**National Public Health Emergency Team – COVID-19**

**Meeting Note – Standing meeting**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Thursday 5th November 2020, (Meeting 62) at 10:00am</th>
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<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
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**Members via videoconference**

- Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
- Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)
- Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair
- Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA
- Dr John Cuddihy, Interim Director, HSE HPSC
- Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital
- Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor
- Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Mr Phelim Quinn, Chief Executive Officer, HIQA
- Dr Darina O’Flanagan, Special Advisor to the NPHET
- Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH
- Dr Breda Smyth, Public Health Specialist, HSE
- Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE
- Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH
- Ms Deirdre Watters, Communications Unit, DOH
- Dr Colm Henry, Chief Clinical Officer, HSE
- Mr Liam Woods, National Director, Acute Operations, HSE
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- Ms. Fidelma Browne, Interim Assistant National Director for Communications, HSE
- Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway

**‘In Attendance’**

- Mr David Keating, Communicable Diseases Policy Unit, DOH
- Ms Laura Casey, Policy and Strategy Division, DOH
- Mr Gerry O’Brien, Acting Director, Health Protection Division
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
- Ms Emily de Grae, Health Systems and Structures, DOH
- Ms Ruth Barrett, Health Systems and Structures, DOH
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Heather Burns, Deputy Chief Medical Officer, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Ms Niamh O’Beirne, National Lead for Testing and Tracing, HSE
- Dr Robert Mooney, NPHET Policy Unit, DOH

**Secretariat**

- Dr Keith Lyons, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH

**Apologies**

- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital
- Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH
- Dr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH
- Dr Ronan Glynn Deputy Chief Medical Officer, DOH
1. Welcome and Introductions
   a) **Conflict of Interest**
   Verbal pause and none declared.

   b) **Apologies**
   Apologies were received for Dr Ronan Glynn, Prof Colm Bergin, Dr Siobhán O’Sullivan, and Mr Colm Desmond. Dr Michael Power provided apologies for the second half of the meeting.

   c) **Matters Arising**
   There were no matters arising at the meeting.

2. Epidemiological Assessment
   a) **Evaluation of Epidemiological data: (incorporating National Data Update, Modelling Report and International Update)**
   The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:

   - A total of 4,139 cases have been notified in the 7 days to the 4th November, compared with 6,061 in the 7 days to 28th October, representing a 32% decrease;
   - As of 4th November 7- and 14-day incidence rates are 86 and 213 per 100,000 population, respectively; these compare with the 7- and 14- day incidence rates of 127 and 299 per 100,000 population, respectively, that were reported on the 28th October;
   - Nationally, the 7-day incidence as a proportion of 14-day incidence is at 40%, demonstrating that there have been less cases in the 7 days to 4th November than in the 7 days to 28th October;
   - As of 4th November, the 5-day average of reported cases is 496 cases per day; this compares with a 5-day average of 839 cases per day on the 29th October;
   - 66% of cases notified between 21st October – 3rd November have occurred in people under 45 years; the median age for cases notified between those dates is 34 years;
   - The 14-day incidence in those aged 65 years and older has decreased from 201 per 100,000 population on the 29th October to 160 per 100,000 population on 5th November;
   - As of 5th November, the growth rate of the disease is currently negative. The current growth rate for the country is -3.5% (compared with +4.9% on the 29th October). The growth rate is slightly higher in Dublin at -2.7% which means the rate of decline in incidence is slower in Dublin than the rest of the country;
   - In the 7 days to 4th November, the trajectory of the disease in Dublin has differed from the national picture; 31% of all cases notified in the 7 days to 4th November occurred in Dublin, this compares with 26% in the 7 days to 28th October;
   - Based on data to 4th November, the best estimate of reproduction number (R) for the country is approximately 0.7 - 0.9;
   - A total of 88,547 tests were undertaken in the 7 days to 4th November. The 7-day average test positivity rate has decreased from 5.5% to 4.6% over in the same period. The positivity rate on 4th November, was 4.9%. It was noted that these data must be interpreted with caution as this indicator is dependent on factors including the proportion of tests arising from serial testing programmes on a given day/week;
   - There are currently 307 confirmed COVID-19 cases in hospital as of 8am on 5th November, compared with 318 on 28th October. There have been 20 newly confirmed cases in hospital in the preceding 24 hours;
   - There are currently 40 confirmed cases in critical care as of 4th November, compared with 40 on 29th October. There has been 1 new admission in the previous 24 hours;
As of 3rd November, there have been 111 deaths notified with a date of death in October. This compares with 5 and 36 deaths notified (to date) with a date of death in August and September, respectively; 45 of the 111 deaths that have occurred in October are associated with nursing homes.

Further relevant information includes:

- 479 additional new clusters were notified in the week to 31st October 2020. There are 3,993 open clusters nationally. Of these, 56 open clusters are associated with nursing homes and 33 open clusters are associated with hospitals;
- In the week to midnight on 31st October (week 44), there were 8 new clusters notified in nursing homes/community hospitals with 96 linked cases, 8 new clusters notified in centres for disabilities, and 8 new clusters in hospitals;
- In the week to midnight 2nd November there were 11 new clusters in workplaces identified, 4 among vulnerable groups, 30 in schools, and 9 in childcare facilities;
- A range of mobility data suggests that current measures have resulted in reduced mobility in the population since 1st September;
- The average number of close contacts has decreased from approximately 5-6 per confirmed case at the end of September to the current level of 2-3;
- As of 3rd November, the 7-day incidence in Northern Ireland is 332 cases per 100,000 population.

The DOH presented “COVID-19 situation in European region and selected countries (England, Belgium, Portugal): NPHET Presentation 5th November 2020”, providing an overview of the epidemiological data and variety of COVID-19 restrictive measures taken in the selected countries in recent weeks. The following trends were noted across countries in the European Region:

**COVID-19 in Europe – epidemiology overview:**

- As per the weekly epidemiological update, with data received by WHO from national authorities, as of 1st November 2020, the weekly incidence in cases and deaths increased by 22% and 43%, respectively, in comparison with the week of the 18th – 25th October;
- As of 4th November, the average 14-day incidence across EU/EEA and UK countries is 539 per 100,000 population, this compares with 279 per 100,000 in the previous 14-day period up to 21st October;
- As per data reported by ECDC on 4th November 2020, Ireland ranks 24th out of 28 EU/EEA and UK countries in relation to 14-day incidence rates/100,000 population. In terms of the 14-day incidence rate, the epidemiological situation in Ireland compares favourably to EU/EEA counterparts, i.e. there has been a 19% decline in the 14-day incidence rate in Ireland in 7 days up to 4th November compared to the 7 days up to 28th October, while the majority of countries in the EU/EEA/UK are experiencing an upward trend;
- France had the third highest number of new cases globally, with over 275,000 cases reported between 25th October - 1st November: a 27% increase from the week of the 18th – 25th October. The COVID-19 occupancy rate of ICUs is rising rapidly. The increases in indicators are most marked among people aged 65 and over;
- In Switzerland, new cases have grown considerably in October, rising from fewer than 2,500 per week from mid-April through to the end of September, to 50 000 new cases in between 265th October-1st November. Switzerland has the fifth-highest incidence of new cases per million population in the region (5,800 cases per million population). Weekly hospitalisations and test positivity are also increasing.

In conclusion:

- The disease profile is rapidly deteriorating across most of Europe with some improvement in disease indicators in specific countries in recent days (e.g. Belgium, Ireland);
- Disease is increasingly impacting older age groups and driving hospitalisations, critical care admissions, and deaths;
• Healthcare services in many European countries are coming under significant strain;
• Increasingly severe restrictions are being applied by many European countries in response to the deteriorating epidemiological situation with some heterogeneity in restrictions applied.

The NPHET noted that the most recent ECDC Rapid Risk Assessment, dated 23rd October, highlights that “all EU/EEA countries and the UK have implemented various non-pharmaceutical interventions, but these have not been fully successful in controlling transmission, and the epidemiological situation is now rapidly deteriorating. Implementation of stricter non-pharmaceutical interventions, which proved to be effective in controlling the epidemic in all EU/EEA countries and the UK during spring 2020, appears to be the only available strategy that may have a moderate (as opposed to high) impact on the disease for individuals and healthcare provision. This results in an overall assessment of the general population being at high risk.”.

The HPSC advised that while the national incidence rate is decreasing, there are areas in the country where it is increasing. These areas include parts of Tipperary, Donegal and Cork. In Dublin there is a divergence in incidence trends between the north and south of the county with incidence rising in the North, particularly in areas close to the border with Louth.

The IEMAG highlighted that, historically, Dublin has had twice the incidence rate of the other counties which may account for why the same drop in cases is not being observed when compared with the rest of the country. The IEMAG also advised that it is evident that people’s behaviour is diverging from government restrictions, for example, people have been observed to change their behaviour in anticipation of restrictions. The NPHET recognised that, while time is needed before the data can be fully understood, it would need to be cognisant of this when formulating any long-term strategy for dealing with COVID-19. The IEMAG advised that data from the COVID tracker app could give an insight into people’s movements and behaviour which would provide a clearer picture of how many people the average person comes in contact with. The NPHET also recognised that being able to understand the nuances in behaviour and incidence rates that occur at a local level will empower local Public Health departments and inform their decisions.

The NVRL provided an update on outbreaks of Covid-19 in mink farms in Denmark. Transfer of the virus from humans to mink and vice versa has been observed; at this stage, these strains of the virus do not appear to be any more transmissible or to cause more severe disease than those already in circulation. However, the situation is evolving and will have to be kept under review.

3. Review of Existing Policy
a) Sampling, Testing, Contact Tracing, and CRM Reporting
The HSE presented “Testing and Contact Tracing Update, 5th November 2020”. The data presented were as follows:

Activity levels across sampling, laboratory, and contact tracing from 27th October – 2nd November:
• There have been approximately 89,502 swabs taken for COVID-19 testing.
  o Approximately 48,205 of these were taken in the community, the majority were performed at fixed testing sites and a portion as home visits, which have increased in recent weeks.
  o Approximately 20,844 swabs were taken in acute settings.
  o The remaining 20,453 swabs were taken as part of the serial testing programmes of staff in residential care facilities for older persons, and staff in food production plants.
• Data from 25th October – 31st October shows that the 0-10 age group makes up 15% of all referrals, a slight decrease from the week 18th – 24th October, when this age group made up 16.2% of all referrals.
• The age group with the highest percentage of referrals from 25th October – 31st October is the 21-30 age group, making up 17.8% of all referrals.
• A total of 19,839 calls were made in the Contact Tracing Centres. A total of 4,440 of these were Call 1s, which involves the communication of a detected result. A total of 15,399 calls were completed relating to contact tracing.
• A new steering group has been established to drive a 6-week service improvement plan for contact tracing. It will set a clear vision and set of actions to be implemented to improve the service overall.

Turnaround Times from 27th October – 2nd November:
• The median end-to-end turnaround time for ‘not detected’ tests in the community setting was 1.8 days.
• The median end-to-end turnaround time for ‘detected’ cases in the community is 2.1 days.
• In the community, the median time from referral to appointment was 0.2 days; 92% of GP referrals are provided a swabbing appointment same day or next day.
• For swabs processed in a community lab, the median time for swab to lab result was 26 hours; for swabs processed in a hospital lab, the median time for swab to lab result was 15 hours; the combined median time from swab to lab result was 25 hours.

Serial Testing Programmes:
• Cycle 4 of the serial testing of all staff within residential care facilities for older persons commenced on 14th October. As of 3rd November, there have been 46,527 tests carried out, with 252 cases detected. This represents a detected rate of 0.54%.
• Cycle 2 of serial testing of food production facilities commenced on 12th October, with a planned 4-week cycle. As of 3rd November, Cycle 2 has carried out 13,534 tests with 80 detected cases. This represents a detected rate of 0.59%. A schedule for Cycle 3 of serial testing of food production facilities has been developed and will commence on 9th November for four weeks. Each facility will be tested once in Cycle 3.
• Public Health have conducted risk assessments in response to ‘detected’ cases linked to schools and, as of 3rd November, testing is currently ongoing or has been completed in 657 schools; approximately 17,167 staff/students have been identified and are undergoing Day 0 and/or Day 7 testing; of these, 444 ‘detected’ cases have been identified, representing a ‘detected’ rate of 2.6%.
• Public Health have conducted risk assessments in response to ‘detected’ cases linked to childcare facilities and, as of 3rd November, testing is currently ongoing or has been completed in 174 childcare facilities; approximately 3,566 staff/students have been identified and are undergoing Day 0 and/or Day 7 testing; of these, 190 ‘detected’ cases have been identified, representing a ‘detected’ rate of 5.3%.

Details of the ongoing recruitment drive were provided. The NPHET welcomed this update and in particular progress on the recruitment of additional contact tracing and community swabbing staff. The NPHET reiterated the importance of repatriating frontline healthcare workers currently assigned to swabbing activities/contact tracing back to their full-time roles as soon as possible.

The NPHET also expressed the importance of developing metrics for testing and tracing turnaround times at a regional level. There was consensus that these data would be essential for regional Public Health teams to inform targeted responses to disease progression at local level.
b) Serial Testing in Nursing Homes (participation rate & scope for including Residents)

The HSE updated the NPHET on their work and experiences of the serial testing programme of staff in nursing homes. The NPHET welcomed the update on this work and reaffirmed the importance of this work in the context of ensuring best practice in nursing homes in terms of infection prevention and control.

The NPHET asked the HSE to develop a paper ahead of its next meeting on 12th November detailing specific proposals for the future direction of the serial testing programme, with due consideration given to the inclusion of residents in nursing homes and other long-term residential care settings (e.g. disability settings) in the serial testing programme.

c) Update on clinical guidance supports to Nursing Homes

The HSE updated the NPHET on the current clinical guidance supports to nursing homes around the country.

The HSE reaffirmed the need for appropriate caution when considering the applicability of COVID-19 treatments used in hospital settings to nursing homes. For example, dexamethasone efficacy has only been demonstrated in patients who are oxygen dependent or ventilated in hospital settings. Application of such evidence to another setting does not currently have an evidence base. The existing clinical guidance for treating COVID-19 patients in nursing home settings focuses on the specific and distinct needs of this cohort in a manner which supports and optimises the clinical oversight and expertise already embedded in these settings.

4. Future Policy

a) Consolidated Paper on testing Strategy


The paper was previously presented to the NPHET on 15th October, however, at that time, there was outstanding work to be completed, with particular regard to the testing strategy for healthcare workers (HCWs) in acute settings. The paper presented the current approach to PCR testing and the proposed future approaches to testing, with the rationale behind the proposals for population sub-groups identified as requiring a more systematic testing approach.

The NPHET endorsed the paper with the exception of the proposal in relation to healthcare workers and requested that the HSE give further consideration to the steps necessary to ensure that the health and wellbeing of healthcare workers in acute hospital settings is protected. The NPHET emphasised that maintaining a healthy and resilient workforce is an integral part of building a robust and sustainable response to the disease into the future.

Action: The NPHET endorses the paper “Sars-CoV-2: A Testing Strategy Approach” and supports its implementation in all respects except in relation to testing of HCWs in acute settings. In this regard, the NPHET recommends that the HSE develop a paper giving additional detailed consideration to the testing of HCWs in acute settings, and detail specifically the suite of measures being taken to protect their health and wellbeing.

b) Saliva as a specimen type

The EAG provided an update to the NPHET on the use of saliva as specimen type in testing for COVID-19. The process is underway to identify community sampling hubs which would be able to undertake the validation
exercise. Two sites have been identified which will be able to begin validation in two weeks with the possibility of a further two sites being added in future.

c) International Travel

The DOH provided an update on international travel and, in light of the Government decision to use the European “Traffic Lights Approach to Travel”, asked the NPHET members to consider what the Public Health response should be in relation to travel as December approaches.

As isolation periods in the traffic light system are advisory, members of the NPHET expressed concern about the possible importation of cases through ports of entry. This could potentially increase community transmission, creating local surges and increased pressure on the testing and tracing system. The NPHET decided that issues relating to International Travel would be considered in more detail over the coming weeks.

d) Public Health Response

The DOH also addressed the letter from the Minister for Health to the chair of the HSE which outlined a number of issues that require attention beyond the current 6-week period. In particular, the letter highlighted the need for a system that is more responsive at a local level. It was noted that, in the interim, the responsiveness of the system must be improved upon in the context of the pandemic. The DOH will provide an update on this work in the form of a short paper at the next meeting on 12th November. The NPHET also acknowledged the considerable work carried out to date in developing the test and trace infrastructure.

e) Transitioning from Level 5 Measures

The NPHET allocated a significant amount of discussion time to the key considerations for the COVID-19 response strategy and a potential transition out of Level 5 measures. To frame the discussion the DOH presented information on the following topics for consideration: an overview of the previous easing of restrictive measures, international “exit-strategies”, and current behavioural research.

The DOH provided an overview of the key objectives of the Public Health restrictive measures currently in place and reiterated the NPHET’s advice to government which indicated a number of areas that require further consideration/development in the coming weeks to support the easing of current restrictions and to provide the best opportunity for maintaining low levels of transmission and preventing a resurgence in cases:

- Enhancement and investment in our public health response system;
- Consideration of international travel;
- The future response strategy for the period following this wave of infection.

The DOH noted that a robust and cautious approach to easing restrictions will be required in order to limit any subsequent increase in cases, and potential further waves of infection, to the greatest extent possible. The approach will also have to consider time of the year, in particular the Christmas period which traditionally brings significant socialisation, family gatherings and travel.

An overview of the approach to easing restrictions in the period following the first wave of infection was provided. The most notable point was that the initial reopening was undertaken in a phased, stepwise manner, with set dates and pre-determined measures for each phase, which balanced the health risks with the broader economic and societal considerations. The final phase of the initial reopening strategy was interrupted by the subsequent deterioration of the situation and was not completed.

An outline of international exit strategies, international research and guidance was presented as follows:
Jurisdictions have tended to gradually ease restrictions and have taken a stepwise approach – Victoria (AUS) eased restrictions in four stages over 8 weeks (roadmap published 6th September), Israel has undertaken two phases of reopening after a recent peak.

A number of jurisdictions have taken a regional approach to easing restrictions. Victoria applied different measures in regional Victoria and metropolitan Melbourne, while New Zealand also took a regional approach in Auckland.

Jurisdictions have taken a flexible approach when using Frameworks with set levels of measures when necessary: Auckland maintained extra restrictions on travel and gatherings when it was moved to “Alert Level 2”.

Wales will take a different approach when it exits its 2-week “fire-break”, directly returning to a moderate level of restrictions. All businesses will reopen, but there will be 4-person limit on the numbers permitted to meet socially.

Some have used social bubbles to enable increased household interaction (repeat contacts) while continuing other measures to reduce transmission, for example Wales and New Zealand.

As jurisdictions have eased out of restrictive measures, additional measures have been introduced to keep the virus under control such as:

- Extending use of face coverings (Victoria);
- Limiting access to hospitality (New York);
- International travel limits and restrictions e.g. quarantine/screening (New Zealand), and;
- The increased use of fines for not adhering to rules.

**European Commission**: published a European Roadmap Towards Exiting from the COVID-19 Pandemic (March).

**WHO/Europe**: published key considerations for the gradual easing of lockdown restrictions (April)

**ECDC**: Guidelines for the implementation of nonpharmaceutical interventions against COVID-19 (September).

**The Lancet**: Lessons learnt from easing COVID-19 restrictions: an analysis of countries and regions in Asia Pacific and Europe (policy paper September).

Current behavioural research indicates that the medical emergency has been normalised, and people are focused on how to cope with the restrictions from an economic, social and mental health perspective. While the majority of people comply with the measures in place, decision-making around self-isolation could be improved. People prioritise the opportunity to socialise with friends and family, viewing current measures as open to reasonable interpretation. Perceived unfairness of restrictions is beginning to affect overall trust in guidance, but people are willing to make some sacrifices if they can do the things they value most. Furthermore, people want to know the Government strategy/roadmap for the next year and to understand the logic behind the guidelines.

The approach taken at the coming juncture will be different due to a number of factors. Significant progress has already been made to develop a robust public health response and the 5-Level Framework is now in place. Restriction fatigue must also be acknowledged, and the upcoming Christmas holiday season will need to be considered. However, the following key principles should remain:

- An element of phasing will still be required, determined by balancing public health risks with other societal and economic considerations.
- A reduction of measures will need to be robustly and continuously monitored in terms of adherence and effect.
- There is no guarantee that measures won’t have to be reintroduced.
- The overarching priorities of protecting key public services of health, social care, education and protecting the most vulnerable remain paramount.
- There will be an ongoing need for some limitations on discretionary congregation/contacts to minimise the risk of cases and size of clusters.
• Recognition that cooperation and solidarity across sectors and society is vital if the disease is to be contained.

To determine the key pillars of the proposed approach, the DOH asked the NPHET members to consider the following:

• Does the current 5-Level Framework provide enough flexibility for it to be used as the Framework for easing restrictions? Note that while the levels are presented sequentially, this does not mean they need to be applied in a stepwise way and there may need to be nuanced measures for the Christmas period.
• What approach should be taken to phasing? Should there be a defined timetable for easing measures, or a more open approach dependent on the disease trajectory?
• Ideally, should a whole-of-country approach be applied to initial easing measures, while retaining the option for regional application of measures?
• Is there a need for further consideration/articulation of proposed strategy in the event of sustained increases in cases post easing of restrictions?

The Communications Team also presented a “Safe Socialising” Proposal for consideration. When meeting in-person, people should only socialise with an exclusive group of 6 people from outside their household for the next six months or until a vaccine is distributed. Groups should, where possible, meet outside. This idea is to limit the potential spread of the virus and assist with contact tracing. Young adults living at home can have a group of 6 separate to their parents.

In the discussion that followed, the NPHET emphasised the importance of the Christmas period in the social fabric of the country, and the hope the holiday season provides for people in the current period of restrictive measures. For this reason, there was emphasis on the need for specific Christmas guidance based on a number of points and observations raised.

• The distinction between pubs and restaurants was noted as important, and the idea of a pub/restaurant as providing a more controlled environment, when guidelines are strictly applied and enforced, than a private house should be considered. Emphasis on how to make higher risk activities safer was highlighted, with particular regard to guidance on ventilation for pubs/restaurants/retail which was noted due to super-spreader events that occurred previously.
• Intergenerational mixing is traditionally increased during the Christmas period as families reunite, which may contribute to an increase of cases among older age groups.
• The NPHET also discussed the important role of messaging in empowering people who may want to reduce numbers at traditionally large gatherings or those who may wish to avoid traditional travel. Realism of the potential for future increases in case number, the possibility for a return to stringent measures, and the necessity to manage expectations accordingly were noted as important to convey. Communications during Christmas should also be inclusive of other religions and groups who may not celebrate Christmas.
• Nursing Home and Long-term Residential Care Facility residents must also be recognised during the holiday period.
• The central role that community, the Arts and Sports traditionally play at Christmas.

With regard to the Safe Socialising proposal, many members of the NPHET expressed concern that the expectation may be unrealistic, especially when tied to the arrival of a vaccine. It was also noted that it may be exclusionary, particularly among younger cohorts.

The Chair thanked members for their contributions to the discussion and added that it will also be important to consider international measures, particularly as the Christmas period sees varied celebrations and increased travel across the European region. The Chair noted that tolerance and understanding need to be central to communications, and the provision of voluntary and statutory services during the Christmas period should be safely facilitated as much as possible.
The DOH will return a draft paper for consideration at the next meeting on 12th November, incorporating feedback from the discussion, initial consideration of potential impact of increased social contacts, monitoring of emerging international advice and proposed strategies in EU member states, further qualitative research to gain a better understanding of the public’s view and draft proposals for consideration.

5. Communications

Aspects of the Communications were discussed in detail under Item 4(e). The NPHET were also presented with “Communications Update – NPHET 5th November”.

According to the Quantitative Tracker, a nationally representative sample of 1,650 people showed that:

- 83% of the population report to be staying at home rather than going out, up from an average of 66% over the summer months.
- The majority (67%) feel that the reaction of Government to the current outbreak is appropriate (22% insufficient, 11% too extreme).
- 15% say they have been tested for COVID-19, with 1% testing positive; 30% know someone in their immediate circle who has been infected with COVID-19.
- 72% believe a vaccine could help control the spread of the virus; 67% would get vaccinated based on recommendation from DOH and 54% on GP recommendation.

Key insights from the Qualitative Tracker as of 26th October, engaging with young adults, Mums & Dads, and older people living alone, reveals:

1. The Irish people want to know the strategy of Government in handling the pandemic. In the absence of this, they feel blinkered and disempowered.
2. Older people know their vulnerabilities and take responsibility of their medical safety. They need the most support in their emotional safety, replacing meeting people with chatting to people. This needs a coordinated national response.
3. Speaking expertly to the vaccine helps prepare the nation for a credible, substantiated, trusted solution. In the absence of this, there may be widespread reticence to a solution which may seem ‘rushed through’.
4. Communication should move to principles on how to protect from COVID (meet outdoors, meet less new people, take personal responsibility etc.). Importantly, these principles will not change, irrespective of the level of restrictions. Consistency in communication will foster better individual choices, and higher rates of compliance.

There are a number of campaigns now underway:

- Cases & Contacts to Self-isolate & restrict their movements.
- HSE Bubble campaign & influencer social media campaign.
- Flu campaign.
- Healthy Ireland Community Resilience campaign.
- COVID public health advertising campaign – we are all the answer.

There are a number of campaigns in development:

- Young Adults:
  - Ad campaign.
  - Creative Council.
- Winter communications campaign targeting older people to commence mid-November.
6. Meeting Close

a) Agreed actions
The key actions arising from the meeting were examined by the NPHET, clarified, and agreed.

b) AOB

a. Wastewater Surveillance
The NVRL director informed the NPHET that many countries have begun wastewater surveillance as an early warning system. It was proposed that 69 wastewater treatment plants, covering about 84% of the population would be sampled weekly, which, for many counties with low transmission, could be a very useful early warning system.

While the use of Wastewater Surveillance had been endorsed in principle by the NPHET in September, it was requested that a paper be returned on this subject at the next meeting, 12th November, so that the process can begin.

b. Critical Care Cooperation with Northern Ireland
The Department of Health informed the NPHET that cooperation has been underway with Northern Ireland to create a strategic framework within which critical care collaboration would be supported. The MOU is now in a position to be signed by the respective CMOs this week.

c. Date of next meeting
The next meeting of the NPHET will take place Thursday 12th November 2020, at 10:00am via video conferencing.