



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

Date and Time	Thursday 4 th February 2021, (Meeting 75) 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 Dr Siobhán Ní 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 Dr Colette Bonner, Deputy Chief Medical Officer, DOH Ms Yvonne O’Neill, National Director, Community Operations, HSE Mr Phelim Quinn, Chief Executive Officer, HIQA Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH Dr Breda Smyth, Public Health Specialist, HSE Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Colm Henry, Chief Clinical Officer, HSE Mr Liam Woods, National Director, Acute Operations, HSE Dr 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 Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital Dr Elaine Breslin, Clinical Assessment Manager, HPRA</p>
‘In Attendance’	<p>Ms Laura Casey, NPHET Policy Unit, DOH Dr Trish Markham, HSE (Alternate for Tom McGuinness) Mr Gerry O’ Brien, Acting Director, Health Protection Division Dr Robert Mooney, NPHET Policy Unit, DOH Ms Sheona Gilson, Senior Health Data Analyst R&D & Health Analytics 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 Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH Prof Martin Cormican, Professor of Bacteriology at NUI Galway and Consultant Microbiologist, NUIG</p>
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH
Apologies	Dr Darina O’Flanagan, Special Advisor to the NPHET Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital

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 the following Members: Prof Colm Bergin, and Dr Darina O'Flanagan.

c) *Minutes of previous meetings*

The minutes of 7th January had been circulated to the NPHE in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHE.

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:

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 8,335 cases have been notified in the 7 days to 3rd February 2021, which is a 30% decrease on the previous 7 days to 27th January 2021 in which there were 11,902 cases.
- As of 3rd February, the 7- and 14-day incidence rates per 100,000 population have decreased to 175 and 424, respectively; these compare with rates of 250 and 674 on 27th January. Incidence rates remain very high with incidence levels 4-5 times greater than observed in early December 2020.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 41%, demonstrating that there have been less cases in the last 7 days, 27th January to 3rd February, compared with the preceding 7 days, 20th to 27th January.
- The 5-day rolling average has decreased from a peak of 6,831 on 10th January to 1,121 on the 3rd February. This is a 19% decrease since the NPHE meeting last week On 28th January (1,383).
- 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, 17% of cases notified were aged over 65 years.
- Of cases notified in the last 14 days from 27th – 3rd February, 56% 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 high 14-day incidence rates remain across the country, all 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 to 3rd February compared with the previous 7 days, 20th to 27th January.
- Incidence in long-term care settings is decreasing, although levels still remain very high. Of note, residential institutions have accounted for a larger proportion of cases in long-term residential settings in recent months.
- The number of healthcare-setting-acquired infections have decreased in the last week although remain high in absolute terms.
- Of the 20,197 cases reported in the last 14 days, 12.2% (2,472) were healthcare workers.



- The best estimate of the reproduction number (R) is 0.5-0.8. The rate of decline of the disease is continuing at -6 to -9%. The halving time is currently 8-12 days.
- There were 132,536 tests undertaken in the last week. The 7-day average test positivity rate remains high; the positivity rate has decreased to 6.5% on 3rd February from 8.0% last week on 27th January.
- Excluding serial testing, the test positivity rate has also decreased over recent days although the rate remains very high. It was 11.3% over the 7 days to 3rd February, a reduction from 13.4% over the 7 days to 27th January.
- According to contact management programme data, 16 counties have test positivity rates (excluding serial testing) greater than 10%.
- There are currently 1,308 confirmed COVID-19 cases in hospital this morning, compared with 1,620 on 28th January; this is a 19% increase since the last NPHE meeting. There have been 77 newly confirmed cases in hospitals in the preceding 24 hours.
- There are currently 204 confirmed cases in critical care, compared with 212 on 20th January. There have been 11 admissions in the last 24 hours.
- To date, sadly, there have been 1,153 deaths notified with a date in January. This compares with 166 and 176 deaths notified (to date) with a date of death in November and December, respectively. Of the 1,153 deaths in January to date, 112 have thus far been associated with hospital outbreaks and 428 have been associated with nursing home outbreaks. In the first three days of February, there have been 65 deaths with 26 related to nursing home outbreaks.
- To date, the prevalence of S-Genome Target Failure (SGTF) is 69.5% (330/475 samples) for week 3 and 75% (833/1111 samples) for week 4, 2021. SGTF is a marker for the new B.1.1.7 variant of concern first identified in England in December 2020.
- 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 4 are likely an underestimate:

Healthcare setting outbreaks:

- There were 13 new clusters notified in acute hospitals in week 4 of 2021.
- There are currently 133 open clusters associated with 49 acute hospitals; there have been 184 linked deaths and 1,886 linked cases to these outbreaks. Of these cases, 39% are related to healthcare workers.
- There were 23 new clusters notified in nursing homes/community hospitals in week 4, this compares with 26 new outbreaks in these settings in week 3. There have been 6 new outbreaks in nursing homes in the current week.
- There are currently 193 open clusters associated with nursing homes; there have been 532 linked deaths and 5,682 linked cases to these outbreaks. Of these cases, 38% are related to healthcare workers.
- There are currently 214 open clusters associated with residential institutions; there have been 23 linked deaths and 1,420 linked cases to these outbreaks.
- There were 18 new outbreaks in centres for disabilities in week 4; there are currently 130 open outbreaks in centres for disabilities.
- There were 2 new outbreaks in mental health facilities in week 4 and there are currently 16 open outbreaks in these settings.

Childcare Facility Outbreaks

- There were 15 outbreaks newly notified in childcare facilities in week 4 with 19 linked cases, there are currently 78 open outbreaks in these settings.

Travelling Community & Direct Provision Outbreaks



- There has been a significant increase in the number of Irish Traveller outbreaks with 29 new outbreaks with 74 linked cases in the Irish Traveller community in week 4 compared with 11 new outbreaks in week 3; there are currently 63 open outbreaks in the Irish Traveller community.
- There have been 7 new outbreaks in Direct Provision centres with 19 linked cases in week 4. Currently there are 21 open outbreaks in Direct provision centres.

Workplace Outbreaks

- There have been continued workplace outbreaks notified, with 29 reported in Week 4 over a variety of settings. There were 8 outbreaks related to food production settings, 9 in commercial settings, 4 in office settings and 2 in manufacturing settings.
- There have been 126 workplace outbreaks reported in the first 4 weeks of 2021 compared with just 33 such outbreaks in the last 4 weeks of 2020- a 281% increase. There were 151 open outbreaks in workplaces up to the end of week 4. The NPHET expressed its particular concern about the increasing number of outbreaks arising in workplaces.

Further information:

- The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 28.4/100,000 population in week 4 of 2021, compared to an updated rate of 45.0/100,000 population in week 3 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 31st January was 15,426, a decrease of 35% compared to the previous week (23,700).
- 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 2.2 per case.
- As of 3rd February, the 14-day incidence per 100,000 population in Northern Ireland was 438; this is 4% less than the 14-day rate in the Republic of Ireland (455 per 100,000 population). The latest 7-day incidence rate in Northern Ireland is 189, which is 4% less than the 7-day incidence rate in the Republic of Ireland (181 per 100,000 population).

The IEMAG highlighted that as the disease is suppressed in the community and incidence decreases, each additional reduction in case numbers will become smaller, which may affect the public's perception about the rate of progress being made.

The Chair that the DOH, the HPSC, and the IEMAG for their inputs and invited the NPHET Members to discuss the data presented, the follow points were made:

- The importance of including comorbidities when reporting mortalities, particularly in younger age groups where conditions like obesity and obstructive sleep apnoea are associated with more severe disease outcomes was raised.
- The NPHET noted a 'weekend effect' on case counts and discussed ways in which this could be addressed. Communications work and efforts to establish the reasons that might be preventing/discouraging the public from seeking COVID-19 tests at the weekend are required.
- The NPHET noted that the reported number of outbreaks in community settings should be regarded as an underestimate due to the overall volume of cases and requirement to prioritise outbreaks amongst the most vulnerable, including in nursing homes and other healthcare settings.
- With regard to workplaces, it was noted that whilst compliance with public health measures is often good when performing work tasks, reports confirm that these measures are often not applied in the same manner during breaks, with individuals congregating in common areas and lapses in physical distancing, hand or respiratory hygiene and/ or mask-wearing contributing to the spread of disease.
- The NPHET agreed that the recent improvements in a number of disease profile indicators, should be considered as very fragile.



The NPHET concluded that Ireland continues to experience a very concerning epidemiological situation. Incidence is falling but remains high with some concern that case counts may be plateauing, although this is not yet clear and will continue to be closely monitored. In addition, it is anticipated that, following the recommencement of referral of close contacts for testing, the resultant additional case ascertainment will inflate case counts over the coming days. Persistently elevated incidence continues to be observed in those aged 85 and older, both in long-term residential settings and in the community. The total number of patients with COVID-19 in hospital has continued to reduce over the last week but remains very high. An ongoing point of concern is that there continues to be extreme pressure on critical care, with the total number of COVID-19 patients in ICUs, although beginning to reduce, remaining very high.

i. ERSI Length of Stay Data

The IEMAG presented an ESRI briefing note titled “Hospital admission probability and length of stay among COVID-19 confirmed cases: 1st February 2021”, for discussion.

The briefing note examined how the relationship between cases, hospital and critical care admissions, and hospital length of stay, may have varied over the course of the pandemic. Particular attention was paid to variation in age-specific distributions of admission probabilities and average length of stay across waves of the pandemic.

The volumes of COVID-19 confirmed cases and hospital admissions have varied across the course of the pandemic in Ireland. Three broad waves can be identified: March through July (Wave 1), August through November (Wave 2), and December onwards (Wave 3). The majority of confirmed cases and hospital admissions have been recorded since December. A number of factors including the rollout of vaccination to at-risk groups, the impact of new COVID-19 strains, and changing policy and behaviours, are likely to impact on the relationships and patterns observed.

The NPHET thanked the IEMAG and noted the importance of data on length of stay for informing future discussions on a range of issues including care pathways, patient rehabilitation, nosocomial infection, and hospital policy. The use of length of stay as a metric for the impact of comorbidities on outcomes for patients in different age groups, particularly in those under 70 years old was also discussed.

ii. Global Epidemiology of Novel Variants

The HPSC presented the paper “Variants of Concern Cases and Processes in Ireland, including an update on Global Epidemiology for NPHET: 3rd February”, for discussion.

The paper reviewed the most up to date data on the VOCs, both nationally and internationally, and outlined the current testing and tracing pathways that have been established to deal with these VOC.

The NVRL updated the NPHET on the current pathways in place to facilitate whole genome sequencing and the ongoing efforts to engage with the ECDC in order to enhance capacity. Increasing the available capacity for whole genome sequencing is a priority, the logistical challenges to further increasing capacity are being addressed.

The NVRL confirmed that it will provide greater detail on the volume of whole genome sequencing being carried out across public and private laboratories. The NPHET thanked the HPSC for its paper and noted same

3. Review of Existing Policy

a) International Travel

The DOH gave a brief update on the topic of international travel. Key updates were as follows:

- Measures have been taken to significantly discourage non-essential travel including increasing the Garda presence at ports and airports and increasing the penalty for engaging in non-essential travel from €100 to €500. Several fines have already been issued to individuals engaged in non-essential travel.



- The majority of those travelling into Ireland from overseas will be required to fulfil a mandatory period of self-isolation at their residence. Individuals will be able to exit this self-isolation early provided they return a “not detected” test result from a PCR test taken on day 5 or later since their arrival.
- However, given ongoing and emerging international evidence on variants of concern of COVID-19, any individuals travelling into Ireland from either Brazil or South Africa will be legally required to complete the full 14-day self-isolation period.
- The creation of self-isolation facilities, other than people’s homes, is now being considered for individuals travelling from either Brazil or South Africa. Primary legislation will be required to ensure these arrangements have an appropriate legal underpinning. Moreover, significant engagement will be required with the HSE and across Government departments in the development of a model for how these facilities will function to fulfil public health requirements.
- The DOH outlined that, in recent days, it appears that there has been a significant reduction in the number of individuals travelling into Ireland.

The Chair thanked the DOH for its update and noted same.

The NPHEP sought clarity on the issues of how individuals required to engage in international travel to avail of essential medical procedures would be navigated. The DOH clarified that the legislation contains detailed provisions and exemptions for people travelling for essential purposes, including medical procedures.

b) Update on IPC Guidance & Information

The Chair welcomed and thanked Professor Martin Cormican from the HSE’s National Antimicrobial Resistance and Infection Control (AMRIC) team for agreeing to present on the topic “*Update on IPC Guidance & Information*”.

The Chair outlined the key questions relating to IPC guidance at present, firstly, that IPC guidance and practice is up to date in terms of how COVID-19 is developing and spreading in healthcare settings, and secondly, that the NPHEP has a good understanding of the data in terms of IPC and nosocomial infection. The Chair added that the Chief Nurse’s Office in the Department of Health had been working closely with the AMRIC.

Professor Cormican thanked the Chair and the NPHEP for the opportunity to present on the work of the AMRIC Team. The key points were as follows:

- The AMRIC team does not see evidence that SARS-CoV-2 is becoming “resident” in congregated healthcare settings.
- The frequency of introduction and the difficulty of recognising introduction of COVID-19 into healthcare settings are both critical challenges.
- The pattern of transmission is more similar to Norovirus than to Antimicrobial Resistance (AMR);
- It is important to emphasise the need for a holistic IPC approach (PPE is just one part of IPC);
- Changes in guidance on respirator masks are likely to have at most a limited impact on healthcare acquired infection for staff or patients.
- Reducing community transmission (thereby reducing introduction to healthcare settings) and vaccination are likely to be the key measures.

The CCO of the HSE commended Prof Cormican for his ongoing work and elaborated on the AMRIC team’s presentation:

- Since the beginning of the pandemic, the AMRIC team has led the development and updating of real-time IPC guidance for healthcare settings and has also delivered extensive training and education for healthcare workers through a newly developed governance structure.
- Engagements on the issue of IPC have been focussed not only with clinicians and scientists, but also with staff organisations and unions.
- The AMRIC team has been consistent in its advice for staff that the most basic IPC procedures (e.g. adherence to social distancing, regular handwashing, not presenting for work if symptomatic) afford the



greatest protection from nosocomial infection. This message has been reiterated in the latest round of training for healthcare workers, reiterating the importance of maintaining IPC while present and in transit to work.

- Finally, as stated in the presentation, a sharp correlation has been observed between rates of community transmission and rates of nosocomial infection in hospitals.

The Chair concurred with the CCO of the HSE, noting the challenges experienced in all sectors which could be linked to the huge volume of disease reported in the community. The Chair then invited the NPHET to discuss the presentation, the following points were raised:

- The NPHET Members strongly welcomed this update and thanked Prof Cormican and the AMRIC team for their work to date.
- Existing infrastructural deficits are a fundamental issue for control of transmission across a range of health care settings including hospitals, some Long-Term Residential Centres (LTRC) centres and Community Nursing Units.
- It was noted that new infrastructural developments were required across several sites in order to move away from providing care in multi-bed, multi-occupancy wards to the greatest extent possible. While this was an issue prior to the COVID-19 pandemic, and it is positive that the AMRIC team are tracking these outbreaks closely, the experience highlights that health environments have the potential to amplify epidemics and that strict IPC measures are therefore required to mitigate this risk. This is important not only from an IPC perspective but also to guarantee the dignity of patients being cared for in hospital.
- Several Members raised the need to draw on what has been learned with respect to IPC and outbreak control practices in the context of a pandemic, highlighting that learnings should be identified and embedded into practice as appropriate.
- With respect to the role antigen testing might play as part of IPC procedures in healthcare settings, it was highlighted that the use of ADTs would have to be determined on a case by case basis by each hospital. It was noted that antigen testing is least effective at detecting asymptomatic infections. One of the primary issues faced by hospitals has been staff and patients who are asymptomatic at the time of PCR testing subsequently testing positive for COVID-19. Antigen testing will therefore have to be deployed with caution. Broadly speaking, IPC has been effective in detecting and responding to symptomatic cases of COVID-19 in healthcare settings.
- The HPSC also raised a cautionary point regarding FFP2 masks. Reports suggest that, if not fitted correctly, FFP2 masks can create a risk of further onward transmission among healthcare workers. Regarding ill-fitted FFP2 masks, it was explained that the protection afforded is roughly equivalent to that provided by a normal surgical mask. This underscores the importance that healthcare workers are instructed consistently to wear FFP2 masks correctly and refrain from adjusting them.
- The rate of infection and outbreaks across both acute and community settings remains high. The rate of infection in LTRCs was cited, with roughly 36% of Nursing Home staff having had cases of COVID-19. This underscores the need for communications campaigns highlighting the continuing need for adherence to basic IPC practices of social distancing, hand hygiene and respiratory etiquette.
- To support communications efforts, DOH & HSE Comms teams have developed a single page of IPC guidance for dissemination across LTRC settings which has been extremely useful across the sector.
- Arising from the recommendations by the Nursing Home Expert Panel (NHEP), a community IPC strategy is being developed.

The CCO of the HSE again commended Prof Cormican and the AMRIC team for their work and input. It was further suggested that a joint learnings paper be developed by the AMRIC team to inform ongoing and future pandemic management. This is particularly timely given the substantial impact of the latest wave of COVID-19 on acute hospitals and rates of nosocomial infection.

The Chair welcomed this proposal and noted that it was important that the NPHET keep IPC guidance under review on an ongoing basis.



c) Close Contact Testing & Restriction of Movements

The DOH presented the paper “Close Contact Testing & Restriction of Movements 3rd February 2021”, for discussion.

The DOH reminded the NPHE that this issue had been considered in previous meetings and that the paper relates to the testing and duration of restriction of movements (ROM) 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 reminded the NPHE of the current position regarding close contact testing and ROM. The DOH outlined that, since this issue was last considered by the NPHE, the HIQA had given it specific consideration in its paper for the NPHE’s meeting on 12th January “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’s paper assessed a number of specific testing scenarios with respect to test demand relative to testing capacity. These scenarios include two-test strategies reflective of unconstrained testing (that is, testing capacity that exceeds demand with no constraints at any point in the process), single test strategies reflective of constrained testing, and strategies with no universal testing of close contacts in the community reflective of significantly constrained testing within a mitigation phase.

The HIQA’s net conclusion from this work was as follows:

- On balance, the scenario, which included ending the period of restricted movements on receipt of 'not detected' test result from a test conducted on day 10 since last exposure, leads to an estimated reduction in the burden of person-days in restricted movements (-607 person-days, 95%CI: -972 to -193) while maintaining similar rates of infectious person-days in the community (1 person-day, 95% CI: -27 to 23) per 1,000 close contacts.

The DOH outlined that, in line with the HIQA’s findings, it is now proposed that for the general population there should be:

- Recommencement of twice-testing of all close contacts, at Day 0 and Day 10 post their last exposure to the case, as soon as swabbing, testing and contact tracing capacity can facilitate this development.
- Close contacts may end the period of restricted movements on receipt of a 'not detected' test result from a test conducted on Day 10 since last exposure.

It is further proposed that, at the point at which the recommendation is implemented, healthcare workers who are designated as close contacts should also move to testing at Day 0 and Day 10 (currently day 5 and day 10) post their last exposure to the case.

The NVRL raised a point of clarification that the release of close contacts from restriction of movements following a day 10 test would only apply on the condition that the close contact did not experience symptoms of COVID-19 during their ROM period. The DOH confirmed that this would be the case.

The NPHE endorsed the paper.

Action: The NPHE recommends that:

- **For the general population, there should be recommencement of twice-testing of all close contacts, at Day 0 and Day 10 post their last exposure to the case, as soon as swabbing, testing and contact tracing capacity can facilitate this development.**
- **For the general population, close contacts may end the period of restricted movements on receipt of a 'not detected' test result from a test conducted on Day 10 since last exposure, so long as they remain asymptomatic.**
- **Healthcare workers who are designated as close contacts should also move to testing at Day 0 and Day 10 (currently day 5 and day 10) post their last exposure to the case.**



4. HIQA

The HIQA gave a verbal update on its ongoing review on the international experience and use of antigen diagnostic tests in EU Member States and in the UK, in asymptomatic people in community settings.

The HIQA offered this update in advance of its '*International Review of Public Health Measures and Strategies to limit the spread of COVID-19*' due for discussion at the next NPHET Meeting, 11th February.

The HIQA outlined for the NPHET how antigen tests are being used in a number of countries across Europe and the UK. The HIQA highlighted a number of issues to consider, including urgency, PCR capacity, prevalence/positivity rate, validation in settings, and manpower requirements.

The Chief Scientific Advisor noted that the HIQA's analysis will be very helpful to the work of group set up by the Minister for Health to look at rapid antigen testing.

The NPHET thanked the HIQA for its update and noted that its final paper will be returned to the NPHET for 11th February. The NPHET further noted that this matter merits ongoing monitoring and review as new evidence becomes available.

5. Future Policy

a) Future Planning

At the NPHET Meeting on 21st January, there was an initial discussion on the NPHET advice and recommendations to inform the Government's review of the *Plan for Living with COVID-19*. Following that meeting a number of group discussions were facilitated to maximise Member contributions. At today's meeting, 4th February, the DOH presented feedback from the group discussions. The key points included:

- Focus of Advice: Provide broad expectations for 2021, articulate common goals, key challenges, and need for continued layering of measures
- Key Overarching Messages: continued strengthening of key aspects of response including public health infrastructure, testing, surveillance and broader public health response, travel measures, recognition of the disproportionate impact of the pandemic on some groups, the critical role of international cooperation and the need for cross Government, cross sectoral responsibility.
- Potential Challenges: maintaining a high level of compliance with measures across the population, the impact of new variants on transmission and vaccine effectiveness, unknowns in terms of vaccine supply, effectiveness and uptake levels, and uncertainty in relation to next winter.
- Health System Resilience: the significant impact of the third wave on non-COVID scheduled care, need to resume non-COVID services, existing deficits across the health system and opportunities for building on innovations.
- Public Health Measures: consensus that there could only be very limited opening in the short term with education, childcare and health and social care services as priority, while acknowledging that there would be pressure to reopen, need to consider the needs of different population groups.

The ensuing discussion focused on a number of areas including:

- Now is the time to bolster measures put in place on an emergency basis and to ensure a sustainable medium/long term response.
- Cross-Governmental, inter-agency and inter-sectoral work and collaboration is vitally important to the response going forward. It was further noted that there has been more inter-sectoral work than ever before, and the focus should be on sustaining and strengthening this work.
- Members reiterated that enhancing Public Health infrastructure is a necessity, not just for COVID-19 but to safeguard against future pandemics.



- There are inherent long-standing fragilities across the health system, opportunity now to address these through targeted investment and reform, including sustaining the many positive innovations over the last year. With regard to IPC, it was noted that de-congregating hospital wards and care facilities is important.
- Need to strengthen all ‘upstream’ measures especially as measures are eased and to harness new innovations and learnings.
- A need for a continuing focus on engagement with employers to facilitate working from home and to create safe workplaces.
- With regard to the 5-Level Framework, there was consensus for its retention for a number of reasons. The language, layout and measures contained within the Framework are now familiar to the public and disregarding it could impact public buy in to restrictive measures. However, it was noted that it should continue to be applied in a flexible manner.
- General support for a cautious approach and very limited reopening in the immediate term, but also an acknowledgement that pressure to reopen will increase and consideration needs to be given to how this can be done in a safe and sustainable way.
- The negative impact that the pandemic response has had across all groups and, particularly on children and younger people was noted and there is a continued need to balance the harms of COVID-19 and the harms of the response and to listen of the voices of marginalised and vulnerable groups.
- Members highlighted the collective trauma of living through the pandemic, particularly when experiencing surges in hospitalisations, ICU admissions, and deaths. Furthermore, as time goes on, people can become desensitised to the severe effects that comes with a high level of infection, especially if the worst of the impact is not felt by their cohort.

The DOH confirmed that a paper incorporating the feedback from the group will be returned to the NPHE at its next meeting, on 11th February.

The Chair thanked the DOH and NPHE Members for their work on developing the paper.

b) Vaccination

The DOH gave a brief update on vaccine rollout.

On behalf of the NPHE, the Chair thanked the NIAC and the RCPI for providing leadership support to the vaccine rollout.

i. HPRA Vaccine Safety Update

The HPRA presented “*2nd HPRA Safety Update, COVID-19 Vaccines, Overview of National Reporting Experience: 4th February 2021*”, for noting. The key points made were as follows:

- Up to 28th January, a total of 740 reports of suspected side effects were notified to the HPRA.
- Up to 27th January, the cumulative total doses of COVID 19 vaccines administered was reported as 147,700 (dose 1) and 13,800 (dose 2).
- Of the reports notified to the HPRA, the most commonly reported suspected side effects are in line with those typically associated with vaccination, including the types of side effects described in COVID-19 vaccine product information.
- National reporting experience to date continues to support the favourable assessment that the benefits of COVID-19 vaccines outweigh any risks.
- The European Medicines Agency (EMA) published its first safety update on the COVID-19 vaccine, Comirnaty[®], on 29th January. This update concluded that the safety data collected for Comirnaty[®] to date is consistent with the known safety profile of the vaccine and there were no changes to the recommended use of the vaccine.



The NPHEP thanked the HPRA for this update and noted same.

6. Communication Update

The HSE updated the NPHEP that the COVID-19 vaccination communication campaign is underway as of last weekend with advertisements appearing across newspapers, radio, television, and other media. These advertisements have focused on high-level messaging regarding COVID-19 vaccination. The HSE outlined that the campaign will be responsive to meeting the information needs of the public on an ongoing basis. Engagements will take place with professional, community and advocacy groups as vaccination continues to ensure that the communication concerns and needs of groups prioritised for vaccination initially are heard and addressed. In the first instance, these engagements will be focused with healthcare worker professional groups and advocacy organisations for older persons who the HSE will be working with in the ongoing rollout of vaccine communications.

The DOH reported that there was nothing to add from a communications perspective to this update.

8. Meeting Close

a) Agreed actions

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

b) AOB

No matters were raised under this item.

c) Date of next meeting

The next meeting of the NPHEP will take place Thursday 11th January 2021, at 10:00am via video conferencing.