Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 Disease Response: Public Health Agency and Department of Health

15 October 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Mr Alex Easton
Ms Órlaithí Flynn
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:

Mr Dan West	Department of Health
Dr Bríd Farrell	Public Health Agency
Ms Olive MacLeod	Public Health Agency
Dr Joanne McClean	Public Health Agency
Professor Hugo van Woerden	Public Health Agency
Dr Gerry Waldron	Public Health Agency

The Chairperson (Mr Gildernew): I welcome, via video link, from the PHA, Ms Olive MacLeod, interim chief executive; Dr Joanne McClean, public health consultant; Professor Hugo van Woerden, director of public health; Dr Gerry Waldron, head of health protection; from the Department of Health, Mr Dan West, chief digital information officer; and Dr Brid Farrell, assistant director of service development at the PHA. I ask the officials to keep their briefings as succinct as possible, because we are keen to get to members' questions. Thank you. Go ahead with your briefing, please.

Ms Olive MacLeod (Public Health Agency): Good morning, and thank you for the opportunity once again to brief the Committee. We are pleased to update you and have submitted a brief to you. The team and I are here to answer your questions, and we are happy to use the time as constructively as possible to allow you to do so. I will pause there.

The Chairperson (Mr Gildernew): Thank you. We are all acutely aware of where we are today: we have been forced into adopting additional restrictive measures to get control of the virus. We are asking people to do an awful lot and to abide by quite restrictive measures and all the regulations and to change their behaviours in order to assist us. However, each and every one of us, in this Building and you in your work, also has a responsibility for what is being delivered from a public health perspective.

On the tracing operation that you are involved in, I am aware of dozens of cases, and I am aware that all reps across a wide area are picking up on difficulties with testing, delays in getting test results back and clear examples of where no contact tracing is taking place. Moreover, there is very little information about the areas in which there is transmission. Other than headline figures for community transmission, there is very little detail.

My first question is about contact tracing. It is clear that the countries that are doing this better are testing and tracing much more rigorously. They are also testing asymptomatic people and tracing the contacts of positive cases. Can you tell us what the plans are for asymptomatic testing? Why are we not carrying out asymptomatic testing and tracing the contacts of people who test positive to try to get ahead of the virus?

Ms MacLeod: OK. I will hand over to Dr Gerry Waldron.

Dr Gerry Waldron (Public Health Agency): Good morning, Chair. As you correctly say, the testing is, by and large, of symptomatic cases, and the test that we have works best when symptoms are present. It is not a good test for population testing in general, because there can be quite a lot of false positives when we test asymptomatic individuals. There may come a time, given where we are going, when asymptomatic testing will be done, but that is a policy decision that needs to be taken at another level. We recommend —.

The Chairperson (Mr Gildernew): Sorry, Dr Waldron. I understand your point about community testing. I take it that that is a capacity issue. However, let us set that aside for a second. We are aware of the great difficulties in testing key front-line healthcare workers, whom we so desperately need at this time. Should we be providing asymptomatic testing of those workers? I asked the Minister about this in the Chamber on 6 October, and he advised that:

> *"One of our strengthening tools is our testing of care homes".*

The Committee had urged that should be testing.

> *"— not just residents but staff. The Chair will be aware that yesterday's figures showed that we have 28 care homes with positive, supported patients. Of those 28, 24 were identified through our testing programme, which picked up residents or staff who may have been asymptomatic."*

Does that not indicate that we need to test key staff who may be asymptomatic once we have established that there has been a contact?

Dr Waldron: What you have identified is the programme — quite a successful programme — for care homes, where there is regular testing. It was a policy decision that that took place. It is important, in the context of care homes, that the primary purpose of asymptomatic testing is the protection of vulnerable individuals in the care homes. That is why it is a priority. It may be necessary to bring that in in future for other groups. However, when talking about asymptomatic testing, it is important not to get it conflated with what a negative test actually means.

If an asymptomatic individual who is a contact of someone who has tested positive — it does not matter whether that is in a hospital or in any other setting — subsequently tests positive, that does not make any difference to the length of isolation that they need to undergo. That is an important consideration for healthcare services as well. Introducing testing for asymptomatic contacts in the health service, or anywhere else, will not release individuals for further work.

The important thing is to keep taking the appropriate precautions such as social distancing, hand washing, et cetera. However, social distancing is particularly important because if an individual tests positive, the number of contacts will be minimal. There are, and will be, other situations outside care homes where we will recommend asymptomatic testing, and that will be in the context of outbreaks.

For example, if we discover a workplace where there are a lot of positive cases, and we cannot track them back to specific incidents or clusters, we may recommend selective testing of all asymptomatic individuals in that workplace. That will allow for the identification of the asymptomatic positives and their contacts in that workplace, and they can be excluded from the workplace. That is our current situation. The situation may change, and, as we know, the COVID-19 context is changing all the time, and we have to respond to that. However, that is the current testing situation for asymptomatic individuals.

The Chairperson (Mr Gildernew): The Committee understands that things change all the time. However, in June, it was very clear that we were facing into a difficult winter, we were aware that schools would reopen in September, that there was going to be a second wave of coronavirus, that winter pressures existed in the system, and that the flu season would be on us. A blind man on a galloping horse could have seen that we would need significant testing-and-tracing capacity. Is it the case that not enough was done over the summer to prepare for those problems and that the test-and-trace system has struggled to keep pace with demand?

Dr Waldron: Chair, you mentioned three things, and you are absolutely correct about schools and winter pressures. Believe me, we were very much aware that that was happening. It was by no means inevitable that we would get a second wave. When restrictions started to reduce, we were very conscious of the risks once people came out of lockdown and went back into the community, as they had to do. It was absolutely right to start reducing the restrictions. However, we warned all along of the dangers of complacency. The risk was that people would not maintain important precautions, particularly social distancing, but also hand hygiene and mask wearing. It was particularly important that people, if they had been advised that they had tested positive or were contacts of confirmed cases, should self-isolate. We put that information out, and messaging went out time and time again while there was a low number of cases. We did have time for respite in that, and, during that time, we prepared. We introduced a contact-tracing service long before other areas. We were coping very well with that — even better than that — and were identifying clusters. We were putting measures in place and moving very well.

We did not anticipate that, by October, we would have the unprecedented numbers of positive cases that we have. Nevertheless, despite all that, we have been working extremely hard to deal with what is coming. We have been innovating and have introduced digital processes, and we will be very happy to cover that if the Committee needs further information on it. That is a sign of how we are responding to the unprecedented and extraordinary circumstances that we face, and we will continue to do that.

The Chairperson (Mr Gildernew): Sorry, Dr Waldron. You said that you did not anticipate how many positive cases there would be, and the fact that we are returning 18% to 20% positives shows that our testing system has not scaled up. By this point, how many positives did you anticipate and prepare for?

Ms MacLeod: The modelling suggested that we would be dealing with 300 cases at the end of September, and we had a more than adequate staff to deal with that. However, you will know that, on 2 October, it jumped by 300% to almost 900 cases, and we have been able to flex up to deal with that demand. It has been very challenging. We recruited over the summer, and we continue to recruit. Many people have come out of retirement to help us, and we have a total of 151 staff, with 25 in training; we have doubled the capacity in County Hall in Ballymena; and our teams are working remotely now. As Dr Waldron said, we have innovated, and we are using technology to reach people to ensure that they understand their responsibilities. We are using our communications to effectively support people to make the right decisions. We will continue to flex up and respond to the demand in relation to contact tracing, but it is a tribute to our staff how well they have worked. We run our service over seven days, 12 hours a day, and we reached almost 900 people yesterday in relation to positive cases.

The Chairperson (Mr Gildernew): No one is questioning the contribution and dedication of the staff, Olive. We are questioning whether there are enough of them and whether they are well enough resourced. You said that you anticipated 300 cases but that the figure increased by 300%. How much of that 300% increase was based on the failure of the test-and-trace system to keep abreast of demand?

Professor Hugo van Woerden (Public Health Agency): I am grateful for the opportunity to present on this, and I recognise the importance of the focus on test and trace. I can reassure the Committee that I believe that we have a high-quality test-and-trace system in Northern Ireland. We were the first in the UK to have one off the block, we were the first to have a proximity app, and, by and large, we have managed to keep up with demand as it has progressed. The evidence is that the test-and-trace service would reduce the R number by 5% to 15% in general, and I believe that we are having that degree of impact on the R factor.

The key is that large sectors of society, understandably, eased up too much when we came out of lockdown. There has been very effective messaging, but it is understandable that people felt frustrated and have not really been sticking to the simple rules that have been recommended and that the

Committee is very familiar with. The test-and-trace service is an important part of the infrastructure, but it is contributing the proportion that it should.

Very briefly, what happens is that everybody who tests positive receives a text message to say that they have received a positive test result. At approximately 8.30 am the next day, they will get another text message to reinforce the message that they must self-isolate. The vast majority of those who test positive will also get a phone call. We are also looking at follow-up text message reminders that people must self-isolate. We are putting in a multi-stage approach through which we can continually reinforce the message.

There is evidence from England, for example, that, despite that intense messaging, a proportion of people do not self-isolate, but that is distinct from the role that we can perform. Thank you.

The Chairperson (Mr Gildernew): OK. Thank you. Just before I go to members, I have another question. On 22 May, the 'Test, Trace, Isolate, Support Strategy' was produced. The Chief Medical Officer (CMO), Dr Farrell, Professor Young, Professor van Woerden and Dan West all contributed to it. On page 5, it states:

> *"Chains of transmission can only be broken if those who could transmit the disease to others are isolated, and get the support they need to maintain that isolation."*

My question is this: where is the isolation and support strategy in our system? We talk about test, trace and protect, but there is no mention of isolate or support. Find is also a key element. You have to be able to trace the right people to isolate them, but, given your assertions in that document, what is your role in isolating and supporting people?

Professor van Woerden: I agree that self-isolation is tough. It is tough to be in a room or very restricted circumstances; it is emotionally draining and hard work.

As I said, we are using text messaging to support people. We also have a health improvement team, which has over 500 contracts with community groups across Northern Ireland. The team has sought to recognise emotional well-being needs and to redirect, as much as possible, the contracts that we have across the community to support individuals who are going through difficult times with self-isolation. Local authorities have also recognised the difficulties and are seeking to support communities in relation to self-isolation.

A societal response is needed. We need families and friends to be encouraging and supportive, and the messaging from you that you value and are grateful to people who self-isolate also makes a huge difference. Thank you.

The Chairperson (Mr Gildernew): OK. Finally, before I go to members, one of you mentioned that you are putting systems in place. Should those systems not have been put in place in June, July, August and September? Is that an acknowledgement that what has been put in place has failed?

Dr Waldron: The systems that we are putting in place now would have been put in place in any event and are enhancing the service that was already in place. We might have said that we have put those in place earlier than we normally would have because of the numbers of positive cases that we are experiencing.

Every innovation needs time to bed in. In this case, it was something that would have been put in, was planned to be put in, and is coming in earlier than it would otherwise have come in. However, like everything, it needs time. It took some time to put the contact-tracing system in place. Dan is on the line and will be able to tell you how long it took from inception to the app coming in. Things have to take a little bit of time to ensure that, when they come in, they perform to the optimum level.

At the same time, when things have to be brought forward, it is absolutely appropriate that they are brought forward.

The Chairperson (Mr Gildernew): As public health officials, are you satisfied with the testing part of this system? Yesterday, it was, I think, 18·3% positive. Is that adequate testing?

Professor van Woerden: Dr Bríd Farrell will want to respond, but I would like to give a high-level overview.

In the very early stages of the pandemic, we had very little testing capacity, so it had to be used judiciously. Over the summer, there was virtually spare testing capacity. It is important to acknowledge at this stage that, going into the winter, there may well be some gap between the testing capacity that we would love to have and what we will realistically have. That will require some prioritisation of testing. It would be good to get Dr Farrell's response.

The Chairperson (Mr Gildernew): We were told recently that resources were not an issue here, so it is, then, clearly a failure to plan and get it into place when it was necessary.

Professor van Woerden: The testing capacity is at about 6,000, and work is going on to increase that. There is a global shortage of those very expensive machines that are required to do testing. It is not the sort of thing that one can turn on quickly. The tests are incredibly complex. There is exciting work happening about much simpler tests: saliva and rapid point-of-care tests that will complement the complex PCR testing, which will, in a few months' time, I think, be used in much more restricted circumstances, and there will be much more access to those new salivary tests that are coming through.

Globally, we are on a developmental journey on testing capacity and equipment. We have support from the UK on pillar 2 testing. Northern Ireland has been privileged in that we have been allowed to use more than our population share of testing in that context, for which we are grateful.

Ms Bradshaw: Thank you very much for attending this morning. About three days ago, I think the figure was sitting at 36 people having been fined £1,000 for not complying with self-isolation regulations. I am concerned that that is part of the reason why we continue to have such high rates of transmission. Could you speak to that, specifically about your relationship with the police and ensuring that information flows to them when you are picking up that people are not self-isolating?

Dr Waldron: It is an important point that you make about enforcement and fines, as it is an area that will possibly have to be considered further. I am clear in my personal view in that once you get to the level of enforcement, certainly in relation to individuals, things have got to the point where we are beginning to lose the battle. We rely very much on people's behaviour in doing the right thing when they are out on their daily business and supposed to be social distancing, etc, or when they are supposed to be socially isolating. We rely on the community and on businesses to do the appropriate thing.

In terms of enforcement, one should concentrate, if one has to, on the more flagrant breaches rather than getting to the stage when people feel that they are doing it only because they might get a fine if they do not. We need to have people engaged with what they need to do and doing exactly what people were doing during the lockdown.

I have always said that the people of Northern Ireland behaved magnificently in taking the messages to heart during the lockdown. If we can only get that spirit back, we will be in a better place to deal with what is going on. There is a role for enforcement, but by no means should it be the single thing to do or the single approach.

Ms Bradshaw: I was not suggesting that it should be the single approach. I have heard of a lot of people finding excuses for why they do not need to self-isolate and reasons why they are a little bit more special than others. My concern is the rising figures and how non-compliance with self-isolation has contributed to that rise.

My second question is on the advice that the Public Health Agency gave to universities over the summer, and even before that, about bringing students back. What interaction did you have with the universities so that they could engage with their students on any decisions that they made and be able to provide evidence for those decisions?

Dr Waldron: We were having extensive discussions with the universities about students returning, going way back. We were meeting very regularly in advance of the university term starting. At that stage, it was not simply a matter of people coming back. Both universities — Ulster University and Queen's — were conducting a lot of their material online, where possible, so the necessity for students to come back was not as great as it has been in previous years.

There was always going to be an issue when large numbers of students came back. We were very much aware of that. We had discussions with the universities and advised them on how that to be

handled. At a very early stage, for example, Queen's had its own COVID dashboard for tracking its students, and it has been using that. I am not picking out students for particular mention, but this is what we have been seeing throughout society. People have not been taking the advice that we have been giving them, particularly about social gatherings. They should not have been happening, because, in a social gathering, people come together. It takes only one infected individual in that gathering for us suddenly to have a large number of cases. Those kinds of situations were happening — almost inevitably, you might say — when students returned to the universities from home. That was compounded by the fact that, in Northern Ireland, we have a situation that may not exist in other areas to the same extent, which is one of students travelling home at weekends, potentially and probably taking the infection back with them.

It was a difficult situation, but it was no different from what we had been warning about all along. We had warned of the dangers of having social gatherings at which the rules on social distancing of 2 metres could not be maintained and at which, to be honest and frank, people were being careless and allowing infection to spread. I am not sure what could have been done about that, other than advising everybody to stay at home, but we have been doing everything in our power to work with the universities and advise them appropriately. We are continuing to do that and will continue to do that.

Ms Bradshaw: The Scientific Advisory Group for Emergencies (SAGE) estimates that student travel alone contributes 0·5 to the R number in GB. Did you give specific advice to the universities, or did you just engage with them? Based on the scientific evidence, such as that which I have just read out from SAGE, did you give the universities specific advice or recommend that they did not bring the students back?

Dr Waldron: We did not make such a recommendation. Such decisions were up to the universities, individual students and individual courses. The advice that we gave to the universities is the same advice that we have been giving to everyone concerned, but it was specifically directed at the universities, given the problems and issues that they were facing. In that respect, it is no different from the advice that needs to go out to every part of society in Northern Ireland.

The Chairperson (Mr Gildernew): At this stage, I have Órlaithí, Gerry, Pam and Pat down to ask questions. Órlaithí, you may ask your question.

We cannot hear you. Are you off mute?

Ms Flynn: Yes. Can you hear me now?

The Chairperson (Mr Gildernew): Yes.

Ms Flynn: I want to ask a question about the testing of asymptomatic people. I heard the Chief Scientific Adviser (CSA) doing some media this morning, and the same question was posed to him about what we can do to try to improve the testing and contact-tracing process. He said that the Department is looking at bringing in additional measures, using new testing models that are arriving on the scene. Does the panel have any further detail on what those new testing models are? That is my first question. I will have one additional question.

Dr Bríd Farrell (Public Health Agency): As Dr Waldron mentioned, the current test that is undertaken is a swab test, but there are a number of new technologies that we are hoping to pilot in Northern Ireland in the next couple of weeks to check whether they have the same accuracy and whether they can be used for testing more people and doing more frequent testing. One of them is a saliva test, which we hope that we will be able to pilot for either healthcare staff or universities. We are still working out the detail. The other developing technologies are point-of-care testing, which you can do at a patient's bedside, or what is called rapid testing. Depending on which testing platform you use, it can take up to 24 hours to get a result back from a PCR test at the moment. Some of the rapid tests can give a result in 60 to 90 minutes, and, if they are performed in a laboratory setting, you can get quite a significant throughput of tests. There is a lot of discussion about that going on this week. I expect that we will receive information about new technology pilots in Northern Ireland early next week, hopefully.

Ms Flynn: Thank you. If the pilots are successful, is the idea to have the new testing models in operation for November or December? Have you set yourselves any timeline to work to?

Dr Farrell: When we get those tests over, we will have to check that they measure what they are supposed to measure. That is the first thing. We then have to work out the logistics for getting good uptake of the tests so that they will achieve their objective. Running in parallel with that, there is active discussion about the capacity to support more widespread use, assuming that the pilot goes well. We will have to do a very careful evaluation of the pilots to make sure that they are achieving the impact that is expected of them.

Ms Flynn: OK. Thank you. That is really useful.

My final question is on the telephone interviews with people who have tested positive and close contacts of people who have tested positive. I know that the text-messaging service is in operation. I am in self-isolation after coming into close contact with someone who tested positive for COVID-19. I got that text message extremely swiftly and followed the advice. Gerry touched on this earlier, but what I am really concerned about is the sense of complacency that is setting in amongst some people. I sincerely believe that, if you were able to step up the structured telephone interviews alongside the text-messaging service, that would make a difference. It is one thing to get a text message but another to understand the seriousness of it and follow the steps on what to do. If it were possible and you had the staff in place, those staff could follow up the text message to all those contacts with a direct phone call that advises, "This is what you need to do: a, b and c". That would make a major difference. You have 151 staff and 25 in training, so I am not sure that that allows you to have that capacity or whether you can you work towards having it.

Ms MacLeod: When our numbers were lower, and we were modelling for 300 cases, we specifically chose a model for which we would use people from professional backgrounds — for example, nurses, social workers, psychologists and dentists — who are used to dealing with people. This is not a call centre. We are dealing with people in distress, who are frightened and who have a lot of fears. We had the luxury earlier of spending a lot of time on our phone calls. They could last up to 45 minutes. We were providing a lot of guidance and support, but, as you can imagine, as the numbers ramped up quickly, we had to shorten the time that we spent on the phone with people. In fact, we had to take a risk-based approach to those, perhaps like you, who may have been regarded as being in a lower-risk group, and believe that a text was enough.

We are ramping up capacity and employing more people. We are hoping to get some student nurses to work with us to give us the luxury of allowing everybody to receive a phone call so that people get the opportunity to speak to somebody who has that sympathetic ear and can provide them with some advice and support.

As we said at the outset, we were planning for about 300 people. We were well staffed for making phone calls to 300 people and their contacts, but the number of cases just took off. We are catching up quickly. Our belief when we set up the service was that it was a service to support people as well as to give advice.

The Chairperson (Mr Gildernew): I will now come back to members in the room.

Mr Carroll: I want to thank the PHA. I received some advice myself in the past few weeks, and it was important and helpful. I thank the staff members who assisted with that.

I want to hone in on some of the stuff that the Chair mentioned. The Committee has agreed to try to have a zero-COVID strategy. I do not know whether we are fully equipped with the capacity to embark on that. New Zealand has adopted such a strategy. In the past few days, the country has had stadiums full of people watching rugby and other sporting events. It has tested one million people out of a population of four million. It seems to me that we need more testing of people who are asymptomatic and of people who have not been contacted by the system, who might not have had Bluetooth switched on or who have fallen between the cracks, which is possible and likely. Do we need to ramp up our testing capacity?

Dr Farrell: We have ramped up our testing capacity in the past two weeks — since the Friday when we were notified of the trebling of cases — by 2,000 tests a day. Through the national initiative, we have therefore been able to ramp up our testing capacity by the order of 2,000 tests a day. We are also seeking to increase our testing capacity in our Health and Social Care (HSC) labs. There is scope for further expansion of testing there. We are continually trying to increase capacity. As I say, we will know more about the new technologies early next week. We will know whether we have been

successful in getting some of those pilots for Northern Ireland. We are actively working on this all the time, continuously.

Mr Carroll: I do not know whether you can answer this, but do you know how many tests have been carried out in total? Another concern is that employers that have a staff member who has tested positive do not automatically have to notify other staff members. Possibilities exist for changing that, in order to make sure that staff know when a colleague has tested positive for COVID.

In Vietnam and other countries, there is door-to-door or on-the-ground contact tracing, or whatever the medical term is. Technology is obviously important, but, as we have seen in Committee today, it can be limited and disrupted. Is there any rationale behind having, or is consideration being given to having, an on-the-ground contact-tracing system that keeps people safe? People wear a mask and so on, but, to me, there seems to be some merit in considering that approach at the very least.

Dr Waldron: I will take both those questions. You raise an important point about employers. Employers have a responsibility. During the pandemic, we have been in touch with a number of employers to advise them. Our advice has been that they should be proactive in what they are doing. A symptomatic person in the workforce may or may not subsequently test positive, so, before contact tracing, if employers identify someone in their workforce, that individual should exclude themselves from work as quickly as possible.

The more responsible employers have got policies in place. Even at that stage, they are identifying individuals in the workforce who would be termed to be contacts of the symptomatic individual who has gone off work and are advising them to stay away from work. When an individual tests positive, proactive employers are advising the contacts. The important thing in that respect is that the people who are at risk in the workforce are the individual who has tested positive, obviously, and the individuals with whom they have come into contact. If there are protective elements in the workforce, the entire workforce will not necessarily need to leave work. It is a matter of employers being proactive, because, at the end of the day, it is in their best interests to be. It is also in the interests of their workforce, because employers have a duty of care to the workers. We encourage employers to put such procedures in place.

The second issue that you brought up was about door-to-door contact tracing. That indeed has taken place in other areas. You probably recall the big outbreak that occurred in Leicester. It was confined to a particular geographical area, so contact tracers went from door to door to encourage people to get tested. That was in the context of asymptomatic population testing, where a specific population had been identified. We certainly could and should consider that if we come across a situation like that, where we have, for example, a discrete geographical area where it looks as though there is quite a high number of cases. Door-to-door contact tracing might be an option there. We would not rule out any specific option. It is just that we have not had circumstances yet in Northern Ireland in which we would need to do that. We need to consider, however, every single possible way in which to get to the bottom of the situation and break the chain of transmission.

Professor van Woerden: I will supplement that by saying that we have used mobile testing, which is an intermediate step. We think very carefully about where that is deployed. A testing facility was opened up in the Holylands in anticipation of the student community coming back to the area and because of the fact that a number of other populations in the area might benefit from very immediate access to testing.

The Chairperson (Mr Gildernew): Thank you. I will go to Pam, Pat and then Colin.

Mrs Cameron: Thank you, panel, for being here today. I want to say at the outset that the work that you are doing is incredibly important and very much appreciated, certainly by me. It is clear how intensively you have been working and adapting to deal with what is a very challenging situation.

I have so many questions, but I will have to try to limit them. The first one relates to pooling of testing. Are you considering that in order to maximise testing capacity? I also want to ask about schools. Given that schools are taking the lead to identify contacts in education settings, is there not a need to ensure that the advice provided to staff and pupils is consistent and clear? Have packs or protocols been prepared for staff and parents? If not, why not? I have one for Dan, because he is not getting any questions and is being left out. How is the under-18 version of the StopCOVID NI app working and what has its uptake been?

Dr Farrell: To answer the first part of your question on the pooling of samples, that is being actively considered. One of the suggestions for a pilot uses that approach, and we will possibly know more about that next week.

Mrs Cameron: Excellent.

Dr Joanne McClean (Public Health Agency): Thank you for the opportunity to answer the question on schools, Pam. My name is Joanne McClean, and I am one of the doctors here. I have been working with colleagues to set up a special support service for schools. We have a special team in the Public Health Agency that is staffed by senior healthcare professionals. We also have a consultant on the floor to support. We are providing direct support for schools.

I will talk you through what we are doing. We have given out packs, but we do a lot more than that. As you know, schools are identifying close contacts among staff and students in their population. They are doing an absolutely amazing job and have worked so hard with us to do it well. I will describe what we do. When a child or member of staff tests positive, quite often the principal will be rung almost immediately. The principal will therefore know that there is a case in the school. The principal then rings our team — we are here seven days a week — and we begin to support the school to identify close contacts.

The first thing that we do is share with the school an information pack and a contact-tracing sheet, which the school will have seen in advance, as it has been widely circulated by the Education Authority (EA). We walk the school through that and help it identify the close contacts in the school. Close contacts in the school are people who have been very near the child. Primary schools, as you know, are operating bubbles, so everyone in the class tends to be a close contact. It tends to be a bit more complicated in secondary schools, however. We identify the staff and the students who are close contacts and need advice to isolate. We then give the principal a letter that is specific to that school and case and that tells staff and parents, "You have been in contact with a case of COVID. You are a close contact". The letter states the date of contact and the date up until which people need to isolate. That is then given to parents and members of staff by the principal. That generally happens quite quickly. We also have more general information for schools to give to parents whose children are not close contacts. That is what happens with a single case. As I said, we are here seven days a week.

Schools are part of our community, and the staff and the children do not live in the school in isolation. They live out in the community. What is happening in schools largely reflects what is happening in the community, so it is not uncommon for schools to have more than one case. If schools are getting more than one case, we again work with the principal, do a risk assessment, see whether there are any links between the cases and follow the community links. We keep a really close eye on every single school that has cases.

I hope that that summarises what we are doing. Yes, we have packs and information, but we also have a dedicated team that is responding really quickly to cases in schools.

Mr Sheehan: The CMO told us as far back as May that there would be 400 to 600 people involved in contact tracing. Olive, you mentioned the figure of 500 people at one time. How many full-time equivalents are involved in contact tracing at the minute?

Ms MacLeod: Thanks, Pat. For whole-time equivalents, we have 151 staff and 25 in training, and we shortlisted 68 more people today. When we said that we would need 500, we were using the stat that a call would last 45 minutes and that it would be 10 minutes per contact, with an average of three contacts. That is where that number came from. We have refined the call and brought the time of the call down. We have technology that is also alerting people —.

Mr Sheehan: Sorry, Olive. How many of the 151 are full-time?

Ms MacLeod: I will get you that figure. I do not have it at my fingertips. You will appreciate that we offered a contract for a year. The majority of the people who have come to work for us are people who have retired, have come back from retirement and have taken a 20-hour or 25-hour contract with us. A small number of people —.

Mr Sheehan: You are telling me that you do not have a figure of full-time —.

Ms MacLeod: I do have it. I will find it. It is in front of me here. I will give the figure to you, if you just give me a moment.

Mr Sheehan: OK. When community testing and tracing was halted on 12 March this year, we were told that 12 people were involved in contact tracing. At that time, there were 47 confirmed cases of COVID-19. Let us say, for argument's sake, that 120 of those 151 staff are full time. That has risen tenfold. However, the number of positive cases, as of yesterday, has risen by over 30-fold. Was the modelling for 300 not a disastrous underestimation?

Ms MacLeod: The modelling was done for us by the experts, based on the disease profile. In fact, it said that, if things were to deteriorate —.

Mr Sheehan: Sorry, Olive. What experts were doing the modelling?

Ms MacLeod: Gerry, do you want to pick that one up? Professor Ian Young and some of the other experts helped us with the modelling, based on the disease profile.

Mr Sheehan: So it was the Chief Scientific Adviser who underestimated the number of infections that were going to take place.

Ms MacLeod: No, I do not think that that is correct. I think, based on —.

Mr Sheehan: You are only after saying that.

Ms MacLeod: The estimate was based on many factors in the community and, as Dr Waldron said, on people complying with the good advice that we were giving. That was the estimate; you know that this is not an exact science. In relation to our ability to flex up, as I told you, we have responded. On 2 October, the number went from 300 from 900 in a day, and we flexed up. We have technology that is helping us, and we have extra staff coming in to help us to flex up. We have responded to the demand, and we will continue to respond to the demand. We had a workforce appeal, and we have 100-plus people interested. We will interview them again this weekend. We have three people delivering training, where previously we had one. We are offering training every day, and we have very expert people who are working with us. We will continue to —.

Mr Sheehan: Olive, we are hearing of dozens and dozens of cases where people have not been contact-traced. I am sure that all of you are aware that the countries that have dealt most successfully with this virus are the ones that have the most rigorous and robust testing and tracing systems. All of you in the room are very well paid. You were tasked to put in place a rigorous and robust contact-tracing system. You have failed abysmally. The contact tracing that is in place at the minute is as useful as a chocolate fireguard. Who among you in that room is going to raise your hand and say, "I'm responsible for this failure"?

Ms MacLeod: Pat, as you know, I am the chief executive of this organisation, so I am responsible, and I cannot accept that you compare the service that we have set up to a chocolate fireguard. I think that that is a disservice to the staff who have volunteered and who have come to work for us. We will continue to —.

Mr Sheehan: It is not about the staff. It is about the leadership.

Ms MacLeod: The leadership is me. The leadership is me. The team and I have worked all summer. As we said, we were the first ones to set up a contact-tracing service. We piloted in May. We have built technology. We have built an IT system to support it. We have attracted staff. We have built and trained very effective staff. We will continue to do that. We are reaching over 80% of people every day. The contact-tracing service is a vital part of breaking the chain of transmission, but we collectively as leaders, including yourselves, need to make sure that the messages are — that everybody is complying and that we are socially distancing, washing our hands and complying with the regulations. With regard to contact tracing, we have an effective service, and we will continue to build on it to deliver for the safety of people in Northern Ireland.

Mr Sheehan: No, Olive, we do not have an effective service —.

The Chairperson (Mr Gildernew): As part of the answer to Pat, did you say that the majority of the 151 people who have been recruited are on 20-25 hour contracts?

Ms MacLeod: They range from one day per week to full-time. We have people working more than full-time, we have people working remotely from home. Where the numbers go up, people will flex up and take those calls into the evening and over the weekend. We have a flexible model that is flexing up and down. We went from 300 one day to 900 the next, and we flexed up.

The Chairperson (Mr Gildernew): Given that range, how many full-time equivalents?

Ms MacLeod: I have found it. People who have taken a full-time contract with us, and the contract is for one year —.

The Chairperson (Mr Gildernew): Olive, I am not asking that, and you know that I am not asking that. How many full-time equivalents overall are at your disposal?

Ms MacLeod: We have 20 people who work full-time —37 hours. We have 45 people who work part-time. We have 86 people who work on the bank; the average person on the bank works 20-25 hours, but will work up to 40 or 50 hours, which has happened. We have —.

The Chairperson (Mr Gildernew): Olive, I am going to interrupt again. The reason we use the phrase "full-time equivalents" is that it captures how many hours are being put in. If you do not have that figure today, that is OK, but can you get us that figure? How many hours are committed? There is such a range of contracts there that is impossible. That is why the health service uses the term "full-time equivalent".

Ms MacLeod: Sorry, I understand what you are asking now. To do 1,000 cases a day, at 30 minutes, we need 40 staff available every day. Is that helpful?

The Chairperson (Mr Gildernew): How many available staff do you have? How many full-time equivalent staff do you have at your disposal today working on testing and tracing?

Professor van Woerden: The question is a very reasonable one. If I was in your position, I would be asking that question. We will seek to get you an estimated figure. The difficulty for the chief executive is that the figure changes, literally, day by day. We initially set the system up as a surge capacity model with core staff, who are there every day, and a large capacity to flex day-to-day, so it was not conceived in terms of full-time equivalents; it was conceived in terms of core staff and flexing staff. The question is a reasonable one, and we will seek to get a figure on the current position.

The Chairperson (Mr Gildernew): OK. I am going to move on, but we want that figure of what you have. Given the very significant underestimation, I also want the figure of what you estimate and will propose to the Department that you need in terms of full-time equivalent. I want to know the level currently existing, and what you assess that you need. I will go to the phone now to Colin McGrath. Are you there, Colin?

Mr McGrath: Yes, Chair. They say that politicians avoid answering questions, but we have just seen a classic example of it from officials.

I want to ask a question about the track-and-trace app. This is as much a personal experience as anything else. I am very concerned that there will be some fatigue amongst the public and that, potentially, members of the public will switch off the app, deactivate it and not use it, because they are concerned about having to spend 14 days in isolation. They feel that, if they are not getting an income, or are getting a vastly reduced income, during that time, that is too difficult a decision for them. My experience is that you are asked to isolate for 14 days from the alert, but the alert comes in response to somebody uploading a positive test case. Their first symptoms may have been four or five days before they got their positive test result, but, in some cases, it may be up to 14 days prior to them uploading that that they were last in contact with you. Is there any way in which we can narrow the gap so that the COVID app can tell you when you need to remove yourself from self-isolation, because it can determine when you were last in contact with the person who uploaded the positive test result? I appreciate that it will require a little bit of work in the background of the app to determine that. It does not need to tell you who it is, but if it could tell you that it was five, six or eight days previously when you were actually in contact with that person, that length of time could be deducted from your 14-day

period of isolation. That means that you would not then need to spend two weeks in isolation. In that example, if it was 13 days ago that you were last in contact with a person and you received the message today and then isolated for 14 days, that, from start to finish, is 27 days. If people were getting messages that said they needed to isolate for six, eight or nine days, there might be bigger buy-in. Are there figures available for the number of people who have deactivated or removed the app, to see whether that is something that we need to work out?

Mr Dan West (Department of Health): Thank you, Health Committee, for the time to talk to you today, and thank you, Colin, for your question. I note that you have written to Minister Swann on that topic. Understandably, that letter has made its way on to my desk, so you should expect a response imminently.

The reason why we originally triggered the 14-day self-isolation period at the point at which the COVID positive test was uploaded to the app was privacy. When relatively small numbers of people were using the app, if you started the self-isolation clock at the point at which there was the last risky close contact with an individual or individuals who have had a positive test, it would theoretically be possible, particularly for somebody who is not out and about much, such as one of the shielded population, to identify the individual who triggered that self-isolation advice and, therefore, an individual in the community who has contracted the virus. For those privacy reasons, and in concert with the Information Commissioner's Office, that is how we set up the design of the app in the first place. Now that we have more users, your point is a great one, Colin. Should we revisit that decision and start the self-isolation timer at the point when that most recent close contact occurred? We are in the process of investigating that. It is highly likely that we will implement that change, as you have suggested, in a future version of the app. That is under analysis at the moment, and we will respond to both your letter and, obviously, your comments today accordingly. We will keep you and the Health Committee updated on whether and when we make that change.

Unfortunately, we do not have information about the number of people who have deactivated or removed the app for the reasons that you have outlined, or, indeed, any other reason. We have some information on usage of the app, some of which I can outline today, but, due to the privacy considerations and the way in which the app stores work, that is one fact that, unfortunately, we cannot discover.

Mr McGrath: What is the usage of the app? Do you have figures for how many people have triggered it and have received the appropriate warnings?

Mr West: Absolutely. Our stats show that over 450,000 people have downloaded the StopCOVID NI app, which is the proximity app; there are two apps in the COVID app ecosystem. For those who are writing it down, the number is 452,762. The number of text messages that we have sent to individuals who have had a positive test result, saying, "If you are an app user, take this code and enter it into your app so that we know that you are you in terms of reducing misuse of the system", is 16,535. Of the app users who have received that SMS, 3,659 have uploaded that to their app. The relationship between those two numbers — the number of app users who have uploaded their diagnosis keys compared to the number of individuals who have had a positive test and have received the SMS — is about a correlation between the number of people in the population in total and the number of people who have downloaded the app; it is about a quarter. There are 11,580 app users who have received a contact notification and been advised to self-isolate.

That is the group of numbers that we tend to talk about with regard to the efficacy of the app. That relationship between the number of individuals who have had a positive test and have uploaded the keys, and the number of individuals who have been identified through an exposure notification is as good as, and is increasingly becoming better than, the number of individuals who are identified as part of that manual public health contract-tracing process. That is one of the measures that we had agreed with the Medicines and Healthcare products Regulatory Agency (MHRA) as a test of the efficacy of the app in obtaining the appropriate CE markings for a medical device according to the MHRA regulation. There some other stats that I can wheel out for you, Colin, around the number of —

The Chairperson (Mr Gildernew): Dan?

Mr West: — cases that we are exchanging across the North/South border, but it may be that it is better to just leave that.

The Chairperson (Mr Gildernew): Dan? Can you hear me, Dan? Dan, I suggest that you forward the Committee a written briefing with regard to those. We are very interested in them, but I just do not think that we want to utilise the time today in going over them. I appreciate that they are there, and we are certainly keen to get more information.

I will refer you back, while we have you on the line, Dan, and then I will quickly go back to Colin. However, Pam asked about how the under-18 app is working and what the uptake is, in very brief terms, please?

Mr West: Sure. In brief terms, there was a new version of the app which was launched on 30 September. It is not a different app; it is just a new version of the one that we released on 30 July. You will remember that that original version was only for over-18s, and that is due to a constraint around the consent process for people who are under 18 to use publicly provided digital tools. The consent process is, by its design, identifiable — you know, "I, as parent or guardian of this individual, consent to them being able to use that service", whereas our app, as you all know, is designed to be very private. However, we knew that not having the app used by that younger population was an issue for us, particularly given how motivated they are to use digital services, if you can get it right. So we worked, following the release of the first version, with the Information Commissioner's Office, the Children's Law Centre and the Children's Commissioner, to develop a new onboarding process which would, in the public interest, allow individuals under that age range — the 11- to 17-year-old post-primary age range — to be able to use the app. We designed that onboarding process with kids, rather than getting a load of grey-haired old men and women to sit in a room to design that. We actually did that in conjunction with children —.

The Chairperson (Mr Gildernew): Dan, can you give us how many, how it is going and what the uptake is on the under-18 apps, please?

Mr West: We do not know how many people have downloaded it who are under the age of 18, because we do not know who is downloading it. However, we do know that, since we launched that new version, the number of people who are downloading it and using it per day has increased from about 3,500 to about 4,500. So we have a marked increase in usage, and we are continuing to work through the schools and head teachers to promote the use of the app and to integrate it with the policy and protocol within the schools for carrying mobile phones and contact tracing.

The Chairperson (Mr Gildernew): OK. Again, we would appreciate receiving any further updates in writing on that. The Committee are certainly keen and wish that system all the very best in how it operates.

We will go to Alex, but we are running short of time.

Mr Easton: I will try to do mine very quickly. How useful would it be for you if everybody who has a mobile phone in Northern Ireland was to download the app? And my second and last question: how are you able to trace people who are actually breaking the isolation rules when they are meant to be isolating? I am just curious as to how you are doing that.

Mr West: To take the app question first, the app is one tool in the public health toolbox. It is by no means the only tool, obviously, as we heard earlier on about the contact-tracing service. We know that, if everybody downloaded and installed it, the app would become increasingly useful in breaking the chains of transmission and, alongside increasing compliance among the public with the self-isolation guidance, that would have a significant impact on our ability to reduce infectivity.

The Chairperson (Mr Gildernew): And the panel on the other part of that question from Alex?

Dr Waldron: Yes, I can deal with that one. We have not got any way of knowing who is or is not complying, and I think that it is taking us back to the unfortunate question that we had earlier on in the session. We put out the message. We make it clear to those who are positive cases and contacts of positive cases as to what their obligation is. If they are a positive case, they need to be self-isolating for 10 days from the onset of symptoms. If they are contacts of confirmed positive cases, they need to be self-isolating for 14 days. That is the message. I hope that we have been quite clear in putting out that message to people. We rely on people to follow that advice. It is really important that they follow that advice. If they do not, we will get the same situation where the numbers will continue to increase. It is an important message that people need to be taking on board. We do not have any capacity at the

moment to be able to monitor that and check on people. We are relying on people to do the right thing when they find themselves in that position.

The Chairperson (Mr Gildernew): OK. Thank you. A quick one from Paula, and then we will have to go into a consideration of this.

Ms Bradshaw: Thank you. I just want to come back to what you said on no way of knowing and no capacity. Is that not something that you should be actively pursuing? The message coming out of this for people who get the text message is that there is a very slim chance that they will be penalised or caught on. The days are gone where we can rely on people doing the right thing, and we need to be looking more at the enforcement and the monitoring.

Dr Waldron: I am not sure if those days are gone. If they are, we are in really big trouble. We had a situation in the first wave where the people of Northern Ireland took the message to heart; they knew what they had to do. The message is still very clear. It is up to every one of us to be putting out that message, but also to take that message to heart if it applies to us. I would even go beyond that: the way things are at the moment, we should all be making the assumption that everybody that we come in contact with, throughout our daily lives, including ourselves, is potentially infectious, and acting accordingly. We really cannot get into the situation, with the numbers that we have, and even without the numbers —. It is a respiratory virus, and it is highly prevalent within our community. We rely on people's good behaviour and their doing the right thing. We should be confident in our people that they will be taking this message to heart and doing the right thing.

Professor van Woerden: Can I supplement that by saying that there is a lot of international evidence around this — not around COVID, but around other diseases like, for example, tuberculosis. People across the world have experimented with what I would call the altruistic appeal to people's better nature, or with the more enforcement type of approach. With infectious diseases, over many decades, the evidence generally is that, from a behavioural science point of view, the altruistic approach tends to work better than the enforcement approach. I am also concerned that, as a society, if we move very strongly in an enforcement approach perspective, as we phone people and ask, "Who have your contacts been?", they will be less and less transparent with us in the information that they will give us. That might have an adverse impact in the longer term on our capacity to contact-trace. I am not against enforcement as a philosophical —. As Gerry said earlier, if somebody organises a rave and there are a bunch of people there, they are acting criminally irresponsibly, and that should be enforced. But there are people who are embarrassed about the fact that they have gone to something that, in retrospect, they regret, and if they do not feel free, in a clinical situation, to confide that clinical information, then we may end up in a difficult situation.

The Chairperson (Mr Gildernew): OK. Dr Waldron, given that you have just said that you do not have the capacity to monitor — nor indeed, I presume, do you have the capacity to provide that ongoing support to enable people to self-isolate, as has just been discussed there — is that another indication of a failure in the test, trace and support system? Have you, as public health officials, put forward any proposal or business plan to the Department to get additional capacity and resource to deal with that?

Dr Waldron: We are grateful for all the assistance that we have been getting from the Department throughout this. It has been very helpful in giving us additional resources, but this is not just about resources; it is about the ability to respond to an ever-changing situation and to respond proportionately. I have been in public health for over 30 years, and I have never come across any situation that has even touched the intensity and longevity of this. Most emergencies are over and done with — even swine flu — within a month at most. This has been going on, from our point of view, since early January, when we first heard about this, and I am absolutely awestruck at how my colleagues in the Public Health Agency have risen to the challenge. I do not think that we need to hear about things like failure. I do not use the word "failure"; I use the word "success" when I see how extremely dedicated individuals working in the Public Health Agency have coped with this challenge and are managing new and increasing challenges every day of the week. As Olive said earlier, it is a seven-day week now. We continue to do that and will continue to do that, because our responsibility to the people of Northern Ireland is to ensure that we deal with this serious and unprecedented challenge in our midst, and we will continue to do that as long as we have the power to do so.

The Chairperson (Mr Gildernew): We will continue to support that. We are, as you say, eight or nine months into the pandemic, and it is our duty and role as a Committee to identify what is working and

not working. I have to say that it is staggering to find out today that there has been an underestimation of 300% of what capacity was needed. That is obviously an area of concern.

I thank you all for coming today. We all recognise that it is hugely important work, and we wish you well in that.

I will go quickly to Alan. I did not have an indication from Alan, but I will take it. We need to move on.

Mr Chambers: Thank you, Mr Chairman. I just want to go back to some remarks that Pat Sheehan made, and I want to completely and utterly disassociate myself from them. He said that this system has been:

> *"as useful as a chocolate fireguard."*

I call on the parties in the room this morning to join me in disassociating themselves from those remarks. They are unfair, uncalled-for and unhelpful. Pat does not need to look any further than the leadership of his party to find evidence of chocolate fireguards in relation to trying to stop the spread of the virus in the community.

The Chairperson (Mr Gildernew): OK. Members, I will allow the PHA staff to get on with their important work. I thank all members of the panel. We can have a discussion about what we have heard and what we need to do as a follow-up to that. Thank you all very much for attending this morning. Good luck.