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

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Thursday 17th December 2020, (Meeting 68) at 10:00am</th>
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<tbody>
<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
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**Members via videoconference**
- Dr 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 Mary Favier, Immediate past president of the ICGP, Covid-19 advisor
- Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH
- Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH
- Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH
- Ms Rachel Kenna, Chief Nursing Officer, DOH
- 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 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 Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital
- Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH
- Ms Deirdre Watters, Communications Unit, DOH
- Dr Colm Henry, Chief Clinical Officer, HSE
- Ms Liam Woods, National Director, Acute Operations, HSE
- 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’**
- 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 Pauline White, Statistics & Analytics Unit, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Ms Ruth Barrett, NPHET Policy Unit, DOH
- Mr Ronan O’Kelly, Health Analytics Division, 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 Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH

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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.
1. Welcome and Introductions
   
   a) Conflict of Interest
   Verbal pause and none declared.

   b) Minutes of previous meetings
   The minutes of the 25th 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.

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 2,323 cases have been notified in the 7 days to 16th December, which is a 23% increase to the previous 7 days to 9th December in which there were 1,889 cases;
   • As of 17th December, the 7- and 14-day incidence rates per 100,000 population have increased to 49 and 88, respectively; these compare to rates of 40 and 80 on the 9th December;
   • Nationally, the 7-day incidence as a proportion of 14-day incidence is 55%, demonstrating that there have been more cases in the last 7 days compared with the preceding 7 days to 9th December;
   • The 5-day rolling average has increased from 286 on 9th December to 339 on 16th December;
   • Of cases notified in the past 14 days from 2nd December to 15th December, 64% have occurred in people under 45 years of age; the median age for cases notified in the same period is 36 years;
   • The proportion of cases notified in the over 65 age group has remained stable. In the last 14 days to 15th December, 12% of cases notified were aged over 65;
   • We continue to see a high proportion of infections in healthcare workers who account for 11% of all reported cases in the 14 days from 2nd December to 15th December;
   • There has been an increase in the 14-day incidence overall in the country, 18 counties have a 7-day incidence as a percentage of 14-day incidence greater than 50% indicating an increase in cases in the last 7 days compared with the previous 7 days;
   • The daily growth rate of cases is currently 1.5%-2%;
   • The best estimate of the reproduction number (R) is currently 1.1-1.3;
   • A total of 83,092 tests were undertaken in the last seven days. The 7-day average test positivity rate has increased to 2.9% from 2.5% on 10th December;
   • Excluding serial testing, the positivity rate has also increased and is estimated to be 4.2% for the 7 days to 14th December;
   • There are currently 211 confirmed COVID-19 cases in hospital, compared with 205 on 10th December. There have been 33 newly confirmed cases in hospital in the preceding 24 hours;
   • There are currently 28 confirmed cases in critical care, compared with 37 on 9th December;
   • As of 17th December, there have been 48 deaths notified with a date of death in December. This compares with 120 and 147 deaths notified (to date) with a date of death in October and November, respectively. Of the 48 deaths so far in December 19 have been associated with hospital outbreaks and 11 have been associated with nursing home outbreaks.

   Further relevant information includes:
   • 410 additional new clusters were notified in the week to midnight 12th December 2020 (week 50). There were 5,646 open clusters nationally;
• There were 9 new clusters notified in acute hospitals with 49 linked cases in week 50;
• There are currently 50 open clusters associated with 21 acute hospitals. Approximately 1,000 cases have been linked to these outbreaks with 51% of these cases related to healthcare workers. There have been 60 deaths linked to these outbreaks;
• There were 5 new clusters notified in nursing homes/community hospitals with 71 linked cases in week 50;
• There are currently 38 open clusters associated with nursing homes/community hospitals. Approximately 960 cases have been linked to these outbreaks, with 39% of these cases related to healthcare workers. There have been 50 deaths linked to these outbreaks;
• 9 new outbreaks in workplace settings were notified in week 50 with 45 linked cases; there are currently 115 open outbreaks in workplaces;
• There were 19 new outbreaks associated with schools with 41 linked cases in the last week (noting that transmission of COVID-19 within the school setting has not necessarily been established in these outbreaks);
• A range of mobility and compliance data suggest that movement and social contact in the population has increased significantly since the introduction of Level 3 measures;
• The influenza like illness rate (ILI rate) has increased in recent weeks and is now 32.1 per 100,000 population;
• The number of close contacts per case has increased significantly over the last week from 2.8 contacts on average per case on the 8th December to 3.4 contacts on average per case on 15th December;
• As of 16th December, the 14-day incidence per 100,000 population in Northern Ireland is 347, this is almost 4 times the 14-day incidence in the Republic of Ireland which is currently 88 per 100,000 population. The 7-day incidence per 100,000 population in Northern Ireland is 179, this is almost 4 times the 7-day incidence in the Republic of Ireland which is currently 49 per 100,000 population.

The NPHET noted with concern that all key indicators of disease transmission are now increasing, including the 5-day moving average of cases, the 7-day and 14-day incidence rate, and the testing positivity rate. The rapid rise in case numbers has surpassed the rates that were projected in November. This increase in cases correlates with the change in public health measures from 4th December onwards. The NPHET agreed that, while it is difficult to accurately project the future trajectory of the disease at this stage, these facts may indicate the country is in the early stages of a third wave of infection.

Modelling analyses show a high risk that the level of disease transmission into early January 2021 may impact further on public health and the ability to maintain the core priorities set out by the NPHET:

• protecting the most vulnerable;
• the continued provision of health and social care services, including non-COVID services;
• the provision education and childcare services.

The NPHET noted the continuing, very concerning, situation both in Northern Ireland and internationally, which have implications for travel over the holiday period and the following weeks. The NPHET further noted reports of the impact of recent holiday periods internationally, including Thanksgiving in the U.S.A and St. Nicholas day in the Netherlands. In light of this, the NPHET reiterated its strong advice against all non-essential travel for the foreseeable future. The NPHET acknowledged that many of the people who were planning to travel home to Ireland will have based their plans around the announced easing of restrictions on 18th November and would be unlikely to change their plans.

The DOH advised the NPHET that there is a formal protocol in place through which requests for support from Northern Ireland could be relayed but that none had been received to date. The HSE advised that ambulance services in the border counties and Northern Ireland often cooperated when necessary and that this had
continued during the pandemic. The IEMAG presented data showing that although Donegal and Cavan have a high baseline of cases, which may be a result of proximity to Northern Ireland, they do not appear to be disproportionately affecting the growth of the disease in the country.

The HPSC provided information on recent outbreaks linked to social gatherings including incidences in hotels and restaurants, and outbreaks occurring at weddings and funerals. The most recent data available indicates that the number of outbreaks linked to the hospitality sector is rising. The NPHET noted that in the period from 16th November – 13th December, the number of infections caused by social interactions was second only to those generated by household contacts. The NPHET recalled its previous advice that the hospitality sector should not be reopened in favour of easing the restrictions on household visits. The NPHET noted the potential risk to individuals and families posed by increased intergenerational mixing over the holiday period as a consequence of recent high levels of socialisation in the preceding weeks. It highlighted the critical importance of everyone keeping their contacts and networks as low as possible, including taking all possible precautions and reducing contact with at-risk relatives.

The NPHET was made aware that, although scheduled care is continuing, there is limited capacity in ICUs available and limited capacity within the hospital system to manage a surge in cases. This is partly due to the closure of certain wards due to outbreaks of COVID-19, leading to a contracting acute capacity across some hospitals. The DOH expressed its concern about the rising number of infections amongst healthcare workers (HCWs) and warned that if left unchecked, it could greatly impact staffing in the health sector. The HSE supported these concerns but assured the NPHET that all efforts were being made to implement and improve infection prevention and control (IPC) measures across the healthcare sector. It advised that although IPC measures were effectively implemented in clinical settings, it was harder to control other aspects such as interactions in canteens or outside of hospitals. Therefore, unless the virus is suppressed in the community it will be impossible to keep it out of hospitals. The NPHET noted the importance of utilising the data obtained in the 1st and 2nd wave of infections to help anticipate and minimise the effects of a potential 3rd wave of infections on acute hospital staff.

The DOH stressed that recent risk assessments from the ECDC and HIQA both highlighted the negative impacts on Long-Term Residential Care (LTRC) facilities when community transmission rates are high.

The HSE voiced its concern that many student nurses, who are on placement in acute hospitals, are working in nursing homes at weekends and that this movement may be exacerbating transmission in these environments. It suggested that guidance should be developed to address this issue. The DOH acknowledged the difficulty in asking student nurses not to work in this capacity as it is often their only source of income. It reassured the NPHET that student nurses are being supported.

The NPHET discussed the relatively high incidence rate amongst members of the Travelling Community. This is linked to several factors including the gathering of families ahead of Christmas, international travel, and the high number of weddings occurring. It acknowledged that this period has great cultural significance for some in the Travelling Community which will make changes in behaviour more difficult to enact. The HSE is engaging with advocacy groups on an ongoing basis to address these issues.

The ICGP informed the NPHET that its members had witnessed an increase in people presenting with symptoms of COVID-19 who were unwilling to get a test due to the impact it would have on their Christmas plans. It warned that this may indicate that a number of cases were going undetected. The NPHET noted its concern at this prospect.

The IEMAG highlighted that when infection rates began to rise again in July there was a 6- to 8-week delay before those cases translated into hospital admissions. It warned that this delay was unlikely to happen again and that a rise in cases would very likely be closely followed by a rise in hospital admissions. The NPHET recognised that as the country is moving into a period of decreased restrictions the baseline level of infection
is currently much higher than it was during the easing of restrictions over the summer months. The NPHET highlighted the concern that its ability to make accurate predictions of how the disease might progress over Christmas would be diminished by the fact that the Christmas period will involve a high level of intergenerational mixing that has not occurred previously over the course of the pandemic and that a very cautious approach was now required.

The NPHET recognised that the deteriorating situation is all the more precarious as a further period of relaxation of measures commences from 18th December. As restrictions ease and inter-household mixing and travel increase, the NPHET is concerned that this will result in an inevitable increase in the levels of social contact and opportunity for disease transmission.

The NPHET is particularly concerned that the social contact over the holiday period will likely involve a greater level of close interaction between younger and older people. This may lead to a wave of infection within a higher risk age profile. While there has been a focus on older people as a very high-risk group, the cohort that is of particular concern in the present context is those aged 60-79 years. Until now, they have protected themselves against infection but may be exposed through the unique pattern of socialisation associated with Christmas and New Year. The NPHET reiterated the need for people to reduce the number of close contacts they have before gathering with family, particularly the elderly or vulnerable, for Christmas.

The NPHET noted that people aged 60-79 years were under-represented in the profile of cases during the second wave; for instance those aged 65-69 years constitute 4.4% of the population but only 2.3% of cases in the early part of the second wave (weeks 39-42) and only 3.6% of cases in the later part of the second wave (weeks 43-46). This cohort is at moderate risk if infected. The NPHET stressed that its concern is that if the profile of cases changes, from a position where those aged 60-79 years are protected to one where they are equally likely to be infected as the rest of the adult population, we would see a significant increase in the numbers hospitalised and dying. The majority of the excess hospitalisations, intensive care admissions and deaths would be amongst those aged 60-79 years.

The NPHET acknowledged that Ireland is in a better position compared to the rest of the EU, but it must be understood that this is only due to the early and comprehensive interventions that were taken by Government in October. The NPHET was cognisant of the fact that the trajectory of the disease can change quickly and can be difficult to get back under control. This view is supported by recent trends in Ireland and internationally.

The NPHET agreed the data clearly showed a significant increase in COVID-19 transmission and that intervention was needed immediately to suppress it. The NPHET discussed the possible actions it could take including introducing new measures, changing the duration of measures that have already been announced, and implementing a communications campaign to reinforce previous advice.

The NPHET was cognisant of the potential for further mixing and socialising on New Year’s Eve, which would further accelerate transmission. The NPHET also had regard for the fact that other countries had much shorter periods of easement over the Christmas holidays compared to those in place for Ireland.

The NPHET was aware that any recommendation it makes to reintroduce restrictions or decrease the period of easement would cause disruption to the population’s plans. It was also cognisant of the fact that if the measures recommended were interpreted as overly restrictive the public would be less likely to comply and adhere to them. It was also noted that it would be prudent to give as much notice to the public as possible of any changes to the restrictions in place.

The NPHET reemphasised the fragility of the current position and the significant risks associated with the upcoming Christmas period. It cautioned that even if the Government intervened now by implementing stricter measures, further measures may be required early in the New Year, unless the current pattern of
transmission improves. The NPHET noted that the number of social contacts people maintained during and after Christmas would significantly impact how the disease progressed into January.

The NPHET recognised the need to be clear in its communications around what constituted a household or a support bubble over the Christmas period.

The NPHET had regard for the tremendous efforts that have been made by both the public and frontline staff. It recognised that people have been looking forward to enjoying Christmas and reconnecting with family. The NPHET was conscious that the introduction of measures to restrict movements would have a huge impact on people’s plans and would be particularly felt by those who live alone. It recognised the fatigue within the general population and stressed the need for communications to be sensitive to this.

The NPHET further stressed the need for clear communications to inform the public on vaccination roll-out, and the likely limited availability of the vaccine initially. Until such time as the vaccine becomes widely available, continued adherence to public health guidance is the only means of protection against the virus.

The NPHET underscored that it is essential that normal levels of service provision for testing and contact tracing are maintained, including rapid access for the public to testing over the Christmas and New Year period. To facilitate this, contingency plans for testing and tracing operations, including regional public health departments, must be robust enough to accommodate increased demand at short notice. The NPHET further stressed that it is vital to continue to collect accurate data over the holiday period in order to maintain a comprehensive and up-to-date understanding of the epidemiological situation and to enable the NPHET to respond accordingly.

The NPHET also made brief reference to emerging evidence regarding possible therapeutic interventions, along with aspects of lifestyle and behaviour that may influence the susceptibility to developing COVID-19 symptoms and the efficacy of the vaccine. It requested that HIQA develop a discussion paper on this for presentation to the NPHET in early January.

Action: Given the current epidemiological position and the real risks of further significant deterioration over the coming weeks, the NPHET advises that:

- The duration of the “Christmas period” of reduced restrictive measures should end at midnight on the 28th December 2020;
- Enhanced Level 3 measures as set out within the Government’s “Recovery & Resilience 2020-2021: Plan for Living with COVID-19” should be introduced from midnight 28th December 2020, in particular:
  - Hospitality (restaurants and bars) should open for take-away and delivery services only. Outdoor services should not open.
  - Visits to private homes should be allowed from one other household. It is proposed that for those who are part of a support bubble, the bubble counts as one household and may meet one other household.

3. Review of Existing Policy

a) International Travel

The DOH updated the NPHET on developments in the area of International travel. The DOH articulated its ongoing concern that an increase in international travel over the Christmas period could seed further cases and increase domestic transmission. The advice remains that individuals should not travel in or out of Ireland unless for essential reasons as per the Government’s “Recovery & Resilience 2020-2021: Plan for Living with COVID-19”.
The DOH also outlined that, following concerns raised by a number of EU Member States, including Ireland, the European Centre for Disease Control (ECDC) is currently revising its previous “Guidelines for COVID-19 testing and quarantine of air travellers”, published in partnership with the European Union Aviation Safety Authority (EASA).

The NPHET thanked the DOH for its update and reaffirmed its existing public health advice that non-essential international travel, including discretionary travel for winter tourism, should be avoided. Those who do travel are strongly advised to restrict their movements for 14 days post-arrival.

b) Results of audit of compliance with restriction of movements
The HSE presented its paper “Audit of Compliance with Self-isolation for Cases and Compliance with Restriction of Movements for Close Contacts”.

An audit was undertaken by the HSE to assess compliance with self-isolation for cases and restriction of movement for contacts by assessing the behaviour, knowledge, and attitude of cases and contacts identified by the national contact management programme. Key results included:

- Of the 1027 cases who tested positive for COVID-19, 96.6% reported that they with self-isolation requirements after being informed of their test by the Contact Management Programme.
- High levels of compliance by cases with self-isolation were reported in men (97.1%) and women (96.2%) in different age groups (from 93.9% in 45-54-year-olds to 98.6% in >65-year-olds) and throughout the country ranging from 95.5% in Dublin to 98.4% in Ulster.
- The most common reasons reported for leaving the house among the <4% (34) of cases who were non-compliant after being informed of their test result were for exercise or a walk (55.9%), to attend a medical appointment (17.6%) and to attend work (5.9%).
- Of the 1027 cases, 95.3% complied with self-isolation after the test and before being informed of the test result.
- Among the 536 cases referred for testing due to presence of symptoms, 82.8% (n=444) complied with self-isolation while waiting for the test.
  - 42 (7.8%) of these cases referred due to symptoms attended work and 21 (3.9%) shopped for groceries or medicines while waiting for the test.
  - The most common reason reported for leaving the house before receiving the test among those cases referred for testing due to symptoms who did not self-isolate included attending work (45.7%), to shop for groceries or medicines (22.8%), for exercise or a walk (13.2%), and to attend a medical appointment (10.9%).
- 95.9% of cases agreed or strongly agreed with statement that ‘Someone could spread coronavirus to other people, even if they do not have symptoms yet’.

Key results relating to the contacts of cases required to restrict their movements included:

- Of the 1078 contacts, 86.6% of contacts complied with restriction of movements after being informed of their close contact status by the Contact Management Programme.
- High levels of compliance among contacts were reported in men (86.1%) and women (87.6%), in different age groups (from 83.4% in 25-34 year olds and 55-64 year olds to 91.9% in 45-54 year olds) and in different regions of the country ranging between 85.8% in Connaught, 85.9% in Dublin and 87.9% in rest of Leinster.
- Among close contacts, 32 (3%) attended work before being tested.
- The most common reasons for leaving the house reported by contacts before being tested were for exercise or a walk (42.9%), going to the shops for groceries or medicines (28.6%) and to attend work (22.9%).

The NPHET thanked the HSE for its update and reaffirmed the importance of public compliance with restriction of movements requirements. The NPHET requested that the HSE verify whether the audit asked
participants to report on their behaviour between the date of test and receipt of test result, or for the full 14-day period.

c) **Recommended period of restriction of movements for close contacts**
The DOH presented the paper “Review of duration of restriction of movements for individuals exposed, or potentially exposed, to COVID-19 (via close contact with a confirmed case only)”.

The DOH clarified that its paper concerned the duration of restriction of movements for individuals exposed, or potentially exposed to COVID-19 arising from close contact with a confirmed case. It did not consider advice for those travelling internationally.

The DOH recalled:
- The NPHET considered advice from the HIQA at its meetings of 1st and 22nd October in relation to whether the period of restricted movement for close contacts should be reduced from 14 days and any consequent implications for the current testing protocol of ‘Day 0’ and ‘Day 7’ tests.
- It was decided at the time to maintain the current advice of 14 days of restricted movement and current testing protocols.
- The HIQA advice concluded that if a change was going to be implemented, the estimates presented from the model suggest that the use of RT-PCR tests on ‘Day 0’ and ‘Day 10’ with end of restricted movements on receipt of a ‘not detected’ result from the second test would present the largest incremental benefit and lowest incremental risk relative to current standard practice in Ireland.

The DOH informed the NPHET that a report published by the ECDC on 24th September 2020 proposed that an individual may discontinue restriction of movements if a PCR test taken on ‘Day 10’ following exposure returns a virus ‘not detected’ result.

The European Commission has developed draft *Recommendations for a common EU approach regarding isolation for COVID-19 patients and quarantine for contacts and travellers* with the view to achieving an EU-level agreement for a more coordinated approach to quarantine and isolation measures in line with the guidance issued by the ECDC and the WHO. The main points of the draft paper in relation to close contacts include:
- Duration of restricted movements for close contacts across Europe varies from 7 to 14 days, with a 10-day period being the most common timeframe currently;
- Proposed recommendation that countries should ensure at least 10-day quarantine period for high-risk contacts with a confirmed case; this could be shortened to 7 days after exposure if a PCR test is negative;
- Early release from quarantine should be assessed on a case-by-case basis for contacts working with vulnerable populations, or contacts in LTRC settings or prisons.

The DOH proposed next steps as follows:
- That NPHET give further consideration at its meeting on the 23rd December to: (1) whether it is appropriate to reduce the period of restricted movement for close contacts from 14 days, and (2) any consequent changes to current testing arrangements for close contacts;
- This consideration should be informed by further modelling by the HIQA of a further range of scenarios, and input from the HSE in relation to the current testing programme for close contacts from both a public health and operational perspective.

The Chair thanked the DOH for its paper and confirmed that the matter would be brought to the NPHET for substantive discussion at its next meeting.

d) **NPHET Action Summary Documentation – Finalisation of Topics**
The DOH presented the paper “Administrative approach to facilitate detailing of Actions taken in response to specific areas of concern”.

The DOH outlined that papers on specific areas would be brought to the NPHET in the coming weeks for its consideration.

e) Social Care – Preparedness and ongoing response to COVID-19
The DOH presented the papers “Nursing Homes: Preparedness and Ongoing Response to COVID-19” and “Disability services – preparedness and ongoing response to COVID-19”.

(i) Nursing Homes: Preparedness and Ongoing response to COVID-19;
(ii) Disability Services: Preparedness and Ongoing response to COVID-19
The DOH thanked colleagues in the HSE, the HIQA, and from across the DOH for their inputs and ongoing interagency work. The NPHET was informed that both papers take account of HIQA risk and regulatory information and the ECDC’s recent rapid risk assessment paper on Long-Term Residential Care Facilities (LTRCs). Both papers unambiguously indicate that LTRCs remain at very high risk of introduction of COVID-19 into these settings in line with levels of community transmission. Once introduced to a LTRC setting, there is equally a high risk of forward transmission and an impact on mortality.

The DOH outlined that in the nursing home sector, as of 12th December there were 34 open outbreaks. In the early phase of the pandemic, the nursing home sector was significantly impacted by COVID-19 in line with the experiences of other European countries. Outbreaks trended downwards during the summer months, before rising again commencing in September resulting in further cases and deaths in October and November. Sadly, the number of deaths linked to nursing home outbreaks was 1,112 as of 13th December. Given the continued incidence of nursing home outbreaks and notwithstanding the lower number of cases associated with these outbreaks, the potential for further deaths in nursing homes remains, underlining the importance of the continued implementation of protective measures designed to safeguard nursing home residents, including the provision of PPE, COVID-19 Response Team deployment, and the serial testing programme, which allows for an early and measured response to new cases detected in nursing homes.

The DOH outlined that in the disability sector, as of 15th December there were 13 open outbreaks. Almost 90% of residential disability centres have never had an outbreak. With approximately 8,300 people living in residential disability care, it is estimated that sadly 16 people to date living in such facilities have died from COVID-19 (0.2% of residents), with 2 of these deaths occurring in October/November.

The DOH explained that both papers outlined the significant and effective interagency working which has been taking place across both sectors, and the significant level of supports which have been stood up. These have included educational supports, regulatory supports, IPC supports, supplies of PPE, support from COVID-19 response teams, and the provision of serial testing in LTRCs.

The DOH outlined that the ECDC’s risk assessment of COVID-19 in the context of LTRCs, published in November, outlines countries’ options for response in the areas of management, testing, prevention and control of transmission, and vaccination. This risk assessment has been translated into a checklist of measures for both settings. When assessed against this checklist, the majority of measures are already in place in LTRCs in Ireland and are well embedded. Ongoing support is required, however, and the DOH highlighted its concern across both disability and nursing home sectors as to the extent of healthcare worker positivity rates reported through serial testing.

The DOH explained that the paper “Nursing Homes: Preparedness and Ongoing Response to COVID-19” also provides an update on progress in implementation of the Nursing Home Expert Panel Report recommendations. The panel’s Implementation Oversight Group has held 9 meetings to date and has
published its first progress report on the DOH website, with the second progress report currently being finalised.

The DOH confirmed that it would be submitting its papers shortly to the relevant Ministers in the Department, with subsequent publication on the DOH website.

The NPHET thanked the DOH for this update.

iii. **Guidance on Visits to and From Disability Services**

The HSE presented the paper “COVID-19 Guidance on visits to and from residential facilities for people with disabilities”.

The HSE explained that managing visiting is challenging for service providers who must balance their obligation to protect all residents and staff from the risk of introduction of COVID-19 with their obligation to facilitate and support visits for residents to the greatest extent possible. To achieve that balance, service providers require that prospective visitors undertake to co-operate fully with measures required to ensure that visiting represents the lowest possible risk to all residents and staff.

The HSE stated that, for many people living in disability facilities in Ireland, Christmas is of particular significance. Equal provision must also be made for people from other traditions and belief systems. At all levels of the Government’s framework of measures set out in “Resilience and Recovery 2020-2021: Plan for Living with COVID-19”, every practical effort should be made to accommodate an additional visit to residents, who wish to receive visitors in the LTRCF on compassionate grounds during major cultural or religious festivals or celebrations of particular significance to the resident. For example, a visit should, where possible, be facilitated during the Christmas/New Year period for those residents for whom this is an important period.

The HSE outlined that the holistic approach taken to developing guidance on visits to disability centres is similar to the approach used to inform visits to and from LTRCFs in that it balances the need for rigorous infection prevention and control procedures with the importance of maintaining family connections with loved ones.

The NPHET welcomed the update from the HSE and endorsed the paper.

**Action:** The NPHET endorses the paper “COVID-19 Guidance on visits to and from residential facilities for people with disabilities”, recommending its communication and implementation.

iv. **Guidance: Risk assessing visits to private homes by resident of LTRCF**

The HSE presented the paper “Approach to risk assessment of visits to private home or similar setting by a resident from a LTRCF”.

The paper outlines an approach to assessing and managing the risk associated with visits outside of the LTRC facility on critical compassionate grounds. The guidance is intended to support the residents, relevant other people, and the person in charge of the LTRC facility in dealing with these issues arising from proposed visits outside the LTRC facility at Framework Levels 3 or higher.

This guidance emphasises that the resident and relevant other people should be fully informed of the risk to them and to others associated with any proposed visits and to support the person in charge in managing the risk to all residents and staff associated with any proposed visits. Best practice in infection prevention and control (IPC) procedures should be followed in all instances.

The NPHET thanked the HSE for its update.
f) **Outbreak Control in Acute Hospitals**

The DOH presented the DOH-HSE joint paper “Control of Transmission of COVID-19 in Acute Hospitals”.

The DOH provided a high-level overview of the steps that have been taken to date to help reduce the risk of nosocomial infection, including the provision of significant additional funding for infection prevention and control in 2020 and 2021. The DOH also outlined the current situation with regard to the extent of COVID-19 outbreaks in acute hospital settings and set out the range of enhanced measures which have been, and will continue to be, implemented, nationally and across the acute hospital system, to address this issue. These enhanced measures include:

- the establishment of a National Outbreak Control Oversight Team;
- the application of national criteria for testing of asymptomatic healthcare workers in the context of hospital outbreaks, with mass testing wherever there is a significant hospital outbreak, and;
- a programme of serial testing of healthcare workers in acute hospitals from 4th January 2021.

The DOH outlined that both the DOH and the HSE are committed to ensuring that these enhanced measures are implemented as a priority and will continue to engage to ensure that the measures are having the anticipated impact to manage and control the transmission of COVID-19 in acute hospitals.

The HSE confirmed that the National Outbreak Control Oversight Team is now in operation, established as a working group of the HSE’s Antimicrobial Resistance and Infection Control (AMRIC) Oversight Group. The Team will provide regular reports to the NPHET on its work. All hospital groups will be included to ensure a standardised approach across the country.

The DOH also confirmed that the HIQA had offered its assistance in this area and that the DOH would continue to work bilaterally with the HIQA and update the NPHET as appropriate.

The NPHET thanked the DOH and the HSE for their update and welcomed the establishment of the National Outbreak Control Oversight Team.

g) **Primary Care Staffing and Service Delivery in a COVID Environment – Community Therapies**

The DOH presented the DOH/HSE joint paper “Primary Care Staffing & Service Delivery in a COVID Environment: Community Therapies”.

The DOH outlined the significant impact of the COVID-19 pandemic on the ongoing delivery of services in the primary care sector, evidenced in particular in the area of community therapies, with fewer services being delivered in 2020 than in 2019.

The response to the pandemic in the primary care sector has not only required the introduction of protective measures that have made service delivery more challenging but has also required staff to be redeployed from their core roles to aid in the response to COVID-19. This has created an additional challenge in terms of maximising the provision of non-COVID care.

This DOH highlighted in particular:

- the strategic response to service challenges posed by COVID-19 through the Community Capacity Working Group and the HSE paper “A safe return to health services – restoring services in a COVID Environment”;
- operational initiatives and innovations that potentially can be embedded in the health system over the longer term in support of Sláintecare;
- the importance of IPC measures and the need to develop an integrated approach to IPC across the acute and primary/community sectors;
• the significant level of redeployment among primary and community staff to support the COVID-19 response and the importance of establishing a dedicated COVID-19 swabbing and tracing workforce to allow a wider resumption of services;
• the fall in non-COVID service delivery compared to 2019 and its impact on waiting lists, while also revealing evidence of a consistent and upward trend in service delivery over the April-October period;
• how COVID-19 has exacerbated historical deficits within the primary care sector and how long-term strategic reform is required.

Entering 2021, the focus will be on:
• continuing to deliver COVID and non-COVID care side-by-side, safely;
• maximising the volume of non-COVID care and catch up where possible in an uncertain environment, and;
• embedding reform in the delivery of services.

The DOH outlined that this will be supported by significant investment in the health services in 2021. However, the success of these efforts is inextricably linked to the levels of transmission of COVID-19 in the community and the successful implementation of the vaccination programme. The DOH also pointed out that although the paper refers to COVID and non-COVID care, this is simply a construct for convenience and clarity; the reality is that all care is being delivered in a COVID environment.

The ICGP expressed significant concern at the impact of disrupted primary care provision due to COVID-19 on waiting lists for community services. There was consensus around the point that all care was now being provided in a COVID environment and that keeping community transmission low is key to ensuring that people can continue to avail of the community therapies they need.

The NPHET thanked the DOH and the HSE for the update and acknowledged the significant impact that high rates of community transmission have on the ability to provide primary care services.

h) Cancer Services in Ireland in the Context of COVID-19.
The DOH and HSE presented the joint paper “Cancer Services in Ireland in the Context of COVID-19”.

The DOH explained that demand for cancer diagnostic and treatment services continued to grow in recent years in line with Ireland’s growing and aging population. While progress has been made under the National Cancer Strategy 2017-2026, the level of funding available for its implementation was lower than originally anticipated and cancer services struggled to meet demand.

It was outlined that cancer diagnostic and treatment services continued throughout the COVID-19 pandemic in line with Government prioritisation. However, the number of people coming forward to their GPs, being referred to Cancer Rapid Access Clinics, and attending these clinics decreased significantly in mid-March to May 2020. In addition, physical distancing and infection prevention and control measures impacted on both diagnostic and treatment service capacity.

The DOH and the National Cancer Control Programme (NCCP) led a coordinated response to COVID-19 in relation to cancer services. Particular focus was placed on the referral of urgent cases to diagnosis as they presented. The three National Cancer Screening programmes, which had been paused, were recommenced and invitations were prioritised for those who had waited longest for screening. Engagement across acute services, primary care, the voluntary sector, and cancer support centres aided the overall effort to the benefit of patients.
The DOH confirmed that the impact of the COVID-19 pandemic on cancer morbidity and mortality due to delayed diagnosis in Ireland to date is not quantifiable at this point. This is due to an absence of near real time data. Reports from the National Cancer Registry cover data from approximately two years previous.

The DOH concluded that the greatest threat to resilience in cancer services in the short-term remains increased community transmission of COVID-19. It is therefore important to continue to promote the message that cancer diagnostic and treatment services are open, and that anyone who has concerns about cancer should attend their GP.

The RCPI commended the DOH and HSE for their work, which has been a subject of discussion for its members in recent webinars.

The NPHET thanked the DOH and HSE for their update.

4) HIQA EAG
The NPHET discussed emerging evidence around effective therapeutic interventions at community level to mitigate the effects of COVID-19. The NPHET acknowledged the need to investigate emerging evidence further.

The NPHET requested that the HIQA EAG undertake an evidence review and provide advice on the therapeutic interventions (pharmacological or otherwise) that could be deployed at a community level or in the early stages of infection.

5. Future Policy
a) Vaccination
The DOH informed the NPHET that, following agreement by Government, the allocation strategy developed by the NIAC and the Department, and signed off on by the NPHET, had been fed into the process for the development of a high-level immunisation strategy under the High-Level Task Force.

The DOH noted that it was now anticipated that that European Commission authorisation of the Pfizer/BioNTech vaccine could occur on 23rd December and that, following this, initial supplies may arrive into EU Member States post-Christmas, with some initial roll-out before the end of the year.

The NPHET thanked the DOH for its update.

i. Finalised data set for the surveillance, monitoring, and reporting for COVID-19 vaccination programme
The HPSC presented its finalised data set for the surveillance, monitoring, and reporting for the COVID-19 vaccination programme.

A query was raised regarding the necessity to include a question on whether a person has been previously infected with COVID-19. The NPHET noted that the collection of such data will be useful from a vaccine efficacy perspective.

The NPHET noted the paper and requested that the HPSC return the data set for the NPHET’s endorsement on 23rd December.

The NPHET stressed that the HPRA is the appropriate body to report on any vaccine-related adverse effects.

b) Antigen Testing
This paper was deferred as the author had to leave prior to the item being taken. As the author will not be available at the meetings of the 23rd of December this item will be taken at the next meeting at which policy
matters are to be discussed, 7th January 2021. In the interim, the chair noted the importance of continuing to progress work on evaluation and validation of antigen testing, particularly in healthcare settings.

6. Communications Update
The DOH and the HSE provided an update to the NPHET on recent and upcoming communications work.

It was noted that media coverage of public health messages and cautions coming up to Christmas has been very consistent across regional and national media on a daily basis. The contact calculator on the HSE website has also proved useful as it allows the public to plan for the festive period and reflect on their number of contacts.

The DOH and the HSE also outlined planned communications around the vaccination process, including information leaflets, a post-vaccine after care form, and a record card, social media and website information.

Research has commenced on a wider vaccination communications campaign for healthcare workers and the public. Feedback received to date indicates good support for uptake of the vaccine.

The NPHET thanked the DOH and the HSE for their update and their continued good collaboration.

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

b) AOB

(i) Strategic multiannual plan to expand adult critical care capacity
The DOH informed the NPHET that the Minister for Health will shortly announce a strategic multiannual plan to expand adult critical care capacity. Under the plan, which was jointly prepared by the Department and the HSE in close consultation with the HSE Critical Care Programme, adult critical care capacity will expand from 255 beds to 446 beds.

Work on Phase One of the plan has already begun and will see 321 adult critical care beds in place by the end of 2021, compared to 255 at the start of this year. This will be funded by €52 million allocated in Budget 2021. This funding will also allow for education and training initiatives to increase the critical care workforce and for investment in critical care retrieval services. Under Phase One, an additional 8 beds will be created in St. Vincent’s University Hospital in 2022, subject to completion of the necessary infrastructural development and planning processes, and with funding to be sought within the 2022 estimates process.

Completion of Phase Two will see a further 117 beds added through the development of new build capacity at five prioritised sites, subject to necessary approval processes. These sites include Beaumont Hospital, St James’s Hospital, the Mater Misericordiae University Hospital, St Vincent’s University Hospital and Cork University Hospital.

The multi-year plan was noted by Government this week. As well as addressing historical under-capacity, the plan supports wider strategic reform and service improvement. When implemented, it will fully address the recommendations of the 2018 Health Service Capacity Review.

The NPHET thanked the DOH for its update and welcomed the forthcoming announcement.

(ii) Clinical vulnerability
The NPHET noted the importance of highlighting in ongoing communications work that there are many in the 45-65 years, who are vulnerable to SARS-CoV-2 infection. Frailty, chronic disease, disability, immunosuppression, poverty, and social deprivation are risk factors for vulnerability to SARS-CoV-2 infection.

The NPHET noted that care should be taken in communications work to ensure that the public understands that being clinically vulnerable does not put one at higher risk of adverse effects regarding vaccination.

c) Date of next meeting
The next meeting of the NPHET will take place Wednesday 23rd December 2020, at 10:00am via video conferencing.