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

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<tr>
<th>Date and Time</th>
<th>Thursday 11th February 2021, (Meeting 76) at 10:00am</th>
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<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH</td>
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### Members via videoconference
- Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
- Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)
- Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair
- Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA
- Dr John Cuddihy, Interim Director, HSE HPSC
- Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- Dr 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 Darina O’Flanagan, Special Advisor to the NPHET
- Mr Fergal Goodman, Assistant Secretary, 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;
- Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH
- Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH
- Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH

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<tr>
<th>Members via videoconference</th>
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- 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
- Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH
- Prof Martin Cormican, Prof of Bacteriology at NUI Galway and Consultant Microbiologist, NUIG
- Dr Robert Mooney, NPHET Policy Unit, DOH
- Ms Ruth Barrett, NPHET Policy Unit, DOH
- Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH
- Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH

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<th>Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH</th>
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<td>Apologies</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH; Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH; Mr Phelim Quinn, Chief Executive Officer, HIQA; Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital; Ms Yvonne O’Neill, National Director, Community Operations, HSE</td>
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1 References to the HSE in NPHET minutes relates to the staff of the HSE present at NPHET meetings and not the HSE Board which is the HSE in law unless otherwise stated.
1. Welcome and Introductions
   
a) Conflict of Interest
   Verbal pause and none declared.

b) Apologies
Apologies were received from the following Members: Dr Tony Holohan, Dr Eibhlín Connolly, Mr Phelim Quinn, Prof Colm Bergin, and Ms Yvonne O’Neill.

b) Minutes of previous meetings
The minutes of 14th January 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
The Acting CMO, Dr Ronan Glynn, welcomed Members and confirmed that he would be chairing the meeting in the CMO’s absence.

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 6,607 cases have been notified in the 7 days to 10th February, which is a 21% decrease on the previous 7 days in which there were 8,335 cases.
- As of 10th February, the 7- and 14-day incidence rates per 100,000 population have decreased to 139 and 312, respectively; these compare with rates of 175 and 424 on 3rd February. Incidence rates remain high with incidence levels 3-4 times greater than observed in early December 2020.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 44%, demonstrating that there have been fewer cases in the last 7 days, 4th – 10th February, compared with the preceding 7 days, 28th January – 3rd February.
- The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January to 848 on 10th February. The 5-day average has decreased by 24% since the last NPHET meeting (1,121).
- Incidence, although still high, has reduced across most adult age groups. Incidence in those aged 85 and older remains elevated but is reducing. In the last 14 days, 15% of cases notified were aged over 65.
- Of cases notified in the past 14 days, 28th January – 10th February, 59% have occurred in people under 45 years of age; the median age for cases notified in the same period is 39 years; the recent recommencement of testing of asymptomatic close contacts has increased the ascertainment of asymptomatic cases which has resulted in a higher proportion of cases notified in those aged under 18. Asymptomatic cases have increased from ≈10% to ≈ 20% of all cases in recent days.
- While 14-day incidence rates remain high across the country, 21 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, 4th – 10th February, compared with the previous 7 days. Of note in recent weeks, the number of cases in Dublin as a proportion of all cases notified nationally has been increasing.
- Of the 14,861 cases reported in the last 14 days, 28th January – 10th February, 10.2% (1,516) were healthcare workers.
- The best estimate of the reproduction number (R) is 0.6 – 0.8. The rate of decline of the disease is continuing at -3 to -7%. The halving time is currently 10-20 days.
- There were 121,402 tests undertaken in the last week. The 7-day average test positivity rate remains high; the positivity rate has decreased to 5.8% on 10th February from 6.5% last week on 3rd February.
- Excluding serial testing and facility testing in response to outbreaks, the test positivity rate has slightly decreased over recent days, although the rate remains high at 10.5% over the 7 days to 10th February, a reduction from 11.3% over the 7 days to 3rd February.
According to contact management programme data, 15 counties have test positivity rates (excluding serial and outbreak facility testing) greater than 10%.

There were 984 confirmed COVID-19 cases in hospital this morning, compared with 1,308 on 4\textsuperscript{th} January; this is a 25\% decrease since the last NPHET meeting. There have been 44 newly confirmed cases in hospital in the 24 hours preceding this morning.

There are currently 170 confirmed cases in critical care, compared with 202 on 3\textsuperscript{rd} February. There have been 8 admissions in the last 24 hours.

Of the 555 COVID-19 patients admitted to ICU over the period 22\textsuperscript{nd} November – 6\textsuperscript{th} February, 87\% had one or more underlying conditions. This is similar to the relevant proportions seen in the previous waves.

To date, there have been 292 deaths notified with a date of death in February. This compares with 1,220 and 182 deaths notified (to date) with a date of death in January and December, respectively. Of the 292 deaths in February, 21 have thus far been associated with hospital outbreaks and 129 have been associated with nursing home outbreaks.

To date, the prevalence of S-Gene 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. It is anticipated that a further update on SGTF prevalence will be available next week.

In total, 11 cases of 501Y.V2 (variant first reported in South Africa) have been confirmed by whole genome sequencing.

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

Further relevant information includes:

Healthcare setting outbreaks

There were 15 new clusters notified in acute hospitals in week 5 of 2021.

There are currently 137 open clusters associated with 45 acute hospitals; there have been 200 deaths and 1,982 confirmed cases linked to these outbreaks. Of these confirmed cases, 40\% are related to healthcare workers.

There were 12 new clusters notified in nursing homes/community hospitals in week 5, this compares with 23 new outbreaks in these settings in week 4.

There are currently 182 open clusters associated with nursing homes; there have been 647 deaths and 5,682 confirmed cases linked to these outbreaks. Of these cases, 39\% of confirmed cases are related to healthcare workers.

There are 18 open outbreaks in community hospitals and long stay units, there have been 28 deaths and 514 confirmed cases linked to these outbreaks with over 50\% of these cases recorded as healthcare workers.

There are currently 200 open clusters associated with residential institutions; there have been 29 linked deaths and 1,569 linked confirmed cases to these outbreaks. Within these residential institutions,

- there were 5 new outbreaks in centres for disabilities in week 5; there were 125 open outbreaks in centres for disabilities at the end of week 5.
- there were 3 new outbreaks in mental health facilities in week 5 and there were 19 open outbreaks in these settings at the end of week 5.

Travelling Community & Direct Provision outbreaks

There remains a high number of Irish Traveller outbreaks with 22 new outbreaks and 78 linked cases in week 5 compared with 29 new outbreaks in week 4; there are currently 82 open outbreaks in the Irish Traveller community.

There have been 4 new outbreaks in direct provision centres in week 5. Currently, there are 22 open outbreaks in direct provision centres.

Childcare Facility & Workplace outbreaks

There were 13 outbreaks newly notified in childcare facilities in week 5 with 41 linked cases. There are currently 85 open outbreaks in these settings.
• Workplace outbreaks continued to be notified, with 29 reported in week 5 across a variety of settings, which is the same number of outbreaks identified in week 4. There were 9 in commercial settings, 8 outbreaks related to food production settings, 5 related to the construction industry, 4 in manufacturing settings and 2 in office settings.
• There have been 155 workplace outbreaks reported in the first 5 weeks of 2021 compared with just 33 such outbreaks in the last 4 weeks of 2020. There were 168 open outbreaks in workplaces up to the end of week 5.
• The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 19.8/100,000 population in week 5 of 2021, compared to an updated rate of 28.9/100,000 population in week 4 of 2021.
• Although low, a range of mobility and compliance data suggest that mobility may be increasing; mobility remains greater than the lowest levels observed in spring 2020.
• The number of close contacts captured during the week ending 7th February was 12,978, a 16% decrease from the previous week (15,426).
• Referral for Test 1 (Day 5) re-commenced on 29th January 2021. Of the 3,342 close contacts created between 29th to 31st January where test results were available, 707 (21.2%) were positive. The highest positivity rate, 29.2%, was seen in household contacts. The HSE reported that Test 2 recommenced on 10th February 2021.
• 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 currently remains low at 2.3 per case.
• As of 10th February, the 14-day incidence per 100,000 population in Northern Ireland was 325; this is 4% more than the 14-day rate in the Republic of Ireland (312 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 139, which is the same as the 7-day incidence rate in the Republic of Ireland (139 per 100,000 population).

IEMAG model projections show that if we can maintain a reproduction number between 0.5 and 0.9 for the coming weeks, we remain on track to have 200-400 cases per day by 1st March 2021, and 100-300 cases per day by 15th March 2021; the latter projections in particular emphasise the importance of keeping transmission as low as possible for as long as possible. The healthcare demand and utilisation models, under the same assumptions, project 500-600 people requiring hospital care (and an additional 70-100 people in critical care) at the end of February, and 250-400 people in hospital care (and an additional 40-60 people in critical care) in mid-March.

The dominance in Ireland of the significantly more transmissible variant of concern (B.1.1.7), presents an additional challenge to continued reduction in disease incidence. In this context, the epidemiological situation in Ireland should continue to be considered very fragile.

The Acting 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:
• Should further surges occur, stopping the testing of close contacts should be a last resort. It was also noted that the limiting factor with testing was with the number of swabbers available and this raised the question of whether self-swabbing should be considered. The NPHET remarked that a contingency plan must be in place. It was also highlighted that there must be a focus on building the capacity for retrospective contact tracing and more intensive measures around close contacts, particularly as cases reduce.
• Regarding delays in people presenting for testing at the weekends, discussions with GPs have highlighted that a significant number of patients with potential COVID-19 symptoms reportedly contact out-of-hours doctors but ultimately choose to wait for their own GP to refer them for testing on Mondays.
• A further point brought to the NPHET’s attention was that a significant number of patients contacting GPs thought they would be charged for their COVID-19 test, with unfortunate reports that people have been charged for referral causing significant some misunderstanding and confusion.
The NPHET noted that communications work should be done to the above points on delayed presentation for testing and the misunderstanding surrounding testing charges. The NPHET also noted that translation services should be involved in this work in order to reach non-English speaking communities.

The Acting Chair thanked the Members for their contributions.

i. Global Epidemiology of Novel Variants
The Office of the NCDHP, HPSC presented the paper “Variants of Concern Cases and Processes in Ireland, including an update on Global Epidemiology for NPHET 10th February 2021”, for discussion.

On the global epidemiology of VOCs, the paper noted the numbers of confirmed cases of the South African (501Y.V2) and Brazilian (P.1, VOC; P.2, Variant of Interest) variants worldwide as reported by the European Centre for Disease Prevention and Control (ECDC). The paper outlined the VOC processes in Ireland and noted the confirmed and probable cases of 501Y.V2, Brazilian P.1 (of which there are no confirmed cases) and P.2 in Ireland. It was noted that the so-called UK variant (B.1.1.7) now accounts for approximately 75% of cases in Ireland and, as such, arrivals from the UK will not be subject to enhanced public health measures.

The paper further provided an update from the National Oversight Group for VOCs meeting on 10th February. On foot of this meeting, the group advised that the "high-risk" list of countries be expanded. The full list of countries recommended for inclusion on the “high-risk” list was provided to the Minister for Health in a post-meeting letter.

Regarding Whole-Genome Sequencing the NVRL informed the NPHET that 10.8% of all positive samples in week 5 have been or are in the process of being sequenced. The NVRL further noted that while Ireland has done well with regard to sequencing throughout the pandemic, it is hoped that the majority of cases will be sequenced going forward as capacity increases and case numbers decrease.

It is expected that the ECDC will shortly issue an updated risk assessment with regard to Variants of Concern and this will inform ongoing consideration and advice with regard to this issue.

The Acting Chair thanked the Members for their contributions.

3. Review of Existing Policy
a) International Travel
The DOH provided a verbal update to the NPHET on International Travel.

The DOH noted that advice from The National Oversight Group for Variants of Concern to expand the list of ‘high-risk’ countries has been reviewed by the CMO and Deputy CMO and has been provided to the Minister for Health.

The DOH outlined the current programme of work being undertaken to draft the necessary policy, legal and operational processes to introduce quarantine hotels which are expected to be brought to Government next week for decision. The DOH further outlined that there is a significant number of challenges when applying measures to inbound travel that must be worked through.

With regard to the health and well-being of those who will be required to quarantine in a facility, it was asserted that measures need to be taken to ensure that those people are safe guarded in all respects and are appropriately taken care of during their stay.

In the ensuing discussion, it was noted that the majority of those travelling into the country by air are resident in Ireland, highlighting that non-essential travel remains a challenge.
The NPHET reiterated its position that there should be no non-essential international travel. The NPHET further noted that this is a dynamic situation and will be kept under review.

b) Update of Research Activity/Clinic Trials at National level
The DOH presented the paper “COVID-19 Related Research: An Update: 10th February 2021” to the NPHET for noting. The DOH thanked the HRB (Health Research Board), SFI (Science Foundation Ireland), HPRA (The Health Products Regulatory Authority), and the NREC (National Research Ethics Committees) for their input into the paper.

The paper provided an update to the NPHET on ongoing COVID-related research activities and infrastructural initiatives in the healthcare and broader innovation spheres in Ireland. The paper gave an overview of COVID-related research activities undertaken in the last year and updates in respect of the planned activities and developments. The DOH noted that while its review was comprehensive, it should not be seen as a complete account of all ongoing research activities as it did not capture research that was funded at a local level. The paper provided an overview on funding for COVID-19 related research as follows:

Funding for COVID-19 Related Research:
- In April 2020, The Irish Research Council (IRC), Health Research Board (HRB), Science Foundation Ireland (SFI), Enterprise Ireland (EI), and IDA Ireland developed a coordinated Rapid Response Research and Innovation programme.
- Two funding streams were made available; the first, through the HRB, in cooperation with the IRC, focused on research that addressed: medical countermeasures, health service readiness, and social and policy countermeasures to COVID-19. A total of 36 research projects have been supported at a cost of approximately 5.5m over the period 2020-2022.
- The second funding stream made available through SFI, EI and the IDA focused on supporting the development of innovative solutions based on new or alternative approaches and methodologies to address the pandemic response. SFI (in two phases) provided funding of €18m for a total of 83 projects.
- In July, the HRB jointly with HSE provided 0.5m funding for four projects through The Research Collaborative in Quality and Patient Safety (RCQPS).
- The European Commission issued two EU COVID-19 funding calls in 2020. The initial call in January allocated €38.5 million to 18 projects involving 140 research teams from across the EU and beyond to develop research on understanding the behaviour of the epidemic through epidemiology and modelling, developing rapid diagnostics, as well as treatments and vaccines.
- A second call in May 2020 allocated €133m to twenty-four successful research projects involving over 350 research teams from 40 countries. Ireland performed well and is involved in 7 successful projects and leading two projects.
- In September 2020, the EU launched EU-RESPONSE - a 5-year multi-national project (€15.7M), in order to design and run a new adaptive European platform trial on COVID-19 and emerging infectious diseases. Ireland is involved in application discussions, with UCC as a listed partner. The HRB is engaging with partners in Ireland, including CRCI, CRFs, and investigators to monitor developments.

The Chief Scientific Advisor to the Government (CSA) welcomed the paper for highlighting the extent of ongoing research work. The CSA noted that research into COVID-19 has been funded by diverting existing resources. The RCPI also welcomed the paper and emphasised the need to showcase to the public the breadth of research projects that are being carried out in Ireland. These projects will inform policy and it is crucial that work continues to find innovative solutions to the challenges that COVID-19 presents. The HPSC emphasised the need to build up the research capacity within the overall public health system, including health protection. It highlighted the lack of a dedicated health protection research facility as one area that needs to be addressed.

The Acting Chair thanked the DOH for its paper, noting that it, and the discussion surrounding it will help to inform the next stage of the COVID-19 response and the long-term strategy for public health.
c) IPC Update - COVID-19 Cases and Outbreaks Weekly Report
AMRIC and the DOH presented a draft “Weekly Health Care Acquired Infection (HCAI) COVID report: 11th February 2021” template to the NPHET for noting.

The DOH and the AMRIC emphasised that the report is still in development and welcomed any feedback, particularly in relation to gathering data from HSE Community Operations which has presented a challenge due to the large number of sites involved.

The DOH and the AMRIC stressed that healthcare associated COVID-19 is a major challenge in community and acute operations. Healthcare associated COVID-19 impacts of service users/patients and healthcare workers. Healthcare associated COVID-19 is also a central part of the overall public health response to COVID-19 with infection introduced into the healthcare setting from the community, potentially amplified in the healthcare setting, and then disseminated widely within the community.

The NPHET provided the following feedback on the template:
• Where possible, vaccination status data for staff and patients should be collected as this will provide an indication of vaccine efficacy.
• Homecare services should be included as part of the community operations data (HPSC provide a weekly report currently).
• The number of hospitalisations originating from residential facilities should be included.
• Serial testing positivity rate, the number of new outbreaks in previous 7 days, and the number of deaths in previous 7 deaths should be included.
• The gathering of data should be coordinated with the departments of public health to avoid a duplication of effort as many of the public health departments are already liaising with local community services to gather data.
• The weekly report should include actions carried out by the HSE. It will provide an opportunity to identify actions that have been completed and any future actions that may be required.
• The HSE advised that there are a number of different reporting systems for the community and that it will work with AMRIC to link these in with the report.
• The first page should summarise actions to address the challenges identified through the data. The learnings paper will address how challenges faced so far have been addressed to date and future actions required.
• The HPSC offered to share any relevant data it had gathered.

The DOH and AMRIC thanked the NPHET Members for their feedback and stated their aim to return in the coming weeks with a finalised version once the feedback has been incorporated.

d) Joint Department of Health/HSE Update on Critical Care
The DOH and HSE presented a paper to the NPHET “Update on Critical Care- 11th February: 11th February 2021”, for noting.

The paper provided a summary of the current critical care situation and update on the implementation of the Strategic Plan for Critical Care. The following key points were noted in the paper:
• The situation in critical care units has remained intensely challenging.
• Surge capacity remains in use across all units and the number of beds open and staffed remains well above the baseline and close to the limit of 350, the level at which clinical risk remains manageable.
• While the levels of disease in the community have begun to show signs of improvement, a ‘high plateau’ of patients requiring admission to critical care units as a result of COVID-19 is being seen.
• At the same time, non-COVID critically ill patients continue to present and the volume of non-COVID critically ill patients will continue to return to pre-COVID levels.
• In order to ensure that critical care is sufficiently resourced to meet demand into the future, a formal structure has been put in place in the HSE to oversee implementation of the Strategic Plan for Critical Care.
Care. This will allow for continuing coordinated oversight of commissioning of new critical care beds and buildings, as well as workforce planning and performance monitoring, with all key stakeholders represented.

- The HSE anticipates that the baseline will increase to 301 beds by the end of Q1 2021, with 321 beds in place by year end, and recruitment is ongoing.

The paper concluded that while the reduction of disease in the community is welcome, it has not yet resulted in an easing of the pressure on critical care units. Continued public support of and adherence to public health measures is extremely important in that regard. The need to significantly increase critical care capacity in Ireland has been exacerbated by the COVID-19 pandemic. Successful implementation of the Strategic Plan for Critical Care will address existing deficits and allow for expansion of capacity into the future, to ensure that sufficient capacity is available to meet demand.

4. HIQA

a) Measures to support self-isolation and Restriction of Movements

The HIQA presented the paper “Rapid Review: Measures to support people in self-isolation or restriction of movements and the evidence of the effectiveness of such measures: 9th February 2021”, for discussion.

The purpose of the HIQA evidence synthesis was to provide advice to the NPHET on the policy question: ‘What measures are being taken internationally to support compliance with self-isolation and restricted movement requirements and is there any evidence as to how effective are these measures?’

The rapid review consisted of two elements; the first was a review of international guidance relating to measures to support those in self-isolation (due to case status) or restricting their movements (due to close contact status) during the COVID-19 pandemic; the second was an evidence summary of the effectiveness of measures used to support individuals in self-isolation or restriction of movements.

Arising from the findings of the paper, the HIQA provided the following advice to the NPHET:

- All of the measures in place (in Ireland) to support those in self-isolation or restriction of movements are necessary, appropriate and need to remain in place.
- Given the high secondary attack rate in households, consideration should be given to the provision of medical masks for those self-isolating or restricting their movements to reduce transmission within the home and to the expanded use of alternative accommodation for those who cannot effectively self-isolate or restrict their movements at home.
- Clear, concise information is critical in equipping and empowering individuals with the necessary knowledge to self-isolate and restrict their movements. In addition to the information already provided through the HSE and HPSC websites, consideration could be given to:
  - use of web-based applications to provide customised information and to help direct individuals to the relevant advice and to the range of resources and supports available to them.
  - enhanced information provision to support individuals for whom English is not their first language.
- When case numbers return to low levels, the use of universal, comprehensive packages should be considered to support individuals. Consideration could also be given to the use of enforcement measures (for example, monitoring and or penalties), where appropriate.

The Acting Chair thanked the HIQA for its advice and invited the NPHET Members to discuss same. Key points in the discussion were as follows:

- The NPHET acknowledged that local authorities, voluntary organisations and community groups all play an important role in supporting the public and identifying those who need help.
- The NPHET underscored the need for supervision and enforcement of public health measures, noting that this responsibility must fall across the whole of government, including local government, and not limited to public health services.
The DOH proposed exploring the possibility of using any unused call centre capacity in the contact tracing system to carry out support calls to those who are isolating due to COVID-19.

It was also proposed that every household should be advised to develop a plan for how they will minimise risk should a household member become infected. This would include having a supply to facemasks in the home for immediate use when needed.

The NPHET thanked HIQA for its paper and noted its advice for incorporation into future proposals.

**b) International experience and use of Antigen Diagnostic Tests in EU Member States and in the UK, with a particular focus on their use in asymptomatic people in community settings.**

The HIQA presented the paper “Public health measures and strategies to limit the spread of COVID-19: an international review: Antigen testing in asymptomatic individuals in community settings–10th February 2021”, for discussion.

The paper contained an international review on the use of, and experience with, antigen testing across EU Member States and the UK, with a particular focus on use in asymptomatic people in community settings. The use of antigen testing in asymptomatic individuals in community settings varied considerably between the 24 countries reviewed. There was variation in the criteria for testing, in the requirements for confirmatory testing and in the settings or circumstances in which the tests may be used (from little or no use in some countries to use in a range of settings in others). Uses include population-wide screening, infection control and outbreak management, and testing contacts after identification.

The HIQA stated that while guidance on the use of antigen testing is quite broad in a number of countries. Furthermore, there is, to date, limited published evidence of the effectiveness of this modality and the extent to which antigen testing is being undertaken, specifically in asymptomatic individuals, is difficult to ascertain.

The HIQA further underlined a number of important considerations. The distinction between laboratory-based testing, where tests are processed by trained laboratory personnel and near patient testing (NPT) where tests are processed outside a laboratory setting (and potentially outside a healthcare setting) is important. There are important considerations in relation to the clinical and quality governance over any NPT testing programme, including the requirement for quality management systems, so to be assured of the performance of antigen test analysis on site. A number of European countries have comprehensive NPT programmes for other conditions, so there may have been the potential to leverage existing quality management systems and to deploy staff that have been trained in NPT.

The Acting Chair thanked the HIQA for its paper and invited the NPHET Members to discuss same. Key points discussed were as follows:

- The NPHET noted the considerations raised for the use of antigen testing which will inform ongoing work to review the potential utility of alternative testing technologies in augmenting the current testing strategy.
- The NVRL welcomed the paper as it will go some way to address the misunderstanding that exists in relation to what the capabilities of antigen tests are and the manner in which they should be used.
- The HPSC noted that the HIQAs findings matched those observed in their own antigen testing group, which they will share with the NPHET as soon as practicable.
- The NPHET discussed the rollout of antigen testing in the HSE. The HSE advised that it is following current guidance on the recommended settings, in which antigen testing should be deployed. It stated that antigen tests have been distributed to hospitals, however, there is only a small volume of antigen tests being utilised at this point. One reason for this is that hospitals already have sufficient rapid PCR capacity and efficient systems in place to carry it out.
- The AMRIC informed the NPHET that given the current strain on staffing capacity, many hospitals are finding it difficult to allocate the resources necessary to verify antigen testing results.
• The RCPI suggested that if there are stocks of antigen tests available that are currently unutilised that these could be used for pilot programmes. The NPHET expressed its support for the distribution of antigen tests to institutions, who wish to use them in a healthcare setting pilot programmes.

• The NPHET acknowledged that those using antigen tests in a community setting would need to remain cognisant of the performance impacts on antigen tests when operationalised outside a laboratory setting.

The NPHET thanked the HIQA for its paper and confirmed that it will inform ongoing work to review the potential utility of alternative testing technologies in augmenting the current testing strategy.

5. Future Policy

a) Vaccination

The DOH updated the NPHET briefly on the issue of COVID-19 vaccination. The key points made were as follows:

• Vaccination of the 70+ age cohort will begin next week.

• In close consultation with the European Medicines Agency (EMA), the EU Commission continues to keep a watching brief on whether there are other possible vaccines that can be added to its portfolio.

• The Commission will continue to work towards having as broad a portfolio of safe and effective vaccines as possible subject to their approval by the EMA and procurement through the EU Joint Purchase Agreement.

The HPRA gave a brief update on vaccine safety reports and explained that its full summary report would be provided to the NPHET next week in line with its bi-weekly publication.

• No safety signals have been raised to date, based on national reports, in relation to any of the vaccines used as part of Ireland’s COVID-19 vaccine rollout.

• The EMA published a COVID-19 Vaccine Safety update for Covid-19 Vaccine Moderna® on the investigation of reports of suspected severe allergic reactions from a single US vaccination site (California). The assessment did not identify new aspects to this known side-effect and there were no recommended changes to the use of the vaccine.

The Acting Chair invited the NPHET Members to give their observations in relation to the ongoing rollout of COVID-19 vaccines:

• Encouragingly, surveys with patients conducted by GPs indicate so far that there is almost no vaccine hesitancy among the first groups prioritised for COVID-19 vaccination.

• The NIAC updated Members on the recommendation for use of the AstraZeneca® vaccine among the over 70s cohort following media attention of the WHO’s report on 10th February. Essentially, there is no substantive difference in what is reported by the WHO as compared to the EMA regarding the AstraZeneca® vaccine – while it can be used in all age-groups, both the EMA and WHO reached the same conclusion that there was insufficient data to reliably estimate the efficacy in those 65 years and older. As immunogenicity was similar across all age cohort similar efficacy is anticipated. Thus, SAGE concluded with recommending its use in those 65 and older.

• The NIAC also drew attention to a recent report submitted to the UK’s Scientific Advisory Group for Emergencies (SAGE). Of the 6 cases of facial paralysis, 3 were in those vaccinated and 3 in the controls. The rate was reported as consistent with the expected background rate.

• In the context of a voluntary reporting system for suspected side effects, the threshold for reporting is based on the professional judgement of the reporter, in that they consider an event to have been associated with the administration of a vaccine, and on that basis notify the HPRA. For many cases, including fatalities of elderly patients with co-morbidities in long-term care, there may be insufficient evidence for a reporter to comprehensively assess causality, and reporting to HPRA is often based on
suspicion alone. For COVID-19 vaccines a conservative approach is likely to be taken to reporting, and HPRA encourage this.

The Acting Chair thanked the contributors for the significant and ongoing work in this area.

**b) Future Planning**

In the context of the forthcoming review of the Government’s strategy “Resilience and Recovery 2020-2021: Plan for Living with COVID-19”, the DOH presented a draft deliberative paper titled “NPHET Advice in Relation to the Ongoing Response to COVID-19”, for discussion. The draft paper was informed by NPHET discussions over recent weeks.

The draft paper contained a number of sections to frame discussions on the ongoing response to COVID-19:
- Learnings to inform continuing response;
- Challenges;
- International Guidance;
- Managing the Next Phase of the COVID-19 Response;
- Health System Resilience & Transformation;
- COVID-19 Communications Strategy.

The Acting Chair invited comments, input, and suggestions from the NPHET Members on the draft document. The discussion focused on a number of areas including:

**Public Health Measures**
- There was general consensus on the need for a cautious approach to releasing public health restrictions, while also acknowledging that expectations in relation to reopening will grow in the coming months.
- A cross Government and cross sectoral response will continue to be necessary with Government Departments and sectors taking responsibility for their sectors at national and regional/local level.
- Greater emphasis on the need to maintain individual protective behaviours including respiratory hygiene, social distancing, mask wearing etc.
- There is a need to communicate that, even with vaccination, we will be dealing with COVID-19 over the longer term and the response must be informed by this.
- The need to pay close attention to public behaviours as part of future planning, acknowledging that the strong public buy-in and adherence with measures could not be taken for granted. There needs to be an ongoing dialogue on public tolerance for measures and on the values and ethics which underpin our response.
- Emphasis on the impact of restrictions on mental health and wellbeing across society.
- As case numbers fall, ongoing efforts to ensure that further increases in transmission are not triggered are required, particularly for younger age cohorts awaiting vaccination.
- The importance that all people, regardless of vaccination status, continue to adhere to public health guidance until the population as a whole can be regarded as protected. There will however need to be consideration of the benefits that will accrue from vaccination and how this can influence our approach to public health measures.

**Public Health Response**
- There needs to be a greater emphasis on the current deficits in public health capacity, the associated risks and the urgent need for improvement and investment. Challenges in relation to recruitment and retention of Public Health Specialists in particular were highlighted. Enabling strong public health leadership across the health system will bring improvements both in terms of the pandemic response and future pandemic preparedness but equally across the other domains of public health as a key enabler for broader health system resilience.
- As vaccination becomes more widespread, it is hoped that the severity of disease will decrease. However, transmission will still continue but is likely to result in greater levels of asymptomatic infection which will
require ongoing surveillance and detection. This is likely to necessitate more widespread community surveillance testing and the use of novel testing technologies.

**Health System Resilience & Improvement**
- Emphasis on the importance of embedding the learnings from the pandemic response to date across the health and social care system, and the opportunities to use targeted investment to drive reform and capacity building.
- Need to address long-standing deficits including in the areas of health system capacity, infrastructure, IPC capacity, laboratory capacity, digital infrastructure, including the rollout of eHealth initiatives such as the Individual Health Identifier.
- There are significant opportunities to review how models of care have been altered to respond to COVID-19 and how the improvements associated with this can be preserved.
- Importance of clinical risk assessment as part of NPHET’s ongoing considerations, particularly given the precarious situation faced in recent weeks.
- It was agreed that the emerging key messages from the current review of learnings in relation to IPC across the health and social care system would be incorporated into the paper.

**Long-Term & Global Response**
- The NPHET noted that the COVID-19 pandemic is a global challenge and must be tackled as such.
- The emergence of vaccine nationalism was cited as a significant concern, and Ireland must position itself squarely in support of the global effort to combat COVID-19 in solidarity with other nations. Unless international cooperation is secured, all of the measures undertaken by Ireland could be put at significant risk.

The DOH thanked the NPHET Members for their valuable feedback. The DOH noted a number of key themes emerging and undertook to incorporate these in the final draft. Noted same for the final draft.

The Acting Chair thanked the DOH for its discussion paper and noted that the NPHET would finalise its advice to Government next week, on receipt of a final draft paper.

**6. Communication Update**
The DOH gave a verbal update on COVID-19 communications.
- The COVID-19 Vaccine Communications Campaign is now underway and is being broadcast on TV, press, and radio.
- Work is ongoing to refresh public communications on COVID-19 symptoms and when people should consult their GP for possible referral to testing.
- Following the findings of the ESRI’s behavioural research paper recently presented to the NPHET, 3 key areas are being progressed:
  - Work is ongoing between the Department of Health and Department of An Taoiseach to develop communications which showcase real-life examples of how COVID can spread.
  - A strategy which targets public health guidance specifically at younger people through peer-to-peer communication on social media is being developed.
  - Work is ongoing to refresh overarching messages to promote adherence to public health guidance for whenever current Level 5 restrictions are lifted.

Members of the NPHET drew attention to challenges arising with younger populations regarding adherence to public health advice, particularly university-level students. There are concerning emerging messages that some students believe that if they have previously contracted and recovered from COVID-19, they no longer need to adhere to fully to public health advice.

Members acknowledged these concerns and added that communications around this point would need to be developed carefully. While antibody immunity may provide previously infected individuals with some level
of protection, they should be reminded of their duty to protect those that have not developed immunity to COVID-19 by adhering to public health measures.

The Acting Chair agreed to the need to carefully develop messages around post-vaccination/infection immunity which strongly highlight the need to continue to adhere to public health guidance.

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

   b) AOB
      i. **Subgroup on Ventilation report**
         The Chief Scientific Advisor to the Government (CSA) presented the paper “Expert Group on the Role of Ventilation in Reducing Transmission of COVID-19”, to the NPHET for noting. This is first report of recently established NPHET Subgroup on Ventilation.

         The purpose of this NPHET Subgroup Group is to provide scientific advice to the NPHET on the role of building ventilation in mitigating against the risk of long-range (airborne) transmission of SARS-CoV-2. The Subgroup has a wide range of multi-disciplinary expertise in indoor air quality and related areas.

         The Subgroup intends to bring further reports to the NPHET in line with its Terms of Reference and identified priority work areas. The initial priority areas are: healthcare environments (including residential care facilities); educational settings; residential accommodation (private and institutional); transport; workplaces with particular environmental risks.

         The DOH welcomed the Subgroup’s plan of work and advised that the Subgroup take stock of work done to date, acknowledging the existing HPSC and other advice on the issue of ventilation that has informed considerations on a range of policy responses relevant to COVID-19 throughout the pandemic.

         The HSE also welcomed the additional focus that the Subgroup will bring to the area of ventilation, while cautioning against overreliance on any individual intervention in the ongoing COVID-19 response. Ventilation should only be regarded as one part of a suite of public health measures which, when used together, can assist in preventing transmission. The NPHET Members further advised that the Subgroup should be mindful of the realities of Ireland’s current health system infrastructure in making its recommendations.

         The HPSC welcomed the multidisciplinary nature of the Subgroup and was pleased that the HPSC and the HSE’s Antimicrobial Resistance Infection Control (AMRIC) team would be involved in contributing to the Group’s work plan. The HPSC further echoed the advice and cautions provided by other Members.

         The CSA thanked the NPHET for its feedback and confirmed that any advice/recommendations of the Subgroup will be presented to the NPHET for its consideration.

         The Acting Chair thanked the CSA for the report and noted same.

      ii. **Vitamin D**
         The HSE brought to the NPHET’s attention the significant number of queries it has received in recent days from members of the public regarding advice on Vitamin D supplementation and its possible role in the prevention and treatment of COVID-19.

On 28th January, the NPHET agreed that efforts should be made to increase awareness of existing guidance on vitamin D supplementation (updated in November 2020). These recommendations for the use of vitamin D are being incorporated into wider messaging, and additionally are being communicated across the health service, including nursing homes and social care settings as necessary. The NPHET further agreed on the 28th January 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.

c) Date of next meeting
The next meeting of the NPHET will take place Thursday 18th February 2021, at 10:00am via video conferencing.