



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

<b>Date and Time</b>	Thursday 18 <sup>th</sup> February 2021, (Meeting 77) at 10:00am
<b>Location</b>	Department of Health, Miesian Plaza, Dublin 2
<b>Chair</b>	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH
<b>Members via videoconference<sup>1</sup></b>	<p>Dr Kevin Kelleher, Assistant National Director, Public Health, HSE          Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)          Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair          Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA          Dr John Cuddihy, Interim Director, HSE HPSC          Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital          Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE          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 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          Dr Darina O’Flanagan, Special Advisor to the NPHET          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 Elaine Breslin, Clinical Assessment Manager, HPRA          Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital          Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)</p>
<b>‘In Attendance’</b>	<p>Ms Laura Casey, NPHET Policy Unit, DOH          Ms Ruth Barrett, NPHET Policy Unit, DOH          Ms Sarah Glavey, Health Protection Coordination &amp; Support Unit, DOH          Ms Sheona Gilsean, Senior Health Data Analyst R&amp;D &amp; Health Analytics Division, 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</p>
<b>Secretariat</b>	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH
<b>Apologies</b>	Dr Tony Holohan, Chief Medical Officer, DOH; Dr Lorraine Doherty, National Clinical Director Health Protection, HSE

<sup>1</sup> 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 NPHET Members: Dr Tony Holohan and Dr Lorraine Doherty.

### **c) Minutes of previous meetings**

The minutes of 21<sup>st</sup> 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 Chair formally welcomed Dr Martin Cormican to the NPHET and thanked him for his work on the COVID-19 response to date.

## 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 5,868 cases have been notified in the 7 days to 17<sup>th</sup> February, which is a 11% decrease on the previous 7 days in which there were 6,607 cases.
- As of 17<sup>th</sup> February, the 7- and 14-day incidence rates per 100,000 population have decreased to 123 and 262, respectively; these compare with rates of 139 and 312 on 10<sup>th</sup> 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 47%, demonstrating that there have been fewer cases in the last 7 days, 11<sup>th</sup> – 17<sup>th</sup> February, compared with the preceding 7 days, 4<sup>th</sup> February – 10<sup>th</sup> February.
- The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10<sup>th</sup> January to 816 on 17<sup>th</sup> February. The 5-day average has decreased by 4% since the last NPHET meeting of 11<sup>th</sup> February (848).
- Incidence, although still high, is decreasing across all age groups except those aged 24 years and younger. Incidence in those aged 85 years and older remains elevated but is reducing. In the last 14 days, 12% of cases notified were aged over 65 years.
- Of cases notified in the past 14 days, 3<sup>rd</sup> February – 17<sup>th</sup> February, 65% have occurred in people under 45 years of age; the median age for cases notified in the same period is 35 years. The incidence in those aged 18 years and under has stabilised or increased with greater detection of asymptomatic infections due to the recent recommencement of testing of asymptomatic close contacts. Of note, there has been an increase in incidence in those aged 19-24 years, which may be due to increased social mixing in young adults.
- While 14-day incidence rates remain high across the country, 16 counties have a 7-day incidence as a percentage of the 14-day rate of less than 50%, indicating fewer cases notified in the last 7 days, 11<sup>th</sup> – 17<sup>th</sup> 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, though it remains lower than in earlier phases of the pandemic.
- Of the 12,460 cases reported in the last 14 days, 4<sup>th</sup> February – 17<sup>th</sup> February, 6.8% (844) were healthcare workers.



- The best estimate of the reproduction number (R) is 0.65 – 0.85. The rate of decline of the disease is continuing at -2 to -4% with a halving time of 18-35 days.
- There were 110,462 tests undertaken in the last week. The 7-day average test positivity rate remains high; the positivity rate has decreased to 5.5% on 17<sup>th</sup> February from 5.8% last week on 10<sup>th</sup> February.
- Excluding serial testing and facility testing in response to outbreaks, the test positivity rate has plateaued over the last week, the rate remains high at 10.4% over the 7 days to 17<sup>th</sup> February, which compares to 10.5% over the previous week to 10<sup>th</sup> February.
- According to contact management programme data, 17 counties have test positivity rates (excluding serial and outbreak facility testing) greater than 10%.
- There were 771 confirmed COVID-19 cases in hospital this morning, 18<sup>th</sup> February, compared with 984 on 11<sup>th</sup> February; this is a 22% decrease since the last NPHE meeting. There have been 48 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 154 confirmed cases in critical care, compared with 170 on 10<sup>th</sup> February. There have been 9 admissions in the last 24 hours.
- To date, there have been 470 deaths notified with a date of death in February. This compares with 1,265 and 193 deaths notified (to date) with a date of death in January and December, respectively. Of the 470 deaths in February, 36 have thus far been associated with hospital outbreaks and 212 have been associated with nursing home outbreaks.
- To date, the prevalence of S-Gene Target Failure (SGTF) is 75% (833/1111 samples) for week 4 and 89% (762/860 samples) for week 6 of 2021. Week 5 SGTF prevalence data (90%, 82/91) should be interpreted with caution as they are provisional and have low sample numbers due to a technical laboratory issue which has since been resolved. Further data will be provided when available. SGTF is a marker for the new B.1.1.7 variant of concern first identified in England in December 2020.
- 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.

#### Healthcare setting outbreaks

- There were 12 new clusters notified in acute hospitals in week 6 of 2021.
- As of 18<sup>th</sup> February, there are 127 open clusters associated with 44 acute hospitals; there have been 231 deaths and 1,974 confirmed cases linked to these outbreaks. Of these confirmed cases, 39% are related to healthcare workers.
- There were 6 new clusters notified in nursing homes/community hospitals in week 6, this compares with 12 new outbreaks in these settings in week 5.
- There are currently 180 open clusters associated with nursing homes; there have been 721 deaths and 6,241 confirmed cases linked to these outbreaks. Of these cases, 39% of confirmed cases are related to healthcare workers.
- There are 23 open outbreaks in community hospitals and long stay units, there have been 39 deaths and 599 confirmed cases linked to these outbreaks with over 51% of these cases recorded as healthcare workers.
- There are currently 194 open clusters associated with residential institutions; there have been 24 linked deaths and 1,617 linked confirmed cases to these outbreaks. Within these residential institutions,
  - there were 7 new outbreaks in centres for disabilities in week 6; there were 106 open outbreaks in centres for disabilities at the end of week 6.
  - there were no new outbreaks in mental health facilities in week 6 and there were 17 open outbreaks in these settings at the end of week 6.
  - There were 2 new outbreaks in Children's/TUSLA residential centres in Week 6, with 8 open outbreaks at the end of the week.



### Childcare Facility outbreaks

- There were 5 outbreaks newly notified in childcare facilities in week 6 with 21 linked cases. There are 73 open outbreaks in these settings at the end of week 6. According to the latest close contact positivity data in this setting from the Contact Management Programme, 11% (56/511) of close contacts (all age groups) in pre-school/creche settings were positive. Of these, 9.1% (35/384) of close contacts who are children (0-12 years) and 16.5% (21/127) of close contacts who are adults aged 18 years and older tested positive.

### Vulnerable Groups, Travelling Community, Direct Provision & Prison outbreaks

- There were 25 new outbreaks reported in vulnerable populations in week 6.
- There remains a high number of Irish Traveller outbreaks with 22 new outbreaks and 82 linked cases in week 6 compared with 22 new outbreaks in week 5; there are currently 103 open outbreaks in the Irish Traveller community.
- There have been 2 new outbreaks in direct provision centres in week 6. Currently, there are 21 open outbreaks in direct provision centres.
- There has been 1 new outbreak in a prison in week 6.
- Currently, there are 4 open outbreaks in prisons.

### Workplace outbreaks

- Workplace outbreaks continued to be notified, with 22 reported in week 6 across a variety of settings, which is lower than the number of outbreaks identified in week 5 (29). There were 9 in commercial settings, 4 outbreaks related to food production settings, 4 in manufacturing settings, and 3 related to the construction industry.
- There were 181 open outbreaks in workplaces up to the end of week 6.

### *Further relevant information includes:*

- The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 18.2/100,000 population in week 6 of 2021, compared to an updated rate of 22.1/100,000 population in week 5 of 2021.
- A range of mobility data and compliance data suggest that mobility is increasing, although levels still remain low.
- The number of close contacts captured during the week ending 14<sup>th</sup> February was 10,616, a 18% decrease from the previous week (12,978).
- The average number of close contacts per adult confirmed case remained below 3.3 until early December 2020, rose to almost 5 on average by 28<sup>th</sup> December, and then decreased rapidly while it remains very low, it is increasing slowly (from 2.1 to 2.4 per case).
- Of the 7,155 close contacts created between 1<sup>st</sup> to 7<sup>th</sup> February where test results were available, 1,783 (24.9%) were positive. The highest positivity rate, 33.3 %, was seen in household contacts.
- As of 17<sup>th</sup> February, the 14-day incidence per 100,000 population in Northern Ireland was 235; this is 10% less than the 14-day rate in the Republic of Ireland (262 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 110, which is 11% less than the 7-day incidence rate in the Republic of Ireland (123 per 100,000 population).

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

- Given the slow increase in reproduction number (R) over recent weeks, IEMAG models suggest that, even if the population continues to work to keep R below 1, case numbers will decline more slowly in February and March than they would have had we been able to maintain R between 0.5 and 0.7.
- It is estimated, if R is maintained between 0.7 and 0.9, which is in itself challenging, that we will have 400-500 cases per day at the end of February and 200-350 cases per day in the week beginning 15<sup>th</sup> March 2021.
- The projections for numbers of people with COVID-19 in hospital at the end of February are at least 500-600 requiring general hospital care and 80-100 requiring critical care, with optimistic projections that



these will further decrease to 300-400 people requiring general hospital care and 50-70 in ICU during the third week of March contingent on R staying between 0.7-0.9.

The IEMAG shared a preliminary model of how vaccination might impact virus transmission in the population, noting that the model was still in the early stages of development so its output should be interpreted with caution. The model suggested that, unless we assume very low levels of transmission in the community and very high levels of vaccine effectiveness on transmission, the vaccine is going to offer a very limited level of population-wide protection from the virus between now and the mid-summer. The IEMAG acknowledged that while their model suggests that public health measures will need to continue for a number of months, this should not undermine the important role the vaccination programme plays in protecting people from the virus and the great progress made so far in this regard.

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:

Re-opening Society:

- The NPHET agreed that the approach must continue to be cautious.
- The preliminary modelling presented by the IEMAG suggests that there will be a continuing need for restrictions to suppress transmission until such time as a sufficient proportion of the population is vaccinated to effectively suppress transmission by immunity alone. It was further noted that while emerging data shows that vaccines will play a critical role in the management of COVID-19, it is simply too early to predict what the full impact of vaccines will be. Uncertainties and unknowns in relation to variants and vaccine effectiveness and uptake levels were noted. A further surge in cases will have a detrimental effect on vaccine rollout and extend the length of time it takes to successfully vaccinate the eligible population.
- At this stage, the vaccine should not be considered a control measure that will allow population-level social restrictions to be released and it could be some time before it can be relied upon in such a way. This view is supported by the fact that countries such as Israel, which has one of the highest rates of vaccination, is still exercising a cautious approach to easing restrictions.
- The focus at this time should be keeping R below 1.
- It is important to remember that the new variant of the virus makes it more difficult to reduce the R number and keep the incidence rate low. Making and maintaining progress is more difficult now than at the start of the pandemic and it is possible that new variants will emerge that are even harder to suppress. It is important to communicate to the public that this is a very different situation than that faced during Spring 2020, and they should not expect progress to be made at a similar rate.
- There is a danger that people have become inured to the case numbers. At no previous point in the pandemic would an easing of restrictions have been considered at the weekly case numbers that are currently being recorded. Although a great deal of progress has been made, the incidence rates are still extremely worrying, and it is vital that people understand that significant further improvement is required before a largescale easing of measures can be considered.
- It was highlighted that the high attack rates shown in the epidemiological data give an indication of the increased transmissibility of the B.1.1.7 variant. If a resurgence of the virus is to be avoided, every effort must be made to suppress transmission and reduce the case numbers as low as possible before society begins to open up. The incidence is far too high now to consider easing restrictions in any significant way.
- We continue to have a constrained public health response capacity; any reopening will put further pressure on it.
- The DOH advised that, while it is important that communications with the public be optimistic and strike a note of hope, they should be realistic and provide a clear understanding of what people can expect from the coming months.
- Continuing with a cautious approach to reopening society is consistent with the most recent public opinion research, which indicates that the vast majority of people are supportive of measures to protect



the population, with 54% reporting that the current Government response is appropriate and 36% saying it is insufficient. 45% believe we are trying to return to normal at about the right pace, with 34% reporting that it is too quick, and only 20% reporting it is too slow.

- It would be dangerous to assume that once the vulnerable members of society are protected that measures can be eased without consequence. While the current narrative is that younger people infected with COVID-19 are only mildly affected, the reality is that a large number of those hospitalised come from younger age cohorts (47% of those hospitalised and 69% of those in ICU have been under 70 years of age). There is also a growing body of evidence showing that even asymptomatic or mildly symptomatic cases of COVID-19 can suffer detrimental health effects linked to long-COVID.
- More work needs to be done on understanding the health impacts of the disease on younger age cohorts in order to help inform communications to these cohorts on why they need to be careful.

Notwithstanding above, the NPHE also agreed that there should be an emphasis on the hope that vaccines bring, and in time, how the vaccination programme will support a gradual easing of measures:

- The positive impacts of vaccination to date in Ireland should be strongly communicated.
- The significant impact that restrictions have on everyone was acknowledged. The difficulty of maintaining compliance with public health measures over the coming period as fatigue with measures grow and as more vulnerable groups are vaccinated was also acknowledged. While the key message must be one of caution, it must also be balanced with messages of hope to protect and support continuing solidarity with the overall approach. For example, the reopening of schools will provide some hope and reassurance to people that progress is being made.
- There should be a focus on explaining why there needs to be a cautious approach, and on the things that we will be able to do safely.
- The NPHE noted that the concept of ‘vaccine bonus’ is important to communicate, that there are tangible benefits to having the vaccine and it is having a positive effect on the lives of those who have received it. An example of this will be potential changes to visiting restrictions in long-term residential care facilities. When measures are eased, the initial focus should be on those areas that are safest in terms of disease transmission and that will provide the most positive impact for people’s wellbeing. This could include guidance on low-risk outdoor activities. There should also be consideration of safe activities for children.
- It is important to have a strong foundation of research available to inform and educate the public when they do seek clarity on why certain measures have been implemented. Providing people with guidance on how they can socialise safely will improve compliance with measures over the long term.
- It was also acknowledged that there is an ongoing need to weigh the detrimental long-term effects of the virus on society and people’s wellbeing, such as disease, mortality and Long-COVID, against the detrimental impact of the measures imposed to protect against the virus, including mental health and well-being. It is important that this tipping point is recognised as early as possible and appropriate action is taken to minimise harmful outcomes.
- It was noted that collecting data on the mental health impacts of the pandemic continues to be challenging. It is difficult to anticipate the possible issues that may arise as a result of the ongoing restrictions.

The NPHE also agreed that the continuing impact of COVID-19 on the health service should be communicated:

- The NPHE acknowledged that hospital and ICU occupancy levels remain high, with past experience demonstrating that they will fall at a slower rate than infections, resulting in prolonged pressure on the acute hospital system over the coming period.
- A difference can be observed in the age profiles of those who have been admitted to hospital and critical care and those who have died (47% of those hospitalised and 69% of those in ICU have been under 70 years, while only 13% of deaths have been in those under 70), and, as such, it can be anticipated that vaccination will not have as significant an impact on hospitalisations initially as it will on mortality as it will take time for the younger age cohorts to be vaccinated.



- Although progress is being made, it is important to remain cognisant of the continuing number of new and open outbreaks with high attack rates in long-stay settings that have occurred over the past two months. While all the HSE and HIQA supports remain for nursing homes, this level of infection impacts on the ability to continue to provide safe services. In addition, the effect on staff must not be underestimated.
- Overall, our health service remains extremely fragile. While it has managed to withstand the significant demands made of it during the recent period, the high levels of disease required a significant ramp up in surge critical care capacity, redeployment of staff and caused serious and extensive disruption to non-COVID services across the breadth of the health and social care system, the impact of which will be felt for some time.
- The HSE reasserted its concern about the enormous amount of strain that healthcare staff are under and its effects on their wellbeing. The following document was shared, which addresses some of these concerns: *“The impact of COVID-19 pandemic and the societal restrictions on health and wellbeing on service capacity and delivery: A plan for health care and population health recovery”*. The Document is available to view at the following address: [https://hse.drsteevenslibrary.ie/ld.php?content\\_id=33403594](https://hse.drsteevenslibrary.ie/ld.php?content_id=33403594)
- A cautious approach to easing measures was urged to ensure that the country is in the best possible position to fully reopen its health services in order to deal with the significant backlog of scheduled care and procedures that has been building throughout the pandemic. It was agreed this should remain a core priority.
- It was also noted there have been a number of Health Service infrastructure and investment projects identified which need to be funded and initiated as soon as possible to assist the health services in overcoming the current situation and preventing such a situation from occurring again in the future.

The NPHEP discussed the role of individual CT values in assisting IPC and surveillance measures. It was noted that this issue remains under ongoing review by the HSE. Other key issues discussed:

- The NPHEP emphasised the need to continually strengthen surveillance mechanisms so as to distinguish between community acquired infection presenting in hospitals and true hospital acquired infection.
- It was noted that the number of HCW associated infections is decreasing.

#### Visitation to LTRCs

The NPHEP also discussed visitation to long-term residential care settings (LTRC) in the context of the rollout of the COVID-19 vaccine in such settings. LTRC visiting guidance has remained under ongoing review throughout the pandemic, given the challenge of balancing protective health measures and normal living within such settings. In light of the advanced stage of the rollout of the COVID-19 vaccine in LTRCs for both residents and staff, the NPHEP agreed the following action be taken.

The NPHEP recommended that that the AMRIC progress a process for considering the scope and application of LTRC visiting restrictions in the context of the Framework of Restrictive Measures, having regard to relevant national and international evidence, the roll-out and uptake of the COVID-19 vaccine in such settings, and the level of disease in the community.

#### Conclusion of discussion on epidemiological situation

In light of the current epidemiological position, the continuing pressures on our health service, and international advice, the NPHEP advised that the approach over the coming months must be one of extreme caution. It is critical that the progress made so far, which has come at huge sacrifice to everyone, is not put at risk. It is imperative that the focus remains on regaining and maintaining control over the disease and preventing a further wave of infection later in the year, until vaccination can offer a widespread population-level of protection. It will be essential that the following are achieved before any significant easing of measures is considered:

- Disease prevalence is brought to much lower levels that can be managed and controlled by public health.



- Hospital and critical care occupancy are reduced to low levels to protect the health service and allow for the safe resumption of non-COVID care.
- The most vulnerable are protected through vaccination.
- When these conditions have been met, any easing should be slow and gradual with sufficient time between phases to assess impact and should be subject to rapid response if the epidemiological situation were to deteriorate.

The NPHET, therefore, advised that current restrictions should be extended. Subject to continued improvement in the profile of the disease to the end of February, there should, however, be scope to facilitate the safe return of in-school education and childcare services but this must be on a cautious and phased basis. The NPHET also advised that non-COVID health and social care services are resumed as quickly as possible, subject to national risk assessments. There continues to be an unacceptably high level of disease in the community. It is therefore imperative that we continue to suppress the disease over the coming period, and this will require that all other restrictions remain in place while these services recommence.

The NPHET also noted that it is essential that the return of these core public services isn't interpreted as a signal of wider reopening and that other forms of interaction or mobility are now acceptable or appropriate. All efforts should be made to ensure that the return to in-school education and childcare is associated with a minimum level of linked mobility and the avoidance of inter-household mixing, and that all those working from home continue to do so. There must also continue to be a consistent and clear messaging from all sectors in relation to the necessity for continued adherence to public health measures.

The Acting Chair thanked the Members for their contributions and noted that there will be a turning point where society can begin to operate more normally but reaching that point will take time and the transition period between now and then must be navigated carefully. The public should therefore be hopeful for the future but also remain realistic about the challenging path for the country in the immediate months ahead.

**Action: The NPHET advises that current restrictions should be extended. Subject to continued improvement in the profile of the disease to the end of February, there should, however, be scope to facilitate the safe return of in-school education and childcare services but this must be on a cautious and phased basis. It is also critical that non-COVID health and social care services are resumed as quickly as possible, subject to national risk assessments. We continue to have an unacceptably high level of disease in the community. It is therefore imperative that we continue to suppress the disease over the coming period, and this will require that all other restrictions remain in place while these services recommence.**

**Action: The NPHET recommends that the AMRIC progress a process for considering the scope and application of LTRC visiting restrictions. This work should be undertaken in the context of the Framework of Restrictive Measures, having regard to relevant national and international evidence, the rollout and uptake of the COVID-19 vaccine in LTRCs, and the level of disease in the community.**

#### ***i. 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: 16<sup>th</sup> February*", for discussion.

On the global epidemiology of variants of concern (VOCs), the paper noted the numbers of confirmed cases of the South African (501Y.V2 & B.1.351) and Brazilian (P.1, VOC; P.2, Variant of Interest) variants worldwide as reported by the ECDC. Key points are as follows:

- As of 11<sup>th</sup> February 2021, according to media and official sources, the variant B.1.351 has been identified in 40 countries and approximately 1 400 cases have been reported globally.
- As of 11<sup>th</sup> February 2021, P.1 has been identified in 17 countries and approximately 200 cases have been reported globally. In the EU/EEA, around 30 cases have been identified in 5 Member States and areas (France, including La Reunion, Germany, Italy, the Netherlands, and Spain).



- The UK has designated the B.1.1.7 variant with an additional E484K mutation as a fourth VOC. The UK has 28 confirmed cases of this variant to date, in clusters in the south west and the north of England. There are no estimates of transmissibility or severity available for this mutation yet.
- Following assessment of several independent studies, UK NERVTAG stated on 11<sup>th</sup> February 2021 that *'it is likely that infection with VOC B.1.1.7 is associated with an increased risk of hospitalisation and death compared to infection with non-VOC viruses'*.
- A large number of cases (295) of the B.1.351 variant has recently been reported in Austria, mostly concentrated in the region of Tyrol.
- Transmissibility of B.1.1.7 is estimated to be up to 56% higher than the previously circulating strains of SARS-CoV2. Preliminary results for B.1.351 indicate that the variant has 50% higher transmissibility. There is no transmissibility estimate for P.1 yet.
- There is a realistic possibility that B.1.1.7 is associated with increased risk of death compared to non-B.1.1.7 cases. There is substantial uncertainty regarding severity estimates for B.1.351 and P.1.

The paper outlined the VOC cases and processes in Ireland and noted 'confirmed' and 'probable' cases of VOCs based on NVRL results up to 15<sup>th</sup> February as follows:

- South African variant cases in Ireland (501Y.V2) (new in the last week): confirmed 11(0), probable 5 (0).
- Brazilian VOC cases in Ireland (P.1) (new in the last week): confirmed 0, probable 2(2).

The paper also noted that Ireland has updated its list of high risk 'category 2' countries to include: Angola, Austria, Botswana, Brazil, Burundi, Cape Verde, Democratic Republic of the Congo, Lesotho, Malawi, Eswatini, Mauritius, Mozambique, Namibia, Republic of South Africa, Rwanda, Seychelles, Tanzania, United Arab Emirates, Zambia, or Zimbabwe. Passengers travelling from, or transiting through, these countries are required to self-isolate for 14 days upon arrival and to be tested at 'Day 5' and/or upon onset of symptoms. Enhanced contact tracing measures will be implemented for any cases identified.

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

### **3. Review of Existing Policy**

#### **a) *International Travel***

The DOH updated the NPHET on its ongoing work in relation to measures to control the impact of international travel on COVID-19 transmission.

- A significant body of work has been progressed over the last number of weeks relating to the establishment of mandatory quarantining facilities for international travellers into Ireland. These will be designated facilities for inbound travellers from any 'category 2' (high-risk) countries, listed in accordance with Regulation 6 of the Health Act (1947), recently signed by the Minister for Health. The NPHET was reminded that the Minister could be advised through the Chief Medical Officer to add additional countries to this list, as necessary, in response to the evolving epidemiological situation.
- This strengthening of approach will complement the mandatory 14-day quarantine requirement recently introduced for inbound travellers from all other countries.
- The rapid establishment of these facilities is a priority for the Government. The Minister for Health has had engagement with his counterpart in New Zealand, concerning what Ireland can learn from New Zealand's experiences of operating quarantine facilities.
- Primary legislation has been drafted to ensure that there is a robust legal underpinning to the establishment of these facilities. This legislation will aim to meet the public health objective of exercising greater control over the likelihood of importing new cases of COVID-19, or possible new variants, whilst remaining proportionate and ensuring that affected inbound travellers, are appropriately supported.
- The facilities will likely require a range of ancillary services and features, once operational. These may include a pre-booking facility prior to travel, a streaming system for arrivals from 'category 2' countries



ports/airports, transport to the quarantine facilities etc. Work is ongoing to secure providers of these services.

- By default, inbound travellers from 'category 2' countries will be quarantined in these facilities for 14 days. If an individual returns a 'not detected' PCR test result on 'Days 5' and then on 'Day 10' post-arrival, they will be permitted to end their quarantine. If an individual returns a 'detected' PCR test during their period in quarantine, they will remain in quarantine until such time as they return a 'not detected' result.
- It was stressed that inbound travellers required to complete their self-isolation in a designated quarantine facility would do so based solely on the country from which they are travelling.

The Acting Chair thanked the DOH for its update, noting that the precise details of how these facilities will operate will be clarified in the coming weeks. The Acting Chair then invited contributions from the NPHE Members. The key points raised in the discussion were as follows:

- Members agreed that the core objective of quarantine facilities for inbound travellers from 'category 2' countries is to arrest the entry of new, and potentially more dangerous, variants of concern into Ireland.
- The NPHE queried the timescale for establishing quarantine facilities.
  - The DOH outlined how quickly measures relating to international travel had evolved since the Christmas period and that significant resources are being allocated to ensure the timely establishment of quarantine facilities. Notwithstanding the urgency of establishing these facilities, there is a delicate balancing of rights to be struck to ensure the facilities' firm legal underpinning in primary legislation. While recognising the need to have in place a system of mandatory quarantine for inbound travellers that meets public health aims, it is essential that this system is fair, humane, and responsive to the needs of the range of persons that may be required to use it.
- The HIQA sought clarity on whether special measures would be put in place for vulnerable inbound travellers, such as unaccompanied minors and those seeking international protection.
  - The DOH confirmed that the legislation takes in account vulnerable international travellers by ensuring that those cohorts will be supported through existing, appropriate services.
- The HSE sought assurance that UK-based medical paediatric consultants, who provide services through the HSE in Crumlin Children's Hospital, will not be impacted by quarantining requirements.
  - The DOH confirmed that individuals travelling from the UK will not be subjected to mandatory self-isolation in quarantine facilities as the UK is not currently listed as a 'category 2' country. Inbound travellers from the UK are subjected to the existing mandatory 14-day quarantine 'at-home' requirement. Exemptions to this requirement for those providing essential medical care would extend to the paediatric specialists mentioned. Moreover, exemptions to this requirement are also in place for those who receive essential medical treatment overseas.
- Members sought clarity on how individuals who transit through 'category 2' countries as part of their journey into Ireland will be managed.
  - The DOH confirmed that travel-related self-isolation procedures are mandated for any individuals who have been in a designated country in the previous 14 days. In practice, if an inbound traveller transits through a 'category 2' country as part of their journey, the legislation will apply to them.
- Some Members expressed the view that travel restrictions should be extended to all inbound travellers to Ireland, regardless of the origin of their destination, noting how quickly the epidemiological landscape is evolving and the need to rollout the vaccination programme nationwide. On this point, there was consensus that Ireland should focus on implementing a robust strategy with a secure legal underpinning for travellers from high-risk countries in the first instance, before considering further extension of these measures, being cognisant of existing HSE resources.

The Acting Chair thanked the DOH for its update.

**b) Weekly IPC report**



The Acting Chair thanked the AMRIC team for submitting its paper on IPC learnings as requested and proposed that it be discussed by the NPHEM on 25<sup>th</sup> February, with a view to allowing the DOH to consider a strategic response to its findings in the interim.

The Acting Chair suggested that the AMRIC team feed some of its high-level findings on IPC learnings into the discussion under item 5(a) Future Policy (below).

Due to time constraints, the Acting Chair queried whether the weekly IPC report compiled by the AMRIC team and Chief Nurse's Office could be taken as 'read' to allow for more substantive discussion on the other agenda items.

The AMRIC team confirmed that the paper could be taken as 'read' as Members had received it in advance of the meeting.

#### **4. HIQA – Expert Advisory Group**

The HIQA confirmed that it had no papers/matters for the NPHEM to consider at this meeting in accordance with its schedule.

#### **5. Future Policy**

##### ***b) Future Planning***

Following presentations at the NPHEM meetings on 21<sup>st</sup> January, and 4<sup>th</sup> and 11<sup>th</sup> February, the DOH presented a revised paper "*NPHEM Advice in Relation to the Ongoing Response to COVID-19: 18<sup>th</sup> February 2021*", for discussion.

The paper was developed in the context of the planned review in March of the Government's strategy for managing the COVID-19 response - *Resilience and Recovery 2020-2021: Plan for Living with COVID-19*. The DOH noted that the paper presented at this meeting had incorporated key feedback and amendments as discussed at the NPHEM meeting on 11<sup>th</sup> February, with key changes outlined in red in the document circulated. It was also noted that the conclusions of the earlier discussion under item 2 would be incorporated into the paper, along with any further feedback from Members, with a view to providing final advice to Government after the meeting.

The NPHEM approved the paper, subject to some final comments and points of emphasis.

The Acting Chair thanked the DOH and Members for their work on the paper, noting its importance ahead of the Government's deliberations on the next phase of the ongoing response to COVID-19.

##### ***c) Vaccination***

###### ***i. Vaccine prioritisation***

The NIAC and DOH presented the paper "*Vaccine Allocation Strategy*" to the NPHEM, for discussion. It was explained that the paper follows the NIAC's issuing of an updated recommendation to the CMO yesterday regarding vaccine prioritisation regarding the top 7-8 cohorts prioritised for COVID-19 vaccination. Review of the subsequent cohorts is ongoing.

The NPHEM was reminded that the provisional vaccine allocation strategy contained a commitment that the priority groups would be kept under review and would be updated and adapted, where necessary, in light of any new evidence and/or a changing epidemiological situation. Since the publication of the provisional priority listing at the beginning of December, Ireland has experienced increasing disease incidence with extremely elevated case counts. Understanding of patient susceptibility and identification of risk factors for



severe disease has increased, both nationally and internationally. This is now taken into account during the prioritisation update.

As part of the reprioritisation process, local epidemiologic data, national, and international evidence pertaining to disease risk and outcome, inputs from the clinical leads of subspecialty programs, and a wide range of submissions from individuals and from patient advocacy groups were reviewed and evaluated.

Consequently, the NIAC included some additional medical conditions to those originally listed as associated with a high risk of severe COVID 19. These were further sub-divided into those associated with a very high-risk and those with a high-risk of serious disease and death. The order of the cohorts for vaccination was then amended taking into account the risks stratification.

The NIAC recommends that:

1. Those aged 16-69 years with a medical condition(s) associated with a very high risk of serious illness and death should be vaccinated directly after the 70 years and older cohort, on the basis that they are at a similar risk of hospitalisation and death as those aged 70-74 years.
2. The next group to be vaccinated should be those aged 65-69 years with an underlying condition which puts them at high risk of severe disease or death.
3. Other healthcare workers not in direct patient contact and those deemed essential for delivering the immunisation programme should then be vaccinated in parallel with all others aged 65-69 years.
4. Directly following this group, those aged 16-64 years with medical conditions which put them at high-risk of severe disease or death should be vaccinated.

In addition, it is recommended that those aged 16-69 years at very high or high risk of severe COVID-19, who have underlying medical conditions that are generally associated with a less robust response to vaccines e.g. chronic kidney disease or immunocompromised patients, should preferentially receive an mRNA vaccine, provided it does not result in undue delay in vaccination; e.g. a delay of more than three weeks following when they would otherwise be scheduled to receive a non-mRNA vaccine.

Those aged 16 -17 years of age should receive Comirnaty® as it remains the only authorised vaccine in this age group.

All others in these cohorts can receive any one of the three vaccines currently authorised for use in Ireland.

The Acting Chair thanked the NIAC and the DOH for this update and requested that sincere thanks be conveyed to the NIAC on behalf of the NPHET for its significant work and input over recent days.

The Acting Chair opened the issue for discussion and invited contributions from the NPHET Members:

- The HSE thanked the NIAC for its significant work and noted that the updated guidance would provide significant reassurance among the clinical community by distinguishing patients at very high-risk versus at increased risk of severe disease.
- The HIQA reminded the NPHET that there is existing guidance on the HSE website distinguishing at-risk and high-risk patients for severe disease due to COVID-19 and queried whether this should be updated in light of the updated vaccine prioritisation.
- The NPHET drew attention to the change of language used from the original vaccine allocation framework of 'high-risk of disease' to 'increased risk of disease' and queried whether this new language substantively altered the practical application of the framework.
- The NPHET drew attention to certain groups not specifically included in the prioritisation, namely Black, Asian and Minority Ethnic (BAME) Groups, in light of international evidence pointing to higher mortality rates from COVID-19 in people from black and south-Asian ethnic backgrounds. Those living in congregated settings with a disability not covered by the updated prioritisation were also mentioned as a group that may require further consideration.



- The NPHEP raised the issue of the multiplicity of risks for negative outcomes due to COVID-19, querying whether attention had been paid to those who were at high-risk on more than one count. The use of the Oxford Clinical Risk tool in the UK, and how this informed guidance on individuals required to ‘shield’, was referenced. This information will be particularly important when Ireland has capacity to vaccinate large amounts on an ongoing basis.
- Members suggested immunising both cohorts of vulnerable patients of very high-risk, and at increased risk, of severe infection concurrently. This is particularly important for patients that do not have the ability to cocoon and may be required to come to hospital sites for regular treatments, e.g. dialysis patients.

The DOH, NIAC and the HSE gave assurances on some of the issues raised by the NPHEP:

- The DOH clarified that existing guidance on the HSE website is to inform cocooning practices as opposed to vaccination. The guidance on cocooning practices is being updated in light of new and emerging evidence. The HSE and the NIAC have had collaborative discussion in this regard to ensure congruence between these lists.
- The NIAC clarified that use of ‘increased’ was in error and the categorisations are ‘at very high risk’ and ‘at high risk’. This will be corrected in the document.
- While concurrent roll-out across both increased risk and very high-risk groups might be useful, the DOH outlined that this would be contingent on rates of vaccine supply.
- The NIAC explained the basis for the current risk categorisations and recognised that there will be a need for clinical input in the assessment of individual exceptional cases that might not fall clearly into a designated risk category. The rolling review of prioritisation continues with focus now on those who, for other reasons, may need to be prioritised for vaccination.
- The DOH acknowledged the multiplicity of factors involved in determining patient vulnerability, which has been a regular source of discussion regarding equitable vaccine allocation. While acknowledging that the allocation framework cannot ever fully capture the complexity of each person’s vulnerability and level of need, simple and broad categorisations are required so that they are comprehensible and the public can be assured that prioritisation lists are fair and evidence-based. If the framework is changed too often or becomes too granular in detail, there is a danger that the framework will become confusing and less transparent.
- Regarding patients with multiple comorbidities, clinicians providing regular care for these patients should exercise their clinical judgment in determining which specific patients should be prioritised for vaccination.

The Acting Chair thanked the presenters and Members for their contributions. The NPHEP agreed that the NIAC’s recommendations are consistent with the primary objective of the vaccination campaign to reduce morbidity and mortality, which, in turn, will improve the resilience of the healthcare system and thus protect it from being overwhelmed. Targeting individuals with medical conditions known to be associated with severe COVID-19 disease for early vaccination should protect the most vulnerable and reduce hospital and ICU admissions as well as mortality. Accelerating the vaccination of those at very high risk and high risk of severe disease or death as a result of COVID-19 is also consistent with the ECDC’s advice to Member States in its rapid risk review of 15<sup>th</sup> February to rapidly roll out vaccination to those populations most at risk of high morbidity and mortality from COVID-19.

The Acting Chair urged Members to treat the discussion and updated allocation framework as confidential until such time that it has been agreed by Government.

**Action: The NPHEP endorses the paper from the Department of Health and the National Immunisation Advisory Committee, which sets out an updated prioritisation of groups for vaccination. The NPHEP considers this updated ranking appropriate on the basis of currently available data and will continue to keep the vaccine allocation strategy under review.**



**ii. Vaccine Safety Summary Update**

The HPRA provided an update, for noting, on suspected side effects to COVID-19 vaccines notified to the HPRA on a voluntary basis by healthcare professionals and members of the public. This information will be included in a report to be published on the HPRA website on 18<sup>th</sup> February. Key points were as follows:

- Up to 11<sup>th</sup> February, a total of 2103 reports of suspected side effects were notified to the HPRA.
- The cumulative total doses of COVID-19 vaccines administered as of that date was reported as 171,239 (dose 1) and 89,834 (dose 2).
- For all COVID-19 vaccines, the most commonly reported suspected side effects notified to the HPRA are in line with those typically associated with vaccination, including the types of side effects described in COVID-19 vaccine product information, available on the European Medicines Agency (EMA) website.
- National reporting experience to date continues to support the favourable assessment that the benefits of COVID-19 vaccines outweigh the risks.
- The EMA has commenced publication of safety updates for the vaccines, with the report for Comirnaty<sup>®</sup> published in January. The first safety update for COVID-19 Vaccine Moderna<sup>®</sup> was published on 5<sup>th</sup> February. No changes to the recommended use of the vaccines were made following these reviews.

The HPRA also noted that a statement for healthcare professionals on how COVID-19 vaccines will be regulated for safety and effectiveness is now available to view on its website.

It was queried whether there is sufficient evidence if vaccine reactions are worse in people who have previously been infected with COVID-19. The HPRA informed the NPHET that there is insufficient evidence available to answer this question at this time, but it is under review.

The NPHET thanked the HPRA for its update and noted same.

## **6. Communication Update**

The DOH presented “*Communications Update: 18<sup>th</sup> February 2021*” to the NPHET, for noting.

The paper noted the findings from the Quantitative Tracker, with particular focus on the topic of vaccination.

The DOH drew particular attention to the Qualitative Tracker for the week commencing 8<sup>th</sup> February, which details feedback from focus groups among young adults. The key points were as follows:

- Young adults are outside of the regular COVID-19 discourse. Although they respect traditional news sources, they rarely visit them. Their channels are often mediated emotionally: through social media or whatever the people they know think.
- Young adults have largely been ignored in the public discourse around vaccines and vaccinations, the framing of which has been about saving lives of the elderly. A reframe is required, where young adults can see the relevance of the vaccine to their lives, i.e. vaccinations bring the virus under control, which allows Ireland to get back on its feet, which enables all of us (including young adults) to resume normal lives.
- There are specific and reasonable concerns regarding the vaccines’ long-term effects for the young adult cohort (notably in fertility). These need to be addressed directly and actively.

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



## **7. Meeting Close**

### ***a) Agreed actions***

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

### ***b) AOB***

It was raised that any plans for self-isolation must enable those in disadvantaged circumstances to make a plan for themselves and should include guidance to wear masks at home, when necessary.

### ***c) Date of next meeting***

The next meeting of the NPHE will take place Thursday 25<sup>th</sup> February 2021, at 10:00am via video conferencing.