DÁIL ÉIREANN

COISTE SPEISIALTA UM FHREAGRA AR COVID-19

SPECIAL COMMITTEE ON COVID-19 RESPONSE

Dé Céadaoin, 16 Meán Fómhair 2020

Wednesday, 16 September 2020

Tháinig an Coiste le chéile ag 10 a.m.

The Committee met at 10 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies
Colm Burke,
Matt Carthy,
David Cullinane,
Cormac Devlin,*
Bernard J. Durkan,*
Danny Healy-Rae,*
Paul McAuliffe,*
Fergus O'Dowd,
Louise O'Reilly,
Matt Shanahan,
Róisín Shortall,
Bríd Smith,
Duncan Smith.

* In éagmais / In the absence of Deputies Mary Butler, Jennifer Carroll MacNeill, Michael Collins and Stephen Donnelly.

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

Business of Special Committee

Chairman: Good morning. We have a quorum so we are now in public session. I have been notified that Deputies Bernard Durkan, Ged Nash and Cormac Devlin will substitute for their party colleagues today. I have also been notified that Deputy Cullinane will chair the second session. Are the minutes of the meetings of 2, 9 and 10 September agreed? Agreed. Is it agreed that we have noted the ten items of correspondence received? Agreed.

To discuss business briefly, I do not want to go into a great amount of detail on proposals but if members have proposals to make we will hear them.

Deputy David Cullinane: We do not need to go into much detail on it. We possibly need a Teams meeting some time this week to hear people's proposals. In terms of my key proposal, obviously, we need an updated work schedule because we have a number of items to book in, including the nursing homes issue. We have the sitting on Friday also in respect of sports, which I believe should go ahead.

Yesterday, we had the launch of the living with the virus plan. No time was made available in the Dáil to debate that plan. We have to wait another couple of weeks before the committees are set up. Whether it is the health committee or business committee that might want to examine different parts of that plan, there is a need for this committee to examine it. There is still much confusion about it, despite the fact that we were told it would bring clarity. Even this morning we had Ministers contradicting what other Ministers had said the day before so there is a need for us to discuss that plan. We need to have the Minister for Health with the officials from the HSE and, if possible, NPHET come before the committee. We need to hear from all of the actors that fed into that plan over a number of sessions or two or three sessions on the same day. There needs to be some scrutiny of the Bill and if this is the only committee that is available to do so then we should do it very quickly.

Chairman: I agree with the Deputy because it is a multidisciplinary plan so does not fall within any particular area. Hopefully, all of the committees will be established at the beginning of October to take over the work that we are doing but, in advance of that, we need to look at the plan. We should organise three meetings, perhaps the same type of meetings that we had in the middle of August. We can discuss the matter at a Teams meeting and hear various views.

Deputy Fergus O'Dowd: I have no problem with the suggestion. However, the plan may very well change. If we are having an urgent meeting then it should be after tomorrow because there may be new developments tomorrow.

Chairman: I propose that we have a Teams meeting tomorrow afternoon.

Deputy Fergus O'Dowd: Yes.

Deputy Bríd Smith: I would like us to delve into two things and the first is young people during Covid. The other night there was a terrible tragedy in Kilmainham. That is in my constituency so I am very well aware that such tragedy is not a rare event. The young people who need the attention of various services, youth services and the justice services are being completely neglected because the drop-in centres and outreach are not available due to Covid restrictions. We need to consider the impact this crisis is having on young people in communities and urgently put in place resources.

Second, Ryanair has requested to return to the committee to deal with the European regulations on airline travel because we are considering opening up travel and adding, for example, Sweden and Germany to the green list. Such a meeting would be very beneficial to us. There are a number of issues that arise from that discussion that we should consider.

Chairman: The Deputy has made valid suggestions. I suggest that we have a Teams meeting at a time to be agreed. Is that agreed? Agreed. We can move on to the business of today and we will discuss all of the proposals tomorrow.

Covid-19: Final Report of Nursing Homes Expert Panel

Chairman: I apologise to the witnesses that we are a little bit later starting than anticipated. The Expert Panel on Nursing Homes was established by the previous Minister for Health. I welcome from committee room 2 Professor Cecily Kelleher, chair, Professor Cillian Twomey, member, and Ms Brigid Doherty, member of the Covid–19 Expert Panel on Nursing Homes.

I wish to 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. However, if they are directed by the committee to cease giving evidence on a particular matter they must respect that direction. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

I invite Professor Kelleher to make her opening statement. It has been circulated, in advance, to members so I ask her to confine her statement to five minutes.

Professor Cecily Kelleher: I thank the Chair and members of the Oireachtas committee for their invitation to attend this morning.

COVID-19 presents, as we all know, a significant global threat to public health and the WHO declared a pandemic on 11 March 2020. As of 14 July 2020, for the purposes of our report, 79% of all notified deaths were in those aged over 75 years. The 985 deaths in nursing homes represented 56% of all deaths in the Republic of Ireland. We, as a society, mourn their loss and offer condolences to the families and loved ones of all those who lost someone during this period.

The four person independent expert panel was appointed by the Minister for Health on 20 May to examine the complex issues in this particularly vulnerable group of nursing home residents. We were tasked to provide assurance that national protective measures were in place in line with international guidelines and best practice; to review International evidence using a systematic research process; and, to report to the Minister on immediate real-time learnings and provide recommendations. The panel took an evidence-based and consultative approach to our work. This was an in-action and after-action review that took account of lessons learned and preparedness, and was forward looking.

We requested an analysis of available epidemiological data from the Health Protection Surveillance Centre and the Department of Health. At UCD, my team undertook a rapid, systematic review of international literature on older people in long-stay care centres. We also undertook a three-part stakeholder consultation over the month of June. We held 13 meetings with

43 people from key groups and received a further 37 submissions. In addition, we received 53 submissions from nursing homes and 60 public submissions. Finally, we undertook three nursing home site visits, one actual and two virtual, with the person in charge and staff. Panel members also had engagement with several residents and relatives.

We know that 5% of those aged 65 and over live in communal establishments. HIQA, the Health Information and Quality Authority, is the regulator for this sector and, as of summer 2020, had 576 registered nursing homes, 444 of which were privately-owned, and 3.6% of the over-65 population reside there. The first notified case in the sector was on 16 March. As of 27 June, 252 clusters had been reported, which represented 18% of all clusters at the time and they were associated with 5,608 cases. Notably, the highest number of clusters were in the more densely populated eastern region. The estimated incidence rate, at 14.5%, was greatly higher than in the general population of comparable age.

The evidence review showed that, despite a limited database to date with a new disease, the importance of infection prevention and control measures was repeatedly highlighted. All stakeholders who consulted with us stressed the need for preparedness. This included discussion on timeliness of response both then and into the future, the challenges of managing a new disease, and the critical public health measures that must be in place. I stress, this is a highly contagious novel virus with continuously evolving understanding of its epidemiology. The significance of asymptomatic spread and atypical presentation in older people was not understood early in the pandemic. The rapidity of spread in frail, older people in a congregated setting was a feature in Ireland and elsewhere across the world. Consideration of the well-being of residents and their voices, and those of their family members, in management structures was emphasised. Preparedness for the next 18 months will be crucial, with a necessary focus on this sector immediately as part of winter planning.

There was also emphasis in the submissions on lessons learned about the model of care for older people more generally. Many submissions focused on the implications for a future model of care. The interdisciplinary co-operation in response to the crisis presented a model for future delivery. The importance of representation of older people in their care and the place of advocacy were stressed. Nursing homes into the future should be part of a continuous spectrum of care of the older person with provision of multidisciplinary support.

It was clear from a range of stakeholders we consulted that healthcare staff worked tirelessly for the residents and all parties, including carer staff, and they now require a range of supports, which we stress in our reports. Great value was placed on the services "stood up" to cope, especially Covid-19 response teams. These supports must be sustained and regularised over the next 18 months. This is a multifactorial challenge and we must be action driven. The recommendations must also reflect that systematic reform is needed in the way care is delivered into the future.

Each area of recommendation in 15 thematic areas has a suggested clear lead agency and timeframe for implementation. We list some examples for discussion in our presentation. This ranges from immediate and ongoing to within two years of the publication of the report. Public health preparedness right now is essential by individual nursing homes supported by the HSE and HIQA.

We have an opportunity to address health policy for older people, with nursing homes playing a key part. There is an implementation plan in train now by the Department of Health which will be crucial to the delivery of the recommendations in this report. I thank the committee.

Deputy Cormac Devlin: I thank Professor Kelleher very much for her opening statement and for the report before us. She outlined the number of nursing homes. We discussed inspections previously at the committee with Nursing Homes Ireland and others and we had HIQA in recently speaking about the number of inspections it carried out. Does she think there was an adequate number of inspections of all care settings during the initial stages of the pandemic?

Professor Cecily Kelleher: The committee has heard from HIQA, which is the regulatory authority. It does periodic inspections and those reports are all available to us. They cover areas relating to governance, staffing, management and infection prevention and control. The committee will be aware, from its evidence, that it necessarily suspended those inspections for public health reasons at the outset of this in March, and it recommenced them around the time of the preparation of our own report. We are forward looking in our recommendations, and we have made some clear recommendations to HIQA to strengthen those regulatory inspections, particularly around infection prevention and control. We have set out a number of those in our report. I draw the Deputy's attention to one specific recommendation we have made in regard to an audit of staff in current homes, which we think is a very important piece of work. We have also placed emphasis on staffing provision and how that might be put in place.

Deputy Cormac Devlin: I thank the witness. Regarding staffing provision, a crucial issue that came to light in my constituency of Dún Laoghaire, and presumably throughout the country, which we are also seeing in schools now, is where somebody presents with symptoms, relief cover is needed. That is essential, particularly in a care setting such as a nursing home or other facility. Graph 3.3 on page 29 of the report refers to the incidence rates. A comparison is drawn between counties Cavan, Monaghan, Westmeath and Longford and the lower number of cases in counties Waterford and Galway. Equally, on page 41, table 3.10, reference is made to the high incidence among healthcare workers in counties Dublin, Cavan, Louth and Monaghan in comparison to counties Waterford and Galway. What, in Dr. Kelleher's opinion, was the difference between those areas?

Professor Cecily Kelleher: It is clear that incidence rates varied by region. The areas with higher incidence rates was reflected in our data in higher incidence in nursing homes. A key component is that it is important to keep the infection out of nursing homes, and when there is a number of possible exposures in that setting, that is something to be hypervigilant about. The first point I would make is that there is a regional variation. That is an important point, which we are again looking at now. In general, preparedness has to take account of means of keeping the virus out of a home, and to have infection prevention and control strategies in place, and indeed contingency plans for the cohorting of staff, and other responses that need to be made. We have made all of those recommendations in the report.

Deputy Cormac Devlin: I turn to the discharges from hospital. The report states 10,710 individuals were discharged from nursing or convalescence homes, or long-stay accommodation and 401 had either caught or already had Covid, and 11 were probable cases. Can Dr. Kelleher elaborate on that?

Professor Cecily Kelleher: We were an expert panel tasked to ask those with that responsibility what the issues were in transfers from nursing homes. The committee will appreciate that we do not have direct oversight of that. We were very clear that we would like to understand whether transfer from nursing homes contributed in any way to this outbreak. We were assured that protocols were put in place rapidly in relation to testing that was appropriate, and that this needed to be in place. Again, we made clear recommendations around transfers from nursing homes, which is a key component of management going forward. I stress that we have also

made recommendations in respect of a number of other factors, including the healthcare workers who are working in those facilities, the ongoing rolling testing that needs to be in place in that regard, and indeed any potential risk for entry into that setting. I could turn to any of my colleagues who would like to elaborate on that.

Another issue in this regard, which we have raised, is a unique identifier. It is very important that we would be able to track the transfer of patients into different settings, and to be able to do that robustly.

Professor Cillian Twomey: To follow up on what Professor Kelleher has just said, an obvious question to ask is whether it is likely or possible that the transfers that occurred from acute hospital settings to nursing homes in the month of February, predominantly, brought Covid-19 to the settings to which they were transferred. The short answer is that we are unable to say with certainty that they did or did not. That relates partly to the way in which data are accumulated and collected but the more likely explanation is multifactorial. It relates to staff working in residential care settings, some of whom were working in several settings at the same time, and residing in congregated settings. The possibility of staff transmission, therefore, is equally an important factor.

We have made a seriously strong recommendation with regard to data collection in order that in future, if the question is asked whether people who transferred from physician or hospital A to facility B had a higher of lower incidence of Covid, we will be able to answer that. We were not able to get that answer in the work that we had done. It is more likely that it was related to staff although much less, I suspect, visitors but that is another area in which potentially there might have been some transmission. There are deficiencies in the way in which data are collated as between the Health Protection Surveillance Centre, HPSC, HIQA data and mortality data. It needs to be tightened and we have made clear recommendations as to how that should be done as a matter of immediate urgency. That has been accepted by the various agencies concerned as something that should be done.

Deputy Cormac Devlin: I thank Professor Twomey for that but in terms of the number of individuals who were transferred either from a hospital setting to a nursing home or a long-stay facility, was he able to establish if they were tested prior to leaving hospital, which for me would be a critical point?

Professor Cillian Twomey: We must bear in mind that we are talking about February. I suspect not everybody who was transferred in February was tested because the facilities for testing were not only not adequately available for the particular requirement the Deputy outlined but, similarly, they were not available globally or nationally. I suspect there were transfers in the early part of that process, in February, in particular, where testing was not universally done but I can tell the Deputy now that it is done in every case. Not only that, when somebody is transferred now from the acute sector to a residential care facility, he or she is quarantined for a period of 14 days so that, test or no test, such people are kept apart from the other residents for that period of time.

I know the committee has heard repeatedly that, inevitably, there has been a significant learning curve about this pandemic because it was new to all of us at the beginning of this year. There is no question that our systems evolved more efficiently as time went on. We were asked by the Minister what needs to be done to ensure, should there be another surge, that the sort of delays that occurred earlier in the process, in February in particular, would not recur. I believe our recommendations, if implemented, will ensure that they do not.

Deputy Cormac Devlin: I thank Professor Twomey for that.

Professor Cecily Kelleher: On page 42 of our report we indicate that from 10 March, testing of people in line with national criteria and two negative swabs before transfer was put in place. The guidance was reviewed again on 6 April and subsequently again on 8 April.

Deputy Cormac Devlin: I thank Professor Kelleher. On that point, it brings into focus chapter 5, which examined the learning from Covid to establish the extent to which nursing homes are better prepared. The witnesses might delve into the recommendations under chapter 5.

The supply of personal protective equipment, PPE, at a very early stage - Professor Kelleher mentioned February and it was new to everybody at that point - took some time to filter to either public or private nursing homes. The witnesses might comment on that, too, in response to my final question.

Professor Cecily Kelleher: It is a matter of record that there was a national issue around supply, that is, the appropriate supply of personal protective equipment and of the appropriate testing and contact tracing process. We have learned from that, which came out clearly in terms of the submissions that we had. We are absolutely clear, as a panel that recommends preparedness, that this now needs to be in place. We have made several recommendations on the HSE's support of that. We have asked that the Covid-19 teams would be continually stood up in that regard. It is absolutely crucial that it is now in place.

Deputy Cormac Devlin: I thank the witnesses.

Deputy David Cullinane: I welcome all the witnesses. I have read the report and my first question is for Professor Kelleher. To some degree, the report had to look back on the most recent events and how nursing homes dealt with Covid-19. However, the report concentrated more on the framework of care under which nursing homes do or do not operate, as the case may be. The essence of the report is recommendations that are forward-looking and looking at what changes needs to be made. Is that what the report sought to do in essence?

Professor Cecily Kelleher: Yes, that is very clear. Without in any minimising the trauma to this country regarding what we experienced so far with Covid-19, and particularly this sector, we were very much charged with looking forward and making those recommendations as to what needs to be done.

Deputy David Cullinane: When the panel went about its work, did it interact with HIQA? Did the HIQA report have an impact on the report of the panel?

Professor Cecily Kelleher: Yes. In terms of our stakeholder consultation, our first ports of call were HIQA, the HSE, Nursing Homes Ireland and all of the stakeholders that have a statutory responsibility in relation to this area. HIQA told us that it had regulatory responsibility and wanted to see a strengthening of its own regulations. We also have made it clear in our recommendations that we both agree with that and want systematic inspections to be undertaken. For instance, we have responsibilities for HIQA in terms of compliance oversight where PPE should be made available, as we have just discussed. In terms of workforce and staffing, recommendation 9.1 in our report is that HIQA should carry out a detailed audit. Recommendation 14.2 in our report referred to a "deficit in infection control and risk management" and suggested "Mandatory training records including infection control should be included consistently". In addition, recommendation 14.5 states that the regulatory assessment should take specific ac-

count of "preparedness of designated centres".

Deputy David Cullinane: My time is limited so I ask Professor Kelleher to confirm whether what I now say is correct. The report refers to very poor clinical governance across the sector and noted that in the HIQA report, there are no formal governance links between the HSE and that 60% of homes with outbreaks were not compliant with the existing clinical governance framework. Is that correct?

Professor Cecily Kelleher: The Deputy will have to indicate the source of that particular quote.

Deputy David Cullinane: It is in the recommendations that talked about poor clinical governance. There is also talk about the structure and relationship between nursing homes, the Department of Health and the HSE. Is that something that the expert panel examined?

Professor Cecily Kelleher: Yes.

Deputy David Cullinane: What was the outcome?

Professor Cecily Kelleher: We have identified, as I think is clear, that the person in charge has a statutory responsibility in relation to the nursing home framework, particularly for those in the private nursing home sector. We have identified, as have others, that there was a gap in the public support for that sector and that was why the Covid-19 teams were put in place. That remains an absolutely crucial thing.

Deputy David Cullinane: It also states there is not a clear delineation of roles and responsibilities of key stakeholders and communication between the sector - the HSE, HIQA and the Department - and it is not standardised or co-ordinated. Was that-----

Professor Cecily Kelleher: That is what we found and what the agencies indicated to us.

Deputy David Cullinane: Okay. The report also states some homes did not communicate meaningfully with residents and families about lockdowns and visitation.

Professor Cillian Twomey: I might be able to help the Deputy by answering that question. He is quoting from submissions that came to us from relatives and the general public about their experiences. There is a chapter in our report which reproduces in summary form the totality of those submissions and many of them are making the statements Deputy Cullinane is now quoting. They are not necessarily comments that we have made or verified.

Deputy David Cullinane: Does the report comment on the structural relationships between the HSE, the Department and nursing homes?

Professor Cillian Twomey: Absolutely.

Deputy David Cullinane: Yes, that is the point I was raising.

Professor Cillian Twomey: With good reason. If Deputy Cullinane remembers, HIQA told the committee some months ago that it felt the HSE did not know the private nursing home sector in its totality because of the sector's current construct.

Deputy David Cullinane: Did the report comment on the view that some homes did not communicate meaningfully with residents and families? Did the expert panel offer an opinion on that?

Professor Cillian Twomey: The opinion I would offer is that in the view of the general public and relatives who responded to us their experiences reflected that very point.

Deputy David Cullinane: Okay. The report also refers to an absence of an integrated infection prevention and control strategy linking nursing homes and the Department of Health and the HSE. Is that correct?

Professor Cillian Twomey: In my view it is correct. The policy decision was taken two or three decades ago to essentially move the oversight of care for older people in residential care settings from a State-controlled one to a slightly distanced one. Twenty years ago, 80% of all residential care facilities were publicly run while today the percentage is exactly reversed. When I was in clinical practice some time ago, that is a policy decision I did not support. I believe that decision needs to be reviewed because one of the consequences has been an inevitable separation from oversight by State structures such as the Department or the HSE by virtue of that new arrangement, where one has independent private providers providing care without any formal structure of communication. We have addressed that in the report and stated it is absolutely essential that some form of connection be established immediately by means of a memorandum of understanding of some sort and, formally, a more firm and permanent arrangement whereby that separation of responsibility is no longer a reality.

Deputy David Cullinane: I thank Professor Twomey. This report is one of the best reports we have seen come before this committee or any committee. The work that was done and the very clear recommendations will serve us well if they are implemented. It is a very thorough report. To be frank, it is hard to disagree with any of its recommendations. We discussed the matter with HIQA last week and we got further correspondence from it. HIQA informed us a number of times when it was before the committee that it has been campaigning, agitating, urging and calling on the Government to change the legislation, improve clinical governance and give it more powers to be able to deal with some of the issues mentioned in the report but it would seem that those calls fell on deaf ears. On foot of the report we got in June 2016, the CEO of HIQA wrote to the Chief Medical Officer seeking amendments to the Health Act. In March 2017, HIQA produced a number of documents, again recommending changes to the regulatory framework. Again in 2017, the CEO wrote to the director of the national patient safety office providing an update on suggested amendments, but that did not happen. The chairperson of HIQA wrote in 2020 to the Minister for Health, Deputy Donnelly, on the issue of adult safeguarding. It is a very long letter that charts all of the recommendations that were made by HIQA to try to put in place better structures between the HSE, the Department and HIQA and to give HIQA the powers it needs. I do not want the witnesses to comment on HIQA's role and the requests it made or the Government's failure to act on them because that is a question we can put to the HSE and Minister.

This is my final question at this point. Are they confident that the report's recommendations will be implemented, given HIQA has been calling for many of these changes itself, over a long period, and they have not been made? Are they confident that they will be made? How important is it, from their perspective, that the clear recommendations relating to clinical governance, the powers of HIQA, and a statutory framework that will work to protect older people and make sure they have all of the choices that they need regarding their care are delivered?

Ms Brigid Doherty: It is important that the regulations that are set out are assessed in great detail. Some of the regulations, in a sense, are still functional. There is more systematic and detailed exercise, for example as regards infection control, looking at training records, etc., and also that it is documented in detail and published in the inspection reports. There is an issue

with staffing levels. There is no statutory requirement for either the number of staff or the skill mix. HIQA does not have any powers, and the regulation clearly states that it is down to the provider to decide the staffing level. That needs to change. The Department of Health is commencing the framework for safe staffing and skill mix. That is being introduced. It is crucial that it happens sooner rather than later, otherwise it is very difficult to assess whether there is an appropriate level of staff, and indeed the skill mix of the staff.

Deputy David Cullinane: I thank Ms Doherty. I again commend the work that was done by the authors of the report. It is a comprehensive report, and if it is implemented, it will serve us well. I commend those who were party to this report.

The committee will publish its final report. The expert panel's report needs to be reviewed on a regular basis by the joint committee on health, when it is established. We need to keep an eye on these recommendations, and make sure, as quickly we can, that they are implemented. I propose that this would be one of the recommendations we make in our final report. This cannot be a report that sits on a shelf or is cherry-picked. We have to get under the bonnet of this and get it right. Significant changes have to be brought about. While the expert panel has done a first-class job, we will need to draw on its experience in the time ahead. The health committee has a big job of work to do to ensure that what is in this report is translated into action. I thank the witnesses.

Professor Cecily Kelleher: We wrote this report with a view to the fact that it would be implemented. That is why we have set out these recommendations clearly and with a timeframe, and that is why we understand that the implementation oversight group of the Department and the reference group will keep a vigilant eye to ensure these are implemented. This is about going forward.

Chairman: Everybody who writes a report does so in the same hope, but very few of those hopes are satisfied in the end. Hopefully, this one will be the exception. I call Deputy Fergus O'Dowd.

Deputy Fergus O'Dowd: I welcome the experts. I agree that this is an excellent report and that it is looking to the future, while also taking account of some of the issues that happened in the past. If I were to take one line from the report, it is that where the authors state, in a narrative that is hugely important, that high-dependent patients can live happily at home. What I take from all of this sadness, the Covid deaths, and all the issues that have arisen, is the fact that we should try, at all costs, to make sure that people stay in their homes for as long as possible. We need to provide them with the facilities and care in their homes. That is the happiest and the safest place for them. Even people who are frail can be looked after well at home. That is what I want to happen. If I am correct, in summary of all the recommendations, the panel is talking about a change in the model of care and making sure that people have better outcomes towards the end of their lives. Unfortunately and sadly, that has not been the case in respect of some deaths that have occurred in nursing homes. I will not name them as they are well known to the public. One of the panel's recommendations, recommendation 15.3, deals specifically with families who have had no closure as a result of the deaths and have not had full explanations and states "The Department of Health should explore a suitable structure and process for external oversight of individual care concerns arising in nursing homes, once internal processes have been exhausted without satisfaction." That is the case right now in respect of a home in County Louth and another in County Meath. What do the members of the panel see as a suitable structure for those aggrieved, for the families who have suffered grievously as a result of deaths which are to date unexplained and unaccounted for to them? How do they see it work-

ing?

Professor Cecily Kelleher: I will hand over to Ms Brigid Doherty on this point.

Ms Brigid Doherty: At present, any complaint made about care in a nursing home is dealt with by the home itself which is not generally satisfactory for the complainant, family members or the resident themselves. The HSE safeguarding service does not have legislative authority to investigate complaints in private nursing homes. It has no obligation, either legal or contractual, to do so. Therefore residents in nursing homes do not have the support a person would have were he or she in a hospital or at home. My understanding is that under the current legislation, HIQA does not have legal powers to carry out investigations of individual complaints either. Therefore, the only option open - and it can be a good and satisfactory option - is to provide independent advocate support to support residents or their families through the complaints process. However, my experience in the past has been that the really good investigations have been where an independent investigator is appointed to investigate complaints within nursing homes. We need an independent advocacy service for nursing homes and I understand the National Patient Safety Office is exploring the rolling of that out from their new service but we need a process of investigation that is independent of the nursing home provider, be it private or public.

Deputy Fergus O'Dowd: It obviously be should independent of the HSE as well.

Ms Brigid Doherty: It needs to be independent of any provider-----

Deputy Fergus O'Dowd: The question I am asking is-----

Ms Brigid Doherty: -----because in order to have the trust-----

Deputy Fergus O'Dowd: The panel's recommendation talks about the timeframe for this being within 12 to 18 months. Can the panel tell me what progress has been made or would it be the Department that could tell me? The timeline should be immediate as it is hugely important for families. I understand members of the panel may have visited some of the homes I am talking about in their professional capacity and there is huge trauma for families attached to constantly fighting to get information and to get at the truth. As Ms Doherty noted, HIQA is carrying out inspections but a key problem I raised last week, about which I think the panel members agree with me, is that the authority can carry out an inspection but not an investigation. Consequently the families are really extremely distressed. The witnesses should respond to that point.

Ms Brigid Doherty: I agree with the Deputy about the families. The lack of information is frustrating for families or for whomsoever is making the complaint around the care. The onset of Covid has highlighted this even more. It has brought it to the fore because of families not being able to visit residents. There is, therefore, a huge gap in information about how the care is provided and certainly with end-of-life care as to how those last few days or weeks of life are. That is a huge issue and it will have implications for the grieving process on an ongoing basis but people will not begin to grieve for their lost relatives until they get the answers. I suggest that advocacy, which is there and is already set up, should be encouraged by the nursing homes and by HIQA to support residents and their families in investigations until the Department of Health has-----

Deputy Fergus O'Dowd: I am talking about the one in County Louth. The Minister for Health has agreed, at my request, to meet the families. I welcome that. Mr. Ian Carter, the chief executive officer of the RCSI, for whom, I think, Ms Doherty works, will also be meet-

ing the families. My key point is that those who have suffered most are the most frustrated by the current process. These people have lost family members and they keep coming up against bureaucracy, which is extremely unhelpful. That is why I welcome the recommendation. The timeline should be immediate and I will ask the Department of Health to give me more information as to what it has done on that.

I will make a point on the vision for long-term care. Sadly, most patients in nursing homes suffer from dementia. I have seen figures to the effect that between 70% and 80% of people in nursing homes have that diagnosis. We need fantastic home care provision, but that is not there at the moment. It needs to be far more integrated and less costly in terms of service provision than is the case at present. Do the witnesses have a view on that? Do they have a vision for the future of people with dementia living at home? Is there a model that we should be following? The one good thing that can come out of all this tragedy is that there is a huge opportunity to change forever the way older people are looked after in their declining years.

Professor Cillian Twomey: I thank the Deputy. On the previous point, Sage Advocacy has been involved in the case to which the Deputy referred and has provided independent oversight, which is very helpful. There are departmental advocacy plans. However, to come back to the Deputy's main point, there is a possibility - through Sage Advocacy - to do things more speedily.

The issue of complaints is complicated. Dementia is more common as people get older but there is a more fundamental point. In this society, we are, with few exceptions, either living at home and well - this is the case for the vast majority, young and old - or we get sick and go to hospital. Hopefully, we get treated and get better or we get treated and need ongoing supervision and care but get better and get home. However, there is a subset of people who have been completely healthy for 60, 70 or 80 years and who suddenly get a devastating illness such as a stroke. The system in place in present means they will either go home, if somebody can look after them, or they will go to a nursing home. It is my view that we have failed, with few exceptions, to develop the alternatives.

People with significant dependencies, including dementia, will do better in smaller congregated settings than in the institutional environment that any residential care facility inevitably is. We know from work done in other European countries, and there are some examples in Ireland as well, that people living in smaller settings, with maybe six or so residents, do infinitely better than those living in the larger ones. We have facilities in this country for residential care nursing homes that range in number from perhaps 30 to 180. I refer to the Years Ahead report of 1988, which the committee might like to have a look at because they will see resonances with what we are saying here. It was never envisaged that we would create large multi-occupancy residences like we now have. What we need, in my view, is a single integrated system of care for older people which allows the person to choose where they avail of that support and care. There should be a single source of funding which should allow them to be supported at home, if that is their wish, to be supported in one of an adequate number of smaller congregated settings - these are yet to be developed - or, if required, to be supported in long-term residential care.

We hear regularly: "This is their home." It is their home in the literal sense but not like your home or my home and we have to recognise that the needs of people with significant disabilities, including dementia, require an alternative system of support to being congregated in large numbers. I am glad that, in the context of the commission on care referred to in the programme for Government, this is instanced as an important development. I hope that we can introduce financial incentives now to develop these alternative, smaller congregated settings of support

which are more locally-based and close to where people live, just as we did with the development of the private nursing homes sector 20 years ago.

Deputy Fergus O'Dowd: That is a very important statement and I am very pleased Professor Twomey made it. That is where we have to go as a society.

Deputy Róisín Shortall: I welcome the members of the expert panel and congratulate them on the panel's report. It is an excellent and comprehensive report which sets out a substantial number of recommendations, identifies the lead agency, which is very important, and suggests a timeframe.

There is no doubt that we need to substantially change the policy on elder care and move towards a new model of care. Deputies regularly deal with this issue. Approximately 6,000 people who have been approved for home care have not received it due to a lack of funding. Many of these people end up in acute hospitals or nursing homes where they do not need or want to be but that is the area for which funding is available. For this reason, I fully support the recommendations on changing the model of care.

It is very important that housing agencies are heavily involved in developing that new model of care. We have a small number of examples, which are very good, of local authorities providing sheltered housing. That could be developed much more widely. The ideal scenario is to have people stay in their own homes with support, although sometimes that is not appropriate. Local authorities have a very important role to play in providing sheltered housing that caters for a range of dependencies, from practically independent to more dependent, with the necessary supports. That requires different agencies to work together, which sounds easy but is often the main stumbling block. It is very important that this happen.

Members are not able to be present for the full meetings so I ask the witnesses to forgive me if this matter has been raised already. On the 88 recommendations, it is often said in this country that we produce many good reports but that we suffer from implementation deficit disorder. There is no doubt about that. The challenge for this committee and for us as public representatives is to ensure that does not happen with this important report. Can our expert panel give us its view at this stage on the response to its report and recommendations? Do the witnesses believe it has been adequate? I have a concern that the committee charged with implementing the recommendations is chaired by the Department of Health. That is an issue. Is the expert panel satisfied with the arrangements that have been put in place to date for the implementation of the recommendations in its report?

Professor Cecily Kelleher: I will first respond to the Deputy's earlier point. We fully endorse what she is saying about taking an inter-sectoral approach to doing this. We have set out a number of the statutory care supports for older people. We are as concerned as the Deputy and others are to ensure this sector is protected into the winter. We have been giving very clear direction on this since we produced our report and we have had a positive response from the Minister. He has communicated very clearly to HIQA, the HSE and Nursing Homes Ireland that we need to be in implementation mode. It is very clear that from the core threat of Covid-19, we need to ensure the Covid-19 teams are stood up, are working, are supporting the individual nursing homes and have the preparedness and resources in place. We have set out a whole range of those resources. We want to ensure this happens.

Deputy Róisín Shortall: I thank Professor Kelleher. It is important now that we look like being on the cusp of a second wave, regrettably, that all those recommendations are in place

with regard to immediate concerns.

Regarding longer-term policy changes that are so badly needed, is she satisfied that a mechanism is in place to implement the recommendations the expert panel is making or does it have further recommendations to make in terms of what needs to happen?

Professor Cecily Kelleher: Certainly, we welcomed the implementation group being set up with those who have the statutory responsibility. A reference group is to be established that will have membership from this expert panel, which we hope will be vigilant with regard to this immediate short term. We think we have learned something very important about an area that has not been given as much attention as the acute sector to date. It is an endorsement of the need for an integrated care policy going forward and we absolutely would like to see these policy recommendations acted on. I will turn to my fellow member-----

Deputy Róisín Shortall: I thank Professor Kelleher very much and I will pick up on a couple of points she made. She mentioned a reference group to be set up comprising members of her own group, which is important. Has she a timeline from the Minister for the setting up of that group?

Professor Cecily Kelleher: Yes, we have. We believe the first meeting is next Monday and I will chair that. I believe this afternoon there will be more information from the Department of Health on the detail of it.

Ms Brigid Doherty: The implementation group that has been set up has met twice. It meets every two weeks on a Wednesday.

Deputy Róisín Shortall: Does the expert panel receive copies of the minutes?

Ms Brigid Doherty: Yes

Deputy Róisín Shortall: I thank the witnesses very much.

Deputy Bríd Smith: I welcome the witnesses and thank them very much for their contributions. I particularly welcome the statement from Professor Twomey on the nature of the type of care we provide for our older persons. One thing is certain; we will all be there some day so it is important that we get the future right.

I would like to look back on the past and what the expert panel's report set out to do. I would Professor Twomey to comment because I believe his terms of reference were quite restricted in terms of what he could delve down into on what happened in the nursing homes. He was tasked to provide assurance that national protective measures were in place in line with international guidelines and to provide recommendations. He does not, however, seem to be able to move beyond that to say who or what was responsible for the spike in deaths or the 56% of all deaths in nursing homes. The report identifies some areas but Professor Twomey has said repeatedly that he completely disagreed with the policy decisions that were made over recent decades and that there was a significant gap in support for the care of our elderly, with 80% being in private settings where there was no oversight. I would like him to comment on the terms of reference. Would he have liked them to be expanded so he could make clearer and more concise recommendations about the nature of care going forward? It is well known that what is called the "grey rush" is now an investment opportunity for a large number of global corporations and it is exploitative of the care of our elderly. We need new ways to develop that. I, for one, will push that because we need to look at reversing the private-public trend that has developed over the

past 20 years with 80% private to 20% public and voluntary homes.

There are alarming or worrying reports, and there was no doubt this was going to happen again, that the numbers of Covid-19 cases are beginning to increases in our nursing home sector. The expert panel has made good recommendations on issues such as access to rapid testing with fast-tracked results and ensuring all residents coming from the community or transferred from hospitals are tested. It is probably in the report that all staff should be tested. Will our guests comment as to whether they are confident that the testing of staff, provision of PPE and the protection of the elderly in these homes, all of the recommendations the panel is making, are now happening? Our guests may not be able to answer that in detail and I acknowledge they have already given some answers about the near future to Deputy Shortall, but I am concerned about now and the return of Covid-19 to our nursing homes in numbers.

Professor Cillian Twomey: We can give some reassurance. A programme of ongoing testing of staff in all nursing homes is under way. Two such exercises have taken place already, one in June and the other over a four-week period ending in August. All staff in all nursing homes were tested. It is good news, though thankfully not surprising, that the positivity rate was very low, 0.1% to 0.2%. I am confident that the process is in place.

We are equally confident that there is a significant and real commitment to ensuring that every nursing home has a core supply of personal protective equipment and, in the event of a surge, will be able to access more without delay. Let us not forget that the PPE dilemma was not confined to nursing homes but was also a difficulty in the acute hospital sector. We all remember the aeroplane arriving from China with equipment that was unsuitable for either type of facility. I am confident on that score.

The Deputy asked if I am confident that the model will change. It must change. The 80-plus age group is going to treble in the next 30 years. Quite frankly, if, in 30 years' time, we have a model of care for older people that is three times the current one, we will have failed abysmally. For example, Denmark has not built a new nursing home since the late 1990s. Finland, which has a population a bit like our own although it is more scattered, has 7,000-plus residential care beds for older people. We have almost 32,000 beds. What is Finland doing that means not everyone requires to be institutionalised? That takes us back to the point I made earlier about the need to have alternative models. Let us be clear and fair that a considerable number of older people are being looked after in their own homes with the support and help of their families. That is to be commended and often occurs under difficult circumstances for the carers involved. That is where the majority of older people are. There are other models of care that will lighten the load on carers, such as the smaller congregated settings that I mentioned.

My nature is one of optimism - one might say it is utterly misplaced, but that is the way it is. I have been involved with reports in the health area for many years. I heard the pessimistic comments that the Chairman made earlier about reports generally. I understand that, but there is an urgency here. Perhaps one of the fortunate spin-offs of Covid-19 is that it has concentrated minds. Perhaps it will be the case that cross-departmental and cross-sectoral support will achieve the change that I believe absolutely must take place.

Professor Cecily Kelleher: I will come in on the points around the terms of reference because they are important. We were given those terms of reference to ensure that preparedness would be in place, based on international evidence. We did a wide stakeholder consultation with every agency that has a responsibility in this area. We also consulted the general public, nursing homes and the relatives and families of people who had been affected. We were very

focused on the lessons to be learned and the preparedness that was needed in the work we were doing. We have learned a great deal more. We would all share the Deputy's hope that if we go through a resurgence of this virus, we will be prepared, understand the condition, know who the vulnerable patients and residents are, and have adequate PPE and other infection prevention and control pieces in place. The key things include having in-house capacity to take swabs, rapid testing and a responsive HSE. We are keeping a firm advocacy position on making sure that those things are being done.

Deputy Bríd Smith: I will ask two shorter questions. Have our guests any concerns? They have outlined clearly that there needs to be testing and have said that testing of patients who are moving from hospitals into nursing homes is happening and will happen. Do the witnesses have concerns that, should patients in the nursing home sector become very ill, they may be moved to a hospital setting for acute care? Even though the witnesses are very optimistic about changing the model for the future, as we speak planning permission is being sought and, in many cases, granted for large-scale nursing homes across the country. I refer to big corporations that are building the sort of capacity that was spoken about earlier - units of 100 or 200 beds, which are not appropriate. How are we to change that? There is also the question of other bodies concerned with the care of the elderly, such as Age Action and Sage Advocacy, not believing the report deals with the questions of families and some staff with regard to what happened in the nursing homes. Would the witnesses agree that, although the group's terms of reference did not require it to look at these issues, another body of work is required to deal with the concerns of families as regards what happened to their loved ones?

Ms Brigid Doherty: I will take the question regarding the families. I agree that something needs to be set up to investigate or talk through the care of residents in nursing homes with families. There is a huge gap in that respect. Sage Advocacy provided a lot of support through the first wave when nursing homes were closed and when families were having difficulties visiting at the end of people's lives. It was very traumatic when end-of-life visiting was not allowed. In the meantime, nursing homes are the providers and have a responsibility to meet families and to provide and release the information they hold under freedom of information legislation, if requested. I strongly support Sage Advocacy. It is a really good organisation and has a lot of experience. Its services should be promoted by HIQA and the Department of Health. When the Minister meets families, it may be worth him suggesting that the family bring an advocate. The advocates make sure that the voices of residents and their families are heard and that they understand what is being said. It is very important. There is a huge gap in that respect. I feel very strongly about that. If we do not deal with this now, it will have very long-lasting effects. It will come back for those people three, five or ten years down the road.

Professor Cillian Twomey: On whether we were concerned about people who are very ill being able to get to an acute hospital, I will mention one of the positives that emerged regarding the Covid response teams that we are now recommending, in recommendation 7.1, be permanently institutionalised as community support teams. This was reported to us by participants, including community nurses, geriatricians, infectious control staff, public health officials and so on. Heretofore the amount of support nursing homes got was decided somewhat haphazardly, perhaps more so in the private sector than in the public sector. These committees, however, were able to give support, including clinical support where necessary. This sometimes allowed the medical issue that had arisen to be dealt with satisfactorily in the nursing home. Equally, these teams were able to say that people needed to be transferred to an acute hospital because of the issue they had and to organise that transfer.

From now on, such community support teams need to be made permanent. This will lead to much better clinical decision-making about which patients or residents should be transferred and when. Sometimes nursing homes are worried about the publicity that might accrue to them if people who are close to the end of their lives and are dying die or if more than one or two such people die in a week. A support team would be able to say that a person is dying and that the humane thing to do is to support him or her where he or she is and where he or she has been looked after so well for so long, if that is the appropriate answer. A structure such as the community support teams which would support that kind of decision-making would make for a much more enhanced level and standard of care, while also providing reassurance to families, residents and staff in residential care settings.

Chairman: I thank Deputy Smith and Professor Twomey.

Deputy Matt Shanahan: I welcome our guests and thank them for their excellent work and the tenor of the report they have produced. It is very important that they have taken a forward-looking view and I accept that there may have to be some retrospective learning done at another time. We must now go about the business of protecting all of our aged in the future and making sure they have adequate resources in private and public nursing homes. I commend the quality of the report and its future perspective. It is to be hoped it will provide a template to deliver dignity, respect and resourcing to nursing home residents.

Early on in the Covid pandemic, I was one of those who engaged with nursing homes. I asked that swabs be taken in-house nationally when clinicians were capable of doing so and that a pathway be provided into hospital labs for PCR testing rather than having samples sent to the National Virus Reference Laboratory which was taking up to seven days to turn around tests. Thankfully, a lot of that was delivered.

I wish to discuss some of the issues for private nursing homes. I know they are vilified from time to time, but in my experience of Waterford county and city I can say that, without exception, tremendous care is given by the public and private sectors. Some of the issues highlighted at the time have probably not been fully dealt with. In terms of the Covid pathway, nursing homes are expected to provide isolation facilities which are taking up potential bed occupancy. This has a knock-on effect in terms of revenue. Another issue at the outset of the pandemic was the management of oxygen in nursing homes, which required sign-off by a palliative consultant, something which did not always happen as quickly as it should. Do the witnesses believe these issues will be dealt with following the report?

I refer to point of care testing. We have heard a lot about PCR testing in this country, but diagnostic testing is available in the United States, in particular. Has such testing been considered in order to allow for a faster turnaround time in nursing homes to allow isolation to take place immediately and contacts to be quarantined?

Professor Cecily Kelleher: All of the points the Deputy made about the earlier stage needed to be addressed and we recommend that they should be. It is very important to have capacity for in-house swabbing and rapid entry points into the laboratory information management system, LIMS, so that there is a quick turnaround in diagnostics.

We included in the report the recommendation that procurement should include the supply of oxygen as appropriate, and that should be the case. That is a key point.

I believe point of care testing has been reviewed and that a review is ongoing. PCR testing

is currently being used and the National Virus Reference Laboratory is keeping a close eye on that. If point of care testing becomes a reliable means of testing, that will be recommended by NPHET.

Deputy Matt Shanahan: I thank Professor Kelleher. She has answered my questions. Does she have an understanding of what the management of oxygen in terms of palliative care will be in the future if we end up with a second wave in our nursing homes? Please God, we will not. Will the Covid response teams that have been highlighted be assigned for that?

Ms Brigid Doherty: Very early on, the HSE asked all nursing homes to link with a palliative care team in their area. Palliative care consultants became part of the Covid response team. In our report, we recommend that continues so that every nursing home is linked with a palliative care team.

Nursing homes manage end-of-life care very well as they are used to doing it, as my colleague said. We had an increased number of deaths in nursing homes, including deaths that happened more quickly than expected. It is essential that palliative care teams are involved. We recommend that they are available 24-7 to support advanced care planning and anticipatory prescribing for symptom management, which would include oxygen if required.

Deputy Matt Shanahan: The witnesses will be aware that at the start of the Covid pandemic many private nursing homes had to buy PPE. They were not being supplied by the State. Subsequently, the State gave them support moneys but this was based on capitation grants and did not cover private patients in nursing homes. I hope this has been rectified at this stage and that in future there is modelling to provide PPE to private nursing homes. When I last engaged with them they had adequate amounts but that was based on very low rates of infection. Is there a pathway to ensure there will not be a delay and that the cost will be subvented to some degree?

Professor Cillian Twomey: The answer to both questions is "Yes". As I said earlier, it is the case that not just private nursing homes but also public nursing homes and acute hospitals had difficulty accessing equipment. Each nursing home is now assured of a core quantity of PPE and, in the event of a surge, having rapid access to additional equipment as required. This also applies to gowns, gear and masks as well as oxygen. Whether they are public or private this has to be done. What may need to be worked out is an arrangement between the public and private sectors as constructed on shared responsibility of the funding arrangements for the care and support needed.

Deputy Matt Shanahan: Staff resourcing was a problem in the private and public sectors and possibly still is. I am aware of a number of nurses with foreign citizenship who are trying to get work here, and there are nursing homes that wish to recruit them, but they cannot get movement through the Department. Is there a crossover with the Department of Foreign Affairs and Trade on trying to fast-track some of these visa applications so we can get these people into position?

Professor Cillian Twomey: That is not something we have been particularly involved with or engaged in. We have to go back a step. Many overseas workers in residential care settings have working conditions that are inferior to those of colleagues working in other residential care settings. This in turn forces them to work in several settings at the same time. These hard-working staff very often live together and share accommodation with seven, eight or nine people. The danger with regard to Covid, and this is a serious issue, is the transmissibility potential that can occur. We have outlined that even agency staff should be assigned to a single

nursing home and not work in several at the same time. It is a dangerous position in the current climate. The employment conditions of some staff in some nursing homes are a cause for concern. Certainly it was reported to our group that it is a major concern that needs to be addressed.

I also want to make the point that the care provided in public and private nursing homes is, by and large, of a very high quality. The staff are unbelievable. Residents have expressed this in the commentary submitted to us. In one of the nursing institutions I visited I met a staff member who had contracted Covid and had to take time off work. She felt very guilty about this fact and was very distressed because she knew that her being off meant the nursing home was down a whole-time equivalent. This was hugely devastating for her. I met her when she had just returned from her time off. She was much better health wise though not fully energised but she still felt guilty that she had to be off work because of her illness when she knew the nursing home required her assistance. In some instances, nursing homes were down many staff. We cannot overstate the devastation for the residents who died and their families but also for the staff during the peak period of deaths from mid-March through early April. It was hugely devastating. If any incentive is required to concentrate on implementing these measures it should be a reminder that we cannot go back to that.

Deputy Matt Shanahan: Absolutely and I strongly agree.

Professor Cecily Kelleher: To be clear, in the early stages of grappling with a pandemic of this scale there was a huge staffing crisis. We are recommending a preparedness plan. As the committee is aware, we have also discovered the need to have an adequate staffing skill mix and we strongly recommend that be put in place.

Deputy Matt Shanahan: I thank Professor Kelleher and Ms Doherty.

Deputy Louise O'Reilly: I thank the expert panel for its report and the comprehensive way in which it has approached its work. I will pick up on a point briefly addressed by Professor Twomey concerning the impact on staff. I do not want to dwell too much on this issue, but we know that 56% of total deaths from Covid-19 in this State, thus far, have occurred in nursing homes. Workers in that area are not unaccustomed to dealing with end-of-life situations. From talking to people in my community and some members of my family, I know that a degree of trauma - this is not exclusive to nursing homes - was experienced by staff in the healthcare sector as a result of how they had to deal with Covid-19. They were almost learning on the job. In nursing homes that was compounded early on by a flight from the sector into more mainstream healthcare areas. We know nursing homes were crying out for staff and that the Be on Call for Ireland initiative did not work or make a substantial difference. It was little more than a public relations exercise, a bit of spin and nonsense.

Regarding staff and how we can build in some resilience, because this situation is not over, do the witnesses have any recommendations regarding supports that could be put in place? The skill mix is important, but we do not need to review that because we have skill mix reports going back some 20 years. That aspect of the health service has been reviewed to death. Do the witnesses have views on the supports available to staff now and what else could be put in place? I ask that question because we owe our healthcare workers a little more than just a round of applause and a pat on the head. This crisis has had a mental health impact, and we have yet to deal with that. I address my question to Professor Twomey.

Professor Cillian Twomey: I will ask Professor Kelleher to respond because she has the answer at her fingertips.

Professor Cecily Kelleher: We agree with the Deputy's point. We make a recommendation, 5.8, regarding occupational health, human resource and psychological supports. We asked the nursing home providers to look at that. We have been clear with the implementation group and the reference group that the mental health aspects of this situation should and must be addressed. This applies to healthcare workers across the sector, but this group of staff is and was particularly vulnerable and we have made several other recommendations regarding employment supports as well. We have had some feedback, as part of the stakeholder exercise, that these supports were being put in place, especially in the larger units with the level of staffing to do it. It is, therefore, a recommendation that we have made.

Deputy Louise O'Reilly: I welcome the recommendation and that it has been made. To elaborate on recovery for staff, I believe that a comprehensive support package needs to be put in place across the healthcare sector, but specifically in nursing homes because of what people working in that area had to go through. Moving on to the issue of transfers out, an issue that may have been covered already, I am reasonably confident that I was the first person to raise this issue directly with the then Minister for Health. I refer to the need to have two "not detected" swabs before a patient was transferred out. Notwithstanding everything that has been said, we know that was not done.

Turning to what we can learn from what happened, and many lessons are being learned, are the witnesses confident that sufficient capacity exists as we prepare for a surge? We can see from the website of the INMO that the issue of trolley waits is back, not that it ever really went away, and some of our hospitals are nearing capacity. I know what was done the last time we had a surge and that we need to free up capacity in the hospitals. Are the witnesses confident that the required testing regime is in place to ensure that every person transferred from a nursing home into an acute hospital setting will be able to have the two "not detected" swabs before being moved?

Professor Cecily Kelleher: I would absolutely hope so. I take the Deputy's point in respect of the beginning of this. There was a huge focus on acute hospital capacity. The nature of the illness was not fully understood at that point, nor was the position relating to asymptomatic, atypical or pre-symptomatic people. This has been in place since 10 March. The two tests need to be undertaken and we have strongly advocated that testing procedure should be in place and that all people transferred should be in isolation for 14 days. It absolutely should be in place.

Deputy Louise O'Reilly: Many private nursing homes do not have the space for isolation. When Professor Kelleher said that the regime has been in place since 10 March, does it mean that every patient who was transferred out from 10 March had two not-detected swabs before being moved?

Professor Cecily Kelleher: I think the evidence we were given was that that was put in place. I cannot answer whether every single one was the case but that was what we were given.

Deputy Louise O'Reilly: I would strongly disagree with that. I understand that might be the witnesses' position but it certainly is not the experience that has been relayed to me.

In terms of ensuring the resilience of the sector, we know there are obvious complications with a for-profit model for any form of healthcare. If one is chasing a profit all the time, it does not necessarily translate into good outcomes for patients, notwithstanding that there are many private nursing homes which are doing an absolutely fantastic job, thanks, in the main, to the men and women and staff working hard in them. On harmonising pay and conditions for work-

ers, because we know what happened at the start where many people were transferred from the nursing home sector to the acute hospital sector, would Professor Kelleher see harmonising the terms and conditions, pay, etc., of those workers in the private sector – I mean bringing them up rather than bringing down those of the public service workers – as being important in terms of building resilience in the nursing home sector in the future?

Professor Cecily Kelleher: Yes. We had a number of submissions to that effect. It would be important that the terms and conditions of people employed across the sector, whether public or private, should be harmonised, and harmonised upwards and not downwards. We have made a number of recommendations around qualifications and support for that in the report.

Deputy Louise O'Reilly: On the level 5 qualification for the care assistants, clearly it would be ideal if they were all qualified to that level. There are many people working in the nursing home sector who perhaps started working a long time ago and who would not necessarily have that qualification but would have the experience. There is a facility there for one's experience to be recognised in some way, shape or form. On bringing everyone up to the standard, would Professor Kelleher see that as being a viable option rather than asking people who perhaps 15 years' experience to go back into a classroom setting?

Professor Cecily Kelleher: That would be up to the specifics of those providing the programmes. However, prior learning is always a consideration in regard to the delivery of those kinds of qualifications. I think it would be very important to take account of that.

Deputy Louise O'Reilly: It would, because there is a danger that we would run towards a piece of paper when the experience and knowledge exist already. The piece of paper would not necessarily be that important.

On the panel's recommendation on reviewing the skills mix, there is model of safe staffing and that was agreed between the INMO, the other unions and the HSE. Would the panel see that safe staffing model as being transmissible to the private nursing home sector, even though I understand it might put pressure on costs? Could that easily translate or would the panel be in favour of developing a specific safe staffing model that would be very much focused on the care of the elderly setting?

Ms Brigid Doherty: The model being rolled out into nursing homes can be adapted to the requirements of nursing home care. However, we need to be able to assess the level of dependency in the nursing homes in order that we can match it with the right number as well as the skills mix of the staff looking after the elderly. It is important, as we get older, that we be cared for by people with the appropriate skills.

Deputy Louise O'Reilly: Absolutely. There is sometimes a fear that the mention of a skill mix can signal a reduction in the number of higher skilled staff in favour of staff who are not as highly qualified. We need, however, to reclaim the phrase "skill mix" and take it for what it implies, namely, the skills appropriate to the level of dependency. I thank the witnesses for the report.

Professor Cecily Kelleher: To reassure the Deputy, we have recommendations on those, Nos. 5.3 and 5.4. The skill mix is really important.

Deputy Louise O'Reilly: I thank the witness.

Deputy Colm Burke: I thank the witnesses for their presentation and the work they have

done on preparing the report. A lot of hard work has gone into it. It is a very good report in terms of how we can plan for the future.

May I revert to the staff issue? It is important because the pressures staff are under in many nursing homes were really challenging. In the expert panel's investigation and work done, did it find any case where there was a lack of support for staff among management or the owners of the nursing homes or care facilities? Did staff receive sufficient support?

My second question is on infection control. This is dealt with in section 7.2 of the recommendations. Clear guidelines are set out regarding infection control and what needs to be done. This is an issue I raised with HIQA last week. Do the witnesses feel nursing homes were adequately prepared for what was a new virus that spread at a phenomenal rate, as implied in the presentation? Was there a sufficient briefing by the whole healthcare sector, including from HIQA to the HSE and from the HSE to the private and public nursing homes? Was the expert panel happy with it?

Third, last week HIQA compared the numbers of deaths in both public and private nursing homes. On the basis of the numbers, I understand that approximately 20% of all people in nursing homes are in public nursing homes and 80% are in private nursing homes. The numbers of deaths in each reflected these proportions. I believe about 23% of the deaths were in public nursing homes while 77% were in the private nursing homes. With regard to infection control, where do we fall down in getting the message to the people on the front line that Covid presented a new challenge and that it had to be approached in a different way?

Professor Cecily Kelleher: The Deputy raised a number of points, all of which we believe are important. The sector has been used to dealing annually with infection prevention and control, including in respect of periodic influenza outbreaks. Covid-19 represented an unprecedented challenge across the healthcare system. It certainly would have been an unprecedented challenge in this healthcare environment, which is not set up for the level of hospital-based prevention and control that the contagious organism required. That is the first point.

Second, we all acknowledge that there was a major issue concerning preparedness, particularly regarding the rapidity of spread during March, the issue of having adequate personal protective equipment supplies and all the things we discussed earlier. I hope many of these issues will have been addressed comprehensively and more fully for the next stage. It is crucial that this be the case.

The Deputy raised recommendation No. 7.2. We are very much of the view that, because this can be managed in an acute scenario, the staffing needs to be thought through in regard to having the necessary supports and somebody available 24-7 for advice and guidance in this area. It is a specific recommendation we have made. I will pass over to my colleagues.

Professor Cillian Twomey: Regarding the preparedness of the community support teams, I do not think anybody was adequately prepared in February because we were just beginning to learn about what was about to unfold. However, we learned very quickly, maybe more quickly than some in other sectors did. A group we have not yet referred to in the context of the community support teams is that of general practitioners. The person in charge in a nursing home is the person HIQA identifies as such and, in a sense, that person is responsible for the totality of care in his or her institution. It is an onerous responsibility and assuming the role can be quite a lonely place for a person to be. If we expect people to take on that type of responsibility, we must have supports in place to ensure they can undertake it without being overly stressed. The

role of the general practitioner is very important in this regard.

We currently have a situation where most residents in nursing homes have a GP assigned to them. Depending on the size of the residence, there could be ten, 12 or 14 GPs visiting the larger facilities and two or three visiting the smaller ones. There may be an urban versus rural factor in this regard. Those GPs provide care to their patients in the nursing home setting. We are strongly of the view that there needs to be a medical oversight role incorporated into the governance structure in nursing homes whereby the person in charge, who usually is a nurse, would have the support of a senior medical person, who should be a GP. We are suggesting that where GPs visit nursing homes, one of them would be identified as the GP lead in that facility and would be the go-to person for the overall review of adherence to all the standards HIQA has laid down and so on. Similarly, there needs to be a GP on the community support teams because GPs are the key medical link between the patient and medical care in the first instance. We recognise that this will put an additional onus on GPs who are currently overstretched in a context where there is not a sufficient number of trainee positions or established GPs. In recognition of this, we say that more places must be made available for general practice training and more GP positions must be created. This cannot be done haphazardly; it must be done properly.

Deputy Colm Burke: Professor Twomey referred earlier to the structure of the nursing home sector. Is it not the case that the sector developed in the way it has because we had a situation in the past where only one person in a household was working, whereas now, almost every family has both partners working and they are unable, therefore, to give support to their parents in the same way that was possible in the past? Another factor is that a lot of people have gone abroad and the type of family support that used to be there is no longer available. This lack of family support is one of the challenges we now have in trying to develop community support.

The other issue in regard to the structure of the nursing homes sector is that it was set up as a separate entity. For instance, I am aware that elderly people in nursing homes are required to attend outpatient departments in certain cases when it would be a very easy prospect for a medical person from the HSE to attend a nursing home on, say, a monthly basis to review the requirements of residents. That type of arrangement was never set up and there is no structure for the connection between the HSE and the private nursing home sector. As a result, we have ended up with the difficulty we now have in regard to the lack of connection between hospitals and the HSE, on the one hand, and the private nursing home sector.

Professor Cillian Twomey: It is not true to say that nothing has been established. In my own clinical practice, for example, prior to Covid, I had assigned to me two community hospitals in the Cork city and county area which I visited on a regular basis. My colleagues in geriatric medicine in Cork continue to do the same. Admittedly, this related to HSE-funded facilities but it was an innovation that was introduced with benefit 15 or 20 years ago. Covid-19 broadened that out considerably because it made clear that it is not good enough to have that sort of support provided to HSE facilities but it also needs to be provided to the private nursing homes. The Covid response teams did not distinguish between a public or a private residential care setting. The work that they did, which was hugely applauded, and we have an article in our report commenting on its success, did provide that necessary medical support. The person who, historically, would have had to inconveniently come from a nursing home to an outpatient clinic and wait for hours to be seen and then go back again can now be seen in that new format when the community support team visits the nursing home. We have now recommended that this model should be applicable to all residential care facilities, both public and private but there is a resources element to that. If we are asking general practitioners and geriatricians to be lead

participants in it, as well as the other consultants like those in palliative care, public health and so on that are in our report, then we have to provide the resources for that to be realised. It is not impossible to do it but it absolutely must be done.

As regards the model, whether it is public or private my argument is that we should not have a huge number of large congregated settings for older people's long-term care residential needs. I am putting a strong case for a revised model, which is smaller congregated settings with a maximum of perhaps six people living in them. They can be managed much more easily, even in the context of someone being the father or mother of sons or daughters who are at work or who have gone abroad. It is about providing it in a more homely and humane way. To my mind, that will be much more a home than the institutions we have tended to generate over the past two decades.

Professor Cecily Kelleher: If I make a couple of other points, in terms of the demographics, there has been a change in family units and support that can be given to older family members but we also have a significantly aging population and the older one is, the more likely one is to be in a nursing home facility. We need to see in a comprehensive way how a community support could be put in place for our oldest old.

To go back to the Deputy's earlier point on the management supports, that did not come out clearly through the stakeholder consultations. I believe most of those were focused on the supports that should be coming from outside of it but, again, management support is a key point that we have recommended in respect of HIQA to ensure that the regulations, as well as that support, are in place.

Deputy Matt Carthy: Once again, I thank the expert panel for their work and their comprehensive report. To reiterate the headline figures, which are stark, 56% of total deaths as a result of Covid-19 occurred in nursing homes. That must point to a systemic failure of the highest degree because behind each of those deaths was a grieving family and the real life of a person who, undoubtedly, had come through hard times in his or her own life and then ended up being failed at his or her end in this State. To contextualise the greater anxieties that were caused to families who also had other members in nursing homes, whether they contracted Covid-19 or not, the restrictions that were in place led to enormous anxiety and fears, some of which have not dissipated.

I also note from the committee's report that there are strikingly high rates in particular regions and counties. The report pinpoints counties Cavan, Monaghan, Westmeath and Longford as having particularly high cumulative incidence rates of death that warrant further examination.

I note also that in the Department of Health's opening statement, if I read it correctly, that there are 39 remaining open clusters. I gather those are in nursing homes, and I seek clarification on that, and that four new clusters in nursing homes have occurred within the past fortnight. My first question to members of the panel is whether they are confident that the lessons have been learned with regard to visitation, the transfer of patients from other health services into nursing homes, the transfer of staff, particularly agency staff, across nursing homes, and the practice of the HSE actively recruiting staff from nursing homes to other areas of the health services? In terms of all of the internal systemic problems in nursing homes, have lessons been learned to such a degree that we can say with confidence that we will not see a prevalence of deaths occurring in nursing homes over the coming months?

Professor Cecily Kelleher: I sincerely hope that lessons have been learned and we will not see a recurrence of what we have seen already. Four things really drove the vulnerability of this particular sector and they are the seriousness of the disease; the frailty and vulnerability of the population in question; the fact that a congregated setting is a very risky environment for the transmission and management of the virus where it is the home of the people concerned; and, the preparedness and response component. We discussed the latter earlier this morning. This rate is a very high rate. It is a deeply regrettable rate but our international review has shown that across the globe we are learning this lesson in terms of this setting. It was not just in Ireland that this situation occured that has thrown up the important questions that we need to address here.

Are we confident? The committee will meet representatives of the Department of Health later on. Earlier we talked about the nature of the current clusters and how many may be picked up now by the rolling testing process, which is a difference from where we originally started. The whole infection, prevention, control and preparedness piece is very important. We said earlier that the incidence on the east coast was higher and hence that drove risk in the congregated settings in those areas. We are trying to do everything we can to keep it out because that is what we absolutely must do to be vigilant and protect people. Essentially, we need to roll out what we have set out in this, and is what the stakeholders told us, in order to have as much confidence as possible.

Deputy Matt Carthy: How much time do I have?

Chairman: One minute.

Deputy Matt Carthy: On page 93 of the report it states: "Other factors at play include the profile of workers in nursing homes and the interaction with other

cluster risk situations such as family members, shared accommodation and contact with other high-risk areas such as the meat packing industry." However, it has been cited that there is a particularly high incidence rate in nursing homes located in counties Cavan, Monaghan, Westmeath and Longford. In terms of what has happened in the North, there is similar data. Outside of Dublin the highest incidence rate seems to be centred around the Armagh Council District, which also happens to be a focal point in terms of the location of food factories in the North. Does the panel intend to recommend that a further examination of the link between the situations is carried out?

Professor Cecily Kelleher: Speaking to the section referred to, this was information that was repeatedly given to us at an anecdotal level so we asked for systematic evidence to link that observation. Obviously there are geographical associations and what we were told by many, as we have said, around the staff who work in the nursing home sector, where they may have shared accommodation or other reasons, that they were associated. I do think it is a very important issue that needs vigilance. We know that rolling testing was also being done in the meat packing industry as well as the rolling testing that is being done in nursing homes. We have recommended that the data sets be linked so that we could have a more systematic report on the risk factors for outbreaks in those settings, which are important to record.

Deputy Matt Carthy: I suggest to our secretariat that that be included for consideration in our report.

Chairman: I thank the Deputy.

Deputy Bernard J. Durkan: Like other speakers, I welcome the witnesses and thank them

for their report. One question arises immediately which I know has been referred to previously. In the event of the report being carefully implemented, are the witnesses satisfied that that will adequately address the issues that came to the fore in the recent pandemic? That is my first question.

Professor Cecily Kelleher: We have done our level best to make the recommendations that we think could ameliorate what we saw already, but we are in an uncharted situation here. We are dealing with a pandemic of a condition where every day we learn more about its impact and effects. We have seen that Covid-19 is a highly contagious condition and that it can have long-term sequelae, so we have to continue to see what the impact of that might be in the population. We are trying to control the pandemic in this country and doing everything we can to keep it minimised and contained. We endorse that insofar of its importance. I hope the recommendations we are making around what we are learning about this particular sector and what we owe older people in policy terms will mean that we can see a change in that in the long term.

Professor Cillian Twomey: We need testing and rapid turnaround of results needs to be applied, not just in the nursing home sector we are discussing in terms of staff and residents but, as we have heard in recent weeks, it is a challenge to apply it nationally as well. If there is a suspicion, a person must have a test as quickly as possible and get the results as quickly as possible. It would be nice to think the testing arrangement that was very publicly promoted and mentioned last evening could be applied across the country. What we need is that level of promptness so that if there is somebody who is positive one can get on with contacting the individuals that person was in touch with. That is a seriously important part and it requires funding and setting up. There are places available to do it, but we have to be vigilant and we also need to crank that up in the event of anything like a surge re-emerging.

Ms Brigid Doherty: It is in our recommendations but what is very important with the winter ahead is to encourage everybody to have the flu vaccination. We hope all healthcare staff and anybody working in a nursing home will take up the flu vaccination. We need to encourage everybody, including members of the public, to take up the flu vaccination because otherwise we will possibly have residents requiring admission to hospital. We sincerely hope that could be avoided.

The recommendations have to be implemented. They are very clear. They are achievable. I believe we have the will of all the stakeholders to implement them now.

Deputy Bernard J. Durkan: May I ask another question, Chairman? How many minutes do I have left?

Chairman: Yes. The Deputy has a minute and a half.

Deputy Bernard J. Durkan: That is very tight.

Chairman: I am told we have to be strict on time because the Seanad will sit in this Chamber at 2.30 p.m.

Deputy Bernard J. Durkan: That is fine. I have a number of questions but I will ask them quickly. Nursing homes have been mentioned many times in the debate on this issue over the past six months and there has been implied criticism. We all have nursing homes in our constituencies, both public and private ones, and without exception the quality and standard of service provision are excellent. From my experience, I certainly could not point the finger at anybody. Like everyone else here, I deal with the nursing and management staff fairly regularly. One can

gauge from the opinions one gets that they do their utmost to give the best possible quality of service.

Have public or private nursing homes been in a better or worse situation in the pandemic, given that it was identified from the outset that nursing homes would be vulnerable for two reasons, namely, congregation and age profile?

Professor Cillian Twomey: The answer is there is no difference, but it was not the nursing homes that were the issue. It was the frail older people who are in nursing homes and happen to be at risk. The concern is greater if one has a setting in which there is a larger number, such as in a bigger facility in which more frail older people are congregated. If the virus gets in, that is the key issue. If the virus gets in, it is almost impossible to stop it spreading, unless one is right on the case in terms of the preparedness we discussed earlier. I agree totally. It is not the case that public was better and private was worse. Both were equally affected. But in my view, by having people who are vulnerable and frail in large congregating settings in the first place, public or private, that puts them at risk that need not be, if we begin to think of alternative models for the future.

Chairman: At the very beginning of your answer to Deputy Durkan, did you say there is no difference between public and private?

Professor Cillian Twomey: In terms of the outcome of mortality, broadly, there was no difference between the two.

Chairman: In terms of preparedness, I think was Deputy Durkan's question.

Professor Cillian Twomey: Preparedness was different. There was not full preparedness everywhere on 1 February this year, because we were only beginning to get on top of it.

Deputy Bernard J. Durkan: For the last question, the witness can send me a written reply. In relation to rapid testing and rapid results, to what extent does the witness believe that can address the issues now arising with the second surge?

Professor Cillian Twomey: By definition, if one has rapid testing and rapid results, one is able to get on top of the case more speedily. If it takes three days to have a test and another three days to get the results, that is six days lost. Then one is having to isolate staff while waiting the six-day period. That was one of the things-----

Chairman: I am sorry to be rushing you. I have three questions, and I would appreciate succinct answers. I am sorry for my time management failures.

One of the key recommendations this committee made in its interim report was that the practice of the HSE sending people into nursing homes which have failed HIQA inspections should cease. The HSE sends them there and pays for them with taxpayers' money and through the fair deal scheme. Is that a recommendation that the panel would agree with?

Professor Cecily Kelleher: We did not make that recommendation, though we are very clear that the HIQA reports have to be adequate in relation to compliance with legislation, in order to answer that question.

Chairman: I suppose the witness cannot answer on behalf of the panel when it did not make that recommendation. Is it a recommendation that the witness personally agrees with, that we have to cease sending people into nursing homes which have failed inspection? There is com-

pliant, substantially compliant, and then fail, which is a different category to-----

Professor Cillian Twomey: The inspection process that HIQA very importantly has to undertake is serious. If a facility continuously fails to meet the standards that are set, generally speaking, it is given the opportunity to correct the areas that are deficient, and it is then revisited. If it is persistently failing on a multiple number of standards, then HIQA, under its regulation, has no option to say that it is an unsafe place for a person or people to be looked after.

Chairman: Does the witness agree with the HSE sending people into these facilities?

Professor Cillian Twomey: The HSE does not send people into these facilities. The future existence of facilities that are substandard, and repeatedly so, and do not meet standards, has to be questioned. In fairness, there has been an incident or two of nursing homes that have been closed.

Chairman: There has but the fair deal scheme is still being used to fund people going into these facilities, as we speak. Unless the committee is going to hear something different from the HSE or that practice has very recently ceased, the fair deal scheme and the National Treatment Purchase Fund are still being used to put people into these facilities.

I want to move on to my next question, and I have two left. The Care Quality Commission of the United Kingdom recommended that a clinical lead be appointed by 15 May in respect of each nursing home. Some HSE facilities have a medical officer. By dint of history some do not, but the majority do. However, private nursing homes, be necessity, have no medical officer who is responsible for the medical treatment of the entire community. Is that something that the witness would like to see happen? I am referring to something like what happened in the UK, where there is a clinical lead to be appointed, who is responsible for-----

Professor Cillian Twomey: It is one of our key recommendations that there will be a GP lead in every nursing home, and there will be a GP lead as a member of each community support team.

Chairman: I thank the witness. This is my last question. I am going to go back to the opening questioning of, I think Deputy Devlin, who talked about the testing of people, in February and particularly in early March, who were being discharged from acute units into nursing homes. Was there an unusual level of people discharged, at that time, from the acute units into nursing homes?

Professor Cillian Twomey: There was. At the time, we were looking at the television screens as to what was happening in Italy, Spain and so on and there was a real concern that the acute hospital system would be overrun.

Chairman: Was there a policy of discharging patients from the acute hospitals into the nursing homes?

Professor Cillian Twomey: I am not sure whether you would call it a policy but there was a reality of an urgent requirement to make available acute bed capacity, which did not exist, and, therefore, a significant number of-----

Chairman: Is Professor Twomey aware of that urgent requirement having been communicated to acute hospitals?

Professor Cillian Twomey: I am not aware of what communications have taken place be-

tween the HSE and the acute hospitals but it was from the acute hospitals that the patients were transferred to care facilities based on the requirement to create capacity. That all happened in February. That is why it happened.

Chairman: I thank the witnesses for answering my questions and those of committee members. I apologise again for the slight delay in getting started earlier.

Sitting suspended at 12.06 p.m. and resumed at 12.30 p.m.

Covid-19: Final Report of Nursing Homes Expert Panel (Resumed)

Acting Chairman (Deputy David Cullinane): We are back in public session. I welcome officials from the Department of Health and the representatives from the HSE to continue our consideration of the Covid-19 expert panel's report on nursing homes. From the Department of Health we have Dr. Kathleen MacLellan, assistant secretary, who is presenting from committee room 2. Dr. MacLellan is very welcome. By video link we have Mr. Niall Redmond, who is a principal officer in the Department. From the HSE, and also in committee room 2, we have: Mr. David Walsh, who is the implementation lead; Dr. Siobhán Kennelly, who is the national clinical and advisory group lead for older persons; and Ms Sandra Tuohy, assistant national director of services for older people. I welcome the witnesses.

Before we commence the formal proceedings I wish to 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. However, if they are directed by the committee to cease giving evidence on a particular matter they must respect that direction. They are directed that only evidence connected with the subject matter of these proceedings is to be given and asked to respect the parliamentary practice to the effect that, where possible, they should not criticise nor make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

I invite Dr. MacLellan to make her opening statement. If Mr. Walsh has an opening statement or wants to make opening remarks, he will have an opportunity to speak after Dr. MacLellan. I ask that opening statements be kept to five minutes because we are operating to a strict two-hour sitting today.

Dr. Kathleen MacLellan: I thank the Chairman and members. This year, 2020, has brought with it the most serious global pandemic in a century. Since the emergence of Covid-19, there have been more than 28 million cases of the disease worldwide. Some 30,500 of these have been in Ireland and, very sadly, 1,781 people here lost their lives.

Nursing homes are where more than 30,000 of our citizens call home. Residents of nursing homes are vulnerable because of their age, underlying medical conditions, the extent of their requirement for direct care involving close physical contact and the nature of living in congregated settings. Nursing homes have been particularly impacted upon by Covid-19, both in Ireland and internationally. For the past six months, nursing home residents, their friends and families have sacrificed the normal daily social and person-to-person interactions. It is with great sadness that I say that 994 nursing home residents lost their lives as a result of Covid-19.

It is essential to recognise the continued and determined professional care provided by healthcare workers in nursing homes 24 hours a day. It is also important to appreciate that

approximately half of nursing homes remained free of Covid-19 and that many of the nursing homes which did experience an outbreak managed very well. The central focus of the response of the National Public Health Emergency Team, NPHET, has been to control the spread of the virus insofar as possible to protect those who are most vulnerable from infection, as well as protecting against causes, situations, circumstances and behaviours that may lead to the spread of Covid-19.

New cases, both across the whole population and in nursing homes, have steadily declined over the past few months. Unfortunately, we are now seeing a gradual change in the epidemiological situation and nursing homes have not remained unaffected. Since the start of pandemic and as of 10 September 2020, there have been 281 clusters in nursing homes. More than 85% of those clusters are now closed, with 39 remaining as open clusters. The open clusters are in areas of high community Covid-19 transmission, including 27 in the east of the country, ten in the mid-west and two in the north east. In the 14 days prior to 10 September, the Health Protection Surveillance Centre, HPSC, advised the Department that 1,997 new confirmed cases had been notified, with 10% of those cases involving people aged 65 years and older. There have been four new clusters in nursing homes in this timeframe.

It is of great concern that heightened community transmission may bring further unwitting transmission of Covid-19 into nursing homes, thereby impacting on those most vulnerable to the virus. Therefore, sustained communication and inter-agency co-operation must remain central to the response to the virus. Extensive ongoing and problem-solving collaboration between Nursing Homes Ireland, the HSE, the National Treatment Purchase Fund, the Health Information and Quality Authority and the Department continues. The State's responsibility to respond to the public health emergency created the need for the HSE to ensure a structured nursing home support system was in place in line with NPHET recommendations. This has been a critical intervention in supporting the resilience of the sector in meeting the unprecedented challenges associated with Covid-19. Guidance, personal protective equipment, staffing, serial testing, infection prevention and control training, accommodation and financial support have been provided to the nursing home sector, both public and private. In addition, multidisciplinary clinical supports are in place at community healthcare organisation, CHO, level through 23 Covid-19 response teams.

HIQA has designed and implemented a regulatory assessment framework of the preparedness of designated centres for older people for a Covid-19 outbreak. In addition, the authority is in the process of developing an infection prevention and control assurance framework for nursing homes, which will include a self-assessment tool for nursing homes and will be supported by an outreach training and support programme by HIQA.

In continuing to monitor the national and international experience of Covid-19 in nursing homes, NPHET outlined its clear view of the need to ensure that all actions that can be taken are taken to protect residents of nursing homes. NPHET therefore recommended, on 23 May, that a Covid-19 expert panel on nursing homes be established by the Minister for Health. This panel was tasked with providing immediate real-time learnings and recommendations in light of the expected ongoing impact of the virus over the next 12 to 18 months. The panel has submitted its report to the Minister for Health, which included a substantial package of recommendations across 15 thematic areas. It contains 86 recommendations, with associated timelines, for implementation over the short, medium and long term by the HSE and associated agencies with responsibilities in this area. The report, which was published on 19 August by the Department of Health, also contains a specific chapter on the model of care.

The Department has strongly welcomed the report and is fully committed to progressing its recommendations. The Minister for Health has already established an implementation framework which will ensure a priority focus on key short-term public health and protective measures for nursing home residents over the coming months, with a particular emphasis on winter and ongoing preparedness against Covid-19. The framework includes an implementation oversight team and a reference group. The oversight team has met twice already and will report monthly to the Minister to outline progress and any challenges for escalation. The reference group will hold its first meeting next Monday.

Early progress on some recommendations has been made, including the commencement of a costing exercise, an additional funding allocation for infection prevention and control, plans to test the safe staffing framework, an ongoing commitment from the HSE and HIQA to implement the public health measures, commencement of the design of a visiting guidance framework, commencement of a review of the current HIQA regulations, and ongoing serial testing in nursing homes.

In conclusion, the Government's plan for living with Covid-19 places an important focus on supports for the nursing home sector. These supports include the continuation of the Covid-19 response teams, implementation of the safe staffing framework, an extension of the temporary financial support scheme and progression of the implementation of the expert panel recommendations, with particular focus on those recommendations requiring urgent and immediate attention in order to ensure all available measures to protect this vulnerable cohort are taken.

Acting Chairman (Deputy David Cullinane): I thank Dr. MacLellan. I invite Mr. Walsh to make an opening statement if he so wishes.

Mr. David Walsh: I have a short opening statement. I thank the Chairman and members for the invitation to meet the Special Committee on Covid-19 Response. As noted, I am joined by my colleagues, Dr. Siobhán Kennelly and Ms Sandra Tuohy.

I wish to begin by taking the opportunity to again express my condolences to the families and relatives of those deceased as a result of Covid-19 and, in particular, those who were residents of nursing homes.

The Health Service Executive welcomes the publication of the report of the COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021. The HSE is committed to working in partnership with the relevant public and private agencies to implement the recommendations within the report.

The report recognises the unprecedented effort made to support long-term care facilities and their residents, and the immediate responses put in place to support them whether under public, private or voluntary governance. These supports must now become more permanent in nature and work to achieve this has commenced across many of the recommendations. In particular, infection prevention and control infrastructure, PPE, Covid response teams and enhanced clinical supports are an immediate priority. The HSE winter plan, which is currently being finalised, will reflect how these supports will be embedded within services.

The continued development and implementation of the HSE's integrated care programme for chronic diseases, the integrated care programme for older persons and the further development of community healthcare networks, in partnership with general practice, form essential supports to all those who are vulnerable in our communities, including those in long-term care.

As already mentioned, we have commenced work on the HSE actions in the report, and will work with the Department of Health and other partners to implement the recommendations that require either policy change or policy development. A comprehensive approach to addressing the future of how older persons' needs are met will require a whole-of-government and a whole-of-society approach with significant development of, and investment in, alternative care and housing models required.

The surest way of protecting residents in long-term care from Covid-19 is to work with communities to suppress the virus in the community. The public health advice and guidance to the population as a whole, along with a comprehensive testing and tracing strategy, form the core of the protective measures against this disease. The earlier phases of this pandemic showed clearly that where the virus is prevalent in the community the risk to those in long-term care in those communities rises commensurately. Suppressing the virus in the community protects everyone in that community.

In conclusion, I reiterate the support and commitment of the HSE to the implementation of the recommendations of this report. That concludes my statement.

Acting Chairman (Deputy David Cullinane): I thank Mr. Walsh. Today, we meet in the Seanad Chamber. I remind members and witnesses that this session of our meeting must finish at 2.30 p.m. as the Seanad Committee on Procedure and Privileges is due to meet here at 3 p.m. Therefore, I must be very strict with people about time, including with myself who, as the first questioner today, has ten minutes. Can I assume that all of the witnesses or the key witnesses have read both the HIQA report and the report from the expert panel group? Yes.

Dr. Siobhán Kennelly: Yes.

Acting Chairman (Deputy David Cullinane): I shall first direct my questions at Mr. Walsh. The HIQA report relays and outlines concerns that were expressed by the chief inspector in terms of nursing homes. Some of the concerns were as follows: the absence of clinical governance in most nursing homes; staffing levels not what they should be; a difficulty in maintaining staffing levels in the event of sudden and unplanned absences; the availability of resources such as PPE; access to specialist expertise; the layout of centres; and a history of non-compliance with relevant key regulations. As people will know, 39 of the 44 centres did not comply with more than one of the measures. Some of Mr. Walsh's colleagues were before this committee facing very tough questioning from its members. Senior representatives of the Department and HSE were playing down some of the issues arising in nursing homes and the fact that there was not a plan. Some of the issues being raised regarding access to personal protective equipment and the structural arrangement between the HSE, the Department and nursing homes were not as dramatic as made out. How does that now sit with the two reports we have, which clearly demonstrate there were failures and that we need to see very substantial changes in the clinical framework, governance and the relationship between the Department, the HSE and nursing homes? In Mr. Walsh's own words, could he explain the position of the Department and the HSE on the two reports, the recommendations therein and the issues that arise from them?

Mr. David Walsh: I will speak from the perspective of the HSE. The HSE clearly notes and supports the recommendations in the expert group report, which puts an onus on us all collectively to further develop and enhance the levels of interaction and support across acute hospitals, community services within the HSE, and the private and voluntary sector. Some of the developments over recent years within HSE services, including the integrated care programme

for older people, of which Dr. Kennelly has been clinical lead, show the direction in which we now need to accelerate.

Acting Chairman (Deputy David Cullinane): May I put a direct question to Mr. Walsh? One of the key issues arising from both reports concerns clinical governance and the role and authority of HIQA to examine issues in nursing homes. I am not sure whether Mr. Walsh saw the hearing last week when we had HIQA representatives before us. They outlined to us the many exchanges they have had with the Department, the HSE and Ministers calling for more powers, better regulations and changes to the Health Act. They have subsequently sent us a detailed note cataloguing all their requests, all of which fell on deaf ears. When the questions on poor clinical governance and the lack of a strong relationship between the HSE and nursing homes were put to the HSE, they were knocked back by very senior representatives of Mr. Walsh's organisation. Now that both reports have identified clinical governance weaknesses, people will want to know what the HSE and the Department are going to do about them. That is a very direct question for Mr. Walsh, and also for the Department.

Mr. David Walsh: I thank the Acting Chairman for that clarification. The HSE is fully committed to implementing recommendations in the expert review. The HSE does not have a role in regard to HIQA bar being regulated by it. At all times, in respect of HSE units, they are subject to-----

Acting Chairman (Deputy David Cullinane): If that is the case, we need to go to the Department. We need to know if the system, whether it involves the HSE or the Department, will take the bull by the horns and deal with the issue of clinical governance once and for all. I do not have the time to go through the lengthy letter we got from HIQA that contains a long list of requests that have gone unanswered. Will the Department state whether we are going to get to a stage where we will improve clinical governance arrangements in nursing homes? Whose job will it be? Perhaps the Department will be able to answer that.

Dr. Kathleen MacLellan: I thank the Acting Chairman. The implementation oversight group has been established by the Minister for Health.

Acting Chairman (Deputy David Cullinane): We know that. We know the groups that exist. We can have all the implementation groups in the world but we need to know whether there is a commitment by the Department to deal comprehensively, once and for all, with the clinical governance deficit in nursing homes and between HIQA and nursing homes. Is HIQA going to get the necessary powers in this regard?

Dr. Kathleen MacLellan: The straight answer is "Yes". There is a significant commitment, by both the Department and the Minister, to implement the recommendations. While not picking out any recommendations, there is commitment to implement those with regard to clinical governance and supporting the HSE with the Covid-19 teams. The report did, however, point out that clinical governance responsibilities in the first instance are with the individual owner, as well as the person in charge, and with that they need support through the HSE. There is a commitment in the expert panel recommendation for that. We are committed to providing a framework around clinical governance, as well as engaging with GPs in building and enhancing their role in providing support for clinical governance across those nursing homes.

Acting Chairman (Deputy David Cullinane): Is it the case then that the model being examined is that there will be an agreed clinical guidance framework, in which the Department will have a role in framing, and the responsibility for delivering that will be with the individual

nursing homes? Will there be any role for HIQA in respect of that?

The most distressing parts of the two reports were the testimonies from family members and relatives of loved ones who passed away or who had experiences of being in nursing homes during a difficult time. We all accept that. It was difficult for the staff in those nursing homes as well. One issue which arose was that HIQA does not have the power to examine individual cases of neglect or abuse. We have seen several such cases raised in this committee, on the floor of the Dáil and elsewhere. There seems to be a weakness in that it is not clear how those individual cases can be dealt with. There is much to be learned about Covid but there are also those issues.

I thank Dr. MacLellan for her explanation of the framework. Those individual issues are rare. Most nursing homes provide an excellent service, as do most of the staff. However, when those instances of abuse and neglect occur, they need to be ruthlessly dealt with and there has to be a process in place. Does the Department support giving HIQA more powers to deal more comprehensively with those types of issues?

Dr. Kathleen MacLellan: The Department fully supports enhancing and building the powers of HIQA, as has been recommended by the expert panel report. Indeed, we have set up a bilateral project group to work across the Department and HIQA examining which of the regulations need to be strengthened, what powers could additionally be assigned and how quickly we can do that.

We work closely with HIQA and meet with the authority on a regular basis. We have ongoing engagement around regulations, powers it has and the form of regulation in place across our older person services. We are working with HIQA on home care services which do not have a structured, formalised regulatory system in place. We are fully committed to work on the legislative programme and to work through the recommendations which have been clear on the Department working with HIQA to assess what processes could be put in place around individual complaints. We also will work generally with HIQA on what additional powers could and should be assigned.

My colleague, Mr. Niall Redmond, wants to come in on this.

Acting Chairman (Deputy David Cullinane): Before he comes in, as a member of the Oireachtas health committee which will be established in due course, I will certainly be asking that the committee keeps a keen eye on the expert panel report. As the Chairman of this committee said, we can have implementation teams and reports. However, they are only as good as their implementation. The health committee needs to keep a watchful eye on this.

I note there is a problem with the audio for Mr. Redmond. I apologise. I will go to Deputy Colm Burke while we get our IT people to sort out the audio problem. We will let Mr. Redmond back in then. He can take a note of issues which arise from Deputy Colm Burke's or other members' questions.

I call Deputy Colm Burke who has ten minutes.

Deputy Colm Burke: I may not use them all.

I thank the witnesses for the work they have done over the past six months. It has been a challenging time for everyone. It is important that we work together to resolve outstanding issues and ensure our nursing homes and the care of the elderly are managed in the best possible

way. My opening question is on an issue I also raised with HIQA, which was mentioned in the presentation, and that is the planning for nursing homes between 1 January and the middle of April. While an approach had been adopted of getting people out of the hospitals to make room available in them to deal with people who need urgent care, there was a need for communication with nursing homes about how they needed to upskill and upgrade the service that they provided, particularly in the area of infection control. Was this issue examined by the Department to put more pressure on nursing homes, both public and private? I will give a simple example of what I am talking about. In one HSE facility as opposed to a nursing home, there were not even changing facilities for staff who came into work or finished work every morning or evening. Were those issues considered by the Department in the planning for dealing with this new challenge in our health service?

Dr. Kathleen MacLellan: I thank the Deputy for his question. Initial planning for infection prevention and control is through the public health departments in the HSE. These engaged very early, towards the end of January, with nursing homes and across the system. The initial guidance that was used was the influenza guidance, bearing in mind that many nursing homes already manage a number of different infections and outbreaks, including influenza, MRSA, and C. difficile infection. These were the first set of guidelines. There was very early engagement on infection prevention and control. That guidance and interaction between the HSE and education and support was built as we continued forward. Very helpfully, the expert report has clearly outlined specific recommendations around infection prevention and control, and processes and systems that need to be in place for nursing homes.

The other piece is that there were very particular recommendations-----

Deputy Colm Burke: On that point, can our committee have copies of those communications because I have not seen any such written communications at any stage over the past three months from HIQA, the HSE or, indeed, from the Department?

Dr. Kathleen MacLellan: Certainly. Perhaps Mr. Walsh may wish to make a contribution.

Mr. David Walsh: I thank the Deputy. I thought that we had submitted an outline of all of the communications with nursing homes to the committee but if that has not happened, I will arrange for it to happen.

Deputy Colm Burke: I am looking in particular for communications during the period between January and the end of March.

Mr. David Walsh: I understand.

Deputy Colm Burke: I know that there were communications after that period but I am anxious to see the communications in that crucial time period. Perhaps they were submitted but I have no recollection of seeing any particular communications dealing with infection control.

Mr. David Walsh: The method used was to disseminate information via the HPSC website, where guidance was updated very often throughout the period and to then make this available through Nursing Homes Ireland, local engagement, and the HIQA portal as well. I will resubmit the timeline along with copies of the documentation for the committee so that it has a complete picture.

Deputy Colm Burke: The second issue I want to raise was discussed earlier and relates to staff working in more than one nursing home. Was any guidance given to nursing homes or

HSE facilities about the challenges that there would be in employing staff coming from another medical facility? Some HSE facilities might have had difficulties in trying to get staff and that may have resulted in staff going from one medical facility to another. Were guidelines issued to nursing homes or HSE facilities? I also refer to mental health facilities because there were several adverse outcomes in those settings as well. Was any information sent out to such facilities at any stage warning of the dangers of taking in staff who were moving from one facility to another?

Dr. Kathleen MacLellan: I will come in first and then hand over to my colleague, Mr. Walsh. This issue was taken seriously by NPHET at an early stage because information was emerging internationally concerning the challenges regarding staff working in, and between, different facilities, as well as sharing residences. Swift action was taken and the HSE undertook some significant actions in this area.

Mr. David Walsh: Clear advice was issued through the management system in the HSE and that advice was also shared with Nursing Homes Ireland. The HSE's national director of human resources wrote to the agencies used by the HSE instructing them not to assign their workers to multiple sites. There were, however, tensions at times. I refer to when the HSE was asked to support some of its own units that were in trouble because of staff being off sick, or private or voluntary units with the same problem. Out of necessity, therefore, that meant transferring an employee from one service to another. It is important to note that aspect, but that had to be done on a risk-assessed basis to do the most good and the least harm. The instruction sent out was to not share staff across units and that instruction was also given to the agencies that we deal with.

Deputy Colm Burke: I know of one facility with ten people where several staff unfortunately contracted the virus and were unable to turn up to work. It was impossible to replace them. Is a mechanism now in place to deal with such a situation? If an HSE or nursing home facility runs into a major problem with staffing, is a mechanism in place to enable that challenge to be dealt with adequately? In the facility I referred to, it was necessary to transfer people and, unfortunately, four of those ten people died. It was not a HSE facility or a private nursing home, but six of the patients ended up having to be transferred to a HSE facility. If there is another major challenge with staffing, do the HSE and the Department of Health have a mechanism to address that challenge?

Mr. David Walsh: The HSE has been working with Nursing Homes Ireland for several months, and nursing homes have also had the benefit of the temporary assistant payment scheme, which has allowed them to invest in an enhanced level of service to enable them to deal with those sorts of issues. We have requested every unit, which is reiterated in the report of the expert review team, to have a plan in place, from the perspectives of management and staff, to give the required resilience to manage if there should be another outbreak in a unit. There may be cases, despite a good plan being in place, where it becomes difficult to manage with staffing. The HSE and other partners will then do all in their power to assist. There are difficulties, such as the one we mentioned earlier in this discussion in transferring staff from one facility to another and the risk associated with that. In the first instance, every unit should have its own plan and the HSE will do all in its power to back up those plans should the worst come to the worst.

Acting Chairman (Deputy David Cullinane): I think the audio problem with Mr. Redmond has been fixed so I will give him two minutes to respond to some of the issues that arose in the first two contributions and then move to our next speaker.

Mr. Niall Redmond: I thank the Chair. I hope he can hear me now.

On the Chair's contribution on clinical governance, it is important to reflect on the fact that HIQA has a substantial number of powers available to it at the moment in terms of clinical governance. Dr. MacLellan has outlined some of the work we will be doing over the next while, to which HIQA will be central. Aside from that, there are a number of other streams of work under way as well as part of that overall package and framework of clinical governance. Important in that is the work the Department has been doing over the past 12 months on an adult safeguarding policy for the health sector which would be the first national safeguarding policy for the health sector. That would have within its scope private and public facilities and nursing homes. That work is advancing this year with a view to going out to public consultation on a draft policy later this year or early 2021. That will be another important aspect of the clinical governance framework.

In the programme for Government, there is also a commitment to exploring the expansion of the role of the ombudsman to examine individual care concerns in relation to nursing homes. That will be another important aspect of that framework. I do not think there is one particular silver bullet. A package of measures is required to put together a robust framework around that.

The role of advocacy cannot be understated. We are doing some work around the programme for Government commitment to the roll-out of the patient advocacy service into the community, which will be another important aspect of the response.

Acting Chairman (Deputy David Cullinane): I thank Mr. Redmond. We heard him loud and clear; he might need to adjust his volume a bit. Perhaps audio can have a look at that? The Fianna Fáil speaker is Teachta Devlin, who has ten minutes.

Deputy Cormac Devlin: I thank the witnesses for their attendance today. I will start with a question for Mr. Walsh regarding his opening statement. He mentioned that the HSE actions in this report will be worked on with the Department of Health and other partners to implement the recommendations that require policy change and/or policy development. For clarity, how do the Department of Health and the HSE work together and what subtle differences are there between the two bodies that require co-ordination?

Mr. David Walsh: I will open on that and then hand over to my colleague, Dr. MacLellan. There are close and tight links between the Department of Health and the HSE. The Department has a clear role in the development of policy and the monitoring of the HSE's implementation of that policy. In every section of the Department, there are clear links to the corresponding section of the HSE and we work continually throughout the year on relevant issues. In recent weeks, it has been around the winter plan and the structures around the implementation of the recommendations of this review. There are longer-term issues, such as the development of how we provide home support, which will be a key facet of how we alter the model of care for older persons in this country, and the Department has a key role in this. Its role is as key as that of the HSE in implementation. I will hand over to Dr. MacLellan.

Deputy Cormac Devlin: In terms of the recommendations made in the report before us, whose ultimate role will it be to see its implementation? Is it the Department, the HSE or another?

Mr. David Walsh: The chief executive of the HSE is accountable for the performance of the HSE. My colleagues and I are accountable to him for our performance. The chief executive is accountable to the board of the HSE. The Minister has accepted the report and has tasked the Department to lead on implementation of the recommendations. I will ask Dr. MacLellan to

outline how the Department is doing this in co-operation with the HSE and others.

Deputy Cormac Devlin: In her opening statement, Dr. MacLellan mentioned the extension to the temporary financial support scheme. Specifically, what does this cover? Does it cover staff supports and staff cover, as the previous speaker asked?

Dr. Kathleen MacLellan: The temporary scheme was set up with two elements. One is with regard to supporting these nursing homes in their preparedness planning and having their contingency plans in place. The other element is to support additional costs these nursing homes may incur if they have an outbreak or cluster within them. My colleague, Mr. Redmond, will give detail on this, including the extent of the funding that has been given through the temporary scheme. It has been very much welcomed by the private nursing home sector and is very much seen to support the additional costs they have incurred in the management of Covid-19.

Mr. Niall Redmond: Approximately €37 million has been paid out. Actually, as of this morning, approximately €39 million had been paid out to providers under the scheme. To answer the direct question, the scheme covers a contribution towards a number of different costs related to Covid-19. These include additional staffing costs, additional cleaning costs, infection prevention and control costs and training. There is a broad range of inclusion criteria and my understanding of the funding paid out so far is that the vast majority has related to staffing costs. This may involve hiring extra staff to cover absences or to supplement the existing staffing complement in a nursing home.

Deputy Cormac Devlin: Mr. Walsh referred to the winter plan. How confident are we as a nation that we have enough PPE for the winter months? How confident are we regarding its supply and distribution and ensuring it gets to the various services speedily?

Ms Sandra Tuohy: I will answer the question on PPE. Since the start of the pandemic, almost €70 million worth of PPE has been supplied to nursing homes throughout the country. Every crisis response team for our nursing homes has a PPE lead. We have assurances on the supply lines of PPE and ongoing supplies specifically for our nursing homes going into winter. I can assure the committee on this.

Deputy Cormac Devlin: My next question relates to our earlier session with the expert panel. There were more than 400 discharges from hospitals into congregated settings, including nursing homes, care facilities and long-stay facilities. I need assurances that anybody discharged from an acute setting will be tested. I would like confirmation on this from the relevant witness.

Dr. Kathleen MacLellan: I will start and my colleagues from the HSE can come in. There is very clear guidance on the testing that needs to happen prior to discharge. It was put together by the HPSC. In addition, the director of acute hospitals has assured the Department in the past few weeks that he has gone out to all of the hospital groups in order to be assured that the guidance is being followed. That assurance has been provided. I will hand over to Dr. Kennelly from the HSE.

Dr. Siobhán Kennelly: To emphasise what Dr. MacLellan said, testing guidance has been in place for quite some time. We know not just testing but also specific protocols around the isolation of people after they transfer from acute hospitals to residential care for a period of two weeks are now accepted as standard practice across the board. That is being implemented across private and public facilities.

Deputy Cormac Devlin: Reference was made to the bilateral group. Is that the same as the implementation framework group or is it separate? How many meetings of the bilateral group have taken place to date?

Dr. Kathleen MacLellan: I will answer that question and then hand over to Mr. Redmond. It is not part of the implementation oversight group, but its work will be part of delivering the recommendations of that group. It is a separate process. The Minister asked for it to be established across the Department and HIQA. I will ask Mr. Redmond to comment.

Mr. Niall Redmond: That is correct. The bilateral group with HIQA and the Department is a separate group that is looking at some of the recommendations made by the expert panel on the regulatory framework. We will be working with HIQA over the next number of weeks and months to examine that framework and look at what we can do in the short and longer term around the regulations. I believe the Minister wrote to HIQA in the past week or ten days regarding the establishment of that group and we are hoping to have our first meeting next week.

Deputy Cormac Devlin: I refer to services for older people. When will community social day care settings resume?

Ms Sandra Tuohy: We recently developed the reopening guidance for day care centres, along with our colleagues in infection prevention and control. We have expertise on that. It is quite complicated to reopen our day centres because many people who attend them are also depended on transport to get them there. We cannot have six or eight people in a bus being transported from their homes to day centres. We are examining how we might mitigate against that.

I wish to provide the House and Deputy with an assurance that those people who are not receiving day centre support are having alternative services delivered to them in their homes, such as meals on wheels and telephone support from people who provide services to them in day centres. We are committed to reopening our day centres, but we want to do that safely and mitigate against the risk of the transmission of the virus to a really vulnerable group.

Acting Chairman (Deputy David Cullinane): The next slot is for the Green Party but there is no one from the party present. We will move on to the Labour Party slot.

Deputy Duncan Smith: I will direct my first couple of questions to the HSE. The report noted that the socioeconomic conditions that many essential front line healthcare staff are living under might be an essential barrier to effective infection controls, in particular staff who do not have access to sick pay, need to work in multiple facilities or live in crowded accommodation.

Public health officials are clearly on the record as having said that workers who need to self-isolate should have no fear about their employment and that economic circumstances should not be a barrier to people coming forward and getting tested. Has any consideration been given to providing some ring-fenced funding that will offer additional sick pay support for all nursing home workers as we approach winter 2020?

Several organisations, including SIPTU, raised recruitment concerns in nursing homes and said pay and conditions were a barrier to achieving safe staffing levels. The report recommends that contracts, pay scales and staff development in nursing homes require review and that there is an immediate and ongoing need to attract staff with career development opportunities. Are there plans to commission a full review into the pay and conditions of workers in the sector? When is that is likely to commence? Who will undertake the review? Will workers' representatives he included in the process?

Mr. David Walsh: I will start with that and hand over to colleagues in the Department of Health. Within HSE facilities staff have access to the HSE sick pay scheme so I think the reference within the review related to terms and conditions in the private nursing home sector. To support those staff, over the last number of months the HSE have made available accommodation that would allow them to avoid the situation the Deputy described in his question. On pay and conditions, there are obviously very clear recommendations about that in the review. Dr. MacLellan will comment on the approach to addressing those recommendations.

Dr. Kathleen MacLellan: Within the responsibility of the Department of Health and the HSE, we have been able to put in place accommodation and accommodation supports for those working within the private nursing home sector. There is a recommendation in the report which is directed toward the Department of Enterprise, Trade and Employment. This is a cross-Government piece. The Department of Health will work with other Departments on education, training and the guidance related to that.

On the terms and conditions, this review is recommended to be completed within 18 months. A recommendation of significant importance is that when the Minister for Health brings this report to the Government for a full discussion, a cross-Government approach will be taken on how that review of employment terms and conditions in the private nursing home sector can proceed and be undertaken. It is of significant importance that we provide these terms and conditions to employees to ensure they do not feel they have to work when they are sick or feel they will not be supported where self-isolation is concerned. There has already been cross-Government support for supporting employees in those areas.

Deputy Duncan Smith: The officials will be aware that one nursing home was taken under operational control as a result of a catastrophic situation which unfolded in April. We still do not know what criteria triggered the RCSI to take control of the nursing home in question. For the sake of future planning and in order that we can learn from what happened, will the HSE advise what threshold applied to trigger such an unprecedented response from a hospital group?

Mr. David Walsh: I am aware that the matter the Deputy raises is the subject of direct correspondence with the CEO of the HSE. I am also aware that the CEO of the hospital group in question has written to the families of some of the residents in the nursing home in recent days. I am not sure what the status of that communication is but I will undertake to check and revert directly to the committee.

Dr. Kathleen MacLellan: If I may add to that, it is important to note that HIQA, as the independent regulator, regularly inspects all nursing homes. It is the eyes and ears of the State within the nursing homes and it has significant powers where it identifies that there are issues with quality or adherence to standards or regulations. Those powers extend not only to imposing conditions on the registration of such nursing homes but also to closing them down. That is a very significant power our regulator has. HIQA, through the Health Act, has the ability and the right to enter nursing homes in relation to their registration and registration conditions. As such, our independent regulator holds a very important function in this regard.

Deputy Duncan Smith: I thank all of the witnesses.

Deputy Róisín Shortall: I thank the officials from the Department and the HSE for their attendance and presentations. I will follow on from an issue raised by Deputy Duncan Smith. Questions of low pay and precarious work are clearly very pertinent to this whole issue. I would like Mr. Walsh to go into a bit more detail about the comments he made about the ac-

commodation many of the staff are living in. It has been identified as a key issue that many staff are not only low paid but are often consequently living in poor-quality accommodation, in congregated settings and, in some cases, in direct provision. Given the growth of the virus, particularly in the Dublin area and the potential threat to residents in nursing homes, what is happening with regard to the issue of unsatisfactory housing conditions? Will the witnesses spell out what action is being taken in that respect? It seems it is the source of much of the spread of the infection. What arrangements are in place for care staff who are diagnosed with the virus to isolate themselves?

Ms Sandra Tuohy: I will take the question on accommodation. For a number of months, the HSE has been providing private hotel accommodation for staff who need to self-isolate from their own households as a result of outbreaks within nursing homes and for staff who are themselves living in overcrowded private housing. We will continue to provide such accommodation for people who are outside of the temporary assistance payment scheme, which is offered to the private nursing homes.

Deputy Róisín Shortall: Approximately how many people have been involved?

Ms Sandra Tuohy: I do not have that figure right now but I can supply it.

Deputy Róisín Shortall: Does Ms Tuohy have a ballpark figure?

Ms Sandra Tuohy: I understand the figure is in the hundreds.

Deputy Róisín Shortall: Okay. On what basis is that provided? Is it that the HSE meets the cost?

Ms Sandra Tuohy: The HSE meets the full cost.

Deputy Róisín Shortall: I am glad that is happening and that there is a contingency in place but this and so many other issues arising from the recommendations really underline the totally precarious nature of the funding model for nursing home care. It is very delicately calibrated to maximise the return on investment for the owners of the nursing homes while limiting the financial exposure of the State, neither aim having much to do with the care of older people.

My question is probably most suited to Mr. Walsh. Arising out of the very significant, wide-ranging and fundamental recommendations about the need to totally change the financial model as well as the model of care, what work has been done on estimating the potential cost of implementing the recommendations regarding the financial model for operating nursing homes?

Mr. David Walsh: I believe that is more of a question for the Department of Health so I might ask Dr. MacLellan to respond.

Deputy Róisín Shortall: Okay.

Dr. Kathleen MacLellan: We have commenced looking at all the recommendations and looking at those bodies which either have responsibility for their implementation or expertise with regard to them. The National Treatment Purchase Fund, which operates the nursing homes support scheme, is carrying out work on costing and the cost of care. The Health Service Executive is also carrying out work on costing. We in the Department are also looking at costing those recommendations. The cost of some of the recommendations will relate to continuing the supports already in place. Some of that will come through the funding in place to deal with Covid, some we will seek through the Estimates process and some we will seek from Govern-

ment when the Minister brings the report to it. Significant work on costing has commenced.

Some of the recommendations apply to the short term and it is very urgent that cost not become a barrier to their implementation. Others, particularly those with regard to the model and cost of care, relate to the longer term. There is a significant amount of work to be done in looking at what model of care we want for our older people in future. Part of that will involve working with our colleagues across Government, including those involved in housing, to see how to develop and design, as quickly as possible, a model to support people living in their own homes for as long as possible. Significant work has been done across the HSE in looking at new forms and processes of home care. This work will allow us begin to move towards supporting people living within their own homes much better. I particularly refer to those who need more care than has traditionally been provided through the existing home care support scheme. Home First is the new model at which we are looking.

Deputy Róisín Shortall: I will ask Mr. Walsh a question about the need to change the model of care but, before I do, I will talk about changing the financial model around nursing home care, the dominance of the private sector, the tax-based approach, returns on investments and all of those kinds of things. Those kinds of issues work against quality care. Who is carrying out costings? What is the timescale involved for the return of that report?

Dr. Kathleen MacLellan: The work has not commenced on examining the model of care on the back of the recommendations within the nursing home expert report so the issue of costing does not yet arise. Mr. Redmond wants to come in and follow up on that.

Mr. Niall Redmond: I will just add to that. When considering the recommendations and the broader work that is happening, looking at and considering how to reform older-person services, we must consider some of the policy work around what the future model might look like and how its models of care and finance might operate. A significant amount of work needs to be done to map out and put granular detail around what that might look like before we can accurately predict what that model will cost in its delivery.

It is fair to say that the National Treatment Purchase Fund, NTPF, is doing a piece of work to look at the pricing system that applies to agreements with private and voluntary nursing homes. That work is ongoing. The Department is also doing a piece of work. It is particularly important that the care needs assessment becomes the critical foundation piece for both the delivery of services and how they are resourced and configured. The roll-out of the single assessment tool will be a key part of that and the Department is working with the Health Research Board at the moment to undertake a review of international evidence for how to take a care needs assessment and define and allocate resources across a range of care bands. That preparatory, evidence-based gathering work is well under way and we are looking at future models.

Deputy Róisín Shortall: I appreciate that as it relates to the model of care but my question related specifically to the continuation of nursing home care. There will be some element of that, and hopefully a reduced one, but questions arise about the role of the State and private sector, tax breaks and all of that kind of thing. I was curious to know whether any of that work has started.

What is the level of financial support currently being provided to private sector nursing homes? Our guests said that there is approximately €39 million in the support fund and talked about providing residential accommodation for hundreds of vulnerable workers in the nursing home sector. I presume there are other costs involved in the provision of personal protective

equipment, PPE. Do our guests have a total cost for the level of financial support being provided to private sector nursing homes?

Mr. David Walsh: I do not have a total cost in front of me. To the items that the Deputy mentioned could be added the costs of other types of support such as infection prevention control advice, other types of support and replacement staff.

Deputy Róisín Shortall: Could Mr. Walsh get that information for us?

Mr. David Walsh: I will seek that information and send it to the committee.

Deputy Róisín Shortall: I have another question for Mr. Walsh. I asked him earlier in the year about the number of people who have been approved for home care and are on waiting lists because the funding provided is totally inadequate. I regularly check how many are on those waiting lists and the last time I checked, there were in or around 6,000 to 7,000 people, predominantly on the north side of Dublin and the north-west area. What is the current number of older people who have been approved for home care and are on waiting lists?

Mr. David Walsh: Ms Tuohy has that information.

Ms Sandra Tuohy: We obviously had a large waiting list when we were most recently before this committee. It is now down to 4,550 people awaiting home support across the country. That figure is from July. We have been working really hard to reduce that even further. We hope to have the August figures very shortly and we also hope that these will show a reduction in the number of people awaiting home support in the community. We hope to reduce the list of those waiting for home support to a very small number, if not to get rid of it entirely towards the end of October, because we recognise that is one of the fundamental ways of keeping people at home, keeping them safe and avoiding hospital admissions where we can.

Acting Chairman (Deputy David Cullinane): I will have to wrap it up there.

Deputy Róisín Shortall: That is good news. Has that funding been secured and what is the level of it?

Ms Sandra Tuohy: We received additional funding from the Department of Health for home support so as to manage more people at home throughout the pandemic and we have been utilising that money to reduce the waiting lists in conjunction with direction from the Department on that. We have also put in for additional home support to assist more people outside of long-term care into 2021 and we are awaiting feedback on that in the winter plan.

Acting Chairman (Deputy David Cullinane): Could the witnesses send on a detailed note to the committee in respect of that matter and the previous one? It would be great if we could be given more information than it is possibly to give verbally. I must move on. I will try my best to keep people to time because we must be out at 2.30 p.m., and I want to be fair to everybody.

Deputy Bríd Smith: I thank all the witnesses for attending. I firmly believe the key issue, if not the cause, of the policy that worsened the impact of Covid-19 in nursing homes was the decision taken in the 1990s to contract out the care of elderly people to private, for-profit nursing homes. Some of the points made by the expert panel and in other reports support that view. The fact is that we have 80% of all beds in the private sector where there are long hours of work, precarious employment and low pay, as well as a skills shortage and a push to cut costs. That is

the reason we saw the restrictions and lack of early use of PPE among other issues. That, combined with a failure of medical care and clinical governance, worsened the impact of Covid on the nursing home sector. I believe that this, as well as other issues that arose during the crisis, such as the lack of testing and other factors, laid the basis for the disaster.

I have a few questions which I want to ask together. Perhaps the witnesses will take note of the following four questions. Could they comment on the call by relatives and loved ones of those who lost their lives in the nursing home sector, as well as advocacy groups, for a full public inquiry into the deaths in nursing homes? Many of us feel that while the report from the expert panel is welcome it is not what is needed.

I seek assurances that all staff in nursing homes have access to a functioning sick pay scheme so that we do not have concerns that employees who are sick may feel compelled to continue to work if they are unwell. Could the witnesses also indicate, if they know, whether the use of agency staff is still as widespread as it was and whether agencies in general are being used widely in the nursing home sector?

My third question is an important one and is probably for Mr. Walsh. Who was it that changed the regulation referred to on page 96, in chapter 7, of the expert panel's report, which specifically meant that it was no longer a requirement for the person in charge on site in a nursing home to be a qualified registered nurse or gerontologist? What was the purpose of that change and what were the consequences when it came to the pandemic and elderly care?

Will the witnesses comment on the view expressed recently by Ms Phil Ní Sheaghdha of the INMO that we do not need an audit of the staffing ratios in the sector? We already know that the staffing problems are bad and we know how to address them. Specifically, how would it help to have a regulated and mandatory staffing ratio and skill set, as well as sector-wide pay and conditions applicable across all nursing homes and elderly care centres? There are four questions there and I am spouting them out together because otherwise I might run out of time.

Dr. Kathleen MacLellan: I will start and then hand over to my colleague, Mr. Redmond, followed by the HSE.

First, regarding those individuals who have lost loved ones in homes, all of us understand how difficult and how hard these last number of months have been. We are particularly committed to the recommendation within the expert panel report to build the advocacy services and ensure those individuals, families and residents have access to professional advocacy as we have seen has been provided through Sage Advocacy and the patient advocacy service. It is available across our acute hospitals and we are working to extend that out into the community as well.

Regarding the staffing, we are committed and the chief nurse within the Department has commenced the implementation of the safe staffing framework. Phase one of the safe staffing framework has been in acute hospitals, phase two in the emergency departments and phase three now is in older people settings. There has been significant evidence-based learning across older people settings with regard to staffing and the care needs of those older people. It is now being progressed through a draft guidance framework which is with the HSE and will be tested over the next number of weeks with a view to having that guidance on safe staffing available for the winter period. I will pass over to my colleague, Mr. Redmond, on the regulatory piece that was raised.

Acting Chairman (Deputy David Cullinane): I thank Dr. MacLellan for the response. Before that happens, however, a direct question was asked on the Department's view on whether there should be a full public independent inquiry. I am aware that Dr. MacLellan referred to other matters but it was a distinct and direct question that deserves a distinct response. Could you respond to that please?

Dr. Kathleen MacLellan: Regarding the question raised, the Department considers at the minute that HIQA is the independent statutory authority. It is on the ground in many of those nursing homes that have been significantly challenged and where relatives and residents have----

Acting Chairman (Deputy David Cullinane): We are all aware of the role of HIQA. I need to press Dr. MacLellan on that point because a fair question was asked on whether the Department supports a full independent inquiry into what happened in nursing homes during the pandemic. It is a clear question. She may not be in a position to answer it but if that is the case just say so. We are all aware of the role of HIQA. It is a direct question that deserves a direct response.

Dr. Kathleen MacLellan: What I can say has to be with regard to awaiting the various inspection reports from HIQA and progressing the patient advocacy service on supporting those individuals and those residents. HIQA has significant powers here with regard to the review and examination of the carer and its meeting of standards in its inspection reports and, indeed, should HIQA decide to do an investigation it has powers under section 9 of the health Act.

Acting Chairman (Deputy David Cullinane): Does the HSE wish to respond to those other issues? I will have to move on, unfortunately, to our next speaker.

Mr. David Walsh: Regarding agency staff usage, agencies certainly have a role in supplying staff right across the system in both acute and subacute hospitals, the HSE and the private sector. The task and the ask, however, really has been to ensure that we do not have agency staff moving from one location to another and then to another. That has been an essential plank in trying to reduce the risk of transmission.

Regarding assurance on the sick pay scheme and nursing homes, I cannot give that except on HSE operated or funded services. I cannot do so with regard to the private sector. I can confirm that I had no act or role with regard to altering the qualifications required to be a person in charge.

On Ms Ní Sheaghdha's comments on safe staffing, I know that the Irish Nurses & Midwives Organisation, INMO, co-operated fully and was a key partner in the development of safe staffing levels for the acute services. I expect it would be fully committed to developing similar models for the non-acute services.

Deputy Bríd Smith: If Mr. Walsh cannot answer my question about the change in regulations of the requirements of the professionalism of the person in charge, then who made the change and when? What Minister, what Department or who in the Department made the change? If he cannot answer it now, will he please find out the answer and give it to me? It is referred to in the expert report on page 96, chapter 7, so I am surprised Mr. Walsh does not have the answer. It is a very clear move away from having highly qualified people in charge of nursing homes and deregulating them to an extent that I believe may show that patients, and residents as a whole, got sick and suffered because of the reduction in the level of qualifications

of the persons in charge. Why was that regulation changed, by whom and when?

Mr. David Walsh: I commit to following up on that.

Acting Chairman (Deputy David Cullinane): If he can do so, I ask Mr. Walsh to provide a written response to that issue with the other issues also. The next speaker is from the Regional Group of Independents, my constituency colleague, Teachta Shanahan. I will be keeping him to his five minutes.

Deputy Matt Shanahan: I thank the Chairman. I thank our guests for attending, particularly those who have been with us a number of times. All of us welcomed the expert panel's report but it contains many recommendations and thresholds that need to be met in the future and the first question that would arise in anybody's mind is the level of sourcing that will be required. The Deputy who preceded me spoke about the difficulties relating to private sector involvement in nursing homes. I am aware of a nursing home proposition in our constituency that was refused by the banks because they said there was not enough profit in it. I am not sure that it is that profitable a business to be in. It may be for some but I doubt that it is for new entrants.

The bigger issue that all of this relates to is resourcing, either the lack of it or the drip-feeding that has gone on within the sector. All of us want to see an end to that but I will touch on a topic spoken about previously, which is community care. Significant reforms are needed in the area of community care, certainly for constituents of mine. We hear all the time of cases where people are allocated an hour but where the person who is providing the care might take 15 minutes to drive to the first client and another 15 minutes to go on to the next client. As a result, almost 30 minutes of the time is spent travelling. That is not sustainable. We have people who are hoping to get up and be showered but, essentially, what they are getting is a very quick wash from a hand basin, an egg and a bit of toast provided for them and then that person is gone out the door. If we are serious about looking after people at home, we need to reconsider the way we do that.

In terms of the multidisciplinary supports at CHO level, there are 23 teams. Can somebody explain how that process will work in the future for nursing homes that have potential cases of Covid-19 and they want to engage with the medics?

Dr. Kathleen MacLellan: I might start by dealing with the plans relating to home care. The Department's commitment - it is also a Sláintecare commitment - is the development of a statutory scheme for the home care services. There has been progress on that and further progress will be made towards the end of this year and into next year. We have looked at international models. We have been working with the ESRI in terms of examining demand. We have also been examining - my colleague mentioned it earlier - the standard assessment tool, which is critically important. It is about the importance of examining the type of care, and the Deputy raised that, in terms of whether somebody needs hours in respect of physiotherapy, the activities of daily living support or their shopping and how we can get the best and most tailored support in place. We have significant plans for the roll-out of a standard assessment tool and the utilisation of that tool to decide the type and volume of care that will be utilised. The roll-out of that will commence as we move towards the end of this year.

There is a significant commitment to look at the type and form of home care being provided. As the Deputy heard earlier, we have invested significantly to bring down the waiting lists and we are hopeful that we will be able to invest significantly over the winter and going into 2020 to introduce what will be a broader and more comprehensive home support system through a

home first approach. My colleagues in the HSE might want to give some more information on that.

Ms Sandra Tuohy: I thank Dr. MacLellan. To pick up on the crisis response teams, CRTs, in the context of nursing homes, the Deputy asked what will happen in future should there be a confirmed outbreak in a nursing home. I can confirm that the CRTs for our nursing homes comprise nurses, public health experts, PPE leads, infection prevention control experts, etc. It is important to note the resilience investment we have put into private nursing homes through the temporary assistance payment scheme to ensure they are readily prepared should there be a new or further outbreak of Covid-19 in a facility. The role of the crisis response team is to support the resilience of the private nursing home sector where it can in providing the expertise which those facilities may be unable to resource themselves. That will continue as per the expert panel report and those teams will remain in place for as long as we need to have them in place.

Deputy Matt Shanahan: I referred in the earlier session to the question of ensuring there are adequate isolation facilities in place in nursing homes. Under the new regulations, nursing homes are required to maintain an isolation space in readiness for a Covid outbreak. I understand that the supports the Department were offering in this regard were based on capitation grants for public rather than private patients and possibly applied to private nursing homes only. Will the witnesses comment on that protocol?

My second question relates to the temporary financial supports that have been given. The witnesses signalled that there will be an extension of those supports. Can they indicate how far into the future that provision will extend?

Mr. Niall Redmond: I will take those two questions concerning the financial support scheme. Dealing with the second one first, the Government's resilience roadmap that was published yesterday outlines an extension to the scheme of nine months, from 1 October to June 2021 approximately. That commitment to an extension of the scheme is covered in the document.

On the Deputy's first point, it is true that at the commencement of the scheme on 1 April, the capitation rates related to nursing home support scheme residents. However, that was changed shortly afterwards such that all residents of a nursing home are included in the framework for calculation of the rates payable.

Deputy Danny Healy-Rae: I thank the witnesses for coming in to answer our questions. For us, as Deputies, to be relevant, we must fight for and ask questions on behalf of the people who cannot fight and ask questions for themselves. I am talking about vulnerable elderly people. First of all, I regret that many such people died on their own without being allowed visits from family members and friends. If their families could not understand why they could not go in to see their loved ones, the elderly men and women who died on their own certainly did not understand why such visits were not permitted. I am still not happy with the number of visits that are allowed for the families of people in district and general hospitals and nursing homes. The severe restrictions that remain in place are not fair on the elderly people who gave so much to their country, their communities and their families. We need to facilitate visits for those people, whether by testing the people going in to see them or by some other means. We must do more for those elderly people who need company and who often have certain things they will talk about only with family members and not with staff or any other persons. I am asking that more be done to allow more visits for those people.

Most nursing homes and hospitals - probably 99% of them - are well run and people are well looked after in them, but we have seen what happened to that poor man up the country. One such case was too much and we do not want any more. I have been requested to ask in this committee about who oversees the nutritional and protein value of the food that is being given to patients. We know that HIQA is responsible for cleanliness, safety and many other issues, but who is responsible for the quality of the food? I thank all of the wonderful home helps, as we call them in Kerry, for the wonderful work they do for people who want to stay in their homes for as long as possible. We do not have funding to employ enough home helps to give adequate time to the elderly people who want to remain in their homes for as long as possible.

Acting Chairman (Deputy David Cullinane): The Deputy should allow adequate time for witnesses to reply.

Deputy Danny Healy-Rae: I ask them to reply.

Dr. Kathleen MacLellan: I will respond first and one of my colleagues will answer on the business piece.

We have addressed some of the issues on home care on which we committed to providing additional information. There has been significant investment in this area. We are looking very closely at the establishment of a statutory home care scheme and building the capacity of the HSE for commissioning home care.

There is a standard in place for nutrition and hydration needs, namely, standard 2.2 of the HIQA standards. It is one of the standards that HIQA inspects against when its staff visit a home. Staff go through a number of elements in that standard, which I will not describe in detail in the interest of time. The standard includes residents being offered daily menus, catering, access to adequate quantities of food and the appropriate types of food. There is a particular standard in place because the importance of nutrition is recognised.

Everybody recognises how hard the visiting restrictions have been. These restrictions have been used internationally as a protective measure for residents. We have worked very hard to see how we can build and enhance the visiting in place. When we published ethical guidance through NPHET, it was around promoting proportionate visiting that strikes a balance between the protective measures and allowing for the health and well-being of residents. Dr. Kennelly will comment further.

Dr. Siobhán Kennelly: From our point of view, as clinicians, this is a critical issue. We recognise that there is significant morbidity and a significant impact arising from the visiting restrictions that have taken place, both at the height of the pandemic and as we start to open up. Clearly, it is about striking a balance, particularly in Dublin and elsewhere where there have been very high rates of community transmission, as alluded to previously. It is about how we continue to maintain the welfare of residents while allowing them to have visits on an ongoing basis. Significant work is being done by me and my colleagues in public health and in infection, prevention and control to achieve that balance in accordance with the Government action plan and its five levels and how the plan might translate over time. That is a critical factor. We hope that, even in circumstances were we will potentially have significant outbreaks, we will continue to have visiting at all times. It depends on the issues that arise for the nursing homes on different occasions.

Acting Chairman (Deputy David Cullinane): I ask Ms Tuohy to respond to the home

help issue if she is in a position to do so, after which we must move on to the next speaker.

Deputy Danny Healy-Rae: I ask that action on visits to nursing homes be expedited as much as possible because elderly people do not have time on their side.

Acting Chairman (Deputy David Cullinane): We all accept that.

Dr. Siobhán Kennelly: We are very conscious of that. It is important to flag that much of the guidance on this was updated on the HPSC website in June. There has been an awful lot more flexibility around visits. It is important in our discussions with advocacy bodies, families and others that they are aware of the guidance, engage with nursing homes and advocate for visiting. Nursing homes are understandably cautious about visitations as they are permitted, particularly in different sectors. It is very important that people are aware of the guidance as it is updated, so that they can advocate and continue to see their loved ones.

Acting Chairman (Deputy David Cullinane): Ms Tuohy must be very quick as I need to move on to the other speakers.

Ms Sandra Tuohy: With regard to home support and home help, people receive home support on the basis of their needs. That will continue. As I stated, we will continue to try to reduce the number awaiting home support or increased support hours as resources allow. As mentioned by the Department representatives, we are moving to the interRAI assessment tool, which will help us to understand comprehensively a person's needs so the correct number of hours can be allocated to address them.

Acting Chairman (Deputy David Cullinane): We are now to have the three speakers from the three main parties. Sinn Féin is next, followed by Fine Gael and Fianna Fáil. The Chair of the committee wants to contribute also. We have 30 minutes remaining, after which we must conclude, unfortunately. I ask the speakers to spare a minute or two, if they can. I will have to be ruthless about time to allow the Chair to contribute. The next speaker is Teachta Louise O'Reilly from Sinn Féin.

Deputy Louise O'Reilly: I thank the Acting Chairman and the witnesses. My first question is for Mr. Walsh. If he cannot say who changed the criteria concerning a person in charge in a nursing home, could he offer a view as to the grade of the individual in question? Would they be in the Department or the HSE? The question deserves an answer. I understand Mr. Walsh does not have the answer today but he might have a view on the grade, group or category of the worker responsible for making the decision.

Mr. David Walsh: I just do not know. I would see it as a function of regulation. I do not know. I will have to follow up on it and revert to the Deputy. I have committed to doing so.

Deputy Louise O'Reilly: I thank Mr. Walsh. We would be very grateful if we received that correspondence.

I have some questions for Dr. MacLellan on March. I asked a number of questions of Mr. Breslin, the then Secretary General, on the transfer, and I also questioned Dr. Colm Henry at the time. We know there were 800 applications to transfer persons from hospitals to nursing homes. I have a series of questions and might ask them all at once. That might be handier. How many of the 800 patients were transferred? Of the 800, how many were tested once and how many were tested twice? Were they tested as a matter of routine, as per the regulations on 10 March, or were they tested only as per the case definition at the time, based on their being

symptomatic? If a person was asymptomatic, would he or she have been tested in the first instance, much less tested twice, prior to transfer? I fully respect and appreciate the need to make space in our hospitals because of the mismanagement by successive Governments, chronic overcrowding and all that. My question is specifically on the 800 people in March.

Dr. Kathleen MacLellan: From 12 March, there was guidance on the testing of those who were being discharged to nursing homes. The guidance on the testing was in line with the case definition available in March. At that time, knowledge and information were simply not available suggesting that there was so much asymptomatic transmission and that the presentation of Covid-19 was atypical within older people and not in line with the traditional signs that were being examined.

With regard to the numbers being transferred out, there is a section in the expert panel report that points out that the hospital inpatient inquiry system, HIPE, data have captured those who would have had a Covid diagnosis in hospital at some stage. It is not necessarily related to whether they were discharged with Covid or admitted with it. With regard to those who were discharged from hospitals to nursing homes, four hundred would have been Covid positive and 11 would have been Covid probable. Our understanding, which would have been confirmed, is that the guidance of 12 March would have been adhered to but the clinical decisions on discharges are obviously made at local level by the clinical doctors. I am not sure whether Dr. Kennelly wants to follow up on that.

Deputy Louise O'Reilly: The decisions were made at local level but the guidance and case definition that applied at the time would obviously have excluded any person who was asymptomatic. I am referring, however, to the guidance that stated there should be two tests indicating "not detected" before a person is transferred out. Were the tests going to be carried out only on those who fitted the criteria at the time? I understand the knowledge is evolving but it was not a matter of routine in March to test twice; it was actually a matter of testing twice in line with the case criteria. Is it correct that this would not have applied to anyone at that stage who was asymptomatic?

Dr. Siobhán Kennelly: The Deputy is correct. As we are well aware, the knowledge around asymptomatic transmission was not there. It was around 25 March that the European Centre for Disease Prevention and Control, ECDC, first highlighted the possibility of asymptomatic transmission. It was well into April before that was actually confirmed as a real route of transmission. Most of our guidance at the time was not based on knowledge or understanding of that particular aspect. As it became more understood, the focus on testing was re-emphasised.

However, our guidance did change, particularly around mid-March and emphasised the need for the isolation of patients for a 14-day period after they transferred out. The key around what came through in the ministerial expert report is that we do not know in terms of the people who did transfer out with Covid at which point in time in their hospital journey they had Covid. We do not know whether it was pre-existing coming into hospital or picked up subsequently in a nursing home because our systems do not allow for information to be communicated in that way.

It was clear to us in the context of testing and the nursing home outbreaks. This is why 14-day isolation is mandated. It is a difficult issue for many residents when they are being transferred because it is quite an onerous piece. It is important to emphasise that we do not over-rely on testing as part of the transfer function for these patients.

Deputy Louise O'Reilly: With regard to safe models of staffing, the trauma that staff working in nursing homes and right across the board experienced is accepted and acknowledged by the witnesses, some of whom I know are clinicians with a significant amount of experience. The level of deaths in the nursing home sector was significant. These are private sector workers, not public sector workers. Is there a proposal from the Department or the HSE to offer these people some kind of meaningful support as they head back into another winter?

Mr. Walsh alluded to the safe staffing model which has been agreed by the INMO. There is a recommendation that there be a review of the terms of conditions. This is to be carried out by the Department of Enterprise, Trade and Employment. I will not hold my breath on that. In the short term, would the model agreed with the INMO be easily adaptable in terms of safe staffing? Would a whole new model need to be agreed? If so, how long would that take?

Dr. Kathleen MacLellan: On the safe staffing model, the Department has already commenced phase 3. Phase 1 was in the acute hospitals. Phase 2 was in the emergency departments. Phase 3 is in the older person settings. The chief nurse working with the HSE has designed a guidance framework to be tested in several nursing homes within the next short while. It is evidence-based and will be based on the experience of the safe staffing within the hospitals and the emergency departments which obviously cater for an older cohort. It will be based on needs. It has commenced and it is with the view that there will be guidance available as we head into winter.

Deputy Louise O'Reilly: Is it envisaged that this will be put on a statutory footing? Guidance is fine and we would all hope that everyone would adhere to it. Guidance will be adhered to, obviously, in the public system. Given the wholesale privatisation of our nursing home sector - 80% of people will be in nursing homes in the private sector - without statutory underpinning of this guidance, does Dr. MacLellan think that this has a reasonable chance of being implemented? Would it be preferable to be belt, braces and baler twine about it and put it on a statutory footing?

Dr. Kathleen MacLellan: Part of the work we are doing in looking at HIQA regulations is how we can encompass the safe staffing framework within them. HIQA inspections are how nursing homes retain their registration. This could be an area inspected by HIQA. HIQA reports, as they are, comment on staffing and staff availability. We would like to see the safe staffing model. We will work to see how that could become part of the regulatory framework for nursing homes. We will look to see if that would be feasible as that would give an extra strength in the regulation of those nursing homes.

Acting Chairman (Deputy David Cullinane): I thank Dr. MacLellan and the Teachta. Our next speaker is Teachta Durkan. Given he is a stand-in chair in the Dáil and is ruthless in keeping people to their time, I am sure that he will have no problem in me holding him to the same standard today by keeping to his five minutes.

Deputy Bernard J. Durkan: I will try to curtail my intrusion as much as possible. Arising from the discussions this morning and the questions to the expert panel, are the witnesses satisfied that adequate resources and information is available to public and private nursing homes, hospitals and the system in general, to deal adequately and early with an ongoing or upcoming surge?

Dr. Kathleen MacLellan: I will commence and then pass over to Mr. David Walsh. The expert panel has been very helpful in this by identifying clearly within the recommendations

that we must continue the current supports that are in place. Those supports will be continued and the commitment is given to that. There has been a commitment on the availability of PPE, which is essential in protecting nursing home residents.

One issue we have not touched on so far is that serial testing within nursing homes has been operating as an early warning to us regarding Covid-19 entering nursing homes and giving us assurance that it is not within our nursing homes. The third round of this serial testing is commencing. It will continue for two weeks over the next month within those nursing homes. The frequency of that, whether it is to be increased or decreased, will be reviewed by NPHET. The resources and the continuation of those tests are in place.

We have also provided additional resources to the HSE to support infection prevention and control and these are already there, as well as towards the recruitment of 18 clinical nurse specialists in infection prevention and control across our community. We have just given sanction to HIQA to recruit nine additional inspectors so that there will be more inspectors available on the ground.

As we look at all of these recommendations, we will cost them to see if additional resources are needed. However, we are looking at the immediate and urgent ones to ensure those recommendations that need to be implemented or the resources that need to be in place are in place. I will pass over to Mr. Walsh now to see if he wishes to add anything to this.

Mr. David Walsh: I thank the Deputy. There is an absolute requirement to press on with the development and enhancement of our integrated care programme for older persons, which will bring more clinical expertise into the field to support people both at home and in long-term care. When those teams were available earlier in the year, they made a very positive contribution.

Dr. MacLennan mentioned the infection prevention and control plans, which have now been funded. The question then becomes whether people are out there who are qualified to take up those posts. We are currently trying to recruit those people but we need to, step by step, increase the level of that clinical expertise in infection prevention and control across the community, with very clear links back to the acute teams.

It is critical that we continue to develop home support, which a number of the committee member colleagues have mentioned, and to develop the structures around it in the way that we assess people and how we provide and manage that service.

Community health networks will be critical supports to general practice. General practice is the bedrock of health care in the community. We need to press on with our plans to develop these networks, which will lead to better availability of key skills in the community such as occupational therapy, physiotherapy and all the other therapies that will help keep people at home.

Acting Chairman (Deputy David Cullinane): I thank Mr. Walsh but I will have to stop him there as I need Teachta Durkan to come in with his final question.

Deputy Bernard J. Durkan: I understand that a rapid testing system with rapid results is operating in some countries. By "rapid", I mean results being provided within a few hours. How effective and reliable is this system? Can it be used at airports as we move into the new phase of living with the virus? How effective could a rapid testing system that produces results within one or two hours be if used in those circumstances?

Mr. David Walsh: I am completely unqualified to answer. The common test in use takes

some time to analyse. I understand there are other options but I will defer to expert clinical advice as to their efficacy or appropriateness in any given setting. It might be better to get an expert response for the Deputy regarding that question.

Deputy Bernard J. Durkan: I would be happy with a written reply.

Acting Chairman (Deputy David Cullinane): If there is an expert in this area in the HSE or the Department, I ask that a written reply be provided to Deputy Durkan regarding international comparisons on rapid testing systems applicable to airports and other settings.

Deputy Bernard J. Durkan: I thank the Acting Chairman.

Acting Chairman (Deputy David Cullinane): Deputy McAuliffe has ten minutes but he might give some latitude to his colleague.

Deputy Paul McAuliffe: Deputy O'Dowd would like to contribute first.

Acting Chairman (Deputy David Cullinane): That is fine.

Deputy Fergus O'Dowd: I direct my first question to Mr. Walsh. What progress has been made on the fair deal scheme for home care?

Mr. David Walsh: I will pass that question to a representative of the Department of Health. Perhaps Mr. Redmond could answer.

Mr. Niall Redmond: One area of work we are looking at is a statutory home care scheme and its roll-out. I refer to regulation, a finance model and service configuration in the basket of services. Work is, therefore, ongoing on that scheme. We had hoped to be able to test some elements of it on a pilot basis this year, but that became challenging due to the impact of Covid-19 and we were unable to do it. We are, however, examining and planning the reinstatement of that testing programme, which will be evaluated as we go to inform the overarching development of the scheme. We are hoping to do that in 2021.

Several elements will be involved. We will be looking at the regulatory framework required, because the home support system and home care services are not currently regulated. Consequently, we will be examining putting regulation in place. We will also be looking at financial models and the type of modelling required, as well as future funding and service capacity requirements. Equally, we are exploring the type of service to be delivered on the ground and how that will be delivered. We are undertaking a fundamental examination of the home support service and what it needs to look like in future. There will be a greater focus on providing far more care at home and, in that context, we are looking at some new models. Those include the enablement model, and work is ongoing with the Health Research Board on an international evidence review. There is also some general work being done on needs assessment and care planning in the community.

Deputy Fergus O'Dowd: How many people are working in that section? This issue has been ongoing for several years.

Mr. Niall Redmond: Between three and five people are working on this scheme in the Department, and then we have several experts working with us in the HSE, as well as in HIQA, to look at standards. As I mentioned, the Health Research Board is also doing some work. There is multi-agency and interagency collaboration, and several stakeholder groups are also involved. The core team consists of between three and five people, with several other people

also plugging into that group.

Acting Chairman (Deputy David Cullinane): I ask Mr. Redmond to listen to what I am trying to say or to Teachta O'Dowd, who is trying to come in. I know the sound is fading at times. That might be because Mr. Redmond is on-----

Deputy Fergus O'Dowd: The question has been answered. Only a small number of people in the Department - between three and five - are working on this issue. The number of people working on this scheme should be increased. The scheme should have been finished, proofed and ready to roll at this stage. A huge change is necessary regarding the care of older people. Enabling people with high dependency needs to live at home is the key to the future well-being of older people. My challenge to Mr. Redmond and the Department, therefore, is to increase the number working on this scheme and not to stop the work on it. I appreciate it has experienced a lot of pressures but I do not think the Department is putting enough care and attention into it. Have I much time left?

Acting Chairman (Deputy David Cullinane): Just one minute, unfortunately.

Deputy Fergus O'Dowd: Very well. I ask for a written reply in respect of recommendation 15.3 in the report, which states "The Department of Health should explore a suitable structure and process for external oversight of individual care concerns arising in nursing homes, once internal processes have been exhausted without satisfaction." What is the progress to date on that and what is the timeline for that change? Waiting 12 to 18 months is far too long. I thank the Chair.

Acting Chairman (Deputy David Cullinane): I thank the Deputy. I ask the witnesses to answer that very quickly.

Deputy Fergus O'Dowd: I thank my Fianna Fáil colleague for letting me in.

Mr. Niall Redmond: Work needs to commence on that as part of the package of recommendations that the expert panel have made. It is one of those areas that will most likely require a legislative footing and that is reflected in the expert panel's own suggested timeline for that, which takes into account some of the complexities involved.

As was mentioned earlier on, we have commenced work looking at the regulatory framework with HIQA and at how we can improve that. That part of the work has commenced already but there are other commitments in the programme for Government, such as looking at the role of the ombudsman. There are a number of avenues which the State is exploring in relation to that recommendation.

Acting Chairman (Deputy David Cullinane): Perhaps Mr. Redmond will provide us with a written response on that, as well. That would be helpful. The next speaker is Teachta McAuliffe. He will take seven minutes to leave some time for our Cathaoirleach.

Deputy Paul McAuliffe: I am happy to yield three to the Chair.

There is a huge array of recommendations here and I will focus on those on visiting nursing homes. The first recommendation in that section refers to balancing personal freedoms and public health measures. However, in the plan published yesterday, it seems clear that at a particular point in the scale, there will be suspension of nursing home visits. In the second recommendation in that section, there is reference to additional facilities. Has consideration been

given to how we would do that? How, for example, would a large number of private operators be supported in doing that? We do not want to waste much-needed public resources. How can we ensure we continue to have visits to nursing homes in what might be an extended level 3 period in Dublin or any other county?

Dr. Kathleen MacLellan: In relation to visiting, everybody is understanding of and concerned about the effect of the visiting restrictions in nursing homes. However, they are a protective measure. We have ethical guidance on this issue through NPHET and what has happened to date is an attempt to promote and design a visiting framework that will be proportionate in protecting residents while supporting visiting in order that visits can continue appropriately. It is also important to say that the guidance has at no stage said there should be no visiting in relation to critical or end of life. We need to support our nursing homes in this and much of that is dependent on local risk assessments in relation to those nursing homes. In line with those local risk assessments, those nursing homes need to work to find processes and facilities that allow them to support visiting at those critical stages in life. Dr. Kennelly articulated earlier the ongoing work within the HSE around looking at a new framework for visiting and enhancing and expanding the visiting processes that are there. The guidance has been updated as we go along in line with public health guidance and there have been significant additions to the ability of nursing homes to provide and support visits from relatives. We are all conscious of the impact of where those people in our nursing homes can see their friends and family.

Deputy Paul McAuliffe: To be more specific, the report talks about additional facilities and such facilities would need to be funded. What model and level of funding would be applied?

Dr. Kathleen MacLellan: That is one of the recommendations currently being examined in respect of the implementation oversight group. We will look at how that can be funded, what type of funding should be available and what funding may already be available through various means. There is a temporary finance assistance scheme in place, which will be extended. There will be opportunities to look at what supports can be provided to nursing homes should they need them and to put additional processes in place to facilitate this.

Deputy Paul McAuliffe: It would be incredibly important. I know from my own family and from many other families that visiting other people with PPE and protective gear makes the visit almost more traumatic than the absence of a visit. We need to make sure that whatever facilities there are ease some of these concerns or make PPE less necessary by having physical barriers. We want to make sure any facility put in place can be turned around to be a non-Covid facility afterwards. This is crucial.

We have spoken about end of life. We saw harrowing scenes during the very early days of the pandemic with people saying goodbye through a glass window. What arrangements can be put in place in the short term for people who are in a situation where a relative is due to pass away and they have a short period of time to say goodbye?

Dr. Siobhán Kennelly: What is useful about this stage of learning about the pandemic is that there is very little evidence that visitors introduce Covid infection to nursing homes. We have a bit of confidence on this with regard to our understanding that much more of the risk is through staff transmission. This was certainly one of the things we learned from phase 1. The early lockdown with regard to visiting means we have not necessarily tested this but international experience is that visitors, once the appropriate precautions are applied, probably constitute less of a risk than was the concern at the start of the pandemic. My clinical colleagues who are engaged in this and I will use that as an important reference point.

With regard to end-of-life care, there are very specific criteria on end-of-life visiting and how it can be facilitated. Much of this is predicated on the nursing home itself. PPE, particularly if there is an outbreak in the nursing home, is an obvious requirement in protecting people who are visiting. What we have seen from the private and public nursing home sectors is that there has been a lot of learning in this respect. There has been a lot of flexibility applied as-----

Deputy Paul McAuliffe: I am surprised that visitors are not necessarily a source of infection but as part of the Government's plan published yesterday, it is very clear that under level 3, visits, aside from critical or compassionate circumstances, would be suspended. My worry is that if we were to be in level 3 for a long time it would have a significant impact on people in nursing homes. I have run out of time and I will ask for a written response on this.

Deputy Michael McNamara: Dr. MacLellan and Mr. Walsh were both members of NPHET. Are they still members of NPHET?

Dr. Kathleen MacLellan: Yes.

Mr. David Walsh: I am not.

Deputy Michael McNamara: Who instructed the acute hospitals to discharge patients to create capacity for the anticipated surge?

Dr. Kathleen MacLellan: The discussions in NPHET were on preparedness and what the expectations would be. With regard to the question, perhaps the HSE could add something on it. There was certainly no directive given that all hospitals would be emptied into nursing homes. There was a considered approach whereby for older people in our hospitals who were ready for discharge, could be safely discharged and would be more appropriately managed in a nursing home setting that this would happen in as safe as possible a way.

Dr. Siobhán Kennelly: I want to bring us back to where we were in February and March and what we were seeing in acute hospitals in Italy, Spain and elsewhere. Key considerations in some of the decision-making that happened in this regard were the risk issues pertaining to older people in acute hospitals who themselves might have become victims of Covid introduction to those hospitals. Two facets of these hospital discharges were very much being balanced at the time. These were the risk to older people who would be inappropriately in hospital and exposed to risk of infection and the need for them to be cared for in a more appropriate place. Lessons learned about asymptomatic transmission, testing protocols and isolation protocols have all been introduced since on this basis. Clearly, there has not been a substantive link made between those transfers and evidence of wholesale transmission into nursing homes of Covid-19. It seems that local community transmission of Covid-19 and staff transmission rates probably played a more important role in terms of how infection was introduced.

Deputy Michael McNamara: Who gave the direction that people were not to be transferred from community hospitals and nursing homes to acute hospitals?

Dr. Siobhán Kennelly: There was never any such direction given. There was very clear guidance, given that all decisions about transfer were to be clinically based using appropriate clinical judgment. There was never any directive around people not being transferred from private nursing homes or community hospitals.

Deputy Michael McNamara: Will all guidance, directions and communications at that time between the Department of Health and hospitals be provided to the committee? I refer to

correspondence on discharging patients, creating capacity and what was appropriate in terms of transferring patients or seeking to have them admitted to acute hospitals.

Dr. Siobhán Kennelly: It has been provided. It is all a matter of public record and was published on the HPSC or HSE websites. We would be happy to provide the information again.

Deputy Michael McNamara: There is nothing further to be provided other than what has already been provided.

Mr. David Walsh: If it is helpful, we will put it into one pack and send it to the committee so it can see it in its totality.

Deputy Michael McNamara: I do not wish to overburden the witnesses. It might be helpful to ensure that nothing has fallen between the cracks.

The committee published an interim report. One of the key recommendations it contained related to care facilities that repeatedly fail in the context of HIQA recommendations - as opposed to being substantially compliant with them - and the fact that the practice of the HSE paying for and sending new patients to these facilities under the fair deal scheme should cease. Do the HSE or Department of Health have any view on that recommendation and its implementation?

Dr. Kathleen MacLellan: We would strongly respect the power and role of HIQA in regard to its inspection reports. HIQA has significant powers. If it has significant concerns about any of its regulations it can impose conditions on those nursing homes up to and including closing down a nursing home. It already has significant powers it can use should it have concerns about any of the standards it is regulating or assessing.

Deputy Michael McNamara: What about cases where it has deemed a facility to have failed an inspection and the HSE continues to send new residents to stay at that facility and pay for their care there? HIQA has not taken the step of closing them down because we know that is legally difficult and burdensome in terms of judicial reviews, etc. The HSE is sending patients into and paying for facilities which have repeatedly failed HIQA inspections. Is there any indication that the Department of Health will adopt a policy of ceasing to do that or will the HSE somehow deem it inappropriate that taxpayers' money be used to pay for patients in facilities which are failing inspections?

Mr. Niall Redmond: The regulatory framework in terms of the registration of nursing homes delivered by HIQA will determine whether a nursing home meets the registration criteria. If HIQA has concerns in respect of nursing homes on an ongoing basis, it has those powers. Obviously, there are natural justice processes in place.

Deputy Michael McNamara: We know that. Do not tell us what we know.

Mr. Niall Redmond: In terms of the fair deal, in many respects the fair deal scheme is the epitome of the money following the patient. The prospective resident of a nursing home makes the decision as to what nursing home to live in or transfer to. It is not the case that the HSE or Department makes a decision; rather it is the decision of the individual or family as to what nursing home a person may attend. I again stress that for any family considering what is a very significant life decision in terms of putting someone into nursing home care, all of the HIQA inspection reports are available online and they should pay close attention to them in terms of making those decisions.

Deputy Michael McNamara: I think we got the crux of it. The money follows the patient rather than the other way around. The Acting Chairman has indicated that we need to finish.

Acting Chairman (Deputy David Cullinane): I thank all of the witnesses for their attendance and the information provided to the committee, which will feed into the its final report. The report will be presented to the Dáil at the end of September or in early October. I also request that all follow up information in written form that has been requested be sent to the committee within ten working days. On Friday, 18 September we will examine the impact of Covid-19 on sport. Throw-in for that will be 10.30 a.m.

The special committee adjourned at 2.35 p.m. until Friday, 18 September 2020 at 10.30 a.m.