Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 Disease Response:
Mr Robin Swann MLA, Minister of Health;
and Dr Michael McBride, Chief Medical Officer

5 November 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 Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Mr Colin McGrath
Mr Pat Sheehan

Witnesses:

Mr Swann	Minister of Health
Dr Michael McBride	Department of Health

The Chairperson (Mr Gildernew): I welcome in person, Mr Robin Swann, Minister of Health, and, by video link, Dr Michael McBride, Chief Medical Officer (CMO). I invite you to brief us, Minister.

Mr Swann (The Minister of Health): Thanks for facilitating the earlier meeting. Thank you for the opportunity to update the Committee. Since my last briefing, we have all been aware that there continues to be a high increase in the number of positive cases of COVID-19 across Northern Ireland. I think that the coming period is still highly uncertain. I am deeply concerned by the increase in COVID cases over the last month.

The Chairperson (Mr Gildernew): Minister, will you move closer to the mic? We are having some trouble with the sound.

Mr Swann: Apologies, Chair. I was trying to keep as far away from everybody as possible.

The Chairperson (Mr Gildernew): I understand.

Mr Swann: It is nothing personal, you understand.

Thanks for facilitating the early morning meeting. Since my last briefing, we have all been aware that there continues to be a high increase in the number of positive cases across Northern Ireland. I think that the coming period is still highly uncertain. I am deeply concerned about the increase in COVID cases over the last month. We believe that further waves are a continuing threat. There are, however,

signs that the action that has been taken by the Executive is having an impact, with the number of infections stabilising. How the virus develops in the coming weeks and months will depend on a range of factors, including the future approach to social distancing and population adherence to the measures through continued frequent handwashing, good respiratory practice and the appropriate use of face coverings.

While the future path of the pandemic is unclear, a second wave coinciding with winter pressures means that we are very likely to face the most challenging winter ever experienced by our health and social care system. We all have an important role to play in minimising the spread of the virus and reducing the pressures on our health and social care system.

It is clear that our system has been under severe pressure over recent weeks, in particular our critical care units. That is why it is so important to have robust plans in place to manage that situation. As members will recall, I published the surge planning strategic framework on 6 October, along with the individual trusts' surge plans. That has ensured that we have a sound framework and detailed plans in place to manage the pandemic. Within those plans, the Critical Care Network Northern Ireland (CCaNNI) has updated the critical care surge plan, which provides the ability to incrementally flex capacity to a maximum of 158 ICU beds across the region. As part of the Critical Care Network Northern Ireland plan, the Nightingale facility at Belfast City Hospital will retain capacity to support the entire region. The Critical Care Network Northern Ireland will continue to oversee and monitor the critical care surge plan and report daily to the Department within our overarching plan. Trusts decide on the need to transfer patients to the Belfast City Hospital Nightingale facility.

It is important to note that the level of staffing required to deliver the 158 ICU bed capacity will be extremely challenging. It is impossible to sustain for long and would have an unavoidable impact on our Health and Social Care (HSC) services. That includes, unfortunately, some complex elective surgeries.

It is important to recognise that rebuilding happens in the prevailing COVID-19 context. Members will be aware of the previous rebuild plans that were produced by each of the trusts and set out how services would be scaled back up as quickly as possible over the intervening periods. I am pleased to say that, at the end of phase 2, which was the period up to 1 October, we exceeded all our key indicators for the volume of activity delivered across the region. For instance, for the three months from July to the end of September, the planned increased activity was for 205,176 outpatient appointments across all our trusts: we actually delivered 247,825 appointments. Similarly, across Northern Ireland, we had a target of 5,458 scopes, and, over the three months, we delivered 7,674.

While hugely welcome progress was achieved over the summer and going into the autumn, the recent upsurge in cases will inevitably slow that momentum. The more scarce resources that the system must allocate to managing the pandemic, the more difficult it is to fully maintain the delivery of our mainstream services. That is deeply regrettable, but it is the reality of the situation. Nevertheless, we continue to consider how we can maximise elective care in the difficult situation that we find ourselves in. That includes protecting COVID-free sites as well as quickly scaling up elective care when COVID-19 pressures abate.

Given the ongoing impact of COVID-19 on our Health and Social Care operating capacity and the resultant reduction in productivity, we continue to require access to the independent sector capacity to deliver core services. From 29 June to 18 October, over 1,000 patients had their procedure undertaken in the independent sector. We will continue to use the independent sector to maximise available capacity and look at wider opportunities in Northern Ireland to maximise those elective provisions.

Of course, one of the key components of our fight against the pandemic is testing and track and trace. Everyone in Northern Ireland is eligible for free COVID-19 testing if they show symptoms of infection, and there is sufficient testing capacity to test everyone who requires a test. I reiterate that everyone who has symptoms must come forward for a test. Testing capacity continues to be kept under active review by my officials. My Department continues to work closely with partners, both locally and nationally, to enhance and maximise the testing capacity across our pillar 1 and 2 programmes. My Department's expert advisory group on testing is also fully linked in to the mass population testing programme that is being led by the Department of Health and Social Care (DHSC). Plans are progressing with the range of local partners and experts for pilot testing in different settings in Northern Ireland. That includes a pilot for repeat testing of asymptomatic healthcare staff and testing of university students. It is important to reiterate that those tests are not a substitute for the fundamental measures that are already in place, which are cutting down our contacts with each other,

maintaining social distancing, ensuring strict hand hygiene, wearing a face covering and downloading the StopCOVID NI app.

The StopCOVID NI proximity app has helped in our fight against the virus and has been well received by people living in Northern Ireland, with just short of 500,000 downloads. It is planned that version 2.3 will be released during the week commencing 16 November, subject to the successful conclusion of discussions with the Information Commissioner's Office and quality assurance testing. The updated version will include features developed in response to public feedback; in particular, it provides a more tailored period of self-isolation connected to the date of actual close contact with someone who has tested positive for COVID-19. For example, if the app user receives a notification relating to a contact with an infected person that took place five days ago, the end date for isolation will be nine days from receipt of the notification. That is something that Colin McGrath will, undoubtedly, have interest in; that was one of the things that he raised with me before. In developing the app and adding new features, we have to balance privacy and precision. There are now enough app users and sufficient numbers of positive test results to add that feature without compromising anonymity. Future updates that are being looked at include the ability to share a validated certificate to self-isolate with an employer or in support of a claim for discretionary support with the Department for Communities.

Another key element of our response to the pandemic to help to minimise the risk of COVID-19 is protecting our care homes through regular testing. The Committee is aware that a rolling regular programme of testing in care homes commenced on 3 August. On Tuesday past, I announced my intention to increase the frequency of COVID testing for staff working in care homes to a weekly basis — every seven days — commencing as soon as possible. Care home residents will continue to be tested every 28 days. That is the right thing to do: the expansion of testing is one of the most important weapons in our continuing battle with COVID-19.

The contact-tracing service in Northern Ireland also continues to play an important role in our response to COVID-19. My Department and the Public Health Agency (PHA) have been developing proposals for a future contact-tracing model for Northern Ireland to ensure that we are well positioned to respond positively to the sustained increase in case numbers. Those proposals will build on the systems that are already in place, learning lessons from here and other countries, with an increased emphasis on automated and digital solutions. In the immediate term, we also continue to improve the operation of the existing system with the embedding of the new texting and digital self-trace platforms and the focusing of contact tracing on the cases most recently notified to the service.

It is worth noting that it is not possible for society to function as previously normal even if test, trace and protect (TTP) is functioning to a gold standard. An effective, functioning TTP service could be expected to reduce R by up to 30%. It, therefore, must be emphasised that contact tracing is not the panacea or silver bullet for the many challenges that the pandemic poses to society. Suggesting that it is would give false hope to our citizens at this time. Countries with contact-tracing systems that have been compared favourably with ours have recently had to impose enhanced restrictions. It would appear that their advanced contact-tracing infrastructure has also experienced significant challenges in the context of an exponential growth in cases. That said, contact tracing remains a vital aspect of our overall response to COVID. It is critical, therefore, that we have the best possible level of service in place.

In conclusion, I cannot emphasise enough that we all have a role to play in minimising the spread of the virus and reducing the pressures on our health and social care system. The more we can minimise COVID-19 transmission and resulting hospital admissions, the more we can protect our services. I, therefore, strongly encourage everyone to follow the regulations, not only for themselves but to help others access essential Health and Social Care services. Thank you, Chair. I am now happy to take questions.

The Chairperson (Mr Gildernew): Go raibh maith agat. Thank you, Minister. I will start on the issue of find, test, trace, isolate and support. We know that there are limited enough options in dealing with the pandemic of this particularly difficult disease. One of those is a vaccine, which does not exist, so that is obviously off the table. It is clear from the impact in terms of both deaths and long COVID that it is not sustainable to countenance population immunity; that is also not a viable option. So, you are really left with only two options, which are lockdowns, as those have become known, or, alternatively, find, test, trace, isolate and support.

A number of weeks ago at Committee, we heard from the PHA that the system of tracing had come under pressure and been severely challenged as a result of a lack of planning around the numbers that they were expecting at the end of September. They told us that they had been planning for

approximately 300 cases per day. That number had surged to 900 by that point and then went above 1,000. What have you done in the meantime to ensure that we upscale the tracing part of the operation to a point where it is flexible enough to deal with whatever the demand is? I note that, in many countries that do this — in fact, the European Centre for Disease Prevention and Control (ECDC) recommends it — it does not necessarily have to be done by clinical staff but can be done by, for example, civil servants who are on furlough, so that you have flexibility to flex the system up and down.

Mr Swann: Thanks, Chair. I think that there is a third option. You said that it is either restrictions or TTP. I think that there is a middle path in between where we have a reduced level of restrictions but supported regulations. If we can embed the good health messaging on social distancing, good hand hygiene and face coverings into the population, that adds to our armoury. Rather than just looking at lockdown or TTP, there is that contribution in between.

As regards where we have been with TTP since the engagement that you had with the PHA, yesterday's update was that we have a total staff of 220. That is made up of 27 full-time staff who work 37 and a half hours a week; 69 part-time staff who work anything between seven and a half and 30 hours per week, which is their contract choice; and 124 bank staff, which gives the fully flexible operation that we need as we can call people in as and when we see increases.

The period that the PHA was talking about was when, within a week, we went from 300 cases per day to over 1,000 cases per day. That is where that challenge came. In the meantime, we have brought forward our text-messaging service, so that positive cases can be texted to be advised that they are a positive result and how to contact trace. We also brought forward our online digital service, which allowed people to input their own contact details and who they had been in contact with. That has been established and brought forward, but it is still being built upon, expanded and updated to make sure that we can gather clustered information from it and go back to the seven days. Paula Bradshaw raised that issue in the Committee — going further back so that we can find the point of infection. A lot of work has been ongoing in regard to that facility.

You referenced what is said about not putting clinical staff in there but putting the call centre staff and civil servants in there. We did not go down that path — rightly so, I think — because we have found that, when we contact some people, they are looking for more than just being told that they have come in contact with somebody who has tested positive. They want to know what they can do, where they should go for help and about their medical needs, and there is also a level of anger and frustration when people get called. When I visited the call centre, I heard feedback from some of the staff working there about anger being taken out on them, such as, "How dare you phone me to tell me that I have been close to someone who has tested positive. Who would have done this to me?". Rather than putting that service into the hands of civil servants working off a script, our direction of travel is that there should be people there to provide that help and support. The staff behind our test, trace, isolate and support service have to be able to give that wee bit more, and that is the direction of travel that we have taken, Chair.

The Chairperson (Mr Gildernew): I agree, although you did say, Minister, that there is a move towards looking at more automated and digital solutions, and I know that there is a reference to the concept of digital first. There is that concern there. For example, I dealt with a family at that time. It was an older couple whose daughter had moved in with them at the very start of the COVID pandemic to provide them with the care that they needed. They were living in a pensioners' cottage. The daughter received a positive test and had to self-isolate, and she was trying to isolate in a house with one bathroom and one very small room. The two parents could not get tested, could not get answers on PHA lines and were absolutely terrified, but they did not have the ability to isolate in that setting.

I agree that we need human contact to provide genuine support for people when they have to isolate, because this system of find, test, trace and isolate is a chain, and, if any one element of that chain is not functioning, the entire system is weakened. In terms of isolation, what support is the Department offering people in terms of the actual building that the people live in and in terms of finances and protection from work issues where people are in more precarious work? What plans are there to reinforce that part of the system?

Mr Swann: Chair, the question is not, "What is the Department of Health doing?"; it is, "What are the Executive doing?". We have had great support over the past number of weeks from the First Minister and deputy First Minister, because this system works with collective Executive support. We cannot provide the ability to give support payments, so we are working with the Minister for Communities on

the additional COVID support payments that are already there. That is in place in Northern Ireland in the way of a non-repayment loan, and that has been there since the first wave. An employee from the Department for Communities is now working alongside the group that is looking at how we expand what test, trace and protect does to make sure that the information flow is there so that, if somebody tests positive, they are directed to the appropriate point in the Department for Communities where they can access that finance.

The Chair asked before about how we can provide accommodation. We do not see that as being within our remit in Health, but, again, we are talking to the Department for Communities about how we can provide that additional support. It is not easy, Chair, because the lack of housing capacity in Northern Ireland or how we commandeer hotels is for a wider Executive discussion. We are seeing that wider engagement in what we are doing in TTP, because this is a holistic approach and not simply a Health one. The work that we are seeing across all Executive Departments in how we support people once they receive that positive result is to be commended.

Would the CMO like to come in with any further updates that have been taken?

The Chairperson (Mr Gildernew): Before we go to that, I want to go back to the issue of tracing. Have there been any additional recruitment programmes, or how many additional tracers are now being recruited to ensure that we do not get the situation that we had back at the end of September?

Mr Swann: There is an ongoing, open recruitment process, Chair. There are currently 40 in training, because we do not want people to come in and work off a script. These people go through a classroom induction and they monitor and shadow current contract tracers to make sure that they get the correct repartee in how they interact with callers.

The Chairperson (Mr Gildernew): Finally, on that element of the system, we do not hear anything relating to a finding strategy. It is key that we find the cases and that we find them early to test them, trace them and do the isolation. Are there any plans to increase the asymptomatic testing of key front-line staff? I ask that in light of your own acknowledgement that, in mid-September, 24 of the 28 care home outbreaks identified had been found by asymptomatic testing.

Mr Swann: Chair, there are plans. The CMO can come in on the advanced mass-testing programmes and the platforms that are coming in. We have capacity within our system for front-line staff who are asymptomatic, but we are looking to expand when that flow of mass-testing capacity comes on and is targeted. Our front-line health service workers will be one of the key groups to test.

You mentioned the asymptomatic findings in care homes. That is why we have increased to weekly testing. We are still running at roughly 50% of our care homes that show a COVID outbreak are showing asymptomatic staff rather than residents. That percentage continues, and it proves the worthiness of our testing programme in our care homes because we are identifying those cases very early. When it comes to that point, it puts stresses on our care home sector and our trusts, because, when those staff, although asymptomatic, test positive, they have to self-isolate for 14 days. The trusts are supporting the workforce to make sure that we maintain the high level of care for the residents in those homes.

The Chairperson (Mr Gildernew): While it is welcome that there is additional testing, that does have the knock-on effect of putting additional pressure on the staff who are doing the testing. That is an issue that I want to come on to, because I am hearing huge concerns from nurses about how they are coping, due to the fact that they have been dealing with the pandemic for so long. It has been a hugely stressful period, and they are now into a second surge. Clearly, in the absence of workforce planning, which is a longer-term issue, fundamental gaps exist in recruitment. Staff were already under pressure before this even started.

I am hearing of many cases where nurses are not getting breaks or hot meals. They are trying to grab a sandwich in the car. By the time they come out and doff and don their PPE, and they find that the canteen closed at 4.00 pm or that the vending machine is broken, it is just not worth their while to take a break. Staff are saying that they feel that they are now letting their colleagues down because they are aware of how much pressure they are under. While I recognise that we cannot recruit nurses quickly, we could do more to support the staff that we have in terms of breaks and meals. What is being done to address that situation urgently?

Mr Swann: Chair, you highlight the concern that we have. It is one that has been voiced recently by the BMA and the royal colleges. Our engagement with the unions and staff echoes exactly what you are hearing. The stress and strain that they are under is unbelievable. I have been saying that for months, but, unfortunately, it fell on many deaf ears. With the pressure that we are putting on our health service when we are trying to run a COVID service and a health service and are still trying to transform, it is the nurses, doctors, porters and cleaners on the ground who feel the strain. When there are many calls on what we do with our health service and we have to keep a service going while we do not turn something else down, it is impossible to do. It is about how we support not just our nursing colleagues but our colleagues across the health service. Trusts have been asked to make sure that all changing facilities and supports for canteen workers are in place. Again, we will go back to the trusts to make sure that those workers have the appropriate facilities on-site, which they should do, especially if they are working on COVID wards or in COVID-positive areas. The facilities need to be accessible and appropriate for the staff who need that support. I will take that back to the trusts to make sure that they are doing what I expect them to do.

The Chairperson (Mr Gildernew): There is a reason that I focused on that. I declare an interest in that my wife is a nurse, so I know the issues at first hand. I have also been approached by staff in hospital and community settings right across the North. In the community, there are significant issues with staff trying to put on flimsy aprons while standing at the side of a road or outside someone's house or trying to put on a paper mask in the rain, which makes it fall apart. They are seeking further PPE but are being told that that is being monitored and that they have already been given their allocation of one or two masks. The practical arrangements for the winter could have been foreseen. We knew that there would be a second surge. There are really practical issues with staff being overworked and difficulties with working in PPE, at a time when they are picking up much more work because the hospital capacity is not there and the GP capacity is, at times, not there. An awful lot of additional work is being picked up in the community. What can be done to ease that situation?

Mr Swann: It is about the physical challenge faced by someone who is doing care home visits. I think that what you are describing is how they get from the car in through the front door.

The Chairperson (Mr Gildernew): I am talking about workers in the community going to people's houses.

Mr Swann: Going into people's houses, and at which point they put on the PPE. During the first surge, we found that there were complaints from the public about seeing domiciliary care workers putting on PPE in their car and then walking to a front door. There were complaints that they were not using the PPE correctly because they were walking outside with it on. The challenge is: at what point should a care worker put on PPE? It should be when they get to the front door of a house or just inside the front door. There is that practicality. I will make sure that the guidance is clear. Nobody expects any care worker to stand outside in the rain trying to put on a face mask or an apron.

The Chairperson (Mr Gildernew): I will leave that and go to members now. However, I want to leave you with some of the things that I have heard in recent weeks. One nurse said, "I just wish this was all over. I'm frightened, exhausted, deflated and feel as though I've been thrown under the bus for a second time". Another nurse described feeling like a lamb to the slaughter. There is a need to protect and support the nurses whom we have.

Mr Swann: Chair, I hear that day and daily. I know that we are doing as much as we can to support all our workforce. There is, however, more that we can do, and there is more that we will do, because it is crucial that we do so. We have tried to get that point across. The BMA, GPs and the royal colleges, which made a statement yesterday, are echoing everything that I have been hearing for the past two or three months about that pressure. I only wish that people out there would appreciate the strain that our health service is under and how they can help by breaking the chains of infection. I have said this in the Chamber and in here: the fewer people coming forward with COVID and needing COVID support, the more people we can get into our normal phase of work and the more pressure that we can take off the workforce. To put things into perspective: there were 418 COVID inpatients yesterday. That is the equivalent of 52 eight-bedded wards. That is a massive footprint across our entire health service that is supporting COVID-positive patients. Those COVID-positive patients are there through no fault of their own; they are there because they contracted a highly transmissible virus. It is our duty to support them, and that is why there is pressure on our system. You have to recognise, Chair, that our health system has been underfunded and understaffed for the past 10 years. We cannot adapt or flex up, no matter how much I have wanted to do so in the past two months between the end of the first wave and the start of this wave. The staff pool is not there; there are no additional resources that

we can provide. The additional ask of our staff is over and above what we should be expecting them to do. They are a professional, dedicated workforce, and that is why we, not just as an Executive but as an Assembly and as a society, have to do everything that we possibly can to make sure that, if there is a third wave, that is as far away from the current situation as we can possibly get it.

The Chairperson (Mr Gildernew): The way to do that is to have a properly functioning find, test, trace, isolate, support and communicate system.

Mr Swann: Along with people following the regulations, Chair.

The Chairperson (Mr Gildernew): Absolutely. That is what people can do, and the Department can ensure that element.

Mrs Cameron: Thank you, Minister, for your attendance this morning. I am sure that you are as excited as I am to get out of the house, just as Alan is, even if it is just to come to the Health Committee.

The Chair covered quite a lot of what I wanted to ask you about testing. I welcome the news that staff in a care setting are to be tested every week, but we heard from the care sector about the challenges posed by the administrative burden. Certainly, from the Committee's side of things, they said that they did not have the resources to carry out any more testing than they were already doing. What plans do you have to support them, especially with the administrative burden of additional testing, which, effectively, is doubling the testing, for which I completely see the need and agree with? I specifically ask whether you have requested military assistance, even to deal with logistical issues. We should take assistance from wherever we can get it in order to help those settings to cope with the burden that has been put on them. It is also interesting that the level of asymptomatic cases that are being picked up through routine testing is proof that it would be good if we could, ideally, have testing en masse. Where are you going with that and how are you working towards increasing it? It is not just about asymptomatic cases. Obviously, even your colleague who tested positive, and probably pinged us — we will not find him guilty for that — has publicly said that he did not have any of the four main symptoms. It throws up issues about additional symptoms, and maybe it should be a case of allowing you to seek that test.

While I am on the theme of testing and tracing, I also have a concern about how the PHA is handling the test, trace and protect programme. We had clarification in today's correspondence about the number of full-time equivalents employed in that programme, which is just 88. That seems like a very low number given the pressures that they are under. My suggestion is that you should seek additional help, wherever that may come from, even if it is military assistance, because we should explore every possible avenue in order to assist that programme, given its importance. I understand where you are coming from in that you do not want to go down the call centre route as such, but, as the Chair said — you admitted it — we have moved to sending texts and requesting information online, which means that we very much rely on the public to do the right thing by taking a call, responding to a text and going online to upload that information. I have a lot of concern about where any type of enforcement is coming from and in making sure that we are getting accurate information. I know many families — this has happened over the last week or so — who have come into close contact with somebody who has tested positive, but they have not received a text, a phone call or a ping: nothing. Those people are very concerned. They have done the right thing, looked for advice and self-isolated, but they were not contacted. I am concerned about the service becoming less effective as time goes on because of the pressures and the sheer quantity of people who need to be contacted.

Mr Swann: I will pick up on your last point. I have also had such conversations. I know of somebody who had tested positive but was never contacted. That person will be contacted only if the person who originally tested positive gave their details as a close contact. I know who you think gave you your ping; they may agree with you. Unless I tell the test, trace and protect systems that I was close to you, you will not be informed that I tested positive. There is a reliance on the people who test positive to give that information. That was one of the challenges that we saw with test, trace and protect. We have already seen upwards of 20% of people who have tested positive going down the route of the automated online system because they are more comfortable with putting information into that. It is about trying to get a service that people are comfortable to interact with. Some people want to talk to somebody, while others are happy to do it on their phone or computer. It is about making sure that we get as much accessibility as possible. If somebody gets told, called or pinged, a person who has tested positive has taken that responsible step of letting other people know.

As I said, we are up to 220 test, trace and protect employees across three employment models. Liz Mitchell, who is a former acting Chief Medical Officer, has come in to head up the test, trace and protect directorate in the PHA. We have brought in additional expertise and management skills to ensure that we are going in the right direction.

We tried to step out in a specific way care home testing and the additional pressures and responsibilities that come with going to weekly testing. That is why, back on 21 October, I announced an additional £27 million of funding support for care homes. Part of that was to allow them to put in systems as we moved in that direction. There is still money from the initial care home support package that we are re-profiling. That means that care homes will get as much financial support in that regard as they need. As you identified, asymptomatic testing is important to us. Work on the mass testing programme is ongoing. We are tied into what is happening across the water. Some pilots are already in train. I will bring in the CMO to talk about asymptomatic testing.

The member raised the issue of military support. We have used the army in the past, and we have used the RAF to transfer extra corporeal membrane oxygenation (ECMO) patients to hospitals in England. We have used them for logistical planning for what our PPE distribution could look like and where our first Nightingale facility could have been located when we looked to either the Eikon centre or to upscaling the tower block. We are in continual conversations with anyone who can supply additional support to us when it is appropriate and where it is available. I will dispel some of the myths that are out there. A number of weeks ago, I heard someone say, "Call in the army to help out our nurses": I think that 75% of our reserve forces, such as the Territorial Army Medical Corps in Northern Ireland, are NHS workers. It is not as though they are an additional workforce who can be called on; they are already part of our workforce. The other part of that workforce is already deployed or involved in administrative or medical situations in the MOD. It is not as though there is a pool of ICU nurses or cancer surgeons sitting ready to be used, but when it comes to logistical support, we have used them in the past, and we will use them in the future as and when necessary.

Michael, do you want to update the Committee on where we are with mass testing?

Dr Michael McBride (Department of Health): Yes, Minister. As the Minister said, we are fully aligned with colleagues in the rest of the UK in terms of the introduction of the new mass testing project and programme of work. That includes new rapid technologies that also have the benefit of being less invasive in sampling. Some of the tests are based on a saliva sample as opposed to swabbing the nasal pharynx, which, unfortunately, many are familiar with, so it is less intrusive. In some tests, the results from lateral flow, as it is referred to, or the new loop-mediated isothermal amplification (LAMP) technology can be available in minutes, or up to an hour, and they can be done at scale. They are less labour-intensive and less dependent on reagents, which have been some of the rate-limiting steps, as members will know, from the challenges around polymerase chain reaction (PCR) tests, certainly in the early phase. Northern Ireland is well placed, and we are building on pilots that have been undertaken in a number of cities in England. We have begun the piloting and validation of those new tests in Northern Ireland, and, increasingly, we will begin to look at their use in cases in which individuals may be repeatedly exposed to the virus across a range of settings. That will include, obviously, healthcare workers and staff in other front-line services. Again, we will look to the universities, where students may be frequently exposed to the virus, and, indeed, it may provide a gateway for students to return home from across the United Kingdom and elsewhere for Christmas.

There is no doubt that, as those tests scale up very rapidly into the new year — I anticipate that, by February, we will have them at scale — it offers a very fundamental change in our approach to how we coexist with the new virus. One can see a situation in which, at a population level, there could be availability to do daily testing for many of us. That is a realistic possibility. It will not replace the diagnostic ability to confirm the presence of COVID-19, but it will provide an opportunity, at scale, for us to reduce the risk of us interacting in society. It will be a game changer, and, as the Chair said, the other game changer that we will, I am confident, be hearing about increasingly is the introduction of vaccines. It is highly likely that vaccines will become available early in the new year.

Mrs Cameron: It was remiss of me not to declare an interest as I have a family member working in an ICU and another one was recently recruited into the test and tracing system.

The Chairperson (Mr Gildernew): OK, thank you. Members, I need to ask you to keep things tight now as the Minister's time with us is limited.

Mr Buckley: I thank the Committee for the warm welcome. I look forward to playing a full role. I do not underestimate the grave responsibility that the Committee has on its shoulders.

I have a question for the Chief Medical Officer and one for the Minister. I welcome the Chief Medical Officer here this morning. I know that you sensed a grave deal of responsibility involved when making public commentary on COVID-19. People's lives and livelihoods hang on every word that is said in Committee and on the airwaves. I want to refer specifically to your comments concerning the reopening of education and hospitality and, rightly or wrongly, how they have been interpreted as a slight on school staff, patients and workers who are acting in good faith. I would like to caution you in that approach, because the last thing that we want is to pit communities and sectors against each other when we face a dangerous time in our health service. Can the Chief Medical Officer elaborate on his claim that hospitality opening up again will push the R number into dangerous territory? How does that stack up with evidence that has been published that closure would only reduce R by 0·05?

The Chairperson (Mr Gildernew): I ask the Chief Medical Officer and the Minister to be as brief as they can with their answers.

Dr McBride: Just to correct the member: when I am asked a question, I answer factually, based on scientific evidence. Unfortunately, how those comments are then interpreted and used or misused in other discussions is not a matter for me. The last thing that I would wish is for this to be pitched as an either/or situation. We are all aware of the importance of education for our children; I have said that repeatedly. They have paid a very high price. We are all aware of the importance of a strong economy, reducing health inequalities and ensuring that people have good life opportunities, live longer and reduce the burden of disease. I am acutely aware and am very measured in all my comments, every one of which is informed by the scientific evidence. Indeed, all that information is in the public domain and is published and available on the departmental website.

Mr Buckley: I thank the Chief Medical Officer. He will agree that interpretation is key in how it takes the public narrative into account and involves it.

I know that time is brief, but the Health Minister will know, from my questions to him in the Chamber, that I have grave concerns, as does he, about non-COVID patients in these times. By Tuesday 3 November, the dashboard confirmed that the total number of beds occupied by non-COVID patients had dropped by over 300 in the past two weeks and had dropped roughly 900 since 11 October. What is the Minister's assessment of where those patients are right now? Surely their needs have not gone away. I have a real concern that we run the risk of failing those patients. Is it likely that some have already, sadly, passed away because the inpatient care was not available to them when they needed it?

Mr Swann: I have answered the member in the Chamber when he has asked this question before, and I also raised the point in my opening comments. The more patients we have to support with COVID, the fewer patients we can support with other needs, because we do not have the footprint — the staff — to do both. We do not have the staff or the ability to run the three health services that I talked about earlier. Bengoa recommended that Northern Ireland would need to run two health services — a transformation health service and our normal health service — to keep on top of things. We are trying to run three: a COVID health service, an elective and registered operational health service and part of the transformational health service that results from the changes that we have to make. Chair, as I said in my opening comments, 418 COVID patients is the equivalent of 52 eight-bedded wards that we have to support. If the member seriously thinks that we can turn away COVID patients to support everybody else, that is not a health service that we can possibly maintain. We have to support the people who present, need medical treatment and support here and now. Unfortunately, we have to turn down many services that our health service, surgeons, doctors and nurses want to keep going. We are not doing this on a whim of turning people away or turning beds down; we are doing it out of necessity. We have to supply medical support. From the early steps, we laid that out clearly when we published our detailed surge plans on 19 March on how we thought that our healthcare system would have to react not only to the number of patients presenting but to those who needed support for COVID. We followed that up on 9 June when we started to publish our rebuilding plans, which were published across the Department and all trusts. They were about how quickly we could re-engage our service to get as many of those patients whose treatments had to be stood down during the first wave back up and running. We have done that successfully over that period.

As I said in my opening comments, on 10 July, the trusts published their three-monthly building plans, which took another step forward. We deliberately moved in three-month blocks so that we could utilise

our capacity — the available staff — to bring as many people who had missed treatments, support, scopes and diagnoses back into the system as quickly, effectively and safely as possible. We know well that COVID has not gone away.

On 6 October, I announced in the Chamber that we had paused the rebuilding framework. We were still trying to meet our current targets, but, unfortunately, we had to relaunch our second surge plan. That is where we are so that we can cope and support the patients who have a positive COVID diagnosis and need hospital support. Unfortunately, we see more of them than we would like, and the only way that we can support them in our Health and Social Care service is, as I said, by turning down the elective services that we want to deliver. I do not think that the member is trying to portray that people are being turned away at the door just because we see that as something that is easy to do. It is not. I think that that is undermining some of the healthcare professionals, who the Chair referred to and who are under immense pressure and strain. They want to support everyone who presents to them, and they do not want to have to be in the position where they have to choose.

Ms Bradshaw: Thank you, Health Minister and CMO, for coming this morning. The Scientific Advisory Group for Emergencies (SAGE) report of 21 September said that, if you are going to reintroduce these types of restrictions, you should at the same time introduce support packages for people who are most acutely going to be affected by it. I am talking about carers and people who may not be shielding but will decide to self-isolate in order to reduce their potential to be infected. Can you give us an outline of what exactly you have done to put in place additional support programmes?

Mr Swann: Is that in regard to carers specifically, Paula?

Ms Bradshaw: Anybody who is vulnerable. I am talking about people in mental health services, support services and anything like that.

Mr Swann: Specifically on mental health services, we were able to put in place a specific part of our mental health strategy. Because we were in the first surge of COVID-19, we put in place mental health support packages. In recent funding applications, we have put in place bids as well. A lot of work has been done online. There is online counselling and online support packages for people with COVID and those who are feeling the stress. We have also put in psychological support for healthcare workers across the entire system, so it is about not only how we digitise a lot of that but how we make available the face-to-face consultations for anybody who still needs them. Again, that is supported by the piece of work that is ongoing with the appointment of the mental health champion, Professor Siobhán O'Neill, who is feeding in not only to our Department but across all Departments on how we put in place those support mechanisms for people who are seeking help and looking for the right place to go. There is an online directory now of online facilities that can provide that mental health support and provision.

Ms Bradshaw: To follow up on that quite quickly, can you in quick time give the cancer charities, which you met recently about the funding, some information about when it will open and what its parameters are? Will it be £10,000, £50,000 or £100,000? Some of them will have to bring staff back from furlough.

My main second question relates to student nurses and midwives. You will know, Minister, that they receive only £430 a month as a bursary. Many of them are now not able to avail themselves of other work that they would usually get involved in to supplement their income. They are not eligible for student loans or grants. They have been told by the Belfast Health and Social Care Trust that they are not eligible for the free parking. Are you going to reintroduce paid placements for student nurses, or are you going to increase the student nursing bursary?

Mr Swann: Thanks, Paula. Our Chief Nursing Officer (CNO) has been leading on a piece of work on that. Part of the restriction comes from the regulations of the Nursing and Midwifery Council (NMC) and its requirements. As part of a nursing student's three years of training, they have to undertake 2,300 superannuated or unpaid hours of placement work, so it is important that they do those to receive their registration. A cohort of nurses is coming forward for graduation in February, and the Chief Nursing Officer is working with us on putting forward a submission so that we can get them online quicker, but there is a requirement that they have to undertake so many hours to get their registration. The NMC looked at that in the first wave, and we are engaging with it now. All four Chief Nursing Officers are engaging with the NMC to see what can be done to allow them to register, but they have to complete their coursework as well.

You rightly identified where the additional financial strain is coming from. It is not about the students' work or placement but about the fact that many of them had other part-time jobs and are now finding that that additional avenue for financial support is not there any more. It is without the responsibility of my Department to supplement that finance, but we are looking at bursaries and car parking charges as ways to support the students. They are a valuable part of our workforce, and they are a part of our workforce that we are putting a lot of investment into because we realise the value that they bring. The Chief Nursing Officer is leading on that piece of work.

Ms Bradshaw: I stress the urgency of that funding and of the cancer charity funding. Thank you.

Mr Sheehan: I agree with what the Chair said about find, test, trace, isolate and support being a chain and that if there is one weak link in it, it undermines the whole system. There is a fundamental flaw in the maths. We are talking about gearing up the contact tracing to deal with x number of cases. According to the ECDC, if there are 1,000 positive cases, in a lockdown situation, there are two to three close contacts for each case, but outside of a lockdown, there are between seven and 20, so you could be talking about 20,000 cases a day that need to be dealt with.

In a recent article in 'The Irish Times', Professor Sam McConkey said that the system in the South was under pressure. Some said that the system in the South was overrun; others said it was understaffed. To benchmark that with the international best practice and those who are doing best at suppressing this virus, we see that there is a need for around 2,500 contact tracers in the South. If you extrapolate from that, you find that we need around 1,000, but we have nowhere near that, and there do not seem to be any plans to put them in place. That is just a comment.

I want to ask you about Justice O'Hara's report on hyponatraemia. It is disappointing that the recommendations have not been implemented to date. What are of equal importance are O'Hara's findings in that report. People will not know what is meant by the findings, so let me quote from O'Hara's report. He said that, in 1996, doctors made:

> *"a breach of both statutory obligation and professional duty."*

and attempted a cover-up. O'Hara's finding is that:

> *"clinicians did not admit to error for the obvious reasons of self-protection and that this defensiveness amounted to concealment and deceit."*

O'Hara also found that, in 2004 and 2006:

> *"inaccurate, evasive and unreliable."*

and "misleading information" was given not only to Claire Roberts's parents but to the coroner. At an inquest in 2006, there was an attempt to:

> *"protect the reputation of the hospital."*

and its doctors. In 2006, the coroner reached an incorrect finding and wrongly certified the cause of Claire's death. What are you doing to address those findings, Minister? How many of the doctors that were involved in Claire Roberts's case are being investigated by the GMC?

Mr Swann: Pat, I do not have the detail with me, but I will get it for the member. I have a brief for today and was not expecting something as specific as that to be raised.

The recommendations from the inquiry into hyponatraemia-related deaths are being taken forward by my Department under a number of different work streams. They are being brought forward, and some have been paused due to COVID. The main onus and one of the pieces of work that is being looked at is that duty of candour. What came out of O'Hara's report was the importance of the ability of a doctor, no matter at what level, to come forward to raise concerns about another professional somewhere in the system. That protection was not there in the past. That is that protection comes with not only that duty of candour but with responsibility. We are working through that as a Department because we realise the value of it. However, it has to be done right so that it does not put people off getting involved in the profession and so that they do not see coming forward to speak out as a restriction on when they can or should speak out. That duty of candour, which is one of the major precepts of the findings of that report, has to be done right not only so that we get the information that we need but so

that the right steps and protections are there in order to allow it to be done in a meaningful way that protects patients and allows those in the profession the assurance that, if they step forward, they will be supported and listened to.

Mr Carroll: I have two questions, Minister. You will be aware that the royal colleges have called for a breathing space, and the CMO alluded to something similar, as has been mentioned. There seem to be different quarters clamouring for a return to normal in eight days' time. How dangerous would it be if we returned to normal then, and what do the Minister and CMO advise should happen after 14 November?

My second question is about the isolation grant, which is available in England, Wales and Scotland for people who have to isolate but is not available here. It seems that people here are being treated worse than those in Tory Britain, which is definitely not a pretty picture. It is not good enough for Ministers, you or others, to toss it into the Executive. We hear the phrase "a collaborative approach" all the time. This needs to be an issue that Ministers come together on in order to ensure that people are not forced to choose between paying bills and rent and taking incorrect public health measures. This is a matter of urgency. The Minister has a role certainly in advocating for that, with other Ministers stepping up. I would like to hear your views on that.

Mr Swann: I will deal with the second point first, Gerry. My understanding is that the grant is already there. Actually, our financial support package goes further than the £500 grant across the water. I made the point that we need an easier way to signpost it. It is there under the Department for Communities. It is a non-repayable loan. Perhaps, Chair, you could get more detail on that from the Department for Communities.

One problem that we have had is that it is not easily linked in. When you get your positive case result, there is not a straight flow pointing people to a place that says, "You can now avail yourself of this grant if you're applicable for it or if it is under your means", rather than there just being a simple £500 payment, as was the case across the water.

There is a financial package. I do not want to misquote her, but Minister Ní Chuilín said that our support package was there before the £500 and that it was more generous. I think, Chair, that it would be worth getting the details of that for your members. When I talk about the collaborative approach, I mean that we need to make it easier to find for those who need it and more publicly and better presented.

When I hear colleagues across the health service say that we need a breathing space, I support them. If we do not want to go back to further lockdown or restrictions this side of Christmas, we need that bit of additional time. The Executive will meet later this morning. We will make recommendations to the Executive. That is where we have that conversation. That has been the way that I have worked since becoming Minister. Any recommendations that we make will be to the Executive first so that they have the discussions. I note that one of our media outlets is already trailing that. That is unfortunate. When a paper that we put in to the Executive last night is already in the media this morning, that is not a good way to work. It is not fair to those who are now uncertain about what the Executive will decide or may decide because of the partial leaking of a document that was presented to Executive colleagues last night.

Ms Flynn: My first question is to the CMO on the pilots and mass testing. I think that you said that you are working towards February to have an expansion of the mass testing programme with asymptomatic individuals and that it will include students and Health and Social Care staff. Can you explain why we have to wait until February for the expansion of that testing? Is that down to the time that it takes for the pilot, or is it down to trying to obtain sufficient resources or staff? As you mentioned, and fingers crossed, we might have a vaccine in the new year. I know that that will not happen or be rolled out right away, but waiting to February brings us through the whole of the winter, which has the most difficult months. Is there any way that that process could be brought forward more quickly, and if not, why not?

Dr McBride: That is a very good question, because everyone wants to see a way through this and a return to a more normal life. The availability of those tests is largely based on our ability to determine their effectiveness and to validate them. These are new tests and new technology, and it is essential that we have confidence in their ability to differentiate those people who have infection from those who do not. As you recall, it was only in February last year that we developed the first diagnostic PCR test. These are brand-new tests, and it is the process of validation that will allow those to become available

as quickly as possible. If we can introduce them earlier, such as early next year and before February, we will do so. However, as you say there is, unfortunately, the time between now and then.

It is important to point out that we have opportunities now to test these at scale. You will have heard the recent announcement about the mass testing programme in Liverpool. That provides a further opportunity to validate the tests. It may well be that information coming out of that pilot informs the work and may allow us to move forward more quickly with the roll-out of these new technologies. It is not a resourcing issue; let me assure you on that. It is about us having confidence that the evidence base is there to support the use of these tests and in what settings.

The Chairperson (Mr Gildernew): Apologies, Órlaithí. I have two other members that I want to get to quickly. The Minister needs to get away. I will go to Colin for a quick question.

Mr McGrath: I have had technology problems and have not been able to hear all of the debate this morning. First of all, I totally distance myself from the remarks of Sammy Wilson, which completely undermine the public health message that we are all trying to put out and the unified approach to reduce the spread of the virus and the numbers going into hospital. I fully commend the Minister and the Chief Medical Officer on the work that they are doing on that front.

Some of those remarks are born out of frustration in the community by some sectors, such as hairdressing, tattooing and others, that do not understand why they have been asked to close down. We need to reduce the number of places that are open, but can Dr McBride give us a short explanation of the benefit of having those types of places closed down so that they understand and, hopefully, feel better about playing their part in staying closed in order to stop the spread of the virus?

Dr McBride: Thank you for the question, Colin. I realise how difficult a time it has been for those who are working in that sector. We are trying to balance lives and livelihoods, and I know how distressing and anxious a time it has been for those working in many sectors, including in hospitality, retail and close personal services. The difficulty with this virus, as the Minister said, is that it is highly transmissible and spreads best when people come close together. The more people who are close together, particularly indoors, the easier it is for the virus to spread. It is also particularly problematic, as we know with all those coronaviruses, at this time of year. With the cooler weather and less sunlight, the virus survives for longer. Prior to the availability of more effective treatments and vaccines, we have had to reduce the contact between people in order to reduce transmission of the virus. Each intervention and each restriction that the Executive consider and put in place adds a little bit to that downward pressure in reducing that all-important number that we are now so familiar with: the R number. While close personal services may contribute only 0·05%, that is a significant contribution to the reduction in the R number. We are trying to get R below 1 and to keep it as far below that for as long as we possibly can. As long as we keep it below 1, that means that fewer people are being infected. We will see the rates of infection fall. We will see the rates and the number of people being admitted to our hospitals and ICUs fall. We will see the outbreaks in our care homes fall. We will see fewer staff being off isolating because they have acquired COVID-19.

As we saw during the summer months, there are unfortunate results when we relax measures. In June, R was somewhere in the region of 0·5 or 0·7. We relaxed measures and allowed some sectors to open up, and, by October, R had got to between 1·4 and 1·6. The interventions that we have now put in place have been effective. We have seen the highly effective interventions in the Derry City and Strabane District Council area. I will say well done to everyone in the community for coming together and achieving that. It was a real effort between community leaders, political leaders and the business sector working with community networks. We are making very significant progress and pressing down on R with the latest restrictions that the Executive have put in place.

Finally, the Chair said that people are fed up with this. I think that we are. I can only apologise to everyone for the pain, distress and anxiety that I know that they are experiencing at this time. Hopefully, into the new year and the spring, things will look different than they do at present.

Mr McGrath: Thank you.

Mr Chambers: Chairman, there have been concerns recently about the availability of testing, but I want to put on record my experience. I went on to the app at 3.30 pm on a Thursday and requested a test. I was offered one at 4.00 pm, half an hour later, and one at 4.30 pm. It was at the Titanic centre, which is 20 minutes up the road. I took the 4.30 pm option. It was a very efficient system. I was out by

5.00 pm. By 4.30am the following day, 12 hours later, I got the negative result. Well done on that; that has certainly improved.

The Minister referred to a change maybe coming in the app whereby the 14 days' isolation will be from the actual point of contact as opposed to when you receive the alert. Could the Minister confirm whether that is a pending change in the guidance, or is that currently the advice?

As regards front-line staff getting tested more often with or without symptoms and our care home staff getting tested on a weekly basis, if somebody in a care home setting continues to get negative results but suddenly receives a close-contact alert, does that alert take precedence over their series of negative results?

Mr Swann: On the last point, it all comes down to the timing of the alert and the result and when the test was taken, because it is unknown when the contact that caused that alert actually happened. The guidance is still that it is from the point that you receive the ping of notification.

What I was actually referring to, Alan, was that the current understanding is that the 14 days' isolation is from when you receive that notification on the app. We are now looking at the app counting back to when the positive case who initiated your alert actually got their positive result. Therefore, rather than having to do 14 days' isolation from when you received the notification on the app, you would do 14 days from when you were in contact with the individual who tested positive. The 14-day period is still there, but it is just that the period of isolation that you have to do may be less. It is not a change in direction in the 14 days.

Mr Chambers: But, currently, it is still 14 days from the alert.

Mr Swann: It is still 14 days.

Mr Chambers: Can the Minister confirm that other countries are experiencing difficulties with their track-and-trace systems? Indeed, just recently, Germany indicated that it was really struggling to cope.

Mr Swann: In my opening comments, I referred to the test, trace and protect systems elsewhere. Once you see an escalation in cases, it is hard for anybody to keep up. One of the things to come out of the German model was that when there are more than 50 cases per 100,000, it is impossible to trace and track effectively. Therefore, it is in our interest to get the rate of infection as low as possible because that is when test, trace and protect works most efficiently. When you have smaller numbers, you can trace back further and get into more depth on when and where they contracted the virus, so it is more effective when advising people when and how they should isolate. I do not think that any test, trace and protect system could cope with the dramatic increase that we saw a few weeks ago, but we are now putting in place measures to make sure that we have those safety fallbacks and that we can pick up on as many cases as possible.

Mr Chambers: Thank you, Minister.

The Chairperson (Mr Gildernew): It is good to hear that. The system should operate with that type of rigour and quick turnaround, because time is of the essence.

Thank you, Minister. I mentioned time, as I know that we have run slightly over it. I appreciate that, and I appreciate both of you being here this morning to answer members' questions. Good luck in the days and weeks ahead. We understand that this is an entire-system approach in that there are lots of areas that need to contribute, and that, potentially, it is your principal role, Minister, to ensure that they are aware of the type of support that is needed to ensure that the chain of defence is in place. Thank you for that, Minister, and thank you, CMO.

Mr Swann: I think that we are back again in early December.

The Chairperson (Mr Gildernew): That is a highlight for your diary. I am sure that you are looking forward to it.

Mr Swann: It is already in. Thank you.

The Chairperson (Mr Gildernew): All the best. Good luck.