Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 Disease Response: Health and Social Care Trusts

21 January 2021

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
Ms Cara Hunter
Mr Pat Sheehan

Witnesses:

Dr Cathy Jack	Belfast Health and Social Care Trust
Ms Jennifer Welsh	Northern Health and Social Care Trust
Mr Shane Devlin	Southern Health and Social Care Trust

The Chairperson (Mr Gildernew): I welcome, by video link, Mr Shane Devlin, who is chief executive of the Southern Trust, Dr Cathy Jack, who is chief executive of the Belfast Trust, and Ms Jennifer Welsh, who is chief executive of the Northern Trust. Good morning, Shane, Jennifer and Cathy. Shane and Cathy, it is good to see you again. Jennifer, I have not met you in person. I am delighted to have you here this morning. I appreciate you being at the Committee to answer questions from members, particularly given the pressure that, we know, each and every one of you are under. Your senior team and front-line staff are all under tremendous pressure, so we appreciate you being here this morning.

Mr Shane Devlin (Southern Health and Social Care Trust): We have lost your audio, Chair.

The Chairperson (Mr Gildernew): Can you hear me now, Shane and company?

Mr Devlin: We can, Chair.

The Chairperson (Mr Gildernew): I am not sure where I lost you, but I reiterate that we welcome your attendance today at the Committee. We very much understand, as a Committee, the pressure that all your senior teams and your front-line staff are under daily in coping with the pandemic. That pressure has been continuous now over a long time.

My understanding is that Jennifer will lead off with remarks. We will take those remarks from Jennifer, and, in the interests of facilitating a question-and-answer session, I ask that one of you give the principal answer or, indeed, the sole answer to the question. If the others then have anything additional to say if necessary, so be it. Rather than getting three answers, we will try to keep it to one,

where that works. I understand that you are three different trusts and that you may have things to add, and that is fine as well. I invite Jennifer to make her opening remarks.

Ms Jennifer Welsh (Northern Health and Social Care Trust): We are all delighted to be here this morning, and thank you for the time. You will have received information from us through a joint introduction and then a brief from each of the organisations.

As you will be aware, the trust chief executives took the unusual or seldom-used step of publishing two statements, one in mid December and one on 10 January, indicating our concern at the level of community transmission of COVID-19, the pressure to date in the entire Health and Social Care (HSC) system and the anticipated third surge that we now find ourselves in. All the modelling projections indicated that we would see this particular surge now in the third week of January, and those projections have been of enormous benefit to all the trusts as we have prepared our surge plans, but that has been with the emphasis on flexibility and the agility to deal with the issues that evolve on the ground.

We have provided you with a number of graphs. The first graph gives you the confirmed COVID-19 daily admissions across all trusts, and that is useful because you can clearly see comparison with the earlier two surges. It is important to note that the second wave, which took place through October and November, did not come right back down to baseline, so we went into a third surge with an already very high level of activity across the Health and Social Care system, which adds to the pressure.

Graph 2 shows the COVID-19 positive cases in the past seven days per 100,000 of population and broken down by postal district. Where there is considerable variation there has been particular pressure, as you can see, in the Southern Trust area. That continues. I have a little bit of concern from the Causeway perspective —.

The Chairperson (Mr Gildernew): Sorry, Jennifer. I can hear you reasonably well, but other members are struggling to hear you. Can you speak up a little, please, use earphones or headphones, if you have them, or turn up your volume if you can?

Ms Welsh: OK. I have turned the volume up. Is that helpful?

The Chairperson (Mr Gildernew): OK. Go ahead, and we will see how that works out.

Ms Welsh: I was talking about graph 2, which shows the new positive cases broken down by postal district. It shows the variation across the region, with different postcodes showing different intensity in the number of COVID-positive cases. Obviously, we have seen particular pressure for Shane in the Southern Trust area. I am somewhat concerned about what we now see in the north coast and Causeway area. As we all know, it is those high levels of community transmission that later translate into pressure at our emergency departments, our medical wards, our enhanced respiratory services and onwards into intensive care.

Graph 3 shows the position with COVID-positive inpatients at midnight last Sunday night. Again, you can see the steep rise as we move into January and the third surge. Graphs 4 and 5 show that, over the last few months, the Belfast Trust and the Northern Trust have been under particular pressure. They are the blue and orange lines. For the Northern Trust, we have seen a steady rise in COVID-19 inpatient numbers since October. You can see that the Southern Trust has a particularly steep rise as we have moved into January and where it starts to reduce again, which shows you the level of transfer of patients across the region away from Daisy Hill and Craigavon to really try to ease the pressures on that site. It is quite interesting, Chair, that you happen to have asked the three of us here today. The three of us in our respective trusts are certainly experiencing the heavy load of the total number of COVID-positive inpatients, and we can see that clearly from graphs 4 and 5.

All of us have worked hard and have prepared and enacted our surge plans. That included doubling the ICU capacity in each district general hospital, including Antrim and Craigavon, and, of course we have the regional ICU Nightingale at BCH. We also have the regional Whiteabbey rehabilitation Nightingale hospital, which opened to patients in November and plays an important role in the rehabilitation of COVID patients. We have very high numbers of people requiring enhanced respiratory support and intensive care, and all of us have had no option but to redeploy skilled staff from other areas, particularly from our theatres to meet the requirements of those sickest patients. That has impacted our ability to perform the normal work that we would be doing, including work on cancer and other time-critical surgery.

Chair, can you still hear me?

The Committee Clerk: Perhaps I can advise the witnesses that those in the room cannot hear you very well at all. Jennifer, if you could try using a headset, that would be helpful. We will hold on for you, if that is possible.

Ms Welsh: I will have to try to get a headset. Bear with me, please.

The Committee Clerk: Can I check that the Chair can hear us and can be heard in the room? We cannot hear you at all, Chair.

The Chairperson (Mr Gildernew): Are you hearing me now, Clerk?

The Committee Clerk: Yes, we are hearing you now.

The Chairperson (Mr Gildernew): We can suspend for a few moments to allow Jennifer to get access to a headset.

The evidence session was suspended from 9.47 am to 9.51 am.

The Chairperson (Mr Gildernew): Members, hopefully, we are now back with our session. Let us see whether that has improved the quality of the sound. Can you resume, Jennifer, please, and we will see how this works now?

Ms Welsh: Yes. Can everybody hear me OK now?

The Chairperson (Mr Gildernew): I am hearing you. It is still quite faint, but it is a bit clearer. Try that now, Jennifer.

Ms Welsh: Is that better?

The Chairperson (Mr Gildernew): Yes, I think that that is better. Members, are you hearing Jennifer any better at this point? Clerk, are you hearing Jennifer in the room?

The Committee Clerk: I think so. We did not hear enough to be sure.

The Chairperson (Mr Gildernew): Jennifer, go ahead, please, and we will see how it goes as you go through your presentation. Thank you.

Ms Welsh: OK. I am not sure where you were able to hear to. I will pick up at graphs 4 and 5, because I think that those are quite important.

We have seen the Belfast Trust and the Northern Trust under particular pressure for some time and a steady rise of COVID patients since October. The Southern Trust area saw a very significant rise — steeper than the other trusts, for instance — around 6 January, reflecting the greater community transmission in those council areas. I commented that I thought that it was interesting that it happened to be the three of us here today because we are the three trust areas that are carrying the biggest load in the number of COVID-positive inpatients.

We have all prepared and enacted our surge plans, which has included doubling the ICU capacity at each district general hospital, including Antrim and Craigavon and, of course, standing up the regional intensive care unit at Nightingale at Belfast City. We also have the regional rehabilitation Whiteabbey Nightingale hospital, which opened to patients in November. We have high numbers of patients requiring enhanced respiratory support and intensive care, and, therefore, we have had no option but to redeploy skilled staff from other areas, particularly theatre staff, in order to meet the requirements of those sickest patients. That has seriously impacted on our ability to perform our normal work, including work on cancer and other time-critical surgery. That is not a situation that any of us wish to see, but I assure members that our entire Health and Social Care system is working together like never before. Urgent surgery, including cancer surgery, is one area where we have prioritised and will continue to prioritise those who are most in need, and we will allocate precious surgical slots accordingly as a

region. Trusts have also worked together to transfer patients across hospitals to best manage the demand within the regional resource that is available, whether that is staffing, beds or oxygen.

All our staff have performed incredibly, and we believe that society as a whole can be really proud of them for what they have had to contend with over a very long time. They have gone well beyond what any of us could have reasonably expected of them, but staffing pressures remain a significant challenge. We have pre-existing staffing pressures that are well rehearsed, and, when we add COVID-19 and other absence into those, we see that they create a position that is far from comfortable, particularly given the current situation. Approximately 10% of Health and Social Care staff are currently absent from work. That includes those who are required to self-isolate.

The COVID-19 vaccines have provided much-needed hope, and, at the time that our document was written, almost 150,000 vaccines had been administered to residents and staff of care homes, Health and Social Care staff and the over-80s.In summary, all our trust services remain under significant pressure. We have seen further rises in ICU admissions this week, and we expect more. All trusts are working and will continue to work together to best manage that surge and to ensure that resources are used to best effect as we emerge from the current high-pressure situation. We all welcome the reduction in new positive cases, but it is certainly not a time for complacency. It is clear that a return to normal is still some way off. The hope that we see from the vaccination programme must go hand in hand with the necessary precautions in public behaviour and compliance with the restrictions.

I will pause there, Chair. You have the individual briefs from each organisation, and, as you say, we will field questions accordingly. Thank you.

The Chairperson (Mr Gildernew): Thank you, Jennifer. Shane or Cathy, go ahead, please.

Dr Cathy Jack (Belfast Health and Social Care Trust): Jennifer has presented a really clear picture. In Belfast, our staff absence is over 12%. We have had a reduction in COVID absence from the first surge to now, but we still have many who are isolating after being tracked and traced, so that continues to put us under strain. Today, in my organisation, I have 210 COVID-positive inpatients within 14 days. An additional 50 have remained in hospital beyond 14 days because they have much more complex needs, and their length of stay, as Jennifer has said, is nearly double that of a normal average patient with a medical illness in the wintertime. We have 32 patients on continuous positive airway pressure (CPAP), and nine of them are actively being monitored by our ICU team. I have 30 COVID-positive patients in ICU, 27 of whom are in the Nightingale hospital. Three of them are in the regional ICU because they came in with other issues and need specialist regional care. I have 17 homes on escalation, so that is four in red and two receiving mutual aid. We continue to be under significant pressure across our services. Indeed, a very small number of children who have been admitted to the children's hospital because of an illness also have COVID, and a small number of looked-after children in our care are COVID-positive.

That is my situation. I will hand over to Shane.

Mr Devlin: Thank you, Cathy. As Jennifer and Cathy said, we are all under extreme pressure. As Jennifer indicated, we had a considerable shift in the last four to five weeks in the Southern Trust area, particularly given our community transmission rate. Armagh City, Banbridge and Craigavon Borough Council, Mid Ulster District Council and Newry, Mourne and Down District Council have had the highest community transmission rates and the highest infection rates. At one point, some of our postcodes had nearly 1,500 positive cases per 100,000, and that resulted in an enormous growth. We moved from a top position in our first surge of having 63 COVID-positive inpatients to last week having 272 inpatients. We have, over the last week, been able to reduce that number primarily because the whole system has been working together. A number of our patients from the Southern Trust area ended up becoming patients of the Belfast Trust and the South Eastern Trust, and that has allowed us to manage. We still have excess of 200 COVID-positive inpatients today. That is a much better picture than this time last week, and that is because we are working collectively as a region to make sure that we keep patients safe.

Our position is very similar to that of the Belfast Trust and the Northern Trust. Our populations have had very high viral positions. Clearly, we are managing a huge number of inpatients that is way over and above anything that we ever imagined we would have to manage. That has resulted in our beds being exceptionally busy and, in our case, our ICU being close to full. Fourteen out of 16 ICU beds are taken today. Every trust is feeling that. Again, we are taking a regional approach to ICU by looking at how we can best use the assets across all five trusts.

Much like the Belfast and Northern Trusts, we have considerable staff absence. Today, we have 759 staff not at work because of COVID. Of course, that does not mean that they are COVID-positive, but it means that they are either COVID-positive or isolating. Taking 759 out of any workforce is a huge number that puts additional pressure on staff who are already exhausted. Our biggest challenge moving forward is how we can support our workforce in what is now month 11 of the pandemic.

I will leave it there, Chair. All three of us are happy to take questions.

The Chairperson (Mr Gildernew): Thank you to each of you and to Jennifer for that overview. It is still very worrying.

My first question is about how you plan and the planning models that you utilise. I know that there are other factors, such as staff absence, that impact on that planning model, but how do you get a baseline for where you expect to be next week, the week after or, for example, for weekends such as that when South West Acute Hospital (SWAH) had to start bringing in people from other areas who, luckily, were available? Is the planning sufficiently robust, or is it very difficult for you, as chief executives, to manage?

Mr Devlin: We have a forecasting model. That model is worked through with the Chief Scientific Adviser (CSA), the Chief Medical Officer (CMO) and our own informatics professionals at trust level. The forecasting model looks at a range of factors that enables us to forecast. It is not a prediction, and it is not perfect, but it is a forecasting model that allows us to understand the number of patients we expect to be inpatients and the number of patients we expect to be in ICU. It allows us to put our surge plans together based on the number of beds that we would need and the understanding of how long a COVID-positive patient stays in hospital etc. That allows us to build a picture of what we may need.

The challenge is not getting a picture of what we may need; the challenge is meeting that need given that our resources are, in fact, limited. I do not mean that in any kind of negative form. We have a fixed resource. That fixed resource is our capacity in our buildings and our staff. We take an understanding of the projections. We look at what we need and best model to meet that need. However, we stress that the limiting factor in that model is the availability of staff. For example, I know that my model says how many ICU beds I need and, therefore, I need to increase my ICU capacity to meet that need. That means that I am taking staff from other parts of my trust to enable ICU to grow and, as a result, there may be other things that I cannot do. That is how we plan. We look at what the demand is going to be. We look at what we need to meet that demand, and then we plan against it. However, we do not have an endless capacity, and, therefore, we have to make choices.

You referred to the situation at South West Acute Hospital two weekends ago when I, as chief executive of the Southern Trust, spoke to all my trust chief executive colleagues, Anne from the Western Trust and Cathy etc to say that the numbers of patients that we had had exceeded our modelling expectations and exceeded our capacity, and, as a result, we needed support to enable us to move some of our patients to other trusts in order to provide a safe service. Therefore, it is not just about the Southern Trust looking after Southern Trust patients; it is about all trusts looking after all patients. However, I stress that, no matter how much planning we do, we are limited by the capacity that we have to meet the demand. The pandemic demand in this surge — surge 3 — is quite enormous compared with the pandemic demand in surge 1.

I am more than happy to ask Jennifer and Cathy to come in on that, but that is primarily how we work. We look at the surge, we look at the demand and then we build our plans around that.

Ms Welsh: The only thing that I would add is that we also try to remain fairly flexible and agile. We want to be able to stay just ahead of the pandemic so that we are not shutting down services too quickly. We have tried to maintain all our urgent and cancer surgery for as long as we can, only stepping back at the last minute when we have to transfer those resources to intensive care. It is really a case of working this on a daily basis to make sure that we stay just ahead and so that we can, when the time comes, de-escalate quickly and turn services back on in a timely manner.

Dr Jack: I know from my modelling that I need to have 219 medical beds for COVID-19 patients. However, we also know that, because my oxygen supply and infrastructure was better, we may be asked to take patients who need high-flow oxygen, because Airvo is three to six times the amount of oxygen that you would use if you were on a ventilator. That is one of the issues that the Southern Trust struggled with, through no fault of its own. You can see from the graph that the Southern Trust had a huge peak in admissions because of community transmission. We were ready. My plan has

some additional beds to cope with that greater Belfast flow, which is right and proper. We need to work as a system because, as you can see from Jennifer's graphs, community transmission is not equitable across Northern Ireland. Whole-system working is so important here.

The Chairperson (Mr Gildernew): OK; thank you for that. My second and final question before I go to members relates to vaccination. You mentioned in your presentation that high levels of vaccination had been rolled out across residents and staff in care homes, but what about hospital inpatients aged over 80? We are picking up significant concern that there appears to be very little vaccination taking place in hospital of people who are over 80, people who are still inpatient and those who are discharged to home, where they will receive a great deal of care related to their condition and encounter potential vulnerabilities in that. What is the situation with vaccinations in hospitals?

Dr Jack: We follow the policy decisions through the Department of Health. It is important to note that the Pfizer vaccine that we are being given from trusts has very tight regulation around it, including the number of times that it can be transported. Currently, there is no system whereby we could take the Pfizer vaccine from ward to ward without significant wastage.

The second factor is that people in our hospitals are sick, and it is not good to vaccinate people who are unwell with intercurrent illness; you will know that from the flu campaign out there. People who have COVID-19 should not be vaccinated until a month — four weeks — after their recovery because their risk of side effects is greater, so we are not vaccinating them. We are looking at some of the clinically extremely vulnerable people who may use our services as an outpatient, such as dialysis patients. That discussion is ongoing with the Department of Health. They are well and could come into the vaccination centre and be vaccinated. That is why it is not individuals who are in hospital. You might have two on this ward and three on another, but you could not carry the vial.

Just so you know, Colm, we have delivered over 27,000 vaccinations. Our wastage is 66 doses, which has largely been in the care homes because we could not transport the vaccine back, as it is not safe to do so. Our wastage is less than 0·25%. It is a really scarce resource, and we need to use it wisely. We are in discussion. We will get as many people vaccinated as soon as we can: that is our absolute commitment.

The Chairperson (Mr Gildernew): OK. Thank you.

Mrs Cameron: Huge thanks for your attendance today, Cathy, Jennifer and Shane. It is good to see you all again. I have a few questions that I will fire at you so that the relevant person can respond to them and we can get as many answers as possible.

On the back of a conversation with the BMA yesterday, you will be aware of the concern about the second dose of the vaccine being delayed for healthcare staff. Do you sympathise with their position? Are you concerned that there may be a continuation of staff absence because of the numbers contracting COVID-19? I ask that because of the figures that I received yesterday that the first dose offers a maximum of 52% protection and only 33% for those over the age of 60. However, in the over-60 bracket, protection goes up to 98% after the second dose. Do you have a comment on that?

Do you expect to breach your ICU capacity in the next day or two? I also wanted to hear your reaction to the announcement of military assistance and the Unison statement released last night.

My final question is this: do you have statistics on the age groups of those being admitted with COVID-19 symptoms to your hospitals, and what is your message to the public?

Mr Devlin: I am more than happy to start with a couple of those and then pass over to the others if that would be helpful. I will take the question about the second dose, and maybe Jennifer will talk about ICU capacity and Cathy military assistance.

On the second dose, the Government, the Scientific Advisory Group for Emergencies (SAGE), Independent SAGE and the four countries and their CMOs took the view that the best and right thing to do was to provide the vaccine to as many people as possible across Northern Ireland. That was the Joint Committee on Vaccination and Immunisation (JCVI) guidance as well, so it is clear that we are following the guidance. I appreciate that there are different views, some of which were reflected in recent papers from Israel and in an article in 'The Guardian' yesterday. However, in agreement with SAGE, Independent SAGE and the four Governments and their CMOs, that is the direction and that is government policy. So far, I am proud to say, we have vaccinated 19,500 people in the Southern Trust

by following that guidance, and we will continue to do that. It is clear that we are following policy and delivering a huge amount of vaccine.

I am more than happy for the others to come in at this point. Maybe, Jennifer, you could address the ICU capacity question.

Ms Welsh: Yes, thank you Shane. I am confident that we will be able to support all those who need intensive care in getting the vaccine. The issue for us is where the capacity might be. We have worked hard to deliver both a local and a regional escalation. Every district general hospital — every big hospital outside Belfast — has doubled its ICU capacity. For example, Antrim normally has seven intensive care unit beds, and we have gone up to 14. In Shane's trust, it is the same, with the number going up to 16. We all agreed that each trust outside Belfast would locally escalate to a particular level and beyond that only the regional ICU in the Nightingale hospital at the City Hospital with Cathy would proceed at the later layers of escalation.

We have always worked together as part of a critical care network, so patients are moved around. If one unit is coming under significant pressure, there is an arrangement called the Northern Ireland Specialist Transport and Retrieval (NISTAR) service, where very sick patients are transported while ventilated. It is an expert service, and they are well used to doing that. I am confident that we will have the capacity, but it may be that we have to transfer people to where that capacity exists.

Dr Jack: I will come in on the Nightingale, ICU and the issue of military assistance. In Belfast, as you know, we have a number of different ICUs normally: we have the cardiac ICU and the regional ICU, and then we have two of our local ICUs in the Mater and the City. Between the Mater and the City, we usually have 10·5 beds. We have the ability and staff currently for 32 beds. Of those, 27 are full today, so I have five empty beds. After that, I have the staff identified, named and trained to staff the first two pods from Belfast's point of view. I, like Jennifer, am absolutely confident today that I have the ability to look after the number of patients who will require ICU over the next week to 10 days.

Let me be clear on the military question: my priority is to provide safe, effective and compassionate care to as many patients as possible and to support my staff in doing so. I am proud of the care and compassion that my staff have delivered to patients to date throughout the pandemic. Retirees, students and volunteers have all come in to help us, and we have welcomed them. This is another group of highly trained individuals who will help us to deliver the care that we need to. They are band 4-equivalent staff. They are medically trained technicians. They can take blood and put in Venflons. They will work under our normal management structures. For me, in Belfast, they will focus on helping to support the regional Nightingale. To date, I have had 80 third- and fourth-year medical students. Another 170 of those have applied for the surge 3, and 177 nursing students have come in to help us. We had medical graduates who started two months early to help us in the first surge. This is another group of highly trained individuals who will support my staff, support patients and deliver the care that they need. I welcome that.

Mrs Cameron: Can I come back on that, Chair? Thank you all for your answers.

The Chairperson (Mr Gildernew): Briefly, Pam.

Mrs Cameron: Yes.

Those were very welcome answers. I put on record — I should have done this at the start — my appreciation for the incredible work that all three of you, your team of staff around you and every healthcare worker in the system are doing. I do not think that we could ever be more proud of you all. I thank you for all that you have done in the past year and continue to do.

Ms Bradshaw: Thank you, panel. Thank you so much for coming. I echo what Pam said about appreciation.

My first question is in relation to the growing evidence and warnings around the potential risk of COVID-19 patients developing ME. You will be aware that a lot of the symptoms are very similar. Unfortunately, the recruitment process for the ME clinical lead is now, I think, into nine years without anybody being in post. Will you comment on the plans to deal with long COVID in your trusts and the specific issue of regional services for ME?

Dr Jack: Paula, you raise a very important question. To put it in context, the Department of Health said yesterday that 1,671 people had died of COVID in the past 11 months. That is approximately 40 deaths a week, so it is a killer disease. Having said that, what is not being reported is the effect of long-term COVID, cardiac problems, clotting problems, stroke and respiratory problems. I think that there will be a huge morbidity from long COVID, and that is something that we need to be ready for.

From the point of view of Belfast, we try to follow up patients who have been in ICU. We have a business case to look at that long COVID condition. I think that it is separate from ME. You are right: since a couple of individuals retired, the service has struggled to get off the ground. That is not because of commissioning; it has been commissioned. We have tried to recruit. I understand that we have not yet appointed, but it is on our radar.

I believe that we will have significant morbidity from COVID, which will need to be recognised, planned and commissioned for as we go forward. However, we are already working in that space. It will require a multidisciplinary team to manage those patients and ensure that they recover to their maximum.

Ms Bradshaw: Thank you very much. My second question relates to postponed cancer surgery. Is there any update with regard to communicating with those who have been affected? All MLAs have received correspondence from people who are incredibly anxious about the potential spread of their condition.

Mr Devlin: I can start. I am sure that Jennifer will want to come in as well.

Obviously, we are hugely sorry for what we have had to do with regard to the downturn of cancer surgery in many cases. We are aware that that is causing pain and anxiety as a result. As I say, that is not something that anyone in our role takes lightly. The difficulty, of course, is that the more community infection there is, the more people come to hospital and, as a result, the more services we have to support for COVID. For example, to escalate our ICU to the stage where we are now, I need 170 staff. Those 170 staff have to come from other parts of the service, primarily anaesthetics and theatre staffing, which has resulted in our being unable to provide surgery for those patients. In addition, of course, many surgeries will need an ICU bed on standby, ready for the patient, as well. Therefore, there is no doubt that this has caused us to have to cancel urgent and cancer services.

At the moment, until I am aware of how we will get out of the COVID surge, I cannot provide an immediate response to those patients. I am truly sorry for that. Collectively, we are looking at how we can provide services for the most urgent cancer patients across Northern Ireland and using available resources and facilities as a collective to find appropriate places for those people to have their surgery. However, the key for me is that I need to turn down the COVID heat so that I can turn up services again. That is totally dependent on the amount of COVID that is in our community and is finding its way into our hospitals.

I wish that I could provide an assurance to my patients about when they will get their surgery. However, I need the COVID level to drop to enable me to re-engage my theatres with anaesthetics and nursing staff to allow me to do that. I will certainly ask Jennifer to come in because her position is very similar to ours, as is Cathy's.

Ms Welsh: Thank you, Shane. Paula, I think that Shane has covered that very well. This is not a situation that any of us wanted to be in. We also have to be mindful of the fact that waiting lists were incredibly challenging in Northern Ireland anyway. We were already worried about that. That was part of the work of the Transformation Implementation Group (TIG) and the Rebuilding Management Board. However, as Shane says, until we drive down the number of new positive cases and the level of community transmission, it is really hard to be clear about when we can switch all that back on.

That is also what I meant about needing flexibility and agility in our surge plans. We waited as long as we could, just staying ahead of the requirement, so that we shut down that surgery only at the last possible moment, just enough to give us time to train the staff and get them moved to the areas where they were needed. We want to do the same thing coming out of this where we start to switch on. We are looking at this across the region. When we look at postcodes, it may be that one area starts to emerge ahead of the others. However, we have a commitment to work together as a region so that the patients who are most in need will be prioritised for surgery. Therefore, someone may not get surgery in their own trust area, but, if they are in need, they will be one of those who get a precious surgical slot.

I also want to mention that it is really difficult for our clinical teams. They have to work hard to identify who is a priority when we know that all those patients are a priority. It is really difficult for our clinical teams to work through all those patient lists and agree that "This is the priority order. These are the very sickest patients for whom we are most worried". Therefore, it is not a situation that any of us wanted to be in. I am sure that we all know individuals who have been impacted by that. Our thoughts go out to Minister Poots. He is a former Health Minister with lots of family working in the service, so he knows as well as anyone. It is a dreadful situation, so our plea to the public is to continue doing what they are doing so that we can drive down the levels of community transmission to enable us to switch some of those services back on as soon as we can.

Ms Bradshaw: I want to come back to what Cathy said about inpatients not getting the vaccine. I have been contacted by nurses in the long-stay rehabilitation ward in Holywell Hospital and the acute mental health ward, where some patients would be in for over three months. They may not have a physical illness, but they are there as inpatients. I just want to let you know that some nurses contacted me concerned about their welfare in terms of vaccination.

Dr Jack: We did an audit of our long-stay patients. In our long-stay dementia unit, we have vaccinated them and vaccinated our inpatients at Muckamore, because the majority stay for over three months. However, we did an audit to determine that, Paula. We take a limited number of vials out. The issue is that you cannot go from ward to ward. I hope that that is reassuring.

Can I put on record my sincere apologies that we cannot treat everyone as we would want at the moment? None of this is easy; none of us wanted to be here. Jennifer is right: there is moral distress among our staff, but that is nothing compared with the anguish and devastation that those families face, particularly those who had a date for surgery that was then ripped out as we had to prepare for COVID. We are doing all that we can. We are tracking them individually, the clinical teams are contacting them, and you have all our assurance that, as soon as we have the staff and it is safe to do so, we will turn that surgery on. However, I need to be honest with you.

We are offering some of those patients neoadjuvant chemotherapy; that is chemotherapy before surgery to try to buy time or hold the cancer. That is not optimal. We would not normally do that. Whilst it will be safe to do that for the majority, there will be a small but significant portion of people for whom, when they come to surgery, it will be too late and the disease will have spread. That, for us, is something that we never, ever anticipated would happen in our lifetime.

I cannot apologise enough. However, the virus does not spread by itself. It spreads by people who carry it, so everybody in Northern Ireland needs to play their part so that we can get back on track and treat the patients whom we desperately want to treat, and their families desperately want us to do that. I cannot say that enough.

The Chairperson (Mr Gildernew): Thank you, Cathy. Time is moving on, so I ask members and the panel to keep questions and answers as succinct as possible.

Ms Flynn: Cathy, we can hear the sincerity in your voice and are aware of the importance of your comments. I want to say, "Thank you so much" to the three chief executives. You are doing a fantastic job in the most difficult of circumstances. We can certainly hear that in your tone.

I have three quick questions. My first is about the psychological impact that, we know, Health and Social Care staff are under. Psychological helplines were put in place at the beginning of the first wave. Do you feel that those meet the psychological needs of your staff, and are there other provisions that you can put in place to help to support staff? My second question is one that Pam touched on, but I do not think that it was answered. Have any of the trusts started to identify trends in younger people being admitted with serious illness in relation to COVID-19? Are we seeing such patterns in the latest wave?

This is my third and final question. It was great to hear your reassurances and your confidence in the capacity of the ICUs and hospitals to deal with the upsurge that you may face, but I wonder about the work on top of that. I am thinking about what Shane said about the ICU capacity in his trust and how there are only two beds left. It is great that you can move patients around the hospitals across the North, but has there been any contingency planning so that, if you reach your peak and there are other emergencies or accidents on top of COVID, you can transfer patients island-wide? Has that happened with the structures in the South?

Ms Welsh: Chair, I am happy to pick up first on the psychological supports. One of the things that we have been able to do in the Northern Trust — I think that our colleagues have done similar things — is not just to put in place the psychological helpline but provide support at ward level. We have had intensive support from our psychologists. Psychologists are aligned to every key ward in our hospitals: our emergency departments, assessment units, respiratory wards and intensive care units. That has worked very well. Staff can contact link workers directly. It can be a phone call or a face-to-face meeting — often, that is what is needed. We have also provided direct supports to managers and team leaders so that they can help to support their teams.

A little bit of regional research has been done on that by the IMPACT research centre. That study took place in November, before the current surge, but it showed the benefits gained in reducing anxiety and so on from having psychological helplines and direct interventions. We will run that study again in February. We anticipate that staff will really have needed that this time round, and I expect that we will need ongoing psychological support for staff for some time. We are mindful that a lot of them are running on adrenaline and are just keeping going. We expect to see a little bit of a dip as we get out of the surge and people are exhausted. The impact on people's emotional health and well-being, among staff and the wider public, will be with us for years to come. We will need to continue to manage that as we go forward.

Briefly, on your question about young people, that is certainly something that we see. It is a combination of older people being careful and listening to the public health messages, families shielding them, particularly over Christmas, and the vaccination of the over-80s. As a result, we are not seeing as many of them in our hospitals. However, we are seeing a lot of 50- to 60-year-olds and even younger, and that is distressing for staff. The message is that it is not just impacting on older people or people with underlying conditions; we see many people in their 50s, 60s and younger struggling with it. Many of them are on enhanced respiratory support and are being admitted to intensive care.

Mr Devlin: If I could follow up on Jennifer's last point, we are starting to see some early evidence of 40- to 50-year-olds, which is very scary. It is also about the 50-year-old male with a comorbidity such as obesity. It is not about the 80-year-olds plus as much; it is about younger people, primarily males. That is very early evidence. I am sure that there will be massive studies of it, but we see that shift. We are also seeing patients in that age profile deteriorating remarkably quickly. That is worrying. It is not simply about those aged 80 years plus — far from it. It is a younger issue, with comorbidities such as diabetes, obesity etc having a huge impact.

I support fully what was said about the psychological impact. We have lots and lots going on there.

Your final question was about ICU capacity. We have a strong local critical care network that we have all worked on together to understand what will happen at certain trigger points with the movement of patients around Northern Ireland and into an enhanced Nightingale facility. I understand that there may be some cross-border support. We have not built that into the Critical Care Network Northern Ireland (CCaNNI) plan, but I am aware that there is not anywhere on the island of Ireland that has lots of capacity sitting doing nothing. Nevertheless, we have the CCaNNI, and, if there is a mutual aid requirement, we have a vehicle that we can explore.

Ms Bradshaw: Thank you very much.

Mr Carroll: Thanks for the presentation, everybody. My first question is for Cathy. I have a constituent whose father is in an independent living setting. He has Alzheimer's. His family were infected with COVID, so they could not care for him or assist him. To cut a long story short, the father eventually got COVID and was wandering around with Alzheimer's unfortunately and inadvertently infecting people. I raise that point because I am concerned that that could happen again. People in that situation can get assistance from carers, but that assistance is limited. Are there any suggestions, ideas or proposals about what people in that situation can do? They need care, but they need to be protected from inadvertently infecting others with COVID.

Dr Jack: Gerry, that is a complex matter. I am aware of that case, because it arose over the weekend. I understand that our out-of-hours team contacted the family, albeit later than they would have liked, because we had to pick him up. We have increased our number of community beds, because sometimes we need an urgent placement. What you are saying is that an individual could leave the house, wander about and infect others, so, if there are difficulties with containing the spread of the

virus, I would rather not use a chemical restraint etc; I would rather put the person in a safe place for his and others' safety.

As I said, we have increased our number of community beds, and we have special teams that go in to care for people who have COVID. We are actively working to maintain them safely in their own home, but, if individuals can leave the house, either you have to do a mental capacity order to make sure that the door is locked or you put them into a place of safety. Those situations are very challenging. I am happy to take that case back and get you the detail of it from the people who are managing it.

Mr Carroll: I appreciate that, Cathy. The specifics are important, but my concern is that, if it happens again, there needs to be a facility that people can go to for their own protection, to protect the community and to protect the workers in the independent living setting. We need to think about that in the longer term.

Dr Jack: I want to reassure you that we have negotiated a number of what we call "rainbow beds", which are for step-down COVID patients or for care homes that can annex a part of the building and take people with COVID in order to provide safe care for the period that they are infectious.

Mr Carroll: I would appreciate getting some information sent through on that, Cathy.

I am pushed for time, so I will move on quickly. How many people have been affected by the cancellation of urgent surgeries and procedures in the Belfast Trust area?

Finally, there has been no real focus on the role that the NHS and the state can play in taking command and control of existing private healthcare capacity, such as beds, staff and facilities. Do we know what the capacity of private for-profit healthcare is, in Belfast at least? How big is it, and how many beds are we talking about? What is your assessment of the role that private care could play, under the direction and control of the NHS, in helping with the pandemic?

Dr Jack: On 7 January, we cancelled 17 inpatient procedures and 33 day-case procedures, Gerry. New dates have been given for nine of those day cases already, so they have been rebooked. Surgery has not ceased. Last week, we did urgent and emergency surgeries on the Royal site, and we continue to do that. We did 233 operations. We did 309 either red-flag endoscopies for cancer or cystoscopies. We also did urgent interventional radiology for 91 patients. We will continue to do that, and we will open up as soon as is possible. A number of patients are waiting for red-flag elective cancer surgery, which is urgent, but we cannot provide that at the moment, because our staff are supporting the Nightingale hospital. As soon as we can, we will release those staff back so that we can undertake such surgery. Although we are working as a region to make sure that we maximise all capacity across the region, there are certain cancers and certain surgeries, such as cardiac surgery, neurosurgery, hepatobiliary surgery and vascular surgery, that can happen only in the regional centre, and it is important that that is realised.

The final thing that you asked about was the independent sector. We have a small number of lists that we continue to use for low-risk cancers, such as breast cancer, and we continue to avail ourselves of those. We are, as a priority, sharing those out across the region. Equally, I know that the Department of Health has had ongoing discussions with private providers, and, in March, another 109 lists will be freed up to allow us to try to catch up on some of the backlog. Gerry, as you will know, in April, May and June last year, they ceased their private lists to hand them over to the NHS, so we had a lot more capacity in the first surge. We do not have that capacity at the moment, but I know that there are ongoing discussions to try to release more. There have been ongoing discussions about how staff can provide support in this surge. That has happened, Gerry; I can give you an assurance on that. Shane or Jennifer may want to come in on that.

Mr Buckley: I have two questions. First, I thank the representatives for their briefing. It was an important insight into the work that you and your staff are doing, and we thank you for that.

One of the most alarming things, from listening to the presentations, is the absentee levels. At a time when we need all hands on deck, unfortunately, owing to circumstances, we face high levels of shortages. Shane, in the Southern Trust area, which includes my constituency, I see that, on 18 January, 759 staff were out of the system. Can you put that in context in percentage terms? What percentage of the total workforce is that? Does anybody on the panel have any suggestions for how we tackle that? Have you brought forward any suggestions to enable as many of the workforce as possible to be there when you need them most?

Mr Devlin: We have about 13,000 members of staff in the overall workforce, and 769 are absent for COVID-related reasons today. To put that into context, out of that 769, about 400 are symptomatic and COVID-positive. The rest of them are absent because they are either a confirmed contact, shielding or self-isolating for other reasons. It is therefore not just about those who are COVID-positive but about those who are contacts etc. That is a reflection of the society that we are in at the moment. Our staff are not in a bubble; they are members of society, and, as with every member of society, there is the potential for them to be both COVID-positive and a contact. Percentage-wise, it is about 750 out of 13,000, so we are not at the same level as some other trusts.

Our occupational health teams work with staff to get them back to work. We are working with them to make sure that they have been tested and that, when they can return to work, they do so. Many of the staff in our teams who are isolating or are unwell are still, where possible, working from home. The number of people who are doing that is phenomenal. That applies to care professionals as well. We have clinicians who are isolating but are still working from home and triaging patients. The numbers do not necessarily reflect the fact that not everyone who is absent is non-productive; in fact, it is quite the opposite: many of our people who are not at work are still working for us. Unfortunately, it is to be expected that, in a pandemic, our staff will get sick. In a pandemic, our staff will have to self-isolate, but we are very much working with them to help them back to work and to understand what work they can do for us when they are isolating.

Mr Buckley: Thank you for that. I am sure that that is echoed across the trust areas.

I want to move on to the cancellation of cancer services. It has been a very emotive issue, rightly so, for people across the country. There is a great fear that cancer services will become a casualty of COVID. I understand that services are stretched, but we must endeavour to ensure that those patients are seen as quickly as possible. I received an email, and I am interested in your thoughts on it. Although I recognise the contribution of all our healthcare professionals across the country and fully welcome the joined-up nature of how the trusts are operating, my primary concern is patients and, indeed, my constituents. The email reads:

> *"I have had two close friends who have passed away because of cancer in the last three months. Both of these cases were identical. Each had pain, called the GP, who said it wasn't a big problem and prescribed painkillers. As the months went on, they contacted the GP several times. Each time, the GP only talked to them over the phone via phone consultation, never a face-to-face appointment for an examination. Eventually, after nine months, the pain of each of them was so bad that they presented at A&E, where they were admitted. The next day, they had a scan and the cancer was found. Each of them died four days later. These two people died in the last three months. The last one is having her funeral today. She was 56."*

I am sure that that is heart-wrenching for any of you to listen to; it is for me, as an elected representative. I would like to know your opinion on the knock-on effect from the unfortunate closure of GP practices for face-to-face consultations. What impact is that having on services and for people presenting at A&E, where their cancer is not being picked up when it should be?

Mr Devlin: I will start and then pass on to my colleagues. I agree fully with you, Jonathan. The story of those two individuals is horrifically sad and one that we would not wish to happen to anyone. I am genuinely sorry for what happened to those two individuals. It is clear that the pandemic, which is a brutal pandemic, has resulted in the numbers of cancers that are identified being reduced. I look at some of our pathology work, for example, and I know that, as a trust, we are not finding as many cancers as we found pre-pandemic. The pandemic is therefore having an impact. I cannot quantify that, Jonathan, however. I do not have the information that would allow me to quantify how many patients we have not seen because of the pandemic, but I agree: we are not seeing the same number of cancer diagnoses coming through the Southern Trust, and I imagine that that is similar for my colleagues' trusts. We need to get our services back up and running, and we need to get COVID reduced to a level at which we can do that. I cannot make any other comment than to say, Jonathan, that I am horrified and saddened and that we will do everything that we can to get services up and running.

I cannot comment specifically on GP services, because I do not run GP services; I really do not. I know, however, from speaking to my GP colleagues that they are working every hour that God sends as well, because of the demands that they are faced with. On the specific issue of GPs, you would need to speak to the GPs specifically, because I do not run the GP service, Jonathan. I can say,

however, that we are having fewer cancer diagnoses coming through the trusts. I will ask whether Jennifer or Cathy wishes to comment further on that.

Ms Welsh: Very briefly, I completely concur with everything that Shane has said. There appears to be some early evidence of late presentations to emergency departments, which is clearly very troubling to us. We see lower numbers coming through in our diagnostics, and it concerns us that people are perhaps not presenting early enough or are not getting to see their GP and that, by the time they get to us, it is a very late presentation, which inhibits our ability to do something to help them. That is a very distressing story about those two individuals.

Dr Jack: It is exactly the same in Belfast. There are fewer red-flag or urgent referrals coming through to us as outpatients. Where they do, we continue to see them face to face and prioritise their endoscopy and cystoscopy etc. We are also aware, however, through our ED colleagues that there is reported increasing incidence of late presentation. As you will be aware, that was already a factor across Northern Ireland because of our long waiting lists historically, but it is a problem that will get worse because of COVID.

The reasons are multifactorial. Some people present late because of fear. Our screening programmes have been under pressure because of social distancing. GPs have been called either to the COVID assessment centres or to do vaccinations. Their focus has been on other things as well on as their primary care service.

Mr Buckley: I appreciate every one of your comments on that, and I understand fully that you do not run GP services. With GP face-to-face consultations not happening, you are facing the knock-on impact on services, and you have clearly outlined that.

I know that late admissions happen. I understand that GPs are working around the clock, as are all other healthcare professionals, but face-to-face consultations with GPs are essential. I would like to think that they will be fed back in to the system. That point has to be echoed. Even for vaccinations, a wide range of community pharmacists could play their part by opening and allowing face-to-face consultations with GPs. I will leave it at that.

Mr Sheehan: Thanks to the panel.

I listened to Fergus Walsh on the BBC news say last night that the UK had the highest death rate in Europe and the worst in the world. In the meantime, other countries have performed much better, having low numbers of deaths and health services that are not under pressure. I suppose that the outcomes depend in the main on the strategic planning of Heath Departments and Governments in those countries. I realise that, even though we have a devolved situation here, the Department develops the strategy to combat the virus and the trusts just deal with the consequences or the failures, some of which have been mentioned, such as services being cancelled and the cases of the two people that Jonathan raised. Given that other countries have performed much better and that the trusts have to pick up the pieces here, have the trusts had any input into the development of plans to combat the virus? Is there any sort of strategic vision into which they are being asked to input?

Mr Devlin: I will start. All trusts are part of the regional management board, which is a structure that allows all stakeholders to be involved in the development of the plans for health and social care. I stress that this is a pandemic, so we use a gold, silver and bronze command-and-control structure. The gold is the Department of Health, but we, as a regional management board, have been involved in many conversations about trying to deal with the situation.

I need to verify this, but I was discussing it with my medical director yesterday. The other thing that I am aware of is that Northern Ireland is in a slightly different place from the rest of the UK when it comes to mortality rates. As I said, I need to do further reading on that. It was made clear to me by my medical director yesterday that there seems to be an indication that our death rate is lower than in the other parts of the United Kingdom. I will ask Cathy whether she is aware of anything further in that regard, but my understanding is that we are different from the rest of the UK.

Mr Sheehan: I apologise for interrupting you, Shane. I am not really concerned about comparing here with Britain across the water; I am trying to make comparisons between here and New Zealand, Australia, Taiwan, Hong Kong, South Korea, Vietnam, Thailand and so on. Why are we doing so much worse than those countries?

Mr Devlin: I appreciate that that is what you were asking, and I think that it is clear that we have worked as a collective to find the best forward plan for Northern Ireland. I will ask whether Cathy or Jennifer wishes to comment on that.

Dr Jack: To put that into context, Pat, when you compare us with New Zealand, you will know that we have had a much higher infectivity rate and a much higher mortality rate, because you cannot have one without the other. You are therefore right, but New Zealand took very different action from that which was taken at a policy level in the Department of Health. New Zealand closed down early, and it is a quite a discrete island that really is fed through Australia. Australia also has done very well in the pandemic.

I think that, across the UK, Northern Ireland as a jurisdiction has done well. Certainly in the first and second surges, our mortality rate has been lower and our hospitals have not been under the pressure that you will have seen in the NHS. We are in the middle of the third surge, so I reserve the right to see what happens in this one. Certainly towards the end of last year, we had some community areas that had very high infectivity rates. Usually what you see in hospitals reflects what is happening in the community, as displayed by what the Southern Trust was facing only a few days and weeks ago. I will watch this space before I make an overall judgement on that, but, certainly in the first wave, we closed earlier and the people of Northern Ireland behaved very differently. They were very conscious, and I think that that was because we in an all-island sense took a different approach. I think that that protected us somewhat, but we have not had the early lockdown and contact tracing, isolation and screening that you have seen in the likes of Korea or New Zealand. It has been a different policy.

Mr Sheehan: Thanks for that. I appreciate that it is not the trusts that develop policy.

I have one final short question. Has any of the Department, the Public Health Agency (PHA) or the Health and Social Care Board (HSCB) communicated to you a contingency plan in the event of a vaccine escape strain developing?

Dr Jack: Pat, are you referring to a situation in which the Pfizer vaccine or the AstraZeneca vaccine no longer gives protection against COVID-19 for the variants and asking whether we have a contingency plan that we are aware of?

Mr Sheehan: Yes. Given the speculation about the high levels of transmission with the mutation of the virus and different strains emerging, there is serious concern that, at some stage, a variant will emerge that is resistant to the vaccines that are being used or being developed. Does the Department have any plans in hand in the event of that happening?

Dr Jack: This is largely about the large protein spike. At the moment, the vaccine still seems to be protective against the variants, but that question is best asked of the Department. As a chief executive, I am not aware of that plan, but that is not to say that the Department does not have it.

Mr Chambers: Chairman, I place on the record my appreciation for the work of the panel and their teams. Undoubtedly, they have saved countless lives during the pandemic.

It is disappointing to hear and read some of the unrealistic narrative around expectations of what the NHS is capable of delivering. If a decision were taken today to instruct all the trusts to run a full range and the normal outpatient clinics and to carry out all elective surgery, over and above the emergency and time-critical work that they are currently carrying out, what would the effect be on each of them? In particular, what would be the impact on the patients being treated in your hospital beds and the staff treating them? Would it be difficult for the trusts to guarantee the full safety of those who would be queuing up to receive elective surgery and, indeed, the safety of patients in the hospitals?

Ms Welsh: I am happy to start, Chair.

The Chairperson (Mr Gildernew): Thank you.

Ms Welsh: Thank you for your question, Alan. As we described, we are under such pressure that we were only able to cope with the COVID demands by having to take the really difficult decision to downturn a range of our elective services. It is simply not possible for us to stand up all those services and deliver them at the same time as trying to manage the COVID response. It is just not possible to do that.

Dr Jack: You will know that there is good evidence about the nurses:beds ratio and the safety of patient care. Any further significant dilution of the likes of the ICUs etc would put patients at risk. Furthermore, if we were to open all our outpatient clinics, because of the footfall through our hospitals — 16,000 people a week are seen in our outpatient clinics — we would only add to community transmission. That is why we are continuing virtually and seeing only those who are red-flag and cancer cases and need to be examined and those with mental health issues, whom we know will deteriorate significantly if they are not seen face to face. We have to play our part in minimising community transmission. Equally, however, I have to provide safe services for those who are in my care, and I will do that.

Put simply, we do not have enough to do everything. Something like over 800 patients with COVID-19 are in our hospitals at the moment. That is 800 people more than we had last year, and that care has to come from somewhere. There are 67 people with COVID in our ICUs. That number did not exist last year. We need to make sure that we have the staff to care for them. That is the reality that we face. Something has to give, and that is a really difficult decision for us. We have to deal with the cases of urgent care and COVID care that present at our emergency departments and manage that safely. As soon as it is safe, we will turn on the cancer and elective work. As soon as it is safe, we will do that.

The Chairperson (Mr Gildernew): Thank you, Cathy.

Ms Hunter: I thank Jennifer, Cathy and Shane for answering all our questions. I know that you are under immense pressure.

My question pertains to the delay in cancer surgeries. I know that that was a decision that nobody wanted to take and is a really unfortunate symptom of this horrible virus and how it has impacted on our society. My question is about the patients who have been affected by the delays. Do they receive any counselling? If so, how is that facilitated? Is it done through Macmillan? What support is available to them?

Ms Welsh: I am sure that my colleagues will want to come in on this as well. As it is relatively early, the clinical teams that are directly responsible for those patients will mostly have been making direct contact with them. It will be individual comments and conversations, depending on their needs.

Ms Hunter: Thank you very much, Jennifer.

Dr Jack: I echo Jennifer's point of view. The clinical teams are in regular contact. Patients are tracked and monitored closely, and, if they go forward for neoadjuvant chemotherapy, the oncologists and the teams pick them up. However, none of this is easy, particularly for the families and the patients, and then for the staff on the front line.

Ms Hunter: I understand. Thank you.

The Chairperson (Mr Gildernew): Thank you to our panel. It has certainly come across how passionate you are and how vexed you are in relation to the impact that this is having.

One of the things that I would like you to send us is a copy of the modelling that is used. It is important that we continue to learn throughout the pandemic. I noted, in the conversation on comparisons with other areas and other countries, that there are some stark comparisons. For me, however, one of the biggest comparisons that we will eventually have to look into is why we are doing so much worse than the rest of this island, never mind any other islands. We have similar demographics and social connectedness, yet our rates are much worse than those in the other part of this island. I am keen to get the critical care modelling that you referred to and the bed planning models, because we know that planning has been a factor here at times.

I thank every one of the panel members for giving us their time today and for answering and addressing all those questions. I reiterate, on behalf of my colleagues on the Committee, our thanks to you for the difficult but important role that you are playing and have played over a serious number of months now. In common with the front-line staff, you have been dealing with this for 11 months. It certainly has, I am sure, taken a toll on everyone who is trying to deliver that service.