



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

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| Date and Time | Thursday 14 th January 2021, (Meeting 72) at 10:00am |
| Location | Department of Health, Miesian Plaza, Dublin 2 |
| Chair | Dr Tony Holohan, Chief Medical Officer, DOH |
| Members via videoconference¹ | <p>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Dr Kevin Kelleher, Assistant National Director, Public Health, HSE Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA Dr John Cuddihy, Interim Director, HSE HPSC Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH 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 Anaesthetics / Intensive Care Medicine, Beaumont Hospital Ms Rachel Kenna, Chief Nursing Officer, DOH Prof Mark Ferguson, Director General, Science Foundation Ireland and Chief Scientific Adviser to the Government of Ireland, SFI 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 Yvonne 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 NPHE Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Dr Breda Smyth, Public Health Specialist, HSE Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH 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, HPRA Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE Prof Mary Horgan, President, RCPI Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)</p> |
| ‘In Attendance’ | <p>Ms Laura Casey, NPHE Policy Unit, DOH Dr Trish Markham, HSE (Alternate for Tom McGuinness) Ms Sheona Gilson, Senior Health Data Analyst R&D & Health Analytics Division, DOH Mr Gerry O’ Brien, Acting Director, Health Protection Division Ms. Sarah Glavey, Policy and Strategy Division, DOH Mr Ronan O’Kelly, Health Analytics Division, DOH Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH</p> |
| Secretariat | Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH |
| Apologies | |

¹ References to the HSE in NPHE minutes relates to the staff of the HSE present at NPHE meetings and not the HSE Board which is the HSE in law unless otherwise stated.



1. Welcome and Introductions

a) *Conflict of Interest*

Verbal pause and none declared.

b) *Minutes of previous meetings*

The minutes of the 17th December had been circulated to the NPHE in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHE.

c) *Matters Arising*

The Chair welcomed Mr Mark Ferguson, Director General, Science Foundation Ireland and Chief Scientific Adviser to the Government of Ireland, Science Foundation Ireland as a new NPHE Member.

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:

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 39,083 cases have been notified in the 7 days from 7th to 13th January 2021, which is a 26% increase on the previous 7 days (31st December 2020 to 6th January 2021) in which there were 31,001 cases.
- As of 13th January, the 7- and 14-day incidence rates per 100,000 population have significantly increased to 799 and 1,449, respectively; these compare with rates of 651 and 819 on 6th January, and with rates of 168 and 273 on 30th December.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 55%, demonstrating that there have been more cases in the last 7 days, 7th to 13th January, compared with the preceding 7 days, 31st December to 6th January.
- Incidence remains very high across all age groups, especially younger adults. Disease incidence in those aged 65 years and older continues to increase and represents a significant cause for concern. Incidence in those aged 18 years and younger remains at or below population average.
- In the last 14 days, 31st December to 13th January, 11% of cases notified were aged over 65 years. Of concern, incidence in those aged 85 years and over is above the population average and rising.
- The 5-day rolling average has decreased from a peak of 6,831 on 10th January to 4,659 on the 13th January and remains almost 4 times greater than the figure for 30th December (1,213 cases).
- Of cases notified in the past 14 days, 31st December to 13th January, 61% have occurred in people under 45 years of age; the median age for cases notified in the same period is 37 years.
- There remains very high 14-day incidence rates across all counties, 19 counties have a 7-day incidence as a percentage of 14-day incidence greater than 50%, indicating an even greater number of cases notified in the last 7 days, 7th to 13th January, compared with the previous 7 days, 31st December to 6th January.
- By focusing the estimation methods on the most recent 7-10 days, the best estimate of the reproduction number (R) that has led to the cases being reported this week is in the region of 1.0-1.3. The growth rate peaked at almost 18% per day over the 14-day period up to 10th January 2021. This compares with an estimated daily growth rate of 14% at the last NPHE meeting on 7th January.



- A very high volume of tests (167,004) was undertaken in the last week, 7th to 13th January. The 7-day average test positivity rate remains very high; the positivity rate has decreased to 17.5% on 13th January from 21.9% last week on 6th January.
- Excluding serial testing, the test positivity rate has also decreased over recent days although the rate remains very high. It was 23.6% over the 7 days to 13th January and down from a high of 28.1% in the 7 days to 7th January.
- According to Contact Management Programme data, 25 counties have test positivity rates greater than 10% and 8 counties have positivity rates greater than 25%.
- There are currently 1,792 confirmed COVID-19 cases in hospital this morning, compared with 1,022 on 7th January; this is a 75% increase since the last NPHET meeting on 7th January. There have been 188 newly confirmed cases in hospital in the 24 hours preceding this morning.
- Of great concern, the number of patients receiving critical care has almost doubled since last week. There are currently 176 confirmed cases in critical care, compared with 89 on 6th January. There have been 25 admissions in the last 24 hours.
- To date, sadly, there have been 182 deaths notified with a date of death in January. This compares with 163 and 170 deaths notified (to date) with a date of death in November and December, respectively. Of the 182 deaths in January to date, 23 have thus far been associated with hospital outbreaks and 38 have been associated with nursing home outbreaks.

Further relevant information includes:

- It was noted that, due to the substantial case numbers in week 1 of 2021, there was delay in the 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 underestimates. The number of outbreaks represents the most reliable indicator.
- There were 17 new clusters notified in acute hospitals in week 1 of 2021.
- There are currently 101 open clusters associated with 42 acute hospitals; there have been 91 linked deaths and 1,153 linked cases to these outbreaks.
- There were 58 new clusters notified in nursing homes/community hospitals in week 1; there are 13 new outbreaks in nursing homes in the current week.
- There are currently 132 open clusters associated with nursing homes; there have been 91 linked deaths and 1,690 linked cases to these outbreaks.
- There have been 3 outbreaks associated with schools in week 1 with 10 linked cases (although transmission in the school setting has not necessarily been established in these outbreaks).
- There were 7 outbreaks newly notified in childcare facilities in week 1.
- There were 3 outbreaks in the Irish Traveller community in week 1; there are currently 47 open outbreaks in the Irish Traveller community.
- There were 21 outbreaks in centres for disabilities in week 1; there are currently 33 open outbreaks in the centres for disabilities.
- There have been 26 newly notified workplace outbreaks in week 1; there are 86 open outbreaks in workplaces.
- The sentinel GP influenza-like illness (ILI) consultation rate increased to 120.4/100,000 population in week 1 of 2021, compared to 63.0/100,000 population in week 53 of 2020 and 42.7/100,000 during week 52 of 2020.
- A range of mobility and compliance data suggests that movement and social contact in the population had significantly increased in the lead up to Christmas. There has been a decrease in mobility since Christmas and in recent days following the introduction of Level 5 measures.
- The number of close contacts during the week ending 10th January was 83,514, a 2% increase compared to the previous week (81,523).
- The average number of adult close contacts per case remained below 3.3 until early December, rose to almost 5 on average by 28th December, and is now decreasing rapidly; it is currently 2.3 per case.
- As of 13th January, the 14-day incidence per 100,000 population in Northern Ireland was 1,121; this is 23% less than the 14-day rate incidence in the Republic of Ireland (1,449 per 100,000 population). The



latest 7-day incidence per 100,000 population in Northern Ireland is 447, which is 46% less than the 7-day incidence rate in the Republic of Ireland (799 per 100,000 population).

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

- Given that the level of infection has stopped increasing and now appears to be declining, it is difficult to estimate the reproduction number, which is itself changing, with accuracy.
- The dynamic situation also makes it difficult to model scenarios for the coming weeks with confidence. However, optimistic projections, which assume we are past the peak of the third wave, show between 800 and 1,600 cases per day at the end of January 2021.
- These scenario models also suggest that peak demand for hospital care will occur in the coming days with 2,000-2,400 people in hospital, including 250-300 people in ICU.
- These models cannot forecast additional COVID-19 cases due to outbreaks in acute hospitals which are a feature during, and in the aftermath of, a major wave of disease. As such, the number of people in hospital with COVID-19 is likely to exceed these projections. These projections will continue to be reviewed over the coming days.
- Models also suggest that deaths in the community (i.e. not including deaths linked to outbreaks in nursing homes and hospitals) will reach a peak of at least 25-30 deaths per day and that these levels will persist at least for the rest of January. Given the large number of recently notified outbreaks in long term residential care facilities and hospitals, unfortunately a large scale of mortality in these settings can be expected. It is therefore anticipated that a total of at least 500-1,000 deaths may occur in the month of January.

The Chair thanked the DOH, the HPSC, and the IEMAG for their respective inputs and invited the NPHE Members to discuss the epidemiological data presented. Key points raised in the discussion are outlined below:

Regarding hospitalisations and outbreaks:

- The numbers of individuals with COVID-19 in hospital and intensive care units remain at very high levels and continues to increase, impacting very substantially on the delivery of non-COVID health and social care.
- The NPHE expressed concern that Ireland may stagnate at high levels of infection if the decline experienced to date begins to slow. It was further noted that although case numbers are decreasing, the severe impact of the recent surge in cases will unfortunately continue to be felt across the healthcare system over the coming weeks.
- The age profile of mortality, those admitted to hospital, and those admitted to ICU was highlighted as a cause for concern as this is not confined to the elderly and many people in their 50s and 60s are presenting with severe COVID-19 symptoms.
- The observed increase in COVID-19 outbreaks in homecare services was noted as concerning. These outbreaks not only impact on the ability to ensure service continuity to support people to continue to live in their own homes but also directly increases pressure across all health services including hospital admissions and discharges, and delivery of GP and public health nursing services. The HSE noted that currently there are approximately 500 homecare workers on COVID-19 related leave.
- The increasing incidence in long-term care settings and vulnerable groups was noted. The marked impact of widespread transmission is being observed in both the number and scale of new outbreaks occurring in health and social care settings. Given the high attack rates in congregated settings it is likely that a number of these settings will now experience a high number of deaths.

Regarding the vaccination process and recent epidemiological data:

- It was highlighted that GPs are coming under increasing pressure with enquiries from patients about vaccinations for those within the various allocation groups.



- The NPHET underscored the importance of adhering to the vaccine allocation strategy and vaccinating groups in order of priority, targeting those at greatest risk of severe illness and death in the first instance. The NPHET considered that equity is a critical consideration in the context of the distribution and administration of the vaccine. Vaccinating groups in order of priority will strengthen the legitimacy of, and public trust in, the vaccination rollout. Vaccinating groups out of sequence could have the unfortunate consequence of undermining trust in the fairness of the process. There was a recognition that the framework needs to be adaptable to the particular set of circumstances that pertain at the time of vaccine distribution and that there should be ongoing assessment of allocation priorities as new data becomes available. The Chair of the NIAC informed the NPHET that, as new vaccine data and evidence continuously emerges, a review of the vaccine schedule will be carried out to ensure that the schedule is focused on protecting those who are most vulnerable to COVID-19.

Regarding contact tracing:

- With regard to contact tracing, the HSE reported the relative value of contact testing is much less at a time of such high levels of transmission. In this regard, the routine testing of close contacts has been paused for the time being and replaced with guidance to restrict movements and only seek a test if symptomatic.

The Chair thanked Members for their contributions and remarked that there are many frontlines in the fight against COVID-19, with public behaviour being the first line of protection to the public health and primary care systems. The Chair reiterated that we are now in a mitigation phase and, as such, the frontlines need to be strengthened in order to alleviate the pressure felt across the healthcare system, particularly in acute hospitals and LTRCs. The Chair further noted the HSE's update on the pausing of contact testing and stressed that this should resume as the earliest opportunity. Finally, the Chair stated that the NPHET's message to the public should be balanced; there is hope but Ireland continues to experience an epidemiological situation of profound concern.

3. Review of Existing Policy

a) International Travel

The DOH presented the paper "*International travel: Update for NPHET meeting 14th January 2021*" for discussion.

The paper provided a comparative analysis of travel restrictions recently imposed at national, European, and international levels in response to increasing concern regarding the implications of increased transmissibility of SARS-CoV-2 via the emergence of a number of new variants of concern (VOC) i.e. UK, South African, and Brazilian Variants. The paper also summarised and outlined the travel measures taken over recent weeks as well as those currently in place.

The paper firstly noted the significant number of international travellers, who have arrived into Ireland in recent weeks. According to figures provided by Dublin Airport Authority (DAA), there were a total of 190,229 arrivals to Ireland via air between 1st December 2020 and 11th January 2021. Significant volumes arrived directly from EU/EEA (118,125), the UK (37,020) and USA (12,032), with the remainder coming from other third countries.

The paper drew the following conclusions:

- Ireland's response to the new variants, and to risks associated with international travel generally, remains less stringent than measures adopted by many other EU countries. The strong public health responses to new variants by Denmark, Germany and Finland are notable. In addition to pre-travel testing, many countries have mandatory quarantine with potential to release following a further 1 or 2 SARS-CoV-2 tests.
- In Ireland, travel related measures are broadly advisory in nature and there can be no assurance that a high level of compliance with this advice is being achieved.



- The only way that the maximum compliance with the key public health measures for arriving international travellers can be assured would be to place the movement-related advice onto a statutory footing, i.e. an enforceable quarantine regime.

The Key points raised were as follows:

- The NVRL emphasised that the focus should now be on containing and controlling the new VOCs from South Africa and Brazil and that stringent quarantine procedures would play an important role in this regard. It advised the NPHET that, relative to other coronaviruses, the human population was still in its early stages of exposure to COVID-19. This means that further mutations are likely. For this reason, it is extremely important to understand how mutation happens and the factors that trigger it.
- The Chief Scientific Adviser proposed that research be carried out to try and identify the selective pressures that are causing the virus (independently in different countries) to accumulate multiple mutations in the spike protein (and so to transmit more easily) e.g. to investigate the difference between accumulation of multiple viral spike mutations in patients suffering from chronic and Long COVID-19 versus patients with acute infection.
- The RCPI stressed the importance of forward-thinking regarding testing and surveillance, as well as ensuring that plans are in place for when the virus moves to the endemic stage.
- Recognising previous difficulties in enforcement and monitoring of restrictive measures for international travellers, the Members of the NPHET agreed that additional and enforceable restrictions are necessary for international travellers to curb the spread of all variants of COVID-19.
- The NPHET further emphasised the importance of collaboration with authorities in Northern Ireland on a cohesive response.
- The DOH raised concerns that people may mistakenly believe that being vaccinated negates the need for a negative PCR test before travel. In this regard, communications should inform the public that all restrictive measures in place, including testing and quarantine, still apply.

The NPHET reiterated that it continues to advise against all non-essential travel and recommends that every effort be made to ensure that discretion as it currently applies to the need for restriction of movements and PCR-testing post-arrival in Ireland is removed. The NPHET further clarified that:

- A pre-travel test alone is not a sufficiently robust system for the prevention of disease importation and modelling shows that even the best-performing tests will miss up to 40% of cases.
- Having regard to the VOC originating from the UK, South Africa, or Brazil, travellers from these countries should continue to complete a full 14 days' self-isolation in conjunction with a "Day 5" test, which is available from the HSE. Close contacts of any positive case who has travelled from Great Britain, South Africa, or Brazil should continue to be requested to self-isolate and get a test at day 5.

Action: Given the changing epidemiology of the disease and the emergence of new variants internationally, the NPHET reiterates its ongoing concern and prior recommendations with regard to overseas travel. It continues to advise against all non-essential or recreational travel and recommends that efforts be made to ensure that discretion as it currently applies to the need for restriction of movements and PCR-testing post-arrival in Ireland is removed.

b) Summary Documents

The DOH presented the paper *"Timeline and Detail of Public Health Restrictive Measures Advised by NPHET in Response to the COVID-19 Pandemic: 13th January 2021"*, for noting.

The paper provided an overview of the considerations and advice provided by the NPHET in relation to the application of population-level public health restrictive measures as part of the overall response to managing the COVID-19 pandemic.



The DOH clarified that the paper was prepared as part of a series of forthcoming papers detailing the advice and actions taken by the NPHET in response to specific areas of concern.

The paper reviews the population level measures across different stages of the pandemic since March 2020. The DOH advised that the purpose of the paper is to capture a timeline of NPHET considerations and advice only, and it does not seek to provide any analysis of the disease trajectory or the impact of the application/easing of public health measures, nor detail on other complementary NPHET considerations.

The NPHET noted the paper and welcomed the future preparation of similar overview papers on specific areas of concern.

c) Home Support Services: Preparedness and impact of COVID-19 on services

The DOH and HSE presented the joint paper "*Home Support Services: Preparedness and impact of COVID-19 on services: 13th January 2021*", for noting.

The paper identified characteristics particular to home care services and to those in receipt of home care that may put them at risk in relation to COVID-19 and which increases the risk of contagion across both clients and Home Support Services care staff. Given these risks, it identified a series of specific measures and guidance, both operational and in terms of public health measures, in relation to home support services that have been put in place throughout the course of the pandemic.

The DOH expressed its view that across the broader health system home care services play a significant and valuable role in supporting people to continue to live and be cared for in their own homes. This supports hospital flow and long-term residential care (LTRC) avoidance. By nature, these are high personal physical contact services which means they are services at higher risk from COVID-19. IPC guidance and access to PPE are in place for home care providers in line with March 2020 NPHET guidance. It would be timely to review current IPC guidance for home care and re-emphasise the importance of and approach to IPC to providers, such as through a training resource.

The DOH emphasised that home care workers are frontline workers and their access to vaccination in line with the prioritisation criteria is important. Attention was drawn to home care providers who are self-employed or working for private companies. The NPHET noted with concern that this group is also at equally high risk and operates, to a certain extent, outside the established healthcare system. The NPHET stressed the importance of provision of support for private home care workers as the service they provide reduces the burden on the public healthcare system.

The NPHET thanked the DOH and the HSE for their joint update.

d) Joint DOH & HSE Update on Critical Care

The DOH and HSE presented the joint paper "*Update on Critical Care-14th January 2021*", for noting.

The paper provided an update on the latest position in relation to COVID-19 patients in critical care, and actions ongoing to support continued delivery of high-quality care to those who need it. Key points were as follows:

The CCO of the HSE has issued a direction to Hospital Groups and Clinical Directors on COVID-19 emergency measures to be undertaken with immediate effect, aimed at maximising capacity and patient flow, including staff redeployment to support separated pathways and critical care surge. These measures include the immediate suspension of all non-urgent/non-time dependent elective activity, escalation in the discharge of patients from acute hospitals, further development of alternative pathways of care that support admission avoidance, minimising length of stay, and reconfiguration of services, as appropriate.



A Critical Care Major Surge Working Group is in place within the HSE and meeting daily to actively manage and support hospitals.

Surge plans are in place and being activated as needed; equipment including oxygen and ventilators are in place with active monitoring as necessary; private hospital capacity is secured in accordance with the recent agreement to support provision of care, for non-COVID patients in the first instance.

- The HSE Acute Operations critical care working group provided an update to the NPHEP on the progress made to increase surge capacity, with 321 critical care beds now available.
- A new arrangement is now in place with the private hospitals which will provide the HSE with access to private hospital capacity, including a safety net arrangement for any further surge of COVID-19 cases. Under the agreement, the hospitals have agreed to supply, depending on the incidence of the disease, up to 15% or 30% of their capacity.
- Staffing is the key constraint: redeployment of staff with previous or partial training in critical care to support fully trained critical care colleagues to the maximum extent feasible is an essential part of the response. Approximately 1,500 nurses received partial training at the beginning of the pandemic to allow them to support fully trained critical care nursing colleagues as required.
- The NPHEP noted the delivery of non-invasive ventilation outside of the ICU environment (within hospital wards), which serves to protect ICU capacity to some extent. The NPHEP stressed the importance of reporting the numbers of patients being treated in this way so that the full extent the COVID-19 burden on the hospital system can be appraised.

The paper concluded that the healthcare system is now at a critical juncture in its ability to safely provide critical care to patients in acute hospitals. With the time lag between the contraction of a COVID-19 infection and admittance to critical care, it is likely that the numbers of patients admitted to critical care units as a result of COVID-19 will continue to rise for at least the next 10 days.

The NPHEP thanked the DOH and the HSE for their joint update and noted same.

4. Expert Advisory Group

a) *Potential impact of different testing scenarios to reduce the duration of restriction of movements and or number of tests for close contacts of a COVID-19 case*

The HIQA presented the paper *“Potential impact of different testing scenarios to reduce the duration of restriction of movements and or number of tests for close contacts of a COVID-19 case: Update of analysis published 4th November 2020”*. The HIQA expressed its thanks to all individuals and organisations who supported this work, colleagues from HSE’s Contact Management Programme, and UCC for their helpful insights on the HSE Audit of Compliance with COVID-19 Restrictions, December 2020.

The key points were as follows:

- Since early January 2021, there has been a significant increase in the incidence of COVID-19 with test demand exceeding available capacity. To mitigate risk within the community, testing of symptomatic individuals has been prioritised.
- Irrespective of testing, standard practice in Ireland is that close contacts should restrict their movements for 14 days from last exposure event. That is, receipt of a ‘not detected’ test result does not impact the recommended duration. While this approach minimises the risk of onward transmission, it can pose significant societal challenges such as resourcing of essential services and impact on population mental health.
- Earlier analysis underpinning advice to NPHEP published on 4 November 2020, modelled the potential impact of a number of different testing scenarios to reduce the duration of restricted movements from 14 days for close contacts. This present report serves as an update to that analysis considering the standard approach and 10 alternative scenarios which reduce the duration of restricted movements and or the number of tests conducted. Given current, and future potential, disease trajectories and testing



constraints, two-test and single-test regimens are considered alongside no universal testing of close contacts.

- Overall, the results presented within the report should be considered with regards to what constitutes an acceptable level of risk relative to standard practice in the context of the current and future disease trajectories, possible broader public and mental health considerations, and the capacity to resource essential services.

The NPHEP thanked the HIQA for its important analysis and welcomed the DOH's ensuing presentation under item 4(a)(i).

i. Review of duration of restriction of movements for individuals exposed, or potentially exposed, to Covid-19 (via close contact with a confirmed case only).

The DOH presented the paper "*Review of duration of restriction of movements for individuals exposed, or potentially exposed, to Covid-19 (via close contact with a confirmed case only): 14 January 2021*", for the NPHEP's decision, acknowledging the important analysis work carried out by the HIQA in this area, as presented under item 4(a).

The DOH stressed at the outset that the paper relates to the duration of restriction of movements for individuals exposed, or potentially exposed to COVID-19 arising from close contact with a confirmed case. It does not consider advice for those travelling internationally.

The DOH then outlined steps taken to date as follows:

- The NPHEP considered advice from HIQA at its meetings of the 1 and 22 October 2020 in relation to whether the period of restricted movement for close contacts should be reduced from 14 days and any consequent implications for the current testing protocol of Day 0 and Day 7 tests. The NPHEP considered updated modelling and advice from HIQA at its meetings of 17 and 23 December 2020 on this matter.
- At its meeting of 23rd December, the NPHEP recommended that, given current infection levels and growing constraints on testing system, the testing protocol for close contacts should change, with the Day 0 and 7 tests to be replaced by a single test five days after last contact with a confirmed case. No change to the duration of restriction of movements (i.e. 14 days) was recommended at the time.
- At a meeting between the Department and the HSE on 31st December 2020, it was agreed that, given the unsustainable pressure on the testing system, that close contacts of confirmed cases of COVID-19 would not be routinely referred for testing, although anyone who developed symptoms suggestive of COVID-19 (whether a contact of a case or not) should be referred for testing. No change to the duration of restriction of movements (i.e. 14 days) was recommended at the time.

The DOH also noted the report published by the ECDC on 24th September 2020, which proposed that an individual may discontinue restriction of movements if a PCR test taken on Day 10 following exposure returns a virus 'not detected' result. The European Commission has also developed draft *Recommendations for a common EU approach regarding isolation for COVID-19 patients and quarantine for contacts and travellers* with the view to achieving an EU level agreement for a more coordinated approach to quarantine and isolation measures in line with the guidance issued by the ECDC and the WHO.

The DOH proposed a number of next steps on foot of its review and noted in summary that no significant changes are being proposed to restriction of movements requirements except for healthcare workers, for whom the slight shortening of the restriction of movements period would provide an incremental benefit to the health system in terms of workforce days lost.

The NPHEP indicated broad support for the proposal as it relates to healthcare workers. Some Members expressed concern around the impact of moving from a Day 0 and Day 7 test to a single test on Day 5 for the contacts of confirmed COVID-19 cases, particularly for healthcare settings, noting that the results of Day 0 testing often set the scene for how transmission may have taken place.



The DOH stressed that the optimum testing interval to complement restriction of movements requirements is testing at Day 0 and Day 10, but until such time as available testing capacity can allow for this, testing at Day 5 for close contacts should be introduced as soon as possible.

The NPHEP cautioned against reducing the restriction of movement protocols for the general public at this time, stating the need to continue with the evidence-based 14-day restriction of movement period for now.

The NPHEP acknowledged that these measures reflect a point in time and can be revised as necessary as further evidence emerges.

The Chair thanked Members for their inputs and the NPHEP endorsed the paper, agreeing the below action.

Action: The NPHEP endorsed the proposals for testing of close contacts as set out within “Review of duration of restriction of movements for individuals exposed, or potentially exposed, to Covid-19 (via close contact with a confirmed case only)”, to include:

- The recommencement of testing of close contacts amongst the general public at day 5, as soon as swabbing, testing and contact tracing capacity can facilitate this development.
- Close contacts of any positive case who has travelled from Great Britain, South Africa or Brazil should continue to be requested to self-isolate and get a test at day 5.
- The urgent implementation of day 5 and day 10 testing for HCWs designated as close contacts, with exit from restricted movements if the Day 10 test is reported as ‘not detected’.

b) Rapid review of current public health guidance for community settings and IPC measures in healthcare settings for COVID-19

The HIQA presented the paper “Rapid review of current public health guidance for community settings and IPC measures in healthcare settings for COVID-19: 13th January”, for discussion.

The HIQA stressed at the outset that the findings from this rapid review were accurate as of 13th January 2021; however, the measures identified may change as the situation and response to COVID-19 evolves.

The rapid review identified that, in general, the current Irish guidance on public health measures for community settings and infection prevention and control in healthcare settings in respect of COVID-19 is at least as stringent, if not more stringent than the guidance specified in the countries and agencies included in the review. However, a small number of additional measures were identified across the guidance documents reviewed. The most consistent finding was the recommendation for increased use of face masks in outdoor and indoor settings regardless of the ability to socially distance, the use of higher-grade masks under certain circumstances in the community setting. Ongoing scoping updates to HIQA published evidence summaries regarding the modes of transmission of SARS CoV-2 did not identify any relevant scientific literature referring to the different modes of transmission of the new variants of recent concern (B.1.1.7 and B.1.351) or that significantly impact the overall conclusions of the original reports.

The HIQA added that the evidence summary presented was shared with Prof. Martin Cormican of the HSE’s Antimicrobial Resistance and Infection Control (AMRIC) team to further inform team’s guidance.

In this regard, the HSE provide the NPHEP with an update as follows:

- The HSE confirmed that on the basis of the evidence summary provided by the HIQA, interim guidance on the new VOC was issued to all settings and hospital groups. The HSE stressed that this guidance was iterative and would be responsive to the emerging evidence base. The HSE further updated the NPHEP that, in line with two papers tabled in December detailing the steps for enhancing IPC in all hospitals, feedback from hospitals sites shows high levels of compliance with IPC procedures. The HSE also updated the NPHEP on the level of healthcare acquired infection in acute



hospitals. The number of healthcare acquired infections has risen in the past week from 180 to roughly 390 cases, with between 40 and 50 cases reported in some hospital sites.

- The HSE identified the need to consider future IPC procedures, and will further advise the NPHEP on the status of IPC in acute sites as coordinated through AMRIC.

The Chair thanked the HIQA for its presentation, noting the nuances of approaches to IPC taken in different countries. The Chair also thanked the HSE for its update. The following points were raised:

- The need to operate on the assumption that the Variants of Concern (VOCs) may be impacting on the infection rate in healthcare settings was stressed. Members highlighted that incidence was roughly 6 times higher among healthcare workers than in the general population based on data from the PRECISE study. This highlighted the need for a systematic review of IPC guidelines for management of COVID 19 in hospitals and other healthcare settings.
- The DOH expressed the need for a report from the HSE's AMRIC on the status of infection prevention and control in both acute hospital and community settings for the NPHEP's consideration. This is particularly timely given recent decisions on the roll-out of antigen testing in acute hospital sites and serial testing of healthcare workers, as well as recently allocated funding to support the strengthening of IPC measures.
- There was broad support for the NPHEP to receive an IPC update paper. This will include the subject of IPC guidance and its possible review in light of the new variant, noting the high level of infection among healthcare workers, particularly for those working in close proximity with patients. It will also include an update on IPC resources and progress on same through the work of AMRIC. It was suggested that this paper come through the DOH National Patient Safety Office (NPSO) given this office's established links with all relevant stakeholders and AMRIC.
- Members of the NPHEP expressed their concern around the increasingly high numbers of healthcare acquired infections being reported. Members queried whether the increasing rates of healthcare acquired infection could be attributed to a greater level of aerosol transmission than previously.
 - On the subject of the new VOCs and increased transmissibility, the NVRL outlined that, based on knowledge of how viruses behave and evolve, there was no current evidence to suggest that the virus had altered its mode of transmission.
 - The HPSC confirmed that the Canadian Public Health Agency recently issued updated guidance on the role of building ventilation in IPC against COVID-19. While similar to the existing HPSC guidance, the Canadian guidance highlights the high risk of transmission related to the build-up of aerosols in any given setting, and the limited efficacy for portable ventilation devices (i.e. HEPA filtration). The HPSC explained that it would further update the NPHEP on this guidance.
 - With regard to both aerosol and droplet spread, they are enhanced in poorly ventilated indoor spaces - common in winter months. It was highlighted that there are a range of scientific and engineering experts, across a range of sectors on the issue of building ventilation. With a view to informing the NPHEP's considerations as to how best the NPHEP might provide guidance on the issue of ventilation and its role in the prevention of COVID-19 spread, it was agreed that this expertise should be harnessed.

The Chair thanked Members for their contributions and summarised the discussion. The Chair echoed the need for a report on progress in implementing enhanced Infection Prevention and Control measures under the remit of the AMRIC and requested that the HSE provide this report to the NPHEP. The NPHEP also noted the ongoing importance of surveillance activity for monitoring the development of new variants of Sars-CoV-2 in healthcare settings. In addition, the Chair noted his intention to establish a cross-sectoral group to provide additional input on the subject of ventilation.



5. Future Policy

a) Vaccination

(i) HPRA Vaccine safety update

The HPRA presented the paper *“Summary of COVID-19 vaccine adverse reaction reports: Update no. 2, including data up to cut-off of 11th January 2021”*. Key updates on the national vaccination reporting experience are as follows:

- Up to 11th January 2021, the HPRA has received a total of 81 reports associated with the BioNTech Comirnaty[®] COVID-19 vaccine. The number of reports received is reflective of the increasing exposure to vaccination.
- The reactions described are generally consistent with those typically observed post vaccination and listed in the approved product information, including events of a mild to moderate nature which resolved/were resolving at the time of reporting.
- No safety signals or concerns have been raised based on national reports received to date.
- Facial palsy – a small number of cases were reported during the clinical trials and following vaccination internationally. It is included as a possible rare side effect in the product information with an expected incidence around 1 in 10,000. The reported rate of this and other rare side effects will be kept under review.
- The European Medicines Agency (EMA) continues to monitor reported cases of suspected anaphylaxis. Current product information for Comirnaty[®] describes reports of anaphylaxis, with advice provided on the need for medical supervision post vaccination, as well as a contraindication for hypersensitivity to the active substance or to any of the excipients.

The NIAC emphasised that when vaccinating in a highly infected population, it is likely that some individuals will become infected after vaccination due to recent prior contraction of the disease. While it is important to monitor these cases closely as to whether an adverse inflammatory reaction occurs, these instances should not be perceived as a failure of the vaccine.

The Chair thanked the HPRA for its update and noted the importance of keeping the public informed through the provision of evidence-based information on vaccine safety.

6. Communications Update

The DOH and the HSE provided the NPHET with a joint communications update. Research shows that people are feeling exhausted now and are very worried. However, profound tiredness should not be confused with non-compliance as people still want the Government to follow a conservative path in managing the pandemic.

The vaccine commands the majority of the public’s attention at the moment. People want clarity on when they are likely to receive the vaccine, immunity, and any potential side effects that may arise. The HSE communications team is working to address the public’s queries and concerns in this regard through the production of comprehensive information material.

It was further noted that communications work will also focus on the new variants of concern that have recently emerged, providing people with information on how they can continue to best protect themselves through existing public health measures.

7. Meeting Close

a) Agreed actions

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

b) AOB



i. Antigen Testing

The HSE confirmed that it would bring a paper on its implementation plan for ADT testing to the NPHEt at its next meeting. The HSE confirmed that it would seek the NPHEt's endorsement of an updated case definition in this regard.

The NPHEt thanked the HSE for its update and confirmed that a national approach will be needed on ADT testing. The NPHEt further noted that ADT testing will become an important part of the State's exit strategy.

c) *Date of next meeting*

The next meeting of the NPHEt will take place Thursday 21st January 2021, at 10:00am via video conferencing.