to discuss three matters: testing and tracing; congregated settings; and the reopening of the economy. The first two items are obviously specifically relevant to the HSE. I will make a few opening remarks before focusing on those two issues.

Members will already be aware that the health services have faced the worst pandemic in living memory. Since we became aware of the pandemic, the HSE has worked tirelessly to build our defences to protect the public from this potentially deadly virus. My first message today is that while we have collectively managed to significantly reduce the transmission rate of Covid-19, the HSE remains resolute in its work to combat the virus. However, we are still dealing with the virus and its potential impacts as we are here today, and we will be contending with COVID-19 for some considerable time to come.

Working with the board of the HSE, my primary focus as CEO is to continue the good work that has been completed to date in dealing with the impact of the virus and to ensure that we prepare for future potential surges. The public would accept nothing less of us.

It is important to cast our minds back to late February and early March 2020 and recall the worrying scenes that were witnessed from Italy and many other countries in Europe with intensive care units and hospitals becoming overwhelmed with the dreadful virus.

Having worked for 30 years in the private sector and for now nine years in the public service, I have never seen such significant and important change undertaken and implemented by so many dedicated people in such a short timeframe. I am extremely proud of how the healthcare system has responded in such difficult and worrying circumstances. I pay particular tribute to our front-line workers. I also recognise the contribution of the voluntary sector and many within the private healthcare sector who have collaborated with us in the national effort. This has been with the support of major Departments and State agencies. I also thank the political system overall for giving us its support throughout, particularly in the early phases of this pandemic.

I will reference some of the achievements we have managed to put in place in recent weeks to protect the public. We have strengthened our ICU capacity from a base of 225 beds to an operable capacity of just over 400 beds, putting in place a surge plan with the support of the purchase of extra ventilators. We have secured a large and sustainable supply of PPE and other equipment in a highly volatile global market. This has been achieved with the support of major State agencies, particularly IDA Ireland and the Department of Foreign Affairs and Trade.

We have put in place agreements with over 3,500 GPs across the country to support us on new pathways of care. We have had the mobilisation of the National Ambulance Service in a way that has never been done before. We have 47 swab testing centres across the country. We have moved from having one laboratory supporting testing to having 41 laboratories now involved. Some 1,800 staff have been trained in contact tracing. We have provided a wide range of supports to long-term residential care facilities. We have put in place innovative ways to support vulnerable groups. We have the use of telehealth, with new technologies deployed over a very short space of time.

This has all been achieved in a very short time and I thank all the agencies and Departments which have worked with us throughout this. I pay particular thanks to our front-line workers who have pioneered many new ways of working and have shown an agility and resilience that has been truly extraordinary. Many lives have been saved because of their skill, innovation

and commitment. I am, however, deeply conscious that many have lost loved ones during the Covid-19 pandemic, including healthcare workers. I again extend my sincere condolences to all of those families.

Testing and tracing have represented a very significant mobilisation for the HSE overall. Last week, we published our change management plan to give us the capacity to process 100,000 tests per week. This involved 41 laboratories now for Covid testing, the availability of 47 swabbing centres across the country, and the deployment of new systems and supports to improve automation and turnaround times. Along with the increased capacity we have recently introduced some innovations. These include a GP service called "Find my Test" for tests which go beyond the committed time frames; a 14-day active management of contacts of a confirmed case; automatic texting of confirmed negative cases, speeding up receipt of this result; automatic testing for contacts of a confirmed case; automated scheduling of appointments to reduce waiting times; automatic test referral for contacts of confirmed cases; improved notification of complex cases to our public health teams; and an automated IT solution that now transfers test results to our contact tracing teams in 90 minutes where previously it was 24 hours.

I am pleased to report significant progress which has put us in a much stronger position to achieve our capacity on targets for the coming weeks. Our focus now is to improve turnaround times significantly. We have committed to an average turnaround time from swabbing to test result-----

Chairman: I ask Mr. Reid to sum up if he can as he has gone over his five minutes.

Mr. Paul Reid: Okay, I appreciate that. The position on congregated settings is on the record so I will make my closing remarks.

The entire health system has risen to meet many of the unpredictable challenges of Covid-19. I pay tribute to every member of staff for their professionalism, dedication and commitment and to their families who are supporting them. I would also like to thank the public for their tremendous support to date and for what they have sacrificed, which has been very significant. I again urge everyone to continue to support our front-line staff by following the public health advice to prevent the spread of the virus. It is really important that we all understand that we are still very much in the middle of this pandemic. We are not at the end by a long stretch. We continue to manage this crisis across several fronts, not least of which is the enormous additional cost associated with this pandemic.

Chairman: I thank Mr. Reid and I thank him for providing his opening statement in advance. I will call Fianna Fáil first. Deputy Butler has ten minutes.

Deputy Mary Butler: I welcome the witnesses, and thank them for giving their time. I thank them for their work to date and the response of the healthcare sector. I have four or five questions which I will put them to all three witnesses and whoever wishes to respond may do so.

This awful pandemic has borne down heaviest on older people, in particular those in nursing homes and residential facilities. Latest figures indicate that 62% of those who died were in such settings. I welcome that testing has been ramped up in nursing homes in recent weeks and all have been tested, staff and residents alike, but such testing should be carried out on a consistent basis. Regular testing in nursing homes will provide some reassurance for residents, their carers and families. Some felt badly let down at the outset. Is there a plan to roll out regular testing

on a monthly or two-monthly basis in residential settings?

Nursing homes closed their doors to visitors on 6 March to protect residents and staff. How many patients were transferred from acute hospitals to step-down facilities - residential homes or nursing homes - during the month of March? Were they tested for Covid prior to their transfer? Of those transferred, do we know which patients subsequently contracted Covid and how many have passed away?

Deaths are highly concentrated in the three age groups over 65 years, which account for 93% of all deaths from Covid-19. Was this the expectation of the witnesses at the beginning? If so, why was the response very slow on personal protection equipment, PPE, and staff support in the nursing and residential home sector? While there were significant issues around sourcing PPE initially, the level of deaths among those over 65 years suggests the response was slow at the outset.

The restoration of BreastCheck and CervicalCheck are vital for the health of women. A clear plan needs to be put in place to address the backlog that has built up during the Covid pandemic, when, understandably, the screening services were suspended. The time has come to supercharge screening as a priority. Routinely, 34,000 tests are taken monthly. Figures published last week showed that no mammograms were carried out in April and that samples sent to CervicalCheck labs decreased by 93%. In terms of my question, when can we see a resumption of those services and what plans will be put in place to deal with the backlog?

I turn now to the homecare sector and the wearing of face masks. Recently, the Health Protection Surveillance Centre, HPSC, issued guidance for immediate implementation that surgical masks should be worn by healthcare workers when providing care within two m. of a patient, irrespective of the Covid-19 status of the patient. Most people receiving home care will be older or more likely to have an underlying health condition and are obviously more vulnerable to the virus. Can Mr. Reid provide any clarity on that? Are face masks mandatory for a homecare worker who may be entering six or seven different homes on any given day?

Chairman: I ask Mr. Reid to reply to those questions. I am aware he cannot see the time limits we are operating under here in terms of the clock in the Chamber but there are six minutes remaining if he can reply to Deputy Butler's questions.

Mr. Paul Reid: I thank the Deputy. I will reply to some of the questions and then call on some of my colleagues. I will be brief going through them to allow my colleagues make some comments also. First, in terms of nursing homes, I will make some general comments. We have said repeatedly that this is a novel virus and as it has spread across Europe, every country is learning about it. We, too, have been learning in terms of how it can spread, particularly in a congregated setting and among a vulnerable group. While we have been aware previously of symptomatic patients, what we have seen in the past few weeks of this pandemic in Ireland is that many in the more vulnerable and elderly population can be asymptomatic, thereby allowing the virus to spread within nursing home settings. We have had to learn from very different symptoms and, in some cases, no symptoms being shown.

On the specific question about testing and nursing homes, we have completed a very significant testing process throughout all of the long-term residential care areas. We have completed all of the nursing homes, both public and private, the mental health facilities and we are well advanced in the disability sector also. A very significant programme has been undertaken by our community and national ambulance services.

We are currently getting some guidance from our public health lead in the country who is developing a strategy that will be recommended to NPHET shortly. That will set out our entire testing process looking ahead to the coming weeks, both in terms of long-term residential care settings and other vulnerable groups and areas of people we would proactively test. That will be part of the recommendations that will go to NPHET. I might ask Dr. Colm Henry to make a couple of comments on that issue.

The second question related to the transfer of elderly patients from acute settings to nursing home settings. As I said in my opening statement, we should cast our minds back to the start of this pandemic. The experience, particularly across Europe, was that a massive surge had impacted hospital and acute settings. Where we needed to provide massive supports also was in acute settings. We would have had an ongoing process of what we would call delayed transfers of care where people are deemed clinically fit and not suitable to be in an acute hospital setting for the transfer of those patients, and in most cases elderly patients, out of that care. That is a process we would have done, and that was the right thing to do at the point in time of doing it.

Third, on the PPE and supply generally to nursing homes overall, as we said a couple of times, this is a very different way for the HSE to work completely with the private nursing homes to the way and extent we have done in the past few weeks. The supports we have put in have ranged from, in some cases, a very significant number of staff. More than 450 staff are now redeployed across long-term residential care settings, including private nursing homes. We have another range of supports in terms of clinical specialists including geriatricians who would go in. Generally, we have multidisciplinary teams who would go in and give advice around infection control. Where outbreaks have taken place, our public health teams have gone in directly to those locations, including private nursing homes, and obviously the State-funded support scheme for private nursing homes has been part of that. We would have put in a range of supports, including PPE. I would make the point briefly that in the past few weeks the vast majority of our PPE has been distributed not to our acute settings but to long-term care settings, primarily nursing homes and, increasingly, home supports. I will make two brief comments and I will then ask my colleague, Dr. Colm Henry, to comment on screening services. We are anxious to get back to non-Covid levels of service in many of our services, in particular screening services. This will be a very difficult period because we have to restore some of our services in a way that protects the public. Nobody will thank us if we restore services in a way that means we see public health outbreaks of the virus. It is a big challenge to get back to previous levels of services, particularly in cancer treatment. I repeat that if people have symptoms or feel they have symptoms, the clinical pathway is to definitely go back to their GP. Referrals are still taking place for support for people with symptoms. Restoring screening services is one area that Dr. Colm Henry is leading on with my colleague, Ms Anne O'Connor. They will come back with recommendations on how we can restore the range of services in a way that is safe for the public.

I will ask Ms O'Connor to comment on masks but I will make a brief comment to give some context. The NPHET definition on the wearing of masks by homecare workers has changed. During this pandemic, we have been distributing approximately 200,000 masks per week to healthcare workers. Now that the definition has been extended to all healthcare workers, that figure has gone up and we are now distributing 1.2 million masks per week to healthcare workers across a range of settings, extending far beyond the HSE. I will ask Dr. Colm Henry to comment on screening and Ms O'Connor to speak briefly as well.

Dr. Colm Henry: I thank Deputy Butler. Screening involves bringing large numbers of

healthy people into a healthcare setting to have a test done to see whether they may have had some changes, whether to the breast, colon or cervix, that may lead to precancerous or cancerous changes. On 27 March, we had a directive from NPHET to stop all non-essential services in this country. Across the world - in the Netherlands, the United Kingdom, Australia and New Zealand - we see that screening services have been stopped because of the risk of bringing healthy people into a congregated setting and thereby running the risk of an outbreak.

In normal times, any screening programme has both benefits and risks. Currently, bringing people into a congregated setting, whether it is a van for breast screening or a waiting room, is something that we cannot do. We cannot go back to business as usual. We have to consider everything. For example, in the case of breast screening, a van could normally accommodate between 40 and 50 cases a day, but this number could certainly not be done based on Covid principles. With good prevention and control principles, one could not do more than ten cases per day. The same applies to the waiting room. A mammogram requires close contact between a radiographer and a patient and will require a new way of working. Our screening programmes are focusing on symptomatic patients, as are other programmes internationally. To give an example, in the case of suspected breast cancer this would include a new symptom that might suggest cancer. We are supporting the symptomatic services in their endeavours to get back up and running in a Covid environment.

As to when we will restore screening services to the way we knew them, it is far too early to say, not just for this country but also internationally. This is because the principle of screening involves large numbers of people being available for testing.

Chairman: My apologies to Dr. Henry, but I have to impose brutal time restrictions because we cannot be here for more than two hours and all members need to be able to ask their questions.

Deputy Louise O'Reilly: On that point, if we are to stick exactly to the time frames, I ask the witnesses to use their phones to time each ten minutes.

Chairman: I am working to ensure the witnesses can see the time but until then, the Deputy's suggestion is a reasonable one. I ask witnesses who have a phone to note the time available to them at the end of each slot.

Deputy Matt Carthy: Gabhaim buíochas leis an gCathaoirleach agus tá fáilte roimh an Uasal Reid, agus roimh na daoine uaisle eile.

I welcome our colleagues from the HSE. I also echo the words of Mr. Reid by thanking and commending all of the healthcare workers who have delivered and served all of us incredibly well in recent weeks. When the story of this pandemic is told, we will find that, notwithstanding how bad Covid-19 has impacted on us, including in the coming months, it would have been much worse were it not for the dedicated healthcare workers who put themselves in harm's way every single day they go to work. My only hope is that we never forget that, particularly in future debates on the terms and conditions under which those great people work. I have a number of very short questions and perhaps I could get some equally short replies. My first question is: how many tests were carried out yesterday?

Mr. Paul Reid: I do not have the exact number of tests for yesterday. I can give the Deputy last week's figures, which were about 38,000.

Deputy Matt Carthy: On the last day that we have figures for, how many tests were carried

out?

Mr. Paul Reid: Over last week, we averaged just over 6,000 laboratory tests per day.

Deputy Matt Carthy: How many test centres were open yesterday?

Mr. Paul Reid: As of yesterday, 29 were open.

Deputy Matt Carthy: Out of 47.

If we recognise that testing and tracing are going to be pivotal in terms of our recovery, those figures suggest we have a bit to go. When Mr. Jim Breslin was here earlier on, he referred to the fact that around 70% of negative test results are conveyed within 72 hours. Can Mr. Reid confirm that this is the case? Even with that, that would indicate that 30% of negative cases are not informed within three days. When is it expected that we will get that figure? When will we get to 98% of negative cases being informed within 48 hours, for example?

Mr. Paul Reid: The Deputy will appreciate I am trying to give him quick answers, but I need to put things in context as I do so. We are meeting the levels of demand that we have. The capacity we have built up has the capacity to build 100,000 tests per week so it is purely a function of the demand levels at the moment in terms of the answer I gave the Deputy on the numbers tested and the number of swab-testing centres open across the country. As the increased demand emerges by new definitions, those centres continuously open up. We have the capacity to do that.

Deputy Matt Carthy: In terms of conveying results, say, for example, we get to a point where we are delivering 100,000 tests per week, how long will it take for negative test results to be conveyed to those 100,000 people?

Mr. Paul Reid: I will tell the Deputy exactly what has been happening over the last couple of week and what is happening this week, and including our targets. There are two levels of targets. One relates to the time elapsed from when the swab is taken to when the laboratory test is available. The second one is what we call the end-to-end, that is, from the time the person is referred for a test to the time the contact tracing is done.

Deputy Matt Carthy: That was my next question. How long is the end-to-end, on average, now?

Mr. Paul Reid: The end-to-end target is to have everything done, end-to-end, 90% of those-----

Deputy Matt Carthy: How long is it currently, rather than the target?

Mr. Paul Reid: Currently, we are meeting the target. The target for last week was 85% to be done within five days. This week it is 90% to be done within three days. Specifically, in relation to the overall performance of our testing and tracing right now, I mentioned in my opening statement some of the initiatives. To get back to the Deputy's specific question about negative tests, what happens now is if we take all the tests that are done on a Monday, currently 97% of tests are negative. We have a 3% positivity rate. Those 97% will get their test result in two days or less. If it was a hospital setting, it will be less than a day. If it was a community setting, overall it will be two days or less.

Deputy Matt Carthy: Does Mr. Reid know offhand how many employers were informed

of their employees' test results before the employees themselves?

Mr. Paul Reid: This came up this morning in the committee's discussions and I am just trying work through the fine details of all of that, but generally, and ultimately our process is overall to inform the individual first-----

Deputy Matt Carthy: I get that but the question I asked was whether Mr. Reid knew how many workers had their results conveyed to their employer as opposed to them.

Mr. Paul Reid: I was coming to that specifically. In relation to some of those we have been proactively testing over the last few weeks, there is a responsibility and a derogation on the public health official to get those results out urgently. There is one case that we know of where the employer was notified of a significant number of positive cases and that is at the discretion of the public health official and the judgment he or she makes-----

Deputy Matt Carthy: Does Mr. Reid agree with what Dr. Holohan said earlier on? I think his words were that this practice would clearly breach patient confidentiality. Does Mr. Reid not agree with that?

Mr. Paul Reid: The way we want to do this is directly through the GP and the individual. That is the route we have taken throughout this process. There are exceptional cases where public health officials have a responsibility and have a derogation in terms of managing a major outbreak. That would be a responsibility that they take in extremely exceptional cases such as in a pandemic or a major outbreak.

Deputy Matt Carthy: We are in a pandemic. Does that mean that the derogation, as defined, applies to anybody?

Mr. Paul Reid: No, it would not because throughout the vast ultimate majority of all of the cases we have tested the result is communicated back through the GP to the individual. That is our process. That is the way it works.

Deputy Matt Carthy: Does Mr. Reid stand over the position whereby, in some instances, employers are informed about their workers' health before the workers themselves?

Mr. Paul Reid: No. Ultimately, that is not the way we want to see this done. We want to see it done directly through the individuals in the first instance. That is exactly the way we want to see it done. That is the way we have done it throughout this process.

Deputy Matt Carthy: Are you going to work to stop it then?

Mr. Paul Reid: The Deputy specifically asked me about a case, the details of which I do not have but have been trying to get since this morning. I will get it. The Deputy specifically asked me about a case of a plant or a particular organisation, which I understand was on public health terms, the way that was managed, in the exceptional pandemic situation.

Deputy Matt Carthy: Today, we received guidance that I understand is from the HSE on the conduct of our meetings here. It states: "If a person develops COVID-19 any person who spent a cumulative period of 2 hours or more during a 24 hour period in an enclosed space", and this place apparently fits that definition, should be advised to self-isolate within 14 days. In other words, if one person in this room gets Covid-19 then all of us should self-isolate. Does Mr. Reid stand over that advice?

Mr. Paul Reid: I shall pass the question on to Dr. Colm Henry, who is our lead on public health advice. The guidance is very clear. It is public health advice and it is clearly documented on our HPSC site.

Deputy Matt Carthy: If one were to take that advice, does Mr. Reid accept that in the situation of a meat factory that if one worker contracts Covid-19 then under the definition that we have been supplied with here the factory would have to close immediately or close for at least 14 days?

Dr. Colm Henry: The advice is as follows. If somebody turns out to have Covid-19 then anybody with whom they were in contact in the previous 48 hours, and as the Deputy described, in an enclosed setting for more than two hours they would be deemed to be a contact. The directive actually states, if we consider the detail on the HSE website, that a risk assessment is carried out by the public health department. In the case of a meat factory or any other congregated setting, or any enclosed setting, the public health department will carry out an assessment and decide based on their assessment and the analysis of the risk what actions will follow, who is go into isolation, who is to be deemed a contact and who is to be tested.

Deputy Matt Carthy: We have been given guidance. This relates to a committee that is doing important work, we hope, in terms of getting answers relating to Covid-19. The guidance very clearly states that even asking people to leave a room for two hours will not change the assessment and that, in the context of the controls, people who have been in contact in a room for over two hours should be asked to self-isolate within 14 days. Has that advice been conveyed to employers and places like meat factories regarding an instance of an individual contracting Covid-19? Essentially, in those settings, that means everybody will be asked to self-isolate for 14 days.

Dr. Colm Henry: I would leave these decisions to public health departments that carry out the outbreak management on all of our behalf. They carry out assessments of each individual area and each individual congregated setting whether it is a meat factory, a nursing home or a direct provision centre, and they will give the advice as to who should be tested, who should be isolated and who should be contact traced.

Deputy Matt Carthy: Only a few seconds remain. In terms of the advice that we were given, is that the advice that has been conveyed to employers this week as they reopen their businesses?

Dr. Colm Henry: Deputy, there is no blanket advice given to every single setting. I am trying to convey the message to him that each assessment is different based on the public health department's assessment of each setting.

Chairman: I thank the witnesses. I call Deputy Colm Burke. Is he taking time from somebody else?

Deputy Colm Burke: I shall take two and a half minutes from Deputy Brophy so I will speak for a total of seven and a half minutes.

Chairman: There is an additional two and a half minutes because the Deputy's earlier contribution was curtailed.

Deputy Colm Burke: I thank the Chairman. I shall try to keep my contribution as short as possible because many people wish to speak.

I thank all of the people in the HSE for all of the work they have done over the last number of weeks and months in very difficult circumstances. Everyone appreciates the dedication and commitment by everyone involved in dealing with this crisis.

I shall revisit an issue that I raised earlier this morning. It relates to congregated settings and setting out a list of where there were risks at an early stage. In a number of facilities there were more than ten deaths. In one of them that I am aware of there were six beds per ward. I note that Mr. Reid spoke in his report about mass testing in 372 mental health residential service locations and in 1,269 residential care facilities. What numbers of people are we talking about in each of these facilities, that is, the number of residents in the facilities and the number of staff? Second, has the HSE prioritised where there are no isolation facilities available if an outbreak occurs in one of the facilities? That happened in one of the facilities I know of and there were no isolation facilities available. Is a clear plan of action ready to be put in place if there is an outbreak?

The second matter I wish to mention relates to people working in the healthcare sector. Some 7,815 positive cases are in healthcare. Is there a breakdown of the number of people in the HSE and those in the private healthcare sector? Of that 7,815 do we know how many ended up having to be admitted to hospital and to intensive care? It is important that we get that information. What action is being taken to reduce the risk to healthcare professionals, be they care assistants, nurses or doctors? What has been identified that should have been put in place and must now be put in place to deal with and try to reduce the level of contamination of people who are working in the healthcare sector?

Mr. Paul Reid: I will ask my colleague, Ms O'Connor, to answer the question on nursing homes and congregated settings.

Ms Anne O'Connor: Regarding the congregated settings, we have been working since this started to examine the facilities we have in terms of the number of residents and the number of staff. As we previously mentioned about residential care, it is not just nursing homes. The mental health facilities and disability settings are also quite complex because we have houses and settings that are quite small with one, two or three residents. We have been working on the de-congregation of disability settings for a number of years, but we still have mental health facilities and disability settings where we have a small congregated setting of six or more and sometimes up to ten and 12 people in a house. In some respects they have been more difficult to manage but our services have been working to examine how they can spread the residents out more. We have moved people and we have looked at different ways of accommodating them. We have been working very closely with many providers across the disability organisations. That is a challenge for us.

Across all three we have prioritised facilities that have an outbreak. In the first instance we have been testing facilities with an outbreak or with suspected cases. They have now been completed. As Mr. Reid said, we have tested all residents and staff across all our nursing homes. We have also tested all staff and residents in mental health facilities. In disability settings we are more than halfway there. Our focus for this week and next week is to conclude the testing, with a particular focus on ensuring we have addressed all facilities with a suspected outbreak.

Mr. Paul Reid: I will respond to the question on the healthcare workers and I will ask Dr. Henry to respond as well. I can briefly give the Deputy some figures he suggested. Among healthcare workers who have had confirmed cases the rate of hospitalisation and ICU admission for Covid-19 is much lower than for the normal population. Some 3.7% or 259 of the positive

cases among healthcare workers have been hospitalised. This compares with an overall hospitalisation rate of approximately 13% for the confirmed cases in the total population. In terms of admission to ICU, 43 healthcare workers, or 0.61%, have been admitted to ICU, which is much lower than the rate for cases among non-healthcare workers in the population.

Deputy Colm Burke: Are the witnesses satisfied that there are adequate facilities to isolate a case if one is identified in healthcare facilities, either mental health or disability services facilities?

Ms Anne O'Connor: We are satisfied that we have processes in place in mental health settings. We are working with providers in disability services settings. Most disability services are provided through funded agencies. In some instances, people are easier to isolate than others for a variety of reasons, and we are looking at ways in which we can work with service users and their families. We have come up with different ways of providing services to be able to provide isolation. I cannot say that we are satisfied that we will not have an issue isolating somebody. However, we have worked a lot with services to see how they can isolate people when required.

Deputy Colm Burke: Is a system in place to check whether fundamental changes made in the running of facilities are being implemented in full? Are these residential facilities visited regularly to make sure that all the changes that were made are being followed through?

Ms Anne O'Connor: Our mental health and disability settings are regulated by external regulators. We are working closely with HIQA with respect to nursing homes and disability settings. The Mental Health Commission is also working with us on disability settings. Our services have been provided with advice. The staff in mental health settings, which are mostly HSE-provided, are involved in developing their own approaches to this with the guidance of public health information and the local area crisis management team. Likewise, the disability sector has availed of all advice and guidance.

On infection prevention and control, in the disability sector, most testing has been done by staff working in the sector rather than by external testing teams, and we will expand that. It is taking this as seriously as possible and doing everything that it can. Its first interest is service users and it is committed, across all of our services, to ensuring that we can continue to provide services that are safe and that do no harm to any service user.

Chairman: The Deputy has two minutes left. I can give that to one of his colleagues later.

Deputy Colm Burke: I thank the Chairman.

Deputy Ossian Smyth: Many people have been avoiding attending hospital. There are also people whose appointments have been cancelled and medical staff who are unavailable to work, especially in the private hospital system. People attend the private hospital system for necessary procedures which are important to their future health. To what extent are people who wish to attend and are willing to go to hospital, who require medical care that they had previously been getting through the private system, being provided for in any sense? Does Mr. Reid know the number of people who are being denied medical care as a result of large sections of these hospitals being empty?

Mr. Paul Reid: The rationale for us making that arrangement with the private hospital groups was to give us surge capacity at the start of and during this pandemic. Thankfully, with the good actions of the public and healthcare workers in following public health advice,

we have not seen that surge. We have a new scenario for how best to use that capacity in the coming weeks. We cannot just assume that the positivity rates or the transmission rates in the community will stay as they are. As restrictions are lifted and more people gather and engage with bigger groups, there is a severe risk of two things happening. One is an increase of the peaks and troughs of the transmission of the disease and the other is a significant surge, which has been the experience of some countries. We have to plan ahead in a different way to have capacity.

Clinical care pathways are still available in private hospitals. If a person was being treated by a private consultant in a private hospital group, the fact now that we have procured their services does not take away from that clinical pathway for the person who is receiving that treatment. If they are still a clinical priority and the service that they were attending is still required, that can still be in place. If that consultant has not signed up for the type A contract, it can be carried on by another consultant who has or it can be done on a *pro bono* basis, which has happened on some occasions. The clinical pathway is still there for the person-----

Deputy Ossian Smyth: Is Mr. Reid saying that there are options for all patients in that situation? In other words, if one's hospital is closed and one's doctor is not signed up, is it the case then that everybody has some option as an alternative?

Mr. Paul Reid: No. As I understand it, the Deputy asked me about a person who was receiving treatment in a private hospital group with a private consultant. The pathway is still available to that person through his or her private consultant, if the consultant has signed up for the type A contract. It is still there based on the clinical priorities, both public and private priorities.

Deputy Ossian Smyth: To exit from this stage where we have this full lease of all the private hospitals, and presumably we are going to return to using a smaller portion of the hospitals and taking them on an as-needed basis, a procedural basis or a National Treatment Purchase Fund, NTPF, style approach to usage, how is the HSE going to get from one of those to the other? Does the HSE have an exit pathway or is Mr. Reid hoping to find a way, as he said earlier, to deliver Sláintecare at speed, that the conversion of consultants into public contracts is something that will last? Are those converted contracts something that are long-term or are they only for the duration of the surge?

Mr. Paul Reid: To answer the Deputy's last question first, those contracts are just for the duration of the agreement. The heads of terms with the hospital agreement is very clear. It is for a specific period, and any decisions to renew that will be ultimately based on a recommendation from ourselves and the HSE board, as well as by the Department, ultimately the Department of Public Expenditure and Reform and the Government. It might be decided to go into some different arrangement in the future. These are all the considerations which will have to be made in the coming weeks.

Deputy Ossian Smyth: What is the expiry date? Do they all expire on the same date?

Mr. Paul Reid: Ultimately, the agreement for all the hospital groups was for three months, with the option for a five-month agreement. That was the nature of the heads of terms of the agreement. To extend it to five months - to extend it to July and August - needs a decision by the end of May. That is a consideration which will be given to relevant key stakeholders.

Deputy Duncan Smith: I welcome the witnesses for coming to the committee today. Why

did they CEO feel he had to write to the Department on 19 April on the Chief Medical Officer's commitments on testing capacity?

In a reply I received from the CMO this morning, I was told that the figure of 100,000 testing capacity, which we have reached this week after a month, will now be a fluid figure and under constant review. Is there a real impact on the delivery of services if the figure for testing capacity shifts? Is there a knock-on impact on what can be delivered if the capacity has to go up to 120,000 or is reduced to 80,000? Will that free up capacity or the delivery of other services?

We had four tragic Covid deaths yesterday. What is the proportion of non-Covid preventable deaths? Is this being tracked? Which is higher at the moment and is this something that is being measured?

Is any consideration being given to the provision of financial, medical and rehabilitative supports for health workers in the aftermath of the Covid-19 emergency, particularly with counselling? Is this being discussed as we seek to move out of this crisis, it is hoped later on this year?

Are Mr. Reid and his colleagues in the HSE concerned about the potential for under-reporting of symptoms or safe public health practices from residents in direct provision? It is well known that many asylum seekers fear speaking out because they are in such a vulnerable position and due to the potential ramifications of whistleblowing.

Mr. Paul Reid: I will try to be brief. On the first question, the reason that I communicated with the Secretary General on communications and capacity specifically related to the agreement that we had all been working to and have recently delivered, namely a pathway that gets us to 100,000 tests to be completed within a week. Specifically, the engagement that I had over that weekend related to communications where that was announced as we were still in dialogue about our pathway to get there. That was the nature of the engagement and communications that I had, and members will have seen the letter which is publicly available. There will be many different engagements between myself and the Secretary General on a range of issues, but I felt that we needed to clarify this one. Subsequently, as members will be aware, we have engaged significantly and collaboratively on the change management plan that I launched last Thursday, 14 May, which is the outcome of those discussions over the past few weeks. The issue was never about how we could get to the capacity for 100,000. The issue was our pathway and the process that we were engaged in to get there, and which we did finish out on. Thankfully, we have a good and agreed shared plan. That specifically is what I wrote about at that stage.

The second question was on whether other services will be impacted by testing and tracing. It is the very nature of what we are going to have to live with, definitely for the next year ahead but who knows, it may be longer. I cannot predict, but we are going to have to have the capacity for the testing and tracing process, while at the same time, as other Deputies have also asked, migrating back to non-Covid services. Unfortunately, it cannot be an either-or scenario for us. We cannot turn the dial down on one, because much of our workforce are workers that we have in the healthcare system engaged in swabbing centres, for example. It is an extra demand on us, but we will have to meet that demand while migrating back to a level of safe non-Covid services.

In terms of the non-Covid deaths, before I finish I will ask Dr. Colm Henry to come in because that is an issue that NPHET is looking through in order to assess the non-Covid deaths that have happened. Are these incremental or is it different? That is a process that the data is

still being compiled on.

The provisional supports for healthcare workers is something that I am hugely committed to. We have put in a range of supports during this period which have, thankfully, been well taken up by our support workers. That can be in terms of support helplines, engagement sessions that they have, collectively or individually, through our employee assistance programme, or dedicated mental health and stress lines that we have put in place for our staff that have been significantly taken up. We are happy to share with members some numbers on that take-up. Who knows about after it, but certainly throughout this crisis I want to maintain and provide the wide range of supports for our staff that they quite rightly deserve.

In terms of concerns regarding non-reporting of symptoms, this week we launched a public media campaign on national and local radio to strongly encourage people to come back for care where they have symptoms that they believe need clinical care, whether that is back through our GP, hospital or community systems. What we want to do in that process is-----

Chairman: Thank you, Mr. Reid. Does Dr. Henry want to respond very briefly on the issue of preventable non-Covid deaths?

Dr. Colm Henry: From the information available to us, any excess mortality we have seen this year to date is largely attributable to Covid-19 deaths, but that said, it does not take away from the fact that there is a morbidity building up through unaddressed illness, through people either not presenting with symptoms or not attending. That would not be immediately obvious-----

Chairman: I am sorry to cut you short. I appreciate that it is difficult without seeing the time periods that we have available. You are hamstrung in your answers. I apologise. We are seeking to remedy this for future witnesses, but it does not help you.

I call Deputy Shortall.

Deputy Róisín Shortall: I welcome Mr. Reid and his colleagues and thank them all for the work they are doing. I have four questions, the first of which is on the fact that we are now thankfully at a point this week where we understand there is a capacity to test and trace 100,000 cases per week. What does Mr. Reid believe is the main challenge to not achieving that figure in the event that the demand arises for that number? What might prevent that being reached? Specifically, can Mr. Reid comment on the reliability of the source of the reagents?

Second, regarding the data the HSE is producing, it is quite frustrating and does not help confidence when we do not get regular data updates. I ask him to commit to publishing the number of tests undertaken on a daily basis, with a breakdown of where those cases are, whether in the community, congregated settings, among healthcare workers, and so on. It would be helpful and would help bring the public along if the HSE did that.

My third question relates to the comment Mr. Reid made a few weeks ago when he stated that we would need to spend approximately €1 billion per year on PPE. That is a vast sum which has huge implications for the health budget and the economy in general. To what extent has he, or anyone else at any level in the HSE, given consideration to sourcing that PPE in Ireland? That would entail setting up a whole new manufacturing operation, but surely given the scale of the cost involved, it would make sense to do that. Have any moves been made in that regard?

My final question relates to high-risk groups such as older people, those with certain conditions, people in congregated settings, meat packers and construction workers, for example. What system is in place to identify those high-risk groups and respond accordingly? We all accept there were unfortunate delays in respect of nursing home residents, but how can we ensure we do not have similar delays in tackling other high-risk groups?

Mr. Paul Reid: I will try to take the Deputy's first three questions together. I acknowledge that it has been a very frustrating period for the public in terms of how we mobilised and got to our current capacity, because we did meet very significant issues. We encountered huge issues in the availability of reagents, test kits and setting up all the test centres across the country. Setting up the operation we did in eight weeks was not easy. We are dealing with a whole lot of legacy systems, from which we are now extracting these data and automating them. I will not go through the technical detail of it but it was a frustration for us as well as for the public. I just want to acknowledge that.

Deputy Róisín Shortall: What does Mr. Reid see as the challenges going forward?

Mr. Paul Reid: Right now the challenges ultimately depend on the transmission of the disease. As I said to Deputy Carthy earlier, as we are dealing with a low positivity rate and a high negativity rate, the vast majority of those tests will now be automated and completed in less than two days because they are negative and texts are sent out automatically. Where we deal with more complex cases, such as testing in congregated settings and among vulnerable groups, the completion of that process and contacting that person and their contacts takes more time. Sometimes we are dealing with people in a congregated setting, an ICU or a non English-speaking community. More complex cases take more time, so as that positivity rate changes, we will deal with more complex cases.

The second part of the Deputy's question related to the availability of reagents, which have largely come from a few suppliers. Roche and Abbott are the two major global suppliers based in Ireland and we have made agreements with them. We have also established a supply line from overseas in China, which now supplies our 41 labs with a steady supply of reagents. That has put us in a much stronger position.

The Deputy also asked about data and reporting. I accept her frustration with this issue because she has been diligent with her questioning of us on it. We are in a much stronger position now and we publish an operational report every day that sets out the number of ICU beds, trends, positive cases, and so on. We are now including a dashboard in that report, which shows the numbers of tests done throughout the week, the referral times - that is, the time it takes from someone feeling symptoms to being referred by a doctor - and the time it takes from swab test to lab test, and we will have the complete end-to-end time shortly as well. That dashboard went live last night and we will be building it further as we go along.

Chairman: I thank Mr. Reid.

Mr. Paul Reid: The significant cost of PPE is largely driven by the volume that we are supplying, the price on the global market and the reach that is required because the equipment needs to be provided beyond the HSE sector. Part of the strategy that we keenly wish to pursue is to get Irish manufacturers to recalibrate their businesses in order to provide PPE. We very much see that as part of stimulating the economy for the future.

Deputy Richard Boyd Barrett: Mr. Reid rightly praised the healthcare workers earlier.

We all praise our heroic healthcare workers. How does that correctly given praise tally with the decision to recruit healthcare workers and nurses who volunteered to answer the call from Ireland through temporary agency contracts provided by for-profit groups such as CPL Resources? Those contracts are the worst of all possible contracts. Under them, the company will not make any payment for a day on which an employee does not attend for work. This appears in these contracts under the heading "Sick pay". I mentioned earlier a nurse who, two weeks ago, was recruited, via CPL, to a Dublin hospital. She has since tested positive for Covid-19 and will not be paid under her contract. Is that how to treat our heroic nurses, particularly when we need permanent increases in healthcare worker, nurse and staff capacity? Who made the decision to recruit people via temporary agency contracts rather than directly through the HSE? The nurse to whom I refer has to self-isolate in City West. When she asked how to get to City West, she was told to get a taxi. When she asked if the taxi driver would have PPE, and know that his or her passenger was Covid-19 positive, she received no real response. That is not how we need to treat our healthcare workers.

What I am saying has important ramifications when we consider that the number of people on trolleys has risen to 114. We have been talking here about people being in the same room for two hours. There are 114 people in hospitals today who are in close proximity to each other and who will be waiting for hours for healthcare to be provided to them. Is it not the case that this is contrary to public health guidance and that there should be zero tolerance for people on trolleys in emergency departments? The only way to address that is by rapidly increasing the level of permanent staffing within and other capacities of our health service, and not via temporary agency contracts.

Mr. Paul Reid: I obviously cannot comment on the specific case the Deputy mentioned. I will give an idea of the scale of the recruitment that has been happening in the past few weeks in permanent full-time employment in the HSE. A range of contracts have been put in place. A total of 2,367 positions have been filled across the HSE. Approximately 1,200 of the people who filled those positions were recruited directly by our HSE teams on permanent, full-time contracts. The Deputy will be familiar with the situation in nursing. Our student nurses in years one to three have been given healthcare assistant contracts for the duration of this period. There are almost 1,200 such contracts. Almost 1,100 others have been recruited through the Be on call for Ireland initiative, albeit just over 120 of those have started. Approximately 1,000 more are to come in as part of the initiative and they will be given contracts.

I have no doubt that some people have been recruited on contracts of a temporary nature because as we went into this crisis, we always expected a massive surge for three months and that after that period we may not need to retain the full numbers we had recruited. Some people are on contracts of a temporary duration and that will be reviewed. We are now, obviously, looking at a very different scenario and a review will take place in that context. To reassure Deputy Boyd Barrett, the vast majority of people who have been recruited over the past while have come in through direct contracts with the HSE and others have been recruited through various agencies and sources such as that mentioned by the Deputy. That recruitment took place on the basis that we were dealing with a temporary crisis that now looks as if it will last longer. We will have to review that.

Deputy Richard Boyd Barrett: I hope all of those people will be made permanent. Does Mr. Reid agree that having people waiting on trolleys in emergency departments is incompatible with the public health guidance on social distancing and has to be addressed, and that there has to be a zero tolerance attitude towards it?

Mr. Paul Reid: The reality for us is that we cannot have a situation where we end up in a winter crisis as happened last year, where significant volumes of people were on trolleys. As we head back into the non-Covid services to the best extent we can, we have to do so in a public health way that protects all of the people who come back to our hospital system. We have to go back to this very differently than we may have done in the past.

Chairman: I thank Mr. Reid.

Deputy Matt Shanahan: I wish to address Mr. Reid first. In terms of public policy communications, I have had representation from Conradh na Gaeilge asking that the HSE look to do some Irish messaging across the English radio and television channels and examine postering to make sure there is a representation of the messaging in Irish.

I refer to the policy on nursing homes. We know that the elderly are most at risk with respect to Covid. Has the HSE thought about any type of asymptomatic testing of staff in nursing homes? In other words, is it trying to find some way to carry out randomised testing of healthcare professionals to ensure they are not going to work as vectors of the disease? We have to go into the centres where people are most challenged.

The Chief Medical Officer was not able to give me a response to an earlier question. I ask Dr. Henry whether NPHET or any of the other medics are looking at the use of hydroxychloroquine, which has been used by a number of medics as a prophylactic. In terms of getting Covid, there is a lot of evidence building about supplemental vitamins, in particular vitamin D and zinc, for the elderly in respect of trying to stave off infection, and whether this should be a policy we consider. I believe Abbott has what may be an antibody test. An Israeli company has, I believe, developed a new generation saliva test. Do we have any information on those tests and when they might become available to us in Ireland?

Could the witnesses describe the difference between at risk and vulnerable in terms of our healthcare personnel? I know of a nurse who has diabetes and uses an insulin pump, and was described as at risk rather than vulnerable. She works in a setting where a patient tested positive. She had not treated the patient for 24 hours and, therefore, was told that she could not isolate and if she did she could do so using her holiday time. She was then asked to swab a patient who had a high temperature, which she did while wearing PPE, but she then had to wait a number of days for a test result to come back which was, happily, negative. She, like a lot of people, is confused about who is at risk and who is vulnerable.

There is a direct provision centre in the south west of the country where refugees have been placed in the past month. They have been largely isolating and have now come into the community. There is a lot of angst in the community that some of the refugees might harbour Covid and no testing regime has been implemented. Could we have some proactive testing in direct provision centres so that those living in them can mix without any issues of racism or anything else arising?

Mr. Paul Reid: I thank the Deputy. I will pass him over to Dr. Henry.

Dr. Colm Henry: On the testing of healthcare workers, we have some information that will inform how useful it might be in a residential care setting. A vast exercise was carried out on all residents and staff in nursing home settings. We know from the report presented to NPHET last week by Dr. Lorraine Doherty, clinical director of health protection, that there was a very low positive result for healthcare workers, in the order of 3% or 4%. It is likely that when there

is a focus on healthcare workers in terms of protecting them, as well as staff, we will consider a range of measures, including infection prevention and control, hygiene, PPE and the screening of healthcare workers going into nursing homes. Testing will form one part of that. My assessment is based on the advice from Dr. Doherty. Testing will be focused rather than blanket, because blanket point-in-time testing yielded very little information apart from telling us that there was a very low prevalence of the virus at that point in time.

The Deputy's second question was regarding hydroxychloroquine, a drug used for other conditions. There have been some small studies done which to date do not show any direct benefit. The current advice from the expert advisory group, in line with that in other countries, is that more research is needed before we demonstrate this is of any benefit in either the prevention or treatment of Covid-19. It is a drug that is not without side-effects, particularly cardiac side-effects. As such, we would not recommend it for prevention of Covid-19.

The third question the Deputy asked was on the salivary test. The current test we use for Covid-19 is a polymerase chain reaction, PCR, test which detects viral ribonucleic acid, RNA, in real time. It is very sensitive, not only to those who are actively sick but even those who are in a presymptomatic phase of two days. It picks up pieces of the viral RNA and obviously it correlates with their degree of infectivity. Other tests proposed include serological tests which look for antibodies. These are not so sensitive in the acute phase and tell us nothing about people's infectivity. We will carry out some so-called zero prevalence studies in this country where we will detect antibodies in two populations. We will, hopefully, get that study done in June. It will tell us something about the exposure of the Irish population in two random populations to the virus throughout this pandemic.

The Deputy asked about a direct provision centre. I will enunciate the same principles that I have enunciated, namely, that outbreak management is a function of public health and each situation is different. Our public health departments are trained and have experience in going into these settings, looking at the layout, congregation, isolation facilities and number of positive tests and giving specific advice along a given set of principles which do not apply in any blanket way across all healthcare settings. With regard to direct provision centres, in some centres there has been testing of everyone in the setting based on the layout of the particular centre and the number of positive tests. In others, not everyone has been tested, either because there has not been an outbreak or there has been a very small number of positive cases. We leave it to the public health departments which are managing these outbreaks to make those judgments on an individual basis.

Chairman: I thank Dr. Henry. I call Deputy Michael Collins of the Rural Independent Group.

Deputy Michael Collins: I thank the officials for appearing before us.

I will concentrate briefly on congregated settings. Community hospitals were meant to be brought up to a standard, as some were, of having up to 80% single-bed occupancy. At some stage, the HSE believed this target could not be delivered. It was a HIQA standard and the 80% figure was later reduced. Unfortunately, as I have seen in west Cork - it is probably the case throughout the country - this standard was not delivered. It is to be delivered going forward. Why were the standards announced initially not applied? Deadlines for bringing hostels up to standard were missed. Has this cost lives, especially in settings where there are multiple people in single rooms?

Was it necessary to remove home help from clients who were receiving only bare essential hours? In recent years, we have been fighting for greater investment in home help. It is proven that people who can stay at home longer are much healthier. Many people are very upset that they have lost their home help service and are trying to have it restored. That issue needs to be focused on.

I mentioned in an earlier discussion the budget available to the HSE. I note it has acquired a PC-12 aircraft to fly swabs to Germany for testing, which is very important. We realise now that these tests could have been carried out in laboratories here. As I said, Animal Health Laboratories Limited in west Cork has stated that, with a little investment, it could have carried out thousands of tests and the company has asked why we spent large amounts on having testing done elsewhere. The tests being carried out in Germany may not cost much but it costs a lot to get them there. We could have had next-day or same-evening results if we had invested in laboratories here. Maybe that issue will be considered.

Doctors and nurses from all over the world have practically given up their livelihoods to come home and help us save lives. What has the HSE planned to encourage them to stay in Ireland?

Ms Anne O'Connor: On community hospitals and the investment programme, we have had a programme of investment in all our long-term residential care facilities and nursing homes, including the HSE community hospitals. That has been a staged programme in line with HIQA requirements relating to environmental conditions in congregated settings. We have developed that in line with available resources. Some of our capital programmes have concluded while others are in train. There is a rolling upgrade to our facilities.

Regarding home help, prior to the emergence of Covid-19 we were providing home support to more than 51,000 people. That came down to 40,000. We saw a reduction of slightly more than 11,000 in the number of people in receipt of home support, but it is important to note that of those, 7,500 wanted to have the service suspended. The only services that were suspended were for priority 3 and priority 4 people, accounting for just under 4,000 people. Services were temporarily suspended for about 3,800 people. The community healthcare organisations are working closely with the providers throughout the country to ensure that people continue to be supported. We have also been signposting people to the voluntary sector and ensuring that we have telephone contact with them. In the majority of cases where service was suspended, this was at the request of recipients because they did not want people coming into their homes. We are working proactively. We have redeployed approximately 166 home support workers into residential care. As the situation in residential care stabilises further, those people will be redeployed to the provision of home support.

Mr. Paul Reid: In response to the last question on laboratories, I note that the German laboratory is one of a total of 41 labs. The other 40 are Irish-based and include the Enfer Group facility in Kildare. That is our strategy. Our arrangement with the German laboratory is quite competitive, allowing for the transport costs which the Deputy quite rightly mentioned. We would not have entered it if we did not need the capacity and it did not meet our competitive tests. Our agreement with that laboratory is quite competitive in terms of logistics and test turnaround times. However, 40 of the 41 laboratories are in Ireland.

Chairman: I thank the witnesses. I now return to the second Fianna Fáil speaker, Deputy Norma Foley. I thank her again for her patience in the first session.

Deputy Norma Foley: I would like to begin by welcoming the witnesses and expressing unreserved gratitude for the superb work of the HSE and its staff in the past several months and on an ongoing basis. I wish to acknowledge that many lives have been saved as a consequence of that work. However, it would be remiss of me if I did not shed light on what my constituents regard as shortcomings within that service. My constituents believe that actions or inaction in recent weeks have resulted in the loss of lives. I refer to a direct provision centre at the Skellig Star Hotel in Cahirsiveen, County Kerry. I wish to pose some questions about this particular facility and about direct provision centres. I ask the witnesses to answer and I will then have two further points to make.

I note that the Department of Justice and Equality claims unequivocally that the HSE failed to inform its officials of a positive case of Covid-19 at a Travelodge hotel in Dublin on 8 March. This Travelodge was home to a large group of asylum seekers. Is it true that the HSE failed to inform the Department of Justice and Equality? The Department of Justice and Equality also claims that the HSE signed off at national level on the movement of people from that same Travelodge to the Skellig Star Hotel in Cahirsiveen, a five-hour bus journey, without testing the group prior to leaving Dublin or on arrival in Cahirsiveen. Is this true?

Is Mr. Reid aware that the HSE Cork Kerry local health office expressed serious concern and misgivings about the movement of a large group of people during a pandemic, and that it expressed grave reservations about the suitability of Cahirsiveen as a location for a direct provision centre due to a lack of primary care facilities in the area? Clearly, these concerns were overruled. I would like to ask Mr. Reid exactly who overruled them. Was it the HSE or was it the Department of Justice and Equality?

There is evidence of what I consider to be not best practice at this direct provision centre, at which there are now 26 or more confirmed cases of Covid-19. Residents who are not blood relatives continue to share rooms, although this is not best practice. Given the size of the premises, there is absolutely no social distancing. There is a shared laundry room, small public spaces, a shared lift, etc. Equally, there was absolutely no professional deep cleansing of this facility at any stage following the confirmation of the 26 cases, and residents continue to live there. Could Mr. Reid explain also, as the body charged with public health, how from the first diagnosis of Covid-19, it took the HSE 39 days to have a public health presence on the campus of the Skellig Star? I will allow him to answer those questions and then, with your indulgence, Chairman, I have two further points to make.

Mr. Paul Reid: I will make a few comments and then I may call on one of my colleagues. I thank the Deputy for her opening comments, which we will pass on to everybody. I am sure they have heard them.

Second, regarding the Skellig Star in Cahersiveen, we have been working very co-operatively with the Department of Justice and Equality in recent weeks, specifically on the location the Deputy mentioned. It has been the subject of joint engagements between the public health teams, the local community teams and with officials from the Department of Justice and Equality on a national level. It has also been the subject of discussions between me and the Secretary General of the Department of Justice and Equality. It is true that there has been a lot of engagement and collaboration in terms of working with us to try to address the issues.

Specifically in relation to our role in that regard, we give public health advice very clearly and such advice is very well publicised. There is an obligation on the operators of direct provision centres to implement the advice. On many occasions we go into centres. In that specific

case, our public health teams would have gone in and given specific advice on the location, both advice for staff and residents of the direct provision centres. There would have been a lot of engagement in recent weeks. I have been engaged locally with the teams down there as well. As I understand it, there has been significant engagement by the HSE.

I cannot comment on the particular positive case and the testing the Deputy mentioned. I do not know the detail of the case but I am happy to get back to her about it. Our Cork-Kerry community-based teams and the public health teams put significant supports in place there, not just in terms of advice. The implementation of public health advice is the responsibility of centres themselves. We will go in and support them in terms of what they need to do, but there is an obligation on the centres to implement the advice.

Separately, in terms of clinical care for anybody, we have been providing that pathway through our own public health teams as well.

Deputy Norma Foley: Could I just conclude?

Chairman: The Deputy can ask one very brief question.

Deputy Norma Foley: Yes, just on brief question. Could Mr. Reid revert in writing in response to the questions I posed, as they are hugely important to the residents and to the community of Cahersiveen?

As HIQA has no overall remit in this regard, I ask that at the very least he would call for an unannounced inspection of the premises in question. On foot of such an inspection, which from all I know I am confident the centre will fail, as a matter of public health and safety and the welfare of everybody concerned, will he will call for the immediate closure of the centre should the public health inspection be failed?

Chairman: Is Mr. Reid happy to answer any questions that have not been answered by way of correspondence?

Mr. Paul Reid: We will ask the local community teams, through our officials, to make sure we get a local response on the issue.

Deputy Louise O'Reilly: Can I assume that all correspondence given will be circulated to the committee in response to questions asked?

Chairman: Yes.

Deputy Louise O'Reilly: Mr. Reid is very welcome. We thank him and the people he represents for all the work they are doing day in and day out. During the course of this pandemic, I have remarked on the manner in which HSE staff have stepped up to the plate. They have changed their work practices in the blink of an eye. I well remember politicians and commentators long bemoaning the fact that staff were the biggest obstacle to change in the health service. I think we have successfully busted that myth now and I sincerely hope nobody ever goes back to it because we saw staff stepping up to the plate in a way that has taken our breath away. They have been absolutely outstanding. Mr. Reid confirmed that.

This morning, I asked the CMO about the specific guidelines in place for construction workers and I asked if similar guidelines were in place for other workers. We now find out that we in this Chamber have very specific guidelines in place for health and safety reasons, which is important. However, I cannot understand where the line is being drawn between what happens

in here and what happens somewhere else. If two hours is the rule, two hours is the rule. If everyone has to self-isolate, they have to self-isolate. It should not matter whether they work in politics, in a meat factory or in a shop. How is that being managed and how are these guidelines being conveyed to workers?

While I am on the issue of workers, healthcare workers account for 31.4% of infections. Does this worry the HSE? Are there plans in place to reduce this figure? Are specific plans in place to protect workers? It is very worrying.

My last point on workers is that nurses are due a pay increase. Some of them have got it and others have not. Can the witnesses tell me what the delay is and where the blockage is?

Mr. Paul Reid: I thank the Deputy. I will be brief; I am watching the clock.

Chairman: While I agree with the Deputy that the issue of nurses' pay is very important, I am not sure it is relevant to the Covid-19 response.

Deputy Louise O'Reilly: It is fine if Mr. Reid declines to answer. I doubted that he would.

Chairman: I just wish to say that the witnesses are not compelled. They may not wish to answer that question as it is not within our terms of reference.

Deputy Louise O'Reilly: I will not compel Mr. Reid to answer.

Mr. Paul Reid: I thank the Deputy for her comments about our staff. In all my comments I refer not only to HSE staff but to healthcare workers in general across the country, including GPs. All our healthcare workers have done a phenomenal job with us, for us, and for the public.

With specific regard to the public health advice, I will say two things. The first is that the advice on the Health Protection Surveillance Centre, HPSC, website is public health advice for all workforces and all organisations. As Dr. Henry said with regard to how that advice is applied, managed, monitored and implemented, our public health teams provide significant amounts of advice - particularly in recent weeks and again this week - to different sectors that contact us about opening arrangements. Our teams provide them with a level of advice separate to what is available on the site. The Health and Safety Authority, HSA, is playing a lead role and takes a big lead from our public health advice. It is directly engaged, even today, with our teams with regard to the application of public health advice. There are a number of significant working groups led by the HSA and our own teams which inspect sites for other reasons. For example, our environmental health officers may be carrying out particular inspections and, while doing so, they may take cognisance of the wider public health advice. All of that is being worked through with the HSA.

On the Deputy's questions with regard to healthcare workers, we are concerned about any positivity rates across the healthcare system and about how the infection may transmit further. Earlier I mentioned that hospitalisation rates and rates of admission to ICU were falling as a result of a number of actions we have taken, particularly some of the actions taken in congregated settings and nursing homes. In some cases agency workers may work between a number of different settings over a period of a week or, in some cases, a day. We took very early actions so that employers and agencies would ensure that staff were assigned to dedicated locations so that they would not have the opportunity to transmit the disease to other locations. That was one action.

A second action relates to accommodation. Significant numbers of staff and healthcare workers, both HSE and non-HSE, were provided with accommodation. Ms. O'Connor will provide details on this in a few minutes. Healthcare workers who shared accommodation with other healthcare workers were put into other locations to reduce the risk of the virus spreading between healthcare workers.

Deputy Louise O'Reilly: I asked Mr. Reid whether he was worried about the rate of 31.4%. That does not seem to be in line with the rate in other jurisdictions. I also have other questions. I am well aware of the measures that are in place, although it seems they are not enough if the rate of infection is 31.4%. We are very constrained on time, for very good reasons.

I will switch to the issue of nursing homes. People in my constituency and elsewhere have expressed to me the view that it was at the very start, when hospitals were cleared and people were transferred into nursing homes, that the virus was brought into those nursing homes. What specific actions were taken arising out of Mr. Reid's meeting with representatives of Nursing Homes Ireland on 19 February? Was a plan - not advice and guidance, but a plan - put in place with regard to the human, financial and other resources that would be needed following the meeting?

Mr. Paul Reid: I will say two things and then may ask Ms. O'Connor to give some wider evidence. On the first assertion the Deputy made that the transmission of the disease can be tracked back to - I am paraphrasing, excuse me, but this is what she may have said - people moving from a hospital setting to nursing homes, there is no evidence whatsoever for that. I think it would be misleading to say that that is where one can track back transmission in these in nursing homes to. It would be unfortunate that that would be perceived because there is no evidence. In fact, the evidence in terms of where the transmission within nursing homes can be identified or tracked back to is still something that NPHET is working through and trying to get a better level of understanding. It is not just us in Ireland. Just today the ECDC published a report on transmission of the disease in congregated settings. It too is learning. In every country mentioned in that report today there are learnings about how the disease may-----

Deputy Louise O'Reilly: I appreciate that. I am not suggesting that is the case. I am saying that has been suggested to me.

Mr. Paul Reid: Okay.

Deputy Louise O'Reilly: When Mr. Reid has said he can be confident that has not happened, he is talking about a report being done. It strikes me that he could not be confident as yet. Specifically, from his meeting on 19 February with Nursing Homes Ireland, what plan in terms of the human resources, financial resources and other resources that would be necessary was put in place immediately following that? There does not seem to have been a plan. If there is, maybe Mr. Reid can share it with me.

Mr. Paul Reid: Sorry, I may have misquoted the Deputy, but equally she may have misquoted me. I did not say I am confident. I said there is no current evidence that demonstrates that was the case in terms of transmission and transfer of patients across.

Specifically, on the meeting with Nursing Homes Ireland, I would meet and discuss with Tadhg Daly on a reasonable basis throughout this whole process - in the pandemic over the last few weeks. There have been very good relationships between Nursing Homes Ireland and the HSE throughout this period. On the Deputy's question of 19 February specifically, I can re-

member the meeting clearly. I have met a wide range of stakeholders since I took over the HSE. That was my first meeting with Nursing Homes Ireland. It was my first meeting with Tadhg Daly and its chairperson, Maurice Pratt. It was really geared towards an informal welcome and discussion-----

Deputy Louise O'Reilly: Therefore Covid-19 was not discussed at that meeting.

Mr. Paul Reid: We had a brief discussion about how this may impact on Ireland. There was a very brief discussion between both of us. I would be doing it an injustice and indeed the HSE an injustice to say it was an in-depth discussion because we were just learning at the start of this - 19 February was very early stages. The world's focus and Ireland's focus were on how this may impact on our acute and ICU-----

Deputy Louise O'Reilly: Come on. Less than two weeks after that meeting, Nursing Homes Ireland imposed visiting restrictions in nursing homes. Did the HSE consider doing the same for public nursing homes? It was clearly thinking ahead. A couple of weeks later it was able to impose the restrictions. Mr. Reid is saying he had an informal meeting with its representatives in the middle of the preparations for the pandemic, but it was not mentioned, or it was not the focus of the discussion.

Mr. Paul Reid: I do not believe there will be any disagreement between us and Nursing Homes Ireland on-----

Deputy Louise O'Reilly: I am not suggesting there is. I am asking Mr. Reid.

Mr. Paul Reid: I am clearly saying to the Deputy that at that stage of it the world's focus and Ireland's focus were on how this could impact on the acute settings. It was a general discussion and was about things we might need to be thinking of in preparation. That was the extent of it. Then we discussed a wide range of matters in general about nursing homes and how they interface with the health service on all of these supports.

I might just ask Ms O'Connor to make some general comments.

Deputy Louise O'Reilly: Time is very tight. When Nursing Homes Ireland introduced visiting restrictions, did the HSE give consideration to doing the same in public nursing homes? Did Mr. Reid request a report? Did he-----

Mr. Paul Reid: Throughout this whole process we have taken guidance and direction from NPHET in terms of the instructions and directions that have come from it. That is where we got our direction.

Deputy Louise O'Reilly: As someone who is responsible-----

Chairman: Thank you.

Deputy Louise O'Reilly: Sorry, Chairman, you did indulge others. I am in the middle of a question.

Chairman: I am sorry too.

Deputy Louise O'Reilly: As someone who is-----

Chairman: I am sorry too. Many people have had less time.

Deputy Louise O'Reilly: I do not mean this disrespectfully, but others have been allowed the facility-----

Chairman: I am sorry, I am not going to-----

Deputy Louise O'Reilly: ----- to go over their time. Indeed, my colleague cut his time short the last time.

Chairman: I am-----

Deputy Louise O'Reilly: I will ask one very brief question if I could.

Arising from that meeting, and in the intervening time the HSE did not commission a report or ask anyone to investigate if it would be a good idea to restricted visiting in public nursing homes; it waited for advice. Is that right?

Mr. Paul Reid: As throughout all this whole process, we take all of our public health direction from NPHET. That is where we get our public health direction.

Chairman: I thank Mr. Reid. I now call Deputy Carroll MacNeill. Is she taking time from somebody else?

Deputy Jennifer Carroll MacNeill: I will take the additional two and a half minutes from Deputy Burke, but I will leave time for Deputy O'Dowd, if there is time at the end.

Chairman: It will be Deputy McGuinness and then Deputy O'Dowd.

Deputy Jennifer Carroll MacNeill: Understood.

Chairman: The Deputy has seven and a half minutes.

Deputy Jennifer Carroll MacNeill: I thank Mr. Reid and his colleagues for coming today. I know they put considerable work into preparing to appear before the committee and it is really appreciated. As we are beginning to learn how to live with Covid and doing so safely as we reopen our economy, we must try to establish confidence in the economy and also in healthcare settings and so on. Bearing that in mind, can Mr. Reid be clear about how many health-acquired infections there have been, that is, people who were in acute hospitals and acquired Covid? Can Mr. Reid break those figures down into those who recovered or died as a consequence? There is one very sad case in my own area. It is a matter of confidence over time. I imagine, subject to Mr. Reid correcting me, that the incidence rate will decrease over time as the reaction, use of PPE and management practice, improves. It will be important for the public to have clarity on if we are asking them to return to hospital settings for treatment of non-Covid illnesses.

On reopening healthcare settings more generally, I refer to paediatric care and clinics. On reopening hospitals, care applies to everyone but it is particularly difficult with children, in relation to social and physical distancing but also often diagnostics. I am particularly concerned about the opening of standard clinics, including diabetes clinics. Picture the management of the standard outpatient clinic in Crumlin hospital on a Tuesday or Thursday afternoon. How will that be managed? I cannot see a way where it returns to its previous form at any time in the future. Is this an opportunity to break that into something that is easier for parents generally to manage, where they might turn up at a specified time with a likelihood of having the appointment within that time. That is an important opportunity that might come from this.

On nursing home testing, Dr. Holohan referred to the European Centre for Disease Prevention and Control, ECDC, technical report which was published today. I do not wish to catch Mr. Reid on the hoof on this but it focuses on the rapidity of testing. Will Mr. Reid confirm two things? There was an ongoing concern on nursing homes in my area about their ability to test patients and staff rather than waiting for a scheduled test, either waiting for GP referral or for a public health authority to come and test or to schedule a test. Nursing homes are capable of doing it and some are beginning to do it but as recently as last week, nursing homes in my area have raised this with me. Linked to that is where those tests go. There was concern that the batch of testing went to more than one laboratory resulting in staggered results back to the nursing home. That creates operational difficulties when one is trying to operate isolation in a confined congregated setting such as a nursing home. Will Mr. Reid confirm that he expects this will happen or that it is already happening, where nursing homes are entitled to do that testing themselves where there is a suspected patient and that any batches will be tested in the same laboratory to accelerate the process?

The ECDC report goes through European countries, Belgium, France, Germany, Ireland, Norway, Spain, Sweden and the UK. All but two have data from as recently as 11 May. Anyone reading it will notice that our data relating to long-term care facilities is from 13 April. I want to flag that with Mr. Reid. There may be a reason for this and I would be delighted if he could provide that to me. If that is not possible now, he might do so later.

Returning to normalisation, the decision to take over private hospitals had to be made at the time it was made, in the expectation of a surge and the pressure on intensive care units. It is incredibly welcome that it has not been needed as expected. It would have been unforgivable not to make those decisions at that time. However, now that we have overcome that first really dangerous period and it looks as though we will experience a series of waves, as described earlier, does Mr. Reid have in mind an appropriate proportion of space that must be retained over time in private hospitals in order to account for those waves? Will he give the committee some information on that? That is enough.

Chairman: That is a lot of questions.

Mr. Paul Reid: I thank the Chairman. I will try to be brief going through the questions. My colleague, Dr. Henry, might mention one of them. The first question related to transmission in healthcare settings; I think it mentioned hospitals and transmission of the disease. The learning from the early phases and the work NPHET has been doing over the past while demonstrates that certainly the early transmission of the disease was happening within the community. That was where the major transmission of the disease took place. Obviously, the work and protections we put in with regard to our own healthcare workers were geared towards stopping the transmission of the disease, particularly in hospitals, and then in nursing homes also.

The second point, and I will answer briefly, was on the opening of outpatient departments, and the Deputy gave some examples. The chief clinical officer and the chief operations officer, who are both here with me today, are working through a plan on how we get back to non-Covid-19 services in a very safe way. The Deputy gave an example of an outpatients waiting room, which cannot be the case any more. We cannot have the numbers of people waiting for the various patient services they would come forward for congregated together. We have to go back to this in a very different way. It may not be the most efficient way but we have to go back to it in a very safe way. That is the work we are doing now. What would be the priorities about the services we would restore, and we spoke earlier about screening services and other services? What are the risks we have to manage for each of those services? What are the equity

issues we need to put in place and the various risks? That plan is currently being finalised by my two colleagues who are with me here today.

The Deputy referred to the European Centre for Disease Prevention and Control, ECDC, report. I briefly went through that this morning. The Deputy is correct. It does reference the various countries, approaches to it and the data collection. I cannot comment specifically on the issue the Deputy referenced at the end of her contribution about the data for our own long-term care settings but I can come back to that.

On private hospitals, and I might ask my colleague to come back on the nursing homes, the Deputy is correct. I want to say again that it was procured for a particular reason. Thankfully, we have got through that. The biggest caution we have to put in place, and this is WHO guidance, is that a healthcare system needs to keep 80% capacity levels. We all know that, traditionally, the Irish health system operates at 95% on a normal day. We cannot go back to the way we were so we have to keep extra capacity. The thought process now is that: first, if we meet another surge we still have to keep capacity; second, even as we head into a winter we have to head into it knowing that we have to create capacity; and, third, what mechanism or way would we create that capacity in the future? That has to be part of the consideration being given to the current usage of the agreement we have with the private hospitals. Would we keep that for a further period as part of the agreement? Would we only keep some of it for a period of the agreement or would we go into something in a very different way? Ultimately, that is a decision for our policymakers in government.

Chairman: I thank Mr. Reid. I will move on now to Deputy McGuinness who has five minutes.

Deputy John McGuinness: Various consultants who contacted us over the past few weeks have pointed to the fact that the current arrangement with private consultants in private hospitals is inefficient and a waste of taxpayers' money. That could have been done differently, it could have been done better and it could be modified now. Who is giving us a look-back on how this contract has worked up to the point of its extension, if it happens, at the end of the three months? A consultant radiologist, for example, tells me that they would normally read 200 patient scans a day and that has gone down to zero. Is that true? Is that a fact of this arrangement the HSE has with the private hospitals? Is that a consequence of it?

Another consultant informs me that a significant number of private hospital appointments have been cancelled. Does Mr. Reid know how many have been cancelled for the months of May and June? Another consultant says that because three months of normal service has been lost, the projection of 1,800 extra cancer deaths is now a figure that is known to the Department. I want to know where that figure came from, does it stand up, and if Mr. Reid has any comment on it?

The other issue is the contract itself. Mr. Reid offers contract A. I want to know if there was a greater saving to be made or a greater use of the time of consultants in terms of contracts B and C.

Is it true that someone informed the State Claims Agency to contact pathologists to say that the cancer biopsies from private hospitals from consultants who had not signed contract A were not to be read? Was that a means of forcing those consultants to sign contract A?

The other issue is also referred to in a consultant's letter in which he states that there are no

pathways for him to look after public patients or for the consultant's patients to be added to public waiting lists. That would seem to contradict what the HSE said earlier. The witnesses cannot ignore the feedback from the consultants in these cases who are pointing to failures within the system and to a lack of governance in the spending of taxpayers' money. Will the HSE tell us how many tests are undertaken in each of the 47 test centres? Do they run on a seven-day basis, how many tests are carried out in each centre, and what are the costs involved?

Ms Anne O'Connor: On the issue of consultants and private hospitals, the decision was taken to go with an A-type contract. Clearly, everything is going to be reviewed, and as Mr. Reid said earlier, there is going to be and there is already a review under way to determine whether this would be extended beyond the current agreement.

On the use of the private hospitals, the core principle is that people will be assessed and seen on the basis of clinical need and that the continuity of care is maintained. For private consultants who have patients already, they can continue to see them. For us, the important bit is that we get to see the sickest people who may have had their treatment deferred or cancelled as a result of the work that we had to do to be able to cope with the potential surge.

We are looking at all of that and at the level of activity in the private hospitals. We know that from an inpatient perspective, that is at about 44-45%, but the day case occupancy is now up to over 80%. We are seeing a higher level of activity. We, along with the Department of Health, did engage and will continue to engage with the consultant bodies as part of this process.

In terms of the activity that we need to continue, it is going to be very important for us that we maintain a flow. Certainly, in terms of the prioritisation of people in line with the waiting lists that we have, we are going to continue looking at that with the National Treatment Purchase Fund, NTPF.

For us, this has not been a simple matter. It has been in response to an extraordinary situation and we are evaluating it in terms of the service response, the impact on people who need health services, and of course the value for money as part of that.

Deputy John McGuinness: The HSE says it listens to the radiologists and to the cancer services. Like this morning, and it is no fault of our committee or indeed of our witnesses, it is very difficult to get the specific response required. Will the witnesses please look at the transcripts and give us the information arising from the questions that members have asked?

Chairman: The Chief Medical Officer undertook to answer any questions that were unanswered and I am wondering if the HSE will do the same. If there are any unanswered questions, can we send them on to you to answer by return?

Mr. Paul Reid: Absolutely.

Chairman: Thank you very much. I call Deputy O'Dowd, who has five minutes.

Deputy Fergus O'Dowd: The Chairman is very kind and has been very fair. I want to back up Deputy McGuinness in what he has said. The fact is that there is a person in my constituency who has cancer and who had a procedure cancelled two weeks ago. He and his consultant are both at home and there is nobody in the operating theatre where this procedure could have been done. That is not acceptable. It is hugely important that, whatever else we do, we ensure that people who had operations and procedures booked and were expecting them to take place have those proceeded with.

The other point I want to ask the HSE, and I want to say very clearly that there is great support for the fantastic work that it has done, is regarding the concerns for the future if Covid-19 comes back. What additional actions can or will the HSE carry out to ensure that the nursing home deaths are not as high as they currently are? While I accept and I said earlier that we know that older people are very vulnerable, particularly people in nursing homes, a nightmare scenario happened in a nursing home in my own constituency of County Louth, where there were more than 80 patients and there have been 22-23 deaths now. Some 60% of the staff were sick and could not come in. Where there were 24 nurses at one stage, there were later just six trying to look after all the patients. It is an impossible task.

When did Mr. Reid first decide to intervene in the nursing home sector? I would like to know. I am not being critical or negative. We need to know when the requests came in for PPE from around the country. What was going on at the HSE's senior administrative level? When did it make the decision to intervene? I want to repeat publicly that the head of primary care in CHO 8 was exceptionally helpful when I made the case to him about the home to which I refer. There was a significant and immediate intervention. I do not know what went on with the complaints which we read in the national press about PPE not being supplied to private nursing homes. It was on Facebook pages. I received questions about why a nursing home was not getting PPE. The HSE told me clearly that if a request was made, nursing homes would get PPE immediately. There is a significant amount that we do not know, and we need to know more. The best way forward is to plan for the future as "Team Ireland", with the HSE, Nursing Homes Ireland and all the other agencies working together on a plan for the winter. We can only base that on the knowledge of what happened in the past, when the HSE knew and when it acted.

Mr. Paul Reid: I ask Dr. Colm Henry to take the question on cancer services and private consultants.

Dr. Colm Henry: On the issue of nursing homes, this is a novel virus and evolving information is coming through week by week. On 12 March, the ECDC described a case report of asymptomatic transmission. The question is what we have learned that we can apply in the context of future prevention. The most important lessons as we garner knowledge about this virus are the atypical presentations in older people and the importance of asymptomatic transmission. Even though that mass testing exercise has been reassuring in that it showed quite low levels of the virus among patients and staff, today's ECDC report had new guidance for residential care facilities, including a more aggressive testing strategy, bearing in mind that there is asymptomatic transmission and atypical presentation. I expect that will inform our own testing strategy in residential care settings from here on.

Wider measures include wider provision of the flu vaccine which, in line with other countries, we are now making available to younger age groups for this coming winter to reduce the reservoir of flu in the wider population, which would certainly challenge us on top of Covid-19 services. Ms O'Connor might address the timeline of providing PPE.

Ms Anne O'Connor: Nursing homes would respond to infection anyway and have a regular supply of PPE. We became aware of significant challenges in the third week of March. It was well aired in the media that certain sites had struggled. At that time, we faced significant challenges in securing PPE in general. We were struggling to maintain a supply of some items. However, from late March through to early April, we significantly increased the supply of PPE. We had to prioritise supply across all sites. The area crisis management teams looked at all of the long-term residential care facilities, not just nursing homes, and what the supply requirement was. At the time, with the supply available, we had to prioritise and distribute PPE ac-

cordingly. The PPE supply going to residential care settings has now gone down to 31% of our PPE supply, whereas home support receives more than 32%. We supply a significant amount of PPE to hundreds of sites every day, including nursing homes and other long-term residential care facilities. There are different timelines for various facilities and areas, but, in the main, it was a challenge in late March.

Chairman: I am sorry to cut Ms O'Connor short. We have just a couple of minutes left before we reach our two-hour threshold. I have a couple of questions. How much has been spent on testing to date? How much is envisaged to be spent on testing based on the contracts that have been signed to date? Are there any plans for antibody testing, which has been suggested as one of the means of opening countries in general?

Mr. Paul Reid: On the antibody tests, I might ask my colleague to comment in a moment, but we are obviously staying very close to this in terms of what is on the market and learnings from other European countries, but there has not been a significant level of success with antibody testing. We see it having a role in the future and we want to monitor how it progresses. Some of the major global players are running some pilot projects and tests to support that overall.

On the overall cost of contact testing and tracing, it is something on which we are still in dialogue with the Department of Public Expenditure and Reform. As we brought our proposals to the Government in the last couple of weeks we set out the strategy and targets that I discussed earlier. Part of that was the funding requirement for it in the coming year.

Chairman: I am not talking about the funding requirement but how much has been spent to date.

Mr. Paul Reid: The total contact tracing spend to date is in the region of about €2 million.

Chairman: That is contact tracing.

Mr. Paul Reid: There are various aspects of it. My apologies, that is for contact tracing. I will come back to it momentarily, but overall it is something that would be a very significant cost for the HSE for this year. In a nine-month period it will be several hundred million. We are just working through the costings on that.

Chairman: You think it will cost several hundred million. How much has been spent up to now?

Mr. Paul Reid: I can come back to you shortly, Chairman. I do not have the cost in front of me.

Chairman: Perhaps you will be able to provide an answer by correspondence.

Mr. Paul Reid: Yes, I can refer back to you.

Chairman: I thank you, Mr. Reid, and your colleagues, Dr. Colm Henry and Ms Anne O'Connor, chief operations officer of the HSE, for attending today and for answering our many questions so fully. My apologies again for the fact that you could not see the timelines under which we were operating.

Mr. Paul Reid: I have the cost so far for testing. It is roughly €35 million between testing and tracing.

Chairman: It is €35 million up to now but you think it will cost a couple of hundred million.

Mr. Paul Reid: It will be a few hundred million based on the volume we are projecting for the rest of the year.

Chairman: Is there a breakdown available for the companies? Various companies have been engaged to do that testing. I am not asking you to provide that breakdown now but can you provide a breakdown of the companies and how much they have been paid?

Mr. Paul Reid: The majority of the laboratories would be Irish based and there is one overseas. Our swabbing centres are primarily our HSE-funded and staffed centres in general.

Chairman: I do not wish to use any more time but is a breakdown available of how much has been paid to whom up to now?

Mr. Paul Reid: Sure.

Chairman: I am not asking for the breakdown now. You can send it to us.

Mr. Paul Reid: I know. You will get that.

Chairman: I reiterate my thanks to you and your colleagues for coming here and answering our questions. I also thank my colleagues in the Chamber.

Sitting suspended at 4.05 p.m. and resumed at 4.30 p.m.

Briefing by ICTU, HSA and CIF Representatives on the Reopening of the Construction Industry

Chairman: We have a quorum and will recommence in public session unless there is anything members wish to discuss in private.

I welcome our witnesses and thank them for coming here today. From the Irish Congress of Trade Unions, we are joined by Patricia King, general secretary; Dr. Sharon McGuinness, CEO of the Health and Safety Authority will join us by video link from committee room 1; and we will also be joined by Mr. Tom Parlon of the Construction Industry Federation, director general. I understand Ms King and Mr. Parlon will join us shortly in the Chamber.

We are working under tight time constraints and I am aware Dr. McGuinness cannot see the time slots from the committee room. We are working to remedy that before next week's meeting. We will indicate whether slots are five or ten minutes and she can perhaps keep track of it on her phone if that might be of assistance. I am just letting her know in case I have to cut across her to ensure there is sufficient time for everybody to ask questions.

Deputy Duffy is substituting for Deputy Smyth. We were not informed of that in advance but it is okay as it is the start of this session. I advise the 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 in relation to a particular matter and continue to do so, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected

with the subject matter of these proceedings, namely, the State's response to Covid-19, is to be given. They are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person or entity by name or in such a way as to make him, her or it identifiable.

While we expect witnesses to answer questions asked by the committee clearly and with candour, witnesses can and should expect to be treated fairly, with respect and consideration at all times. If they have concerns with regard to their treatment, they should bring them to the attention of the committee immediately and they will be considered.

I ask witnesses to limit their opening statements to five minutes. We have received their statements in advance. I call on Ms Patricia King, general secretary, the Irish Congress of Trade Unions, ICTU, to make her opening statement.

Ms Patricia King: I thank the committee for its invitation to present to it this afternoon.

As this pandemic began to emerge globally, as well as in the early weeks when the first cases of Covid-19 were confirmed in Ireland and public health measures were advised, ICTU notified the Government through the labour employer economic forum, LEEF, of its intention to put forward proposals to ensure the health and safety of all workers in all workplaces. ICTU based its submission on the principle that the safety, health and well-being of every person is paramount, and therefore supersedes all others. We also took the view that all public health advice should be adhered to without exception. During the course of our interactions in the LEEF process, we advocated a mandatory national protocol be developed which would encompass a set of directive actions to which every employer, worker, contractor, customer and client had an absolute duty to strictly adhere in order to maintain safe workplaces.

We set out a number of key principles which we believed were crucial to the delivery of a mandatory protocol capable of ensuring safe workplaces upon a return to work. Those principles included worker representation; training; negotiated or agreed changes to work practices; mandatory compliance with all the listed health and safety provisions with no opt-outs; and the assignment to the Health and Safety Authority, HSA, of the responsibility to oversee the implementation of all aspects of the national protocol, including the use of its powers to inspect and order the closure of workplaces where appropriate.

On workplace representation, we submitted that a workplace worker representative infrastructure be put in place across all sectors and in every workplace. The primary purpose of this measure was to ensure that workers could be confident that their voice would be heard, that the provisions of the protocol would be strictly adhered to, as well as allowing such a representative or representatives to liaise directly with the HSA inspectorate. This measure was essential given that, outside of Statutory Instrument 146, which deals with some individual representative trade union rights, there are no provisions in Irish law which specify the right of workers to be represented. Section 25 of the Safety, Health and Welfare at Work Act 2005 sets out the provisions relating to such workplace representatives. However, it confers no obligation for the appointment of such representatives. It should also be noted that in SI 291/2013, Safety, Health and Welfare at Work (Construction) Regulations 2013, section 23(1)(*b*) provides that "the project supervisor for the construction stage shall facilitate ... where more than 20 persons are normally employed at any one time on a construction site at any stage of the project, the appointment of a site safety representative from among the employees of the contractor or contractors undertaking the project in accordance with the procedure outlined in Schedule 6." The national protocol now commits to each workplace having such a role. The inclusion of provisions for

induction training for all workers and training of workplace representatives on their role and function, together with specialised training in the proper use of cleaning, storing and disposal of personal protective equipment, PPE, are in our view critical to the operation of the protocol.

It is agreed within the protocol terms that any changes to workplace policies or work patterns will be agreed through negotiations with trade unions or worker representatives. The protocol is intended to be universal but does not replace existing obligations under current health and safety legislation, nor does it prevent the development of further specific measures in a particular sector, industries or companies, provided they reflect the principles of the protocol.

The document outlines in a detailed way all of the safety measures required to be put in place and implemented. This virus is very active and can cause serious personal injury to a worker who may contract it. These measures, therefore, seek to mitigate the risk to workers and are vital to maintaining safe workplaces. This is not a set of discretionary guidelines but a suite of mandatory directive actions with no exceptions or opt-outs.

Chairman, it is not my intention to refer in detail to the health and safety provisions set out in the document, as I am sure the committee is very familiar with them. However, I am satisfied that all of the necessary expert advice from the relevant State agencies was sought and utilised in the final output. ICTU advocated strongly that all of the necessary measures, under each safety heading, should be specified in the interests of clarity and compliance.

On the matter of compliance and enforcement, the HSA, which is the statutory body charged with ensuring the safety, health and welfare of workers is protected in the workplace, has been assigned responsibility for the implementation of all aspects of this national protocol, including being available to advise and train worker representatives. It will also have the powers to inspect workplaces and order their closure when appropriate. This is reflected in the broad range of functions assigned to the authority by section 34 of the Safety, Health and Welfare at Work Act 2005, including functions to encompass the prevention of danger to workers from the spread of infectious disease. Section 35(1) of the Act empowers the Minister to confer additional functions on the authority, which are connected with the functions prescribed in section 34 of the Act. For the avoidance of doubt, in our view the Minister should exercise her power under section 35(1) to expressly assign to the authority a function to promote, foster and enforce compliance with the provisions of this protocol. We hope the committee will consider making a recommendation in this regard.

Inspectors of the authority have extensive powers of enforcement, including the power to serve-----

Chairman: I thank Ms King and ask her to conclude. We have the benefit of her opening statement.

Ms Patricia King: Very good. Thank you.

Chairman: Dr. McGuinness is joining us from Committee Room 1. I ask her to make her opening remarks and to please limit them to five minutes. I shall ask her to conclude after five minutes.

Dr. Sharon McGuinness: I thank the committee for the invitation to attend. I am the CEO of the HSA.

The Return to Work Safely Protocol was developed by all those who have an interest and

role in ensuring workers are kept safe, businesses can operate and the public health measures around Covid-19 can be met. In this regard I acknowledge the support of all the stakeholders involved, including ICTU and CIF that are here today as well as IBEC, Chambers Ireland, the HSE, the Departments of Business, Enterprise and Innovation and Health and the Minister for Business, Enterprise and Innovation.

Covid-19 has challenged us all. The authority recognises that there are particular challenges in the workplace. We have the worker who has fears and anxieties about returning to work. We also have employers and businesses that are looking to reopen, regain their markets and plan for a future that may seem uncertain. The key to a safe return to work over the next number of weeks is shared collaboration, communication and compliance with and enforcement of the measures outlined in the protocol, which sets out in detail the steps businesses, employers and workers need to implement in order to reduce the risk from Covid-19 in the workplace. By following the protocol, employers and workers will be able to meet these challenges and ensure a safe working and business environment.

The authority will be involved in ensuring compliance, in line with occupational health and safety requirements. Through the Safety, Health and Welfare at Work Act 2005 the authority has the powers to advise, monitor, inspect and enforce adherence to the protocol. We will provide advice and support to employers, employees and workers on how they are implementing the Covid-19 measures as set out in the protocol through our helpline, website and during site inspections. A range of checklists and templates has been developed and is available on our website for use by employers, workers and worker representatives. Further material is being developed.

During a site inspection a range of enforcement actions can arise. For example, the inspector can address and advise on any shortcomings in relation to the measures through a report of inspection, which is left with the employer at the end of the visit and can include timelines and follow-ups that are needed. We can also take an appropriate action under the 2005 Act, including an improvement notice and a prohibition notice. Furthermore, if, following an inspection, the inspector forms the opinion that the risk to the safety, health and welfare of persons is so serious that the use of a place of work should be restricted or immediately prohibited, an application can be made *ex parte* to the High Court for an order restricting or prohibiting the use of the place of work or part thereof.

The authority has been Ireland's regulator of occupational health and safety since 1989. In normal circumstances, we implement a risk-based occupational health and safety inspection programme across all sectors covering some 10,000 inspections and investigations in any given year. The programme is based on both proactive and reactive inspections with the latter often arising from complaints, reports of serious incidents and fatalities.

Our inspection programme has been refocused now to oversee compliance with the protocol. In the first instance, the prioritisation of inspections will be focused on those sectors that are scheduled to open in line with the road map and based on any complaints received.

Any worker or employer can submit a query or a complaint to the authority's helpline, the workplace contact unit, WCU, with the attached details. This helpline is confidential and every contact, whether a query or a complaint, is acknowledged and receives a reference number for tracking. Each complaint is initially followed up with the relevant company or employer by the WCU, our helpline, and if there is no response, or if the response is not satisfactory or in the event of receipt of multiple complaints, etc., we will follow up with the employer through

an inspector. The inspector may then decide to do an unannounced inspection or, indeed, a pre-arranged inspection if warranted.

As a general rule, our inspections are unannounced. However, due to the fact that workplaces may have different working arrangements in place to protect against Covid-19, we recognise that in a number of cases, and we expect very few cases, that we will need to arrange a suitable time to visit. Once on site, we will ensure compliance against the protocol and where there is a breach of a statutory obligation the inspector, based on his or her evidence and expert opinion, will determine what enforcement action may be needed.

In terms of staff numbers, the authority has a full staff complement of 182 which is made up of staff in administration and inspector grades. The inspector grades comprise of grade I, which are senior inspectors who run teams, as well as grade II and grade III field inspectors. Generally, our inspectors cover field inspections across all our mandates. We have occupational health and safety, chemicals, and market surveillance of products. Inspectors can be involved in general or specialist inspection, or policy implementation at national, European, and international levels. Of the 109 inspectors currently in the authority across all three grades, we have 67 field inspectors fully assigned to inspect on foot of the protocol. These include both general and specialist, as well as policy inspectors reassigned to field inspection.

A cohort of inspectors must be retained to ensure our other legal mandate. As Ms King said, the general rules on health and safety continue to apply. We continue to have that role in terms of reactive and proactive inspections.

Chairman: Thank you very much Dr. McGuinness. Could someone from the broadcasting unit raise the volume slightly from Committee Room 1? Could we hear Mr. Parlon's opening remarks? Please limit them to five minutes.

Mr. Tom Parlon: I thank the Chairman for the opportunity to talk to the committee today.

Yesterday, the construction industry reopened partially. Workers returned to sites and jobs that are utterly changed due to Covid-19 and the new measures that have been put in place to protect them, their families and our communities. They are literally building the new normal the Government said we will enter in the coming months.

Since the Government shut down our industry on 28 March, construction companies and workers have been preparing to return to work safely. In terms of safety, our industry is recognised as one that is well-developed. That other countries facing similar lock-downs did not include construction is a recognition of the safety culture baked into modern construction. In Ireland, our preparation has involved extensive consultation with unions, Government, and international experts. The CIF's standard operating procedure, SOP, translates the latest HSE, WHO and medical advice into a construction context. The SOP fits into the national protocol agreed between Government, industry and unions and enforced by the Health and Safety Authority, HSA. Today just over 130,000 out of a total of 147,000 employees have completed the SOP's online safety induction in advance of returning to work. Not all of these are traditional on-site construction workers, it includes office-based professionals, engineers, design teams, architects, etc.

I would like to commend the industry's companies and its employees for their commitment to safety. These workers are rebuilding our economy while they are building. Homes, roads, hospitals, schools, and other essential construction has begun again. Our industry is also well

placed to contribute to economic recovery as we enable other sectors to operate. We are able to recommence work without major State support and 100,000 of our employees can now gradually be taken off the pandemic unemployment payment, PUP, and temporary wage subsidy scheme, TWSS.

I want to assure people that companies are being sensible and practical in returning to work. There was no big bang return to work yesterday. Larger contractors allowed a reduced workforce on site yesterday to assess sites, test new measures, and embed new protocols in safety culture. It will take months for the industry to reach previous output levels.

Covid-19 compliance officers have been appointed and are monitoring progress. Under the national protocol agreed with the Government and Irish Congress of Trade Unions, ICTU, workers representatives are also being appointed. The important message we have all been sending to workers is that if they are unsure about safety they can inform these representatives so any issue can be addressed. All the SOPs and national protocols are important guidance and can help shape behaviours but I am confident our workers will also step up and operate safely.

The SOP provides guidance, based on the HSA advice, not just on site but on the way to site and on the way home. For example, we have provided best-in-class guidance on travelling in vans on the way to work. We are asking that PPE is taken off and left on site. Larger companies are putting in place one-way walking systems and have reduced headcount on site. We have very clear isolation protocols for anyone reporting symptoms and we will now keep logs of work to assist contact tracing.

Those companies that have been able to operate over the past month working on essential services have been operating new safety measures. Reports are positive but implementation of the SOP is challenging and companies are reporting a significant drop in productivity.

It is understandable that the public is afraid. The pandemic has shut down our society but it has also paralysed us. We now know that we must restart our economy in a manner that prevents the spread of the virus or we face horrific long-term economic, social, and psychological consequences. I want to assure the public that we are taking the responsibility that falls on the construction industry very seriously. Our workers want to work but want to contribute to stopping the spread.

They are also building a sustainable and safe future for Ireland, helping us recover from the impact of this pandemic. I would appeal to members of the public, the media and our politicians to support us and our workers as we take these first steps towards reopening our economy and society for everyone. I thank the Chairman.

Deputy John McGuinness: I am glad to see Dr. McGuinness and Ms King here and they are very welcome. Mr. Tom Parlon has not lost the knack of slipping into the Government benches so easily, although it is a different kind of combination of Government we have across from us. It would be challenging, I am sure.

Deputy Colm Brophy: The Deputy will be here himself shortly.

Deputy John McGuinness: Yes. Mr. Parlon is very welcome, anyway. The different actions that have been taken on the various sites will have incurred much cost to the builder or the contractor. How is that going to be covered? Given what Ms King is asking for and what Dr. McGuinness will be overseeing, it is clear to me that there is going to be a huge amount of cost. In terms of the CIF and the contracts that it knows of, can Mr. Parlon tell us what the impact will

be on the contracts? If one has entered into a contract, how can this be catered for?

Mr. Parlon deals with the bigger contractors but who represents the smaller contractors? Does Mr. Parlon have a direct line to them beyond his membership and is he exercising that in order to make sure that they are protected and that their employees are protected? Can Mr. Parlon comment on that, please?

Mr. Tom Parlon: It is the case that there are going to be increased costs. Different people have attempted to put a figure on that. I regularly talk to my colleagues across Europe and their view, and that represents the entire industry across Europe, is that the extra costs will be between 5% and 10%. I spoke this morning to a very substantial house builder in Ireland and he reckons that the cost per house that he is turning out at the moment will be increased by between €10,000 and €15,000. He expects that the cost in respect of apartments, which are obviously more intense and where it is more difficult to practice physical distancing, could be as much as €20,000 extra. He tells me that the programme for building a house currently is about 15 weeks and he estimates that with new physical distancing and so on that will go to 25 weeks. There are some more intense sites that could be substantially more than that.

Currently, the Office of Government Procurement is examining that. It issued a guidance note last week. We in the CIF were disappointed to find that it only applied to the extra expenses that we have to incur in terms of coping with the new national protocol but we are expecting a new note, maybe this week, that is going to look at how the extra costs are going to be dealt with in the public sector. However, in the private sector, one has to negotiate one's own terms.

Deputy John McGuinness: I can assume from that that there will be an extra cost, particularly in State contracts, and that is not resolved as yet. A formula must be found to agree this with Government but we can expect something in the region of 5% to 10% or maybe more, depending on the nature of the site. Is that correct?

Mr. Tom Parlon: That is right.

Deputy John McGuinness: Does the HSA have the required number of inspectors to visit sites without notification and in the proper protective equipment? Is the legislation robust enough to deal with Covid-19 and what might be found on sites? When is the HSA going to commence inspections - not planned inspections, but random ones?

Dr. Sharon McGuinness: As I said, we have assigned 67 field inspectors with immediate effect and they have already been out this week enforcing the protocol and checking compliance with it. It has been recognised by the Government that the HSA did not have sufficient resources and that we would need additional resources to oversee compliance with the protocol. We have therefore been in discussions with others across the Government. I am confident that the resources the authority needs will be fully there to oversee compliance with the protocol, drawing from other Departments as-----

Deputy John McGuinness: Can Dr. McGuinness quantify the cost of that?

Dr. Sharon McGuinness: The cost-----

Deputy John McGuinness: Will the HSA be increasing the number of inspectors? What cost would relate to that increase and has the Government sanctioned it?

Dr. Sharon McGuinness: The intention is to use existing inspection structures across the

different Departments and the HSA to oversee compliance with the protocol, so in a way the cost relates only to the specific actions people are taking. Those discussions are quite advanced and we are hoping to have that signed off very shortly. We will roll those additional resources out as needed over the course of the road map, including reallocating our own inspectors on a rolling basis if and when they are needed.

Deputy John McGuinness: Is there no issue regarding equipment and the fear of going on sites?

Dr. Sharon McGuinness: As an employer, I am responsible for the staff of the authority, as is every other person who is an employer. We are clearly acting in line with public health advice and guidance. We are also the market surveillance authority for PPE regulation and we have been working very hard to ensure a constant supply of suitable and proper PPE across the board throughout these last few weeks. The need for PPE depends on the situation and the protocol is clear that PPE is used depending on the hazard involved. One may not need it on the first basis but it is something we look at.

Deputy John McGuinness: Does the HSA have that equipment now?

Dr. Sharon McGuinness: Yes.

Deputy John McGuinness: Does it have a full range of it?

Dr. Sharon McGuinness: Yes.

Deputy John McGuinness: As regards the requirements of protecting those on sites and the different grades of workers, is Ms King satisfied that there has been a proactive response from the construction industry and the HSA? Does Ms King see weaknesses in that response, even at this stage, and what would she like to see improved?

Ms Patricia King: Only 67 HSA inspectors is not adequate at all. There is a resource issue. The Government has to improve the resource throughput to the HSA to do this job. The first phase of return is the construction sector and we are not satisfied at all that the resource inspectorate is there for that. As the other phases of the economic reopening go on, this will get much more acute. Very small employers in the hospitality sector and so on will all require the same level of scrutiny.

Deputy John McGuinness: I must cut across Ms King because my time is up. What protections and supports are in place for small builders and contractors? I put the same question to Mr. Parlon. Are the witnesses satisfied with those protections? Does Mr. Parlon represent those contractors?

Ms Patricia King: As employers under the legislation, contractors have a duty and an obligation to protect their staff. If they are in operation as an employer and are employing people, they must make sure the workplace is safe. The HSA is there to advise and support them but by the same token, the staff are entitled to go to a safe workplace and ensure everything that should happen does. As I said in my presentation, this is a virulent virus. It does not make exceptions whether one is a small or a big employer. All of the measures have to be put in place.

Deputy John McGuinness: Can Mr. Parlon confirm whether the Construction Industry Federation represents small contractors or not? Does he represent small contractors or the main contractors?

Mr. Tom Parlon: We claim to represent the entire industry but our members are among the larger contractors.

Deputy John McGuinness: Okay.

Mr. Tom Parlon: We have a lot of house builders.

Deputy David Cullinane: I am taking time from Deputy Pearse Doherty so I will have ten minutes. I welcome our witnesses and commend them on the work they are doing, and for the collaborative effort of the CIF, the trade union movement, the HSA and others to get the protocols in place in the first instance. That needs to be noted and the people involved should be commended on it.

We all accept that there is a desire from sections of society to go back to work and have restrictions eased. Equally, there is a balance to be struck because people want to be made safe and protected. My questions are about process and making sure that we have a plan in place to protect workers. Obviously, we want the economy to reopen but it has to be done in a safe way.

My first questions are for Dr. McGuinness. I presume she would accept that a plan needs to be put in place. Protocols can exist but will be irrelevant if there are not the resources and capacity to enforce them, so enforcement is key. Any plan needs to be resourced from human and financial perspectives. On the human side of it, Dr. McGuinness said that 67 field inspectors have been assigned to deal with this protocol. I presume that is across a whole layer of businesses and not just construction as the economy starts to reopen.

Ms King said that 67 inspectors is totally inadequate and I agree. We spoke on the phone about this earlier in the week. Dr. McGuinness said that additional resources may be made available, although those may not be financial resources. Is she talking about assigning more inspectors or people from different organisations being assigned to the HSA? Are those 67 inspectors adequate? When, and how, will more become available? What is the regional breakdown for those inspectors? Is it done centrally or broken down regionally?

Dr. Sharon McGuinness: Good afternoon Deputy. It is broken down both regionally and in specialist teams. We have a number of different regional teams, two based in the Dublin and eastern region and others in the west, south east and south west. There are specialist teams across the county doing particular elements.

Deputy David Cullinane: For example, how many inspectors will be in the south east?

Dr. Sharon McGuinness: There are probably eight in the group, including the senior inspector. There is a range of people in that area.

Deputy David Cullinane: How many counties are covered by those eight inspectors?

Dr. Sharon McGuinness: The south east includes Athlone, Kilkenny, Waterford and Tipperary.

Deputy David Cullinane: That does not strike me as adequate. Dr. McGuinness said there are two teams in Dublin and other regional teams. When one starts to break down the figure of 67, it does not appear to be anywhere near enough.

Can Dr. McGuinness move on to the next question I asked? She said that the number of 67 inspectors will be increased. How will it be increased? Will it be through additional resources

or staff coming from elsewhere? What number of inspectors does she anticipate the HSA will get to?

Dr. Sharon McGuinness: As I said, I am confident that the resources we need will be given to us. We will be drawing from departments such as environmental health in the HSE.

Deputy David Cullinane: Surely the HSA has a plan. Dr. McGuinness is saying that she is confident the HSA will get additional resources. Does she, as the CEO, know what additional resources will come and in what number? As I said earlier, plans need to be in place and resourced. We saw what happened in meat factories and nursing homes where plans were not in place. Rather than saying that the HSA will, or may, get additional resources, surely Dr. McGuinness has an idea as to how many additional inspectors she will have at her disposal when those additional resources arrive. She must have a number in mind.

Dr. Sharon McGuinness: We are working through that final number and I would prefer not to give an exact number because we are still in discussions. We have a range of protocols working to ensure that support is put in place to ensure full oversight and compliance with the protocol. The challenge is that we are reopening the road map, as the Deputy said, on a staged basis. We are on day two and we have already been out and have done over 80 unannounced inspections. We are confident that we can get to them. In a general sense in any given year we do 10,000 inspections, even with that number.

Deputy David Cullinane: I have 28 seconds left. It is unacceptable that we cannot have the number here. We should have it. People want reassurance and to know that they will be protected. The figure of 67 is woefully inadequate. If Dr. McGuinness cannot provide this committee, of all committees, with the numbers that does not instill confidence in me that the HSA will have the capacity it needs. We heard from the leader of ICTU, who does not believe the capacity is there. Even today, Dr. McGuinness is not in a position to tell this committee how many additional inspectors the HSA will have over the next number of weeks. We have to bear in mind that more businesses will be open as the second, third, fourth and fifth phases kick in. I want to note a concern. It is unacceptable that we do not have the numbers. The main point I will make, and I will finish on this, is that-----

Chairman: You have an additional five minutes. You were initially given five minutes and then you said you were taking five-----

Deputy David Cullinane: I thought the time was flying. The clock let me down. I will return to the point I made to Dr. McGuinness. I am concerned about the numbers and the fact that we do not have a number from her today in terms of the increase.

Ms King, in response to Deputy McGuinness, said that she felt 67 inspectors were inadequate. Has she made any representations in terms of how we can beef up those numbers? The trade union movement and trade unions have expertise, such as the people in Ms King's organisation who have experience in health and safety. Could they help in this emergency situation? Notwithstanding the HR issues that might arise, is there the possibility of reassignments from other areas into this area? Is Ms King in any way comforted by the fact that there are only 67 inspectors and we do not know what the number will increase to?

Ms Patricia King: I thank the Deputy for the question. I take no comfort from the fact that only 67 inspectors are assigned because that will not do the job. The HSA has assigned a call centre to take complaints. The implementation programme will not be completed just by hav-

ing a call centre. I want to make that exceptionally clear. It is part of an infrastructure, but it is not by any means the entire system.

The HSA inspectors are very professional people and we will need many more of them. There is an inspectorate across the country in various State agencies and Departments who have the role of inspecting workplaces. They cover agriculture, food, the environment, health and so on. All of those people have the title of inspector and duties and responsibility relating to different aspects. There may very well be some conversation that could be had, taking account of all the issues for those individuals in terms of any changes to their work and so on. Conversations about reassignment could take place while this pandemic is ongoing. We do not have any role, as such, other than the trade unions which represent those workers which have a role in terms of dealing with any change in work practices.

Something which is very tricky and difficult, but which is now coming to the fore, is the fact that in the workplace having the voice of workers heard without them feeling threatened or anything else is not covered under any law in this country.

Deputy David Cullinane: We will get to those laws. I agree with Ms King on that. We can all agree that we need to strengthen those laws.

Ms Patricia King: To answer the Deputy's question, the trade union movement has people who are well trained in health and safety and could, in my view, offer their expertise insofar as the HSA was prepared to-----

Deputy David Cullinane: I thank Ms King for her response. That is very helpful because if this committee has value then it should be making recommendations. We know there can be a reprofiling of people from elsewhere. People can be reassigned. There could perhaps be use of the expertise of the trade union movement to beef up the inspectorate that is already in place with the HSA.

Can I just go back to Dr. McGuinness? Has Dr. McGuinness's organisation any remit in relation to meat factories?

Dr. Sharon McGuinness: Yes. In terms of all workplaces, we have a role.

Deputy David Cullinane: "Yes" is the answer. I thank Dr. McGuinness. Did the HSA receive any complaints? Has Dr. McGuinness's organisation received any complaints in relation to meat factories?

Dr. Sharon McGuinness: We have received a number of complaints.

Deputy David Cullinane: Were there any inspections done on foot of those?

Dr. Sharon McGuinness: Not at present, but because there is a national outbreak control team which takes from public health, the Department of Agriculture, Food and the Marine and ourselves.

Deputy David Cullinane: Sorry, I find extraordinary the situation that we have in meat factories. Here is an example of one industry where we have a real problem. We are being told the HSA is the body that can go in, do the inspections and then put in place penalties or sanctions, and close businesses. The HSA has received complaints about meat factories where we know there were clusters and none of the authority's inspectors has been able to go in there. That does not instill any confidence in me in how Dr. McGuinness's organisation will respond

to other queries.

Dr. Sharon McGuinness: The challenge here is that Covid is a public health matter. The issue in meat plants has been very much directed by the public health element to get that under control and a range of guidance and advice has been involved there. We are being included in those discussions and arrangements are being made for inspections, as we speak. However, the primary responsibility was first and foremost to get those outbreaks under control in those workplaces so that it did not spread into the community and that is where we come in. We are now moving forward with those inspections.

Chairman: I thank Dr. McGuinness. Is Deputy Brophy of Fine Gael speaking for-----

Deputy Colm Brophy: I will speak for five minutes. I would appreciate a little latitude, if the Chairman can provide it.

Chairman: The latitude was all used up in the previous session.

Deputy Colm Brophy: I would like to continue with Dr. McGuinness. It is important that we tease out this point. My understanding of the point Dr. McGuinness was making is that this primarily was led on a health grounds intervention within the meat factory inspection process. Is it correct that the HSA was involved in that process but the reason that the inspection process per se did not take place is because it was being dealt with through the public health departments?

Dr. Sharon McGuinness: That is the current situation. There is, as I said, a national outbreak control team led by the HSE.

Deputy Colm Brophy: Is the correct interpretation that there was an intervention in those plants on that taking place?

Dr. Sharon McGuinness: Yes. There is a national intervention and there is a range of different involvement in that regard.

Deputy Colm Brophy: Can Dr. McGuinness quantify for me again - I just want to make sure - the approximate total number of inspections carried out by the HSA on a yearly basis?

Dr. Sharon McGuinness: Ten thousand last year, roughly speaking.

Deputy Colm Brophy: There are actually 10,000. I know one can break figures down whichever way one wants, but there are approximately 10,000 inspections. Do I understand from what Dr. McGuinness was saying that, as an organisation, the HSA is in discussion with Government and that Dr. McGuinness is proactively looking to increase the capacity within the HSA to carry out inspections?

Dr. Sharon McGuinness: Absolutely. I regret that I cannot give a number. Those discussions are ongoing and we hope that they will be fully informed by the end of this week. As I said, we are talking to all of the supports. Ms King mentioned several of the different agencies that already have inspections bodies. We are looking to those and the support is there. We are merely nailing down, I suppose, the final number so that we can inform people. There is the support and the commitment to working with us to ensure the compliance with the protocol.

Deputy Colm Brophy: I will ask one specific question on that. Is the HSA open - my understand is it is not - to re-employing recently retired inspectors as a priority as part of that

process? Obviously, it is a highly-qualified job. There is a great deal of knowledge required to do it well. We are talking about people who are in a position to step back into a role. Is the HSA actively looking, as part of its negotiation with Government, to make sure there is an allowance to bring back recently retired people who might wish to work in this area?

Dr. Sharon McGuinness: If that is an option, we would certainly look at that. In terms of the three areas, the workplace contact unit has been reassigned staff from other Departments already so that we are building up the capacity to take those complaints. Inspectors will be augmented by others across the board, and, indeed, as needed by external resources, but with the resources that the Government is committing to we should be adequately in a position to fully ensure the compliance with the protocol.

Deputy Colm Brophy: In light of both the way this country operates and the nature of the inspection process, I presume that the primary obligation to ensure a safe workplace is on the employer. We obviously need a robust inspection regime and I am glad to hear that the Health and Safety Authority is committed to strengthening that. However, we need to be conscious of the fact that the Return to Work Safely Protocol is designed to create a robust regime which employers, working with their employees, will honour. That is the cornerstone of safe workplaces. It is backed up by a robust inspection regime.

I would like to ask Mr. Tom Parlon about the construction industry. I accept the case concerning the larger active members of the CIF. Anecdotally, however, one hears that the larger operators are more likely to be have the resources and more able to operate accordingly. What is the industry doing to ensure that smaller sites throughout the country are actively involved? They are more difficult to inspect and less likely to follow all the obligations. Although they are not the CIF's core members, this represents a very major obligation because if they do not do this right they will shut this industry down again. What is the CIF doing to ensure that this happens?

Mr. Tom Parlon: According to reports received up until lunchtime today, we have had dozens of Health and Safety Authority inspections. That agency has been very active on the ground. It has made quite robust inspections and has not encountered any major issues. Our standard operating procedure has been downloaded approximately 10,000 times. Every large and small contractor has taken that on board. It is their licence to get back to work. I mentioned that approximately 130,000 workers have completed the induction course throughout the length and breadth of the country. It is available in several languages, including Russian, Polish and Romanian. It is also available in Irish. More than 1% of our workers downloaded the induction as Gaeilge. The industry has really come together on this. I certainly would not accept the claim that smaller firms, the one-man or two-man family operations, are any less diligent than the big players.

Deputy Colm Brophy: I thank Mr. Parlon.

Deputy Francis Noel Duffy: I thank the witnesses for the briefing. It is fantastic that continuing professional development has been rolled out so quickly to workers across the construction sector. I applaud everyone involved. I work in the sector. It is great that this has happened and people can get back to work. I have several questions, some of which have already been answered. What is the metric for social distancing on sites? Is it a question of area per person? Is it similar to the 2 m radius? Who will implement and enforce on-site safety checks? Will there be a dedicated member of staff for this, apart from the usual health and safety officer who is there already? Will sites run on a 24-hour basis? If not, is there a possibility of redundancies

and how will they play out? What are the Covid-19 protections for subcontractors on site? Are they similar to those for the main contractors? Lastly, will Government contracts be extended in light of this situation?

Chairman: Is there anybody to whom the Deputy particularly wishes to direct those questions?

Deputy Francis Noel Duffy: I will leave it open to the witnesses.

Ms Patricia King: The Deputy raised two points. Social distancing is hugely important to ensuring that we are part of the defence against the virus. There are exceptional cases of what is described as "close working". In those circumstances PPE must be in place. Close working cannot happen otherwise. That is very clearly stated in the protocol. Members might notice that the protocol uses the word "must" - not "should" or anything else - and that is for a very good reason. The second point is that the worker representation infrastructure on the ground is more than the health and safety representatives. They will play a role as well, but the idea behind it is that there would be a worker representative, alongside a management representative every day. They should be easily identifiable and they should be known to be the anti-Covid person. Their job is to go around and ensure that all the measures are being implemented, and they must do that two, three or four times a day if that is required. They should have regular audits, daily if necessary, but certainly twice weekly with senior management to ensure that people are satisfied that this is happening on the ground. The representatives must be afforded the respect and support of the employers and workers because they have a very key role. That is the point that I had in mind when we suggested this should happen. If that infrastructure is respected and it works, then we have a much better chance of ensuring that all those measures are in place on the ground. That was the overall objective of putting the system in place.

It is not just about having the stripes on the ground and the queueing pieces and so on; it is making sure the infrastructure is respected and works all day, every day to make sure that we give every workplace a chance to be safe.

Mr. Tom Parlon: I do not find myself agreeing with ICTU very often, but I certainly agree in this case. The collaboration on this has been very strong. Physical distancing is a challenge. As those who have worked on sites know, it is tricky and, in some cases, it is quite difficult. The direction is that if there is a need for closer working that one should seek every opportunity to do it differently. That may be with the help of mechanical aids or by whatever other means but, as ICTU has said, if one must do that it is necessary to work while using the proper PPE.

Yesterday, both the Trade Union Federation and the Construction Industry Federation reached an agreement that will be signed tomorrow. BATU, Connect and SIPTU claim to represent 90% of the entire construction workforce. We have agreed all the terms. It is very much a collaboration. The union representative on site will be the eyes and ears of the workers. If they see a difficulty, they will bring it to the attention of the Covid supervisor and then it will be brought to the attention of management. If an issue cannot be resolved it will come to the attention of the trade unions and CIF. We have a facility in place where that can be worked out.

Chairman: That is great. If Dr. McGuinness wishes to come in on any point I urge her to be brief. I am sorry about that.

Dr. Sharon McGuinness: As has been said already, the protocol does set out the process for employers and workers and the engagement with the worker representative in anything that

happens on site. As I stated, that is key. As with compliance in any organisation, it is about getting it right on the ground. Collaboration and engagement in adopting the protocol in full in terms of the worker representative and employer duties is key.

Deputy Duncan Smith: Much work has gone into the protocol to make it a comprehensive document and it stands out among all the documents we have received from the various sectors as one that much work has gone into.

I will direct my first couple of questions to Dr. McGuinness. They relate to people who are looking to return to work but whose safe passes have expired. Is there any process in place for them to have their safe passes renewed or for those who want to apply for a new safe pass?

Dr. Sharon McGuinness: As Deputy Duncan Smith is aware, while the safe pass is part of our regulations, it is SOLAS that determines the process. We have adapted and amended the regulations so that those whose safe pass was due to expire have been given an extension for up to six months.

Deputy Duncan Smith: My next question is for Mr. Parlon. I wish to follow on from what Deputy McGuinness said about the extra costs for building a house or apartment. I know that sites can range from small or medium to big, but they are not necessarily the most complex of building projects. Mr. Parlon mentioned an increase in costs of between 5% and 10%. With regard to more complex sites, such as the national children's hospital, how does Mr. Parlon estimate costs might shift on projects of that size and complexity? It has been well-documented that the cost of that project has increased from €400 million to €1.7 billion. A higher figure of €2.4 billion has been suggested. There is great concern about the cost of this project. Would those kinds of percentages apply in this case? Would they increase exponentially?

Mr. Tom Parlon: Some sites are obviously more complex. The Deputy referred to one of them. The industry is building data centres, highly sophisticated pharmaceutical plants, IT plants and so on. The industry has suggested the extra cost to complete such projects while the very strict regime is in place could be as much as 40%. One of the big sites had 1,800 people on site. Under the new physical distancing measures, the maximum allowed will be 500 to 600. That will extend the period of building. The cost of having cranes and other facilities on site will increase. That will have to be worked out. We are striving-----

Deputy Duncan Smith: Would Mr. Parlon advise co-operation?

Mr. Tom Parlon: -----for collaboration. I am in a group called the Construction Industry Council, which includes engineers, chartered engineers, surveyors, architects and so on. We have come out with a statement to say we should attempt to agree costs collaboratively, because there is a legal industry that lives off disputes. That will be the big challenge. We hope the Office of Government Procurement will take a lead role. If it gives guidance this week as to how it sees these measures affecting public sector projects, it would set a positive example for private sector projects.

Deputy Duncan Smith: We all expect to live with these measures for an extended period of time. To clarify, Mr. Parlon is saying that the cost of a large complex project such as the children's hospital could increase by 40% during the extended period in which we will be living with these measures.

Mr. Tom Parlon: People in the industry have said that to me. For the most complicated projects, the increase could be in the range of 40%.

Deputy Duncan Smith: That is astronomical. I believe that improvements could be made in our communications to smaller construction companies, particularly those involved in kitchen and bathroom fitouts. They may be able to go on to a new site in a housing development but they cannot go into someone's home to fit a new kitchen or bathroom. I am getting a number of representations about that. Improvement could be made and extra effort could be made in communicating with those workers. That would be very appreciated.

I have a question for Ms King about protecting workers who raise issues on sites. There is nothing there to protect such workers at the moment. Can any comfort be given to them at this time? Is there anything that could be brought forward to give them the confidence to call out health and safety failures if and when they see them?

Ms Patricia King: We have put out our own material. In a sense one could call it promotional material. We are trying to reach out to those workers. Workers who are used to being in a trade union are familiar with the structures. They know where they need to go, they contact their officials and they have regular meetings. We are trying to reach out to workers who are not currently part of the trade union movement to tell them that the important thing is that workers are safe. Much of the conversation here today has been about construction. We are going to have much bigger problems in the next phase because, while there is a fair bit of trade union organisation on construction sites, there are other parts of the economy in which there is not and in which there is vigorous anti-trade union sentiment. We are going to meet much bigger problems as the economy opens.

Deputy Róisín Shortall: I thank all the witnesses for their presentations. I will concentrate on the issue of construction workers on big sites because they must be regarded as very high-risk workers. They are different from any other category of worker in that, in the main, they do not have an employer. Many of them are self-employed sub-contractors. They do not necessarily have any representation from either of the bodies represented here. In fact, it has been suggested that more than half of them are not represented. They travel a lot; they come up from the country to work on the big sites in Dublin during the week. They stay in quite unsafe crowded lodgings during the week. They shop in local shops and mix in the community. I note that little or no risk assessment has been done on the impact of large numbers of workers mixing in the community. A few weeks ago, a very large site in Santry in my constituency reopened illegally. It was brought to my attention by local people who contacted me to complain about large groups of construction workers in local shops buying breakfast, lunch etc. and not observing any of the rules at all. People were really concerned about the threat to the community. It is on two levels: there are the on-site risks and the local community risks. I am not satisfied that adequate risk assessment has been done on either front.

We know that guidelines and regulations tend to be meaningless without a robust inspection, enforcement and penalty regime. What is Ms King's view on the provision of penalties - fines in particular - in the protocol? Does she think these are effective? Should other measures be taken to improve the effectiveness of the penalty option to ensure adherence to the guidelines in the protocol?

Ms Patricia King: The protocol is based on the terms of the Safety, Health and Welfare at Work Act 2005. As we know the penalties in that are dealt with in sections 77 to 79. That is just on the penalties. The other piece is the power of the inspectors. The inspectors can go on site with powers that range from just doing an inspection and giving some advice right up to saying: "I'm seeing here a risk of serious personal injury and therefore that activity has to stop now and that means it has to be closed." The power that inspector has means that even if the

employer wants to appeal that, the activity is still stopped while that appeal is being made. That is fairly robust power.

Deputy Róisín Shortall: Is there provision for on-the-spot fines?

Ms Patricia King: Two things can happen under section 78 of the Act. At the moment a €1,000 fine can be imposed but it is one of these that needs to be paid within 21 days of issuing the ticket. Twenty-one days is far too long; that should be addressed. I would urge this committee to consider that. it should be an on-the-spot fine from our perspective.

A HSA inspector can move to go to the District Court. A €3,000 fine or 12 months' imprisonment applies if the complaint is handled in the District Court. If it is on indictment and the Director of Public Prosecutions, DPP, goes to another court, it can be €3,000 or two years in jail. Those are the penalties that exist in the current legislation. Somebody said to me this morning that it is the value of the deterrent. The value of a deterrent even of a €1,000 fine is based on how many times a person does it. It could be very effective if it was utilised on a constant basis and people felt threatened by it.

Deputy Róisín Shortall: I have some questions for Dr. McGuinness. It has been reported that 200 complaints of breaches of the Covid regulations have been made. How many of those have been inspected? It was also reported today that there is some issue about the HSA not being in a position to make unannounced visits to construction sites. This is mind boggling if we are talking about high-risk situations and poor risk assessment done on the reopening of building sites. What will the HSA be doing to ensure adherence to the regulations on construction sites?

Dr. Sharon McGuinness: On the Deputy's last point about unannounced inspections, I made clear in my opening statement that the majority of our inspections are unannounced and all of those that happened yesterday were unannounced. I made the point that because-----

Deputy Róisín Shortall: Is that on construction sites?

Dr. Sharon McGuinness: Yes, and on other sites - anything that reopened yesterday.

Deputy Róisín Shortall: How many has the HSA done? Has it done many since yesterday?

Dr. Sharon McGuinness: We did more than 80 yesterday. The final figures are coming in. We are collating them at the moment. More than 80 inspections were carried out yesterday.

Deputy Róisín Shortall: Eighty.

Chairman: Thank you very much.

Dr. Sharon McGuinness: They were unannounced inspections. What I said about needing to do a planned inspection and contact a company in advance may depend on the type of inspection that we need to carry out if we were expecting to meet with somebody on the site and, because of working arrangements, they were not there. It is very limited and we do not expect it to be the norm, which we expect will primarily be unannounced inspections which are the norm for us anyway.

We have looked at all complaints received and they have been addressed. On the protocol -----

Deputy Róisín Shortall: How many inspections were done on foot of the 200 complaints?

Chairman: I will have to ask the Deputy to disallow that and just answer the existing questions.

Dr. Sharon McGuinness: Sorry, should I answer?

Chairman: Dr. McGuinness may answer if she wishes but I will ask that there be no more questions as we are out of time. If Dr. McGuinness could continue briefly.

Dr. Sharon McGuinness: Complaints can arise for many different reasons. We have looked at all the complaints and addressed them with employers. They run from the period beginning at March which covered many of the Government announcements. Not all would have warranted site inspections and some would have closed as sites and are now re-opening. We received complaints in the recent past which will all be addressed and, if warranted, there will be a follow-up inspection.

Deputy Paul Murphy: The issue of workers returning to work confident that they will be safe at work is vital and the State has a crucial role to play in that. I have questions for Dr. McGuinness from the HSA on this issue. The first relates to the question of the 200 complaints. I received a letter from the Minister, Deputy Humphreys, on 13 May, which said there had been 200 complaints about non-adherence to Covid-19 public health guidelines in work and there had been zero physical inspections by the HSA of any of those complaints. I found it astounding that there were over 200 complaints. I take Dr. McGuinness's point that the HSA addressed them but I know that two of those complaints came from me and I was not told anything of what had happened on foot of them. I know of other workers who complained who were not told anything about what had happened either. How can the HSA have had over 200 complaints and not had any on-site inspections? How can that be explained?

Dr. Sharon McGuinness: The HSA workplace contact unit receives quite a significant level of contacts, which can be either queries or complaints. Since 1 March we have had over 3,735 different contacts to the HSA workplace contact unit. The majority, 3,188, referred to requests for information, where someone asked a question and we provide an answer. There were about 547 complaints in total, of which roughly 288 to date related to Covid. We are still addressing a number of those.

As I said previously, a complaint to the HSA - and we continue to have the same process - can be made, we must assess it, track it, refer it to, and discuss it with, the employer and we follow up as appropriate with the employer, be it indirectly or through an inspection. We keep everything confidential, both for the complainant and the employer, and we do not tend to go back and explain when and if we have done an inspection. That is not part of our general role. What we do is ensure that everyone is addressed. The challenge was, and the benefit of the protocol is now, that we have a clear framework both from an employer and worker perspective, that they know what is expected from us as the regulator and that will allow us to take the appropriate action and steps.

Deputy Paul Murphy: Therefore, Dr. McGuinness is saying that the HSA did not do the on-site investigation because no protocol was in place.

Dr. Sharon McGuinness: What I am saying is that the complaints, when we receive them, have all been assessed and it was determined that an on-site investigation was not materially required at the time.

Deputy Paul Murphy: Dr. McGuinness mentioned that about 80 inspections were done yesterday, is that right?

Dr. Sharon McGuinness: Yes.

Deputy Paul Murphy: How were 80 done yesterday and zero done prior to a week ago? How is that explainable? Surely that is some policy choice or decision? How can it be that all of a sudden there is a requirement to have 80 in one day, which I welcome - although I suspect that it is not enough - but up until last week there were zero, despite the HSA having received complaints?

Dr. Sharon McGuinness: Inspections have generally been reactive to serious accidents and fatalities. We are adhering to the protocol now and with the economy re-opening, we are going out and inspecting and enforcing, where needed, against the protocol.

Deputy Paul Murphy: It seems to me that there was a problem and that the complaints were not being treated appropriately previously, if the authority had 80 such complaints yesterday.

In early April, the HSA was advising workers and those who complained that it "did not have the powers to enforce the public health guidelines". It said it could not do anything about this. This was said repeatedly to many people. Does the authority now have the powers to enforce the public health guidelines and did anything change legally to result in that?

Dr. Sharon McGuinness: The protocol brought up together in a concept under the Safety Health and Welfare at Work Act. Previously there was general guidance out there from a public health perspective done by our public health colleagues but now, in the protocol, it is clear how these can be managed and addressed by employers, workers, and ourselves in line with the protocol.

Deputy Paul Murphy: Dr. McGuinness is saying that the protocol was key in giving the HSA the powers. It did not previously have the powers and the protocol gave it these powers.

Dr. Sharon McGuinness: The protocol has put it in a way that is enabling us to enforce and ensure compliance with measures that workplaces can address. The challenge up to now has been that there has been much advice and recommendations from a general concept and now this has been put into an operational format for workplaces that we can take forward. Workplaces and workers now understand where their role and obligations can be met.

Deputy Paul Murphy: Finally, hundreds of thousands of employees were in work before this week and before the protocol. Dr. McGuinness is saying that if a protocol had been in place previously, the HSA would have been able to act more effectively, and could have, for example, been doing on-site inspections before the last week.

Dr. Sharon McGuinness: The protocol is very much now focused on the reopening of the economy. We have been engaging with all of the different sectors and have been doing primarily reactive inspections in that regard.

Deputy Matt Shanahan: My first question is for Dr. McGuinness. The Minister for Enterprise, Business and Innovation was asked in the House last Thursday whether she had staff available to migrate temporarily to the HSA. She did not answer the question: she said 290 staff members were available but that she was waiting to be asked. I know that negotiations are

ongoing but has Dr. McGuinness given any figure to the Department or are there any plans in place to consider training up additional HSA inspectors for site inspections? If not, could I ask what is delaying that?

I welcome the fact that the construction industry is opening up. There are many industries around the country watching Mr. Parlon's sector and they are hoping that it will be successful and will have limited difficulties with Covid-19 so that others might follow its path quickly.

Has anything changed in the insurance market with respect to opening up? Is additional risk being levied against those who are working in the construction sector, particularly smaller subcontractors, who are open to insurance gouging?

My second question is on PPE. I have been involved in some projects recently to source Irish PPE for the healthcare sector. I hope that the CIF will make a deliberate attempt to re-source and to standardise all of its PPE through Irish manufacturers rather than buying it overseas. That would be a very good message.

In the event of a Covid-19 breakout on site involving more than a couple of workers, at what point does the scale of the breakout determine when the site would be closed for a period?

Mr. Tom Parlon: It is in both in our own standard operating procedure and in the national protocol that if workers displays symptoms on site, they have to be isolated and seek help, and their doctor must be called. An isolation facility must also exist for them. If a positive case transpires, the HSE moves in and will use its own protocol to check. As I said in my opening address, we now will have a log of people. Certainly, there is a major attempt now on sites to keep different groups separate. They will have separate staggered breaks, lunchbreaks, arrival times and so on. So if there is an outbreak we hope to be able to confine it but that is entirely up to the HSE in terms of how it does that.

In terms of PPE, we do not want to compete with the HSE on that. The jury seems to be out still in terms of the use of face masks. The wearing of masks is recommended in crowded areas or where people are close. The protocol says, "in line with HSE advice". We know that both our own standard operating procedures or SOP and the national protocol are living documents and if some new direction comes out then it will be included. We are sourcing products. Some former sportswear people are now commercially manufacturing face masks. I am amazed by what has been achieved by people in this country and some of my own members have come up with standalone facilities for working on-site. When they were off for the last three or four weeks they spent time in their workshops creating stuff.

Earlier somebody asked me about smaller players. All of the safety advice and so on that we have is freely available on our website and the webinars are open freely to big and small players whether they are members or not. Likewise, on our LinkedIn page we have a massive lot of followers and a commercial page. If some Irish supplier comes along and says he or she is providing X, Y or Z then we invite him or her to put it up on our LinkedIn commercial page, which is very full. Certainly it will be our intention to buy locally and it is probably a hell of a lot easier to get supplies locally now.

Deputy Matt Shanahan: What about the insurance issue?

Mr. Tom Parlon: We are working on that area. Insurance companies are pretty quick to change. They have issued new policies and said that they no longer cover anything related to Covid-19. Clearly, there is a major debate about their liability in terms of what they covered

previously and that is a big issue.

In terms of the liability of our members, we have a national protocol that is very comprehensive. Our advice to our members is to follow the protocol to the letter of the law and by doing so they will not have any major liability in terms of anybody who has an issue on a site.

Deputy Michael Collins: Many developments have closed down. I respect that some of my questions cannot be asked today but perhaps Mr. Parlon will furnish me with the details later. The final stages of many of these developments such as council houses in west Cork, Dunmanway, Bandon and Rosscarbery all had to be pulled due to Covid-19. These developments were very urgently required social houses for people in need. Are there dates for specific projects? Can Mr. Parlon give us a breakdown on the specific projects? Can he give us a date for when these council houses will be finished and made available to residents? Projects, like the children's hospital in Dublin, have run very much over budget, which we have debated all along. Does the fact that constructions like this and others have had to close down due to Covid-19 mean taxpayers will have to pay added costs to conclude these projects?

There are many hospitals builds going on throughout the country at the moment, especially community hospitals in west Cork, Skibbereen and Castletownbere. That is fine, they are going on and I presume they will see out their term. I worry about the Clonakilty Community Hospital and other community hospitals because funds were supposed to be made available to allow projects to go ahead. Will those funds remain available? Has that been indicated? Will the projects go ahead or be pulled, which is a serious issue? I would like to ask questions on roads funding but we get so little roads funding in west Cork that it is pointless to ask specific questions.

Mr. Parlon might answer my next question. Some large house builders have told their subcontractors that the new environment of reduced house prices will require a 20% reduction in their rates of costs charged to the main contractor. If so, subcontractors will go bust. Is that the case?

Mr. Tom Parlon: In terms of projects, a couple of weeks ago the Department of Housing, Planning and Local Government deemed a number of social housing projects that were close to completion to be essential and they were allowed to start up again. That has worked successfully and all of them adopted our SOP before the national protocol came into place.

As regards the extra cost, whether on the taxpayer or someone else, the industry is very conscious that the economy is heading for a major challenge. We all know that. First-time buyers and people buying privately are going to be in a worse situation because incomes will be tightened and qualifying for mortgages in that situation will be more difficult. The reality is that that is going to add to the cost as well and it will be a difficult balance to find.

The Deputy mentioned big projects such as the national children's hospital. There is no question that a complex project like that will involve substantial costs if it is to be completed under the new protocol. I understand that particular project has not opened up yet, and I am sure those discussions and negotiations are going on. Not every site has reopened. Some individuals dealing with public sector clients were extremely disappointed with the cavalier attitudes of the employer representatives when they were closing down sites and the contractors were told it was their problem. Some of those contractors are now saying they need to know what is happening before they open up again. The ball is in the court of the Office of Government Procurement, which is part of the Department of Public Expenditure and Reform. The Government

has been extremely supportive of the construction industry because a massive number of construction employees have taken part in the subsidised employment scheme and that has allowed them to go back to work. Many are on the pandemic unemployment payment as well. That is an issue and a major challenge for the current Department of Public Expenditure and Reform and the future Government to deal with, but the cost is just a fact of life. Whatever contractor is advising subcontractors that they will have to cut their costs by 20% is not going to have too many subcontractors coming to the site this week. That is for sure.

Deputy Stephen Donnelly: I thank all the witnesses for coming in and commend all sides on the development of the Return to Work Safely Protocol. It is very useful. There were some very different perspectives around the table when that protocol was being put together, but it is very useful to have this agreed approach between workers, employers and the Government.

I will start with Dr. McGuinness. Advice given to this committee today, which I think is new advice, essentially says that any worker who spends two hours or more in an indoor area, even a big room such as this one, with someone who tests positive would have to self-isolate for two weeks. As people return to work in large indoor areas such as supermarkets or entire floors of office blocks, is it Dr. McGuinness's understanding that if somebody tests positive - even though workers may have had no contact and might have been quite a bit away - everyone who has been in that indoor area for two hours at the same time as that person would have to self-isolate for two weeks? Is that Dr. McGuinness's understanding of what needs to be applied in workplaces in order to comply with the public health advice on close contacts?

Dr. Sharon McGuinness: The protocol is underpinned by public health advice, so if that advice changes, parts of the protocol will change. At the moment the protocol still seeks to keep people working at home and that is a driver. The intention would be, where practical, not to have non-essential people in the office environment-----

Deputy Stephen Donnelly: I am sorry to cut across Dr. McGuinness but I know all that. I am asking a very specific question. Is it Dr. McGuinness's understanding that the advice I have just laid out, which is the advice this committee received yesterday evening, now applies to all workplaces and is that going to have to be enforced? For example, most people who work in a supermarket will have been in the same large indoor area with each other for two hours. Would it therefore be the case that if a single employee tested positive, everyone who has been in that space with him or her for two hours or more would also have to self-isolate?

Dr. Sharon McGuinness: Our understanding of the protocol is that if someone is in a room, he or she should keep it to less than two hours. If the public health advice is now recommending that, we will have to look at it. I think it depends. There are issues around contact tracing, etc., which is part of the reason we also have contact logs in the protocol. I did not hear that specific advice but this is the importance of having linkage, as we do, with the public health piece.

Deputy Stephen Donnelly: I will turn to the HSA's support for workers and employers because it obviously has a vital role to play. The return to work document is useful but, ultimately, this is going to have to be dealt with on a case-by-case, workplace-by-workplace basis. It is entirely possible that many workers and employers are going to be phoning in. An email address and phone number for the HSA have been given for all workers and employers returning to work. What has been committed to is that any such worker or employer will get a response from the HSA. Is there a target time for how quickly the HSA intends to get back to workers who have arrived into a workplace and are concerned that it is not compliant and safe, or to get back to an employer who is looking for help?

Dr. Sharon McGuinness: Seven days would be our normal operating protocol but obviously we can do it much faster. Depending on the nature of the complaint or query, that can be prioritised. Seven days is set but we generally do it within a much shorter time period. It depends on the nature of the issue that needs to be addressed.

Deputy Stephen Donnelly: Is Dr. McGuinness confident that the HSA has the resources in place? I imagine that many workers and employers will phone and ask for that help.

Dr. Sharon McGuinness: Indeed. We have reassigned people and others have been seconded from other departments to support our workplace contact unit. We will obviously keep that in mind because the Deputy is right, and we are already hearing those queries coming in.

Part of the work we do is supporting SMEs, as we have been doing for many years. We also support workers. We were talking earlier about learning materials for safety representatives. We have had checklists and templates for the Covid-19 response plan on our website since yesterday and we hope companies will not need to come to us as often. If a representative of a company has a specific question, there is now a lot of advice coming on stream and we will continue to do that.

Deputy Stephen Donnelly: I apologise because I had questions for Ms King and Mr. Parlon but the five-minute time limit did not allow for them. I thank our witnesses again.

Chairman: I believe Deputy O'Reilly is taking ten minutes.

Deputy Louise O'Reilly: I am indeed. I have some questions that relate to the construction industry and some that relate to other areas of work. We have received new public health advice for how we conduct our business here. I am sure that nobody, least of all our esteemed witnesses, would suggest that there should be a kind of upstairs-downstairs situation whereby there is one rule for us and another for the poor unfortunate who happens to be working in a supermarket or on a construction site. Is it everybody's understanding that this protocol is a living document that is capable of being updated, as and when the public health advice is updated? We have had updated public health advice so we are updating how we do our business. Would that be our witnesses' understanding? As health advice is received, as we have received it and I assume that same advice is intended generally as public health advice, can that be incorporated into the protocol? Are all parties prepared for, and happy with, that?

Ms Patricia King: I thank the Deputy for the question. It is a fact that the protocol is a living document. There is also provision in it for an oversight group under the labour employer economic forum, LEEF, process because we were the people who created the document in the first place. I expect that group will meet regularly, at least once a week and more often if required. That group should take on board all of the changes that will arise and evolve as the pandemic goes on and the economy reopens. I expect that group to be active to ensure this protocol, as a live document, can be adapted and altered to keep it in step with what is actually happening on the ground.

Deputy Louise O'Reilly: Might I suggest, if it is not too cheeky, that our witnesses take the advice we were given and factor that into their considerations? Public health advice is public health advice and if it applies here, it applies everywhere. I know that nobody, least of all our witnesses, would want a situation whereby we had a different set of rules from anyone else because every worker deserves protection, even a politician.

I refer to the 200 complaints that were made. People have contacted me and they are very

frustrated. They have made complaints, and they describe doing so as screaming into a void. They do not know what follow up, if any, is being done. I know 80 inspections took place yesterday and I would be interested in knowing how many are planned for the rest of the week. Can the HSA sustain that level of inspection? I am not sure if, in the normal course of things, a figure of 80 inspections means everybody is making their best effort or is a normal day. What happened to the 200 complaints made?

Dr. Sharon McGuinness: As I said, those complaints dated from the time period of 1 March and overlapped a series of different Government elements. All of them would be addressed through the workplace contact unit and have been followed up, in some instances by inspectors where necessary. In terms of the complaints process, while we do not always go back to a complainant we address his or her complaint and he or she can, if asked, come back to us and see what has happened. We do not generally divulge, on either side, whether we have inspected a site because not only is the nature of the complaint confidential to the complainant, what happens at a workplace is also confidential. We can talk about it in the round. Each of those complaints would have been followed up and addressed to the complainant, who would have received a response, and the employer would have been contacted and checked in respect of the public health measures in place.

Deputy Louise O'Reilly: Would that have been a telephone check?

Dr. Sharon McGuinness: Yes, and an employer would have been asked to submit information. If we were not satisfied with that we would have followed up further, with an inspector having a discussion with the employer.

Deputy Louise O'Reilly: There were no physical on-site inspections, but there were 80 yesterday. Is that right?

Dr. Sharon McGuinness: Due to the nature of complaints, inspections were not always warranted. As I said, some sites closed down at the time because, as the Deputy knows, those figures come from 1 March.

Deputy Louise O'Reilly: Okay. I want to tease this out. Dr. McGuinness said some sites closed down and some complaints were resolved by telephone or a non-physical presence on site. What about the other ones?

Dr. Sharon McGuinness: They would have been addressed or will be, as I said, when they are looked at over the course of the next while. They will be addressed further if necessary. In terms of the complaints, some involved queries about what was and was not essential and other issues of which the Deputy is aware. Each of those would be addressed, as I said, in that manner.

Deputy Louise O'Reilly: Perhaps Dr. McGuinness and I have different definitions of what does and does not constitute a complaint being addressed. Some of those who have contacted me do not feel their queries were addressed. I respect what she is saying with regard to the process.

Can she talk me through what happens now if a worker on a construction site has a complaint? I take the point made by Mr. Parlon earlier. From my perspective, I do not often find myself agreeing with him, but I agree with him when he says the union representative on site is the eyes and ears of the worker. Never has there been a time when it has been more important for workers to be organised and members of and active in their trade unions.

I ask Ms King and then Mr. Parlon to talk me through what happens when a worker comes on site and wants, like most of the people in the HSA, to do the right thing but finds it is not being done and he or she has very serious concerns about his or her health and safety. What happens then?

Ms Patricia King: That is the nub of the entire piece. The infrastructure would mean that the representative on the ground would be the eyes and ears in a workplace. The workers should feel confident about being able to liaise with that person and say something is not happening or is not happening correctly or often enough, such as cleaning, hygiene or whatever. Under this protocol, that representative is supposed to be able to liaise with the management representative during the course of the day and have a conversation about what needs to happen. If something does not happen, the representative has a number of options. If he or she is in a trade union, he or she can go to a trade union official. As the Deputy knows, larger companies have health and safety representatives. Smaller companies do not usually have them.

Deputy Louise O'Reilly: They do not.

Ms Patricia King: He or she can go to the health and safety representative and both can make contact with the HSA. That is all reactive. The protocol also states that we need to have a proactive approach. One of the ways of being proactive is to have boots on the ground and to go out checking so that employers know this will be checked. The second point is that something like on-the-spot fines, which is what we are suggesting the committee should consider, brings with it an alertness that brings a deterrent value. From that point of view, that also will boost and bolster. When those things are in operation, workers become confident that their place of work will be kept safe. In the first instance, ICTU put forward the proposals on the protocol. The objective of that was to gain the confidence of workers that going back to work can be safe.

Finally, a feature of this pandemic across the labour market is that the lowest paid workers are much more exposed. They are the people in the essential services, aside from the health service. I am leaving aside the health service for obvious reasons because there is a combination of pay grades, etc., delivering that service. This is a global feature. This is the same in Australia, in America and in Ireland. If one sets the health service aside, these are the same people who do not have a significant representative infrastructure, who are not recognised and who suffer, and have for years, lots of resistance to issues they would raise within the workplace. We are seeing some of that in the meat factories. We saw an incident today where tests were not even given to the individuals who should have had them. Their individuality was not even being respected. From that point of view, this should bring about, as I think Deputy O'Reilly suggests in her question, some form of major reform. I hope this House helps us to bring forward legislation that, once and for all, will respect worker representation and their rights.

Deputy Louise O'Reilly: I hope we do too. Mr. Parlon might be very brief on that. I ask him to address whether, in the event that these protocols are not followed, his members are prepared and understand that they may have to close a site. If the protocols are not followed, that is the next logical conclusion. Are Mr. Parlon's members prepared for that?

Mr. Tom Parlon: If the HSA gives us a directive to close a site, we do not have any option whether we like it or not. We agree, and that is part of our agreement to the protocol.

The Deputy mentioned about the living document. That certainly is the case whatever changes come about. I got notification today from the Department of the Taoiseach that there is a meeting of the consultative stakeholder forum on the national protocol at 2 p.m. on Friday

next. Immediately, we are working. This is an opportunity for any issues that arise.

Deputy Louise O'Reilly: Mr. Parlon might consider the public health advice we have received here.

Mr. Tom Parlon: What is that?

Deputy Louise O'Reilly: Mr. Parlon might consider our public health advice at that meeting. I will make sure Mr. Parlon gets a copy of it, and the other document I hold as well.

Mr. Tom Parlon: The HSE - the medical experts - will be there. They will advise us, if that is the case.

In terms of the unions, I have the agreement here. If a worker representative raises an issue with management and it is not being dealt with, the trade union forum, the CIF and the HSA have a forum and they meet and discuss. There is an agreement that this would be done promptly. If it cannot be dealt with at that level, it is referred to the Covid-19 department of the HSA. All of those particular actions are there. It is good that it is there.

There is much focus here on the HSA and inspectors. I expect everything will not be perfect. It will take a while. I note some of our contractors have been dealing with this for the past month. It took a while. There were toolbox talks having to be called every couple of hours to say, "Lads, this is not the way it will work."

Chairman: I thank Mr. Parlon.

Mr. Tom Parlon: That brought about a new culture and it works well. I expect most of these issues will be dealt with on site.

Chairman: Is Deputy Colm Burke the next Fine Gael speaker?

Deputy Colm Burke: Yes.

Chairman: How long are you speaking for?

Deputy Colm Burke: Just five minutes.

Chairman: There are 15 minutes to Fine Gael, however the Deputies divided it.

Deputy Colm Burke: I am taking my five minutes.

I thank the witnesses for the work that they are doing. It is a challenging time for everyone, no matter what type of employment one is in. Much work has been done behind the scenes over the past few weeks in preparing for this.

My main question is to Mr. Parlon and it relates to the set-up in the construction industry. As I understand it, there is quite a high labour input in the construction industry in Ireland. Will this force or bring about changes in how we approach the construction industry? For instance, I was speaking to someone recently in the UK, where they are doing a lot of modular building in relation to apartments. It is difficult to do that here because of a certain regulation that does not allow it. Are we going to see a change in the whole construction industry and how we approach building projects? We have to ensure health and safety at all times. Coming from a legal background, I have dealt with several cases where I have seen major tragedies on building sites which should not have occurred. They occurred because the necessary support was not

there for the employee when the accident happened. We are trying to strike a balance between having enough people on site to do the work and making sure nobody is put in danger of Covid-19. From their experience in representing the industry, do the witnesses think there will be change? How can we protect jobs if that change does come?

Mr. Tom Parlon: Before the pandemic we faced a challenge in getting people to work in the construction industry because we were competing with all the other sectors. We were just about to embark on a careers campaign funded by our members. That pressure is now off because there are forecasts of 300,000 people in long-term unemployment, so we have a pool of people to call on. The Deputy mentioned the move to off-site and modular work. That is a global shift which we are certainly reflecting. Strangely, several members of the Construction Industry Federation, CIF, provide modular buildings to the UK because we do not have sufficient scope in Ireland. If we were to embark on a very substantial social housing or apartment building programme, that would allow our operators to get into modular work. There is no question that it is the way forward.

The Deputy referred to some tragedies in construction. We have a very strong culture of health and safety. My colleague who is present here, Mr. Dermot Carey, is director for safety and training. Massive investment is made by all and sundry into health and safety. Complying with those requirements is a very big cost. We were able to get our standard operating procedure together so quickly, ahead of most other players, because we have that good culture. The move to off-site and modular construction is inevitable. It will probably mean that people will be working in enclosed factories, putting modular pieces together, rather than on sites. It will protect people from the worst of the weather but it will still involve a substantial amount of labour. We foresee that about 150,000 people will be back to work in the industry within about six or seven months.

Deputy Colm Burke: I have one more question for all of the witnesses. House renovation involves very confined spaces. I am not sure what action can be taken there. With fewer people there, can there be sufficient health and safety measures to protect the workers while complying with regulations concerning Covid-19? House and building renovation is where the real risks are. What are the witnesses' views on that?

Mr. Tom Parlon: The guidance issued to the construction industry stated that construction sites are to be opened where it is safe to do so. I can understand that at the moment it would be highly risky for construction workers to go into a house where a family is living to replace a kitchen or something like that. However, I read today that the negotiations for the new Government have called for a very substantial number of retrofits. That is one of the ways forward. We are going to need stimulus. There will be a green agenda regardless of who forms the Government. That will be highly labour-intensive. If the physical distancing requirements continue, retrofitting will be a challenge. It will probably involve much smaller teams. Retrofitting cannot be done off-site. Workers have to move into the house to do the work.

Chairman: I thank Mr. Parlon. I would like to give the floor to Deputy Murnane O'Connor, who I believe has seven and a half minutes.

Deputy Jennifer Murnane O'Connor: I will take five minutes and Deputy McGuinness will take two and a half.

Many of my questions have already been asked. I thank the witnesses. I would like some clarification. Does each construction site have sufficient personal protective equipment, PPE?

This question is for Dr. McGuinness. Are the guidelines sufficiently clear? It is important that there is good communication with workers. Is there guidance in place to help those whose first language is not English?

It is important that the HSA be better resourced. That is an issue that has been raised today and it is one of my concerns. I believe there will be a cross-body approach with the WRC, environmental health and the Garda all pitching in. Will all of the information be in a database setting out what will happen? What will be the outcome from everyone pitching in together? That would be good, but I would like clarification on that.

What happens when a site, factory or shop is found to be in breach of safety standards? I heard the steps that were set out, but what is the reality? The Covid-19 protocol is a living document and it can change. Is there room for manoeuvre before a written warning is issued or a site shut down and healthy workers are put out of work? What can we do to help ensure total compliance on sites so that they are not shut down? That question is also for Dr. McGuinness.

My next question is for Ms King. I agree that workers need a statutory right to representation. However, I believe there is a missing link in workers' rights in Ireland, namely, the right to raise concerns without penalisation. While the emergency legislation and the protocols provide workers with the ability to raise issues of health and safety without suffering, that is not the reality on the ground. In the meantime, we need to put a statutory framework in place. I agree that something definitely must be done in that regard.

Does Ms King think there is fairness in the system whereby a worker is put in charge of his or her employment location safety rules? It is well established in the construction industry, but it might be new to a hardware store or garden centre. Are workers consulted on who the person should be? It is very important that the representative should be fair, trusted and look after the needs of workers.

The following question is for Mr. Parlon. The CIF designed a standard operating protocol for the return to work process. As part of that, it created an online safety induction programme for workers returning to work. I was informed by the federation that more than 130,000 workers employed in the industry have completed the induction and are continuing to complete the programme and receiving digital cards so that they can return to sites. I wonder whether oversight is robust. How does anyone know if the workers are fully engaged with this process? I would like to think it is not just a box-ticking exercise and that during the inspections, Mr. Parlon's organisation will check that workers understand the protocol and that there are no language or computer literacy issues, which are major concerns. We must support workers.

Dr. Sharon McGuinness: I will try to take the Deputy's questions in the order she asked them. There is already a requirement on employers in all workplaces to provide PPE if it is required. It is provided in accordance with the hazard facing the worker and the worker must be trained in how to use it properly and how to remove it. That is a general health and safety requirement. It is up to the employer in each workplace to ensure adequate supplies of PPE are available, as required.

The language issue has been raised in certain areas. It is something we have addressed in the past and it is something that could be considered. That is something we could bring back to the consultative forum, which will meet later this week. The forum's resources and its cross-body nature are fundamental, as we need such a cross-body effort. We will bring all of the findings together. The consultative forum will not only take account of any changing health

measures but also anything we find on the ground, including if particular sectors are at issue or we feel some of the advice needs to be modified. All those issues will be raised and taken into account at the consultative forum. We get an input from the various bodies that are involved in inspections.

In terms of a breach of safety, as I stated, we have improvement notices and prohibition notices. The latter, in particular, stops work activity, which is a deterrent. It can also stop part of a work activity so it may not close down an entire site. There are different steps involved. In general, the steps in any inspection very much involve advice and support and ensuring people can comply and know how to bring about compliance. We can give advice in written form following an inspection and give general guidance on when issues need to be addressed. That needs to be done. Improvement and prohibition notices have more legal basis and can be followed up appropriately within a legal context. As I have said, these should allow employers to put measures in place to rectify matters as quickly as possible.

Mr. Tom Parlon: I thank the Deputy. First-----

Chairman: We will have to stick to the time fairly strictly. Perhaps Mr. Parlon and Ms King could provide Deputy Murnane O'Connor with an answer in writing. We will move on to Fine Gael and then to Deputy McGuinness.

Deputy Fergus O'Dowd: I very much welcome the return to work. I live in a town that produces a lot of cement. We have a cement factory in the town and we are delighted that business is beginning again and that people are getting back to work. Seeing more lorries and people involved in construction on the road down here and back is very welcome. I accept and acknowledge that this will only work properly if the unions, workers and employers can work together and reach sensible consensus on issues. Where the HSA has to get involved, it will have to have a defining role with regard to safety, which must be paramount.

The State has provided many subsidies to get businesses going again, in addition to wage and income supports. While I accept that costs are increasing, the headline run by one of our national papers - and I appreciate the Mr. Parlon did not say this - that there could be a 40% increase in the cost of the national children's hospital is an appalling vista. It is entirely unacceptable, particularly to the taxpayer. I am very unhappy with that.

I accept that costs are increasing but I am not happy about the implications for our construction industry and for people who need housing, including social housing. Mr. Parlon will obviously want to give his arguments but I believe it is wrong that the first point of departure today is that everything is going up. I am particularly concerned for young people. I know many young couples who want to buy their own houses. They were expecting a stabilisation, if not a fall, in house prices. It is not good enough that they would face a 15% to 20% increase.

What alternatives are there? Deputy Burke spoke about a different type of construction and different ways of doing things. Why do people always have to pay more and why do they have to pay more to the builder? Why does the taxpayer have to pay more for all of these hospitals and other construction projects? It is a mantra that we must challenge.

Mr. Tom Parlon: To clarify, I did not make that suggestion with regard to the children's hospital. That will be subject to many negotiations. The Deputy mentioned the hospital but I referred to complex sites that will involve a great deal of fitting out. I am sure the children's hospital will fit into that category. Some of our industry professionals have suggested the in-

crease in cost for such projects could be as high as 40%. I am sure that is negotiable. That will all be worked out. The Deputy can laugh but unfortunately-----

Deputy Fergus O'Dowd: I am emotional because it is so important.

Mr. Tom Parlon: If it is being suggested in the House that workers can only stay together for a maximum of two hours on a major complex that will involve millions of work hours, the project will extend over years, which will have cost implications. It is going to be a challenge. There is no question about it. Under the rules laid out under the protocol, finishing off complex sites such as the children's hospital, data centres or the new pharmaceutical plants will be a major challenge. A two-year programme could well end up being a four or five-year programme, which is bound to have cost implications. I do not suggest for a minute that it is a good idea, but it is the factual situation at the moment. We all appreciate that if house prices come under pressure, the potential buyers of those houses will have fewer resources and less chance of getting a house. That is something with which we will have to deal. While the industry has to work to the letter of the law in meeting the protocol, we will have to find innovative ways of doing so more cheaply. It is to be hoped that some of the restrictions under the protocol can be loosened over time as we make progress with the pandemic.

Deputy John McGuinness: Mr. Parlon is correct to put on the record that there will be substantial increases to existing contracts, and the delivery of houses and other major projects. It is no harm to mention the children's hospital because of its size. The Government needs to understand the major implications for cost. There is also an issue with insurance, which Mr. Parlon did not cover adequately. Most of the insurance companies are running from anything to do with Covid-19 claims and will do anything not to pay those who are insured.

I also ask him about the collapse in funds relative to US or other international funders of the massive projects being undertaken across Dublin and other centres. That must also be a concern. If that happens, we will be left with major problems for the employees on those sites and for reopening those sites and avoiding an economic crash relative to the sites.

I would like the committee to recommend a Government-led forum or a place where issues like this can be worked out without it going to court. From what Mr. Parlon has said and based on the reality on the ground, it seems that there will be major legal issues with insurance claims for the sites themselves. The costs will need to be dealt with in that kind of forum. I ask him to press these measures so that we do not end up being confronted with this overnight. Now is the time to plan for it.

The point I was making about small contractors was that they need support and encouragement; I was not saying that they were less diligent. I was saying that they are very diligent, but they are coping with an entirely new scenario now. Rather than just looking at the big contractor, we need to embrace all those smaller contractors who are giving fair employment and doing their best. This is something that has not been dealt with by them previously.

I say this to Dr. McGuinness on the meat factories and so on. Someone fell down on that job. Ms King referred to employers who are responsible, acknowledge the workforce and so on. They were not and that is why they got into trouble. While we expect so much from them, greater vigilance on the part of the HSA and other Government agencies needs to be put in place. I encourage the committee to look at the alarming figure of 40% and other issues relating to insurance and funding on these major sites. We need to deal with it and plan ahead for what will be a serious legal quagmire. The Dáil needs to confront that at an early stage, otherwise the

taxpayer will pay substantially more in costs, and court appearances and challenges.

Chairman: I thank Deputy McGuinness. Does Dr. McGuinness wish to come back on that or are we-----

Dr. Sharon McGuinness: No, I have listened to the Deputy's point.

Chairman: I thank the three witnesses for coming here today and answering all the questions so fully.

Before the next meeting, I will be in extensive contact with members to agree our work programme. Deputy Shanahan made the point that it would make sense for us to look at the extension of the private hospital contract before that extension is decided rather than afterwards, but we can only have a finite number of sessions in a week.

The committee adjourned at 6.30 p.m. until 11 a.m. on Tuesday, 26 May 2020.

A clarification received from Mr. Tom Parlon, director general of the Construction Industry Federation, can be viewed in the Recent Documents section of the committee's web page.