Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

COVID-19 Disease Response: Public Health Agency

16 April 2020

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Ms Olive MacLeod	Public Health Agency
Mr Rodney Morton	Public Health Agency
Professor Hugo van Woerden	Public Health Agency

The Chairperson (Mr Gildernew): Officials from the Public Health Agency (PHA) are joining us by telephone conferencing to discuss the COVID-19 testing strategy and related matters. I refer members to the testing strategy and a letter raising issues for social workers. Members will also be aware of the revised guidance on PPE.

I welcome Olive MacLeod, chief executive of the Public Health Agency; Professor Hugo van Woerden, director of public health; and Mr Rodney Morton, director of nursing. Thank you all for joining us.

Olive, would you like to brief the Committee?

Ms Olive MacLeod (Public Health Agency): Thank you for the opportunity to speak to you in these difficult and different circumstances that we find ourselves in. I appreciate that you have many questions that you will want to raise with us. You have been introduced to my colleagues here this morning.

I have been working as the interim chief executive of the Public Health Agency for just a number of weeks. However, the staff of the agency have been working from the beginning of January on the evolving public health emergency. Since 22 January, the PHA has operated together with the Health and Social Care Board, the Business Services Organisation as health silver within the gold, silver and bronze emergency planning management structure across Health and Social Care to support the management of the pandemic. Within that structure, we have clear processes for helping to anticipate, mitigate, manage and escalate risks and issues across Health and Social Care partners under the

oversight of Department of Health colleagues. Those are tried and tested arrangements that have been designed and tested for difficult situations, including this pandemic.

It is important to remember and to remind ourselves of the work that we have done to date and, from the public health perspective, the work, for example, that we have done. There is an infrastructure to support Health and Social Care silver, including a range of silver subcommittees. They are health protection, surge, personal protective equipment (PPE), social and community care, and human resources, just to name a few. We have implemented mechanisms to safely provide testing for symptomatic individuals; established a system of contact tracing; provided advice on self-isolation and activities; liaised with the four nations public health group to share emerging knowledge; provided advice to professionals and the public; worked with the regional virology lab to establish local testing; scoped hospital capacity to assess the initial threat of COVID; provided infection control advice; secured cross-trust agreement on the management and transport of the very first case; worked with the Health and Social Care Board and the trusts and Northern Ireland's Blood Transfusion Service for its readiness; worked with the regional laboratory and microbiology network; assessed and coordinated critical care, escalating *[Inaudible]* ; coordinated and clinically engaged on regional proposals for ventilators; worked with the Health and Social Care Board on diagnostic and treatment capacity, including CTs and oxygen supplies; and coordinated the clinical engagement on a complex proposal for paediatric services, including the reduction to three sites to release capacity. That is a list of the issues that we have been dealing with in the last number of weeks.

Much remains to be done, as we have yet to reach the peak of the pandemic in Northern Ireland. I want to assure you and your Committee that the Public Health Agency will continue to play a leading role, working with partners across the statutory and non-statutory sectors. However, I know that you have many questions for us, so I will pause now

The Chairperson (Mr Gildernew): OK. Thank you, Olive. Can I ask everyone on the phone to keep close to the phone and speak up? It is a little hard to hear some of the contributions. Can people be conscious of that, please?

The first one from me is about testing in care homes. We are very aware, given the experience that there has been in other countries around the world, that the care home sector is a site of particular vulnerability. We have some very vulnerable residents in those settings, and the staff in those settings are vulnerable to exposure in the care homes and to transfer beyond the care home setting. There have been indications that people who have symptoms will be tested and that will be subject to a risk assessment. A lot of people, me included, feel that that falls far short of what is required and that what we actually need to do is test people who are being admitted into care homes, people in the care home setting and the staff in the setting. Can you advise on the nature and the approach of the risk assessment element of testing and whether there are plans and what those plans are to scale up testing, as indicated by the Minister yesterday in the Assembly? Can you please outline for us what those issues are?

Ms MacLeod: Yes, I will pass you over to the professor

Professor Hugo van Woerden (Public Health Agency): Thank you very much for that question. I will just give you an introductory sentence on testing first of all and then address the questions that you have asked specifically.

The way I would articulate it is that we have moved quite rapidly in Northern Ireland from being able to do four tests a day to 40 tests a day to 400 tests a day and now to be close to doing 2,000 tests a day. I will say that those tests are not tests that you can turn on and off as if they work instantaneously; they are very challenging tests, and the laboratories have worked relentlessly to deliver the testing. We are in a good position, in that there are no outstanding waiting lists of staff or patients to be tested. We are meeting the demand and have spare capacity in the system. As you rightly point out, there is an obligation on us to rapidly use that additional capacity as it continues to grow, particularly with those who are most vulnerable. One of those sectors is the care home and domiciliary care sector.

As you have said, in the early days, when we had very restricted laboratory testing capacity of 40 to 400 tests per day, our approach to care homes was to test five individuals in a care home where we had two cases, which was to characterise and make sure that we understood what was happening. We intensely focus on outbreaks in care homes. The health protection team here work intensely with any care homes that have an outbreak and do so, for example, through the flu season in a similar way.

As you have noted and as the Minister outlined, it is a rapidly changing field. We are now moving to testing everyone. In the last few days, we have moved to testing everyone in a care home where we have evidence of an outbreak. We are also doing a small study in a number of care homes to map the epidemiology in greater detail. We are in a position where we will provide testing for any member of staff who is symptomatic in any way, and there are circumstances in which their family members can be tested as well. In comparison with other parts of the five nations, we are doing relatively well at this point in time on testing.

The Chairperson (Mr Gildernew): When do you expect that those tests will be carried out on a regular basis in care homes? What time frame are we looking at?

Professor van Woerden: A working group has been set up by the Chief Medical Officer (CMO) that is largely being led from within the Public Health Agency and colleagues in the Department. It is working up plans so that we can do large-scale contact tracing in society. In the care home sector, the number-one thing is that we identify rapidly any outbreaks in care homes; that we provide good advice to the care home around hygiene, the isolation of cases and the cohort nursing of cases to make sure that we minimise spread; and that we provide PPE to care homes and undertake swabbing in the care homes of anybody who needs swabbing. What I am trying to say is that that is a dynamically assessed pattern that will change with increasing testing as we have capacity to do additional testing.

The Chairperson (Mr Gildernew): OK, but I am still not getting a sense of when that will be in place. Are we talking about days or weeks?

Professor van Woerden: We are currently testing everyone who requires to be tested. There is no bottleneck.

The Chairperson (Mr Gildernew): Including staff, Hugo?

Professor van Woerden: Yes, absolutely.

The Chairperson (Mr Gildernew): On that point, there appears to be some confusion around the training that is in place for the staff who are to take those specific swabs. Is that an issue of concern, and should that guidance have been provided to care homes in a more timely way? I understand that district nursing will do it in residential settings but it will be nurses in the nursing home settings. Are there issues there that you are concerned about?

Ms MacLeod: That is correct. I will pass you on to Rodney, and he will give you the details.

Mr Rodney Morton (Public Health Agency): The position in relation to supporting nursing homes is that the infection prevention and control and health protection team in the Public Health Agency will support nursing staff in nursing homes to undertake the swabbing as well as providing infection prevention and control advice. That includes using the correct personal protective equipment in undertaking that swabbing procedure. I acknowledge that we need to provide additional and further training, and we will work with our Clinical Education Centre to do so. In addition to that, we have been working with colleagues in Regulation and Quality Improvement Authority (RQIA) to, hopefully this week, issue further guidance in relation to infection prevention and control in care homes and on swabbing.

The Chairperson (Mr Gildernew): The other question that I want to ask is on contact tracing. Clearly, we test to identify who has the disease and who is potentially at risk of spreading the disease in the community, so the contact tracing is the actual purpose of the test. It is so that you can identify where the disease is and where there are potential clusters. In light of that and in light of the fact that, in the South, it has been undertaken for some weeks, with, I think, up to 1,500 people engaged in it, with a system in place for data protection and a system in place for follow-up calls, can you elaborate for us on what planning is in place at this time to roll out the contact tracing that will be necessary once we do the testing? Can you elaborate on which organisations are involved, how many people have been recruited to carry that out and what the anticipated scale and plans are to roll out that contact tracing in a meaningful way?

Professor van Woerden: Thank you for that question. You are touching on a really important topic and an area that has caused some concern because of the variation in approach in different jurisdictions. I think that it is fair to say that the view of the PHA is that, as of today, across the gamut

of features of the COVID epidemic, we can make a strong case for saying that Northern Ireland is in the strongest position of the five jurisdictions that we might compare ourselves with. That is not to be complacent and not to say that that could not change even within 72 hours, but the methodology that has been followed here has been successful. That is not to say that there are not other methodologies by which an approach can be taken.

Maybe I was not quite clear enough, but, as I said earlier, there is a working group that is intensely focusing on the gearing up of additional testing. As the testing capacity increases, we need to use that testing capacity, and we need to test a lot more people in the community. That may be associated with slight changes to the lockdown approach that is in place. If changes are made to that, it will be even more important that we have strong advanced testing approaches. We have identified about 500 environmental health officers who are happy to help us with testing, and other groups, particularly medical and nursing students in the universities, have been identified as being willing to support large-scale testing approaches. There are a number of exact methodologies by which you can do that.

In that context, it is also important to say that technology is being used increasingly across the world to contact-trace. Mobile phone apps, in particular, can help us with the contact-tracing approach and identify people who may have been inadvertently put at risk by somebody who was probably shedding the virus. There is intensive work being done on that. It will be reported to the CMO with some recommendations, and I think that the CMO will then make a decision on the approach that he wishes to take. A proposal around the development of that approach has been put to the CMO already, and a brief update will be provided by the close of play tomorrow. It is an evolving picture, but there is intense focus on ensuring that, as we grow the capacity, we make absolute maximum use of it. That is being overseen by an expert advisory group on COVID testing, which is chaired by *[Inaudible.]*

The Chairperson (Mr Gildernew): That raises some concerns. You elaborated on the testing and the 500 environmental health officers and university students who are prepared to help with testing. Part of contact tracing is enabling people to provide advice on isolation. That cannot be done easily by apps. I am also concerned that we are considering using an app. The contact-tracing element of the app would need to be in place. We have not even signed off on whether we will use the app approach: is that correct?

Professor van Woerden: I am sorry. I did not catch the bit about the app.

The Chairperson (Mr Gildernew): Are you telling me that the option of whether we will use an app for contact tracing or any other form of human endeavour is still being considered?

Professor van Woerden: Northern Ireland has produced an app that is gathering useful information. There is collaboration around an app that is being developed by NHSX, and there is global collaboration on the use of apps. For example, if you can have an app that spots whom you have walked close to and been in close contact with over the previous seven days, for example, that is useful information on who might have been inadvertently put at risk by an individual at the stage when they had the virus but were not yet having symptoms. The most infectious period is, perhaps, the day or so before somebody starts symptoms, when they may be shedding the virus but are not yet symptomatic and are not aware that they may be putting other people at risk.

The Chairperson (Mr Gildernew): This is, essentially, new, untested technology, which we are planning to rely on at some point. I am concerned about that. Attention needs to be focused on this, because this is not something that needs to happen in weeks' time; it needs to happen along with the testing. We need to be ready to do the contact tracing in parallel, going back 48 hours before symptoms, as you say. We live in a part of the world where there is very bad mobile coverage at times; I am not sure about how that impacts on apps. I am not sure if that approach has been robustly evidenced or tested as being effective. The approach of other countries of making calls to people has proven to be robust. That is an issue that we need to look closely at. I want to go to members now.

Ms MacLeod: Chair, I can provide you with an assurance that we have an established system for contact tracing and for providing advice on self-isolating and monitoring. We did that at the outset of the pandemic.

The Chairperson (Mr Gildernew): Olive, what is that system?

Ms MacLeod: Sorry, we have just described to you that we have recruited 500 people who are currently being trained.

The Chairperson (Mr Gildernew): For testing.

Ms MacLeod: Yes, for testing.

The Chairperson (Mr Gildernew): I am asking about contact tracing.

Ms MacLeod: Yes, this is contact tracing. Sorry, I will hand over to Hugo.

Professor van Woerden: We would never rely on an app in itself. There is a *[Inaudible]* well tried and tested approach where you phone somebody up, explain things to them and go through where they have been and who they have been in touch with. That is a well-tried and tested methodology.

The Chairperson (Mr Gildernew): Hugo, do we have enough people in place who are trained and ready to do that? That is my question.

Professor van Woerden: I believe that we will have that workforce in place as the testing capacity comes on stream, yes.

The Chairperson (Mr Gildernew): OK. I will go to members. Similar to last week, we propose to take two groups of questions. Could members all ask two succinct questions, please? I am conscious that, while some members stuck to that last week, others did not get a chance to ask a question because we ran over time. Olive, Hugo and Rodney, we will take a round of questions on testing and then come back to PPE guidance. You can take a note of the members' questions on testing as we go through and then answer them after we have presented the group of questions to you: is that OK?

Mrs Cameron: Thanks to you all for your presence at Committee this morning. My first question is on testing kits and testing procedure. I will give you a scenario that I have been made aware of in the last week or so. There is a household consisting of three junior doctors. One of them developed symptoms and was promptly sent for testing. They had their test done but were not contacted within the time frame that they were told that they would be. Eventually, they were told that their test result was void and that they needed a retest. The outcome of all of that was that all three of those junior doctors were at home and unable to get to their place of work to do what they really needed to do. Is there or will there be special emphasis on testing healthcare professionals who are on the absolute front line and need to get back into the workplace as quickly as possible? That is my first question. The second is on antibodies. Do you know the prospective timeline for the validation of any potential antibody test?

Mr Sheehan: Good morning, Olive, Hugo and Rodney. I want to focus on contact tracing. I asked the Minister about it in the Assembly yesterday. We are aware that, on 12 March, Public Health England made a policy decision to stop contact tracing across the water entirely. A similar policy decision was taken here, presumably by the Minister. Why was that policy decision taken? The Minister, in his response yesterday, spoke about the first case that was detected here: a woman who had travelled through Dublin Airport and back to the North. The Minister talked about how the system of contact tracing had been put in place in collaboration with the Health Service Executive (HSE) in the South. Everyone the woman had come into close contact with was contacted. We know that the countries that have been most successful in suppressing the virus are those that have used a combination of measures: widespread testing, rigorous contact tracing, self-isolation and social distancing. Why was the policy decision taken to cease contact tracing here, and who made that decision? How many people will be required to put in place a rigorous system of contact tracing in future?

Ms Flynn: I regularly follow the daily surveillance reports published by the PHA and am concerned by the limited scope of those that are being reported and tested. I understand that there are issues around timing, but I do not think that it is the comprehensive testing and reporting system that we need at this time.

I am aware of the European Centre for Disease Prevention and Control (ECDC) document on strategies for surveillance, so I ask the panel whether they think that the surveillance system that we have in place is good enough to accurately inform the decision-making of the core team headed by the CMO. If that is not the case, what, do you think, is missing?

Mr McGrath: Thank you for your presentation this morning. The first thing is to get more detail on the parameters and how you set the criteria for testing, because I get a bit concerned when I hear that you are reaching your testing capacity and reaching the targets. Those are targets that you have set. There is a difference between the expectation on the ground as to who should be tested and how often testing should take place and what you are implementing as policy. I think that people will be shocked to hear that we have a surplus in our daily testing regime and that, in other words, we do all the testing that we need to do but could do more. The view on the ground is clearly that there needs to be more testing, so I am concerned and would like to have some explanation of why we, at this stage, have capacity for testing each day when there is that need on the ground. If we think of the care worker going into the home of someone who is asymptomatic but has the virus and the proper protections are not put in place, that is where the worry and the concern come from.

The second question is this: what work have you undertaken with your counterparts in the South to specifically instigate a testing and contact-tracing regime on an all-island basis? We need to accept and understand that we live on an island, and, with the ferries not working and the airplanes not flying back and forwards, our people are moving about on the island. That is the focus for contact tracing and testing. Can you tell me how that is being taken into consideration?

Ms Bradshaw: Good morning, and thank you very much. My question follows on from Colin's. You may be aware that, today and tomorrow, there are three flights out of Dublin to Romania. I assume that those are repatriation flights, and I am aware that members of the Roma community in my constituency of South Belfast will be on those flights. How will you manage when they come back, as they are entitled to do? Given the cultural and linguistic complexities, there will be a need for population surveillance, so how will you manage that? That is the first question.

The second question relates to a news bulletin this morning. The BBC was at the SSE Arena testing centre for an hour, and nobody turned up. Is that an Easter issue, or are there wider systemic problems in the referral system?

Mr Easton: It is my understanding that we can do 1,000 tests a day but that has not been reached: is there any particular reason why that is not happening? As I try to get my head round contact tracing and look at it logically — I am not saying that I am right or wrong — it appears to me that contact tracing is impossible because so many people now have the virus. To have the resources to do that is practically impossible. Would that be your assertion?

Mr Carroll: Thanks for the presentation. Following on from Alex's point, I think that there is capacity for 1,100 tests to be carried out per day, and Monday's figure was 456 or thereabouts. I am concerned that testing is not being ramped up quickly enough. Do the PHA officials think that enough has been done already on testing? I also want to share some concerns raised by the Chair about contact tracing.

Mr Chambers: A member of my family has worked in the care home environment for many years and has reported to me. It is difficult to control even the seasonal vomiting and diarrhoea bugs once they get into a care home; indeed, the staff go down with them as well. Many care homes have been in lockdown for some weeks with no visitors coming in. Obviously, the vulnerable residents in those homes are not picking the virus up spontaneously; it has been brought to them. What are the views of the panel on how the virus gets into care homes and what steps are being taken to mitigate that? I know that it is impossible to completely avoid something like this coming in, but what steps are being taken to mitigate it?

Are residents of care homes who show symptoms being routinely moved to hospital to prevent further spread in the home, or is it the responsibility of the home management to look after the treatment of the person showing symptoms and to try to avoid the virus spreading to other residents?

The Chairperson (Mr Gildernew): That is the final question on testing for the panel. Would you try to work your way through those questions, please?

Professor van Woerden: The questions being asked are incredibly important and reflect the wider societal concerns and anxieties that, I know, front-line staff express to MLAs. It is important that those concerns are taken seriously. Maybe we need to do more to communicate and provide reassurance that the approach that we are using would, I believe, be internationally recognised as very robust.

As I have already said, I am of the view that, at the moment, Northern Ireland is in the best position of the five countries. When one looks at the numbers at a high level across testing, admissions to hospital and intensive care units (ICUs), one sees that admissions to hospital are falling, we discharge more people than we admit and the numbers in ICUs are falling. Deaths will lag behind; they will continue to rise probably for the next two or three weeks. None of those parameters is free from being queried — somebody could say that our data may be weak — but I believe that Northern Ireland is currently in the best position. That is not an excuse.

Let me pick up on the testing. As I said in my opening remarks, these are not tests that produce an answer at the push of a button; they are challenging to undertake. The Belfast laboratory has used a variety of tests because of challenges with the tests. Machines have broken down at times, and, at times, there has been a global shortage of some of the reagents. There has been intense work, and we have done very well, as a system, to keep it ramping up very rapidly, probably proportionately higher than the other five nations that we might compare against.

There are different types of test. There is testing for the DNA of the virus — polymerase chain reaction (PCR) testing, as it is called — and there is testing for the antigens for the proteins that are on the surface of the virus. None of those tests is perfect. You take a tiny sample from a swab that may not pick up everything that is there or from a very small amount of blood. Given the volume of the blood, you may easily miss virus in it. Of course, one has to remember that it is not a blood infection primarily but an infection in cells, so it only spills into the blood when there is a lot of virus. A negative test does not automatically mean that the person does not have the virus. Testing is really important, but it is only one tool in the toolbox. The analogy that I have used is that a good tradesman will do the same job relying on slightly different tools in a toolbox but do an equally good job, and that is part of the context here. Testing, contact tracing and social distancing are all tools in the toolbox, and they can be used in fractionally different ways. There are some common broad principles, but there are nuances to that.

I will try to answer the question about the gap between the capacity and what is actually being used. The most important thing to say is that, for over a week now, nobody has, as far as we are aware, been held up; in other words, there has not been a backlog or a queue of people in the system waiting to be tested. The laboratories have worked relentlessly to meet all the requests that have been made of them. However, as testing capacity increases, one simultaneously has to increase the number of people one offers the test to, and the expert advisory group has produced clear guidance that has been revised several times, often on, at least, a weekly basis, listing priorities. Therefore, we start with the highest category of people to test, then category 2, 3, 4, 5, and 6, as it were. When you know that your top categories are fully saturated, you go on to the next group to be tested. That has been very well worked through. We have worked into the independent sector, the care home sector and family members of those who require testing. The next big stage, as we said, would be to do large-scale testing of the population as a whole in combination with contact tracing. There is a working group considering the tools in the toolbox and the best way to deploy them.

Somebody asked about antibody testing, and we are moving ahead with planning for seroprevalence studies. We can do studies so that we know the percentage of the population that has been infected with the virus. That is dependent on the regulators authorising antibody tests for use in such circumstances. We are in close collaboration with the Republic of Ireland on the development on antibody tests that we can use and with other parts of the United Kingdom, where tests are being developed by academics and industry. As soon as those tests are authorised and available, we will be in a position to use them. We are working closely with academics from the universities in Northern Ireland to ensure that our methodology is robustly developed with senior academic advice.

I am looking through the questions. There is particular recognition of groups such as the Roma and their needs. There is a proactive programme led by the Belfast Trust on the needs of the Roma community. Other groups being considered are fishermen and the homeless, and there has been intensive work on those vulnerable groups, who are rightly being pointed out as needing additional support. Those are my remarks at this stage.

The Chairperson (Mr Gildernew): OK. There are elements that have not been covered. Órlaithí asked about surveillance: what surveillance is in place in the community at present?

Professor van Woerden: There is a survey of 1,000 people a week that is being undertaken by the Northern Ireland Statistics and Research Agency (NISRA). It asks people about their symptoms, as it were, which is a way of trying to get a sense of what is happening in the community. As I said, we also get feedback on admissions to hospital, admissions to the intensive care units and deaths, all of which

give us a sense of the pattern in the community. Does that answer the question, or is there a component that I have missed?

The Chairperson (Mr Gildernew): Órlaithí, does that answer your question?

Ms Flynn: Yes, Chair. With the surveillance reports that are being released, can the panel identify any gap in that current system? In their view of where we are, is there anything missing?

Professor van Woerden: The theory of a daily report is that it is focused more on timeliness than on accuracy. We then would produce another report that has a more bespoke focus, but the capacity to do so has been limited so far. We are working intensely with the Department, which is working on a dashboard that will be made available to the public, and that would release some expertise in the surveillance community to produce more bespoke, more niche analyses of specific topics, as it were. There is also that recognition that there is the opportunity to do more detailed deep dives into particular aspects of the pandemic over the next month or so.

The Chairperson (Mr Gildernew): I will go through some of the questions quickly and ask for direct answers. I will group Pat's and Gerry's questions: how many people, do you assess, will be required to do the contact tracing that is necessary, and has enough been done at this point on contact tracing?

Professor van Woerden: For phase 1, up to 500 people but kept under close review.

The Chairperson (Mr Gildernew): In relation to the question that Alan asked, are residents with COVID-19 being removed to hospital from care home settings?

Professor van Woerden: Where appropriate, yes.

The Chairperson (Mr Gildernew): On the lack of take-up of testing, there appears to be a gap in what is available currently. Is that to do with referrals? Is it to do with public messaging? Why, in your view, are the tests that are available at this time not being availed of on some days?

Professor van Woerden: I think that it is about people who might make the referral not wanting to overload the system, so we are increasingly encouraging people who might be holding themselves back from testing when they might benefit from a test to come forward.

The Chairperson (Mr Gildernew): That leads us into Colin's question. What are the parameters and criteria for testing? If there is further scope at the minute, are they being rapidly increased to allow more people to be contacted and advised to take up a test? What has been done across the island between you and the authorities in the South to coordinate contact tracing on an all-island basis?

Professor van Woerden: There is both a testing strategy and guidance that is reviewed and refreshed on an approximately weekly basis, in collaboration with the approaches in the five nations. Cross-boundary, there is close working between the health protection teams here and in the Republic of Ireland. There is recognition of the importance of that, particularly, as you say, as, at the border, there are individuals where that is particularly important. There is academic collaboration across the modelling cell, which is looking at modelling, and there is cross-university work around collaboration to ensure the sharing of data for research purposes and informing policy.

The Chairperson (Mr Gildernew): Was the policy decision made by the British Government to stop tracing on 12 March a mistake?

Professor van Woerden: As I tried to say earlier, different tradesmen will use different tools in the same toolbox in a slightly different way to do the same job. I believe that some of the reflections that one has had from different groups are perhaps expressing that preferential style that individuals will have.

The Chairperson (Mr Gildernew): In your view, Hugo, if we have lost ground on testing and tracing, how will we make that up?

Professor van Woerden: As I tried to indicate earlier, the fact that the data, at the moment, shows Northern Ireland to be in a very strong position does not indicate that any decisions taken so far in relation to that have been problematic.

The Chairperson (Mr Gildernew): OK. I want to wrap this section up, before we go into PPE. You referred to a global shortage of reagents. I am aware that the South has moved, I think, to secure supply for 900,000 tests over a period. Now that the memorandum of understanding is in place, is it possible for us to coordinate our efforts with the South to address the issue of a lack of reagents?

Professor van Woerden: They are a really important partner in the issue of reagents. I strongly agree with you on that.

The Chairperson (Mr Gildernew): We have a quick follow-up question from Paula.

Ms Bradshaw: The issue of cultural and linguistic sensitivities around the population surveillance has not been addressed.

The Chairperson (Mr Gildernew): The issue of cultural and linguistic sensitivities affects some of our diverse communities. How have you dealt with those language and cultural issues in relation to the crisis?

Professor van Woerden: There has been work to ensure that translators are available. I know that questions were asked about the different sign languages used as well, and that has been important to address. There is recognition of the importance of maintaining sensitivity to that important issue.

The Chairperson (Mr Gildernew): I concur with Paula: I do not think that enough has been done on that. In the south Tyrone end of my constituency, almost 15% of the population has come here from another country, and I see no evidence that that community is being engaged with directly or in a way that suits them. Has there been guidance issued in Tetum, Polish and other languages?

Professor van Woerden: You touch on an important point. It is really important that we provide information in different languages. Some of that has been led by the Department in London, and there has been translation into a very wide range of languages. The top 10 languages in Northern Ireland have been the immediate focus, but you are right in saying that it is important that we continue to recognise particular communities and get feedback from them on whether the information provided is suitable and is in the languages that they need.

The Chairperson (Mr Gildernew): Many members of those communities are particularly vulnerable. Language is one thing. They also tend to live in higher-density housing. They are in precarious work. The PHA should consider engaging directly with community leaders to assist your communication to them, so that you can work more closely with them. That would warrant a specific approach, given the diverse nature of some of our populations. OK, I am going to —.

Mr Sheehan: Colm, sorry, can I ask for clarity on something? I am not sure about the answers we got on contact tracing. I have two very short questions. Going by what we were told last week by Shane Devlin and a letter I received from the trust this week, there is absolutely no contact tracing taking place at the moment. When can we expect contact tracing to start?

Professor van Woerden: There is contact tracing. It is being undertaken in a number of contexts but not using the same methodology that is being used in the Republic of Ireland. We recognise that the approaches have been different. For example, a nosocomial infection is one that spreads from person to person in hospital, and that is an area where we intensively assess the spread. That sits under infection control, as well as public health. The approach to the community component that is being undertaken in the Republic is, at present, different.

Mr Sheehan: I wrote to the Belfast Trust about two members of staff in Muckamore Hospital testing positive for COVID-19, and there was no follow-up contact tracing in the hospital at all. The Belfast Trust confirmed that.

Professor van Woerden: If we can get the details, we will definitely pick up on that as a specific incident. I am grateful to you for pointing it out.

The Chairperson (Mr Gildernew): Pat, you can follow that up with the PHA directly.

Members, I am moving on to guidance around PPE. I will do things slightly differently this time, because we had to double back a wee bit. I will go to members in the same order, but I will ask for a single, short question and a short response.

Home visits have been an area of concern for social workers. It can be difficult to maintain two-metre social distancing in child safeguarding visits, for instance. Social workers have raised concerns about the lack of PPE in those circumstances and the lack of guidance around PPE, which is also crucial. Will guidance for social workers engaging in home visiting be published? How is the system addressing that type of risk and concern in social work? I declare an interest as one who has come from a social work background. I understand that the dynamics around those home visits can be difficult and dealing with an infectious disease adds an extra element of concern. How are you addressing those concerns in social work?

Mr Morton: The short answer, as outlined in the guidance, is that three factors have to be taken into consideration in respect of PPE: the nature of the task being undertaken; the level of risk that, the individual believes, they may be *[Inaudible]* —.

The Chairperson (Mr Gildernew): Rodney, I am sorry to interrupt, but can you speak up a little — it is quite hard to hear — or move a bit closer to your phone?

Mr Morton: Apologies for that, Chair. I was saying that there were three factors that had to be considered for all health and social care practitioners. One is, primarily, the nature of the task being undertaken, particularly if it takes that practitioner within two metres. The second is the level of risk that, the individual practitioner feels, they may be exposed to. The third is the organisational assessment; for example, each health and social care provider should do a risk assessment to indicate what level of PPE would be required, in line with the guidance. A significant amount of work has been done by our social work cell in issuing guidance to health and social care practitioners, including social workers. I understand that the Department has done further work in relation to social workers working in children's services. I understand that that will be issued shortly.

The Chairperson (Mr Gildernew): Is it the case that the current guidance deals only with direct care? Social workers, obviously, are not providing direct care but may still be within two metres.

Mr Morton: No, that is why I said that it relates to the nature of the task. There are two other pieces of related guidance. In the context of the Public Health England (PHE) guidance, we look at those who are vulnerable and shielded and those who have confirmed COVID-19 or are suspected of having it. As part of the risk assessment, if a child, young person or adult meets any of those criteria, our advice is that staff members should wear appropriate levels of PPE.

The Chairperson (Mr Gildernew): I go now to Pam Cameron. Members, if you do not have a question or your question has already been asked and answered, that is fine; just pass on. I will ask each of you in turn to ensure that you have had an opportunity.

Mrs Cameron: Thank you, Chair. I just want to say, on the back of your question re social workers, that it is a big concern. Last week, I asked Sean Holland a question, and the response that I got was not really very positive. I understand that guidance on the use of PPE has changed since then for social workers in particular. Obviously, when people who are mentally unwell are being treated in the community, there can be a real difficulty in assessing what type of PPE is necessary, given that circumstances can change very rapidly due to the state of a person's mental health at that particular time and place. How do social workers protect themselves, to the best of their ability, in those circumstances?

Mr Morton: The first and most important thing is that a risk assessment is done in every care situation. That is crucial, because the social worker — indeed, any healthcare professional, hopefully — will understand the individual with whom they work. The guidance requires each health and social care practitioner to do a risk assessment, particularly if that individual is in the vulnerable or shielded group. In that context, any health and social care practitioner, including social workers, should wear appropriate levels of PPE. Where that is uncertain, the guidance suggests that, as a minimum, the practitioner should wear PPE where they are concerned about the level of risk.

Mr Sheehan: I have a more general question about PPE. More and more countries are instructing the population to wear masks while they are out in public. The evidence seems to be becoming stronger that it is advantageous in stopping the transmission of the virus. Has any discussion taken place here between the PHA and the Department on instructing citizens to wear masks? Have any plans been put in place to ensure that sufficient masks can be procured for the population?

Professor van Woerden: Rodney, I think, will also want to come in on this one. The Scientific Advisory Group for Emergencies (SAGE) advises the four CMOs and Ministers. That group is authorised to undertake the evaluation and assessment of particular interventions, such as the one that has been raised. I guess that I am trying to say that there is an awareness of the World Health Organization's exploration of the issue and a recognition of the need for it to be explored by SAGE. My personal *[Inaudible]* if anybody wants to wear a home-made mask or one that is not drawn from a resource that would reduce the availability of masks for health and social care workers, I could not see any circumstances in which one would say that that was an unwise thing to do. At the moment, it would be an individual's choice. As I say, it is recognised as a question that is hanging out there and will eventually, I am sure, have a slightly more formal answer.

The Chairperson (Mr Gildernew): Thank you.

Mr Morton: I do not really have much to add to that other than to say that I know that it has been discussed at the national infection prevention and control cell. I think that discussions and debates are going on, but I do not think that a policy position has been defined yet.

The Chairperson (Mr Gildernew): Thank you, Rodney and Hugo. Órlaithí, do you have a question on this section?

Ms Flynn: Yes. You had mentioned that the PHA and the BSO, along with others, are part of the gold management team on COVID-19. Obviously, we hear constantly that PPE is still an issue in care homes, GP surgeries and other places. Just yesterday, the Minister confirmed that he would launch an investigation of the issue. Do you regularly see documents on internal stock checks of PPE in the system? Can you share those documents with the Committee, going as far back as February, if you have them?

Mr Morton: The first comment that I will make on that is that you will, of course, all be aware that there are significant challenges across the world in relation to PPE. We in Northern Ireland have been working extremely hard. Although I cannot speak for Business Services Organisation colleagues, I know that they continue to try really, really hard to source additional PPE. They have been doing so for several months, so I would not want to underestimate the challenge. However, I can say to you that over 29 million items of PPE have been pushed out to our Health and Social Care organisations. I can also say that our BSO colleagues have somewhere in the region of 91 million PPE items ordered. The reason that I share those numbers is to indicate to you the level and scale of activity around trying to secure PPE. Indeed, very locally, we have engaged a number of manufacturers in the production of visors, for example, and we have orders placed for up to 30 million visors. I share that with you just to *[Inaudible]* level of commitment that is being made by our BSO colleagues and our departmental procurement colleagues, to ensure that we have PPE stock. All that I can say to you is that every effort is being made to ensure that we have the right level of PPE for our staff, and, of course, that means appropriate use of PPE as well.

The Chairperson (Mr Gildernew): Rodney, you seem to have switched something on or off that has caused you to become a bit echoey, so perhaps there is something that you can do. We can hear you, but it is a wee bit more difficult.

Mr McGrath: My question on PPE is about staff in an office environment. I think of the example that I used in the Assembly last week: a Health and Social Care open office that 25 staff — social workers, district nurses and other community-based staff — operate out of, where 13 of the staff are off work with coronavirus symptoms. Does the panel feel that the guidance that is there forces people to come to work because, it says, they are essential service providers? Are there proper measures in place in the office environment that they work in to prevent people catching the virus in that manner?

Professor van Woerden: You raise an important question. The essentialness of an essential worker varies, does it not? Somebody who is in theatre operating on a patient cannot stand two metres apart, because they cannot get round the person whom they are operating on by standing two metres apart.

As I say, it is very clear that it is completely essential that people are not operating within a two-metre space. A nurse who is bed-bathing a patient cannot stand two metres from that individual. As you move outwards, as it were, in concentric circles to individuals who perform essential work in the health and social care system but at a more managerial or administrative level, it comes down to more individual risk assessment, with a responsibility on managers to consider the needs of their teams. We know that, in the Health and Social Care Board and the Public Health Agency, there has been regular recognition and review of that at organisational level, at the level of directors and at the level of individual managers, with advice sought, as appropriate, from occupational health.

There is a recognition that some staff may have conditions that they wish to keep confidential and not disclose to their manager. We have to exercise sensitivity on that issue. If an individual says that they wish to be treated in a particular way, even if they are part of an essential worker group, sensitivity is required in that context. I guess I am trying to say that one can do simple things, and I go back to the old, simple messages about handwashing, avoiding surfaces that might be contaminated, regular cleaning, trying to have good airflow through an area that people work in and regular review of the capacity to undertake work from home. That holistic risk assessment, being done on a dynamic, ongoing basis, is the best approach to that. That would be my reflection. Rodney, do you want to comment?

Mr Morton: The only thing I would say is that the social distancing rules still apply in work environments, where that is practicable, and should be adhered to.

The Chairperson (Mr Gildernew): OK. Thank you. I am conscious of time, so I ask Members and the panel to be as succinct as possible.

Ms Bradshaw: My question relates to your assessment of the provision of scrubs for our front-line healthcare workers. I believe that there are some filtering through the system — late in the day, might I add? However, there are concerns that they only get one set, and, after a long, arduous day, staff have to go home and boil wash them and bring them back and, potentially, bring infectious disease into their home. They have the option of going to the laundries in the trust, but they say that there can be delays in getting their clothes back. What is your assessment of how the issue of scrubs is being handled?

Mr Morton: I have a couple of comments on that. First, I cannot comment on the volume of scrubs because I do not have that data with me. However, I know, again, that local manufacturers have been producing significant levels of scrubs for our hospitals. Some of the products that we use and some of the items we use are reusable, and, obviously, if an item is reusable, appropriate decontamination measures should be applied. In each of our Health and Social Care organisations, there are infection prevention and control teams who will guide practitioners about how to safely decontaminate any reusable items.

Mr Easton: Just to confirm — I asked this yesterday following the statement from the Minister — can private sector homes avail themselves of PPE if they have problems getting supplies privately? And —

Mr Morton: I can confirm — sorry. Apologies, I thought that you had finished.

Mr Easton: Secondly —.

The Chairperson (Mr Gildernew): We are only taking one, Alex, sorry. I will not get a chance to get back to you, but we are only taking one. Gerry.

Mr Carroll: Thanks. This follows on from Alex's point. We have heard a lot about a lack of PPE for care home staff, and, in previous reports before the crisis, I have heard about care homes rationing tea bags, adult nappies and so on. Is there a concern that equipment may be rationed, or is it the case that care homes do not have enough? If not enough is being provided centrally, surely it should be.

Mr Morton: I can confirm that the local trusts are working with their home care providers to ensure sufficient supply and utilisation of PPE. It is an improving position. There is now a single point of contact for care home staff — *[Interruption.]*

The Chairperson (Mr Gildernew): Is that a shaggy dog story, Rodney? *[Laughter.]*

Mr Morton: Yes. They say that you should never work with children and dogs, don't they?

My understanding is that there is a single point of contact for the care home sector in each trust in order to support them with PPE issues. It is an improving position. I am not suggesting for one moment that it is not still challenging, but it is definitely improving.

The Chairperson (Mr Gildernew): Thank you. Finally, Alan.

Mr Chambers: We have to recognise that the shortage of PPE is not uniquely a Northern Ireland problem; it is a worldwide problem. Indeed, in your guidance, the World Health Organization comments that industry would need to increase its capacity by 40% to meet the worldwide demand. The guidance also says:

> *"Governments and health agencies across the world including the UK will need to find a balance between ensuring that frontline health care workers are afforded the utmost protection to treat the public while also rationing supplies to ensure availability over the course of the pandemic."*

My question is this: are you closely monitoring and exercising care in where and how much PPE is being distributed? Do you have a system in place to respond quickly to establishments that are running dangerously low on supplies of such equipment?

Mr Morton: My understanding is that our Business Services Organisation colleagues monitor levels of stock daily. I also understand — I think someone alluded to it earlier — that there will be an audit of the utilisation of PPE across our health and social care system. Finally, if an organisation is running low, there are well-defined mechanisms to ensure that that organisation gets some stock, as well as mutual aid. By that I mean that we work across Health and Social Care organisations. Where one organisation has more stock than another and it is needed, we have a system for sharing that.

The Chairperson (Mr Gildernew): Just a final one from me in relation to concerns and issues that we are picking up around trusts having different guidance at different times. Is that an issue at the PHA? Should we not see consistent guidance being rolled out at the same time across all trusts?

Mr Morton: I entirely agree with you that on that. I believe that there is consistent guidance in the Public Health England PPE, and, more recently, the Department issued, for example, guidance on domiciliary care in relation to infection prevention and control and PPE. I agree absolutely: consistent guidance *[Inaudible.]*

The Chairperson (Mr Gildernew): Thank you very much to the panel for our session this morning. I recognise that it is a bit more difficult with the restrictions imposed by the need for physical distancing. On behalf of the Committee, I wish you all well in your important work over the time ahead. In terms of the issues addressed today, I am sure that it is something that the Committee will keep an eye on, and we will be keen to see some improvements across that range of issues. I thank you very much for your presentations this morning and wish you all the best for the time ahead. Go raibh maith agaibh.