## National Public Health Emergency Team – COVID-19

### Meeting Note – Standing meeting

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Thursday 23rd December 2020, (Meeting 69) at 10:00am</th>
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<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
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</tbody>
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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 Colette Bonner, Deputy Chief Medical Officer, DOH
- 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 Siobhán Ní Bhriain, Lead for Integrated Care, HSE
- Dr Colm Henry, Chief Clinical Officer, HSE
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- Mr Liam Woods, National Director, Acute Operations, HSE
- Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA
- 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 Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Ms Aoife Gillivan, Communications Unit, DOH
- Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH

### Secretariat

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

### Apologies

- Dr Matthew Robinson, Specialist Registrar in Public Health, DOH;
- Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE

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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) Apologies
       Apologies were received from Dr Lorraine Doherty.
   c) Matters Arising
       The Chair informed Members that he had written to the Minister for Health on Monday 21\textsuperscript{st} December to apprise him of the most recent epidemiological situation in advance of the Cabinet meeting on 22\textsuperscript{nd} December. In the letter, the Chair confirmed that the epidemiological profile of the disease had deteriorated very substantially since his letter of 17\textsuperscript{th} December, issued post NPHET, giving cause for grave concern. The Chair stated in the letter that his considered view was that measures as set out in Level 5 of the Government's Plan were now necessary and that this would be the subject of discussion by NPHET on Wednesday 23\textsuperscript{rd} December. The Chair stressed that in his correspondence with the Minister, he did not make any specific recommendations as there hasn’t been a NPHET decision in this regard.

       The Chair further confirmed that he had written to the Minister on 20\textsuperscript{th} December, updating him on the epidemiological situation in Britain and the emergence of a new COVID-19 variant.

       The Chair then noted the Government decision of 22\textsuperscript{nd} December to reintroduce Level 5 measures with certain modifications on a phased basis, commencing on the 24\textsuperscript{th} December, and asked the DOH to briefly outline the detail of these of measures.

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

       • A total of 4,992 cases have been notified in the 7 days to 23\textsuperscript{rd} December, which is a 115% increase on the previous 7 days to 16\textsuperscript{th} December in which there were 2,323 cases; and a 164% increase on the 7 days to 9\textsuperscript{th} December in which there were 1,889 cases.
       • As of 23\textsuperscript{rd} December, the 7- and 14-day incidence rates per 100,000 population have increased to 105 and 153, respectively; these compare to rates of 49 and 88 on 16\textsuperscript{th} December, and rates of 40 and 80 on 9\textsuperscript{th} December.
       • Nationally, the 7-day incidence as a proportion 14-day incidence is 68%, demonstrating that there have been substantially more cases in the last 7 days to 23\textsuperscript{rd} December compared with the preceding 7 days to 16\textsuperscript{th} December.
       • The 5-day rolling average has more than doubled from 339 on 16\textsuperscript{th} December to 785 on 23\textsuperscript{rd} December and has close to tripled on the figure for 9\textsuperscript{th} December (286 cases).
       • Of cases notified in the past 14 days to 23\textsuperscript{rd} December, 64\% have occurred in people under 45 years of age; the median age for cases notified in the same period is 36 years.
       • In the last 14 days to 23\textsuperscript{rd} December, 10\% of cases notified were aged over 65; incidence rates are now increasing across all age groups.
       • We continue to see a high proportion of infections in healthcare workers who account for 12\% of all reported cases in the last 14 days to 23\textsuperscript{rd} December.
• There has been an increase in the 14-day incidence rate in the country overall, however 20 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 to 23rd December compared with the previous 7 days to 16th December.
• The best estimate of the reproduction number (R) is currently 1.5-1.7. The current daily growth rate of cases is 7-8%. This compares with a daily growth rate of 1.5-2% at the last NPHET meeting on 17th December.
• A total of 95,537 tests were undertaken in the last 7 days to 22nd December. The 7-day average test positivity rate has rapidly increased to 5.1% from 2.9% last week on the 16th December.
• Excluding serial testing, the test positivity rate has also rapidly increased over recent days. It was 7.2% over the 7 days to 23rd December, up from 6.5% in the 7 days to Monday 21st December and 5.2% in the 7 days to Friday 18th December.
• There are currently 251 confirmed COVID-19 cases in hospital on 23rd December (2 pm), compared with 207 on 16th December. There have been 24 newly confirmed cases in hospital in the preceding 24 hours.
• There are currently 25 confirmed cases in critical care, compared with 32 on 16th December.
• To 23rd December, there have been 86 deaths notified with a date of death in December. This compares with 125 and 154 deaths notified (to 23rd December) with a date of death in October and November, respectively. Of the 86 deaths so far in December, 28 have been associated with hospital outbreaks and 29 have been associated with nursing home outbreaks.

Further relevant information includes:
• There were 9 new clusters notified in acute hospitals with 50 linked cases in week 51. There have been 4 new outbreaks notified in the current week to 23rd December with 15 linked cases.
• There are currently 58 open clusters associated with 25 acute hospitals. Over 1,000 cases have been linked to these outbreaks with 48% (514) of these cases related to healthcare workers. There have been 67 deaths linked to these outbreaks.
• There were 11 new clusters notified in nursing homes/community hospitals with 130 linked cases in week 51; there are 7 new cluster associated with nursing homes. More than 1,000 cases have been linked to these outbreaks with 41% of these cases related to healthcare workers. There have been 56 deaths linked to these outbreaks.
• There has been an increase in the number of outbreaks associated with schools (although transmission in the school setting has not necessarily been strongly suspected in all instances) with some large outbreaks associated with schools.
• There has been an increase in the number of cases in Irish Travellers in the past 2 weeks to 23rd December with 60 cases notified amongst Irish Travellers in week 51 and 48 cases in week 50, compared with an average of 28 per week in the previous 4 weeks.
• A range of mobility and compliance data suggest that movement and social contact in the population have increased significantly since the introduction of Level 3 measures.
• The influenza-like-illness rate (ILI rate) has increased in recent weeks and is now 45.0 per 100,000 population (week 51), representing a significant increase from 30.1/100,000 in week 50.
• As of the 23rd December, the 14-day incidence per 100,000 population in Northern Ireland was 387, this is 2.5 times the 14-day incidence in the Republic of Ireland (153 per 100,000 population). The 7-day incidence per 100,000 population in Northern Ireland was 207, just under twice the 7-day incidence in the Republic of Ireland (105 per 100,000 population).
• On 21st December, Ireland ranked 6th in the EU/EEA and the UK in terms of percentage change in 14-day incidence (54%); Ireland ranked 1st in terms of percentage change in 7-day incidence (93%).

The best estimate of the reproduction number (R) is very high at 1.5 — 1.8, the highest level since estimates have been produced. The IEMAG noted that SEIR scenario models, calibrated to 22nd December 2020 and assuming that the additional public health measures announced on 22nd December result in immediate changes in the level of social contact, show that if R is reduced to 1.4, we should see 1,100 cases per day by 4th January 2021 and 1,600 cases per day by 18th January 2021. If the measures are more effective in reducing
R, to 1.1 or 1.2, the IEMAG projected 940-990 cases by 4th January and 1,000-1,200 cases per day by 18th January. If the current measures reduce R below 1.0, case numbers can be expected to peak at just over 1,000 per day in early January.

The IEMAG stated that the age profile of cases led it to believe that we will see more severe disease than we did in October and November. If the age profile of cases remains as at present, relatively evenly distributed across age cohorts, the IEMAG project between 340 and 380 people in hospital by 4th January 2021 (for R of 1.1 and 1.4, respectively) and between 440 and 580 in hospital by 18th January 2021. This does not account for the possibility that, due to increased intergenerational mixing over Christmas, we might see a disproportionate increase in incidence in those aged 65 and older, leading to further hospitalisations and mortality. Furthermore, if action is not taken now to ensure that R remains close to or below 1.0, the numbers in hospital will escalate further in the latter half of January: for a constant R of 1.1, 1.2 and 1.4, respectively, the IEMAG projects 450, 560, and 850 people in hospital by 31st January 2021.

The NPHET further noted with particular interest the epidemiological situation in Finland. The DOH presented details provided by Finland’s Ministry of Social Affairs and Health which included general points that might explain their success in controlling the disease, including: Finland’s more sparse population density when compared to Ireland, that Finland has a highly digitised society which facilitates working from home and distance learning, a lower-than-average EU economic impact of COVID-19, and significant border control.

(i) Update on Vulnerable Groups (travelling community, Roma, homeless, direct provision, etc.) and future risks

The HSE presented the paper “Epidemiological report on COVID-19 cases in vulnerable groups 02/08/2020 – 16/12/2020 (week 32 to week 51 2020)”. Key data is as follows:

**Irish Travellers**

- In the almost 20-week period from 2nd August to 16th December 2020 (week 32 to mid-week 51), there have been 1,344 laboratory confirmed COVID-19 cases amongst Irish Travellers, the majority of which (86%) were linked to 77 separate outbreaks all over Ireland.
- The number of cases increased in week 50 to 58, compared to an average of below 30 in the previous 5 weeks.
- While Travellers account for less than 0.7% of the Irish population, they represented 2.6% of the total number of cases in this time period. When cases among Irish Travellers peaked in week 42, they represented 6.2% of all cases in that week. In week 50, this percentage has again risen from previous weeks to 2.9% of all confirmed cases.
- Counties with high numbers of Traveller-related COVID-19 cases include Dublin and Limerick, with Leitrim, Limerick, and Cavan having the highest COVID-19 cumulative incidence rates among their Traveller populations.
- Overall, 46% (622/1,343) of Irish Traveller cases were male (compared to 49% among non-Irish Traveller cases in this period) and the median age was 24 years (compared to 33 years among non-Irish Traveller cases in this period). The lower age profile of Irish Traveller cases in part reflects the younger age profile of the Irish Traveller population in general.
- Over half (59%) of Irish Traveller cases in this period were symptomatic (72% where status known) compared with 64% among non-Irish Traveller cases (74% where status known), and among Irish Traveller cases, 4.5% were hospitalised (4.3% among non-Irish Traveller cases), and 0.4% were admitted to ICU (also 0.4% in non-Irish Traveller cases).
- 18 of the 77 outbreaks were linked to halting sites. There is some evidence to suggest that weddings, First Communions and a funeral may have contributed to transmission to or between clusters.

**Homeless and Addiction Services**
• Between 2nd August and 16th December 2020 (week 32 to mid-week 51), 48 notified confirmed cases of COVID-19 were linked to 9 COVID-19 outbreaks in homeless and addiction services, resulting in one hospitalisation and one ICU admission. The largest outbreak occurred in an addiction service with 31 linked cases. The numbers presented include cases among staff as well as clients.
• This compares with 15 cases (four admission to hospital, one ICU admission and one death) linked with 4 outbreaks in the period 1st March – 1st August 2020 (week 10 - week 31).

Roma
• From 2nd August (week 32) up to midnight 16th December (mid-week 51) there were 8 outbreaks associated with the Roma community. There were 143 laboratory confirmed cases linked to these outbreaks. Of these confirmed cases, 9 were admitted to hospital and 3 cases were admitted to ICU. There were no deaths among the cases.
• In addition to the 143 Roma community outbreak-related cases, there were 210 laboratory confirmed cases not linked to outbreaks among the Roma community. Of these, 18 were admitted to hospital, 1 was admitted to ICU, and 2 cases died. Over half (59%) of Roma cases in this period were symptomatic (status known for 95% cases).
• While the Roma account for just 0.1% of the Irish population, on average they accounted for 1% of cases in the time period analysed (week 32 to mid-week 51).
• In the time period (week 32-mid week 51), there were 123 cases in people who identified as Roma linked to 99 outbreaks that were not confined to the Roma community and 87 cases were not linked to any outbreak.
• Cases in Roma were younger compared to the general population, with 84% of cases under 45 years of age versus 57% for the general population. The median age of a case was 27.

Direct Provision Centres
• Between 2nd August and 16th December 2020, 150 notified confirmed cases were linked to 23 COVID-19 outbreaks in Direct Provision Centres. There were no hospital admissions or deaths linked to these outbreaks.
• This compares with 263 cases (15 admissions to hospital, no ICU admissions and no deaths) linked with 21 outbreaks in the period 1st March – 1st August 2020 (week 10- week 31).

The Chair thanked the DOH, the HPSC, and the IEMAG for their input and invited Members to discuss the epidemiological data presented, while noting specific future policy measures flowing from the epidemiological data would be considered under item 5. The Chair encouraged all to contribute to the discussion, especially in terms of the impact on the health system.

The NPHET noted that the epidemiological situation as of 23rd December is the most serious it has been since March 2020. The level of infection in the country is increasing very rapidly considering the 5-day average and 14-day incidence. Disease incidence is rising across all age groups with the growth rate estimated to be at least 7-9% per day with a doubling time of 8-10 days or less. It was also noted that in just one week the 5-day average case count has doubled, suggesting the growth rate is accelerating. The growth rate is currently similar to, or greater than, that seen approaching the peak of the second wave. The best estimate of the reproduction number (R) is very high at 1.5 — 1.8, the highest level since estimates have been produced. The number of confirmed COVID-19 cases in hospital is increasing and while numbers in intensive care and the number of deaths is static at this time, these are likely to increase very soon in line with expected lag effects.

The NPHET stressed that Ireland is now experiencing a surge of infection, with older and vulnerable adults, at high risk of significant morbidity and mortality, a key concern. The stark epidemiological situation represents an immediate and grave threat to the State’s public health priorities, which include the protection of vulnerable groups and the continuation of care across all areas of the health and social care system.
The NPHET further took cognisance of the fact that the epidemiological data and modelling projections strongly suggest that it will be very difficult to effectively control viral transmission in the coming weeks, showing that the situation is likely to escalate further. The NPHET stressed that the reason for this is that we are now in a fundamentally different position than we were in October. Incidence is growing more rapidly. We had a 5-day average of 300 cases per day on 26th September and reached 800 cases per day on 13th October, 17 days later. We had a 5-day average of 315 cases per day again on 15th December and reached an average of 785 cases per day on 23rd December, 8 days later. The fact that the level of infection is growing faster in December than it was in October is underscored by the fact that current estimates of the reproduction number (1.5-1.8) and growth rate (6-9%) are higher than they have been at any point in the pandemic since March.

Furthermore, the NPHET noted that the October surge started with younger adults, with a delayed and attenuated increase in incidence, hospitalisations, and deaths in those aged 65 and older. Now, incidence is rising rapidly across all age groups. The NPHET underscored its fundamental concern that there is an imminent and serious challenge not just to public health, but also to the capacity of our healthcare service to provide adequate and timely COVID and non-COVID care.

The NPHET also noted the position in Northern Ireland and current plans to implement additional measures from 26th December, expressing concern in relation to any unintended cross-border movement into the country as a consequence, if one jurisdiction has less restrictive measures in place than the other.

NPHET Members reported increasing pressure across all aspects of the health service.

The HSE reported that the testing system is under strain and it will come under significant pressure should the current demand for testing be maintained. Similarly, as the number of confirmed cases grows, so does the number of contacts, further compounding the strain on the testing system. It was raised that General Practice is also constrained at the moment and it will be difficult to maintain current levels of services should levels of transmission remain high. The likelihood that GPs can maintain current services for the public is unlikely with such high levels of transmission.

The NPHET noted that data on sequencing is required to monitor disease evolution but also to inform our understanding of community-acquisition versus hospital/healthcare transmission for healthcare workers. As more healthcare associated outbreaks are reported, we need to evaluate the viral sequencing data to help understand the drivers to those outbreaks.

The HSE noted with concern the numbers of outbreaks in Long-Term Residential Care facilities (LTRCs) and noted the reduced lag effect previously experienced between community transmission and LTRC outbreaks as these numbers began to rise since the end of December, LTRCs are under significant pressure at present with increasing number of outbreaks and the resulting COVID-related staff absences placing significant pressure on safe staffing levels. The HSE confirmed that it is now reluctantly looking at both redeploying staff from other community services and use of the staff derogation policies.

NPHET Members noted their grave concern regarding the deteriorating epidemiological situation and stressed that urgent action must be taken to protect the health service.

The DOH stated that it shared the HSE’s concerns, particularly with respect to LTRC’s. Noting the high level of infection amongst HCWs, the DOH expressed doubt about surge capacity should the situation worsen and warned that we are heading towards a workforce crisis equivalent to that experienced during wave 1 in April 2020.

The DOH emphasised that it is essential that the health service is supported in so far as is possible, given that the primary role of the NPHET is to protect public health. The first peak of COVID-19 infections occurred in an environment in which most elective care was cancelled and a significant reduction in
patients presenting to hospital was seen. The current situation is now more complex. It was also noted that delayed routine care has the potential to become urgently needed care over time, and that the impact of the deferral of elective care on waiting lists should be considered. The DOH presented the following data to bring the matter into sharp focus:

**General practice**
- General practice is under pressure and GPs are reporting very high numbers of referrals for testing.

**Community therapies**
- Significant numbers of primary and community staff were redeployed to support the COVID response during the year. The trend has been that staff are moving back into their core roles but community therapy waiting lists are still rising. As of end-October:
  - In occupational therapy, 253,476 patients have been seen compared to a target of 326,254 - we are 22% below where we should be in terms of activity over the year
  - In physiotherapy, we aimed to see 492,086 patients and 337,642 have been seen - we are 31% below where we should be
  - In speech and language therapy, 131,216 patients have been seen rather than the target of 237,657 - so more than 100,000 patients who should have been seen this year have not been seen. We are 45% below where we should be.
  - The total number of clients seen across all primary care therapies (including those listed above) is 924,005 – down nearly a third on the 1.3 million seen in the same period last year.
  - Inevitably, this means that the number of individuals waiting for treatment or assessment is also rising.
  - There are 11,198 people waiting for SLT treatment, which is up over 36% on the same period last year.
  - There are 21,169 waiting for SLT assessment which is up nearly 38% on the same period last year.
  - In the same for the other primary care therapies with very significant increases in the numbers waiting for both assessment and treatment, and the number of long waiters is also going up.
  - There are now 4,217 waiting over a year for SLT assessment which is up nearly 3,000 on the same period last year.
  - There are 4,537 people waiting over a year for SLT treatment which is up 3,485 on the same period last year.
- Clearly there are longstanding capacity problems, but the figures demonstrate the additional impact for patients of what was a necessary COVID response.

**Acute hospital outbreaks**
- Notwithstanding investment and improved IPC practice, data from the HPSC show that the number of COVID-19 outbreaks in acute hospitals is increasing. In the week from 15th – 21st December, there were 9 new outbreaks in public acute hospitals, including 7 in Beaumont Hospital. As of midnight, on 21st December, there are 52 open outbreaks in public acute hospitals, comprising 1,010 cases, including 473 cases in healthcare workers.

**Acute hospital occupancy**
- As of 21st December, there were 244 confirmed COVID-19 cases in hospital, compared with 211 on 17th December. The number of confirmed cases increased by 20 or almost 9% in the 24 hours between Monday 21st and Tuesday 22nd December.
- Hospital occupancy rates are back at pre-COVID levels and already well above the recommended 85% - they are at almost 100% based on HSE’s daily COVID reporting. We have very little capacity in the hospital system to respond to increases in COVID presentations.
- As of 8am on 23rd December, TrolleyGAR reported 58 patients waiting on trolleys nationally, marginally higher than the same day last year. Trolley numbers normally drop in the final week of December and rise in early January, but it is difficult to predict what will happen this year.
Critical care
• Of the 276 critical care beds open on Tuesday 22\textsuperscript{nd} December, 241 were occupied including 28 COVID-19 patients. This left 31 adult critical care beds available.
• We had good outcomes earlier in the pandemic for COVID patients in critical care - 21% mortality as compared with 41% for the UK, to the end of June. This reflects the fact that our critical care units were not overwhelmed. This needs to be maintained.

Cancer services
• Despite the huge focus on minimising the impact of COVID-19 on cancer services, latest data show public patient cancer surgery numbers stand at 72% of 2019 levels; daycase radiotherapy sessions are at 91% of 2019 levels; the number of new patients commencing chemotherapy is at 85% of 2019 activity; while cancers diagnosed in Rapid Access Clinics are at 90% of 2019 levels.

Routine elective care
• More routine elective care has resumed since June, but there has been significant disruption. Hospital waiting list figures are higher than at the start of the year:
  o the Inpatient/Daycase waiting list 9% higher (72,843 people) at the end of November than at the start of January.
  o the Outpatient waiting list 11% higher (612,576 people).
  o GI Scopes 50% higher (33,411 people now waiting).
  o inpatient and daycase waiting list has come down marginally between the end of August and end of November, from 77,620 waiting at end of August to 72,843 people waiting.
  o the GI endoscopy waiting list has come down from 34,674 people waiting at the end of August to 33,411 people waiting at the end of November. More of these are waiting over a year – that’s 5,541 people now where it was 3,943 at the end of August.

Some NPHET Members, currently working in the acute hospital environments, stressed that we are heading back to a situation similar to that experienced in March 2020. Those working in hospitals have more experience now in dealing with COVID-19 cases. What we have seen recently is that if we have capacity on the wards, we can protect the ICU.

The Chief Nursing Officer confirmed that she had received feedback from her counterparts in Northern Ireland, Scotland, and Wales and England. They report that all health services in the UK are now overwhelmed with most at the point of risk-assessing what services can continue to be delivered. The UK is experiencing significantly high levels of infection amongst HCWs and mitigation efforts through the use of student nurses has met with strong opposition. The Chief Nursing Officer also noted that there may be challenges in deploying nursing students to respond to a workforce crisis if one emerges. The advice from UK counterparts is, if Ireland has an opportunity now to curtail the spread of COVID-19 and reduce the impact on services, everything possible should be done so the situation does not deteriorate to the reality the UK is now faced with.

NPHET emphasised continuing priority should be on protecting the most vulnerable and maintaining essential services such as health and social care, education and childcare, but noted that this would have to be kept under review.

The DOH reminded NPHET Members that the vaccine allocation framework is very clear that changing conditions, including the prevailing epidemiological situation, can lead to changing priorities. There is a requirement for a flexible, agile response, which takes into account operational issues. This may mean that priority groups may change, or several groups may be vaccinated concurrently. It was noted that in the case of healthcare workers, there was a multiplier effect of vaccinating this group.
as they are at high risk of contracting SARS-CoV-2 and they are more likely to transmit the virus to vulnerable patients.

Some Members suggested that direct public access to testing may be helpful at this point. It was also mentioned in the discussion that consideration should be given at this point to whether we are doing all we can with regards to PPE and whether any new approaches to IPC might be worth considering.

The HSE confirmed that it has put in place a system for access to testing over the Christmas period, including GP ‘out of hours’ services.

3. Review of Existing Policy

a) Update on control of transmission of COVID-19 in Acute Hospitals

The DOH presented “Joint Department of Health and HSE Update on Control of Transmission of COVID-19 in Acute Hospitals”. The paper provided an update on specific measures that are being implemented by the HSE to reduce the risk of nosocomial infection and to manage and control hospital outbreaks. These measures include the establishment of the National Working Group for Control of Transmission of COVID-19 in the Acute Hospital Setting; engagement with acute hospitals regarding efforts to control the spread of COVID-19; mass testing in the context of significant hospital outbreaks; and the proposed trial programme of serial testing of healthcare workers, which will be rolled out in early January.

The DOH and the HSE stated their full commitment to ensuring that these enhanced measures are implemented as a priority so that they have the anticipated impact to manage and control the transmission of COVID-19 in acute hospitals.

The National Working Group met for the first time on 21st December and agreed its Terms of Reference. The HSE developed and circulated a questionnaire/checklist for all acute hospitals to gather real time information in relation to the implementation of specific measures to prevent the introduction of the virus into the hospital, and to reduce the risk of transmission where it is introduced.

The DOH informed the NPHET that, to date, mass testing has been undertaken in response to significant hospital outbreaks, citing a number of hospitals where it was underway.

The HSE is currently planning the rollout of the serial testing programme for healthcare workers on 4th January. This will be undertaken with the assistance of the National Ambulance Service, with bookings scheduled through the Swiftqueue platform.

The DOH and HSE expressed grave concern at the rate of transmission of the virus within acute hospitals. They further expressed their commitment to ensuring that the enhanced measures are implemented as a matter of urgency, and that any further additional measures necessary to address the current situation are introduced and prioritised as required.

The NPHET’s attention was drawn to the potential impact of this current surge of infection on the health care system:

- Hospitalisations as a result of COVID-19 are already increasing and are projected to rise rapidly in the coming weeks. This is happening against a backdrop of an already constrained hospital system, with occupancy rates now back to pre-COVID levels and close to 100%, and Trolleygar figures similar to those at this time last year, and as we enter a period when the hospital system traditionally experiences the highest levels of demand.
- Long term care facilities, especially nursing homes, remain highly vulnerable to this disease. While incidence in these facilities had decreased in the latter half of November, cases are now rising in parallel to rising incidence in the community.
• Levels of disease in healthcare workers continue to be persistently high, and similarly to the position with long term care facilities, we are now experiencing a further increase in incidence in healthcare workers. The resilience of the healthcare system is wholly dependent on the availability of healthcare workers, and the NPHET expressed serious concern that a continuation of current trends could lead to potential workforce challenges in the coming weeks at a time when healthcare workers are already exhausted.

• All aspects of the testing and tracing system, including general practice, are already experiencing pressure and are likely to be severely constrained in a short space of time if transmission continues to grow at current rates. In particular, it will not be possible for public health teams to effectively identify and manage outbreaks, and in some cases a process to prioritise and focus resources on those areas that are most vulnerable to the disease has already been activated. This will greatly impact on our overall ability to contain further transmission of the disease.

There was a consensus across the NPHET that the health system is in an extremely precarious and fragile position, is at heightened risk of becoming overwhelmed and is facing into difficult decisions in relation to the ongoing provision of care. This comes at a time when activity levels across all services were necessarily reduced significantly over the course of the year and waiting lists have grown. For example, activity levels across primary care therapies were almost 30% lower this year than expected and the numbers waiting for speech and language therapies alone has increased by more than 35%. While scheduled acute care resumed in June, there has been significant disruption with hospital waiting list figures across inpatient, day and outpatient services all higher than at the start of the year. Our experience with the disease to date demonstrates how difficult it is to protect health care services and health care workers when there is widespread community transmission, and the NPHET is of the view that all available actions must be taken to prevent any further disruptions to health and social care services.

The NPHET thanked the HSE and DOH for their update and welcomed the intention to provide regular updates to the NPHET on progress.

b) International Travel
The DOH updated the NPHET on developments in the area of International travel. The ban on flights from the UK that was implemented on the 21st December, and which has been extended by Government to 31st December, was noted. The DOH advised that compliance overall was high, as the majority of flights had been cancelled and the number of persons travelling by ferry had also reduced. However, it cautioned that more permanent regulation, if decided upon, may be difficult to achieve on an effective basis, given the likelihood that, for a number of reasons, a significant number of exemptions to the ban would need to be provided for.

4. HIQA – Expert Advisory Group
a) Review of measures taken internationally on schools
HIQA provided a paper ‘Public health measures and strategies to limit the spread of COVID-19: an international review – Education Only’ and this was shared with NPHET members. The key points are as follows:

• Subsequent to the last data updated on 11th December, primary schools have closed in Czechia, Denmark, Germany, and the Netherlands; schools will remain closed in Austria when they are due to return on 7th January 2021.
• Primary schools are also closed in Bulgaria, Estonia, Lithuania, Poland, and Romania, and are closed for grades 5-9 in Latvia.
• Primary schools remain open in Belgium, France, Ireland, Italy, Portugal, Sweden, Switzerland, Hungary, and all UK countries. Schools in Scotland will return later than originally planned after Christmas.
• Subsequent to the last data updated on 11th December, secondary schools have been closed in Czechia, Denmark, Germany, the Netherlands, and Wales (except years 7 and 8); schools will remain closed in Austria when they are due to return on 7th January 2021.
• Secondary schools are also closed in Bulgaria, Estonia, Hungary, Latvia, Lithuania, Poland, and Romania.
• Secondary schools remain open in England, Ireland, Northern Ireland, Portugal, Scotland, and Switzerland.
• Belgium, France, Italy, and Sweden are operating a combination of face to face and distance learning.
• Universities and higher education colleges have moved to distance learning in all countries except England, Portugal, and Scotland.

The NPHET thanked the HIQA for this update and noted same.

b) Testing & Restriction of movement of close contacts
The HIQA presented the interim results of its review of testing and restriction of movement of close contacts for the NPHET’s consideration.

The NPHET thanked the HIQA for its presentation and advised that, given current infection levels and growing constraints on the testing system, the testing protocol for close contacts should change. The current Day 0 and Day 7 tests should be replaced by a single test, five days after the last contact with the confirmed case. The NPHET stressed that this should be implemented as soon as possible and remain in place until at least the 12th January. The NPHET emphasised that it is important to note that this does not impact on the requirement for all close contacts to restrict their movements for 14 days from last contact with the confirmed case, irrespective of their test result.

The HPSC confirmed that it would communicate this change in guidance in the form of an alert attached to the guidance document.

Action: The NPHET recommends that close contacts of a confirmed case are referred for a single COVID-19 PCR test at day 5; this represents a change to the current practice of referring close contacts for two PCR tests, at day 0 and day 7 respectively. A negative test result at day 5 does not dispense with the requirement for a close contact to self-isolate for 14 days. This should apply during the current period of high transmission, until at least 12th January pending further review.

5. Future Policy
a) Vaccination
The DOH and the NIAC gave an update on planned and ongoing vaccination work.

The DOH explained that it had been working closely with the HSE regarding consent to COVID-19 vaccination for individuals that may have not have full capacity under the Mental Health Act. This has included both the content of the COVID-19 vaccination consent form as well as the overall approach to be taken with this cohort.

The NIAC reported that it had been advised that COVID-19 vaccines will begin to arrive in Ireland from 26th of December. Given recent international reports that small numbers of vaccine recipients can experience serious suspected adverse allergic reactions following the receipt of the vaccine, the NIAC has advised the DOH that, while all vaccinators are well trained in the emergency management of anaphylaxis, in the first vaccine sites on a precautionary basis, it is deemed optimal to choose facilities where there is immediate access to a medical team that can help to support the identification and management of any acute severe reaction.
While the prioritisation framework developed by the NIAC identified nursing home residents as the first priority for receipt of COVID-19 vaccines, to ensure medical facilities were available to manage any acute severe reaction, a selection of acute hospitals has been chosen for the initial 2 days of roll-out of the first vaccines arriving in Ireland. Experiences from administering this first, relatively small quantum of vaccine will inform wider rollout of the vaccine when further quantities arrive in January. The NIAC also added that, in line with the recent European Medicines Agency (EMA) authorisation, prioritisation groups are now licensed down to the age of 16 as opposed to in the previous prioritisation groups which were licensed to age 18. This will have implications for who can safely receive the vaccine under the prioritisation framework, in particular those 16 and above who are health care workers or those would be considered “vulnerable” in medical terms given their underlying health conditions.

The NIAC further outlined that evolving evidence on the apparent efficacy of certain vaccines among certain groups after one dose may need to be factored into the immunisation programme, particularly in a context of vaccine shortage. In the context of vaccine shortage and the imperative to safely vaccinate as many as possible quickly, and in recognition of the overfill in each vaccine vial, the feasibility of safely obtaining 6 doses from each vaccine vial also needs further consideration.

It was raised that as vaccination in HCWs rolls out, it would be important to analyse in parallel how vaccine rollout affects workforce and staffing requirements by healthcare worker (HCW) discipline, this data could then be used inform a targeted vaccination strategy across HCW disciplines. The NPHET emphasised the need to encourage high uptake of the vaccine amongst healthcare workers. The positive impact on HCW morale of receipt of COVID-19 vaccination in other jurisdictions was noted.

The HPRA informed the NPHET that the Moderna COVID-19 vaccine’s authorisation review was now being brought forward. It was also explained that the EMA has developed useful communications materials regarding the new variant of COVID-19 recently identified, and vaccine efficacy.

The DOH confirmed that it is developing legislation to expand the pool of healthcare workers eligible to administer vaccinations, in the event that this is needed for public health reasons.

The NPHET thanked all contributors for their updates and welcomed the news that the initial doses of the COVID-19 vaccine would be rolled out in the coming week.

c) Public Health Measures

The NPHET noted the Government’s decision of 22nd December to reintroduce Level 5 measures with certain modifications on a phased basis, commencing on 24th December.

The Chair asked Members for their views on whether these measures will be sufficient to suppress transmission to the extent required to control the disease and mitigate the level of associated hospitalisations and mortality, noting that this requires an R number of much lower than one.

The NPHET revisited the epidemiological and modelling data to inform the discussion. The Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) reminded the NPHET that, prior to the nationwide adoption of Level 5 measures in October, Dublin was already in a state of heightened restrictions at Level 3. This meant that the virus was already being suppressed by roughly one quarter of the population in advance of the impact of nationwide Level 5 measures. Thus, notwithstanding the Government’s recent decision to curtail the period of relaxed measures over the Christmas period, the introduction of increased restrictive measures may not decelerate disease progression as quickly or as effectively as during the second wave of the pandemic.
It was noted that, in the past 10 days, Ireland had seen its highest increase in disease incidence since the COVID-19 pandemic began. Planned Christmas day celebrations involving multiple households and intergenerational mixing, combined with the rapid growth of the disease posed a significant risk for further acceleration in the rate of transmission and resulting hospitalisations.

Concern was also expressed that, as is generally the experience with seasonal flu in other years, the number of cases reported over the Christmas period is likely to be an under-representation of the actual position requiring that case numbers in the coming days are interpreted with increased caution.

The NPHET stated that, as in all of its previous advices to Government, any recommendations must be grounded in the best evidence and information available. It was restated that certain settings (e.g. retail) pose significantly lower risk than others (e.g. hospitality) for contributing to disease transmission. However, it was emphasised that when there is widespread community transmission, comprehensive population-based measures across all sectors are required. It was also noted that it can be difficult to identify evidence of transmission in certain settings, and the NPHET acknowledged the significant difficulties for public health departments to isolate disease outbreaks and transmission to precise settings where individuals typically congregate and socialise, particularly in the context of widespread community transmission and rising cases. In instances where precise evidence of outbreaks cannot be readily isolated to specific settings, the NPHET should draw on evidence from other international comparators as appropriate.

Further key issues raised in the discussion:
- Members expressed the challenge in remaining proportionate in terms of restrictions whilst remaining aware of the social, cultural, as well as religious importance of Christmas to many members of the public. Notwithstanding the current level of restrictions and the recent Government decision to curtail the period of relaxed measures, communication with the public should emphasise the urgent need to significantly reduce socialisation. The public must also be made aware that at present, vaccines will not play a significant role in combatting COVID-19 on a national basis, so adherence to the established public health guidance remains vital. The challenge for the NPHET is to consider how these messages, combined with possible alterations to the overall public health response, might be combined to encourage widespread public buy-in. Public health guidance should focus on reducing opportunities for social interaction, with improved monitoring and supervision, while also ensuring that the public are not disadvantaged in terms of what individuals are permitted and encouraged to do.
- Members stressed that, given the short space of time between the NPHET meeting and Christmas day, many of the public are likely to have committed to their plans for Christmas day already. Therefore, the NPHET should focus on coordinating its messaging to encourage the public to have safe and small Christmas Day celebrations, with any new restrictions coming into effect immediately after this date. The public must also be made clearly aware of what “at-risk” means in the context of families gathering over the Christmas period, paying particular attention to those that may have less visible vulnerabilities (e.g. diabetes, heart disease, respiratory diseases).
- Members also reaffirmed the need to focus on the NPHET’s key objectives when considering what measures should be introduced, with certain services (e.g. continuation of scheduled healthcare activities) taking clear priority over others (e.g. continued opening of non-essential retail).
- Data from the Amárach behavioural tracker now indicates the public’s worry about COVID-19 is at its highest level since COVID-19 began. Moreover, the public’s view as to whether more restrictions are required has radically changed in the past week; as of Monday 21st December, 60% of respondents say more restrictions are needed, contrasted with 26% of respondents indicating that the current level of restrictions is adequate.
- The NPHET discussed the impact that the reintroduction of severe restrictions might have on an individual’s mental health. It was outlined that the Christmas period is often a particularly challenging time for people’s mental health. The NPHET acknowledged the anxiety and distress that further restrictions might create for people but was equally cognisant of the impact that continued inaction
could have for the ongoing viability of health services, including mental health services. There was consensus that the increasing disease transmission could significantly disrupt the provision of formal mental health services if allowed to continue.

- The issue of direct access to COVID-19 PCR testing was also raised. Members spoke favourably of instances where direct access to PCR testing has been piloted by the HSE, namely in Beaumont Hospital and on a pilot site in Limerick. Members also expressed that this type of testing service could draw from experiences in STI testing in sexual health clinics, notwithstanding the obvious differences in staffing requirements and clinical governance. While there was agreement on the potential usefulness of this initiative, such as extending access to testing to asymptomatic people in a more expeditious manner, the NPHET were reminded that approach could have significant operational implications for the HSE. Equally, any approach piloted should serve to complement existing referral pathways in which GPs occupy an essential clinical governance role.

- It was outlined that data from the Contact Management Programme (CMP) shows that there is frequently a delay observed between symptom onset and presentation for testing. While it is possible that this delay might be reduced through more direct access to COVID-19 PCR testing, the NPHET expressed the need for caution not to disrupt existing clinical governance arrangements for referral for testing through an individual’s GP. If introduced, a clear clinical support pathway would be required.

- The HSE outlined that direct access to COVID-19 PCR testing has been an area of significant debate and discussion among its clinical Expert Advisory Groups, and that a diverse range of opinions exist on the matter. Future decisions on direct access to COVID-19 PCR testing should involve further input from these groups.

- While there was consensus in relation to Level 5 measures, there was also some discussion on the need for the NPHET to consider what other innovations/approaches could be considered for managing the response to COVID-19 in the longer term. This will be returned to in future meetings.

The NPHET agreed unanimously that all of the indicators for introducing Level-5 restrictions had been met. Each of the core objectives identified by the NPHET and the Government – namely, protecting the medically and socially vulnerable, protecting childcare and education settings, and preventing unnecessary disruption to non-COVID health and social care services – were at risk based on the current disease profile. Notwithstanding the desire to have as targeted and proportional a response as possible, the NPHET agreed that only population-wide measures which reduce mobilisation, congregation and socialisation could adequately halt and reduce the current rate of disease transmission.

The NPHET concluded that it does not believe that the measures announced on 22nd December will be sufficient to suppress transmission to the extent required to control the disease and mitigate the level of associated hospitalisations and mortality. The required R number of much lower than 1 will only be achieved by widespread population level measures aimed at significantly reducing levels of mobility, congregation and socialisation. The NPHET agreed that there is now too great a risk in waiting to assess the impact of measures announced on 22nd December and advised that the full suite of Level 5 measures be introduced with effect from midnight on the night of 26th December for a period of six weeks.

The NPHET noted that a further significant deterioration in the profile of the disease over the coming weeks will seriously impact on our collective ability to protect public health, particularly in relation to those most vulnerable to the severe outcomes of COVID-19 and to ensure the continued delivery of non-COVID care and education and childcare services into the New Year.

Members expressed that Level 5 restrictions alone may not sufficiently suppress the virus given its current growth rate and the implementation of more severe restrictions seen in other jurisdictions may need to be considered. However, consideration of such measures, which could have significant further ramifications for individuals’ civil liberties, would only be warranted where level 5 measures have been observed to be ineffective at reducing disease transmission.
The Chair summarised and concluded the discussion. The Chair reiterated the core objectives agreed by the NPHET and the Government which must be protected. The Chair noted that each of these activities requires a certain amount of socialisation. The reopening of other parts of society, with socialisation of a more discretionary nature, further increases the likelihood of disease transmission. Ireland has been successful in previous months at keeping disease transmission at a manageable level which allows for a more targeted and nuanced approach to enabling increased opportunities for safe socialisation. In the current situation of widespread community disease transmission, however, it is no longer possible to discern where each new case is arising. As a result, only population-wide measures designed to significantly limit socialisation will be effective at reducing transmission to a level from which a more targeted approach might be feasible. It is necessary, therefore, to maintain socialisation only in specific, limited and essential contexts (e.g. schools and early education settings, health and social care services, essential shopping) thereby removing the majority of all other discretionary opportunities for socialisation which could lead to continued disease spread.

Noting the ongoing work on antigen testing in the discussion, the Chair requested that the HSE bring a paper in the New Year to examine issues of Antigen, PCR and genomic testing which includes consideration of the issue of direct access to COVID-19 PCR testing.

Action: The NPHET recommends, in line with the “Framework for Restrictive Measures in Response to COVID-19”, the full implementation of Level 5 public health restrictive measures nationally from midnight on the night of 26th December, for a period of 6 weeks with ongoing review.

6. Communications Update
The DOH and the HSE gave an update on COVID-19 communications.

The HSE explained that communications materials for the COVID-19 Immunisation Programme are in development and close to completion. It was also outlined that the HSE is coordinating with the European Commission on media coverage regarding the arrival of the first batch of vaccines into EU Member States and the first individuals to have vaccines administered to them. Work is ongoing to identify individuals at the first vaccine sites to take part. In relation to healthcare settings, it was stressed that very limited media presence will be allowed. It is hoped that these recordings might take place on the 26th and 30th of December.

7. Meeting Close

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

b) AOB
i. Novel UK SARS-CoV-2 Variant
The National Virus Reference Laboratory (NVRL) gave a presentation on “Novel UK SARS-CoV-2 variant”.

It was explained that Public Health England (PHE) have identified a novel variant of SARS-CoV-2 which has spread rapidly within the United Kingdom. While further studies are underway to characterise the variant, PHE have concluded with a high degree of confidence that this variant has substantially increased transmissibility.

The NVRL outlined that whole genome sequencing is now underway to definitively confirm whether the strain is present in Ireland.

Members of the NPHET highlighted that these data could be useful if aligned with epidemiological disease modelling, but that whole genome sequencing would be required first.
The NPHET thanked the NVRL for its update and noted that preliminary data suggests that the variant is present in Ireland, but further work is ongoing to confirm this. The UK has indicated that the trajectory of disease in the area of England most affected by the new variant demonstrated exponential growth in the last two weeks of November, at a time when substantial restrictive measures were in place (no household visiting, all non-essential retail and hospitality closed). This suggests that, if the variant grows to a significant level in Ireland, anything other than a combination of measures equivalent to Level 5 plus substantial adherence to, and enforcement of, those measures will be required to regain control of the current situation.

c) Date of next meeting
The next meeting of the NPHET will take place Wednesday 30th December 2020, at 11:00am via video conferencing.