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Number	Deputy	Question	Answers
388	Mary Lou McDonald	To ask the Minister for Health the impact of Covid-19 on school immunization programmes.	The immunisation programme in Ireland is based on the advice of the National Immunisation Advisory Committee (NIAC). The NIAC is an independent committee of the Royal College of Physicians of Ireland comprising experts in several specialties including infectious diseases, paediatrics and public health. The committee's recommendations are based on the prevalence of the relevant disease in Ireland and international best practice in relation to immunisation. It makes recommendations on vaccination policy to my Department. The NIAC continues to revise recommendations to allow for the introduction of new vaccines in Ireland and to keep abreast of changes in the patterns of disease. Therefore, the immunisation schedule will continue to be amended over time. As you will be aware, due to the Covid-19 outbreak no vaccines are being given by the HSE School Vaccination Teams. However, this matter remains under review.
403	Ruairí Ó Murchú	To ask the Minister for Health what steps have been taken to ensure that private nursing homes are correctly interpreting the 'Preliminary Clinical and Infection Control Guidelines for Covid-19 in Nurse-led Residential Care Facilities' and communicating the guidelines to families?	All nursing homes, public and private continue to be regulated by the Health Information and Quality Authority and have a duty to ensure continued adherence to the existing regulatory and standards framework in the discharge of their duties. Under the Health Act 2007, as amended, the registered provider is responsible and accountable for the quality of care and safety of residents in designated centres. The Chief Inspector for Social Services confirmed that HIQA inspectors can carry out preparedness assessments and risk- based inspections. Inspectors of course will comply with and take all the necessary precautions in line with Public Health advice. A series of enhanced measures have been agreed by NPHET for long-term residential care settings and these are currently being implemented by the HSE, HIQA and service providers. They include measure to support facilities which have outbreaks of COVID-19, measures aimed at stopping the transmission of the virus and support the provision of PPE to and screening of staff. Each HSE Area Crisis Management Team is in a position to offer significant support to the facilities in their areas which includes management support, PPE, other supplies, public health inputs, other

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			clinical inputs, support with sourcing staffing and, in some cases, the reassignment of HSE staff to support nursing homes during an outbreak.
405	Matt Carthy	To ask the Minister for Health, in tabular form, the number of Covid-19 tests that have been carried out in each testing centre, and the number of positive tests at each location.	Significant progress has already been made in a very short space of time to develop the required testing capacity including the establishment of 48 community testing hubs. Significant laboratory capacity is being sourced nationally and internationally – HSE advise that there is now capacity to process 12,000 tests a day. This includes labs in hospitals, the community (NVRL, Enfer and smaller labs) and some international provision. As of Monday 4th May, over 214,000 laboratory tests have been carried out. Over the past week 61,707 tests were carried out and 2,280 were positive. Regarding the question of the number of positive tests at each location I have referred this to the HSE for direct reply.
408	Rose Conway Walshe	To ask the Minister for Health if he can give assurance that an adequate supply of PPE is available for staff working in nursing homes.	The HSE confirms that it has expanded the span of its PPE coverage to cover all health services including nursing homes, both public and private. No distinction is made between HSE and non-HSE. PPE supplies are allocated on the basis of patient need only and the HSE has outlined that a nationally coordinated forecasting and supply model is nearing finalisation in order to address universal healthcare needs including residential care settings. Additionally, a significant package of guidance tools developed in accordance with international guidance are available to support and guide planning for and responses to COVID-19 in nursing homes. The HSE is progressing an extensive range of supports in line with the above NPHET actions including specific training to support nursing homes. The HSE national quality and safety team are providing onsite infection prevention support. I can assure the Deputy that there is an intense focus on PPE for residential settings. Over 8 million pieces of PPE delivered in the last week, 62% has gone to Long Term Residential Care facilities.

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415	Sean Crowe	To ask the Minister for Health if he can outline the average waiting time of an individual to access a COVID-19 test; if there are delays due to the geographic location of the individual.	Community testing (i.e swabbing) capacity is currently meeting the level of referral from GPs, with swabbing currently running at approximately 1,500 per day. The time from GP referral to receiving a swabbing appointment is now just over 24 hours. In addition, hospitals are averaging up to 1,500 tests undertaken (swabbing and tests analysed) per day. There is a quick turnaround within a hospital setting - normally 24-48 hours. As of Monday 4th May, over 214,000 laboratory tests have been carried out. Over the past week 61,707 tests were carried out and 2,280 were positive.
417	Johnny Mythen	To ask the Minister of Health if he is satisfied the way deaths involving Covid 19 are currently recorded, (up to 3 months as present), in order to give a more empirical assessment, and to extend testing to nursing homes beyond those where outbreaks have occurred.	My Department is working to identify and report publicly suspect cases of Covid-19 deaths and in line with a NPHET recommendation on Friday 17th April a mortality census was conducted over the weekend of 17 April to provide a snapshot of the mortality rate in long term residential care settings in order to ensure we are capturing effectively the level of mortality in these settings in a timely and robust manner. The census covered all LTRC settings registered by the Heath Information and Quality Authority (HIQA) and the Mental Health Commission (MHC). There has been a strong response rate and it is intended to bring a primary report to NPHET on Friday. This information is currently being analysed. Under the Infectious Diseases Regulations 1981, and subsequent amendments, the Health Protection Surveillance Centre is authorised by law to collect information from doctors and laboratories, via Medical Officers of Health, about diagnoses of certain infectious diseases in Ireland. These diseases are referred to as notifiable diseases. The most recent amendment to the Regulations is the Infectious Diseases (Amendment) Regulations 2020 (S.I. No. 53 of 2020) added COVID-19 to the list of notifiable diseases. The Chief Medical Officer has written to the Funeral Directors of Ireland asking them to encourage all families to register the deaths, regardless of cause, of a loved one at the earliest opportunity. This will enable more timely mortality figures which can inform the public health response to COVID-19. The Chief Medical Officer has also advised that to facilitate the registration of deaths during the COVID-19 pandemic, the General Register Office has made provision for families to register deaths online or by post. The Health Protection Surveillance Centre has also written to all medical

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			practitioners advising them to make all families aware of the online death registration portal so that they can register the death of their loved ones during this time. Data is collected on COVID-19 related mortality for both laboratory-confirmed and probable cases, in line with recommendations from the European Centre for Disease Prevention and Control in both hospitals and the community. The Deputy might note that the collection of mortality data in Ireland exceeds that of many other countries in the world. The National Public Health Emergency Team (NPHET) has emphasised the critical importance of testing and contact tracing as part of the national disease control strategy. A significant programme of testing across Long Term Residential Care Facilities including nursing homes commenced on 17 April following a recommendation by NPHET. This is part of a range of measures and supports that have been put in place for this sector. It involves: • The testing of all staff and residents in facilities where there is an outbreak • The testing of all staff and residents in facilities where there is a new case • The testing of all staff in facilities that have no cases. This programme is under way by the HSE.
421	Martin Browne	To ask the Minister for Health what the current availability of PPE for public and private nursing homes is and what additional measures have been taken to ensure the safety of staff and residents as nursing homes that now account for 146 clusters of the Covid19 outbreak	The HSE has expanded the span of its PPE coverage to cover all health services including nursing homes, both public and private. No distinction is made between HSE and non-HSE. PPE supplies are allocated on the basis of patient need only and the HSE has outlined that a nationally coordinated forecasting and supply model is nearing finalisation in order to address universal healthcare needs including residential care settings. I can assure the Deputy that there is an intense focus on PPE for residential settings. Over 8 million pieces of PPE delivered in the last week, 62% has gone to Long Term Residential Care facilities.

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425	Bríd Smith	To detail any communication from his department , the HSE or other agency or body to the providers of Nursing Homes in relation to suspected Covid cases in their facility and specifically the circumstances under which residents should be moved to acute hospital settings and if he will make a statement on the matter?	The HSE guidelines aim to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The HSE through the Health Protection Surveillance Centres (HPSC) developed an extensive body of guidance and support tools to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The current relevant guidelines are the: "*Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units"* The principle of the right care in the right place at the right time applies. Nursing homes are people's home and in general residents with or without COVID-19 diagnosis should be managed in their facilities unless transfer to hospital is deemed clinically appropriate and will confer additional benefit. Decisions to transfer are clinical decisions made on a case by case basis by senior staff and the attending doctor usually the GP. Decisions should always be made in conjunction with the person, their families and their advanced care plans. The National Public Health Emergency Team (NPHET) approved the guidance document "*Ethical Considerations Relating to Critical Care in the context of COVID-19"*. This guidance is clear that no single factor (e.g. a person's age) should be taken, in isolation, as a determining factor and decisions should not be made arbitrarily or in such a way as to result in unfair discrimination. In the interest of fairness and to protect against unjustified discrimination, it is important that clinicians apply a consistent approach to considering the predictors of outcome for all ICU admissions, including patients with COVID-19 and patients without COVID-19. Where it is decided that the provision of intensive care treatment is not beneficial or possible in light of the circumstances, patients will be provided with other available and potentially beneficial forms of treatment. For example, in the context of COVID-19, other respiratory supports may still be effective (e.g. non-invasive ventilation, oxygen). In cases where a patient is unlikely to recover, appropriate palliative and/or

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			end-of-life care must be provided. Withholding of critical care does not mean a patient will no longer be cared for.
428	Bríd Smith	To detail the amount and specific type of PPE equipment sent from the HSE to private nursing homes in order to deal with the Covid 19 crisis since Feb 1st 2020.	The HSE confirms that it has expanded the span of its PPE coverage to cover all health services including nursing homes, both public and private. No distinction is made between HSE and non-HSE. PPE supplies are allocated on the basis of patient need only and the HSE has outlined that a nationally coordinated forecasting and supply model is nearing finalisation in order to address universal healthcare needs including residential care settings. Additionally, a significant package of guidance tools developed in accordance with international guidance are available to support and guide planning for and responses to COVID-19 in nursing homes. The HSE is progressing an extensive range of supports in line with the above NPHET actions including specific training to support nursing homes. The HSE national quality and safety team are providing onsite infection prevention support. As an indication of the scale of the operation involved in distributing PPE, the HSE delivered more than 1.5 million individual items of PPE to Irish healthcare settings on 28 April. Given this scale, it is not feasible to provide a detailed breakdown of deliveries to each facility. I can assure the Deputy that there is an intense focus on PPE for residential settings. In the week dated 20 April – 05 May, over 9m items of PPE have been delivered to 2,802 locations across the health service of which 33.3% was delivered to Community Residential settings.

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441	Mick Barry	To ask the Minister for Health to report on the cost of the deals with private hospitals; can he outline the criteria by which the costs are to be calculated, for example the cost per bed or day, the compensation for staff costs and so on; and if he would make a statement on the matter.	Under the agreement between the HSE and the private hospitals in response to the Covid-19 pandemic payment will be on a cost only Open Book model whereby the hospitals will be reimbursed for the operating costs properly incurred during the period. The costs that will be covered will be limited to normal costs of operating the hospital. Since the rationale for the arrangement relates to the COVID-19 epidemic for which no one can provide a definitive time horizon it is not possible to indicate a precise cost estimate attaching to the arrangement. The final cost will be verified by independent firms of accountants appointed by the HSE and the private hospitals and there will be an arbitration mechanism in place in the event of any disagreement. Under the Heads of terms private hospitals are funded to 80% of their estimated monthly costs in advance, by the HSE, €90.2 million was advanced to the hospitals for April. Since the overarching were agreement was made at the end of March patients have been transferred from public hospitals to the private hospitals as deemed clinically appropriate. As of the end of last week the average level of occupancy of the private hospitals was 33% of their bed days being utilised.
441	Mick Barry	To ask the Minister for Health to report on the cost of the deals with private hospitals; can he outline the criteria by which the costs are to be calculated, for example the cost per bed or day, the compensation for staff costs and so on; and if he would make a statement on the matter.	Under the agreement between the HSE and the private hospitals in response to the Covid-19 pandemic payment will be on a cost only Open Book model whereby the hospitals will be reimbursed for the operating costs properly incurred during the period. The costs that will be covered will be limited to normal costs of operating the hospital. Since the rationale for the arrangement relates to the COVID-19 epidemic for which no one can provide a definitive time horizon it is not possible to indicate a precise cost estimate attaching to the arrangement. The final cost will be verified by independent firms of accountants appointed by the HSE and the private hospitals and there will be an arbitration mechanism in place in the event of any disagreement. Under the Heads of terms private hospitals are funded to 80% of their estimated monthly costs in advance, by the HSE, €90.2m was advanced to the hospitals for April. Since the overarching were agreement was made at the end of March patients have been transferred from public hospitals to the private hospitals as deemed clinically appropriate. As of the end of last week the average level of occupancy of the private hospitals was 33% of their bed days being utilised.

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443	Thomas Pringle	To ask the Minister for Health the number of persons referred for a test and who have not yet been tested in tabular form, by county; the length of time such persons have been waiting for a test by number of days; the number of persons removed from the list of those to be tested following each change to the criteria; and if he will make a statement on the matter.	Significant progress has already been made in a very short space of time to develop the required testing capacity and the HSE advises that the capacity in place now to test 12,000 people a day. A roadmap to further develop processes and turnaround times across the full testing pathway and to build capacity for 100,000 tests a week in the coming weeks has been agreed. Sample taking (swabbing) is currently undertaken in three main settings, 48 Community Testing Hubs, in hospitals and by the National Ambulance Service. Turnaround times in hospitals is normally 24-48 hours, turnaround times in the community improving. Testing is now taking place in 40 laboratories – 35 on hospital sites and 5 others – NVRL, Enfer, Department of Agriculture in Backweston, Public Health Lab in Cherry Orchard and a European lab. As of midnight Monday 4 May, over 200,000 tests have been carried. Over the past week, 61,707 tests were carried out and of these 2,280 were positive. The specific questions in your question have been referred to the HSE for direct reply.

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449	Thomas Pringle	To ask the Minister for Health how realistic are claims that the current isolation restrictions can be eased when we get the likelihood of the getting test results down a to overnight response in light of the difficulties with testing that have been experienced to date?	The National Public Health Emergency Team is currently engaged in a detailed planning process for the phased reduction of the current COVID-19 public health social distancing measures, taking into consideration the current epidemiological data, the experience in other jurisdictions, the progression of the disease to date, mathematical modelling and European and international guidance. NPHET's approach to easing of the current restrictive social distancing measures is going to be a slow and gradual incremental process, and any reintroduction might not necessarily follow the same sequence as when the measures were put in place. In reducing measures, the NPHET is cognisant that extreme vigilance will be needed so as to limit increase in new cases and deaths, potential for a post-peak wave or the size of any second wave. Consequently, the reduction of measures needs to be underpinned by robust sampling, testing and contact tracing strategy, real-time epidemiological and clinical data, and mechanisms to protect 'at risk' groups. Ireland continues to adopt a robust process of testing, isolation and contact tracing as a key public health strategy for containing and slowing the spread of COVID-19, as advocated by the World Health Organization, the European Commission and the European Centre for Disease Prevention and Control. The overriding aim is to sample, test and report cases within a rapid turnaround time so as to enable early contact tracing, testing of contacts and active follow up of all close contacts for 14 days to break further chains of transmission. Significant progress has been made in a very short space of time to develop our testing capacity. The scale of this effort and the pace at which capacity is being developed cannot be understated. Huge progress has already been made: • The establishment of 48 community testing centres across the country, and a steady supply chain of swabbing kits is in place. • Significant laboratory capacity is being sourced nationally and internationally and range of supply chains for reagents and other materials have been sourced. • A robust testing referral pathway for GPs has been put in place, and new IT systems have been developed and existing ones modified to

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			ensure tracking of testing across the full process. • 9 new contact tracing centres are in operation and 1,700 people have been trained to date to support specialist teams in public health, occupational health and infection prevention and control. • A major programme of testing is underway in Long Term Residential Care facilities. Over 65,000 tests have been complete from 540 nursing homes out of 581. This is a significant, complex and large scale operation spanning a number of sectors and hundreds of providers. The HSE is working intensively to further develop processes, capacity and turnaround times across the full testing pathway to ensure we have a system that can aggressively identify and isolate cases on a real-time basis. Following the significant ramping up of sampling and testing thus far by the HSE, capacity is now in place to test 10,000 people a day. The HSE has also now developed a roadmap for building capacity to 100,000 tests a week and this is at an advanced stage of discussions between the HSE and officials in the Department of Health. On 1 May 2020, the Government published a Roadmap for Reopening Society and Business to ease the COVID 19 restrictions and reopen Ireland's economy and society in a phased manner. The Roadmap will start from May 18th, from which point our country will re-open in a slow, phased way. The plan sets out five stages for unlocking restrictions, at three week intervals. As we ease restrictions, the rate of the virus in the community will be constantly monitored by the National Public Health Emergency Team and the Government. The framework sets out how we can keep the level of transmission as low as possible while balancing continuing restrictions proportionately with the positive social and economic benefits which will be brought about by lifting restrictions. Further details can be found at https://www.gov.ie/en/news/e5e599-government-publishes-roadmap-to-ease-covid-19-restrictions-and-reope/

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450	Thomas Pringle	Does the Minister for Health regret not meeting with Nursing Homes Ireland before 30 March given the emails and letters In the previous four weeks requesting engagement on priority testing for Covid-19 and personal protective equipment which some nursing homes and their staff could not access?	I met with Nursing Homes Ireland on 30 March 2020 and the Department of Health have been in on-going extensive communication with the representative body for the private and voluntary nursing home sector during these challenging times. The HSE have also have been regularly engaging with the representative body since January. The CEO of the HSE met with the CEO and Chairman of Nursing Homes Ireland in mid-February where the HSE committed to providing all possible assistance and, at the same time, the NHI committed to ensuring that their members were prepared to the highest degree possible for what lay ahead. The challenges in the nursing home sector remain an absolute priority in the overall response to COVID-19 and that actions and measures to support nursing homes and their residents have been taken early in line with international WHO and ECDC guidance and have evolved quickly and decisively at various milestones on foot of epidemiological data and evidence. Measures for nursing home residents have evolved from enhanced general infection prevention measures such as handwashing and respiratory etiquette to social distancing to visitor restrictions and to cocooning. A range of enhanced measures were recommended by NPHET on 31st March and 3rd April. These include actions to strengthen HSE national and regional support structures, actions focused on reducing transmission of the disease such as prioritisation of staff for screening, and access to specific training and PPE for providers. Additionally, a significant package of guidance tools developed in accordance with international guidance are available to support and guide planning for and responses to COVID-19 in nursing homes. In addition, on 17 April, the National Public Health Emergency Team met to continue its ongoing review of Ireland's response to COVID-19 and its decisions included: • To expand testing capacity to 100,000 tests per week operating on a seven-day week basis for a minimum of six months; • Over the course of the following 7-10 days, testing of staff and residents in all Long-Term Residential Care (LTRC) facilities to be prioritised; • A census of mortality across all LTRC facilities to be carried out during the weekend ending Sunday 19 April 2020 to cover all deaths, COVID-19 and non-COVID-19 since 1st January 2020, regardless of where the death

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			occurred. A Temporary Financial Assistance Scheme is also established and open to applications from nursing homes, which represents significant financial support, in addition to the other supports. I am in regular direct contact with NHI and I am committed to continuing this level of engagement.

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456	Éamon Ó Cuív	To ask the Minister for Health the cost per month of the agreements entered into with the private hospitals as a result of the Covid-19 pandemic; the usage, including the number of patients, made of these hospitals to date; the method by which value for money will be assessed in relation to these arrangements; the controls on these costs that will apply; and if he will make a statement on the matter.	Under the agreement between the HSE and the private hospitals in response to the Covid-19 pandemic payment will be on a cost only Open Book model whereby the hospitals will be reimbursed for the operating costs properly incurred during the period. The costs that will be covered will be limited to normal costs of operating the hospital. Since the rationale for the arrangement relates to the COVID-19 epidemic for which no one can provide a definitive time horizon it is not possible to indicate a precise cost estimate attaching to the arrangement. The final cost will be verified by independent firms of accountants appointed by the HSE and the private hospitals and there will be an arbitration mechanism in place in the event of any disagreement. Under the Heads of terms private hospitals are funded to 80% of their estimated monthly costs in advance, by the HSE, €90.2m was advanced to the hospitals for April. Since the overarching were agreement was made at the end of March patients have been transferred from public hospitals to the private hospitals as deemed clinically appropriate. As of the end of last week the average level of occupancy of the private hospitals was 33% of their bed days being utilised.

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475	Éamon Ó Cuív	To ask the Minister for Health whether it is intended to suspend all reviews of medical cards during the Covid-19 crisis and extend the expiry date of the cards accordingly in view of the difficulties medical card holders have at present accessing information from state agencies, employers and doctors etc. required as back up for medical card reviews; and if he will make a statement on the matter.	Eligibility for medical and GP visit cards is determined by the HSE National Medical Card Unit in accordance with the Health Act 1970 (as amended). During the Covid-19 pandemic, the HSE will extend eligibility automatically for up to one year for existing medical and GP visit cards which fall due to expire during this period. Notification of these extensions is being communicated to medical and GP visit cardholders by the HSE. Further information in relation to the processes that the HSE National Medical Card Unit will follow when assessing eligibility for Medical and GP Visit Cards during the Covid-19 Pandemic can be found online at the HSE website.

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500	Norma Foley	Can the Minister confirm that a 17 yr old awaiting the HPV vaccination will not be penalised on reaching 18 yrs of age in late Summer and be required to pay 400 euro for said injection. The roll out of said vaccination is currently paused due to the Covid 19 situation.	The immunisation programme in Ireland is based on the advice of the National Immunisation Advisory Committee (NIAC). The NIAC is an independent committee of the Royal College of Physicians of Ireland comprising experts in several specialties including infectious diseases, paediatrics and public health. The committee's recommendations are based on the prevalence of the relevant disease in Ireland and international best practice in relation to immunisation. It makes recommendations on vaccination policy to my Department. The NIAC continues to revise recommendations to allow for the introduction of new vaccines in Ireland and to keep abreast of changes in the patterns of disease. Therefore, the immunisation schedule will continue to be amended over time. As you are aware, the NIAC recommended that the HPV vaccine should also be given to boys. The ages at which vaccines are recommended in the immunisation schedule are chosen by the NIAC in order to give each child the best possible protection against vaccine preventable diseases. On foot of the NIAC's recommendation, my Department asked the Health Information and Quality Authority (HIQA) to undertake a health technology assessment (HTA) to establish the clinical and cost-effectiveness of extending the immunisation programme, which offered the HPV vaccination to all girls in their first year of second level education (generally 12 to 13 year olds), to a programme that also offers the vaccination to boys in their first year of secondary school. The HIQA completed the HTA in December 2018, recommending that the HPV immunisation programme be extended to include boys. As the HPV vaccine is preventative it is intended to be administered, if possible, before a person becomes sexually active, that is, before a person is first exposed to HPV infection. A policy decision was made to extend the HPV immunisation programme to include boys starting in September 2019 with the introduction of a 9-valent HPV vaccine. However, the HIQA did not recommend inclusion of a catch-up programme for boys who have already completed the first year of secondary school. My Department will continue to be guided by NIAC's recommendations on any emerging evidence on this issue in the future. In relation to the restrictions on vaccination due to Covid-19, this matter is under review.

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500	Norma Foley	Can the Minister confirm that a 17 yr old awaiting the HPV vaccination will not be penalised on reaching 18 yrs of age in late Summer and be required to pay 400 euro for said injection. The roll out of said vaccination is currently paused due to the Covid 19 situation.	The immunisation programme in Ireland is based on the advice of the National Immunisation Advisory Committee (NIAC). The NIAC is an independent committee of the Royal College of Physicians of Ireland comprising experts in several specialties including infectious diseases, paediatrics and public health. The committee's recommendations are based on the prevalence of the relevant disease in Ireland and international best practice in relation to immunisation. It makes recommendations on vaccination policy to my Department. The NIAC continues to revise recommendations to allow for the introduction of new vaccines in Ireland and to keep abreast of changes in the patterns of disease. Therefore, the immunisation schedule will continue to be amended over time. As you are aware, the NIAC recommended that the HPV vaccine should also be given to boys. The ages at which vaccines are recommended in the immunisation schedule are chosen by the NIAC in order to give each child the best possible protection against vaccine preventable diseases. On foot of the NIAC's recommendation, my Department asked the Health Information and Quality Authority (HIQA) to undertake a health technology assessment (HTA) to establish the clinical and cost-effectiveness of extending the immunisation programme, which offered the HPV vaccination to all girls in their first year of second level education (generally 12 to 13 year olds), to a programme that also offers the vaccination to boys in their first year of secondary school. The HIQA completed the HTA in December 2018, recommending that the HPV immunisation programme be extended to include boys. As the HPV vaccine is preventative it is intended to be administered, if possible, before a person becomes sexually active, that is, before a person is first exposed to HPV infection. A policy decision was made to extend the HPV immunisation programme to include boys starting in September 2019 with the introduction of a 9-valent HPV vaccine. However, the HIQA did not recommend inclusion of a catch-up programme for boys who have already completed the first year of secondary school. My Department will continue to be guided by NIAC's recommendations on any emerging evidence on this issue in the future. In relation to the restrictions on vaccination due to Covid-19, this matter is under review.

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506	Bríd Smith	To detail any instructions or guidance issued by the HSE, the Department and any sub group to clinical directors or management at nursing homes on the correct treatment of residents suspected or confirmed as cases of Covid 19, and specifically the conditions under which these residents may be transferred to acute hospital settings?	The HSE guidelines aim to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The HSE through the Health Protection Surveillance Centres (HPSC) developed an extensive body of guidance and support tools to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The current relevant guidelines are the: "*Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units"* The principle of the right care in the right place at the right time applies. Nursing homes are people's home and in general residents with or without COVID-19 diagnosis should be managed in their facilities unless transfer to hospital is deemed clinically appropriate and will confer additional benefit. Decisions to transfer are clinical decisions made on a case by case basis by senior staff and the attending doctor usually the GP. Decisions should always be made in conjunction with the person, their families and their advanced care plans. The National Public Health Emergency Team (NPHET) approved the guidance document "*Ethical Considerations Relating to Critical Care in the context of COVID-19"*. This guidance is clear that no single factor (e.g. a person's age) should be taken, in isolation, as a determining factor and decisions should not be made arbitrarily or in such a way as to result in unfair discrimination. In the interest of fairness and to protect against unjustified discrimination, it is important that clinicians apply a consistent approach to considering the predictors of outcome for all ICU admissions, including patients with COVID-19 and patients without COVID-19. Where it is decided that the provision of intensive care treatment is not beneficial or possible in light of the circumstances, patients will be provided with other available and potentially beneficial forms of treatment. For example, in the context of COVID-19, other respiratory supports may still be effective (e.g. non-invasive ventilation, oxygen). In cases where a patient is unlikely to recover, appropriate palliative and/or

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			end-of-life care must be provided. Withholding of critical care does not mean a patient will no longer be cared for.

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520	Richard Boyd Barrett	To ask the Minister for Health to provide the timeline of discussions with NPHET and the Expert Advisory Group with regards to the management of nursing homes in advance of Covid19 in Ireland, including the expert advice received from the EAG, the date the advice was received on, the decisions made by NPHET and the DoH on the back of this advice and the actions that were taken with regards to this advice and all the dates of the above phases of the discussion and to make a statement on the matter.	A range of enhanced measures for nursing homes recommended by NPHET on 31st March and 3rd April are being implemented. The enhanced measures build on actions already adopted for nursing homes, including general and specific infection prevention measures, specific public health and clinical nursing home guidance published March 12th and subsequently updated, social distancing measures, visitor restrictions and cocooning. These include actions to strengthen HSE national and regional support structures, actions focused on reducing transmission of the disease such as prioritisation of staff for screening, and access to specific training and PPE for providers. Additionally, a significant package of guidance tools developed in accordance with international guidance are available to support and guide planning for and responses to COVID-19 in nursing homes. HIQA, as regulator for the nursing home sector has completed a risk assessment of all nursing homes. On 3rd April, it commenced a focused COVID-19 Infection Prevention and Control Hub to provide nursing home providers with guidance and supports; including an escalation pathway where required to the HSE. In addition, a HIQA COVID-19 regulatory assessment framework, in line with the Health Act 2007, was published and is now operational. On 17th April, the NPHET met to continue its ongoing review of Ireland's response to COVID-19 and its decisions included expanding testing capacity to 100,000 tests per week and the prioritising testing of staff and residents in all Long-Term Residential Care (LTRC) facilities to be prioritised along with a census of mortality across all LTRC facilities to be carried out to cover all deaths, COVID-19 and non-COVID-19 since 1st January 2020, regardless of where the death occurred. Over 65,000 tests are complete under the residential care facilities mass testing programme with testing complete in 93% of nursing homes. NPHET approved the guidance document "*Ethical Considerations Relating to Critical Care in the context of COVID-19*". This guidance is clear that no single factor (e.g. a person's age) should be taken, in isolation, as a determining factor and decisions should not be made arbitrarily or in such a way as to result in unfair discrimination. In the interest of fairness and to protect against unjustified discrimination, it is important that clinicians apply a consistent approach to considering the predictors of outcome for all ICU admissions, including patients with COVID-19 and patients without COVID-19. The Temporary Financial Assistance Scheme

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			was established and is open to applications from nursing homes, which represents significant financial support, in addition to the other supports.

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521	Richard Boyd Barrett	To ask the Minister for Health if the Department , the HSE, or the Minister issued guidance notes or instructions to private nursing homes on how to deal with Covid 19 infected residents, specifically the circumstances in which residents should be transferred to acute hospitals for intensive care, who should be making these decisions and to provide us with copies of these guidelines and to make a statement on the matter.	HSE guidelines aim to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The HSE through the Health Protection Surveillance Centres (HPSC) developed an extensive body of guidance and support tools to assist staff in residential care facilities, including nursing homes, in their management of COVID-19 cases, including in relation to decisions on transfer of residents, to hospitals, where appropriate. The current relevant guidelines are the: "*Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units"* The principle of the right care in the right place at the right time applies. Nursing homes are people's home and in general residents with or without COVID-19 diagnosis should be managed in their facilities unless transfer to hospital is deemed clinically appropriate and will confer additional benefit. Decisions to transfer are clinical decisions made on a case by case basis by senior staff and the attending doctor usually the GP. Decisions should always be made in conjunction with the person, their families and their advanced care plans. The National Public Health Emergency Team (NPHET) approved the guidance document "*Ethical Considerations Relating to Critical Care in the context of COVID-19"*. This guidance is clear that no single factor (e.g. a person's age) should be taken, in isolation, as a determining factor and decisions should not be made arbitrarily or in such a way as to result in unfair discrimination. In the interest of fairness and to protect against unjustified discrimination, it is important that clinicians apply a consistent approach to considering the predictors of outcome for all ICU admissions, including patients with COVID-19 and patients without COVID-19. Where it is decided that the provision of intensive care treatment is not beneficial or possible in light of the circumstances, patients will be provided with other available and potentially beneficial forms of treatment. For example, in the context of COVID-19, other respiratory supports may still be effective (e.g. non-invasive ventilation, oxygen). In cases where a patient is unlikely to recover, appropriate palliative and/or

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			end-of-life care must be provided. Withholding of critical care does not mean a patient will no longer be cared for.

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524	Richard Boyd Barrett	To ask the Minister for Health if all the private healthcare capacity, hospital beds and staff, including private consultants, has been brought fully under the control and direction of the public system and to make a statement on the matter.	A major part of the Government's Action Plan in Response to Covid-19 was to urgently ramp up capacity for acute care facilities. A critical element of the strategy was to put in place an arrangement with the private hospitals to use their facilities as part of the public system, to provide essential acute hospital services for the duration of the emergency. An overarching agreement with the 18 private acute hospitals was agreed at the end of last month and individual contracts are due to be signed with the individual hospitals or groups of hospitals shortly Under the terms of the agreement the HSE will secure access to 100% of the capacity of the private hospitals. The private hospitals will effectively operate as public hospitals for the duration. The private hospital sector is made up of 18 hospitals and has an estimated bed capacity of 1,900 inpatient beds, 600 day beds as well as 47 ICU and 54 HDU beds. This is equal to 17% of the existing capacity in the public system which has approximately 11,000 inpatient beds and 2,300 day beds or places. The private hospitals have nearly 1,000 single bed inpatient rooms. The staff of the private hospitals will continue to be employed by the hospitals. There is a significant number of consultants who work wholly for the private hospitals but who are not employees of the hospitals. The HSE has offered them locum public only Type A contracts. The latest information available is that approximately 244 consultants had signed up to the new contract. Others are still considering the matter. This additional capacity will play a crucial role in enabling the acute hospitals system to deal with the challenges it faces during to the Covid-19 pandemic

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527	Richard Boyd Barrett	To ask the Minister for health if the HSE is still on track to be carrying out 16,000 tests a day by the end of April; what plans are in place for widespread community testing regime capable of tracking the trajectory of the disease, including testing for immunity, when will this be rolled out and how does this fit with plans to relax restrictions in the coming weeks or months and to make a statement on the matter.	Significant progress has already been made in a very short space of time to develop the required testing capacity including the establishment of 48 community testing hubs. Additional sampling is being undertaken by the National Ambulance Service and in hospitals and the HSE advise that there is now capacity to process 12,000 tests a day. This includes labs in hospitals, the community (NVRL, Enfer and smaller labs) and some international provision. As of Monday 4th May, over 214,000 laboratory tests have been carried out. Over the past week 61,707 tests were carried out and 2,280 were positive. A senior manager has been appointed, reporting directly to the CEO, to lead work across the full process of testing and contact tracing. The HSE has also now developed a roadmap for building capacity to 100,000 tests a week. The development of the plan benefitted from the input of my Department and its implementation has my full support. NPHET has been clear on the things it will be assessing to inform decisions on changes to current restrictions. The most important one of those is that the incidence is as low as possible including of community transmission and within community residential settings; as well the impact of the disease on rates of mortality and hospitalisation including admissions to intensive care units. Improvements are still needed in these important measures of the virus. Public health preparedness is also important, hence the current efforts underway to develop testing and contact tracing capacity, and to have them supported by IT systems that can allow real-time monitoring of this public health led response. With regard to testing for immunity, The National Public Health Emergency Team commissioned a rapid health technology assessment to examine the alternative diagnostic approaches for the detection of SARS-CoV-2. These alternative approaches include antigen detection tests and the detection of antibodies and other rapid tests. Work is currently underway internationally to validate the analytical performance of the different diagnostic tests. Until the clinical performance of these newer diagnostic methods tests, in particular rapid antibody and antigen-based tests, has been validated, they cannot currently be recommended for use in routine clinical diagnostics. NPHET continues to keep international developments on this topic under review and will make recommendations accordingly.

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528	Ruairí Ó Murchú	To ask the Minister for Health what plans are being drawn up by the HSE and other pandemic advisory agencies, in conjunction with sectoral stakeholders, to allow for the safe, staggered re-opening of businesses?	On 1 May 2020, the Government published a Roadmap for Reopening Society and Business to ease the COVID 19 restrictions and reopen Ireland's economy and society in a phased manner. The Roadmap announced by the Government will start from May 18th, from which point the country will re-open in a slow, phased way. The framework sets out how we can keep the level of transmission as low as possible while balancing continuing restrictions proportionately with the positive social and economic benefits which will be brought about by lifting restrictions. As restrictions are eased, the rate of the virus in the community will be constantly monitored by the National Public Health Emergency Team and the Government. The risk of a second wave of the virus is ever present. The WHO and ECDC are warning that the measures have to be lifted in a very slow, gradual and stepwise manner in phases separated by sufficient intervening time (every 3 weeks) in order to avoid a rapid upsurge in infections. The Government has been clear that moving from one phase to another here in Ireland is dependent on the virus being under control between each phase. There will be close and continuous monitoring across Government as measures are eased, to understand their impact on the disease and as far as possible to avoid a surge. If that happens, certain measures may have to be re-imposed. The plan sets out five stages for unlocking restrictions, at three-week intervals. Each phase consists of a menu of options that will be considered by Government as it gradually opens up economic and social activities. The Roadmap sets out a framework for future decision making, which will at all times be underpinned by public health advice. It will be a risk-based approach, considering risk both from the perspective of protecting those most vulnerable to infection as well as protecting against causes, situations, circumstances, and behaviours that may lead to risk of spread of disease. Measures will be assessed on a regular basis, individually and in combination to consider their impact. The approach to reducing measures will evolve as more information becomes available and in line with international learning and experience, in particular from countries ahead of Ireland in terms of their outbreak, to assess closely the effectiveness of their approaches to easing restrictions.

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			The government will regularly assess the following criteria as we seek to keep the level of transmission low while gradually restarting the economy: • the latest data regarding the progression of the disease • the capacity of the health service • the capacity of the testing and tracing system • the measures in place to protect vulnerable groups • an assessment of the impact of excess morbidity and mortality as a consequence of the restrictions