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

Date and Time
Thursday 28th January 2021, (Meeting 74) at 10:00am

Location
Department of Health, Miesian Plaza, Dublin 2

Chair
Dr Tony Holohan, Chief Medical Officer, DOH

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 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 Anaesthetics / Intensive Care Medicine, Beaumont Hospital
Ms Rachel Kenna, Chief Nursing Officer, DOH
Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH
Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
Dr Colette Bonner, Deputy Chief Medical Officer, DOH
Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI
Ms Yvonne O’Neill, National Director, Community Operations, HSE
Mr Phelim Quinn, Chief Executive Officer, HIQA
Dr Darina O’Flanagan, Special Adviser to the NPHET
Dr Breda Smyth, Public Health Specialist, HSE
Ms Deirdre Watters, Communications Unit, DOH
Dr Colm Henry, Chief Clinical Officer, HSE
Mr Liam Woods, National Director, Acute Operations, HSE
Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE
Prof Mary Horgan, President, RCPI
Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)
Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;
Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH
Dr Elaine Breslin, Clinical Assessment Manager, HPRA

‘In Attendance’
Ms Laura Casey, NPHET Policy Unit, DOH
Dr Trish Markham, HSE (Alternate for Tom McGuinness)
Mr Ronan O’Kelly, Health Analytics Division, DOH
Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH
Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH

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

Apologies
Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH

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 Mr. Fergal Goodman.

   c) **Minutes of previous meetings**
   The minutes of the 30th December had been circulated to the NPHET in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.

   d) **Matters Arising**
   There were no matters arising at the meeting.

2. Epidemiological Assessment
   a) **Evaluation of Epidemiological data: (incorporating National Data Update, Modelling Report and International Update)**
   The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:
   - A total of 11,902 cases have been notified in the 7 days to 27th January 2021, which is a 41% decrease on the previous 7 days to 20th January 2021 in which there were 20,238 cases.
   - As of 27th January, the 7- and 14-day incidence rates per 100,000 population have decreased to 250 and 674, respectively; these compare with rates of 425 and 1,223 on 20th January. Incidence rates remain very high with incidence levels 6-8 times greater than observed in early December.
   - Nationally, the 7-day incidence as a proportion of 14-day incidence is 37%, demonstrating that there have been less cases in the last 7 days, 20th to 27th January, compared with the preceding 7 days, 13th to 20th January.
   - The 5-day rolling average has decreased from a peak of 6,831 on 10th January to 1,383 on the 26th January. This is a 46% decrease since the NPHET meeting last week (2,556).
   - Incidence is very high across all age groups, in particular, there has been a very significant level of infection in recent weeks in those aged 65 and older, even when cases associated with outbreaks in long-term residential care are excluded. Incidence in this age group is decreasing slowly although it remains at a very high level. In the last 14 days. 16% of cases notified were aged over 65.
   - Of cases notified in the last 14 days from 13th – 27th January, 55% have occurred in people under 45 years of age; the median age for cases notified in the same period is 41 years; incidence has decreased significantly in younger adults but remains very high.
   - While there remain very high 14-day incidence rates across all counties, 25 counties have a 7-day incidence as a percentage of the 14-day rate less than 50%, indicating fewer cases notified in the last 7 days compared with the previous 7 days.
   - Incidence in long-term care remains very high. The incidence in these settings was less in the second wave compared to the first; however, the recent number of cases linked to outbreaks in long-term care settings (LTRC), following the unprecedented levels of infection in the community, is now very high. Nonetheless, when compared to the total burden of disease in the community (total case per week) the relative proportional contribution of infection in LTRC, although of ongoing high consequence in terms of morbidity and mortality in absolute terms, is significantly less than in April-May 2020.
   - The number of healthcare-setting-acquired infections is very high. Nonetheless, when compared to the total burden of disease in the community (total cases per week), the level of infection in healthcare settings is significantly less in relative proportional terms than in April-May 2020. Hospital-acquired infections have occurred in the latter part of each surge of disease seen to date, and in each of the three surges, hospital acquired infections account for 20-30% of hospitalised cases.
   - Of the 32,103 cases reported in the last 14 days, 12.5% (4,013) were healthcare workers.
The best estimate of the reproduction number (R) is 0.4-0.7. Growth rate peaked at almost 18% per day over the 14-day period up to 10th January 2021; since then the growth rate has reduced and now the rate of decline of the disease is -7% to -9%. The halving time is currently 8-10 days.

There were 142,027 tests undertaken in the last week. The 7-day average test positivity rate remains very high; the positivity rate has decreased to 8.0% on 27th January from 12.2% last week on 20th January.

Excluding serial testing, the test positivity rate has also decreased over recent days although the rate remains very high. It was 13.4% over the 7 days to 27th January, a reduction from 18.0% over the 7 days to 20th January.

According to contact management programme data, all counties have test positivity rates (excluding serial testing) greater than 10%.

There are currently 1,620 confirmed COVID-19 cases in hospital this morning, compared with 1,949 on 21st January; this is a 17% increase since the last NPHET meeting. There have been 87 newly confirmed cases in hospitals in the preceding 24 hours.

There are currently 212 confirmed cases in critical care, compared with 210 on 20th January. There have been 12 admissions in the last 24 hours.

To date, sadly, there have been 830 deaths notified with a date in January. This compares with 164 and 176 deaths notified (to date) with a date of death in November and December, respectively. Of the 830 deaths in January to date, 87 have thus far been associated with hospital outbreaks and 282 have been associated with nursing home outbreaks.

The prevalence of S-Gene Target Failure (SGTF) has increased from 58% (90/156 samples) in week 2 to 63% (59/94 samples) in week 3. SGTF is a marker for the new B.1.1.7 variant of concern first identified in England in December 2020. As a result, to date more than 400 SGTF samples have been identified in Ireland.

To confirm that these SGTF samples continue to reflect the presence of lineage B.1.1.7 (SGTF can be seen with other lineages), an additional 70 cases have undergone whole genome sequencing. All 70 sequences were confirmed as lineage B.1.1.7, supporting the utility of the TaqPath assay as an important surveillance method for this lineage in Ireland.

In total, 9 cases of lineage B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing.

No confirmed cases of lineage P.1 (variant first reported from Brazil) have been identified in Ireland to date.

Further relevant information includes:
Due to the recent surge in case numbers, the number of outbreaks and linked cases in week 3 are likely and underestimate:

There were 20 new clusters notified in acute hospitals in week 3 of 2021.

There are currently 132 open clusters associated with 47 acute hospitals; there have been 137 linked deaths and 1,521 linked cases to these outbreaks. Of these cases, 40% are related to healthcare workers.

There were 32 new clusters notified in nursing homes/community hospitals in week 3, this compares with 46 new outbreaks in these settings in week 2. There have been 10 new outbreaks in nursing homes in the current week.

There are currently 181 open clusters associated with nursing homes; there have been 338 linked deaths and 4,512 linked cases to these outbreaks. Of these cases, 37% are related to healthcare workers.

There were 28 outbreaks newly notified in childcare facilities in week 3 with 33 linked cases, there are currently 65 open outbreaks in these settings.

There has been an increase in the number of Irish Traveller outbreaks with 11 new outbreaks in the Irish Traveller Community in week 3; there are currently 36 open outbreaks in the Irish Traveller community.

There are currently 199 open clusters associated with residential institutions; there have been 16 linked deaths and 1,089 linked cases to these outbreaks.

There have been 2 new outbreaks in Direct Provision centres with 42 linked cases.
There were 17 new outbreaks in centres for disabilities in week 3; there are currently 95 open outbreaks in centres for disabilities.

There have been 36 newly notified workplace outbreaks in week 3 with 125 linked cases; there are 131 open outbreaks in workplaces. Of note, there have been 11 new outbreaks in meat/poultry/other food production and processing facilities with 110 linked cases.

The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 42.5/100,000 population in week 3 of 2021, compared to 70.2/100,000 population in week 2 of 2021.

A range of mobility and compliance data suggest there has been a sustained decrease in mobility following the introduction of current restrictive measures, but that mobility remains greater than the lowest levels observed in spring 2020.

The number of close contacts during the week ending 24th January was 23,700, a decrease of 37% compared to the previous week (37,541).

The average number of close contacts per adult confirmed case remained below 3.3. until early December, rose to almost 5 on average by 28th December, and then decreased rapidly; it is currently 2.1 per case.

As of 27th January, the 14-day incidence per 100,000 population in Northern Ireland was 583; this is 19% less than the 14-day rate in the Republic of Ireland (721 per 100,000 population). The latest 7-day incidence rate in Northern Ireland is 246, which is 10% less than the 7-day incidence rate in the Republic of Ireland (274 per 100,000 population).

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

**Regarding nosocomial infections:**
- The NPHET emphasised the importance of being able to differentiate between those who were admitted to hospital while incubating COVID-19 and subsequently tested positive, and those who acquired COVID-19 while in hospital.
- The NPHET noted that the AMRIC and the HPSC are currently working on producing reports on the pattern of infection in hospital which will detail the data collected by AMRIC and through the CIDR system.
- The HPSC confirmed that it applies the standard WHO and EU definition of hospital acquired infection, which involves onset of symptoms 7 days or more from admission.
- The HSE advised that data collected by other EU Member States indicates that healthcare associated infection amongst staff and patients represents a challenge internationally.
- The NPHET emphasised the need to look ahead and plan for the reopening of non-COVID health services, how it will be orchestrated and how patients are going to be protected from nosocomial infection when coming into hospitals for scheduled services.

**Regarding hospital capacity and frontline healthcare staff:**
- The variance in the burden across hospitals was noted, with some ICUs beyond surge capacity, which has resulted in inter-ICU transfer of patients between hospitals. The impact on scheduled care was also highlighted, there have been 406 ICU experienced nurses redeployed from existing services to augment ICU capacity during the surge.
- The HSE informed the NPHET that a Psychosocial Framework had been developed to provide support for staff and the population in general and communications have been issued to advise staff on matters of personal resilience and how they can access care. A tiered approach to care has been described ranging from level one which focuses on societal health, well-being and resilience to level six which provided information on the provision of mental health services.
Regarding vaccination:

• The NPHET discussed the importance of employing sero-surveillance measures to monitor the progress of the vaccine programme and the impact it is having. An investment is needed, both financially and organisationally, to ensure that the best quality surveillance data is available to inform operational and policy decisions.

• The NPHET was aware that the success of the vaccination programme would not just be measured in lower incidence and mortality rates but also in the ability to ease restrictions in areas such as visitation to long-term residential care facilities, which have greatly impacted the quality of life of patients and their family members.

The NPHET agreed that Ireland continues to experience a very concerning epidemiological situation that represents an ongoing significant and active threat to all key public health priorities. Notwithstanding recent improvements in some disease profile indicators, progress in terms of case number reduction should be seen as particularly fragile at this time with a critical need to sustain over the coming weeks. This fragility is further underscored by the increasing dominance in Ireland of the substantially more transmissible variant of concern (VOC) (B.1.1.7).

The NPHET expressed its strong view that, as the virus is brought back under control and the country moves to the next phase, prevention should be prioritised. All decision makers must remain cognisant of the risks that can occur should restrictive measures be relaxed too quickly. Should measures need to be re-introduced, this must be done promptly.

The Chair thanked the NPHET Members for their contributions and concluded by stating that the rapid increase in incidence observed after Christmas should serve as a reminder of how quickly the epidemiological situation can deteriorate. The Chair cautioned that the decline in cases observed in recent weeks could quickly be reversed if restrictive measures are not maintained as required. The Chair outlined the layers of defence against the virus and emphasised that an effective and responsive Public Health System is of primary importance and can greatly reduce the burden on the acute hospital system.

3. Review of Existing Policy

a) International Travel

The Chair noted the Government’s decision of 26th January in relation to International Travel and updated the NPHET on the current situation on behalf of the DOH:

• The European Centre for Disease Control (ECDC) published its latest guidance last week in which it recommended actions on international travel focused on countries where known VOCs have been identified.

• The Department of Health is preparing legislation to give effect to a mandatory period of quarantine in a person’s residence and it is also intended to introduce, by law, quarantine at a designated facility for those travelling from (initially) South Africa and Brazil. There will scope for increasing the number of countries from which travellers will be subject to this approach, subject to the evolving situation regarding SARS CoV-2 variants of concern.

• Those who present with a “not detected” PCR test result on arrival from non-“high-risk” countries will be required by law to quarantine at their home address for 14 days, with release conditional on their returning of a “not detected” PCR test result, taken on or after day 5 post arrival.

• Measures are also being considered to review the various categories under the title of “essential travel” with a view to removing subjectivity within these categories which could be exploited to enable individuals to travel when it is not essential.

• The Chair concluded that these arrangements are not designed to “seal” the border, but to significantly slow any disease transmission which could be seeded by international travel deter people from breaking public health advice and engaging in international travel unless absolutely essential.

The HPSC and NVRL also provided the NPHET with additional information on VOCs as follows:

• A group had been convened nationally on VOCs on an all-Island basis.
• The NVRL clarified that the 6 confirmed cases with the VOC first reported in South Africa (B.1.351) were confirmed the previous weekend (Jan 23rd/24th), bringing the total to 9 confirmed cases in Ireland, all of which are currently being analysed using whole-genome sequencing.
• Regarding the importation of novel VOC from the continent of Africa, the NVRL explained that Denmark and the UK have reported cases of B.1.351 associated with travel from other countries, including Tanzania, Zambia, UAE, and Dubai.
• There have been no confirmed cases of the novel Brazilian VOC identified in Ireland yet. However, given the significant migratory flows of workers from Brazil into Ireland, it is important to remain vigilant for such cases.
• New arrangements for enhanced contact tracing for travellers from South Africa and Brazil have been introduced from 26th January. This will include more detailed information on inbound travellers, with plans to expand this to inbound travellers from these countries, who travel to Ireland via another country.

The Chair acknowledged the Director of the National Virus Reference Laboratory (NVRL) and the Clinical Director of the Health Protection and Surveillance Centre (HPSC) for the manner in which they and their teams have worked to quickly identify imported variants of concern. The Chair opened topic for discussion:
• The NPHET noted the increasing concern at European level regarding the importation of new variants of SARS CoV-2. Work is ongoing at European level with respect to travel, including a potential update to the previous European ‘Traffic Light’ model for international travel. In this context, countries could be further classified as ‘dark red’ regions based not only their disease incidence, but also the proportion of new variants of concern reported in that country.
• The Chair added that by taking a selective approach to international travel from countries with identified variants of concern, this enables public health actions to be focused on the containment of these new variants. While the UK B.1.1.7 variant is on the path to becoming the dominant variant in Ireland, it is worthwhile to focus efforts on minimising the presence of any new variants that could potentially further increase the transmissibility of the virus.
• The HPSC echoed the need for certain core restrictions to be in place on all international travel into Ireland with certain enhanced, targeted measures for countries of higher risk. The HPSC explained that this is particularly important given the ongoing challenge to quickly identify any new variants of concern, noting that a new mutation of concern had been identified in California recently.
• Some members drew attention to the possible need for a broader approach to whole genome sequencing of inbound travellers. Reflecting on the experience of importation of cases due to international travel in March 2020, there may be merit in pursuing a universal strategy whereby all inbound travellers would give samples for analysis through whole-genome sequencing and be subject to enhanced contact tracing.
• The NPHET noted that hotel-based isolation facilities, while an important aspect of the overall response, are complex to establish.
• The core message to the public of ‘do not travel unless for essential purposes’ should be the key element to Ireland’s approach, and decisions and actions by Government that solidify this message are to be welcomed.

The Chair re-emphasised that in the first instance, adherence to basic public health measures at national level is necessary to significantly reduce community transmission. However, measures designed to curb non-essential international travel can significantly slow any possible importation of new variants once community transmission is at a more manageable level. This will be particularly important in the context of the roll-out of the vaccination campaign.


**b) IPC guidance**

The CCO of the HSE gave an update on infection prevention and control (IPC) guidance and nosocomial infection in healthcare settings.

The CCO updated the NPHET on communications that were issued to health services on 26th January with respect to IPC, PPE and the use of FFP2 masks. The letter stated that the HPSC/AMRIC recommends that healthcare workers in community and hospital settings should have access to a well-fitted respirator mask (FFP2) and eye protection when in contact with possible or confirmed COVID-19 cases and COVID-19 contacts. In the context of a ward or facility-based outbreak or a COVID-19 assessment hub it is appropriate to consider all patients in the setting as suspected or confirmed COVID-19 cases. A surgical mask and visor also offer a high degree of protection. A surgical mask is appropriate for non-patient facing activity and when caring for patients where there is no suspicion of COVID-19 and there is no evidence of transmission in the service.

Further key points in the CCO’s update to the NPHET were as follows:

- While the rate of nosocomial infection was progressing at a relatively low and steady level from June 2020 onwards, there has been a sudden and sharp escalation of healthcare acquired cases of SARS CoV-2 since the last week of December 2020.
- In the past two months, the situation with respect to the prevention and control of COVID-19 infection in the healthcare setting has been extremely challenging. Multiple COVID-19 outbreaks have been reported in several major hospitals. Likewise, long-term residential care facilities are facing major challenges with an increase in transmission of infection.
- The HSE highlighted that a total of 846 cases of hospital acquired COVID-19 were reported between 4th and 17th January 2021 as compared with 995 cases from 20th June 2020 to 3rd January 2021.
- In line with the experiences of other international comparators, control of transmission of the virus in hospitals is significantly impacted by levels of transmission in the community. Patients who test negative on admission may be incubating the virus and subsequently test positive, and staff are more likely to acquire COVID-19 in the community.
- Notwithstanding the importance of provision of high-quality PPE for healthcare workers, the HSE stressed the ongoing importance of adherence to basic IPC measures such as social distancing and hand hygiene.
- It is important to emphasise that PPE is only one element of a comprehensive approach to IPC as outlined in HPSC/AMRIC guidance documents. PPE is only likely to be effective when used in conjunction with rigorous adherence to the fundamentals of IPC including hand hygiene, environmental management, early identification of people with COVID-19 and the application of contact and droplet precautions.

The Chair thanked the HSE for its update and invited the NPHET Members to discuss the information presented:

- The NPHET highlighted the importance of IPC to the resumption of non-COVID care. Noting with concern that nosocomial spread appears to have occurred in hospitals recently despite adherence to established IPC procedures. Environmental and hospital infrastructure factors were also noted as contributors to nosocomial spread.
- The HPSC echoed the need for attention to be paid to the basics of IPC, highlighting that the Pandemic Incident Control Team (PICT) had expressed concerns that FFP2 masks, as well as vaccination, were being viewed as ‘silver bullets’ in reducing nosocomial spread in some quarters. It is essential that these masks are viewed only as an element of a wider suite of IPC guidance.
- The DOH queried whether guidance on FFP2 masks had issued to both residential care and homecare sectors. The HSE confirmed that the updated guidance issued is targeted both at ward and facility-based outbreaks and should be distributed to both acute and community-based settings as appropriate. The DOH and HIQA confirmed that this guidance would be distributed through HIQA’s Provider Portal as soon as possible.
• Members stressed the importance of having specialist IPC nurses on the ground in LTRCs in order to ensure that IPC is being fully implemented, noting that this measure was recommended by the Nursing Home Expert Panel. IPC nursing posts are currently being prioritised for recruitment.

• The CCO of the HSE thanked the NPHET Members for their contributions and reported that the key messages coming from frontline healthcare workers pointed to the need to reduce community transmission in the first instance. Moreover, the ongoing reinforcement of the core messages of IPC must continue to prevent further nosocomial spread. The CCO of the HSE concluded by acknowledging existing weaknesses in infrastructure of Ireland’s healthcare estate. Lessons learned from nosocomial transmission of COVID-19 should be incorporated into infrastructural developments going forward to ‘future-proof’ healthcare settings against future mutations of SARS CoV-2 and/or other pandemics.

The Chair thanked the HSE for its update and welcomed the valuable discussion. Noting the inappropriateness of some elements of hospital infrastructure in preventing nosocomial transmission, the Chair highlighted that the primary strategy for protecting healthcare workers must be to first reduce community transmission. Ensuring the ongoing buy-in of the public to adhere to public health advice, as well as the buy-in of healthcare workers to stringently adhere to IPC measures in their ‘on’ and ‘off-site’ behaviours, remains essential.

The Chair suggested that an update from the Antimicrobial Resistance and Infection Control (AMRIC) team would be useful for the NPHET’s next meeting to facilitate a greater understanding of the AMRIC’s ongoing work to protect staff and patients. The NPHET supported this proposal, with the DOH suggesting that this update should address IPC procedures in both acute and community settings.

c) Trends and Analysis of Nosocomial Infection
The HSE and the AMRIC presented the paper “Brief Update on COVID-19 Outbreaks and Hospital acquired cases in Acute Hospitals: 27th January 2021”, for discussion. The key points in the paper were as follows:

• The emergence of a new variant of COVID-19 in Ireland with reported higher transmissibility has compounded the risks of transmission in all settings including acute hospitals. Staff absence rates have significantly increased during the current surge, and there are now approximately 4,000 acute hospital staff on COVID-19 related leave.

• Although it has been increasingly difficult to control transmission in hospitals with community transmission levels as they are, every effort is being made to minimise the risk of contracting COVID-19 in hospital for patients and staff. Mass testing is applied based continuous risk assessment.

• The HSE has increased its focus on IPC procedures and personal protective equipment (PPE). Several procedures to minimise the risk of nosocomial spread are in place, namely:
  o Staff who have symptoms of COVID-19 are instructed not to present for work and monitoring of staff for symptoms of COVID-19 continues.
  o There is continued emphasis on social distancing, hand sanitisation, basic IPC practices and standard precautions.
  o The AMRIC team provides on-going support with IPC education and information, providing updated guidance, webinars, and advice to acute hospitals, as appropriate.
  o There has been a tenfold increase in demand for FFP2 masks and further orders will be required to meet this demand.

• The vaccination programme for frontline healthcare workers has been rolled out since 29th December.

d) Update on critical care
The DOH and HSE presented the paper “Update on Critical Care: 28th January 2021“, for noting. The current situation was summarised as follows:

• The situation in critical care units has remained intensely challenging since the update provided to NPHET on 21st January.

• Surge capacity has been deployed across all units and the number of beds open and staffed is now close to the limit of 350, the level at which clinical risk remains manageable.
• High levels of staff absenteeism are still being seen.
• The redeployment of non-specialist staff to support the provision of critical care is continuing.
• A significant number of high acuity patients are receiving advanced respiratory support in a ward setting, with associated impacts on the resources available for redeployment to ICU.
• While there had been a welcome reduction in the burden of disease in the community, it has not yet resulted in an easing of the pressure on critical care units.
• The HSE is continuing to actively manage the situation and to provide support to hospitals and critical care units. However, a continued reduction in the levels of disease in the community remains the only answer to reducing demand, increasing the numbers of staff available to attend work and alleviating pressure on critical care units.

The DOH and HSE also underscored that critical care units would not be operating at the level they are now without the dedicated commitment of staff in critical care units and across our hospitals, who remain focused first and foremost on patients. These staff have been working in very difficult circumstances and under immense pressure, and their response in this crisis has been extraordinary.

The Chair thanked the DOH and HSE for their update and echoed the sentiments of the DOH and HSE regarding the commitment of staff on the front line.

4. HIQA Expert Advisory Group
   a) Review of interventions in an ambulatory setting to prevent progression to severe disease in COVID-19 patients.

The HIQA presented the following papers to the NPHET, for discussion:

The HIQA’s advice to the NPHET was as follows:
• With respect to interventions for the prevention of progression to severe disease in patients with COVID-19 in community and ambulatory care settings:
  o The evidence identified and included in this review does not currently support the use of any additional pharmaceutical intervention outside of clinical trials.
  o No evidence was identified for non–pharmaceutical interventions.
• A large number of COVID-19 clinical trials are ongoing. Additional evidence will therefore continue to be reported both for novel interventions and those identified in this review. Consistent with current requirements:
  o Evidence regarding the effectiveness of therapeutic interventions, particularly for pharmaceutical treatments, must be subject to the highest standards of rigour.
  o As there are potential harms associated with all interventions, including non-pharmaceutical interventions, interventions must have a robust safety profile, and be subject to appropriate governance, before they can be recommended for widespread use in the ambulatory or primary care setting. This is important given the serious risks of harm associated with unproven interventions.
  o If effectiveness evidence does emerge, all current due processes will be required.

Following discussion, it was agreed that a paper should be brought to the NPHET on outlining the research activity/clinic trials at national level. The DOH agreed to coordinate this paper.

The Chair thanked the HIQA for its papers, noting in particular the recommendation concerning communication of the evidence summary to those working in ambulatory/primary settings. Noting some
promising developments in this area, the NPHET committed to periodic review of such evidence, with a view to further identifying additional evidence-based treatment options as the emerge.

b) Rapid Evidence Summary: Vitamin D in COVID-19
The DOH presented the paper “Rapid Evidence Summary: Vitamin D in COVID-19: 24th January 2021” to the NPHET, for decision. The DOH confirmed that the rapid review was conducted to assess the following question: “What is the current evidence in relation to the role of vitamin D in prevention and treatment of COVID-19?”

Key points in the paper were as follows:
- National Department of Health guidelines on vitamin D were updated in November 2020 and advise adults aged 65 and older to take a daily vitamin D supplement of 15 micrograms (600 IU) to support bone and muscle health.
- In the context of COVID-19, advice has previously issued recommending that individuals that are self-isolating or unable to go outside should consider supplementation.
- The role of vitamin D in bone and muscle health is well documented. Public health guidelines support supplementation in older adults based on these benefits and the risk of deficiency in older adults particularly those spending increased time indoors or in long-term nursing home care. A possible immunomodulatory role has been suggested by in vitro studies and association studies.
- There is currently insufficient evidence linking vitamin D use in the prevention and treatment of COVID-19. Evidence reporting an association between low vitamin D status and poorer outcomes in COVID-19 infection do not confirm causality and in most cases are of low quality.
- Previous research shows a modest reduction in the risk of acute respiratory illness with daily vitamin D3 supplementation over weeks to months. This evidence also has limitations, including publication and reporting bias and heterogeneity in study populations, interventions, and definitions of respiratory infections that include upper and lower respiratory tract involvement.

The report concluded that there is insufficient high-quality evidence to support a change to existing guidance. However, as research has identified a high prevalence of low vitamin D levels in winter months in Ireland, and given its role in bone and muscle health the report made the following recommendations:
- Increase awareness of existing guidance that adults age 65 and over should take a 15 microgram daily supplement for bone and muscle health.
- Adults spending increased time indoors or are housebound or in long-term residential care or have dark skin are also recommended to take vitamin D supplementation.
- That ongoing developments, particularly RCTs, in this area be monitored with guidance reviewed accordingly.

The Chair thanked the DOH for its paper and invited the NPHET Members to discuss same. The key points in the ensuing discussion were as follows:
- The NPHET agreed that at present, there is insufficient high-quality evidence with respect to vitamin D in the prevention and treatment of COVID-19, and noted that ongoing developments, particularly Randomised Control Trials, in this area be monitored by the NPHET with guidance reviewed accordingly.
- The NPHET agreed that efforts should be made to increase awareness of existing guidance. It should also be articulated that adults who are spending increased time indoors or are housebound or in long-term residential care or have dark skin are recommended to take vitamin D supplementation.
- The NPHET advised that recommendations for the use of vitamin D should be incorporated into wider messaging, and additionally be communicated across the health service, including nursing homes and social care settings as necessary.

The NPHET thanked the DOH and endorsed the recommendations in the paper.
5. Future Policy

a) Vaccination

The HPRA gave a brief update on vaccine safety reports and explained that its full summary report would be provided to the NPHET on 4th February in line with its bi-weekly publication. Key points made were as follows:

- As expected, the number of reports is increasing as more people receive the vaccine, with over 500 reports up from last week’s 257.
- The HPRA noted the 3 fatal reports in Norway and informed the NPHET that all 3 cases occurred in patients over 75 years with compounding factors; none of the reports give rise to concern or implicate the vaccine.
- An issue was reported in the USA, where a batch of the Moderna vaccine induced 7 reactions but to date, there is no evidence of a large-scale specific issue with the vaccine.
- The AstraZeneca vaccine is expected to be authorised by the EMA on 29th January.

The NPHET further noted provisional data from the UK, which is seeing lower vaccine uptake across certain population groups. The need to look at similar data in Ireland and anticipate challenges will be necessary going forward; a one size fits all approach may not be feasible.

The NPHET thanked the HPRA for the verbal update and noted that a safety update report will be brought to the NPHET at next week’s meeting, on 4th February.

b) Additional Behavioural approaches and Insights

The DOH presented “Behavioural Insights on Sustaining Compliance with the Public Health Advice: 28th January 2021” to the NPHET, for discussion.

The DOH stated that the paper aims to provide advice from the behavioural sciences on how best to sustain compliance with the current COVID-19 public health advice through identifying key messages/themes, potential interventions, and areas where further research is needed to fully understand the nuances of behaviour and the level of compliance.

Among the paper’s key points, the following were highlighted as particularly important:

- Show how super-spreader events (e.g. funerals, weddings etc.), at-home socialising, and unnecessary attendance at work premises events can easily lead to large numbers of cases and bad outcomes for attendees and others. Use vivid examples from contact tracing case studies in Ireland.
- Strengthen supportive measures in businesses, workplaces, and other controlled environments.
- Focus on increasing compliance with key behaviours such as contact tracing, attending testing appointments, and most importantly self-isolation.

Recommendations were provided under the following headings:

- Providing strong motivational and educational messaging for the general public.
- Strengthening supportive measures in businesses, workplaces, and other controlled environments.
- Vaccination, testing, contact tracing, and self-isolation communications.
- Consider the importance of ‘marginal’ compliance and the opportunity for marginal improvements.
- Further research into potential explanations of higher case numbers among the 19-24 age group.

The NPHET expressed support for this body of work. It was noted that stories and anecdotes have the power to illustrate the true impact that COVID-19 has had on people across the country. While data shows that there are high levels of compliance with important behaviours such as mask wearing and staying at home, it is recognised that continued efforts are required to ensure sustained compliance.

c) Implementation Plan for ADT testing programme in Healthcare and Community outbreak settings

The HPSC presented the paper “Update on HSE plans for implementation of Antigen Detection Tests: 26th January 2021”, for noting. The paper provided updates on specific issues reported at the last update at NPHET on 21st January. The key points made were as follows:
The use of Antigen Detection Tests (ADTs) in point of care settings has been approved by the Health and Safety Authority as long as a written risk assessment for the use of the test in the particular setting is conducted.

The new case definition as agreed with NPHET on 21st January, will go live on 27th January 2021.

An operational framework identifying the settings for use, the criteria for ADTs and the standards for use in acute hospitals and community settings has been finalised by HSE.

Guidance on use of ADTs has been developed. And a framework for their use in acute hospitals has been completed. Within the acute hospital setting, deployment of ADTs will depend on the local laboratory capabilities for provision of large-volume batch testing, rapid PCR testing, and staffing levels.

The local and national governance of tests and results has been clarified.

The CSA further informed the NPHET that a group on antigen testing will be set up under his chairmanship, as requested by the Minister for Health.

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

d) Proposal for a National SARS-CoV-2 Surveillance & Whole Genome Sequencing Programme

The Chair of the SARS-CoV-2 Surveillance & Whole Genome Sequencing Working Group presented the paper “Proposal for a National SARS-CoV-2 Surveillance & Whole Genome Sequencing Programme: 27th January”, for decision.

In presenting the paper it was acknowledged that, in parallel, considerable work has been undertaken by a number of clinical and academic institutions, including the National Virus Reference Laboratory (NVRL) and the Irish Coronavirus Sequencing Consortium (ICSC), to build capacity for WGS for SARS-CoV-2 in Ireland. Work has also been undertaken by the HPSC to identify how national WGS capacity can be optimally used to enhance the national and targeted public health responses.

The paper detailed a number of recommendations in relation to the establishment of a National SARS-CoV-2 Surveillance & Whole Genome Sequencing Programme, regarding: Structure and aims; Governance and strategy; Short term capacity; Long term capacity.

The NPHET endorsed the paper and particularly welcomed the clarity on governance, and integration of the proposed programme into the wider public health response. The Chair noted that recommendations of the Working Group will require consideration by the DOH and the HSE to support implementation.

6. Communication Update

The HSE updated the NPHET on the COVID-19 vaccination communication programme.

- The vaccine rollout continues to be covered widely in daily national and local media around the country. This includes celebrations of vaccines being delivered, as well as queries about aspects of the rollout process.
- The vaccine rollout has been covered significantly on social media, with individual stories of receiving vaccination garnering significant public attention (e.g. Annie and Bernie’s second dose).
- Engagements are being planned to ensure that the communication concerns and needs of groups first prioritised for vaccination are heard and addressed. These will involve engaging with partners and stakeholders for older people and other community groups, building on the kinds of supports developed during the recent ‘Hold Firm’ campaign.
- A range of qualitative and quantitative research has been conducted to inform vaccine roll-out communications. Among the older cohort, there is an appetite for ‘when’ and ‘where’ information regarding their vaccination, and a clear consensus that vaccines are a real source of hope and optimism.
- Communications targeting the older cohort regarding their vaccination will continue to rollout this week in Radio, TV and other media.
The Chair thanked the HSE for this update.

7. Meeting Close
   a) Agreed actions
   The were no key actions arising from this meeting.

   b) AOB
      i. Evaluation of saliva as a specimen type for SARS-CoV-2 PCR in the community
      The Director of the NVRL informed the NPHET that work on salivary testing in the community setting is now complete and has been returned to the HSE to inform planning.

Chair Closing Remarks
The Chair closed the meeting by noting this meeting marks one year since the first COVID-19 NPHET meeting.

The Chair took a moment to read out a ‘thank you’ card from a member of the public and encouraged the NPHET Members to continue with their vital work.

   c) Date of next meeting
   The next meeting of the NPHET will take place Thursday 4th February 2021, at 10:00am via video conferencing.