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

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<tr>
<th>Date and Time</th>
<th>Thursday 25th February 2021, (Meeting 78) 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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</table>
| Members via videoconference² | Dr Kevin Kelleher, Assistant National Director, Public Health, HSE  
|               | Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)  
|               | Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair  
|               | Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA  
|               | Dr John Cuddihy, Interim Director, HSE HPSC  
|               | Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital  
|               | Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE  
|               | Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH  
|               | Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor  
|               | Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital  
|               | Ms Rachel Kenna, Chief Nursing Officer, DOH  
|               | Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH  
|               | Dr Lorraine Doherty, National Clinical Director Health Protection, HSE  
|               | Dr Colette Bonner, Deputy Chief Medical Officer, DOH  
|               | Ms Yvonne O’Neill, National Director, Community Operations, HSE  
|               | Mr Phelim Quinn, Chief Executive Officer, HIQA  
|               | Dr Darina O’Flanagan, Special Advisor to the NPHET  
|               | Mr Fergal Goodman, Assistant Secretary, Primary Care 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  
|               | Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)  
|               | Mr Liam Woods, National Director, Acute Operations, HSE  
|               | Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway  
|               | Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications  
|               | Prof Mary Horgan, President, RCPI  
|               | Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)  
|               | Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;  
|               | Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH  
|               | Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital  
|               | Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)  

| ‘In Attendance’ | Ms Laura Casey, NPHET Policy Unit, DOH  
|                | Dr Trish Markham, HSE (Alternate for Tom McGuinness)  
|                | Mr Gerry O’ Brien, Acting Director, Health Protection Division  
|                | Mr Ronan O’Kelly, Health Analytics Division, DOH  
|                | Dr Desmond Hickey, Deputy Chief Medical Officer, DOH  
|                | Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH  
|                | Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH  
|                | Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH  
| Secretariat    | Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH  
| Apologies      | Dr Tony Holohan, Chief Medical Officer, DOH  
|               | Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI |

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, and Prof Mark Ferguson.

   c) Minutes of previous meetings
      The minutes of the 28th 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 NPHET Members conveyed their deepest sympathies to Dr Holohan on the passing of his wife, Dr Emer Feely, and thanked Dr Holohan for his leadership in very difficult personal circumstances.

2. Epidemiological Assessment
   a) Evaluation of Epidemiological data: (incorporating National Data Update, Modelling Report, and International Update)

      The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:

      The DOH, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:

      - A total of 5,116 cases have been notified in the 7 days to 24th February, which is a 13% decrease on the previous 7 days to 17th February in which there were 5,868 cases.
      - As of 24th February, the 7- and 14-day incidence rates per 100,000 population have decreased to 108 and 231, respectively; these compare with rates of 123 and 262 on 17th February.
      - 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, 18th to 24th February, compared with the preceding 7 days, 11th to 17th February.
      - The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January to 700 on 23rd February. The 5-day average has decreased by 14% since the last NPHET meeting on 18th February (816).
      - Incidence, although still high, is decreasing across most adult age groups. Incidence in those aged 85 years and older remains elevated. In the last 14 days, 11th to 24th February, 11% of cases notified were aged over 65 years.
      - Of cases notified in the past 14 days, 11th to 24th February, 68% have occurred in people under 45 years of age; the median age for cases notified in the same period is 33 years. The incidence in those aged 18 years and under is stable or decreasing as the effect of resumed testing of asymptomatic close contacts wanes. While incidence in those aged 19-24 years has increased, this is not yet an established trend.
      - While 14-day incidence rates remain high across the country, 15 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, 18th to 24th February, compared with the previous 7 days, 11th to 17th February.
      - Of the 11,017 cases reported in the last 14 days, 11th to 24th February, 5.3% (578) were healthcare workers.
      - The best estimate of the reproduction number (R) is 0.6 – 0.9. The rate of decline of the disease is continuing at -0% to -4%.
      - There were 105,561 tests undertaken in the week to 24th February. The 7-day average test positivity rate has decreased to 5.0% on 24th February from 5.5% on 17th February.
• The number of close contacts captured during the week ending 21st February was 10,969, a 3% increase from the previous week (10,616).
• 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 28th December 2020, and then decreased rapidly; while it remains very low, it is increasing (from 2.1 to 2.6 per case over recent weeks). To note, this indicator is currently over-dispersed, meaning that a small number of cases with large numbers of contacts are inflating the mean.
• Of the 6,141 close contacts created between 8th to 14th February where test results were available, 1,783 (27.1%) were positive. A high positivity rate of 35.4% was seen in household contacts.
• Excluding acute, serial, and mass testing in response to outbreaks, the community test positivity rate has decreased over the last week to 23rd February; the rate remains high at 15% over the 7 days to 24th February, which compares to 17.1% on 17th February.
• The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January to 700 on 23rd February. The 5-day average has decreased by 14% since the last NPHET meeting held on 18th February (816). According to contact management programme data, 20 counties have community positivity rates (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%.
• There were 593 confirmed COVID-19 cases in hospital this morning, 25th February, compared with 771 on 18th February; this is a 23% decrease since the last NPHET meeting. There have been 20 newly confirmed cases in hospital in the 24 hours preceding this morning.
• There are currently 136 confirmed cases in critical care, compared with 154 on 17th February. There have been 8 admissions in the previous 24 hours.
• To date, there have been 637 deaths notified with a date of death in February. This compares with 1,284 and 194 deaths notified (to date) with a date of death in January and December, respectively. Of the 637 deaths in February, 77 have thus far been associated with hospital outbreaks and 250 have been associated with nursing home outbreaks.
• The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 6.9/100,000 population in week 7 of 2021 (below baseline), compared to an updated rate of 18.0/100,000 population in week 6 of 2021.
• To date, the prevalence of S-Gene Target Failure (SGTF) is 89% (762/860 samples) for week 6 of 2021 and 91% (911/1003 samples) for week 7. SGTF is a marker for the B.1.1.7 variant of concern first identified in England in December 2020.
• In total, 12 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing.
• 3 confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date.
• As of 24th February, the 14-day incidence per 100,000 population in Northern Ireland was 213; this is 8% less than the 14-day rate in the Republic of Ireland (231 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 101, which is 6% less than the 7-day incidence rate in the Republic of Ireland (108 per 100,000 population).

Healthcare setting outbreaks:
• There were 4 new clusters notified in hospitals in week 7 of 2021 (14th to 20th February 2021).
• As of today, there are 133 open clusters associated with 44 hospitals; there have been 265 deaths and 2,048 confirmed cases linked to these outbreaks. Of these confirmed cases, 38% are related to healthcare workers.
• There were 12 new clusters notified in nursing homes/community hospitals in week 7, this compares with 6 new outbreaks in these settings in week 6.
• There are currently 172 open clusters associated with nursing homes; there have been 711 deaths and 6,039 confirmed cases linked to these outbreaks. Of these cases, 39% of confirmed cases are related to healthcare workers.
• There are 22 open outbreaks in community hospitals and long stay units; there have been 43 deaths and 640 confirmed cases linked to these outbreaks with 52% of these cases recorded as healthcare workers.
• There are currently 195 open clusters associated with residential institutions; there have been 23 linked deaths and 1,605 linked confirmed cases to these outbreaks. Within these residential institutions, there were 3 new outbreaks in centres for disabilities in week 7; there were 104 open outbreaks in centres for disabilities at the end of week 7.

Outbreaks associated with educational settings and childcare facilities:
• There were 9 outbreaks newly notified in childcare facilities in week 7 with 26 new linked cases. There were 66 open outbreaks in these settings at the end of week 7.
• There were 3 outbreaks newly notified outbreaks associated with third level institutions/students in week 7 with 13 open outbreaks associated with these settings. A number of significant clusters in the community associated with students who attend third level educational settings in the West and Mid-West are currently under investigation with outbreak control measures being implemented as appropriate (including targeted testing).

Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:
• There were 28 new outbreaks reported in vulnerable populations in week 7.
• There remains a high number of Irish Traveller outbreaks with 22 new outbreaks and 59 linked cases in week 7 compared with 22 new outbreaks in week 6; there were 120 open outbreaks in the Irish Traveller community at the end of week 7. This represents a 17% increase on the number of open outbreaks on the previous week.
• There have been 2 new outbreaks in direct provision centres in week 7. Currently, there are 23 open outbreaks in direct provision centres.
• There have been 3 outbreaks in homeless facilities in week 7. Currently, there are 12 open outbreaks in these settings.

Workplace outbreaks:
• There were 33 workplace outbreaks reported in week 7 across a variety of settings, which is 33% higher than the number of outbreaks identified in week 6 (22). There were 10 in commercial settings, 9 related to food production settings, 6 in manufacturing settings, and 5 related to the construction industry. There were 210 open outbreaks in workplaces up to the end of week 7.

The IEMAG advised that we are maintaining suppression of transmission, but this progress is still fragile. Rate of decline in case counts has slowed, with daily growth at zero to -4%, and halving time at 18 days or longer (central estimate 35 days). In addition, the latest estimates indicate that R is at 0.6-0.9. To note, the estimates of growth rate and R have not necessarily worsened, but the associated uncertainty around them has increased.

The latest estimate of prevalence of the B.1.1.7 variant of concern (first identified in England) indicates that this lineage now accounts for approximately 91% of cases in Ireland, with its increased transmissibility continuing to be evident from the high attack rates observed in the most recent close contact testing positivity data. Of particular concern, these data indicate that 35% of household close contacts of confirmed cases are testing positive on the “Day 0” test, highlighting the elevated risk of transmission within households.

The HSE informed the NPHET of a significant COVID-19 outbreak in Galway, identified in the third-level student population. The cases appear to be linked to social activity among the student population. There was no linkage to on-campus education activities. The outbreak has been brought under control by Public Health West through effective intersectoral and interagency cooperation including: the prompt establishment of an Outbreak Control Team, the establishment of testing centres on campus, and an increased presence of An Garda Síochána in student neighbourhoods and at transport hubs. The HSE advised the NPHET that HSE colleagues in Limerick had also put in place robust response measures to an outbreak in the student population there.
In the discussion, the following key points were raised:

- With regard to the successful response to the outbreak in Galway, many Members noted that there are lessons to be learned from this experience, for example, ease of access and on-site availability of testing on third-level campuses, a dedicated communications plan, how to support students to limit contacts and social gatherings.
- The success of the third-level response was noted and commended, given the size and spread of the student population.
- The importance of proactive approaches to potential “trigger” super-spreading events.
- The risks associated with students travelling home and potential onward transmission to older more vulnerable relatives was noted.
- Some Members suggested that open access to testing should be given consideration.

The NPHET agreed that work should be carried out to harness the learnings from this outbreak response, and other similar responses, with a view to replicating them across the country, as needed. The NPHET further emphasised that the student cohort must be supported in the coming months, acknowledging that the vast majority of third-level students are complying with the prevailing public health guidance. In summary the NPHET noted that Ireland continues to experience a very concerning and fragile epidemiological situation. We are seeing continued, albeit slower, progress against all disease indicators. Health and social care services continue to experience significant pressure from the current wave of infection and demand from the resultant disease burden.

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: 25th February 2021”, for discussion.

The paper set forth the following recommendations:

1. That mandatory quarantine and testing be enforced for all incoming travellers having originated, or transited through, ‘category 2’ countries. Recent contact tracing activities conducted on a flight containing three confirmed cases of the Brazilian P.1 variant highlighting the significant risk of introduction and transmission of variants of concern from international travellers. This places a substantial burden on Departments of Public Health and Contact Tracing Centres, which is not sustainable.

2. That a robust process is put in place to check and verify negative PCR tests performed up to 72 hours prior to the departure of any incoming international travellers, and that Medical Officers of Health have access to these reports where requested.

3. That Portugal and all South American countries and Panama be added to the ‘category 2’ list of countries. The close travel and geographical links between Brazil and these countries is considered to increase the risk of spread of the Brazilian P.1 variant of concern.

4. That an Impact Assessment be performed on the possible increased demand placed on Departments of Public Health and Contact Tracing Teams following the addition of the above countries to the ‘Category 2’ list.

Regard to Whole-Genome Sequencing:

- The NVRL informed the NPHET that around 850 detected samples were sequenced in the previous week, representing approximately 15% of cases.
- A SARS-CoV-2 surveillance programme steering group has been convened to oversee the operation of the national surveillance programme.
- Some sequencing capacity is being procured from the private sector at present, but it is intended that all sequencing will be undertaken by public sector entities shortly.

The Acting Chair thanked the HPSC for its paper and the NVRL for its update. Detailed discussion of this item took place in conjunction with International Travel under Item 3(a).
3. Review of Existing Policy

a) International Travel

The DOH provided an update to the NPHET on ongoing work concerning efforts to control the impact of international travel on COVID-19 transmission.

Legislation providing for a system of mandatory quarantine has been published. The system is to be put in place as soon as possible, once the details of the legislation’s implementation have been finalised by Government. Once the system is in place, people arriving in Ireland from countries designated under the legislation will be brought from their point of entry to a hotel, where they will quarantine. There will be integration with the current testing regime through the HSE, with results from those in mandatory quarantine being incorporated into the existing reporting system and being sent for genome sequencing, as required.

The DOH liaises with the Department of Justice’s Border Management Unit and others regarding the pre-departure PCR testing system. Generally, documentation is provided in English or in a machine-readable format. Overall, the number of travellers arriving without appropriate pre-departure test documentation is small, recorded at or below 1%. Of note, many travellers coming from outside of Europe are already legally resident in Ireland and cannot therefore be prohibited from returning to the State. Given its complex nature, international travel and associated quarantine requirements is an issue that remains under review.

The Acting Chair thanked the DOH for the update and invited contributions from the NPHET Members. The points made were as follows:

- With respect to overseas travel and the testing of arrivals to Ireland, the NPHET reviewed available global epidemiological data relating to variants of concern and noted that South American countries and Panama are to be classified as ‘Category 2’ countries.
- Portugal was removed from the ‘Category 2’ list. The NPHET noted that Portugal has stopped flights from Brazil. This was the reason for its inclusion in the list originally.
- The NPHET considered the issue of quarantined travellers from ‘Category 1’ countries not presenting for a ‘Day-5’ test. As this test is carried out at the expense of the person in quarantine, it was proposed that this test be made free of charge in future to increase the number of people availing of it.
- It was suggested that the ability to self-refer for testing would also increase uptake. Further to this, it would reduce the burden on GPs, who would otherwise have to refer all those seeking a ‘Day-5’ test. It was also noted that providing a ‘Day-5’ test free of charge would most likely enable a larger proportion of those in home quarantine to exit quarantine in the event of a not-detected result.
- The NPHET discussed the challenge of ensuring that the list of Category 2 countries requiring mandatory quarantine keeps pace with the evolving epidemiological situation. The application of uniform quarantine measures to all countries was suggested as a possible solution to this problem. It was noted that legal advice available to the Government advises that a mandatory hotel quarantine regime should be targeted and proportionate, hence the current approach targeting high risk countries.
- The NPHET was cognisant that caution must be exercised in making further changes to the requirements for travellers and how such changes are communicated to the public.
- It was noted that although the primary goal of the quarantine regime is to prevent the introduction of variants of concern into the State and reduce virus transmission, it also acts as a deterrent to unnecessary foreign travel. The requirement to quarantine for 14 days is a large part of this deterrent.
- The NPHET Members were also cognisant of the socio-economic and cultural backgrounds of many of those travelling into and out of Ireland. There are often language barriers that prevent people from understanding what is required of them or why it is necessary. It is therefore important that there are appropriate linkages and communications plans tailored to the needs of these communities in order to improve understanding and increase compliance with measures.

The Acting Chair acknowledged the view held by some NPHET Members, who called for broader international travel restrictions beyond the plan for country categorisation. The Acting Chair stated that although the NPHET has always advocated for a stringent approach to international travel, it must be pragmatic in its recommendations; a blanket approach to designating all countries as high risk in the absence of hotel
quarantine would likely overwhelm the public health response capacity and its ability to deal robustly with positive cases in travellers from countries deemed to be of greatest risk. Focusing the enhanced public health response on countries deemed highest risk is therefore the most appropriate approach at present (pending the implementation of mandatory hotel quarantine). The NPHET acknowledged that it must continue to reassess its approach to international travel as the situation evolves and new factors, such as vaccination programmes, increasingly come into play.

Action: With respect to overseas travel and the testing of arrivals to Ireland, the NPHET noted that South American countries and Panama are to be classified as ‘Category 2’ countries. Furthermore, the NPHET recommends that:

a. Arrivals from ‘Category 1’ countries be offered a ‘Day 5’ test through the public system, subject to operational capacity and feasibility, and the development of an appropriate referral pathway;

b. Arrivals from ‘Category 2’ countries be offered a test as soon as possible following arrival (i.e. Day 0/1) and again at ‘Day 10’, subject to operational capacity.

a) IPC weekly update—COVID-19 Cases and Outbreaks
The AMRIC presented the “Weekly HCAI COVID Report Week Ending 14th February 2021”, for noting. The report included the following key points:

• The overall situation for the week ending February 14th reflects continued improvement compared to the previous week. There is a marked improvement in the number of new confirmed cases in healthcare workers (95 compared with 173 the week ending February 7th).
• There is also a significant reduction in the number of patients with hospital acquired COVID-19 (95 compared with 177 the week ending February 7th).
• The number of acute operations linked outbreaks is decreased slightly compared with the previous week (135 compared with 148 the week ending February 7th).
• The number of acute operations linked outbreaks is expected to decrease slowly because outbreaks do not close until 2 incubation periods (28 days) after the last case was detected.
• The number and severity of community operations linked outbreaks continue to stabilise; however, the situation is still presenting significant operational challenges.

The Acting Chair thanked AMRIC for this report and the NPHET noted same.

b) IPC learnings – COVID-19
The AMRIC presented the paper “Infection Prevention and Control in Healthcare in Ireland-Learning to date from COVID-19- 25th February 2021”, for discussion. The paper highlighted the progress made to date to expand Infection Prevention and Control (IPC) capacity and capability across the healthcare system, as well as key areas that require continued focus.

Congregated health care settings, such as nursing homes, hospices, and hospitals, are by their nature, settings in which the spread of infectious diseases can easily take place. Managing healthcare associated infection (HCAI) is therefore critical but very challenging, and the experience over the past year has not only identified what worked well but also highlighted the current gaps and weaknesses in the control of HCAIs, not only in Ireland but across health care systems internationally. A review of the learnings to date from COVID-19 in Ireland has been undertaken and has identified a range of areas of focus to continue to improve infection prevention and control across the health system. This includes:

• Continue to strengthen and develop an integrated governance structure to oversee IPC and the control of HCAIs/outbreaks system wide.
• Enhance IPC capacity and support systems at a local and national level, including workforce, ICT and surveillance systems and laboratory services.
• Appropriate integrated clinical models at local service provider, regional and national levels which encompass IPC requirements and oversight.
• Ensure a strategic reserve and secure supply line of critical IPC supplies.
• Sustain and accelerate changes in the way care is delivered including greater provision of care in the community and in less congregated settings, greater separation of scheduled and unscheduled care, and provision of surge capacity.
• New build healthcare facilities that meet current standards and refurbishment of existing areas that are likely to continue in use until new build become available.
• In relation to long term residential care services there should be a move towards household or own door accommodation on a campus and away from mini-hospital style construction.
• Develop robust contingency planning for large staff absences to ensure good IPC practice can be sustained.
• Develop and increase occupational health services and develop greater integration of the work of IPC and occupational health.
• Ensure IPC guidelines are applied in a timely, consistent, proportionate and compassionate manner to support system wide service delivery balancing public health requirements with service user wellbeing.
• Build knowledge, skill and resilience in healthcare workers at all levels from undergraduate education and empower servicer users and their advocates.
• Publication of clear and timely surveillance information on HCAI.
• Review of IPC standards, regulation, and licensing in the context of learning from the pandemic while a programme of clinically led IPC research and development is also required.

The Acting Chair thanked the AMRIC for the update and invited contributions from the NPHET Members. Key points made were as follows:

• The HIQA commended the paper for highlighting the importance of governance and expressed that reform needs to take place within agencies commissioning care, particularly on the issue of clinical governance.
• The DOH welcomed the report and supported strengthening the leadership role that the AMRIC holds in this area. It called for interim regulatory reform, including reassessment of educational and professional requirements. It also highlighted the importance of bolstering clinical indemnity across the whole system as well as addressing any weaknesses in the existing infrastructure. The DOH was particularly cognisant of the report’s suggestions with regard to improving the model of care for older people, using appropriate integrated clinical models, and the benefits of including homecare data in their assessments.
• The DOH acknowledged that the COVID-19 pandemic had provided the impetus needed to drive the necessary improvements in IPC that are required across the community and acute care systems. It was proposed that the DOH and the HSE work on a strategic plan for government, outlining the improvements in IPC and infrastructure that are needed and how these can be best implemented.
• The ISCM emphasised the need to expand the laboratory capacity available for IPC testing as a lack of capacity in the past has hampered other IPC measures.
• An improvement in infrastructure would not only be beneficial to IPC measures but also free up staff who are attending to patients that have been grouped in separate wards for isolation purposes. The AMRIC advised that there is potential for healthcare systems with IPC deficits to become major amplifiers of VOCs. Having up-to-date and effective IPC measures in place not only protects patients and staff in hospitals, but also protects the wider public.

The NPHET noted the importance of the IPC learnings identified and endorsed the work between the DOH and HSE to develop an IPC strategy that integrates IPC across community and acute settings.

4. HIQA Expert Advisory Group

a) Immunity/reinfection following COVID-19
The HIQA presented the paper “Advice to NPHET - Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection: 23rd February 2021”, for discussion.
The purpose of the HIQA evidence synthesis was to provide advice to the NPHET on the policy question: “How long does protective immunity (that is, prevention of antigen or RT-PCR confirmed reinfection) last in individuals who were previously infected with SARS-CoV-2 and subsequently recovered?”

The HIQA outlined that it conducted an evidence synthesis, which comprised three elements: a systematic search of databases to identify cohort studies that estimated the risk of reinfection over time; a scoping review of the long-term duration of humoral and cellular responses following SARS-CoV-2 infection; input from the COVID-19 Expert Advisory Group.

On the basis of the findings of this evidence synthesis, the HIQA provided the following advice to the NPHET:

- Evidence from 5 large cohort studies, including three studies that enrolled healthcare workers, demonstrated that the risk of reinfection with SARS-CoV-2 is very low up to seven months post-infection. These findings were supported by evidence of long-term duration of T- and B-cell responses up to eight months post-infection.
  - The included studies provided estimates in the general population and in healthcare workers. It is unclear if the findings are generalisable to other populations such as the elderly, those with comorbidities and immunocompromised individuals.
  - The applicability of included studies may be limited as all were completed before December 2020, preceding vaccine roll-out and the widespread identification and reporting of emerging variants of international concern.
- On the basis of this evidence, consideration could be given to extending the period of presumptive immunity (lower risk of reinfection) from 12 weeks to 6 months post-infection. This would have implications for a range of policy areas including current policies for serial testing, testing prior to admission or transfer to a healthcare facility, and policies regarding possible exemption from close contact status. However, given the uncertainty that exists relating to reinfection potential with emerging variants, any policy changes:
  - may not be applicable to possible exposure to emerging immune escape variants of concern;
  - should be kept under review and informed by the international evidence and national surveillance data.

The Acting Chair thanked the HIQA for its work on this question and opened the issue for wider discussion to the NPHET:

- The NPHET agreed that extending the period of presumptive immunity could have positive and tangible impacts for the health system and the public. The extended period of presumed immunity could positively impact IPC practices in healthcare settings by allowing more exemptions from close contact status, enabling earlier discharge of patients in some cases, and providing greater reassurance to those previously infected in terms of caring for children or elderly parents.
- Members raised queries around the risk of onward infection from individuals with presumptive immunity, and whether these individuals experienced less severe symptoms if reinfected with novel variants of SARS-CoV-2. Members were informed that current evidence suggests that individuals with presumptive immunity are low risk for onward transmission, this possibility cannot be ruled out. The sample of cases presenting as reinfections with novel variants of SARS-CoV-2 is small, but these cases have not shown any significant clinical differences thus far.
- Members discussed the broader implications of acquired immunity to SARS-CoV-2 and its implications for public health guidance. The NPHET acknowledged that significant cross-cutting work is underway to determine the benefits of vaccine acquired immunity afforded at individual and societal levels, and that findings on infection acquired immunity must also feature as part of these discussions. However, Members noted that the scope of the HIQA’s review is limited to infection acquired immunity and its recommendations should only be considered in this light.
- There was consensus that the issue of infection acquired immunity had to be kept under review, particularly in light of new variants of SARS-CoV-2 emerging and the evolving epidemiological picture.
The Acting Chair thanked Members for their contributions and proposed the HIQA’s recommendations for adoption. The NPHET endorsed the HIQA’s recommendations.

**Action:** Based on advice provided by the HIQA, the NPHET endorsed recommendations to extend the period of presumptive immunity (the period of lower risk of reinfection) from three to six months post natural infection, subject to ongoing review, and further recommends that the HSE review relevant policy and guidance in light of this recommendation.

### 5. Future Policy

#### a) Vaccination

The Acting Chair invited the NIAC, the HSE, the HPRA, and the DOH to provide an update on the ongoing vaccination programme against COVID-19. Key updates were as follows:

- The HSE informed the NPHET that vaccination of priority Group 1 under the prioritisation framework, namely those in long-term residential care, is nearing completion. Significant progress has been made in vaccinating front-line healthcare workers in direct patient contact, and roll-out is now moving to those aged 70 years and over in the community through the nationwide GP network. Additional work is underway to ensure that non-patient facing healthcare workers and those over 70 years, who are currently receiving care in hospital, are vaccinated as soon as possible.
- The updated prioritisation framework for COVID-19 vaccination, endorsed by the NPHET at its meeting last week, has been well-received within the clinical community and work is ongoing to translate its recommendations into an operational model across relevant specialties.
- Positive evidence continues to emerge regarding vaccine and infection-induced immunity, which will be relevant to policy considerations as to what the ‘benefits’ conferred by vaccination may be in terms of public health guidance.
- Notwithstanding the wider benefits of vaccination that might be afforded at a population level, the vaccination programme is having significant benefits throughout the healthcare system. Significant decreases in healthcare-acquired infections and in cases reported in residential care settings have been observed.
- The HPRA provided a brief verbal update on suspected side effects to COVID-19 vaccines reported nationally.

The Acting Chair thanked contributors for this update and invited the NPHET Members to discuss the matter. Key points made in the ensuing discussion were as follows:

- While it is appropriate that current post-vaccination advice should remain that vaccinated individuals adhere fully to public health guidance, several contributors raised the issue of what ‘benefits’ might be afforded at an individual level following full vaccination against COVID-19. It was noted that this issue is being given detailed consideration across a range of fora, including at EU level through the ECDC Advisory Council and the European Council. While much of the European Council’s work has focussed on how vaccination might facilitate international travel for individuals, this work is part of a wider question around what vaccination-induced immunity might entail for access to other services, spaces and amenities. Developments will be kept under review.
- It was cautioned that, while it is understandable that individuals may expect to experience a ‘benefit’ as a result of vaccine-induced immunity in terms of how public health measures apply to them, it is also important to view the future easing of non-pharmaceutical interventions in terms of the evolving disease epidemiology as a whole and not only linked to the proportion of the population that might be vaccinated at a particular point in time.
- The NPHET agreed on the importance of carefully developing evidence-based communications around post-vaccination immunity for the public, noting the significant hope this could offer to the population in the ongoing response to the pandemic.

Noting that significant suppression of the virus is still required before any easing of public health restrictions will be possible, it is important that this issue is given due consideration ahead of any possible easing of
restrictions in April. The phased reopening of schools, and the NPHET’s consideration of visitation guidance to LTRCF’s scheduled for decision by the NPHET on 11th March represent tangible positive steps towards the reopening of society until further easing of restrictions can be considered.

The Acting Chair proposed that the NPHET should consider this issue in the coming weeks as part of broader considerations in relation to the potential easing of measures, taking account of international developments and harnessing a range of inputs from the NIAC, the HSE, the HPRA, the DOH, and others. The Members agreed that this advice would also likely evolve over time subject to emerging evidence.

b) Updated ECDC Guidance on Facemasks in Household Setting
The DOH presented the paper “Updated ECDC Guidance on Facemasks in Household Setting”, for decision.

The DOH outlined that a recent ECDC technical report on facemask use in the community proposed the following:

- In areas with community transmission of COVID-19, wearing a medical or non-medical face mask is recommended in confined public spaces and can be considered in crowded outdoor settings.
- For people vulnerable to severe COVID-19, such as the elderly or those with underlying medical conditions, the use of medical face masks is recommended as a means of personal protection in the above-mentioned settings.
- In households, the use of medical face masks is recommended for people with symptoms of COVID-19 or confirmed COVID-19 and for the people who share their household.
- Based on the assessment of the available scientific evidence, no recommendation can be made on the preferred use of medical or non-medical face masks in the community.
- When non-medical face masks are used, it is advisable that masks that comply with available guidelines for filtration efficacy and breathability are preferred.

The Acting Chair thanked the DOH for this update and proposed that the existing public health advice be updated to reflect the ECDC’s most recent guidance and recommendations, namely that surgical masks should be worn by vulnerable groups in crowded settings and confirmed cases of COVID-19 in self-isolation. Members of the NPHET discussed the recommendations and their wider implications:

- Regarding the wearing of surgical masks by household contacts of COVID-19, it was noted that this was a reasonable proposal given the higher positivity rate observed among household contacts recently.
- Members raised the need to ensure consistency of interpretation of “high-risk” and “very high-risk” categories of patients for the purposes of implementing this recommendation. The NIAC confirmed that it was working in parallel with the HSE to ensure that definitions of “high-risk” and “very high-risk” are standardised across all public health guidance, included advice on wearing facemasks.
- In light of the recommendation, members queried what educational and practical supports might be required to ensure that the wearing of facemasks could be implemented where necessary, noting the affordability and access issues faced by more disadvantaged populations. It was noted that work is ongoing to consider how cases and close contacts can be best supported to comply with self-isolation protocols. This work will include consideration of practical measures to support mask-wearing by contacts and close contacts in the household.
- While acknowledging that existing guidance does not discourage children under the age of 13 from wearing masks, members raised the issue of whether evidence and guidance around mask-wearing by children under the age of 13 should be further reviewed. It was noted that the HIQA’s Expert Advisory Group (EAG) and HPSC’s Pandemic Incident Control Team (PICT) had reviewed this evidence on several occasions. The NPHET agreed that an updated review of the evidence and corresponding recommendations is warranted. The Acting Chair requested that HIQA’s EAG revisit evidence regarding mask wearing for children under the age of 13 and update their recommendation for the NPHET’s consideration at its next meeting.
Action: The NPHET endorses the paper “Update on using face masks in the community” and with respect to the community recommends:
a. That medical grade masks are worn by vulnerable, high-risk, and very high-risk cohorts, and older age groups when in crowded outdoor spaces or confined indoor community spaces;
b. That medical grade masks are worn by those with a confirmed COVID-19 diagnosis, symptoms suggestive of COVID-19 and the household contacts of confirmed cases. This recommendation does not apply to residential care facilities, which are people’s homes.

6. Communication Update
The DOH provided the NPHET with its usual weekly update. Key points made are outlined below.

The nationally representative sample of 2,200 people conducted on behalf of the DOH, reveals:

- The level of worry is at 6.4/10. It has fallen back to October 2020 levels, as public concern about the health system overload falls back. However, the level of worry over prolonged restrictions has risen to a peak, at 3.6, now at the same level as worry over the health of family and friends, and the economy.
- People are more emotionally negative since the emergence of speculation about measures which may need to be in place until May. Some of the negative emotions (anxiety, loneliness, anger) are at record high levels this week, while some of the positive emotions (happiness) are at record low levels.
- 44% of the population do not want further restrictions, 41% do, though this may be related to travel restrictions. A third of the population now think that Ireland is too slow in ‘returning to normal,’ the highest level yet.
- The burden of COVID-19 negativity weighs heavily. 2021 is about coping with COVID-19, and part of this is about finding hope. This is a core challenge of Government communication, which will help it retain engagement with the ‘solid core’ of citizens.
- Managing the Vaccination Programme and the hope that it brings is a key part of communication in this phase of Covid.
- People are disengaging from COVID-19 related news.

Quantitative Tracker – vaccine module:
- 53% of the population know someone in their immediate social circle who has had COVID-19.
- 90% (68% definite, 22% probable) say they will get the COVID-19 vaccine when it is offered to them.
- 36% say they have concerns around the vaccine – 28% are worried about the side effects of the vaccine, 22% worried about the long-term effects on health.
- GPs are the most trusted source of information on the vaccine for 75% of the population, followed by the HSE (55%) and the DOH (52%).

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

b) AOB
The HPSC confirmed that the system for monitoring vaccine status and impact (CoVax) would be linked to the Computerised Infectious Disease Reporting (CIDR) reporting system shortly, with a view to recording data on vaccine failure.

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