# National Public Health Emergency Team – COVID-19
## Meeting Note – Standing meeting

<table>
<thead>
<tr>
<th><strong>Date and Time</strong></th>
<th>Thursday 3rd December 2020, (Meeting 66) at 10:00am</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
</tr>
<tr>
<td><strong>Chair</strong></td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
</tr>
</tbody>
</table>

**Members via videoconference**
- Dr Ronan Glynn, Deputy Chief Medical Officer, DOH
- 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 Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- 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 Colette Bonner, Deputy Chief Medical Officer, DOH
- Ms Yvonne O’Neill, National Director, Community Operations, HSE
- Mr Phelim Quinn, Chief Executive Officer, HIQA
- Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- 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
- Prof Mary Horgan, President, RCPI
- Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)

**‘In Attendance’**
- Mr Gerry O’Brien, Acting Director, Health Protection Division
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- 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**
- Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
- Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital
- Ms Rachel Kenna, Chief Nursing Officer, DOH
- 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
1. Welcome and Introductions
   
a) **Conflict of Interest**
   Verbal pause and none declared.
   
b) **Minutes of previous meetings**
   The minutes of 5th and 12th November had been circulated to the NPHET in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.
   
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 1,928 cases have been notified in the 7 days to 2nd December 2020, compared with 2,168 in the 7 days to 25th November, representing a 11% decrease;
   - As of 3rd December, the 7- and 14-day incidence rates are 40 and 85 per 100,000 population, respectively; these compare with the 7- and 14-day incidence rates of 48 and 108 respectively, reported on 24th November;
   - Nationally, the 7-day incidence as a proportion of 14-day incidence is 47%, demonstrating that there have been fewer cases in the 7 days to 2nd December than in the preceding 7 days to 25th November;
   - The 5-day rolling average has decreased slightly from 293 on 24th November to 275 on 2nd December;
   - 66% of cases notified between 18th November and 1st December have occurred in people under 45 years; the median age for cases notified between those dates is 34 years;
   - The proportion of cases notified in the over 65 age group is stable. In the last seven days to 2nd December, 12% of cases notified were aged over 65 years;
   - We continue to see a high proportion of infections in healthcare workers, who account for 11% of all reported cases in the 14 days to 2nd December;
   - Incidence rates in County Donegal remain high relative to the rest of the country. As of midnight 1st December, the 14-day incidence in Donegal is 212 per 100,000 population, which is 2.5 times the current national 14-day incidence rate of 85 per 100,000 population;
   - There has been a reduction in the national 14-day incidence, however, 14 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 2nd December compared with the preceding 7 days to 25th November;
   - As of 3rd December, the daily growth rate of the disease is estimated at between zero and -3%;
   - As of 3rd December, the best estimate of the reproduction number (R) is currently 0.8 to 1.0;
   - A total of 74,647 tests were undertaken in the 7 days to 3rd December. The 7-day average test positivity rate has remained stable at 2.7% since 24th November;
   - Excluding serial testing, the positivity rate has also remained stable over the last week and is estimated to be 4.2% in the 7 days to 3rd December;
   - As of 3rd December, there are currently 234 confirmed COVID-19 cases in hospital, compared with 269 on 25th November. There have been 23 newly confirmed cases in hospital in the preceding 24 hours;
As of 3rd December, there are currently 32 confirmed cases in critical care, compared with 36 on 25th November. There have been 2 new admissions in the previous 24 hours; the total number of cases in critical care has stabilised but is not decreasing;

As of 3rd December, there have been 140 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 140 deaths that have occurred in November, 41 (29%) are associated with nursing homes and 46 (33%) are associated with hospital outbreaks. There has been 1 death reported in December as of midnight, 1st December.

Further relevant information includes:

- 348 additional new clusters were notified in the week to midnight 28th November 2020 (week 48). There are 5,524 open clusters nationally;
- In the week to midnight 28th November (week 48), 54 open clusters were associated with nursing homes and community hospital/long-stay units;
- In week 48, there were 6 new clusters notified in nursing homes/community hospitals with 40 linked cases;
- In week 48, there were 10 new clusters notified in acute hospitals with 94 linked cases;
- As of 3rd December, there are currently 60 open clusters associated with 24 acute hospitals. Approximately 1,000 cases have been linked to these outbreaks;
- There were 21 new outbreaks in workplace settings notified in week 48 with 44 linked cases, there are currently 135 open outbreaks in workplaces;
- There were 12 new outbreaks in schools in week 48 (this does not necessarily indicate that transmission in the school setting was strongly suspected) with 19 linked cases;
- A range of mobility and compliance data suggest that movement and social contact in the population has increased in recent weeks;
- The average number of close contacts 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 7 days up to 3rd December;
- As of 2nd December, the 14-day incidence per 100,000 population in Northern Ireland is 283 cases; this is more than 3 times the 14-day incidence in the Republic of Ireland, which is currently 87 per 100,000 population. The 7-day incidence per 100,000 population in Northern Ireland is 136 cases; this is more than 3 times the 7-day incidence in the Republic of Ireland, which is currently 40 per 100,000 population.

The NPHET noted the progress made during the period in which Level 5 measures were in place with significant suppression of viral transmission. The NPHET stressed that it remained concerned that the level of infection in the population is now static or decreasing slowly and noted that we are approaching the Christmas period with a significantly high force of infection and healthcare burden. The NPHET also noted that measures of mobility and contact appear to have increased in anticipation of the recent relaxation of Level 5 measures.

The number of hospital outbreaks in recent weeks, along with significant numbers of associated cases and deaths was also voiced as a matter of concern. The NPHET further observed a persistent and delayed incidence in healthcare workers. There also remains a substantial disease burden in the acute healthcare system with the trend in hospitalised COVID-19 cases decreasing slowly against high absolute levels. The number of confirmed cases in intensive care and deaths associated with COVID-19 are not reducing substantially. Persistently high incidence in older age cohorts continues to be observed; this population is most vulnerable to morbidity and mortality associated with the disease.

The IEMAG presented updated modelling data to the NPHET, highlighting at the outset that model projections of the likely future trajectory of the disease have worsened over the last week, as it has become clear that case counts are unlikely to fall below 200 cases per day. Current projections for a reproduction
number (R) held at 1.2 to 1.4 through the Christmas and New Year period suggest that there would be between 300 and 600 cases per day in the second week of January 2021. This is likely a conservative projection. It will be challenging to maintain R below 1.4, and it is possible that a major increase in close social contact, and especially a greater diversity of contacts, during Christmas and New Year would lead to much higher levels of viral transmission than have been seen to date. This has been modelled by superimposing on the above scenarios a period from 22nd December to 6th January where R is increased to 2.0. This scenario projects 300-450 cases per day by New Year’s Day and 800-1200 by the second week of January 2021.

The Chair voiced his concern about the speed of outbreak detection and response in acute settings, the Chair also posed the question whether a national outbreak control team has been established and if not, the reasons why?

The HSE[^1] highlighted that one of the core challenges faced by hospitals is isolating the virus quickly within the hospital and protecting staff in order to reduce the burden on the system. The HSE also referenced the existence of AMRIC which is the structure in place within the HSE to develop guidance and oversee the implementation of infection control policies. The HSE pointed to some areas in need of improvement in hospital infrastructure and isolation capacity. While some facilities are well-equipped to deal with isolation requirements along with occupational health needs, there are other hospitals that are not. These deficiencies have been exacerbated by the pandemic.

The HSE stated that Public Health departments have been responding as rapidly as possible with the information that is available to them. The HSE highlighted issues with the coordination of information as well as unfilled senior clinical vacancies within Departments of Public Health as factors influencing the speed of response. The HSE further highlighted the difficulties caused by deficiencies in the current IT infrastructure, which requires investment to allow for better integration of outbreak management and Occupational Health IT Systems.

The HSE confirmed that it was in the process of collecting information on the role of Public Health in outbreak settings across all regions and stated that the feedback received to date indicates that the role varies greatly from region to region. The HSE explained that while Public Health staff are present to offer advice and help with decisions, they do not lead the response in facilities. The primary decision-making role rests with the hospitals themselves, who then choose the extent to which they follow Public Health direction.

The HSE updated the NPHET on the significant engagement from the Antimicrobial Resistance and Infection Control (AMRIC) team in relation to the recent outbreaks reported in hospitals in Letterkenny and Naas, particularly with regard to the provision of occupational health support.

The RCPI emphasised the importance of each hospital having an established written plan for how they will manage the rollout of testing for health care workers and patients.

The HSE acknowledged that the current system needs to be improved, while stressing the resource constraints that exist, particularly with regard to recruitment of additional staff.

The NPHET requested that the HSE provide a comprehensive report on how outbreaks in acute settings are currently being managed, along with details on staffing, outbreak management IT system(s), and investment. The NPHET requested that the report address whether any gaps remain where investment is still required. The HSE expressed the need to be cognisant of the fact that the easing of restrictions over the holiday period will most likely result in a surge in cases coming into January, which is an existing annual period of high pressure for the Health Services. Concern was also raised about the possibility of intergenerational

[^1]: References to the HSE in NPHET minutes relates to the staff of the HSE present at NPHET meetings and not the HSE Board which is the HSE in law unless otherwise stated.
transmission over the holiday period. If transmission to older age cohorts increases it will lead to an increase in hospitalisations and ICU admissions, this will put further pressure on an already burdened system.

The NPHET recognised that while maintaining low levels of virus transmission over the Christmas period would be challenging, a surge in cases was not inevitable. Success in mitigating the risk of a substantial increase in incidence would be dependent on a number of factors, including continued whole-of-Government communication aligned with the key public health advice, and a high degree of public cooperation with the recommended measures. Areas of particular concern over the coming weeks are the potential for intergenerational transmission, healthcare-worker morale, and the fact that managing COVID-19 over the winter period is a new and unique challenge. The NPHET understood that with each additional implementation of restrictions, it will become more challenging to secure the cooperation of the public.

3. Review of Existing Policy

a) International Travel

The DOH gave an update on ongoing work between the Department of Transport and the Department of the Taoiseach (DOT) on the provision of further advice to the public on international travel during the COVID-19 pandemic.

The DOH drew the NPHET’s attention to the technical report published by the ECDC and the European Union Aviation Safety Agency (EASA) on 2nd December titled, ‘Guidelines for COVID-19 testing and quarantine of air travellers - Addendum to the Aviation Health Safety Protocol’, which raised a number of concerns.

The NPHET thanked the DOH for its update and a number of members noted significant initial concerns with the ECDC-EASA report. The NPHET confirmed that it would consider the report at its meeting scheduled for 10th December and arrive at a formal view. In this regard, the Chair requested that the DOH prepare an analysis paper on the report for circulation to Members in advance.

In its wider discussion, the NPHET reiterated that it remains concerned that international travel over the coming period has the potential to rapidly undermine the progress achieved by the country in recent weeks.

The NPHET confirmed that its continuing recommendation is that the Government advise against all non-essential travel during the forthcoming holiday season. The NPHET stressed that it continues to recommend that those who must travel only do so in the limited situations advised, such as to attend a funeral, for essential healthcare reasons, or for imperative business reasons. All discretionary travel should be discouraged.

The NPHET further stressed that for those who proceed to travel into Ireland, it remains the NPHET’s recommendation that such passengers are advised to strictly adhere to the public health advice to restrict their movements for 14 days if they do not avail of PCR testing before or after travel. Due to the risk associated with the transmission of the virus during conveyance and the incubation period of the virus, all passengers, irrespective of PCR-testing, should closely monitor for any symptoms and immediately self-isolate and seek medical advice if any symptoms do arise. In particular, passengers should be advised to limit their interactions with family members and friends, especially persons who would be at a particular risk should they contract COVID-19.

b) Updated Contact Tracing Guidance

The HPSC presented the paper “National Guidelines for the Public Health management of close contacts of cases of COVID-19, 1st December 2020” for the NPHET’s endorsement, along with an accompanying report titled “Rationale for why some advice in the ECDC contact tracing guidance has not been included in the proposed Irish contact tracing guidance: Report for NPHET, 1st December 2020”.

5
The HPSC confirmed that the HSE Pandemic Incident Control Team (PICT) reviewed the ECDC’s updated contact tracing guidance, published on 18th November 2020. Each situation where advice in the ECDC document differed from draft revised Irish guidance was considered, and decisions were taken on whether to incorporate them or not. The HPSC paper presented to the NPHET set out the rationale for the decisions taken, in 13 situations where the ECDC guidance was not incorporated into the Irish guidance.

The NPHET thanked the HPSC for the paper. Following a brief discussion, the NPHET recommended that the HPSC make arrangements to finalise the guidance for subsequent implementation. As part of this, it was agreed that, as per ECDC guidance, household contacts (‘secondary contacts’) of people identified as close contacts would be advised to restrict their movements. It was agreed that they would be advised to do this until the close contact had received a ‘not detected’ result from their Day 0 test. It was agreed that this was an appropriate and necessary measure given the high proportion of household contacts who have tested positive on Day 0 testing, and that this advice has the potential to impact on further onward transmission within and between households.

The NPHET noted that ongoing consideration is being given to the duration of quarantine for close contacts (currently 14 days) and that this will continue to be reviewed, subject to the outcome of an ongoing audit of compliance with restricted movements being undertaken by the HSE.

**Action:** The NPHET endorses the updated “National Guidelines for the Public Health Management of Close Contacts of Cases of COVID-19”, notwithstanding additional considerations that are required for the testing and recommended isolation periods for close contacts in light of recently published ECDC guidance.

c) **Updated Guidance for Religious Services**

The HPSC presented the paper “COVID-19 Guidance for Religious Services, 1st December 2020”, which provides advice for religious leaders and organisers of religious ceremonies and events; and provides information for those attending services about preventing the spread of COVID-19.

The HPSC emphasised that the guidance document presented should be read and interpreted in conjunction with the Government’s COVID-19 “Resilience and Recovery 2020-2021: Plan for Living with COVID-19” risk management strategy.

The HPSC explained that aspects of the guidance are specific to certain denominations but the guidance in general is intended to be relevant to all religious groups. An addendum to the guidance provides a summary of the measures required during the holiday season.

The key points made were as follows:

- The gathering together of people indoors, such as in religious settings, has been associated with a higher risk of infection with COVID-19. This document outlines the measures that should be adopted in order to enable religious services to take place, in a safe manner.
- **Current Government Guidelines** must be adhered to. This includes the total number of worshippers allowed to congregate, dependent on the current level of restrictions.

The NPHET endorsed the guidance presented and requested that it be communicated to all religious groups to facilitate timely planning for the festive season.

**The NPHET endorses the HPSC’s “COVID-19 Guidance for Religious Services” and recommends their dissemination.**
4. HIQA - Expert Advisory Group

4.1 International review of public health measures and strategies to limit spread of COVID-19

The HIQA presented the paper “Public Health Measures and Strategies to Limit the Spread of COVID-19: An International Review”.

The paper provided a summary of the epidemiological data, public health frameworks for living with COVID-19, and current public health measures in place across a number of countries: Austria, Belgium, Czechia, Denmark, France, Germany, Ireland, Italy, Netherlands, Portugal, Spain, Sweden, England, Northern Ireland, Scotland, Wales, and Switzerland.

The paper concluded that public health measures are currently being applied across all countries included in this review, either nationally, regionally or a combination of both. The paper noted that although the measures that are being applied are largely consistent across society, there are many differences in the detail between countries. The more prominent differences include how movement is restricted (e.g. curfew hours, travelling distances permitted, and requirement to complete a certification card if leaving home); numbers permitted at gatherings, events, religious services and sporting activities; and the operating hours of businesses allowed to open within the hospitality sector. The paper further noted that while a range of epidemiological data is presented to describe the current epidemiological situation in each country, comparisons across countries are difficult for a number of reasons.

The NPHET thanked the HIQA for its review and noted same.

5. Future Policy

5.1 Vaccination

The Department of Health and National Immunisation Advisory Committee (NIAC) presented the joint paper “Draft COVID-19 Vaccines Allocation Strategy”.

The NPHET acknowledged that the development of safe and effective vaccines will be a major step forward in limiting the impact of COVID-19 on our health, society and economy. Given the global demand, it is likely that initial supplies of any authorised COVID-19 vaccine will be limited and will require certain population groups to be prioritised for vaccination. The NPHET were reminded that Ireland is part of an EU-level Advance Purchase Arrangement (APA) with a number of vaccine candidates. Until such time that there is adequate supplies of vaccine, it is necessary to develop a framework for prioritising which cohorts of the population should receive the vaccine first. It was outlined that the current draft framework was not based solely on health considerations but also sets out a number of ethical principles. These ethical principles include:

- Moral equality;
- Minimisation of Harm;
- Fairness;
- Reciprocity.

At this time, the primary objective of the vaccination programme is to reduce mortality and morbidity as a consequence of COVID-19, protect the health care system from being overwhelmed and maintain non-COVID care. The prioritisation list takes into account the current and evolving understanding of the distinctive characteristics of COVID-19, its modes of transmission, the groups and individuals most susceptible to infection, and the characteristics of the vaccine candidate. Vaccine allocation strategies depend upon a number of factors, including vaccine efficacy in different age/risk groups, the availability of effective therapeutics, and the epidemiological situation at the time the vaccine becomes available. It is important to stress that the prioritisation list is subject to constant review and may be modified as more evidence about COVID-19 epidemiology and the characteristics of vaccines becomes available, including information on vaccine safety and efficacy by age and target group.
The NPHET thanked the contributors for their work on what was is a challenging task and held a substantive discussion on the draft allocation framework.

The NPHET stated the importance that healthcare workers are given priority in terms of vaccine allocation given the enormous contributions they have made in responding to the COVID-19 pandemic. The placement of frontline healthcare workers in group 2 to be vaccinated was questioned in the context of the overall aim of the vaccination programme, namely reducing mortality and morbidity. It was pointed out that front-line healthcare workers were at significant risk of exposure, representing over 30% of cases reported at present. Given the essential roles that front-line healthcare workers play in maintaining both COVID and non-COVID care, protecting them protects health and social care services, thereby indirectly impacting on mortality and morbidity. Moreover, if evidence emerges that vaccines do indeed disrupt the transmission of COVID-19, vaccinating frontline healthcare workers would benefit vulnerable persons and other staff members. It was also noted that the principle of reciprocity justified prioritising this sub-group of healthcare workers. If healthcare workers are to be allocated the vaccine first under the framework, it will be essential to have good communications and information in place to ensure there is high uptake, as well as a clear definition of who qualifies.

Attention was brought to deciphering exactly the numbers of people falling into each category under the allocation framework in order to understand how an efficient, expeditious roll-out of the vaccine could be achieved. The possible role of vaccines in strategic outbreak management was raised. There is also a need to consider where those who will administer the vaccine should fall in the allocation framework given their inevitable exposure to significant numbers of contacts.

It was highlighted that social acceptance of the prioritised distribution of vaccines will depend upon the clear communication of information and the consistent, transparent implementation of the programme. In line with the procedural value of inclusiveness, timely public and stakeholder engagement on the goals, values and allocation strategy for COVID-19 vaccine(s) is recommended.

The NPHET stated that any widespread vaccination campaign which might require redeployment of the health workforce must be done so appropriately and not detrimentally impact on essential, front-line services. Learnings from redeployment of healthcare staff for contact tracing during the first wave of the pandemic should be factored into planning for vaccine programme implementation.

Given that a vaccine targeted at reducing morbidity and mortality is likely to target more vulnerable groups, the NPHET stated the need to address issues around capacity to consent to receiving the vaccine. The NPHET also discussed the evidence base for obesity being a clear risk factor for admission to ICU and length of stay in hospital. The NPHET also re-emphasised the need to use chronological age as a key risk factor when guiding this prioritisation process, given international mathematical modelling data indicating prioritising COVID-19 vaccine allocation for older populations (i.e., greater than 60 years old) led to the greatest relative reduction in deaths.

While acknowledging the significant logistical challenges associated with a nationwide roll-out of the vaccine, the NPHET reaffirmed that the programme must be led by public health principles and expertise. It will be important, however, for the vaccination campaign to leverage the significant and effective inputs of the High-Level Task Force on Covid-19 Vaccination, chaired by Prof. Brian McCraith, to expedite the roll-out of a future vaccine.

The DOH and NIAC thanked the NPHET for their contributions on what will continue to be a complex task. The DOH and NIAC reaffirmed the iterative nature of their work which will evolve in light of new and emerging evidence around COVID-19 and the various vaccine candidates for immunisation against COVID-19.
The Chair thanked the DOH and NIAC for their significant work, recognising that the allocation framework is provisional and will be updated in light of relevant, new and emerging evidence. The Chair stated the need for other relevant sectoral actors to be empowered to take necessary decisions in future to ensure that the operational roll-out of a vaccine is not delayed due to repeated recourse to the NPHET for guidance on these matters. The Chair confirmed that the issue of vaccination would be a standing item on the NPHET’s agenda so that it can be given thorough and substantive consideration going forward.

**Action:** The NPHET endorsed the joint DOH and NIAC paper setting out a provisional priority list of groups for vaccination once a safe and effective vaccine(s) has received authorisation from the European Medicines Agency.

**b) Antigen Testing**

The HPSC presented the paper “Evaluation of Rapid Antigen Detection Testing (RADT) - Progress Report 1st December 2020”. The validation of the use RADT is continuing across a number of pilot sites.

The HPSC confirmed that a finalised paper with recommendations will be brought to the NPHET for decision at its next meeting.

The Chair thanked the HPSC for the update and reaffirmed the importance of coordinating requests in relation to RADT through the appropriate DOH and HSE channels to ensure a unified approach.

**c) Protection of HCW/analysis of testing in Healthcare settings**

The HSE presented the papers “Enhanced measures for the control of spread of COVID-19 in Acute Hospitals” and “Serial Testing of Health Care Workers in Acute Facilities”.

Based on evidence across a number of acute sites, the HSE detailed a number of measures to (i) reduce the risk of virus introduction into acute settings, and (ii) reduce the risk of virus spread if introduced into an acute hospital setting.

Measures to prevent virus introduction into acute settings include:

- Support for staff in adhering to public health guidance outside of the workplace setting;
- A defined process for assessment of staff for symptoms before commencing work;
- Ensure that all staff including agency staff are not subject to financial penalty if they are unable to attend work for reasons related to COVID-19;
- Agreed national criteria for testing of asymptomatic staff.

Measures to reduce the risk of virus spread once present in the acute setting include:

- Patient adherence to social distancing and mask-wearing;
- Ensuring adequate controls and supervision of break and meeting rooms, closing certain rooms if necessary;
- Introducing COVID-19 support managers in acute sites to support staff adherence to infection prevention and control advice;
- Establishing ‘pods’ of staff who care for the same patients to the greatest extent possible.

The paper “Serial Testing of Health Care Workers in Acute Facilities”, which sets out a number of recommendations for commencing serial testing, was discussed by the NPHET. The HSE proposed that hospital sites utilise PCR testing capacity as part of this exercise until such a time that Rapid Antigen Detection Testing (RADT) is validated for use in acute settings, notwithstanding the need to conclude validation of RADT as soon as possible. RADT validation work is ongoing as part of a mass testing operation in Letterkenny University Hospital. To allow sufficient time for site identification, planning and set-up, the HSE proposed that the first serial testing cycle begin on 4th January 2021.
The NPHET thanked the HSE for their paper and welcomed their clear recommendations for how best to engage in the serial testing of healthcare workers. The NPHET stated the need to expedite the roll-out of this programme insofar as possible. The NPHET also highlighted the need to ensure that the planned roll-out does not detract from the immediate need for mass PCR testing in a number of acute sites where cases are growing. Notwithstanding the mass testing operations ongoing in Letterkenny, Naas and Limerick, there are other sites where similar mass testing may now be required. To the extent possible, RADT should be used in parallel with PCR in these settings as a way of validating RADT’s sensitivity and efficacy and deciphering its role in proposed serial testing across acute sites.

**Action:** The NPHET endorses the HSE papers “Enhanced measures for the control of spread of COVID-19 in Acute Hospitals” and “Serial Testing of Health Care Workers in Acute Facilities” and recommends that mass testing continue for all hospital outbreaks. The NPHET also notes and welcomes the planned implementation of a serial testing programme for healthcare workers commencing on 4th January 2021.

6. Communications

**a) Weekly Communications Update**

The DOH presented its weekly communications update. The key insights included are detailed below.

According to the Quantitative Tracker, the nationally representative sample of 1,600 people conducted on 30th November reveals:

- The level of worry, now at 6.2/10 has fallen back to the level seen in July and August, with 80% self-reporting to be staying at home
- 32% of people now believe the worst of the pandemic is behind us, 27% now believe that it is ahead of us, with 23% believing the worst of the pandemic is happening now.
- 61% believe Government reaction to the pandemic is appropriate, 23% insufficient, and 13% believing it is too extreme.

Feedback from the qualitative tracker, for the two-weeks ending 29th November 2020, with focus groups among adults aged 25-55 and in-depth interviews with young adults reveals:

- A shift away from anger (at others for not following guidelines) to acceptance that people are responsible for their own decisions and what they can control. Personal Responsibility is the key theme at present.
- Young Adults are deeply challenged by COVID’s grip. Their response is amplified versus the population average – but this includes their ability to bounce back also. Key to keeping going is the knowledge that everyone is in the same boat and is keeping positive.
- The vaccine is met with cautious welcome. It is not a silver bullet and should be very carefully managed. There is significant confusion and worry regarding its safety and efficacy. A programme of managed communication is needed to articulate the country’s strategy and plan, led by expertise willing to address people’s fundamental concerns.
- As Ireland’s pandemic experience stretches into its ninth month, a new set of communication needs are now evident with citizens. Many are disengaging from ‘numbers-led’ information. Key to their re-engagement is a moderation in tone, towards balance, optimism, encouragement and emotional meaning. Straight-talking and clear guidelines are still needed. Citizens have moved beyond fear-based attention of March 2020, and now seek informed empowerment and support to live better alongside COVID-19.

The following communication campaigns are underway:

- #HoldFirm 40” TV ad;
- COVID Video stories;
- Cases & Contacts to self-isolate & restrict their movements;
• Show me the COVID – Bubbles campaign;
• Young adults #antiviral;
• Winter campaign for older people.

The following communication campaigns are in development:
• Young Adults - Creative Counsel;
• Stay Safe at Christmas;
• COVID-19 Vaccine campaign.

The NPHET thanked the DOH for its update and stressed the need to ensure that GPs are equipped with sufficient information regarding the COVID-19 vaccine to enable them to be in a position to answer their patients’ queries. The NPHET welcomed in this regard, the confirmation received that the ICGP is compiling a Frequently Asked Questions document for submission to the DOH.

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

b) AOB

   (i) Advice on children’s festive activities
   The item was deferred to 10th December, in anticipation of the publication of ECDC guidance for the festive season.

   (ii) HSE Pandemic Incident Control Team (PICT) note for the NPHET regarding the draft updated Guidelines for the public health management of close contacts of cases of COVID-19
   The NPHET acknowledged a note from the HSE Pandemic Incident Control Team (PICT) regarding the draft updated Guidelines for the public health management of close contacts of cases of COVID-19 (presented under item 3(b) above), which highlighted the resource challenges inherent in the implementation of the updated contact tracing guidelines.

   The note explained that the updated guidelines have expanded the situations in which contact tracing is likely to be subject to a Public Health Risk Assessment (PHRA) and therefore the number of referrals to Departments of Public Health is likely to increase.

   The note emphasised that the implementation of the updated guidelines will require operational guidelines that can outline a mechanism for prioritisation of PHRAs depending on changing demands, case and contact numbers, and available resources.

   The NPHET thanked the HSE for its note and the Chair confirmed that he would correspond with the Chief Executive Officer and Chair of the HSE National Crisis Management Team (NCMT) regarding the highlighted resource constraints to operationalising the appropriate Public Health management of cases, clusters, and outbreaks under the updated guidelines.

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