Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

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

11 February 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
Ms Carál Ní Chuilín

Witnesses:

Mr Swann	Minister of Health
Dr Michael McBride	Department of Health

The Chairperson (Mr Gildernew): I welcome, by video link, Mr Robin Swann, the Minister of Health. Good morning, Minister.

Mr Swann (The Minister of Health): Good morning, Chair.

The Chairperson (Mr Gildernew): Minister, is Dr McBride with you this morning?

Mr Swann: He will be joining remotely. I cannot see him on the screen, and I do not know whether the Committee Clerk can. He intends to join us this morning, so he will probably catch up with us at some point.

The Chairperson (Mr Gildernew): I propose that we move on and hope that the Chief Medical Officer (CMO) will join us in due course. I will give you the opportunity to make your opening remarks, Minister, if you are content with that.

Mr Swann: Certainly, Chair; no problem. Good morning. As ever, I thank the Committee for the opportunity to update members. I will keep my opening remarks short to allow more time for questions and answers and engagement.

My last briefing to the Committee was on 14 January, and I am pleased to say that we are seeing evidence that the measures that were introduced after Christmas have had a positive impact in reducing the number of COVID-19 cases and hospital admissions. That has been reflected in the R

number, which has fallen from between 1·5 and 1·9 at the start of January to below 1 for the past number of weeks. That has undoubtedly saved lives and interrupted a potentially catastrophic crisis for the Health and Social Care (HSC) service and society as a whole. Again, I thank you and the Committee members for your support, Chair, and the people of Northern Ireland for all their efforts and the sacrifices that they have made for the sake of themselves, their families, our health service and others.

Although the downward trend in new cases continues, there is increasing concern that R has stabilised, stagnated and, at times in recent weeks, started to creep up towards 1. That means that the rate of hospital occupancy may fall more slowly and that pressures will be ongoing for a number of weeks, so just bear that in mind. We always need a period of time when R is as low as possible to more quickly break the chains of infection that result in people becoming sick, being hospitalised and losing their life to COVID-19. Our Health and Social Care service needs time and space to deliver other care that has been delayed or disrupted by the epidemic. There is also the risk of increased transmissibility of new variants of the virus, the first of which was identified in Kent and now accounts for between 40% and 60% of new cases in Northern Ireland. The full impact of that new variant and other new variants will be seen only when measures are relaxed and the R number rises more quickly than we have previously seen. I have always been clear that I share the desire for our economy and society to open up, but we do not want to see more cycles of relaxations and lockdowns with all the harm that that brings. As I said yesterday at the press briefing, we must take small steps and watch the consequences of each step to avoid R reaching 1 again, which would take us back into another vicious cycle of epidemic growth.

As we all know and as members of the Committee acknowledged the last time that we were in the Chamber, the vaccination programme is proceeding at pace and will save lives. The number of vaccines administered in Northern Ireland is well over 361,000, following the initiation of our twin-track approach whereby GP practices and regional vaccination centres vaccinate members of the public from the prioritised groups. The focus firmly remains on protecting those who are most at risk from the virus. The current phase of the programme covers everyone who is aged 65 and over and those who are clinically extremely vulnerable to COVID-19. On the basis of the amount of vaccine that should be available throughout February, we are confident that we will see rapid progress through the first five priority groups.

It is critical that people who receive the vaccine, as well as their friends and family, continue to limit their contacts as much as possible, particularly in the period directly after vaccination. That applies to us all, because it is essential that contact is limited between people to allow the epidemic to slow, to prevent illness and death, and to allow our Health and Social Care service to treat those who have already been admitted and to deliver other normal services that have been affected by the epidemic of COVID infection. It is anticipated that we will start to see the full effects of the vaccination programme soon. However, until then, we need to do all that we can to protect ourselves, to protect wider society and to protect our health service. That will be done by staying at home where possible. That will protect the health service and save lives. I have always been clear that there is no room for complacency, and that is still the case.

Following those comments, I am happy to take members' questions.

The Chairperson (Mr Gildernew): OK, thank you, Minister. I see that we have been joined by the Chief Medical Officer, Dr McBride. Dr McBride, you are welcome.

Minister, I acknowledge everything that you said there and acknowledge again the difficult work that your team has been doing. I also acknowledge the hard work of front-line staff and the pressures that they have been under, as well as the huge cost that this has all had on members of our society and the toll that it has taken. Over the past number of days, you have set out your concerns as we move into the future, and the Committee shares those concerns.

The Committee wrote to you, on 27 July, on the issue of Independent SAGE and zero COVID. Independent SAGE was putting forward a two-island approach plus an each-island approach for maximum suppression. Sometimes that is referred to as "zero COVID", and other times it is referred to as "maximum suppression". I have seen other debate emerging in Germany on no COVID, where you take maximum suppression and a regional approach. The Committee also brought a motion to the Assembly in November that was passed unanimously on significantly upscaling the whole find, test, trace, isolate and support element, which, I and many others believe, will be essential alongside the very welcome vaccination programme. I do not think that vaccinations, at this point in time or in the near future, will be the entire solution.

What changes have there been to the strategy moving forward, given that we have now experienced three waves of this? The first wave was unprecedented. There was massive learning to be achieved and massive measures to be put in place around PPE, but, as time goes on, we are keen to see what learning has been garnered from that and what is being done differently now. As you say — I agree with you — we do not wish to see more cycles of this or more cycles of lockdown. What can you tell us about the strategy?

Mr Swann: We are preparing papers. As you will be aware, the Executive have put together an Executive COVID task force. Part of that is one of the four pillars, and it is part of the health response, which includes the protection section of it. That includes vaccination, the test, trace and protect (TTP) element and the regulations, which we take responsibility for because of the driving nature that we have. The main step forward in the differential in the strategy of how we are coping at this point in time compared with where we were in the initial phase, Chair — what you referred to as the "learning" — is very much in regard to where we are now with test, trace and protect. It is a massively scaled-up system that makes those contacts at a rapid speed. I signed off on a written answer to Paula Bradshaw yesterday or the day before, and our average time for making a contact through TTP is something like six and a half hours from initial recommendation to the system. The system has been massively scaled up and is still achieving very high success rates. Back in January, during the first peak of this wave — the worst week that we saw — we transferred, that week, something in the region of 12,000 positive cases to our TTP system, and we were able to contact 93·5% of those people. That is a massive operation for those numbers. In last week's report, that was down to 3,000 cases because of the restrictions and where we are at this minute in time. That was expected. There are fewer positive cases coming through, but we are still sitting at that 94% contact level.

As an aside, what is concerning, Chair, is that, even though we are in a lockdown situation, we see an increasing number of contacts connected with each positive case. It has moved from just below what it started the year at to now being nearly 2·5 for every positive contact, so I am slightly concerned that positive cases are still seeing more people even though we are in a period of restriction. From the initial wave to where we are now, TTP has moved on massively in regard to the scaling-up of the system and how quickly people interact with the advice and guidance that we give, even through the electronic methods that we use.

There have been other big changes. We will bring recommendations to the Executive; I will table the paper to them tomorrow. It is about how we look at the wider interventions of testing and the use of loop-mediated isothermal amplification (LAMP) testing in workplace settings, hospital settings and special school settings. It goes back to *[Inaudible]* as part of the strategy that you referred to, and it has been referred to there as well. We are targeting that in a more intelligent way, in which we go into areas of high risk, where, in the past, we have seen outbreaks occur. There are already similar practices up and running in a number of meat factories. That is about to be rolled out to Translink as well. There have been large-scale moves in regard to that.

Another area that has been progressed in the background is the testing of waste water for the identification of COVID in particular geographical locations. That has been done in collaboration with three universities: Queen's and, I think, Trinity and Dublin. It is all about the advances that we have seen in science *[Inaudible]* test, trace and protect.

You specifically mentioned the two-islands approach. Especially as we see the easier identification of new variants across the world, as I am on record as saying, we have to take a two-islands approach in how we manage international travel. I am assured that that work is progressing. A task force led by TEO was established a couple of weeks ago and is engaging with Westminster and Dublin on how we pull that international piece together. I heard on the news headlines this morning about the steps that the Irish Government are taking with travellers coming in from other countries. At this time, we still do not have international flights coming into Northern Ireland. The First Minister and deputy First Minister have raised the point that anybody who comes in on an international flight must quarantine at the point of arrival, whether that is at a London airport, Dublin airport or wherever. That work is still being bottomed out at that level. Those are the changes and advances that we have made.

The other one is the medical treatments. Increasingly, we hear of medications that are already on the market and are having positive rehabilitation effects for people suffering the effects of COVID. All those changes in how we treat COVID patients have been developing over that time. A lot of learning has been done from the first wave.

The Chairperson (Mr Gildernew): With all of that having been said, are you confident now that the system would be able to prevent the type of surge that we have seen, given the new variants?

Mr Swann: Chair, I do not want to say that we could prevent another surge, because that is outwith my hands; it is in the hands of the people of Northern Ireland and the Executive. It is down to how we react over the next three or four weeks and then the next two or three months from where we are. As I said in my opening statement, we have seen R below 1 for a couple of weeks now, but I always caution and have to caution that that started from a high level. If you remember towards the end of last year and the start of this year, you will recall that we had approaching 1,000 people in hospital with COVID. As of yesterday, that number was 554. At the peak of our first wave, it was 322. Although I strongly welcome the decrease in the number of people in hospital and in ICU, it is still in excess of where we were at the peak of the first wave. We are going in the right direction, but we have a long way to go. As I said yesterday, it is about taking small steps, and I think that the First Minister and deputy First Minister have used that language as well.

The Chairperson (Mr Gildernew): Thank you. Minister, I move on to the issue of the vaccines. You have reported this morning that more than 361,000 people have been vaccinated. I acknowledge that significant and fantastic work has been done in that respect. However, I am sure that you are aware, as all representatives on this call are, that there are significant concerns and areas of confusion about how the roll-out is working, how people book their vaccinations and things like that. For example, a 72-year-old man in the north-west who has significant underlying conditions and has secluded himself since the very start of this wants to get the Pfizer vaccine, having done his own research into that, but has been offered the AstraZeneca vaccine. There are other cases where people who are clinically vulnerable are really confused. I get a lot of enquiries about when they will be offered a vaccine. They hear of issues such as what happened in the Belfast Health and Social Care Trust with the community and voluntary sector and wonder when they can expect to get vaccinated. One woman is caring for a young Down's syndrome man who had been very active and independent and is also caring for her husband. They, too, have literally secluded themselves in their home since the start of COVID-19 without any break or respite, and they are desperate. Are there issues that can be addressed around the speed of vaccinating those vulnerable sectors and communicating how the system is working in order to avoid confusion and to provide clarity to people?

Mr Swann: As I said, we are now vaccinating the 65-plus age group in GP surgeries and trusts. The clinically extremely vulnerable are our next cohort to come forward. Last night, there was a conversation between Patricia Donnelly, the trusts and GPs on how we manage that.

Northern Ireland has a very high percentage of people who fall into the category of "clinically extremely vulnerable". Through some of the trust centres, we have started to bring forward those who are deemed to be extremely clinically vulnerable. Over 4,000 of those have been done through the trust centres. Again, it is about taking the Joint Committee on Vaccination and Immunisation (JCVI) guidance and risk assessment, and we are working down through it and are now at that 65-to-69-year-old cohort. We will then move into the next group, which is the clinically extremely vulnerable, and that communication will come out soon.

We are moving at the speed at which our vaccine deliveries allow us. If we had more vaccines, we would move faster. That has always been the limiting factor. If you compare where we are with any of the other three nations across the UK, you see that everybody is at about the same level. That is because —.

The Chairperson (Mr Gildernew): Apologies, but I lost coverage there slightly. Can you hear me, Minister?

Mr Swann: I can, yes.

The Chairperson (Mr Gildernew): I lost you there just towards the end of that. I am not sure what happened with my screen. Will you just repeat the last bit, please?

Mr Swann: Was it the good bit that you missed?

The Chairperson (Mr Gildernew): Yes, it always is *[Laughter.]*

Mr Swann: I was saying that we will be moving into that clinically extremely vulnerable group. We have identified those who are extremely clinically vulnerable. They have been identified through trusts and surgeries. Over 4,000 of those have been done through our trusts, and more will be called

forward. Once we get through the 65-plus cohort, that will be our next step. Patricia met GPs and trusts last night, and we will communicate with people.

You asked whether there was anything that we could do to speed that up. Unfortunately, we move at the speed of the vaccines that we have. As I said, if you look at the delivery across any of the four nations, you will see that everybody is at about the same level, because we are all working to the maximum of the vaccine supplies that we have.

You highlighted that there are some very personal cases, and we will get the vaccine to those groups as soon as we can. We are working through those cohorts as quickly, efficiently and safely as we can.

The Chairperson (Mr Gildernew): Thank you, Minister. Before we go to members, my final question is on cancelled surgeries and the dire situation that we were in before the pandemic and the fact that we are now worse off than England, Scotland and Wales in the metric of how many have been cancelled proportionally. I am concerned about that. I am concerned about cancelled paediatric surgeries because many of those conditions can have serious health impacts, first of all, but also serious psychological impacts on younger people, maybe even more than for older people. It is an area of huge concern.

We really have reached a position where we would like to be dealing with COVID to the extent that we are not allowing it to impact on the important work that has to be done around surgeries and the whole issue of inequalities and how that impacts on people who are already struggling with other multiple inequalities. What can you tell us about plans to reinforce, rebuild and catch up on those important surgical operations?

Mr Swann: Chair, I heard you say that you had had a meeting with the Royal College of Surgeons. It has worked extensively with us on its approach to the formation and prioritisation of the regional waiting lists. I am sure that, in your engagement, it will have told you about the challenges of prioritising people on a regional basis, rather than using its local lists. Surgeons have taken a step forward and are willing to travel to utilise theatre space wherever it may be. We are looking to establish a regional response and to set up regional lists in the Royal, the Ulster, the South West Acute Hospital (SWAH) and the Southern Trust. It is about taking surgeon and patient to where the facilities are, which has never been done before.

We are also looking at the utilisation of the independent sector, which has offered us, I think, another 112 available slots. It is about working with that sector in the long term. Chair, you highlighted that we started from a bad place. I have said and I think that other parties now acknowledge that we started in a bad place due to underinvestment in the health service over the past number of years. We are now, unfortunately, paying the price. From theatre nurses to anaesthetists, we need more staff with the skill sets required to support our increased ICU capacity. Some of the surgeons to whom I have been talking are coming up with creative responses to manage the situation, such as the utilisation of the day procedure unit at Lagan Valley, which is really progressing. Coming out of COVID, if we can replicate that elsewhere, it will be one of the benefits. It is about utilising every bit of spare capacity that we have.

Chair, like you and everyone else, I am keen to get back up and running as quickly as possible once we get through the pandemic. Our staff will need respite before moving from the intense pressures of COVID straight to the challenges of reducing the waiting lists. That gear shift means that we will have to factor in some respite for their psychological and physical well-being, and that is being looked at. We have to get on top of our normal day procedures as soon as we can.

Chair, we can treat more non-COVID patients when we have fewer COVID patients. It is about driving down the infection rates and the number of COVID patients in hospital. That frees up capacity and allows us to utilise more of it and our skill sets for non-COVID patients.

The Chairperson (Mr Gildernew): OK. Thank you. I will go to members.

Mrs Cameron: Thank you, Minister and Chief Medical Officer, for your attendance at the Committee today. I have a few questions for you. How many people are expected to have received a first dose of the vaccine by the end of April? When vaccinating the generally healthy population, will GPs and the seven centres have enough capacity to maximise delivery? Are you considering an appropriate standby list for people who are extremely clinically vulnerable or vulnerable to ensure that we do not waste vaccine and that those who need the vaccine before the healthy population receive it as quickly

as possible? I was thinking of the use of a standby list at the end of each day to avoid wastage. You could have a list of people who were readily available and had agreed that, at short notice, they could travel to a vaccine centre.

Mr Swann: I do not have exact figures for how many will have received their first dose by the end of April. Our stocks do not allow us *[Inaudible.]* Our pre-planned deliveries do not allow us to get to that point. When looking at where we hope to be, we look more at the cohorts. By the end of April, we hope to be well into the sixth cohort.

You asked about our vaccine centres delivering maximum output. We are taking a twin-track approach through using regional centres and GPs. That is working well because it matches the delivery of vaccines that we currently receive. We can scale up. We are looking at locations for further regional vaccine centres, should more vaccine become available.

I caution that, fairly shortly, we will move to the second dose of the vaccine. We need to make sure that we have the vaccine to supply the second dose while continuing to give people their first dose. Running two vaccination programmes, one delivering the second dose and the other continuing to deliver first doses, will be a logistical challenge, and it will be dictated by supply. We have the abilities and places to run those two systems in parallel.

Re vaccine wastage, because of the booking systems that we use, we have a good idea of who is coming through the regional centres. There are few no-shows, to be honest; in fact, people are queueing to be vaccinated, rather than losing their slot. If it comes to a point where there may be wastage, we have healthcare workers on standby to receive their second dose. Rather than wasting vaccine, maybe because it has timed out or there is a danger of breakages, we give second doses. Pam, that standby system is for healthcare workers, not for large numbers, because the majority of those who are booked in come forward.

Mrs Cameron: Thank you for that, Minister.

I want to move on to child protection issues. Weekly child protection referrals have dropped by 37·5% since 22 December. Have we reached the point where the risk of not being able to prevent harm to vulnerable children now outweighs the wider health benefits of closing schools?

Mr Swann: That is a challenging question, Pam. That is not how I have previously thought about it. Looking at the number of referrals, I think that there could be a direct correlation with the closure of schools. Cases are not being reported, and the Chief Social Work Officer has referred to that. However, the counterbalance is the number of children in care, which has increased over the same period. I need to take a further look at that and get further guidance on it. There could be a direct correlation, and the balance needs to be assessed. Michael, do want to come in on that from a medical point of view?

Dr Michael McBride (Department of Health): You make an important point, Pam, about referrals. You are absolutely correct that referrals have fallen by just over 11%. They picked up again in November, and the Minister issued a press release to indicate that the child protection services and family support hubs were operating, to encourage parents who had concerns etc that the services were available and accessible.

We all recognise that the pandemic has had a significant impact on children: their education, health, mental health and well-being as well as the emotional impact. At all stages, the Executive have faced difficult choices with regard to the risks associated with more interactions versus the benefits of restricting some of those social interactions, including the mixing that goes on in schools and the potential to drive the pandemic. As our experience of the virus has grown and the evidence has accumulated, we know now that mixing in schools drives infections in the community, particularly through contacts with families. Particularly in the context of the new variant, which the Minister mentioned, the reopening of schools will certainly add significant upward pressure on the R rate. There is no doubt about that. That could be as high as between 10% and 50%. It just depends to what extent schools are opened, when they are opened and the mitigations in place.

Clearly, as the Minister said in his responses earlier, the longer we delay the relaxation of restrictions, the more we suppress the level of community transmission and the more people we get vaccinated and protected. Then, the gradual easing of restrictions would allow us to ensure that we have prioritised the things that matter most — the Executive have been clear that children's education

matters most — and, in a phased and careful way, as the Minister said yesterday, to look at easements of some of the other restrictions. You are absolutely correct: the virus has had a devastating impact on children.

Mrs Cameron: Thank you for those responses. My final question for the Minister relates to click and collect. In particular, Robin, do you accept that some shops such as baby shops, which provide goods for expectant and new mothers, really need to open soon, even on an appointment basis? Has there been any progress on that vital issue?

Mr Swann: It is one of those things, Pam. When we relaxed our approach to click and collect towards the end of last year, we saw it being abused. I think that other Ministers have put that on record. Therefore, we need to be cautious about how we manage that. Health and the Department for the Economy are working together on this; I think that that is the best way in which it could be described. The Minister for the Economy has brought forward a paper on click and collect. We are cautious about reintroducing it because our message is still, "Stay at Home". People can buy online and get deliveries. We have asked Economy to look at the specific list of essential and non-essential retail and to come forward with an assessment of specific risk.

With regard to support for new mothers and, especially, premature babies, we are not doing this because we are cold, heartless, unsympathetic and lack understanding; it is about how we manage the risk that additional travel and the opening of more shops and shopping centres bring. The Department for the Economy is working with us on how we can safely support the opening of a specific section of shops on a click-and-collect basis. However, I will be clear: I do not support going back to widespread click and collect at this point, when we still see the spread of COVID in the community.

Ms Bradshaw: Thank you, Minister and Chief Medical Officer. Minister, yesterday, it transpired that all five trusts had opened up their vaccine programme to the community and voluntary sector, with, I might add, very little scrutiny. What do you say to the people who have shielded for the past year, carers and those who want to be care partners for their loved ones in care homes? What do you say to them about how the process has been handled? Since all five trusts have adopted the same approach, who took the policy decision to allow them to do that?

Mr Swann: Thanks, Paula. An approach was made re trusts opening up to the community and voluntary sector, which works in partnership with us to deliver services and acts on behalf of some of the most vulnerable and isolated people in our communities. It was not about a widespread opening up to the voluntary and community sector. I am aware that some trusts took a step outside that and issued letters to their entire voluntary and community sector contact base, for want of a better term. When we were first made aware of that happening — it was in the Belfast Trust — we contacted the Belfast Trust, and it withdrew the large-scale invitation. The invitation was then narrowed down to those in the community and voluntary sector who work in partnership with the trust and the Health Department in delivering our services.

I will put this in perspective: the Belfast Trust vaccinated in the region of 260 people out of a cohort of 42,500. What do I say to those who received the vaccine? I say, "Please, come forward for your second dose because we don't want to waste the first dose". If they are working in the sectors that supply direct support to those most in need — the people who are shielding — that is why they were called forward. A mistake was made by the Belfast Trust regarding the widespread contact list that it put out, and it pulled that back quickly, and only a small number — about 260 — received the vaccine.

Ms Bradshaw: Thank you. Minister, you said in your opening remarks that you were moving rapidly through the vaccination programme and that, by the end of February, you will have reached priority groups 1 to 5. You will be aware that the vaccination deployment plan indicated that you would get to group 6 by then. Group 6 is the carers. Why will they not be vaccinated by then? It has also come to my attention that there is an issue between your Department and the Department for Communities with the sharing of data on those who are in receipt of carer's allowance. Is that what is holding up carers being brought forward?

Mr Swann: No, it is not, Paula. I do not know where you are getting that information, but it is not related to the vaccine programme. The carers who will be identified to come forward for vaccine will come through the trusts and GPs, not my Department. One of the challenges that has come to light through the pandemic is that we do not have a central database of carers in any Department, so there is a sharing, I suppose, of carer identification among the Health, Education, Communities and Justice

Departments. There is a data deficit across government in how we identify carers. The carers group will be brought forward, because they are group 6, and they will follow the clinically extremely vulnerable, because we recognise the support that they bring. It will also be in direct line with the JCVI guidance, which has carers as one of the priority groupings.

Ms Bradshaw: The recognition payment for Health and Social Care staff has caused a lot of concern and disappointment among non-trust staff. I am talking about dental nurses and community pharmacy staff. These are people who do not run their organisation but are involved in healthcare provision. They feel that they played a vital role in the pandemic over the past year. Is there any move to extend that payment to non-trust staff?

Mr Swann: The first trust payment *[Inaudible]* open to everyone on the Business Services Organisation (BSO) payroll. That includes doctors, community dentists and any Agenda for Change staff. It is my intention to make it as wide as possible. We followed the Scottish model for the initial recognition payment and took our first go at this from there. One of the differences between my original take and ministerial direction on the payment and the Scottish model is that the Scottish model did not include agency workers. It is my intention that agency workers who are on Agenda for Change terms or, because of the agency that they work for, even less, unfortunately, will also be eligible for a recognition payment. That was not in my initial ministerial direction, so I have to make another ministerial direction to do that. I am hopeful of support from Executive colleagues, including the Minister of Finance, to progress that as quickly as we can. Part of the challenge is being able to identify across all sectors and trusts the agency staff who were working during the relevant period.

Ms Bradshaw: My final question is about the vaccination rate and performance of GP practices. I am aware of some GP practices that vaccinate only on Wednesday afternoons, for example. Who is monitoring the rate at which they bring their patients forward?

Mr Swann: Some GP practices are operating like mass vaccination centres so that they can work with social distancing, book other venues, such as community halls, and get staff in place to deliver a mass vaccination programme, rather than running continually over a number of days. When some GPs receive each delivery of the Oxford-AstraZeneca vaccine, they programme a mass vaccination clinic, rather than running it over a number of days. They have the additional challenges of social distancing, hand hygiene and managing and inviting cohorts forward. Rather than bringing forward people over a number of days, they do it in one block booking. It is about even more efficiency and delivery *[Inaudible.]*

Mr Carroll: Thanks, Minister. My first question is about private healthcare capacity. I have raised this before. I believe firmly that it should be utilised for public control and to help to tackle COVID and the ever-mounting waiting lists. It is really sickening that some private providers are boasting that they have never had it better in terms of the number of patients whom they are seeing at the minute. It is obscene that people can get treatment if they can afford it. That, in effect, creates a two-tier health service: if you have £15,000, you can get treatment, but, if you do not, you are forced to wait on an NHS waiting list like everybody else. I raised this in passing in the Assembly this week. I asked the Department what the private healthcare bed capacity was in the North, and I was told that that information was not readily available and could not be collected without disproportionate costs. I am concerned that that does not seem to be even on the radar of the Department as an avenue to deal with the pandemic and increasing waiting lists. Is any further work being considered by the Department on that avenue? If not, why not?

Mr Swann: Gerry, I will segregate the two points that you have raised. One is about taking over the private facilities *[Inaudible]* your political ethos or the maximum utilisation of what is there. Between April of last year and the end of January this year, 4,200 patients went through our local private healthcare facilities. That was about using the capacity that they were able to allocate to us. They have taken some steps to increase capacity and make more lists available to us. We met them a number of weeks ago, and they were able to release an additional 112 theatre sessions to help to treat suspected cancer and time-critical patients. We have that working engagement. They have downturned some of their non-urgent capacity to fit in some of our urgent capacity. It is about a working partnership; that is the best way that I can describe it. We are progressing our relationships at pace so that we can get as much utilisation as possible from them. It is not just about looking at the independent sector here; we are also working with the independent sector in the Republic of Ireland to get as much capacity as we can so that as many patients as possible can be seen quickly. As I said — we agree on this — we have to do that because we have failed to invest proportionally in our National Health Service in the last number of years.

Mr Carroll: Thanks for that, Minister. We have been told that this is an unprecedented period, so the fact that we have — I do not know how many — a sizeable bed capacity that is not being utilised for the public fight in a pandemic is unbelievable not just from my perspective but from many other people's perspectives, and I strongly suggest that that be looked at. The state has done many things in this period that it would not normally do, so why can private healthcare capacity not be utilised for the battle against the pandemic and the fight against the ever-increasing waiting lists?

I will move on. I am looking for a bit of clarification on the payment for healthcare workers. Concerns have been expressed to me that, if that is provided on a pro rota basis — I do not know whether that is the case — that would negatively impact on part-time workers, who are mostly female. Also, on the student payment, which, I think, is the Economy Minister's responsibility, will all medical students get a payment, or will it only be some? Can we get a bit of clarity on that as well?

Mr Swann: Gerry, it will be pro rota. That has been communicated. Again, as I said, our initial framework came from the Scottish model, and we took the approach that Scotland took. The rationale for doing so was that it gave us and Scotland a common platform on which to approach Westminster about the taxation and HMRC implications for both payments. My thought *[Inaudible]* working in conjunction with my Scottish colleague, on a common platform with a common payment system, we could approach Westminster on a common basis. I cannot make that approach to Treasury because it is not within my remit, but the Finance Minister has done and continues to do so. The Communities Minister is making sure that our approach does not have an adverse impact on payments, although we do not have a guarantee on that. I thought that there was a benefit to the two of the four nations that have made the acknowledgment payment going forward on a joint platform.

On the payment to healthcare students, I need to be clear: the £2,000 is directed towards our nursing and midwifery students and other healthcare students who were unable to take up paid placements because they were in that position. A number of Committee members have asked why we have not paid our student nurses, as England has done. I have made it clear that paying them would delay their graduation date, because they have to do so many supernumerary hours before they can graduate. The introduction of the acknowledgement payment allows them to complete their supernumerary unpaid training placement hours and still graduate in time to enter our workforce in June or July. That is why the recognition payment was made at that point. I know that medical students have raised an issue. It is not my intention to include them in that. I know that other organisations have raised concerns about that, but there is a differential between medical students and nursing students and what they are able to do on wards. The reason for the £2,000 payment was to allow our nursing students to complete their training and come into our workforce as soon as possible. Other medical students have been able and were encouraged to take up temporary part-time student assistant posts across the health service. They were paid for those posts, and many of our nursing students could not do that. If they took up those paid student assistant posts, they would be eligible for part of the £500 payment because they would be on our BSO payroll for any work that they did. They would also be eligible for the £500 student support payment that the Economy Minister brought forward. There are a number of avenues for them to be provided with support.

Mr Carroll: Finally and quickly, Minister, I have a constituent who has a heart condition and other medical issues. She is trying to get a shielding letter. Her GP has told her to go to the consultant, and the consultant has told her to go to the GP. Can you give clarity on whom she should approach to get a shielding letter?

Mr Swann: Both avenues are right, Gerry. Some patients will get a shielding letter from a consultant, and others will get it from a GP. One of them should provide it. If you want to send me through the exact details to the private office, I will follow up on that.

Mr Carroll: Thanks, Minister.

Ms Ní Chuilín: Good morning, everyone. Good morning, Minister. I have three questions, and it is up to you in what order you want to answer them.

The first question is about the Kent variant. I note your correspondence, but cases of that variant were growing well before Christmas, and, indeed, there was a proposal to bring in tighter travel restrictions, which you voted against. That appears to have been a constitutional position rather than a health one. What advice did you take before you voted against that proposal?

The second question is about a replacement for the Chief Scientific Adviser (CSA) in the modelling. What are the alternative arrangements? I note the correspondence to the Committee, but could you put on the record that no public funds will be used for his legal bill?

Thirdly, which of the 96 recommendations of the hyponatraemia inquiry are you supporting?

My last question is this: rather than just doing a high-level screening exercise on the draft budget, will you conduct a full equality impact assessment (EQIA). Those are my questions.

Mr Swann: Thanks, Carál. I told you the other day that I was looking forward to you being here today.

I do not know whether we have time to do a full equality impact assessment due to the time frame, the consultation and all the rest of it. We will consider the matter, and I will come back to you on whether we will do a full equality impact assessment on our budget proposals as well. I will clarify that and whether that has been done as a totality for the Budget when it is agreed at Executive level.

On what I voted for or against in the Executive, I have always thought that what was done in the Executive stayed in the Executive. I am happy to have that conversation, as you were a Minister in the Executive at that time. I brought the paper forward on that evening. I think that it was in late' December and at about 10.00 pm. It was at one of those meetings that I brought forward the paper, and we introduced the 10-day quarantine for travellers coming from GB or the Republic of Ireland. That is still in place, and I still support it.

Another proposal was brought to the Floor at that point. If you recall, we asked for further information to be brought back about the assessment of how many people it would affect, what economic impacts it would have and whether it would have an impact on road haulage and all the rest of it. A commitment was made, I think, by TEO and other Departments to bring that information to a subsequent meeting when the issue could be discussed again. I will not say whether that information was brought back, but the issue has not been raised for a vote or decision since. To be clear about what I voted for and voted against, I voted against a proposal that was brought in the middle of a meeting when I did not have substantive information to back me up. You sat with me long enough on the Executive to know that I do not take those decisions without substantive information.

I have always said that, as an Executive and with everybody on it, any decision should be made with proportionality and the information to support it. That is where that position fell. If you recall, on that night, on the basis of my proposal for a 10-day quarantine for anybody coming from GB or the Republic of Ireland and staying over in Northern Ireland, the paper that we brought forward received cross-party support.

You asked two further questions, one of which was about the hyponatraemia report. We have accepted all the recommendations in the report and are on record as saying that. Even before my time, the Department had accepted all the recommendations.

As regards the Chief Scientific Adviser, no public funds are being used. Ian has taken a private legal case. On his replacement, we have split the roles that Ian was providing while he is off on health grounds. Dr Declan Bradley from the school of medicine, dentistry and biomedical sciences at Queen's University, who is the Deputy Chief Scientific Adviser, will represent us at the Scientific Advisory Group for Emergencies (SAGE) and will chair our modelling group, which brings forward modelling recommendations and information to the Executive. Professor Stuart Elborn, the pro-vice-chancellor for the faculty of medicine, health and life sciences at Queen's, will represent us at the UK's New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG). He will also chair our strategic intelligence group. The roles have been split between two professionals.

Ms Ní Chuilín: Chair, may I come back in quickly?

The Chairperson (Mr Gildernew): Yes, go ahead, Carál.

Ms Ní Chuilín: Thank you for that, Robin. On the equality impact assessment —

Mr Swann: Sorry, Chair, I have lost sound.

Ms Ní Chuilín: Can you hear me?

The Chairperson (Mr Gildernew): Can you hear Carál now, Minister?

Ms Ní Chuilín: Can you hear me now, Minister?

The Chairperson (Mr Gildernew): Can you hear me, Robin? I do not think that Robin can hear any of us.

Ms Ní Chuilín: No, he probably cannot. Will I give it a couple of seconds, or what will we do?

The Chairperson (Mr Gildernew): We will give it a few seconds, but these issues can be more easily addressed by Broadcasting when we are still online. Robin might be signing back in so we will give the Minister another minute or two.

Ms Ní Chuilín: The signal is very bad, Chair. I do not know whether it is StarLeaf. I was in a Zoom meeting earlier, and it was fine.

The Chairperson (Mr Gildernew): Yes. It seems to be poor this morning, and the Minister has been hard to hear at times. There may be some issue at his end.

I can see you back on the screen, Minister. Can you hear us now? No, I do not think so. I will give it another minute and then, if necessary, we might need to pause the meeting. I wonder whether it is something on the Minister's side.

Can you hear me, Carál?

Ms Ní Chuilín: I can hear you fine, thank you, Chair.

The Chairperson (Mr Gildernew): Dr McBride, can you hear us?

Dr McBride: Yes, I am hearing you loud and clear, Chair.

The Chairperson (Mr Gildernew): Are you both in the Department today? The Minister is back on visual. Can you hear me now, Minister?

Mr Swann: Yes, I can, Chair.

The Chairperson (Mr Gildernew): OK. We will try to pick up again with Carál, and, hopefully, you can hear her.

Ms Ní Chuilín: Thank you, Chair, and thank you, Minister. There is a proposal for a full equality impact assessment on the budget. I urge you to do that. The Minister for Communities did that. There are significant concerns even with the budget presentation that you gave us. There will be people, according to your £165 million shortfall, who will be adversely impacted, so I urge you to do that assessment.

In relation to the hyponatraemia report, while you have accepted the recommendations, the Department has been silent on the findings and on an action plan — if I have missed that, I apologise — for how those issues will be addressed.

In relation to the Executive and the Kent variant, the information was public as soon as the Executive happened. Lots of things happen at the Executive, and I have not spoken out of school, Robin, and will not. If it is on the public record, I will. It is on the public record, so I will mention it. Given that the Kent variant, according to your correspondence, will cause global concern, with tighter travel restrictions, passenger locator forms and managed quarantine, what are your plans to ensure that the potential for it to infect people in the North or, for that matter, across the island does not happen?

Mr Swann: Thanks, Carál. I was not accusing you of speaking out of school. That was not my intention.

In regard to hyponatraemia, there is a full work programme for the working out of that. I will get a detailed written response to you because you have just joined the Committee.

You asked about the budget. I will check with the Chair, but I think that my officials will provide that update directly after this session.

The Chairperson (Mr Gildernew): They will.

Mr Swann: They can update you on that.

I am not sure whether you were here for the Chair's opening comments on international travel and about how I believe that we need to work across both islands. I welcome the steps that are being taken. They are not yet going far enough in sharing passenger locator form information with the Republic of Ireland. There was a meeting at quad level Monday week ago where junior Minister Kearney, the First Minister and I met, and some of the information coming forward from the Irish Government is still not to our satisfaction about data being fully shared.

Steps are being taken at First Minister, deputy First Minister, Taoiseach and Chancellor of the Duchy of Lancaster level as to how we progress that issue because I think that it will move pretty quickly in regard to how, where and whom we quarantine. We have to do that in lockstep across these islands.

Mr Buckley: Good morning, Minister. Cancer has been one of the issues that have really touched me throughout the COVID-19 period. With cancer detections down 20% on average, affecting around 1,300 people, does the Minister accept that a return to the operating table is not the only piece in the puzzle to be worked out and that work is ongoing to enhance face-to-face contact and ramp up diagnostic services?

Mr Swann: Definitely, Jonny. That is one of the things that we did in developing the cancer reset cell. You are right: it is not just about the operating table being the answer. In terms of current cancer treatment, no chemotherapy or radiotherapy has been cancelled in any trust. Both services have been maintained throughout the pandemic. There may have been changes to some treatment plans, which have been modified for patient safety and in line with national guidance. Any changes have been made in consultation with the patient. You are entirely right about how we need to get that diagnosis back up and working as quickly as possible. We have already seen that the capacity is there, and we are working on a regional basis to carry out those phase 2 operations. We have over 1,800 people on the regional list who can be seen and treated in any hospital in priority order. A lot of work is going on in the independent sector as well. As you say, cancer is one of those diseases that touch near enough every family in Northern Ireland. However, we have to recognise that other conditions are still causing harms.

Mr Buckley: OK. I am also greatly alarmed by the adverse impact that COVID has had on mental health. You rightly made that a priority when you first took up office, and you received widespread support in the Chamber. While we fully recognise that things have been difficult, I welcome the fact that vaccinations are being administered at a record pace. With the emphasis on the word "hope", I hope that we can begin to get society back to some form of normality.

After an interview with the Chief Medical Officer, on the day when the COVID infection rate in Northern Ireland was at its lowest since 1 October, some news outlets chose the headline that COVID restrictions may be in place until 2022. That runs a real risk of destroying hope. People cling to the realisation that we are rolling out a vaccination programme that could lead to some form of normality. Do you agree that it is important that Ministers and officials tread carefully to ensure that we do not create further anxiety and diminish the light and hope that vaccination can bring in the coming days?

Mr Swann: Thanks, Jonny. It was apt that you commented that some news outlets decided to run that headline. It is a pity that they did not run what was said in its entirety. Had they been present, they would have known that the Chief Medical Officer gave an hour and a half of media interviews and briefings that he does along with other senior officials every Tuesday. He said that there was some hope, and that was clarified yesterday at the press conference. The Chief Medical Officer is on the call. Unfortunately, what was reported in the news headlines did not reflect a lot of the substantive detail and input that the Chief Medical Officer gave to the media briefing. Even if you read past the headlines, what was reported made many of those same stories as well. It is about giving hope, but, as I said yesterday at the media briefing, it is also about balancing hope with caution. We cannot get ahead of ourselves.

I would also offer a note of caution about the R rate. It is now as low as it has been since October, but it is not as low as it was in June and July; it is still high. When we brought in regional restrictions, we

used a rate of 80 positive cases per 100,000 as an indicator that we had an area of concern. We do not have a local district across Northern Ireland that is lower than that. When somebody compares where we are now with where we were at a certain point in time, that point in time may not have been a particularly good one either. It is about taking those comparisons into account as well.

Mr Buckley: I appreciate that, Minister, and, as I say, it is important that we do not lose sight of the hope that vaccination brings. However, we need to lay out clearly the road map to recovery.

My final question is about something that is in the briefing papers. There is correspondence from you in the tabled papers about the public inquiry into Dr Aidan O'Brien in the Southern Trust. I thank you for corresponding on that matter. I am deeply concerned about the grounds for that inquiry. When we look at other thresholds for public inquiries, we see that the threshold for this one appears to be weak. The issues surrounding Mr O' Brien's case focus entirely on administrative matters rather than on any clinical concerns or complaints. Given that a public inquiry costs massive amounts of public money, surely there is a better way to establish a way forward.

Mr Swann: I hear the points that you make, Jonny. I called a public inquiry because, as of 8 February, 1,906 patient records had been reviewed and 287 families had been identified. We are also reviewing nine initial serious adverse incidents that I referred to in my oral statement in November. Through other pieces of work, other concerns have been highlighted. We started with other avenues and have now finished up at a public inquiry. There are also concerns about the private patients who were being seen. We do not have contacts for them and have encouraged them to come forward.

Mr Buckley: My time is probably nearly up, Minister, but I know that you have taken decisions like this before where you have never been afraid to go back, rethink and look at the evidence that is before you. You referred to your statement in the Assembly. I do not believe that we have been garnered with the full facts, including the very crucial point that there were significant prior grievances initiated by Mr O'Brien against the trust that had not been dealt with. We, as an Assembly, did not have prior sight of that, and it was not referenced in your statement.

I have talked to medical professionals and patients, and I have not met one who can criticise Mr O'Brien's work; in fact, it is quite the opposite. They believe that Mr O'Brien has been treated abysmally by the trust and that its actions should be investigated, not those of a man who has given a lifetime of service. I would appreciate it if the Minister could give this further consideration, and, if it goes down the road of a public inquiry, which it seems to be doing, I urge him to think on those terms of references and engage with the Committee and the Assembly to ensure that, if we have to go down that route, we gain a full picture of all that went on during Mr O'Brien's time with the trust.

Mr Swann: The point that you make shows one of the benefits of a public inquiry, because that will all come out. Another avenue of inquiry or investigation may not bring that out. A public inquiry may prove one way or another whether those concerns stand. I have initiated a public inquiry, and I intend to continue down that road.

Ms Flynn: Thank you, Chair. Minister, if you do not mind, I would like to go back briefly to the recognition payment, which Paula and Gerry raised. I am pleased, of course, that it will include agency workers, but it is disappointing that it might be on a pro-rata basis. I know that Gerry touched on workers who might be on part-time contracts but have clearly been working over and above full-time hours over the past year. Can the way that that payment will be rolled out be reconsidered at this stage? There is still a lack of detail, and I understand that the Department is still working its way through it. I am sure that your office, along with most MLA offices, are being lobbied from concerned Health and Social Care workers who want a wee bit of clarity on the situation. Has the Department agreed a date of application? For example, will the date of application begin from when you made your statement or from when the pandemic began?

Mr Swann: Sorry, I am just looking at notes. The criterion date for anyone who was working in the health service is between 17 March 2020 and 31 January 2021, and *[Inaudible.]* I hope to have a further Q&A session on that probably later today *[Inaudible]* that we have done.

If anyone was working part-time during the qualifying period and worked additional hours, that will be reflected in the payment, because their part-time hours, including the additional hours worked, will be averaged over the qualifying period, so the payment will be based on the average hours worked in a week. The payment will be calculated on a pro rata basis against the full-time payment of £500.

Ms Flynn: Minister, that is great. Thank you very much for that detail.

Secondly, I am conscious that, after the Health and Social Care workers went out on strike, it took over a year to process the industrial action moneys. As you try to progress the payment for the Health and Social Care workers, particularly agency workers, has the Department approached the agencies that outsource those staff to the Health and Social Care service? There would be undue delay if that process was going through the trusts because those agency staff are technically not employed by the trusts.

Finally, has any work been done on or has any thought been given to preventing multiple payments? For talk's sake, that would include people who are working in the Health and Social Care service but have dual contracts with the NHS and with private agencies.

Mr Swann: Órlaithí, yes, it has. You are picking up on the fine detail that we are working through on how we differentiate that. As I said in an earlier answer, I will have to make a further direction on agencies because we will have to look at those as two very separate pieces of work. We are working with the trusts to identify the agency workers, what the implications are, how many there are and what payments are being made. There should be some mechanism in the trust to identify them, and we will then engage with the agencies in order to pick up that additional data. It is one of the more challenging pieces of work to define who, where and when.

Órlaithí, can you repeat the first point that you made?

Ms Flynn: I think that you covered it. It was on the contracts with the agencies.

Mr Swann: Yes, the engagement.

Ms Flynn: Sorry; it was on preventing multiple payments for people who may have dual contracts.

Mr Swann: Again, that is something that we are tying into, and it will come across when we look at the agency work specifically as well as at that separate piece of work.

Ms Flynn: That is great, Minister. I appreciate those responses.

Finally, as was discussed, it is unfortunate to hear that there are still issues with data sharing on the island. I think of the similar problems that we have been having from east to west. I think that it is the Home Office that designs the passenger locator forms for people travelling from Britain onto the island. A couple of weeks ago, I made a suggestion to some of your officials about trying to amend that form because there is no section on it for people who live in the North to make contact with the PHA or the local contact-tracing authorities to let them know that they are isolating etc. Elaine Colgan said that she would take that away. Do you and Michael have any updates on the Department's progress on that work? If it is picking up any additional people who are travelling onto the island, it is useful, as it may help to reduce transmission at any level.

Mr Swann: I will ask Michael to come in on that, Órlaithí, because I am sure that he is feeling left out.

Dr McBride: I am enjoying being left out, Minister, Chair and members of the Health Committee. It is a welcome relief, and it is not often that it happens.

I am not aware, Órlaithí, of particular problems relating to the sharing of information between the Home Office and the authorities here. Information on international travel is being shared with us. We are passing that information on to the Public Health Agency, which is then actively following up on international travellers. As the Minister said, we are making progress with the authorities in the Republic of Ireland, and that is very much to be welcomed. We have an interim solution in place over the next couple of days that will allow individuals arriving into Dublin and the other ports in the Republic of Ireland to be advised of the legal requirement to complete the UK passenger locator form, and they will be directed to the nidirect website. We put that arrangement in place, if you remember, when we had the Denmark variant of concern.

As Carál mentioned, we will increasingly see new variants arising around the world. It is important that we have genome sequencing so that we can detect those early; that we have controls in place that allow us to assess their impact, if any; that there is sharing of information about the new variants

globally; and that information on travel from countries where the new variants are emerging is also made available to us. There is more work to be done. We are making good and sustained progress.

Ms Flynn: Thank you, Michael and Minister.

The Chairperson (Mr Gildernew): The final member to indicate that they want to ask a question is Cara Hunter.

Ms Hunter: Good morning, Minister and Michael. Thank you for coming before us. I will keep it brief, as I know that you have to leave shortly. It is welcome news that we have vaccinated over 361,000 people.

I will ask you both of my questions at the same time. I recently met Community Pharmacy representatives. I am mindful that they have played such a key role throughout COVID-19 and that they have seen an increase in referrals and in footfall, especially with GP closures. What conversations have you had with that sector? Have you identified any potential additional funding for it?

Another issue that has been raised to me a number of times by staff who are working in COVID test centres across East Derry is their real concern about not having received the vaccine. They are high-risk, as they are around people who are COVID-positive. Another concern is that, if those staff were to become COVID-positive, they would have to self-isolate and would not receive sick pay.

Mr Swann: Thank you, Cara. We have a good working relationship with Community Pharmacy. Our Chief Pharmaceutical Officer meets Community Pharmacy regularly. In fact, I think that we have an excellent relationship. I do not want to put the scud on things, but we have progressed the relationship that my Department and Community Pharmacy have had over quite a number of years. We have a good partnership up and running and a relationship where we understand each other's abilities and needs. I especially welcome the fact that Community Pharmacy picked up the additional flu vaccine roll-out as an additional piece of work, which allowed our GPs and regional centres to concentrate on COVID.

The COVID test centres are facilities that are contracted by the Department of Health and Social Care (DHSC) in Westminster, so the people working there are not our direct employees. We will be happy to pass on your concerns to that Department, which is the employer rather than us. Those staff should not come into contact with COVID-positive patients because of the set-up that they have. They should always be doing things at arm's length and wearing PPE. I went to a couple of centres to see them in operation at the start. There should not be any great threat of staff coming into contact with COVID-positive patients. We can check up on the supports that those staff receive if they are off sick due to contracting COVID.

Ms Hunter: That is great, Minister. Thank you.

The Chairperson (Mr Gildernew): I have a late entrant, as Alan has come in. I hope that the Minister will indulge him, in the circumstances.

Mr Chambers: I was having difficulties and actually lost video, but I will get stuck into my question if you can hear me.

Minister, we had a lot of concerns about transmission rates in care homes and nursing homes in the early days of the pandemic. You have now managed to vaccinate most of the residents and staff in our care homes. I am hearing about positive trends in transmission rates in those homes. Can you confirm whether the trends are indeed positive?

There is another issue that I want to raise, Minister. Last week, in the House Robin Newton, one of my MLA colleagues, said that the Education Minister had appeared in the Chamber more than any other Minister. I am sure that you would disagree with that. Every Member is entitled to ask five Assembly questions for written answer (AQWs) a day, one of which can be for priority answer. It is clear that the Department that, from an administrative perspective, is under most pressure is yours. I am sure that your Department is not immune to staff shortages from self-isolating. I know that one Member of note has asked the same question for written answer three times over the last few months. I know that it is part of the routine for most Members to now direct questions to your Department on a daily basis. Vaccination has opened up another topic for questioning. I also know that you have no problem with

transparency, Minister, but will you give me a sense of the practical implications of and the difficulties for your staff with the amount of Assembly questions for written answer that are coming into your Department?

Mr Swann: Thanks, Alan. We are starting to see early green shoots in the care homes. Each care home has been visited once. In the next few days, they should all, hopefully, have received their second visit, and after that we will start to see the real benefits of the vaccination of the second doses. That comparative data is available on our dashboard. On 11 January, we had 150 care homes that were managing COVID outbreaks. As of yesterday, that figure was down to 83. There can be impacts from community transmission, but there are also impacts, which I think are beneficial, from the take-up of the vaccines.

I want to make clear that your last point was not a planted question, but I have the information on that to hand. I see the Chair laughing, but come on *[Laughter.]* In the Economy Committee yesterday, the permanent secretary of the Economy Department raised the high levels of absence and the effect that they are having on departmental officials. I asked for some work to be done before yesterday's media briefing. To date, my private office staff have dealt with over 18,000 pieces of direct correspondence, AQWs or general enquiries coming into the office over the past year. By comparison, the last time that there was a Minister in place, the figure was just over 6,000. So, the workload of my private office has trebled.

One of the other pieces of information that I had for yesterday's media briefing was that the departmental press office dealt with over 4,000 press queries in 2020. In 2019, that figure was 900. Those offices are working with the same staff complement. Yesterday, I paid tribute to my departmental staff because of the workload that they continue to do to a very high level. It is seven days a week in this Department and has been since the start. They do a very professional job to a very high level.

You asked specifically about questions for written answer. As of yesterday, we had 3,660-odd. By comparison, the last time that a Minister was in post, that figure was just over 2,000. There has been that increase even with the Speaker and Chief Whips asking some Members to curtail how many questions they ask and to make sure that the questions that they ask are actually of use.

Alan, I do not have the detail of a Member asking the same question three times over the past number of months. I can only hope that I gave the same answer *[Laughter.]*

Mr Chambers: Thank you.

The Chairperson (Mr Gildernew): *[Inaudible.]* I knew that the Minister would be prepared to take a final question from Alan.

I know that it has to be onerous, and we all recognise that, in an unprecedented global health pandemic, there will be unprecedented numbers of questions for the Department of Health. That is recognised, but it is, obviously, an important part of the scrutiny role of the Committee, the Assembly and individual members. No one is under any illusion that the Department is not working at a high level and doing an awful lot of things that were totally unprecedented in terms of volumes of questions and responses.

I thank you both for attending this morning. We indicated to you, Dr McBride, that you did not have a huge contribution this morning *[Laughter]* but I am sure that equilibrium will be restored in due course with further engagement. I have no doubt that that will happen.

I wish both of you all the best in the time ahead as we continue to battle this very dangerous pandemic, and I wish the best to your staff and the entire team of Health and Social Care workers out there who continue to battle very difficult situations. I note the comment that you made, Minister, and it is very true: at some point, we have to give the hard-pressed staff some kind of rest and break. They have been working, probably on pure adrenalin at times, through difficult and traumatic situations. That will have to be considered, planned for and facilitated in a way that supports those staff through what has been a horrendous time for them.

Thank you for your attendance today, Chief Medical Officer and Minister.

Mr Swann: Thank you, Chair.

Dr McBride: Thank you, Chair.