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

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<thead>
<tr>
<th><strong>Date and Time</strong></th>
<th>Thursday 7th January 2021, (Meeting 71) at 10:00am</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td><strong>Chair</strong></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
- Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor
- Dr Michael Power, Consultant in Anaesthesics / Intensive Care Medicine, Beaumont Hospital
- Ms Rachel Kenna, Chief Nursing Officer, DOH
- Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
- Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Ms Siobhán O'Neill, National Director, Community Operations, HSE
- Mr Phelim Quinn, Chief Executive Officer, HIQA
- Dr Siobhán O'Sullivan, Chief Bioethics Officer, DOH;
- Dr Darina O’Flanagan, Special Advisor to the NPHET
- Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH
- Dr Breda Smyth, Public Health Specialist, HSE
- Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH
- Ms Deirdre Watters, Communications Unit, DOH
- Dr Colm Henry, Chief Clinical Officer, HSE
- Mr Liam Woods, National Director, Acute Operations, HSE
- Dr Elaine Breslin, Clinical Assessment Manager, HPRRA
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- 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
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Mr Gerry O’ Brien, Acting Director, Health Protection Division
- Ms Aoife Gillivan, Communications Unit, DOH
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Dr Matthew Robinson, Specialist Registrar in Public Health, DOH

**Secretariat**

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

**Apologies**

- Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital

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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) Matters Arising
   In his opening comments, the Chair welcomed new NPHET Member, Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH.
   The Chair then noted the gravely concerning epidemiological situation, stating that it is the worst the country has faced since the beginning of the pandemic. He expressed the hope that the NPHET could, in the future, state that the epidemiological situation on 7th January represented the worst day regarding the path of infection and asked all members to reflect on that point.

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 31,001 cases have been notified in the 7 days to 6th January, which is a 286% increase on the previous 7 days to 30th December in which there were 8,018 cases;
   - As of 6th January, the 7-and 14-day incidence rates per 100,000 population have significantly increased to 651 and 819, respectively; these compare with rates of 168 and 273 on 30th December, and with rates of 104 and 153 on 23rd December;
   - Nationally, the 7-day incidence as a proportion 14-day incidence is 79%, demonstrating that there have been substantially more cases in the last 7 days to 6th January compared with the preceding 7 days to 30th December;
   - There has been a rapid rise in age-specific incidence rates across all age groups, including in those aged 65 and older. In the past 14 days, 10% of cases notified were aged over 65 years. The incidence in those aged 18 and under remains at or below the population average;
   - The 5-day rolling average has increased rapidly from 1,213 on 30th December to 5,524 on 6th January and is 7 times greater than the figure for 23rd December (785 cases);
   - Of cases notified in the past 14 days to 6th January, 64% have occurred in people under 45 years of age; the median age for cases notified in the same period is 35 years;
   - There has been a significant increase in the 14-day incidence rates across the country with all counties now having a 7-day incidence as a percentage of 14-day incidence significantly greater than 50%, indicating a considerable increase in cases in the last 7 days to 6th January compared with the previous 7 days to 30th December;
   - The reproduction number (R) is extremely high and is currently estimated to be 2.4 to 3.0; this estimate has increased significantly over the last week and is now estimated to be at its highest point since March 2020. The current daily growth rate of cases is 14%. This compares with a daily growth rate of 7-10% at the last NPHET meeting on 30th December. The doubling time is currently 5 days;
   - A very high volume of tests (171,931) has been undertaken in the last 7 days to 6th January. The 7-day average test positivity rate has rapidly increased to 21.9% on 6th January from 9.3% last week on the 29th December;
   - Excluding serial testing, the test positivity rate has also rapidly increased over recent days. It was 27.5% over the 7 days to 6th January, up from 10.9% in the 7 days to 29th December;
   - According to the contact management programme data, 25 counties have test positivity rates greater than 10% and 16 counties have test positivity rates greater than 25%;
   - There are currently 1,022 confirmed COVID-19 cases in hospital as of 7th January, compared with 454 on 30th December. There have been 131 newly confirmed cases in hospital in the preceding 24 hours;
There are currently 89 confirmed cases in critical care, compared with 37 on 30th December. There have been 18 admissions in the last 24 hours;

As of 7th January, there have been 34 deaths notified with a date of death in January. This compares with 158 and 162 deaths notified (as of 7th January) with a date of death in November and December, respectively. Of the 34 deaths so far in January 10 have been associated with hospital outbreaks and 6 have been associated with nursing home outbreaks. Of the 162 deaths notified in December, 54 have been associated with hospital outbreaks and 45 have been associated with nursing home outbreaks.

Further relevant information includes:

- Due to the surge in case numbers in week 53, there was a delay in reporting of outbreaks to the national surveillance system (CIDR) and the linking of cases to outbreaks. Therefore, the number of outbreaks and linked cases are likely to be underestimated. The number of outbreaks represents the most reliable indicator.
- There were 23 new clusters notified in acute hospitals in week 53.
- There are currently 79 open clusters associated with 32 acute hospitals. There have been 71 deaths linked to these outbreaks.
- There were 23 new clusters notified in nursing homes/community hospitals in week 53; there are 41 new outbreaks in nursing home in the current week.
- There are currently 101 open clusters associated with nursing homes. There have been 69 deaths linked to these outbreaks.
- There have been 11 outbreaks associated with schools in week 53 with 15 linked cases (although transmission in the school setting has not necessarily been established in these outbreaks).
- There was 1 outbreak in the Irish Traveller community in week 53. There are currently 45 open outbreaks in the Irish Traveller community.
- A range of mobility and compliance data suggest that movement and social contact in the population had increased significantly in the lead up to Christmas. There has been a decrease in mobility since Christmas and thereafter to date, 7th January.
- The number of close contacts during the week ending 3rd January was 81,523, a 144% increase compared to the previous week (33,390).
- The number of close contacts remained below 3.3 on average until early December, rose to almost 5 on average by 28th December, and then decreased rapidly; As of 5th January, it was 3.0 per case.
- The sentinel GP influenza-like-illness consultation rate (ILI rate) has increased in recent weeks and is now 65.1 per 100,000 population (week 53), compared to 45.2/100,000 in week 52 2020 and 44/100,000 in week 51 2020. A rate of 65.1/100,000 population is above the medium intensity threshold (57.5/100,000). The sentinel GP ILI consultation rate continues to reflect Sars-CoV-2 circulation, as there are currently no reports of any confirmed influenza cases in Ireland for the 2020/21 season.
- As of the 6th January, the 14-day incidence per 100,000 population in Northern Ireland was 1,051; this is 28% higher than the 14-day incidence in the Republic of Ireland (819 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 652, which is the same level as the 7-day incidence in the Republic of Ireland (651 per 100,000 population).
- On 21st December, Ireland ranked 1st in the EU/EEA and the UK in terms of percentage change in 14-day incidence (390%); Ireland ranked 1st in terms of percentage change in 7-day incidence (245%).

The chair of the Irish Epidemiological Modelling Advisory Group provided an update on current modelling projections, the key points were:

- While it is not yet possible to separate out the role of increased socialization and social contact from the potential role of the new UK SARS-CoV-2 Variant (also known as B.1.1.7 Variant), it is likely that the new variant has, at least since the week beginning 21st December 2020, contributed to this major increase in transmission and reproduction number.
• If the measures taken on 26th December, 31st December and 6th January succeed in bringing reproduction number below 1.0, the models show a peak case count between 8,000, and 8,500 per day around 13th January 2021, and a decline in cases throughout January to between 2,600 and 5,600 cases per day by the end of January.
• There is some evidence that the rate of transmission may have started to decrease over the last 7-10 days.
• When cases are examined by the date on which the laboratory specimen was taken, there is a possible inflection point on 30th December which suggests that case numbers may be starting to plateau. This raises the possibility of a more optimistic trajectory over coming weeks, with a peak of 5,000-6,000 cases per day now, and 1,100-2,900 cases per day by the end of January.
• Given these projections for case numbers, and assuming the age profile of cases remains unchanged it is projected that there will be 1,200-2,200 people in hospital and 200-400 people in ICU by mid-January if transmission and incidence do not decrease radically in the coming week.
• The IEMAG shared a provisional model it had developed which showed the expected progression of prevalence of the UK Variant of the virus. Given that this strain may be up to 70% more transmissible, the model predicts that within 6 weeks the UK Variant will become the dominant strain of the virus in the country.
• Addressing the likely impact of vaccination on incidence and severity of disease over the course of the coming months, and the implications for the management of the pandemic, is now a priority for the IEMAG.

The National Virus Reference Laboratory (NVRL) update the NPHET on the ongoing work with respect to novel variants of concern, the key points were as follows:
• The NVRL continues to make efforts to improve its ability to identify novel variants. These include increasing the sample size, improving the geographic representativeness of samples, and the targeted testing of cases with UK links.
• It was found that the UK Variant was detected at a significantly higher rate in people with known travel to the UK.
• Currently the earliest sample in which the UK Variant was detected in Ireland is from the week ending November 8th December 2020.
• The UK Variant of the virus is present in all nine Community Healthcare Organisations and across all age cohorts.
• The amount of whole-genome sequencing performed to date in Ireland by both the NVRL and the Irish Coronavirus Sequencing Consortium has been commendable and compares favourably with other efforts internationally.

With respect to the potential impacts of novel variants, members agreed that it would be pertinent to reassess IPC measures in healthcare settings. New guidance may be necessary to ensure that IPC precautions are robust enough to mitigate the increased risk of transmission from the new strain. The HIQA agreed to develop a rapid evidence review to inform updated Infection Prevention and Control (IPC) advice in light of high levels of transmission and novel variants of SARS CoV-2, liaising with IPC leads in the HSE, where necessary. The NPHET proposed that the information presented by the NVRL be shared with AMRIC so that existing guidance can be updated in line with the work to be carried out by the HIQA.

In addition to a review of IPC guidance members requested additional information on nosocomial infection be made available, including the breakdown of community versus hospital acquired cases in acute settings. The DOH supported this view but advised the NPHET that, due to some data from hospitals being bed-based (rather than patient level), along with the limited enhanced surveillance data currently available as a consequence of the recent surge in case identification and notification (including incomplete coverage of data on healthcare worker status), further work is required to develop an accurate assessment and
breakdown of nosocomial infection rates. In addition, definitively attributing source of infection (community versus healthcare setting) may not be possible in all instances.

The NPHET was apprised of the preparations being made to reinforce the health care system, particularly ICU capacity, in light of the escalating number of hospital admissions. This includes the establishment of a HSE Acute Operations critical care working group, which will coordinate surge response across all acute settings in the context of overall HSE Acute Operations oversight and coordination of responses.

The DOH highlighted that the current level of new LTRC outbreaks over the past few weeks is of grave concern, where there have been 41 new nursing home outbreaks since midnight 2nd January, with the current number of open outbreaks at 101 in nursing homes and 33 in disability centres. While monitoring by the HSE and HIQA continues, alongside the ongoing provision of significant supports, this level of disease in congregated long-term care is unavoidable while levels of community transmission remain high and will inevitably lead to increased morbidity and mortality in these settings. In addition, staff absenteeism due to COVID-19 leave is increasing. This will create substantial challenges to support nursing homes with staffing supports. The DOH stressed that is critically important that all nursing homes review their infection prevention and control processes and their contingency planning to mitigate such risks as far as possible.

The high level of disease and reduced staff availability directly impacts on the ability of community older people and disability services to continue to deliver safe services and may lead to a requirement for the prioritisation of the delivery of home care. Having regard to this, enhanced mobilisation of community and support coordination services through the COVID-19 Community Call Forum initiative is vital in the coming weeks and months to provide community supports and safe and wellbeing check-ins.

In concluding its discussion on the epidemiological situation, the NPHET noted that the disease incidence is very high across all age groups and still rising especially among young adults. Disease incidence in those aged 65 and older remains high and a notable cause for concern given the vulnerability of this cohort. Incidence in those aged 18 and younger, although high, remains at or below population average. The NPHET further noted that it is seeing ongoing marked increases in the number of confirmed COVID-19 cases in hospital. In addition, the number of COVID-19 patients in intensive care units is rapidly rising and deaths have also begun to increase. The substantial detrimental impact of widespread viral transmission is also being observed in the number of new outbreaks occurring in health and social care settings, including in acute hospitals and long-terms residential care facilities (LTRCs). The decrease in the average number of close contacts from a peak of 4.7 on 28th December offers some degree of hope that disease transmission may be interrupted. However, Ireland continues to experience a severe third wave of infection, with older and vulnerable individuals a key concern.

The Chair gave thanks to the exceptional work of the Health Protection Surveillance Centre, Public Health Departments, and the Office of the Chief Information Officer, who, over the past few days, ensured that the backlog of positive lab results to be notified to CIDR was cleared. The Chair further recognised the important work that was being done to sequence, monitor and protect against the UK SARS-CoV-2 Variant and thanked all those who had contributed so far. Due to these timely efforts the NPHET was in a position to swiftly update the Minister for Health on the unfolding situation.

The Chair confirmed that the NPHET fully supported the proposal to update IPC guidance, as necessary, in light of the emergence of the so-called ‘UK Variant’. The Chair further emphasised the importance of continuing work to develop a more complete understanding of the impact of nosocomial transmission.
3. Review of Existing Policy

a) International Travel
The DOH updated the NPHET on the issue of international travel.

It was outlined that, following the emergence of evidence regarding the novel UK Variant of SARS CoV-2, a flight ban between Ireland and Great Britain was instituted before Christmas. Irish citizens in Great Britain were also strongly discouraged from using ferries to travel back to Ireland for the Christmas period. The Department of Foreign Affairs facilitated a small number of flights to repatriate a limited number of Irish citizens for essential reasons.

The DOH outlined that, from this weekend, a statutory response to international travel from Great Britain and South Africa into Ireland will take effect. Individuals travelling from these regions will be legally required to present a ‘not detected’ PCR test result prior to departure to allow them to travel. While provisions will allow individuals in specific, limited circumstances to travel without availing of a test, the aim of this statutory response is to deter people from taking discretionary international journeys from these regions.

The DOH explained that individuals who travel from Great Britain and South Africa will also be invited through a GP for a PCR test on Day 5 of their arrival into Ireland using the details they provide on their passenger locator form. Travellers from these regions will be required to fulfil the full 14-day restricted movements period regardless of the result of their Day 5 test. The DOH has also made clear in its advice to Government that a ‘not detected’ PCR test result prior to travel should not be interpreted as exempting individuals from the recommended restricted movements period. Rather, these new measures must be implemented as part of a suite of other public health measures. The DOH concluded that similar measures may be contemplated for international travellers from other countries in future subject to Government decisions.

The NPHET thanked the DOH for this update and welcomed the progress in strengthening Ireland’s approach to international travel in relation to transmission of COVID-19.

b) Update on Acute Hospital and Primary Care Preparedness for Covid-19
The DOH presented its joint paper with the HSE “Update on Acute Hospital and Primary Care Preparedness for COVID-19: 7th January 2020”.

The DOH outlined that the level of COVID-19 in the community is a key determinant of the level of healthcare that can be delivered and of the associated risk to patients, service users and healthcare workers. The widespread transmission level of the virus has significantly impacted on the delivery of non-COVID care including the deferment of all but essential time-critical elective care in hospitals and pausing/reduction of some community services in order to meet the highest priority needs in residential, community and home delivered services. The situation across all settings is continuing to deteriorate in line with growing case numbers.

- As of 2pm on 6th January, there were 954 patients with COVID-19 in hospital, an increase of almost 500 when compared to the previous week (30th December). Of those 954, 105 had been diagnosed within the previous 24 hours, with a further 200 patients awaiting test results.
- As of 2pm on 6th January, there are 87 patients in intensive care. This compares to 39 patients just seven days earlier on the 30th December.
  On 2nd January, the HSE issued correspondence to the acute hospital system recommending that only critical time-dependent elective procedures are undertaken due to the on-going and significant increased demand for bed capacity related to COVID-19.
- Data provided by the HPSC indicates that there were 78 open hospital outbreaks in hospitals on 5th January, comprising 1,099 cases, including 493 cases in healthcare workers. A total of 81 deaths have been associated with these open outbreaks.
The DOH outlined that the situation in the acute hospital system is one of extreme pressure. Further increases in the numbers of patients hospitalised with COVID-19, which are expected to be seen in the coming days, will further reduce the ability of hospitals to provide safe, high-quality care. Such a scenario presents a significant risk to both patients and staff, who have been working in extremely challenging circumstances for some time now.

Similarly, primary care services are coming under increasing pressure as they try to operate in an environment with widespread transmission and prioritisation of service delivery is taking place, particularly in some geographic locations with higher levels of community transmission and outbreaks. The service impacts of open outbreaks in long term residential facilities (131 reported as of 6th January) are most visible in availability of staff and are impacting on other care areas, with nursing staff being redeployed from primary care services.

The DOH concluded that the level of transmission and associated rise in cases and in patients requiring hospitalisation means that the system will not be able to continue the delivery of non-COVID health and social care to the same extent as was possible in the summer and autumn of 2020.

However, the DOH and HSE will continue to work together to ensure all possible mitigation actions are taken in response to the gravity of the current situation, and to maximise the use of the innovative approaches and practices, adopted earlier in the pandemic, to maintain delivery of care.

The HSE informed the NPHET that the HSE acute operations taskforce is in the process of identifying ICU nursing expertise throughout the system for redeployment to ICU at this time, in line with surge planning. The DOH reaffirmed their commitment to working with colleagues in the HSE in its oversight and implementation of the critical care plan published before Christmas.

The NPHET thanked the DOH and HSE for their joint update. The Chair further informed members that he had briefed Government opposition health spokespersons earlier in the week on the current COVID-19 situation, during which there was significant interest in ongoing planning in relation to ICU capacity.

4. HIQA Expert Advisory Group
The HIQA submitted “Public health measures and strategies to limit the spread of COVID-19 in the Education Sector: an international review: 6th January 2021” for information. Key points were as follows:

- Primary schools are re-opening after the Christmas holidays for face-to-face teaching in a number of EU/EEA countries including Sweden, Portugal, Switzerland, Belgium, France, Italy and Norway. However, distance learning is operating in primary schools in Austria, Denmark and the Netherlands until 17th January, and higher primary school classes in Czechia until 10th January. Primary schools remain closed in Germany until 11th January and will then operate by distance learning until the end of January.
- In the UK, primary schools will move to distance learning until 18th January in Wales, 29th January in mainland Scotland, and until February half-term in England and Northern Ireland.
- In Ireland, the re-opening of primary schools has been delayed until 11th January, after which distance learning is due to be introduced until the end of January.
- Secondary schools in Norway, Portugal and Switzerland, lower secondary schools in Sweden and those secondary schools in Finland that are not in regions of ‘epidemic spread’ are re-opening after the Christmas holidays for face-to-face teaching.
- All other EU/EEA countries are operating by distance learning or a combination of distance learning and face-to-face teaching.
- Austria, Belgium Denmark and the Netherlands currently have an end date of 17th January for distance learning in secondary schools, while Sweden has an end date of 24th January for distance learning for upper secondary schools.
• Secondary schools remain closed in Germany until 11th January and will then operate by distance learning until the end of January.
• In the UK, secondary schools are operating by distance learning until 18th January in Wales, 29th January in mainland Scotland, and until February half-term in England and Northern Ireland.
• In Ireland, the re-opening of secondary schools has been delayed until 11th January, after which distance learning is due to be introduced until the end of January.
• Universities and higher education colleges are operating by distance learning in all countries except Portugal.

The HIQA also outlined that it is continuing to update the evidence synthesis in relation to duration of restriction of movements for individuals exposed to SARS CoV-2, which had been considered by NPHET previously. This work will be concluded shortly, and a final evidence synthesis report will be brought to the NPHET for decision at its next meeting.

5. Future Policy
a) Testing
The HSE presented “Public Health Prioritisation of Testing in Current Epidemiological Context”, which outlines an approach for the prioritisation of PCR testing should testing capacity be overwhelmed and the role of Antigen Detection Tests in the current epidemiological context.

i. Antigen and ii. PCR Testing

The paper outlined the current and planned PCR testing capacity, the maximum daily capacity available for community PCR testing currently c. 24,850, including off-shore testing capacity. This figure excludes current capacity of 4,000 acute hospital laboratory tests focussed on supporting patient care within the acute hospital network. The paper further noted that, at the current level of demand, the limiting step within the Test and Trace pathway is the swabbing function. The current community swabbing capacity is c. 17,000 samples per day, with an additional 4,000 samples taken within the serial testing facilities, and a further 4,000 samples taken within the acute sector. Increases in outbreak management associated with higher infection rates creates a demand for additional mobile swabbing teams and ‘pop-up’ swabbing centres placing a substantial strain on the 17,000 per day community sampling capacity.

The paper stated that if the demand for testing exceeds capacity in the coming weeks, prioritisation of testing may be required. Sources consulted in defining priority groups include the WHO and ECDC, with the priority groups for testing published by the HSE in April 2020 also reviewed.

The proposed priority groups for PCR testing set out in the paper are as follows:

• Symptomatic healthcare workers.
• Asymptomatic healthcare workers identified as household contacts of a confirmed case.
• Symptomatic people who live in the same household as a healthcare worker or a person categorised as High Risk or Very High Risk as per HSE risk categorisation.
• All acute hospital admissions. Note, consideration may be given to use of antigen detection tests, with PCR confirmation of negative results, in this group.
• Symptomatic people at risk of developing severe disease. This includes all those categorised as High Risk or Very High Risk, by virtue of their age or medical conditions, according to HSE (appendix A).
• Symptomatic people who work or reside in closed settings or who are members of vulnerable communities – includes residents of long-term care facilities, hospital inpatients, members of the Travelling Community, Roma, Homeless, residents of direct provision centres, prisons, etc. In an outbreak situation wider testing of asymptomatic people will be determined by Public Health Risk Assessment. Consideration may be given to use of antigen detection tests, with PCR confirmation of negative results, in this group.
• Testing of first few cases in a suspected outbreak in setting such as schools, workplaces etc.
People with a history of travel from the United Kingdom or South Africa regardless of symptoms. Close contacts of confirmed cases with a history of travel from the UK or South Africa.

The paper noted that field evaluation of Rapid Antigen Detection Tests (RADTs) is underway in Ireland and is nearing completion for some of the 6 RADTs, with final results of verification of performance in symptomatic people for some assays due in the coming days.

Interim validation results show sensitivity above 80% and specificity >97% in one of the assays when used in symptomatic patients. Results in asymptomatic patients however have shown lower sensitivity, below the minimum performance requirements set by WHO at >=80% sensitivity and >=97% specificity.

The paper highlighted that there are significant operational and logistical challenges in introducing Antigen Detection Tests. In particular, it was noted that, while these tests are described as rapid and are simple to perform, they are not designed to be delivered in large numbers. Each test requires approximately 20 minutes to prepare, process and read the result. In many hospitals, rapid PCR turnaround times are available (3-4 hours) and the addition of RADTs may slow down the testing process.

The following points were raised by members of the NPHET:

- With respect to testing in general it was noted that Ireland is now facing a crisis among healthcare workers, with staff absences due to COVID-19 increasing across hospitals and nursing homes. Emphasis was also placed on the issue of nosocomial infection.
- Considering the logistical and operational challenges of introducing ADTs set out in the paper, such tests could be focussed on hospital sites with the necessary clinical experience. It was raised that the currently available ADTs are not appropriate for asymptomatic cohorts or large-scale use at present. However, if hospitals feel the need to introduce ADTs, ideally for use in symptomatic cohorts, then they should be able to make such a decision given their clinical expertise and understanding of the limitations of ADTs.
- Other members noted that as ADTs should only be used in very specific situations thus far, this reinforces the importance of having a robust PCR testing infrastructure. Furthermore, labs are also experiencing staff shortages; adding the extra testing modality could prove difficult.
- Concern was raised about transmission within hospital settings. It was reiterated that testing is only part of the solution and should take place alongside adequately protecting staff and minimising the risk of contracting the virus within the hospital setting. It was further emphasised that much of the current acute hospital infrastructure is not conducive to the maintenance of the highest standards of IPC.
- It was suggested that the introducing ADTs as part of a suite of measures could be helpful.

The Chair proposed the recommendations as set out in the paper for approval and the NPHET agreed to endorse same. The Chair emphasised that the NPHET is open to the incorporation of additional testing strategies or modalities once their role is supported by evidence. The NPHET is available to provide any necessary expertise for the design of studies or statistical surveillance. The Chair noted that any proposals in this regard would be welcome and members should work together in this capacity.

Action: The NPHET endorses the recommendations on the use of Rapid Antigen Diagnostic Testing and the prioritisation of PCR testing as set out in the paper “Public Health Prioritisation of Testing in Current Epidemiological Context”.

b) Vaccinations

The HSE informed the NPHET that vaccination is underway for the two priority groups and will be rolled out to Long-term Residential Care Facilities next week. The HSE emphasised that this is a significant exercise, and that by the end of February all but the buffer capacity should be rolled out. It was noted that the Moderna vaccine will arrive in small doses and there is no further update on the AstraZeneca vaccine.

It was highlighted that vaccinations should be viewed as a one measure within the suite of public health measures. As the vaccine begins to get rolled out, and as the impact of the vaccine on transmission is examined, this raises the question of how vaccination changes the assessment of the public health restrictive
measures in place for the rest of the population. It was noted that although this is a rolling and dynamic situation, there is a perception that when a certain number of vaccinations has been reached, public health restrictive measures can be removed for the rest of the population. The Chair of the IEMAG noted that work is underway to incorporate the likely impact of vaccinations formally in the future modelling work carried out by the IEMAG.

The DOH noted that the prospect of supplies increasing as other vaccines become available will increase the challenge as well as the opportunity. The system must be ready to respond with the requisite steps and workforce in place to meet the challenge as soon as new products arrive.

The importance of addressing the concerns and doubts that healthcare staff may have in relation to the vaccine was raised as healthcare workers have influence on their patients and communities. It was noted that webinars are taking place in order to address such concerns and to encourage confidence in the vaccine among healthcare staff.

Thanks were expressed to the HSE team for the work done to roll out the vaccine thus far. It was noted that vaccinating the GP community plays a critical role in the pandemic response as GP closures could have a knock-on effect for Emergency Departments. Furthermore, once GPs are vaccinated, they can play a key role in the vaccination programme. It was further noted that vaccine uptake among GP staff has been excellent and this enthusiasm will be important to demonstrate that receiving the vaccine is a social norm.

The issue of geographical distribution was raised, with the DOH emphasising that distribution should be equitable across rural and urban areas. In addition to distributional equity, differences across institutions as to how the vaccine is rolled out within priority groups could impact the perception of fairness.

The Chair of the NIAC noted that work is underway to assess the issue of extra doses in vaccine vials.

The HPRA will present a regular safety summary report on vaccinations to the NPHET from the next meeting, 14th January 2021.

c) Finalised data set for the surveillance, monitoring and reporting for COVID-19 vaccination programme

The HPSC provided the finalised data set for the surveillance, monitoring, and reporting for the COVID-19 vaccination programme in advance of the meeting. The NPHET noted that this is the current data set being collected.

6. Communications Update

The DOH provided an update on ongoing communications work. Quantitative research has commenced on tracking public attitudes to the COVID-19 vaccine; it appears that 80% of the public intend to avail of the vaccine, once available. This reinforces anecdotal reports received from NPHET Members to date. Qualitative research shows that people are looking to the vaccine with a sense of optimism. They are taking note of vaccine rollout with great attention. However, the public still has some concerns around immunity and safety and feel that some questions remain to be answered. Many stressed that the vaccine needs to be framed as a medical intervention and not as an inducement to return society/the economy back to normal.

8. Meeting Close

a) Agreed actions

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

b) AOB

No matters were raised under this item.

c) Date of next meeting

The next meeting of the NPHET will take place Thursday 14th January 2021, at 10:00am via video conferencing.