# National Public Health Emergency Team – COVID-19

**Meeting Note – Standing meeting**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Wednesday 25th November 2020, (Meeting 65) at 11:00am</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
</tr>
<tr>
<td>Chair</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
</tr>
</tbody>
</table>

### Members via videoconference

- Dr Ronan Glynn, Deputy Chief Medical Officer, DOH
- 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
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital
- Dr Siobhán Ni Bhríain, 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 Siobhán O’Sullivan, Chief Bioethics Officer, DOH
- Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- Ms Yvonne O’Neill, National Director, Community Operations, HSE
- Mr Phelim Quinn, Chief Executive Officer, HIQA
- Dr Matthew Robinson, Specialist Registrar in Public Health, DOH
- Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH
- 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
- 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 Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE

### ‘In Attendance’

- Ms Laura Casey, NPHET Policy Unit, 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, NPHET Policy Unit, DOH
- Ms Ruth Barrett, NPHET Policy Unit, DOH
- Ms Aoife Gillivan, Communications Unit, DOH
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Dr Robert Mooney, NPHET Policy Unit, DOH

### Secretariat

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

### Apologies

- Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
1. Welcome and Introductions
   a) Conflict of Interest
   Verbal pause and none declared.

   b) Minutes of previous meetings
   There were no minutes for adoption from previous meetings.

   c) Matters Arising
   The Chair of the NPHET reminded members that the COVID-19 Cabinet sub-committee would be meeting on 26th November, in advance of a special Cabinet meeting on 27th November, after which a decision is expected on the potential easing of Level 5 restrictions post 1st December.

   The Chair noted the heavy NPHET agenda and confirmed that full consideration of all items listed, with contributions from all members, would enable the NPHET to set out clear and detailed advice to Government in advance of the meetings above.

   The Chair, once again, stressed the importance of treating the NPHET discussions with the utmost confidentiality and appealed to all those present to respect this strict requirement.

   The Chair acknowledged that today’s meeting would be longer than usual, given the size of the agenda, and thanked members in advance for their understanding.

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 2,278 cases have been notified in the 7 days to the 24th November 2020, compared with 2,895 in the 7 days to 17th November 2020, representing a 21% decrease;
   - As of 24th November, the 7- and 14-day incidence rates are 48 and 108 per 100,000 population, respectively; these compare with the 7- and 14- day incidence rates of 173 (21st October) and 310 (26th October), respectively;
   - Nationally, the 7-day incidence as a proportion of 14-day incidence is 44%, demonstrating that there have been fewer cases in the 7 days to 24th November than in the preceding 7 days to 18th November;
   - The 5-day rolling average has decreased from a peak of 1,204 on 21st October to 292 on the 24th November;
   - 64% of cases notified between 10th November and midnight on 24th November have occurred in people under 45 years; the median age for cases notified between those dates is 35 years;
   - The proportion of cases notified in the over 65-year age group is stable. In the last 7 days to 24th November, 12.3% of cases notified were aged over 65 years. This compares with 12.9% of cases notified in the previous 7 days; however, high incidence in older persons continues to be observed overall;
   - We continue to see a high proportion of infections in healthcare workers who account for 13% of all reported cases in the last 14 days. In the week from 15th November to 21st November, 70% of cases associated with healthcare workers were located in acute hospitals or nursing homes;
• There has been a reduction in the national 14-day incidence, however, 7 counties have a 7-day incidence as a percentage of 14-day incidence greater than 50% indicating an increase in cases in the 7 days to 24th November compared to the preceding 7 days to 18th November;
• The daily growth rate of the disease has disimproved from around -5 to -7% (rapid decline in cases) to approximately zero in the 7 days to the 24th November;
• The best estimate of the reproduction number (R) is currently 0.7 to 1.0;
• A total of 77,919 tests were undertaken in the last seven days. The 7-day average test positivity rate has decreased from 3.9% to 2.7% in the 7 days to 24th November;
• Excluding serial testing, the positivity rate is estimated to be 4.7% in the 7 days to 24th November;
• There are currently 269 confirmed COVID-19 cases in hospital, compared with a peak of 354 on 27th October. The 7-day average of daily newly confirmed cases in hospital is 12, compared with a peak of 28 in the week to 28th October. The total number of cases in hospital has stabilised but is not decreasing;
• There are currently 36 confirmed cases in critical care, compared with a peak of 47 on 1st November. The 7-day average of daily admissions to critical care is 2, compared with a peak of 3 in the week to 1st November. The total number of cases in critical care has stabilised but is not decreasing;
• As of 24th November, there have been 94 deaths notified with a date of death in November. This compares with 37 and 119 deaths notified (to date) with a date of death in September and October, respectively. Of the 94 deaths that have occurred in November, 37 are associated with nursing homes and 26 are associated with hospital outbreaks.

Further relevant information includes:
• 772 additional new clusters were notified in the week to midnight 21st November 2020 (week 46). There are 5,639 open clusters nationally;
• In the week to midnight 21st November, 52 open clusters were associated with nursing homes and community hospital/long-stay units and there were 53 open clusters within acute hospitals;
• There were 5 new clusters notified in nursing homes/community hospitals with 19 linked cases, a reduction on the previous week (140 cases); there were also 8 new clusters notified in acute hospitals with 28 linked cases;
• 20 new outbreaks in workplace settings were notified in week 47, there are currently 121 open outbreaks in workplaces;
• There were 19 new outbreaks in schools (this does not necessarily indicate that transmission in the school setting was strongly suspected) with 53 linked cases in the last week;
• A range of mobility data suggest that current measures have resulted in reduced mobility in the population in recent weeks following the introduction of Level 5 measures, but at higher levels than in Spring 2020;
• The average number of close contacts has decreased from approximately 5-6 per confirmed case at the end of September to approximately 3.5 per confirmed cases in late October/early November; this indicator has increased to 3.8 per confirmed case in the seven days preceding 22nd November;
• As of 24th November, the 14-day incidence per 100,000 population in Northern Ireland is 327 cases, this is more than 3 times the 14-day incidence in the Republic of Ireland, which is currently 106 per 100,000 population. The 7-day incidence per 100,000 population in Northern Ireland is 130 cases, this is more than 2.5 times the 7-day incidence in the Republic of Ireland, which is currently 48 per 100,000 population;
• The latest estimates for week 46 from EuroMOMO show substantial overall excess all-cause mortality for participating European countries, coinciding with a reported increase in COVID-19 cases in several countries. This is driven by a very substantial excess mortality in some countries, while other countries observe normal mortality levels. The excess all-cause mortality is seen primarily in the age group of 65 years and above, but also in the age groups of 15-44 and 45-64 years. To date, during wave 2 there has been no excess all-cause mortality observed in Ireland.
The Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) gave insights on the predicted epidemiological patterns of the disease. It was outlined that it is difficult to discern with certainty (i) the effect of any specific public health intervention on viral transmission and incidence of infection or (ii) the rate of transmission or population average reproduction number that might be associated with any given level of restrictive measures set out in Resilience and Recovery 2020-2021: Plan for Living with COVID-19. Correlation and temporal association do not necessarily imply causation, there are important confounding factors, and it is clear that the relationship between the formal public health measures and the human behaviours that lead to viral transmission are complex.

The best indicator for the level of close social contact in the population is the number of close contacts per case. Using this indicator, in combination with behavioural survey data, suggests that the population anticipate changes in measures and adapt their behaviour accordingly, certain conclusions can be drawn:

- The current restrictions which are broadly equivalent to Level 2 appear to be associated with a reproduction number (R) in the range of 1.2-1.6;
- Level 3, with hospitality closed, as applied to Dublin and Donegal appears to be associated R in the range 0.9-1.2;
- Level 5 appears to be associated with R of 0.6-0.9.

The Chair of the IEMAG explained that it is not possible to determine the effect of the additional restriction of prohibiting visits between households within Level 3 on viral transmission, given that the measure was applied in a dynamic situation and for a 6-day period only.

Based on these insights, the Chair of the IEMAG outlined different modelling scenarios in the event that restrictive measures are eased from 1st December 2020. At the outset, it is important to recognise that should cases begin to rise again at a point in the future, early intervention is essential to bring the virus under control. Based on previous modelling work, it was outlined that a 3-week period of restrictions would bring the virus back under control only if it begins as soon as case numbers approach 400 cases per day. Using this number as a benchmark, it is possible to roughly project in different modelling scenarios when this threshold might be reached. It was outlined that this modelling data accounts for a certain amount of increased socialisation typical of the Christmas period, which could see R increase substantially to roughly (R)=2. This depends on the background (R) in the weeks leading up to Christmas:

- The model predicts that, if R is in the range of 1.4 o 1.6, there will be a rapid acceleration of the disease, with exponential growth beyond 400 cases per day in very early January 2021;
- In a more controlled scenario where R is held at 1.2 in the weeks preceding the Christmas period, followed by a quick return to 1.2 from 7th January onwards, modelling still suggests that the level of disease in January would present a real and substantial threat to the ongoing protection of public health and the most vulnerable, the protection of health and social care services (including non-COVID care), and the protection of schools and the education system.

The Chair of the NPHET highlighted the importance of the above input as part of the NPHET’s ongoing communications with the public and with Government. The Chair particularly noted the differences in the epidemiological data informing the NPHET’s deliberations around the lifting of restrictions between the end of the first wave of COVID-19 in Ireland and now. The epidemiological data currently predicts that Ireland will end its Level 5 restrictions with a significantly higher 5-day average case count than at the end of the period of stricter restrictions in May.

There was discussion about the nature of the epidemiological model and the predictions it was generating. Members remarked on the significant number of cases and deaths avoided due to the public’s collective response during the Level 5 period, which reduced the reproduction rate. Based on the model’s predictions, it was remarked that had R remained at its pre-Level 5 number, case counts would have risen to a level whereby the number of hospitalisations would have exceeded available capacity.
It was explained that, according to current modelling, it would be early January by the time single digit case counts might be observed. It was outlined that, given that the current R estimate is influenced by the behaviour of the R estimate during the summer months (which does not account for the increased socialisation and travel typically seen during Christmas/Winter period), the model’s predictions show the ‘best case scenario’ for how the disease may behave at different case projections. It was explained that it would not be suitable to factor seasonality of COVID-19 into the epidemiological model at this time, given that the level of immunity present in the population is a key factor that contributes to the seasonality of all respiratory viruses; however, no such immunity to SARS-CoV-2 exists at present.

The NPHET also drew attention to the issue of nosocomial (hospital-acquired) infection. The data indicates that as community transmission reduced during the Level 5 period, the number of infections in hospital settings increased. It was remarked that some of these settings are difficult to manage in terms of infection prevention and control, and further action is needed to prevent COVID-19 becoming a long-term issue in some hospital settings.

(i) Rates of infection per occupation
The HPSC presented the paper “Request for breakdown of sectors of employment for COVID-19 positive cases”.

The HPSC explained that there are challenges to collecting occupation data, and the report comprises a sample of cases for which occupation data was available. Based on this sample, the rates of infection per occupation are consistent with what has been observed in previous outbreak reports. For example, ‘healthcare and related workers’ comprise 11.2% of occupations infected based on this sample, followed by ‘students including schoolchildren’ at 9.2%. Further work is required to develop a more comprehensive picture of these data.

The NPHET noted the usefulness of this paper and further suggested that percentage of cases in each profession should be expressed per 100,000 of the occupation in order to develop a greater understanding of the relative magnitude of contribution from different occupations to overall infection. The Chair welcomed this suggestion and proposed that work be undertaken in cooperation with the DOH Statistics and Analytics team in this vein.

(ii) Trends in Nosocomial Infection in HCWs
The HSE presented the paper “Epidemiology of COVID-19 in Acute Hospitals”.

The HSE outlined that since June 2020 it has instituted a weekly reporting process for patients with hospital acquired COVID-19 and is also analysing data extracted from CIDR to monitor trends in diagnoses of COVID-19 in staff working in acute hospitals. There were small numbers of cases of either hospital acquired COVID-19 in patients or of COVID-19 diagnoses in hospital staff during the summer months but there has been a marked increase in these infections over the last number of weeks. It was outlined that the trends mirrored those of increased community transmission.

The increase is a cause for concern because of the health impact on patients and HCWs themselves. There are also concerns regarding the ability to sustain services because of the impact of COVID-19 diagnoses and of COVID-19 contact status on the availability of hospital staff for work. Throughout the year, hospitals have implemented a range of Infection Prevention Control (IPC) measures as per HPSC guidance to reduce the risk of COVID-19 transmission in hospitals, and to improve the detection and management of outbreaks in association with Public Health Departments. These measures, outlined in detail in the paper, include clinical assessment and testing of patients before, or on presentation for admission, supporting staff to stay away if symptomatic, rapid testing of symptomatic staff, and ongoing support for good IPC practice in clinical areas and good practice in non-clinical areas to reduce spread.
The Chair welcomed the update and echoed the need to take action to reduce nosocomial infection in hospital settings so as to prevent COVID-19 from taking root in these settings as community transmission subsides.

**b) Comparative analysis of Ireland vs International Wave 1 & Wave 2**

The DOH presented the paper “Comparative analysis of European COVID-19 epidemiological situation across infection waves 1 and 2 with a focus on severe health outcomes (hospitalisations, critical care, and mortality)”. Its findings can be summarised as follows:

- As with many countries across Europe during wave 1 in Spring 2020, Ireland experienced substantial COVID-19 transmission with consequent morbidity, mortality, and impact on acute hospital and critical care;
- Following the introduction of significant population-level restrictions in response to wave 1, Ireland followed a similar disease trajectory to many other European countries during the summer, with low case numbers growing consistently from August to significantly elevated levels of community transmission in late October, particularly in younger age groups;
- This was followed by increased incidence in older age groups, hospitalisations, critical care admissions, and sadly, deaths;
- After the introduction of Level 5 measures, Ireland diverged from European neighbours in terms of disease trajectory. Since then we have seen a substantial reduction in disease incidence commensurate with a stabilisation or reduction in terms of hospitalisations, critical care admissions, and deaths;
- It is reasonable to conclude, given the disease trajectory/modelling prior to the application of Level 5 measures along with the trends seen in many other European countries in recent months, that Ireland averted substantial disease transmission and its associated morbidity, mortality, and pressure on healthcare capacity and delivery;
- In addition to the implementation of population-level restrictions, other contributory protective factors may include, but are not exclusive to, the enhanced behavioural changes in vulnerable population groups (e.g. older persons) and the various infection, prevention, and control measures implemented across a range of vulnerable settings since the onset of the pandemic, which have been continuously strengthened over recent months.

The NPHET welcomed the paper and remarked on the significant differences in Ireland’s disease trajectory in wave 2, and the resulting numbers of cases, hospitalisations, and deaths, in comparison to other European countries.

**3. Review of Existing Policy**

**a) Health System Preparedness**

The DOH presented the paper “NPHET- Joint Department of Health and HSE Update - Health System Preparedness for COVID-19, 25th November 2020”, which set out a high-level summary of the current position on the delivery of health services, COVID and non-COVID, across the health system, to inform the NPHET’s consideration of the next steps.

Key points considered included capacity and surge planning, ensuring continued access to healthcare services (including non-COVID care), and the anticipated impact of investment in the health sector as planned in Budget 2021.

The paper noted that the level of COVID-19 in the community will inevitably be a key determinant of the level of care that can be delivered across all settings, and of the associated risk to both HCWs and service users:
• Notwithstanding good Infection Prevention Control (IPC) practice, increased community transmission would be likely to drive outbreaks in hospitals and residential care facilities, resulting in closure of services where necessary;
• Where outbreaks occur, these services are impacted by the loss of staff on COVID leave; other services are impacted due to the redeployment of staff;
• Any necessary redeployment of staff to respond to urgent COVID needs would impact the level of non-COVID care that can be delivered;
• Significant numbers of COVID cases would lead to increased demand for primary and acute health services, displacing non-COVID care and potentially leading to an overwhelmed system, in which quality care is not delivered and outcomes are poorer;
• Irrespective of infection rates, services have had to be reconfigured to provide for the necessary physical distancing and IPC requirements, with a resultant impact on levels of service available;
• All health and social care services have to be provided in a COVID context irrespective of the rate of transmission.

The DOH concluded that COVID-19 has presented an unprecedented challenge to the operation of the health system across all services. Moreover, this challenge has presented itself in a myriad of ways, including business capacity, staff capacity, delivery models, infection prevention and control, and staff safety. The system, and those who work within it, are strained. The priority must be to maximise the provision of services across all areas of service need in order to support attainment of the best possible outcomes across the population in the short, medium, and long term.

The DOH emphasised that high levels of community transmission increase the number of COVID-19 patients in hospitals. This leads to staff shortages and, if a critical point is reached, the health system becomes overwhelmed which impacts all other non-COVID services. The ECDC guidance on residential care supports the idea that unless community transmission is suppressed, it will be impossible keep COVID-19 out of Long-Term Residential Care Facilities.

The DOH addressed the issue of mental health and confirmed that this area is being closely monitored. In relation to the impact of the pandemic on the wider mental health of society, trends, including for suicide and self-harm, are not yet showing any significant change compared to 2019 local and international data.

The HSE noted that while it welcomes the significant investment in the health services planned for 2021, there are significant challenges in recruitment and implementation still to be faced. It will take time for the HSE to recover in areas of service that were impacted by COVID-19 before the benefits of investment become fully apparent.

The HSE stressed that every health service provided must be looked at in the context of COVID-19 as it impacts all areas. The ICGP and the DOH supported this point, particularly in relation to General Practitioners, who in addition to providing their regular practice are also key to providing COVID-19 related services. Regarding potential increases in testing and the rollout of the vaccination programme, the HSE warned that these were going to further divert resources and staff from regular services. Diverting the necessary resources to these programmes will be more difficult if the virus is not supressed effectively over the winter period.

The NPHET noted that non-COVID care must continue to be protected as one of the NPHET’s primary objectives. The focus for the remainder of this year and into 2021 must be the concurrent delivery of both COVID-19 and non-COVID care in order to maximise the volume of non-COVID care and recover any lost delivery. The NPHET acknowledged the great resilience of the healthcare system but also stressed the fine line between resilience and fragility. The NPHET acknowledged the work carried out to protect the healthcare system to date, a feat that many other countries have not been able to achieve. However, the NPHET warned
that scaling back staff to minimal levels over the Christmas period poses a real danger this year and stressed that the system must be in a position to respond as if at any other time of the year.

b) Review of control measures at local level
The HSE updated the NPHET on its ongoing review of control measures at local level. A report will be presented to the NPHET at the next meeting, 3rd December, which assesses the speed of deployment and robustness of local control measures according to outbreak setting and population cohort.

The NPHET thanked the HSE for its update and emphasised the importance of carrying out a thorough review as control measures at local level will be a key measure to protect against any potential surges in the future.

c) Updated Contact Tracing Strategy
The HPSC presented the paper “National Guidelines for the Public Health management of close contacts of cases of COVID-19”.

The paper was informed by recently published HIQA, ECDC, and CDC guidance and outlines recommendations for the public health follow-up and management of contacts of confirmed cases of COVID-19. The HPSC informed the NPHET that the document is not yet finalised and that it welcomes any feedback or suggestions.

The NPHET welcomed the work carried out so far and asked that the finalised paper be presented next week for formal endorsement.

The Department of Health raised concerns about the lack of active follow-up and support for close contacts and cases once the contact tracing process is complete. It also emphasised the importance of completing an exposure investigation for each case and stated that this, along with retrospective contact tracing, should become standard practice.

The NPHET noted with concern the accessibility issues with the Contact Management Programme (CMP) system. The NPHET noted that ECDC guidance recommends that secondary contacts should also be advised to restrict their movements and emphasised that strong reasons would need to be put forward for not following that advice in Ireland. THE NPHET requested that the HPSC highlight areas of divergence from ECDC guidance clearly in its final paper. The NPHET further noted the need for a risk assessment on masks.

d) Nature of Outbreaks: Hospitality Sector
The HPSC presented the paper “Information Note on Hospitality and Social Settings, 25th November 2020”, which reviews evidence in relation to the risks associated with hospitality settings, discusses the current evidence arising from cases in these settings in Ireland, and outlines some of the additional measures that the NPHET may wish to consider if hospitality reopens.

The NPHET recognised that caution must be taken when interpreting the available data on outbreaks associated with the hospitality sector, stressing that such data may underestimate the level of transmission of COVID-19 in hospitality settings. The NPHET noted the various possible reasons for this, namely: Public Health resources being deliberately directed to investigating outbreaks in vulnerable settings, and the higher threshold that exists for declaring an outbreak in the hospitality sector.

The IEMAG presented data showing that outbreaks in the hospitality sector often precede a more widespread surge in cases. These initial outbreaks appear to seed transmission in other social settings.
The NPHET thanked the HPSC for this information note and stated that any further advice relating to the hospitality sector would be informed by it.

e) Update from behavioural group including Amárrach data

The DOH presented the ESRI research note “Survey Evidence on Attitudes, Plans and Expectations for Christmas 2020”. The paper digests survey evidence collected on 9th and 16th November 2020 which gives insight into public opinion on some of the dilemmas posed by Christmas in the context of the COVID-19 pandemic. The paper provides evidence that the public’s social plans for Christmas are already underway and quantifies some relevant expectations held by the public for the festive period.

The paper concludes that while people are concerned about not seeing friends and family, a clear majority of the public want a cautious approach to predominate most aspects of Christmas 2020. The paper maintains that simple, clear, and consistent messaging is important when communicating with the public. It also advises that people are more likely to cooperate with measures if they understand the connection between behaviour and outcome and if they believe that the majority of others will also engage in the behaviour.

The NPHET welcomed the ESRI’s research note and findings, the import of which will frame the NPHET’s advice to Government. The NPHET also noted how people’s expectations around the availability of a COVID-19 vaccine could potentially impact on their level of compliance with public health measures in the future, emphasising that communications will need to account for this going forward.

f) Updated visitation guidance for LTRC

The HSE presented its draft guidance “COVID-19 Guidance on visitations to Long-Term Residential Care Facilities, 24th November 2020”. The guidance provides an updated framework, in which visitation to Long-Term Residential Care Facilities (LTRCFs) can occur in a more regular fashion, whilst protecting residents, staff, and visitors from risk of infection.

The HSE confirmed that the draft guidance document has been updated to redefine critical and compassionate circumstances and to clarify a number of additional points that have emerged as questions since the previous version of the guidance was issued.

The NPHET thanked the HSE, endorsed the amendments made in the draft guidance, and confirmed that implementation should proceed. THE NPHET also thanked the Chief Clinical Officer of the HSE for initiating the process that led to this piece of work being completed and acknowledged the contributions provided by all those involved.

Action: With regard to the general wellbeing of those living within long-term residential care the NPHET agreed updated and enhanced visiting guidance where, for critical and compassionate grounds, residents can receive a weekly visit by one person at Levels 3 and 4 and a fortnightly visit by one person at Level 5. In line with operational advice these should come into effect on 7th December.

4. HIQA - Expert Advisory Group

a) Scoping review of evidence on use of face masks in the community

The HIQA presented the paper “DRAFT Addendum to ‘Evidence summary for face mask use by healthy people in the community, 21 August 2020: 24th November 2020’, outlining its up-to-date advice regarding the
evidence available to indicate that routine wearing of face masks in the community reduces the transmission of SARS-CoV-2. The paper is an addendum to a previous HIQA evidence summary published in August 2020 and takes into account expert interpretation of the available evidence by HIQA’s COVID-19 Expert Advisory Group.

Based on the evidence presented and practice on other countries, the NPHET recommended:

• The use of face masks (not visors) in all communal areas in indoor workplaces, including shared offices, corridors, and other shared workspaces;
• The use of face masks (not visors) in all places of worship;
• The use of face masks (not visors) in busy or crowded outdoor spaces, where there is significant congregation and where social distancing may not be possible, including busy shopping areas.

The NPHET agreed that a clear and comprehensive communication campaign should be implemented to increase public awareness of the updated guidance on face coverings. The provision of information on the correct disposal of masks should also be considered.

5. Future Policy

a) Protection of HCW/analysis of testing in Healthcare settings

The HSE presented the paper “Enhanced measure for the control of spread of COVID-19 in Acute Hospitals”.

The paper provided information under the following headings:

• Epidemiological overview of COVID-19 cases among Healthcare Workers in Ireland;
• Measures in place to reduce the risk of virus introduction in acute hospital settings;
• The response to detection of a hospital acquired cases of COVID-19 or an outbreak;
• Measures in Place to Reduce the Risk of Virus Spread if Introduced into Acute Hospital Setting;
• Implementation of Key COVID-19 Control Measures Across Acute Hospitals in Ireland;
• Additional Measures to reduce the Risk of Virus Introduction in Acute Hospital Setting;
• Additional Measures to Reduce the Risk of Virus Spread if Introduced into Acute Hospital Setting;
• Current Testing Approach in Acute Hospitals.

The paper noted that there are approximately 75,000 healthcare workers in the acute sector, and, therefore, serial testing of all HCW is logistically challenging and could require diverting resources away from other areas. Identification of those who should be tested poses challenges and requires consideration of risk to individual patients and healthcare workers, as well as consideration of risk posed by particular practices and settings. When available, results from Rapid Antigen Detection Test Validation Exercises and the seroprevalence study among healthcare workers in two large acute hospital sites may provide additional evidence in this regard. It was suggested that it may be appropriate to target scheduled testing of asymptomatic staff groups towards those who may pose additional risk due to frequent movement between hospitals/wards/patients, for example pool or agency staff and certain healthcare students on placement.

The paper also provided an update on the evaluation of Rapid Antigen Detection Testing (RADT) for SARS CoV-2 in healthcare workers and the pilot evaluations that are due to be initiated.

The NPHET welcomed the paper but raised concern about the ability to collect occupational health data, noting that this dataset needs to be developed. A second point was also raised about the need to better define who should make decisions with regard to testing. There is further work to be done on evaluating the use of rapid Antigen Testing in healthcare workers.

The NPHET requested that this paper be returned at the next meeting, 3rd December, for decision.
b) International Travel

The DOH presented the paper “International Travel”, which provided an update on the epidemiological situation internationally and the risks associated with increased international travel in the context of the potential for increased travel into, and out of, Ireland over the Christmas and winter period.

The paper highlighted that international travel presents a continued significant risk, particularly in the context of the anticipated increase in volume over the Christmas period. The progress made in suppressing domestic transmission and reducing case numbers under Level 5 restrictions could be eroded through the importation of cases. The level of risk is reflected in the travel policies adopted across the EU, which generally continue to be more stringent than those applied in Ireland. Globally, the countries that have had the most success in controlling transmission – Australia, New Zealand and countries in South Asia – have exercised close control over the management of risks associated with the importation of cases through travel.

The paper set forth the following:

- The NPHET continues to advise that people in Ireland should be encouraged to avoid non-essential travel outside Ireland and that all measures be utilised to discourage travel from overseas to Ireland.
- Given the continuing risks associated with travel and the desire to enable the country to safely transition from Level 5 restrictions, it is recommended that Government continue to advise against non-essential travel during the upcoming holiday season.
- That passengers travelling into Ireland are asked to strictly adhere to the advice to restrict their movements for 14 days if they do not avail of testing. In addition, the advice should also be clear that the period of restricted movements should only end once they have received a ‘not detected’ result, and not from the point the test is taken. Furthermore, for those who arrive with a ‘not detected’ test result taken in the 72 hours pre-departure, it is important that they exercise caution and be aware that such a result does not mean that they are not incubating the virus.
- Given the profile of the disease in Europe, there is also a significant risk to travellers leaving the country to visit areas of high incidence and subsequently returning to Ireland. These travellers should also be made aware of the advice to restrict movements for 14 days on return, or to avail of testing. Given that that implementation of the traffic-light approach provides an exemption from advice to restrict movements if there is an imperative family or business reason, it is recommended that Government communicate that this should be confined to limited situations, such as travel for a funeral or other essential reasons. This would mean that travel to visit family or friends is not considered an imperative reason.
- That public health messaging for the coming weeks include communications targeted at people who come to Ireland over the Christmas/New Year period, advising them of the need to follow public health advice generally and, in particular, to limit their interactions with family members and friends, especially where persons are at particular risk should they contract COVID-19.

The NPHET expressed concern that international travel will lead to the importation of cases and undermine the progress achieved thus far and supported the above recommendations in recognition of the moral imperative to protect the health system and those most vulnerable. The NPHET was reminded that many countries have implemented mandatory guidelines, while Ireland’s guidelines remain advisory.

The NPHET advised against all non-essential travel to and from Northern Ireland due to the continued high incidence of disease.
c) Transition from Level 5 Measures

It is important to note that the evidence and data presented under the preceding agenda items informed the discussion under this item; the agenda was set out in a manner that facilitated this approach.

The DOH presented the proposed advice to Government on transitioning from Level 5 measures to the NPHET for agreement, noting the aspects for which consensus must be reached at this meeting.

The DOH updated the NPHET on international developments with regard to the lifting or imposing of restrictive measures for the upcoming holiday period in France, Germany and the UK.

The proposed phased approach:

- Application of Level 3 measures on a national basis for an 8-week period (2nd December 2020 to c. 27th January 2021).
- A further easing of some specific measures on a time-limited basis to enable close family and friends to meet over the Christmas/New Year holiday period.
- A return to Level 3 measures following the period as a proactive strategy, with a formal assessment of the position towards the end of January.

In recognition of the flexibility provided for in the 5-Level Framework, the DOH noted that the specific measures to be recommended for private homes and hospitality are to be discussed and agreed upon.

The NPHET were reminded of key messages from previous discussions on 5th, 12th and 19th November:

- The situation remains fragile and there is a risk of jeopardising the progress made over recent weeks.
- The need to protect the core priorities.
- The importance of facilitating people to have as enjoyable a Christmas as possible, even if it will be different; the focus will be on close family and friends, keeping contacts to a minimum (core group), and meeting safely and outdoors.
- The inevitable increase in socialisation, inter-household and inter-generational mixing for concentrated periods presents a real risk, which must be managed as much as possible. This presents difficult decisions regarding measures, which can’t be relaxed in all areas.
- All population groups need to be considered.
- Messaging is as important as the measures and should focus on personal responsibility, empowering people and risk mitigation. Messaging should be clear and simple.
- Vaccine developments bring hope and should strengthen resolve.

In the ensuing discussion, members of the NPHET raised the following points while deliberating the specific measures to be recommended for private homes and hospitality in both Level 3 and the Christmas period:

- Members voiced support for a cautious approach to the upcoming period. Many cited the convergence of a number of important factors as the reasoning behind this, including the epidemiological situation, modelling data and projections, the likelihood of a third wave occurring in early 2021, and the risk of undoing the progress that has been achieved over recent weeks. Furthermore, January typically presents a challenging time for the health system, a system that has shown resilience but is also fragile. If the factors mentioned converge at this time, it will put the system under severe pressure to cope. A further point in favour of a cautious approach is the exit strategy employed following the first wave, the case count was much lower, and, at that time, retail opened prior to hospitality.
- Many raised concerns for healthcare workers across the board who have been working on the frontline of the pandemic since its onset, noting the negative effects of working at such consistently high stress levels throughout the Christmas period and January. Once again, the fine line between resilience and fragility was highlighted. It was stated that it is incumbent upon the NPHET to support and protect healthcare staff.
• The core priorities of preventing unnecessary disruption to non-COVID health and social care services, particularly given the impact on those services in the first half of 2020; protecting the medically and socially vulnerable people; and proactively protecting and averting significant disruption to childcare and education.

• Citing the above points, many members spoke against the reopening of hospitality for the upcoming period. In addition, members discussed whether restaurants could be considered controlled settings, and many noted that, while restaurants can be controlled environments when all necessary restrictive measures are in place and adhered to, the congregating that occurs when people go to and come from a restaurant can often be a source of transmission. However, other members drew attention to the potential for people congregating in private homes, which tend to be much less controlled environments, should hospitality remain closed. One member requested whether modelling data could show the projected outcome of opening hospitality. Concerns about ventilation, capacity, street drinking and congregating, and the potential for hospitality settings to be conducive to superspreading events were also raised.

• With regard to private homes, members urged caution for Level 3, with many in support of limiting visits to one other household (excl. Christmas/New Year period).

• The question of churches opening and religious services resuming was also discussed, with many recognising the importance of religious services for many at this time of year, but noting that churches present a high-risk environment for several reasons, including the potential for congregation and singing. It was also noted that the potential for close contact cases is higher in a church setting than retail due to time spent adjacent to others. However, it was noted that opening other sectors but recommending that religious services should not go ahead will be very difficult for people and may be disproportionate. Furthermore, it was highlighted that Ireland is a multi-cultural society with many religions celebrating various religious holidays this time of year.

• It was stated that success in the upcoming phases will depend on the clarity, consistency, simplicity and humanity of the messaging. Messaging should empower people to make safe decisions and should highlight high-risk settings and activities. In particular, the message should be conveyed that restricting movement prior to travelling across the country for Christmas is of the utmost importance to ensure as much as possible that one is virus free.

• The perception that Ireland has implemented harsher restrictions than other countries in Europe and internationally.

• The necessity for rules and guidelines to be logical and sensible to make it easy as possible for people to comply.

• The issues of supervision and regulation. Retail and hospitality, it was asserted, must have increased supervision and regulation than they have hitherto, and the element of self-regulation that people are expected to employ must be assisted with harm reduction measures that facilitate people to partake in activities in the least harmful way;

• The issue of sports and intercounty sports were also raised, as some counties were unable to complete their championships prior to the implementation of Level 5 measures.

• The concern that people will purchase rapid antigen tests online and self-test. It was highlighted that the NPHET must provide advice on this matter.

• It was reiterated that the purpose of the NPHET is to provide public health advice and the team must remain focused on the risk the virus imposes on the population.

Some members highlighted the perception that there was a “social contract” with the public, i.e. implementing Level 5 measures for 6 weeks would result in a more open, normal Christmas. The HSE raised concern about the potential reaction to keeping all hospitality closed and restricting home visiting considerably for the full duration of the upcoming 8-week period, noting that some of the options discussed may fall short of the public’s expectations as outlined in consumer research. Particular attention was drawn to the needs of people living alone or in varied family circumstances, for whom significant restrictions on household visiting could be more difficult or call for more options to be considered. The question was raised
of whether closed hospitality could lead to increased gathering in private homes or in public, without controls or staffing in place to support safety measures.

Following this, many members asserted that they were struck by these comments, noting that recognising and avoiding groupthink is highly important in such decision-making contexts.

To conclude discussion, the following was noted:

- The tendency of the disease to spread when people come on close contact, indicating that messaging should be that people avoid conditions conducive to the development of such clusters.
- Intergenerational risk when families come together over the holiday period.
- The 2-week Christmas/New Year period is longer and more open than that proposed in other countries and may require stricter measures in the following period.
- Christmas is a time to protect the most vulnerable, and this must be underpinned by the NPHET.
- Religious services present a risky environment but disallowing them to go ahead is disproportionate.
- Measures should be conservative over the coming weeks to allow the country to be in the best position possible for the Christmas/New Year period.

The Chair noted the importance of recognising that households will reform during the Christmas period as many people travel across the country to spend time with family and loved ones.

Taking the above into consideration, the DOH presented the points for consensus, as follows:

1. Hospitality.
2. Visiting private Homes.
4. Face Coverings.
5. Timeframe for Christmas period.

The Chair made a number of proposals:

- **Proposal: Move from Level 5 to Level 3 on 2nd December 2020.**
  This proposal was agreed to by the NPHET

- **Proposal: The following period will comprise 8 weeks to the end of January 2021.**
  This proposal was agreed to by the NPHET

- **Proposal: There will be an interval of 2 weeks in recognition of the Christmas/New Year period, which will see a variation on what will be in place over full 8 weeks, including lift on county restrictions to domestic travel.**
  This proposal was agreed to by the NPHET

- **Proposal: Adhere to measures set out in Level 3 for 8 weeks, excluding Christmas/New year period, with exception of those where flexibility is provided (Hospitality and Private Households).**
  This proposal agreed to by the NPHET

  - **Proposal: Hospitality to remain closed in Level 3 for 8 weeks, excluding Christmas/New Year Period, with delivery and takeaway permitted.**
    During deliberation, the recommendation to permit outdoor dining during summer and into autumn was highlighted. However, based on the data presented, the NPHET agreed to this proposal.
Proposal: Visits to private homes should be limited to one other household, up to a maximum of 6 visitors, for Level 3 from 2nd December, excluding Christmas/New Year period. This was agreed to by the NPHET following deliberation, during which the epidemiological data, evidence and behavioural research was further considered.

- **Proposal: Hospitality to remain closed during the 2-week Christmas/New Year period.**
  Some members spoke in favour of opening hospitality in some capacity, noting that restaurants can be considered a controlled environment when measures are in place and adhered to. Others voiced support for this proposal, citing the epidemiological data, evidence, the potential risk of people gathering in such high-risk settings and compliance concerns. On this basis, the NPHET agreed to this proposal.

- **Proposal: Visiting limited to a maximum of 6 visitors from 3 other households for the 2-week Christmas/New year period.**
  On this point, many members highlighted that considerations need to be inclusive and mindful of types of households beyond the typical nuclear family. The NPHET agreed to this proposal, stating that messaging should inform the public that such gatherings should only take place a limited number of times throughout the period.

In making the above decisions, the NPHET had particular regard for the relationship between interhousehold mixing and opening hospitality, noting that both cannot take place without a serious risk to the disease trajectory in a short space of time. The priority is to facilitate people having a safe Christmas with close family and friends.

- **Proposal: Religious services to go ahead from 21st December 2020 to 3rd January 2021 with strict protective measures in place and the recommendation that face masks (not visors) be worn in all places of worship.**
  This proposal was agreed to by the NPHET on the basis that places of worship be included in face mask guidance.

- **Proposal: Extend face mask guidance to include all communal areas in indoor workplaces, including shared offices, corridors, and other shared workspaces; places of worship; crowded outdoor spaces where there is significant congregation and social distancing is not possible, including shopping areas.**
  This proposal was agreed to by the NPHET.

- **Proposal: The 2-week Christmas/New Year period will begin on 21st December.**
  This proposal was agreed to by the NPHET following a brief deliberation of an appropriate date.

This concluded discussion of the transition from Level 5 measures, with all recommendations and advice to be relayed to Government in the post-NPHET letter to the Minister for Health.

**Action:** The NPHET advises the application of enhanced Level 3 measures for an 8-week period from 2nd December to 27th January. Additionally, the NPHET advises a further easing of some measures for the Christmas/New Year period from 21st December to enable close family and friends to meet. Finally, it advised that enhanced Level 3 measures should be fully reinstated after the holiday period as a proactive strategy to mitigate, in so far as possible, the impact of inevitable increased levels of transmission over the holiday period.

**Action:** In addition to existing guidance on the use of face masks the NPHET recommends that face masks are now used in outdoor community settings, particularly in busy retail areas during peak shopping periods.
d) Public Health Response

The DOH presented a Public Health Response update. The update noted that speed across the continuum of the public health response is particularly important due to particular characteristics of SARS-CoV-2, including its propensity to be spread by asymptomatic and pre-symptomatic individuals and emerging strong evidence of the relative importance of cluster infections and superspreading events as potentially critical contributions to the rapid evolution of transmission. An overt focus on public health responsivity and resilience at a local level is now required as this will be critical to the robust prevention and suppression of any future escalation in cases.

The following key principles required to underline and further enhance the ongoing public health operational response were outlined:

1. *Streamlined national governance and organisational model, with vertical and horizontal integration, and a focus on a robust regionalised response.*
2. *A public health-led response with appropriately devolved leadership, responsibility and accountability, and resourced as such.*
3. *Integrated IT systems and data. With a focus on ensuring access to data and resources to facilitate analysis and intelligence-led action at local level.*
4. *Community engagement and partnership, with promotion and empowerment of voices to actively inform and engage at local level.*
5. *Performance measurement to facilitate assessment within and between regions, with indicators which reflect the continuum of the public health response.*

The NPHET agreed to the above principles and, following discussion, a set of supporting actions were outlined and discussed. The NPHET requested further engagement between DOH and the HSE, with a view to ensure the implementation of those actions in the short-term, thereby supporting the continued development of a fast, dynamic, integrated and intelligence-led public health response organised at local level.

e) Antigen testing

This item was deferred to the next meeting of the NPHET, 3rd December.

f) Vaccination Programme

A paper setting out initial recommendations from the National Immunisation Advisory Committee (NIAC) identifying priority groups for any future SARS-CoV-2 vaccine was presented. The recommendations are subject to refinement as more evidence becomes available about COVID-19 disease and severe outcomes, SARS-CoV-2 vaccine safety, efficacy and effectiveness, virus transmission, and population immunity. The criteria used for the prioritisation exercise were outlined as was a sequential approach to vaccination including various priority groups.

In recognition that any vaccine allocation strategy has tangible implications for people’s health and quality of life and that such decisions are underpinned by ethical values, an allocation framework was presented by the Dept. of Health. The framework sets out a series of ethical principles and procedural values which can guide decision making on this issue.

**Action:** NPHET noted the content of the two papers and it was agreed that a consolidated paper be prepared for NPHET consideration. The paper will offer guidance on the prioritisation of groups for vaccination when vaccine supply is limited and provide a values foundation for the objectives of COVID-19 vaccination programme and links those to target groups for vaccination.
6. Communications
   a) Weekly Communications Update
   There was substantial communications discussion under Item 5(c). Nothing further was discussed under this item.

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

   b) AOB
      a. Education Settings: Mid-Term review; this item was not taken due to the length of previous discussions.

   c) Date of next meeting
   The next meeting of the NPHET will take place Thursday 3rd December 2020, at 10:00am via video conferencing.