### National Public Health Emergency Team – COVID-19

#### Meeting Note – Standing meeting

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<tr>
<th>Date and Time</th>
<th>Thursday 16th September 2021, (Meeting 93) 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 Tony Holohan, Chief Medical Officer, DOH</td>
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#### Members

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<th>Members via videoconference</th>
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<tr>
<td>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH</td>
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<tr>
<td>Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)</td>
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<tr>
<td>Dr Kevin Kelleher, Assistant National Director, Public Health, HSE</td>
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<td>Dr Mary Favier, Past president of the ICGP, Covid-19 advisor</td>
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<tr>
<td>Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital</td>
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<td>Ms Rachel Kenna, Chief Nursing Officer, DOH</td>
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<td>Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH</td>
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<td>Dr Colette Bonner, Deputy Chief Medical Officer, DOH</td>
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<td>Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI</td>
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<td>Ms Yvonne O’Neill, National Director, Community Operations, HSE</td>
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<td>Dr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH</td>
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<td>Dr Breda Smyth, Public Health Specialist, HSE</td>
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<td>Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA</td>
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<td>Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH</td>
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<td>Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH</td>
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<tr>
<td>Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)</td>
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<tr>
<td>Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway</td>
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<td>Prof Mary Horgan, President, RCSI</td>
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<td>Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)</td>
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<td>Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;</td>
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<td>Mr Liam Woods, National Director, Acute Operations, HSE</td>
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<td>Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital</td>
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<td>Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)</td>
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<td>Dr John Cuddihy, Interim Director, HSE HPSC</td>
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<td>Dr Colm Henry, Chief Clinical Officer, HSE</td>
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<td>Dr Darina O’Flanagan, Special Advisor to the NPHET</td>
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<td>Ms Deirdre Watters, Communications Unit, DOH</td>
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<td>Mr Phelim Quinn, Chief Executive Officer, HIQA</td>
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<tr>
<td>Dr Conor Teljeur, Chief Scientist, HIQA</td>
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<td>Ms Aoife Gillivan, Communications Unit, DOH</td>
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<td>Ms Laura Casey, NPHET Policy Unit, DOH</td>
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<td>Ms Sheona Gilsenan, Senior Health Data Analyst R&amp;D &amp; Health Analytics Division, DOH</td>
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<td>Ms Sarah Glavey, Health Protection Coordination &amp; Support Unit, DOH</td>
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<td>Dr Trish Markham, HSE (Alternate for Tom McGuinness)</td>
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<td>Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH</td>
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<td>Dr Robert Conway, Specialist Registrar, DOH</td>
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<td>Ms Pauline White, Statistics &amp; Analytics Unit, DOH</td>
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<td>Ms Elizabeth McCrohan, Statistics and Analytics Unit, DOH</td>
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<td>Mr Michael O’Leary, Public Health Policy Unit, DOH</td>
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#### Secretariat

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

#### Apologies

| Apologies | Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital |
|-----------| Dr Cillian de Gascun, Laboratory Director, NVRL |
|           | Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications |
|           | Dr Siobhán Ni Bhríain, Lead for Integrated Care, HSE |
|           | Dr Lorraine Doherty, National Clinical Director Health Protection, HSE |

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1 References to the HSE in NPHET minutes relates to the staff of the HSE present at NPHET meetings and not the HSE Board which is the HSE in law unless otherwise stated.
1. Welcome and Introductions
   a) **Conflict of Interest**
   Verbal pause and none declared.

   b) **Apologies**
   Apologies were received from Prof Colm Bergin, Dr Cillian de Gascun, Ms Fidelma Browne, Dr Siobhán Ní Bhriain, Dr Lorraine Doherty.

   c) **Minutes of previous meetings**
   The minutes of 25th August 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**
   In his opening comments, the Chair remarked that the NPHET’s advice, based principally on the criteria for transition, was accepted by Government. In accepting the advice, the Government identified dates for the further easing of certain restrictions, commencing as early as 1st September with the return to full capacity on public transport, through the return to workplaces and certain indoor activities on 22nd September, up to 22nd October which will see the majority of restrictions lifted and the transition to a guidance-based approach.

   The Chair noted that over the coming weeks, the NPHET will give consideration to the nature of monitoring over the winter period in the context of other respiratory viruses, Long COVID, and the endemicity of COVID-19.

2. Epidemiological Assessment
   In advance of presenting the epidemiological data, the DOH confirmed that since 2nd September 2021, the reported epidemiology of COVID-19 as it relates to COVID-19 cases, associated deaths, and outbreaks is based on notifications to the Computerised Infectious Disease Reporting (CIDR) system.

   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 8,966 cases have been reported in the 7 days to 15th September 2021 (cases to midnight 14th September), which is a 12% decrease from last week when 10,207 cases were notified in the 7 days to 8th September, and a 30% decrease from the last NPHET meeting on 25th August when 12,751 cases were reported in the 7 days to 24th August 2021.

   - As of 15th September, the 14-day incidence rate per 100,000 population has decreased to 402; this compares with 458 a week ago and compares with 526 reported at the last NPHET meeting on 25th August.

   - Nationally, the 7-day incidence/100,000 population as a proportion of 14-day incidence/100,000 population is 47%, demonstrating that there have been less cases in the last 7 days, 9th to 15th September, compared with the preceding 7 days, 2nd to 8th September.

   - The 5-day rolling average of daily cases is 1,212 as of today 16th September, which is a 14% decrease from 1,407 a week ago (8th September) and a 33% decrease from that reported at the last NPHET meeting on 25th August (1,814).

   - Of the 19,155 cases notified in the past 14 days to midnight 14th September 2021, 76% have occurred in people under 45 years of age; and 8% were aged 65 years and older. The median age for cases notified in the same period is 26 years. Disease incidence was highest in the 5–12-year-old age group following a significant increase in testing in this age group recently.

   - Of the 9,365 cases reported in the latest epi-week (Week 36 ending 11th September 2021), 3.9% (364) were healthcare workers and 3.3% (306) were determined to be travel-related. Additional data on healthcare worker status and transmission source for COVID-19 cases is currently sourced using data collected from the COVID Care Tracker (CCT).
• Over the 7 days, 8th – 14th September, there have been 165,717 laboratory tests reported in community, private and acute laboratories, this compares with 144,608 laboratory tests in the previous 7 days (1st – 7th September), a 15% increase. The 7-day positivity rate in the community was 8%.
• From the 8th- 14th September, there were circa 149,495 community referrals. Overall, total referrals have increased by 24% in comparison to the same time-period last week. From the 6th – 12th September, the group with the largest number of referrals was the 0-14-year-old age group. The detected rate for the 0-14-year-old age group is 6%.
• According to the Contact Management Programme (CMP), from 6th- 12th September 2021, the total number of close contacts was 29,262, an increase of 10% compared with 26,400 the previous week. The average number of cases managed per day increased from 3,771 to 4,180.
• The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 12th September was 2.6, an increase from 2.3 for the week ending 5th September.
• There were 290 confirmed COVID-19 cases in hospital this morning 16th September, compared with 332 last week on 9th September, and with 323 on the morning of the last NPHET meeting on 25th August. There have been 37 newly confirmed cases in hospital in the 24 hours preceding this morning.
• There are currently 67 confirmed cases in critical care as of this morning, compared with 54 last week on 9th September, and with 56 on the morning of the last NPHET meeting on 25th August. There were 2 new admissions in the previous 24 hours.
• Of the 301 COVID-19 patients admitted to ICU between 1st April and 11th September 2021, vaccination status was known for 288 patients. Of those where vaccination status is known, 84 had received either one or two doses of vaccine, and 57 received all recommended doses of vaccine before admission to ICU. In total, 51 patients had an epidemiological date 14 days or more after receiving all recommended doses of vaccine.
• As of 15th September 2021, there have been a total of 5,179 COVID-19 related deaths notified in Ireland. This is an increase of 24 notified deaths since the previous weekly update on 8th September. To date, 45 deaths have been notified which occurred in September, 67 in August, 18 in July, and 17 in June.
• In total, 6,783 cases of Delta (B.1.617.2), 77 cases of Beta (B.1.351) and 32 cases of Gamma (P.1) have been confirmed through whole genome sequencing in Ireland to date.
• Other cases of variants of note/under investigation that have been confirmed in Ireland to date: 210 Kappa (B.1.617.1), 73 Eta (B.1.525), 15 Zeta (P.2), 11 Iota (B.1.526), 7 Epsilon (B.1.429), 4 Lambda (C37), 4 Mu (B.1.621 & B.1.621.1), 246 B.1.1.318, and 2 A.27.
• Taq-path S-gene PCR target results by specimen week show that the prevalence of S-gene positivity (proxy for Delta) has increased from 90.3% in week 28 to 98.4% in week 36.

Outbreaks and associated cases are based on those reported up to midnight on 11th September 2021. Week 36 refers to 5th – 11th September 2021.

Healthcare setting outbreaks:
• There were 4 new nursing home outbreaks with 24 confirmed linked cases and 2 community hospital/long-stay unit outbreaks with 6 confirmed linked cases reported in week 36.
• There were 10 new acute hospital outbreaks with 30 confirmed linked cases reported in week 36.
• There were 9 new outbreaks reported in residential institution settings (6 in centres for disabilities, 1 in a mental health facility and 2 in non-specified residential facilities) with 30 confirmed linked cases in week 36.
• There were 4 new outbreaks in ‘other healthcare services’ with 10 linked cases in week 36.

Vulnerable Groups/ Key Populations outbreaks:
• There were 10 new outbreaks reported involving members of the Irish Traveller community in week 36 with 50 linked cases.
• There were 2 outbreaks associated with the Roma community with 15 confirmed linked cases reported in week 36.
• There were 2 outbreaks associated with clients of mental health facilities reported in week 36 with 6 linked cases.
Outbreaks associated with school children and childcare facilities:
- There were 22 outbreaks newly reported in childcare facilities in week 36.
- There were 40 outbreaks reported in schools in week 36 (34 in primary schools, 3 in post-primary schools and 3 in special education schools) with 191 confirmed linked cases.
- There were 3 new university/college outbreaks in week 36.

Workplace outbreaks:
- There were 14 workplace outbreaks reported in week 36 across a variety of settings. Of these, 2 were in the construction sector, 3 were related to food/meat production and processing settings, 5 in other types of workplaces (including office, commercial, manufacturing, health and dental and defence/justice/emergency services) and 4 were in “not-specified” workplace types.

Outbreaks associated with hospitality settings:
- There were 3 outbreaks reported related to hotels in week 36.
- There were 3 outbreaks associated with restaurant/café settings reported in week 36 and 5 associated with a public house.

Other Locations:
- The remaining 50 outbreaks in week 36 were across a number of other locations:
  - 2 related to social gatherings;
  - 3 associated with religious/other ceremony;
  - 8 related to retail outlets;
  - 1 related to personal grooming services;
  - 7 extended family outbreaks;
  - 27 private house outbreaks;
  - 2 in ‘other’ location.

Disease incidence across the country remains high but has stabilised and recently is showing an overall downward trend. There has been a surge in the demand for testing, matching levels last seen in early January and particularly in the cohort of primary-school aged children, with incidence now highest in those aged 5-12 years old. The high incidence in this age cohort is more likely representative of greater case ascertainment than an increase in the overall incidence. This trend, and in particular the impact of the return to school and the opening of the third-level sector, will continue to be monitored closely over the coming weeks. Other age groups are showing signs of stabilisation and there has been a decrease in the incidence of those aged 16-24 years of approximately 60% compared with early August.

The growth rate of cases is currently estimated as decreasing at approximately 2% per day. The total number of confirmed cases of COVID-19 in hospital has also been decreasing at approximately 1.5% per day, while the total number of confirmed cases in ICU has remained largely stable. It was also stressed that the situation within ICU is ongoing and an increase in admissions will place a significant strain on ICU capacity.

While the majority of infections are occurring largely in the young, unvaccinated population, the current force of infection is resulting in a number of infections in older, vaccinated people. At the same time, the number of outbreaks notified in settings with vulnerable populations, such as nursing homes, has increased in recent weeks and this is being closely monitored.

The IEMAG shared the latest modelling scenarios which run from 26th August, highlighting that we are performing well overall against optimistic projections. The optimistic but conservative scenario assumes a return to pre-pandemic social contact on 22nd October but with continued adherence to non-pharmaceutical interventions (NPIs), i.e. approximately 70% of pre-pandemic effective social contact (the product of actual social contact, the relative risk of contact, and the effect of risk mitigations). The pessimistic scenario assumes a return to pre-pandemic levels of social contact with no adherence to NPIs, which would translate into a
surge in cases in October. The primary variable in the scenarios is the susceptibility of children to COVID-19 and whether they are major drivers of transmission. The best estimate is that we are currently on a long, slow decline in cases which will be reflected by a long, slow decline in hospitalisations with a plateau and then a long, slow decline in ICU admissions. The IEMAG will conduct work on the effect of waning immunity and the potential impact of booster doses in the coming months.

The HPSC noted that of the 257,000 cases notified between 31st January – 31st August 2021, 2,979 (1.2%) were deemed vaccine breakthrough cases. Of those, 11% were healthcare workers. The median time from second vaccine dose to infection was 51 days. Where variant data was available, 31% were infected with the Delta variant.

The Chair thanked the DOH, the HPSC, and the IEMAG for their respective inputs and invited observations from the Members. Key points made were as follows:

• It was raised that paediatric admissions to ICU should be incorporated into overall reporting. Since the beginning of 2020, 30 children were admitted to ICU, of those 10 tested positive for COVID-19 and a small number were ventilated. The remaining 20 tested negative for COVID-19 but developed Paediatric Inflammatory Multisystem Syndrome (PIMS) associated with SARS-CoV-2 infection and 7 of those were ventilated.

• It was remarked that while on a positive trajectory, the situation is not yet stable, particularly in critical care. The lag time between high case numbers and ICU admissions was noted.

• The negative impact of missing school on children’s welfare was also noted as a concern.

3. HIQA Expert Advisory Group

a) Advice Re: screening and surveillance of asymptomatic individuals

The NPHET considered the recommendations proposed in the HIQA paper “Advice to the National Emergency Team: Rapid antigen testing for screening or surveillance of asymptomatic individuals to limit transmission of SARS-CoV-2 - 24th August 2021”. The paper had been circulated in advance of the previous NPHET meeting to allow adequate time for it to be considered fully by Members.

The NPHET had regard for the uncertainty of the effectiveness of rapid antigen detection tests (RADTs) for screening in asymptomatic individuals (who have no known or suspected exposure to SARS-CoV-2) to limit the transmission of SARS-CoV-2.

Where RADTs are being considered for screening asymptomatic populations, these should be considered as an additional public health measure, rather than a replacement for known mitigation measures. A negative antigen test result in this population should not be viewed as a ‘green light’ to engage in activities that would otherwise be considered as high risk for transmission.

Action Point: The NPHET recommended that any decision to use RADTs in screening asymptomatic populations should consider the following factors:

• Prevalence of SARS-CoV-2 infection in specific populations;
• Proportion of the population that have adequate immunity;
• Type and number of close contacts;
• Public health measures in place;
• The vulnerability of the population involved;
• The modality of test delivery;
• Resource implications;
• Ethical considerations.

b) Recommended Minimum age for Mask Wearing

The NPHET considered the recommendations proposed in the HIQA paper “Advice to the National Emergency Team: Reduction of the minimum age for the application of mask wearing requirements and
recommendations – updated advice 24th August 2021”. The paper had been circulated in advance of the previous NPHET meeting to allow adequate time for it to be considered fully by Members.

The NPHET was cognisant that the potential benefits of a requirement or recommendation for children to wear face masks must outweigh concerns regarding potential harms associated with face mask use.

Although limited, the available evidence suggests that the harms of face mask use in children are minor. The evidence for the additional benefits of face mask use in younger age groups is of low certainty and benefits are likely to be small in the context of an existing suite of mitigation measures.

Where such measures are in place, national and international evidence suggests that transmission of SARS-CoV-2 within schools and childcare facilities is limited, including within the context of more transmissible variants (for example, the Alpha variant and early experience with the Delta variant).

As individual circumstances vary, parents and guardians should be supported if they choose for their child to wear a face mask in primary schools or other public settings.

The NPHET endorsed the recommendations made in the paper.

Action Point: The NPHET adopted the recommendations within the HIQA paper “Reduction of the minimum age for the application of mask wearing requirements and recommendations - updated advice 24th August 2021”, noting no substantive change to current guidelines. There should be no reduction in the minimum age for requirements and recommendations with respect to mask use in the community.

4. Future Policy

a) Public Health Management

In opening this agenda item, the Chair noted that it is now timely to give consideration to the ongoing approach to the public health management of cases and contacts.

The Chair reminded the NPHET that the Office of the Chief Clinical Officer of the HSE had submitted for information the paper “HSE Preparedness planning for transitioning from Pandemic to Endemic COVID-19 – Briefing Update for NPHET” to inform the discussion under this item. Prior to opening the issue for discussion, the Chair invited the DOH to present briefly on the key proposals contained within the paper.

The DOH outlined several considerations to inform the present discussion:

- The public health management of the pandemic has evolved and must continue to evolve in light of changing circumstances and risk.
- Planning for a transition from open access or mass scale testing is important because as the harm from infection declines, the negative impacts of testing at the current scale are likely to become disproportionate to the benefits to human health.
- It is essential that the changes to the testing programme are planned and implemented in parallel with overall changes in the public health response and public health messaging.
- This will require a review of the public health response to COVID-19, including testing, contact tracing, outbreak management, surveillance, and sequencing. This review will inform an agreed plan and prioritisation framework to enable a robust and rapid response to local and regional outbreaks, particularly among vulnerable groups. This plan will also address the surge response to new variants of specific public health concern.
- The HSE will finalise its strategy for Autumn/Winter 2021/22 to ensure implementation at the point at which the criteria to transition are fulfilled.

The DOH outlined that the HSE is in the process of finalising a strategic framework for guiding the phased reconfiguration of the public health response to ensure that it:

- Is measured and proportionate to disease indicators and the burden of disease in the population;
- Strikes the right balance of minimising the threat of endemic COVID-19 while maximising health, economic, and social outcomes;
• Is adaptable to future changes in the natural history of the disease and the emergence of new variants and;
• Optimises the use of available resources.

The DOH continued that an agile, responsive, integrated, and intelligence-led public health response, organised at a local level, will be critical to preventing a further resurgence in cases in the medium and long term. The HSE is now implementing an enhanced service delivery model which will help to ensure that as Ireland emerges from the pandemic, we have a significantly enhanced and resourced Public Health service, aligned to international best practice. The HSE will take a phased approach to scaling down services in accordance with disease indicators and will ensure robust plans are in place to build back up capacity if required.

The DOH explained that the proposed reconfiguration of the of the public health response would proceed in two phases:
- As an initial Step 1 - reconfigure the approach to testing children under the age of 13.
- As a subsequent Step 2 - reconfigure approach for all adults and children, subject to the achievement of the transition criteria decided by NPHET at its meeting on 25th August.

The Chair proposed that the NPHET proceed to deliberate on each proposal in turn.

**Step 1 – Initial Phase of reconfiguration of public health response**

The DOH proposed the initial phase for reconfiguration of the public health response as follows:

Subject to assessment of the impact of the return to education on the epidemiological profile of the disease, and not prior to September 27th, it is recommended that:
- Automatic contact tracing of close contacts in childcare facilities and primary education is discontinued;
- Testing of asymptomatic close contacts in childcare facilities and primary education is discontinued, with a focus instead on clinically relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds;
- Children <13yrs who are identified as close contacts in childcare, educational settings, or other non-household settings and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;
- Children <13yrs who are identified as household close contacts in household settings will still be required to restrict movements and get tested, regardless of symptomatic status;
- Public health advice remains that any child <13yrs with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school or to socialise until 48 hours after resolution of symptoms.

The Chair invited contributions from NPHET Members, summarised as follows:
- Several Members welcomed the proposed reconfiguration of the public health response because we have reached what can be considered an ‘inflection point’ in the benefits versus secondary harms of the current approach for children aged less than 13. Having had time to observe the impact of the Delta variant in schools, and as we enter a new phase of the pandemic, the low risk of children aged less than 13 of contracting and spreading COVID-19 or becoming seriously unwell as a result of infection must be balanced against their social, emotional, and developmental needs.
- It was acknowledged that coordinated engagement and communication will be required with key stakeholders in the Education sector to outline the rationale for reorienting the public health response and to communicate the ongoing commitment to keep education safe for all those involved.
- The necessity for continued self-isolation for 48 hours after resolution of symptoms of an acute viral respiratory tract infection in children who are not confirmed cases of COVID-19 was discussed. It was noted that the 48 hour time interval did not appear to be supported by evidence and it was suggested on this basis that there is merit in considering an end to self-isolation as soon as acute symptoms have resolved. It was however also noted that the 48 hour interval is based on established custom and practice. The discussion resulted in no change to the 48-hour interval.
• It was also noted that scientific journals Nature and The Lancet recently included studies that support the experience observed thus far that children aged less than 13 are biologically less likely to transmit COVID-19 or experience serious symptoms.

• Members welcomed the positive impact that the proposal could have for Public Health teams, local General Practitioners (GPs), parents, and school management for whom cases and outbreaks in educational and childcare settings have resulted in significant disruption. It was acknowledged that, in light of this change, work will need to be refocused towards improving vaccination uptake for families of children from marginalised communities linked with these settings and defining clearly what would constitute an ‘outbreak’ in these settings for Public Health departments.

• It was confirmed that this guidance will not apply to special educational facilities, acknowledging the deleterious impact that school absence can have for this cohort in particular.

• While there was broad support overall for the proposal, Members expressed some hesitancy. Attention was drawn to the example of some countries where testing of schoolchildren has continued, and to the possibility of children aged less than 13 bringing the virus into a family household where there may be a medically vulnerable person. Although planning is underway for medically vulnerable persons to receive a third dose of vaccine, there is no certainty that this will prevent breakthrough infections for all medically vulnerable persons. Members queried whether additional mitigating measures could be considered in light of these cohorts.

• The NPHET noted that under the current advice and testing algorithm, GPs typically refer children displaying symptoms consistent with COVID-19 for testing. The HPSC suggested that, under the proposed reorientation of the public health response, children displaying symptoms of COVID-19 should rapidly self-isolate but should continue to be referred for testing.

• While the proposed reorientation of the public health response would encourage parents to pay close attention to their child’s symptoms, Members acknowledged that informing the pod of a case in the absence of a formal public health risk assessment could create unnecessary anxiety, noting the low attack rate of COVID-19 in school settings in general.

• There was consensus that detailed guidance would be required on this issue, acknowledging that clarity is required on what information should be given in the event of a case in an educational/childcare setting, and on what steps parents/guardians of children involved could take. Members noted the important ethical and consent issues relevant to this.

• In concluding the discussion on Step 1, Members agreed to proceed to discuss Step 2 before concluding on their advice to the Minister on both counts.

Step 2 – Second Phase of reconfiguration of Public Health response

The DOH proposed the second phase for reconfiguration of the Public Health response as follows:

Subject to the achievement of the transition criteria as agreed by the NPHET on 25th August, it is recommended that:

• automatic contact tracing of all close contacts is discontinued;
• automatic testing of all close contacts is discontinued, with a focus instead on clinically relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds;
• people who self-identify or who are identified through risk assessment as close contacts and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;
• automatic testing of people with symptoms should cease, with a focus instead on testing on public health or clinical grounds;
• public health advice remains that people with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school/college/workplaces or to socialise until 48 hours after resolution of symptoms.
• Maintain and enhance our surveillance capacities and systems to identify outbreaks, with a particular focus on rapid identification and management of outbreaks in vulnerable groups, & monitor trends in the disease profile nationally and regionally;
Continued strengthening of our genomic sequencing capacities to ensure the prompt identification and investigation and management of new variants, including sequencing of all travel-related cases.

The Chair invited contributions from NPHET Members, summarised as follows:

- Members strongly agreed on the need for the continued enhancement of other surveillance activities if automatic testing and contact tracing are to be discontinued in most cases. Assurance is required that any potential new variants can still be detected through robust Whole-Genome Sequencing (WGS), and that the hospital system, including surveillance in acute settings, is sufficiently well-equipped to adapt to the proposed reorientation of the public health response. While the need to normalise the ongoing public health response was accepted, caution is required. Certain mitigations may need to be preserved, for example, having assurances around the vaccination status of hospital patients.
  - The DOH informed the NPHET that Ireland had been successful in availing of €4,805,061 million of EU funding specifically targeted at strengthening WGS over the next 11 months, enabling Ireland to monitor closely the potential emergence of any new variants.
- The required change in the public’s behaviours to support the proposed reconfiguration of the public health response was re-emphasised. Strong communications will be required to inform and empower symptomatic individuals to avoid certain activities in order to protect those around them.
- Communications should stress that the threshold for testing for vulnerable groups living in congregated settings will be lower than that for the general population, and that guidance should reflect this.
- Members welcomed the proposed shift to a testing model for symptomatic persons based predominantly on the clinical discretion of Public Health doctors, consultants and GPs. The HSE submitted that, as COVID-19 becomes an endemic infection, vaccination, isolation of symptomatic cases and continued acceptance of NPIs by the general public will be necessary in reducing the overall harm from infection and that testing to identify asymptomatic cases will become progressively less important. Several members emphasised that these changes represent a reorientation of the public health response to focus efforts on the highest value surveillance and harm-reduction activities in the context of a progressive return towards normal life and normal clinical practice.
- It was noted that messaging around this proposal would be of great importance, particularly given the nature of the current testing operation. If the current model for testing is to be scaled back, clarity is required around how this would proceed, as well as the likelihood of needing to up-scale capacity at short notice if required.
- The NPHET voiced a number of points regarding the proposed phasing of the reconfiguration of the Public Health response:
  - While cautiously welcoming the overarching aim of the proposals, some Members queried whether they should proceed according to the phases proposed, and whether all of the elements of the reconfiguration should proceed at the same time. Members pointed out that the removal of automatic testing would signify a notable shift in the public health response and would likely have ‘knock-on’ effects (e.g. implications for access to testing, the ability to detect cases, and the protection of HCWs where there is attendance in Emergency Departments regardless of vaccination status).
  - While acknowledging that the Government has accepted the NPHET’s transition criteria for when it would be appropriate to reconfigure the public health response, and the reconfiguration is not tied to any date per se, Members queried whether there should be a delay of some weeks before moving to the testing of symptomatic individuals only on clinical grounds.

The Chair noted the differing opinions of Members and made the following points:

- The Chair reaffirmed that the NPHET is not bound to an external timeline regarding the reconfiguration of the public health response, but to the transition criteria decided upon at its previous meeting and accepted by Government.
- The Chair reminded Members that surveillance is not a fixed activity and that tools, such as testing for COVID-19, serve a particular purpose, namely the identification and subsequent self-isolation of confirmed cases. It is important, therefore, to reflect on whether testing every asymptomatic close contact automatically is the most effective public health response at present, as compared with testing
based on clinical grounds, effective public health messaging regarding when to self-isolate, wastewater surveillance, and other surveillance activities.

- The Chair acknowledged that outbreaks may continue to occur in certain vulnerable settings, and that clinical discretion will be required at a local level when responding to these events and advising on whether testing in these settings will be required. The Chair affirmed that guidance would explicitly state that testing requirements in vulnerable settings will differ from those of the general population.
- Taking on board all viewpoints around reorienting the Public Health response and noting that some Members felt that 2 phases may result in too speedy an adjustment, the Chair suggested that the proposed reorientation could instead be divided into 3 phases, whereby testing of people with symptoms would only transition from automatic testing to testing on public health or clinical grounds in the third phase, subject to a favourable epidemiological assessment and not less than four weeks following phase 2.
- The Chair once again stressed that the transition criteria rather than certain timelines would remain the determinant of readiness to move through the phases. The Chair further emphasised that incidence and trends in the disease will always need to be monitored and confirmed that we are not committing ourselves to an inexorable path if we run into unforeseeable problems with the disease.

The Chair invited additional contributions, from NPHET Members, summarised as follows:

- Members noted that issues around waning immunity and/or the impact of new variants will need to continue to be monitored. It was agreed that any recommendations from the NIAC in this regard will need to be implemented in a timely and robust manner.
- It was noted that pending the approval of the proposed reorientation of the public health response, Contact Tracing Guidance will be updated by the HPSC to reflect the NPHET’s proposal.
- Members stressed the need for discussions and future decisions to be guided by public health assessments and the agreed transition criteria, as opposed to any other external date.
- It was suggested that a distinction could apply to the proposal such that unvaccinated close contacts would automatically be advised to get a COVID-19 test.
- The DOH re-emphasised that, regardless of the proposed reorientation of the public health response, the approach would not preclude an individual clinician/GP from referring an individual for COVID-19 testing on clinical grounds.

The Chair thanked Members for a robust and wide-ranging discussion on the proposal. While acknowledging that the proposal is unlikely to become operational for a number of weeks, and until the epidemiological transition criteria have been met, the Chair emphasised the importance of determining the overarching approach for the reorientation of the public health response in the medium-term.

Acknowledging the consensus view that the reorientation of the public health response should proceed according to a three-phased approach, the Chair re-proposed the amended action point as below. This was endorsed by the NPHET.

**Action:** With respect to the public health management of cases and contacts as we approach and achieve the transition criteria, the NPHET recommends a systematic stepwise approach as follows:

**Step 1:**
Subject to an assessment of the impact of the return to education on the epidemiological profile of the disease, and not prior to September 27th;
- Automatic contact tracing of close contacts in childcare facilities and primary education is discontinued (not including special education facilities);
- Testing of asymptomatic close contacts in childcare facilities and primary education is discontinued (not including special education facilities), with a focus instead on clinically

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relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds;

- Children <13yrs who are identified as close contacts in childcare, educational settings, special education settings or other non-household settings and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;
- Children <13yrs who are identified as household close contacts in household settings will still be required to restrict movements and get tested, regardless of symptomatic status;
- Public health advice remains that any child <13yrs with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school or to socialise until 48 hours after resolution of symptoms.

Step 2:
Subject to the achievement of the transition criteria as agreed by NPHET on 25th August:

- automatic contact tracing of all close contacts is discontinued (public health guidance, including in relation to vulnerable groups, should be developed in this regard);
- automatic testing of all close contacts is discontinued, with a focus instead on clinically relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds (public health guidance, including in relation to vulnerable groups, should be developed in this regard);
- people who self-identify or who are identified through risk assessment as close contacts and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;

Step 3:
Subjective to favourable epidemiological assessment and not less than four weeks following step 2:

- testing of people with symptoms should evolve to focus on testing on public health or clinical grounds;

The above recommendations are premised on

- public health advice remaining that people with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school/college/workplaces or to socialise until 48 hours after resolution of symptoms. A robust communications campaign will be required in this regard;
- a reorientation and continued enhancement of our surveillance capacities & systems to identify outbreaks, including across primary care and the acute hospital systems, with a particular focus on rapid identification and management of outbreaks in vulnerable groups, & monitor trends in the disease profile nationally and regionally;
- a continued strengthening of our genomic sequencing capacities to ensure the prompt identification and investigation and management of new variants, including sequencing of all travel-related cases;
- a continued monitoring of the potential for and impact of waning immunity and prompt and robust implementation of booster programmes in line with NIAC advices.

5. Vaccination Update
   a) Vaccination Update
The HSE gave a brief update on the COVID-19 Vaccination Programme. The key points were as follows:
- Ireland’s COVID-19 Vaccination Programme continues to make significant progress. There have been over 7 million vaccines administered to date. As of 14th September, 88% of those aged 16 years and
over are now fully vaccinated, with 90% having received at least one dose (includes partially vaccinated and J&J). Vaccine uptake and completion has been very high in all age groups (ranging from 81% completion in those aged 16-49 years, through to 95% completion in those aged 50-69, to an almost universal vaccination, in those aged 70 and over. However, vaccination has been offered to younger people relatively recently, and many younger cohorts have yet to receive their second dose. Fortunately, uptake in younger cohorts has been very high.

- Vaccination records have been linked with the CIDR system. This has allowed for better understanding of breakthrough events and the impact of vaccination on cases and outbreaks. Due to this insight, a clear link has been established between vaccination and a reduction in mortality in vulnerable groups.
- It is anticipated that a programme providing a third dose of vaccine to immunosuppressed individuals will commence at the end of the month. These doses will be administered through vaccine centres, GPs and in hospitals.
- The HSE and the National Immunisation Office (NIO) will work together to align the annual flu vaccine programme with the rollout of COVID-19 vaccine boosters.
- As the vaccination programme moves into its final stages the HSE acknowledged the vital guidance provided by the NIAC throughout the process and thanked them for their ongoing support.

(i) Vaccine safety Update

The HPRA provided a verbal report on the national reporting experience for COVID-19 vaccines.

No new safety issues have been identified from national reports since the last update to NPHET. A report was published on the HPRA website on September 9th - (Report #11) which includes more details regarding the type and nature of reported reactions. The next report will be published on October 7th.

The HPRA also provided a brief update on vaccine review at EMA. The variation to the Comirnaty product information to introduce data on booster dosing is expected to be submitted to the EMA soon.

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

6. Meeting Close

a) Agreed actions

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

b) AOB

The NPHET extended its sincere thanks to the IEMAG and in particular to Professor James Gleeson and Cathal Walsh of the University of Limerick, Dr James Duggan of National University of Ireland Galway, Dr Elizabeth Hunter of Technological University Dublin, Professor Chris Brunsdon of Maynooth University, and Professor Brendan Murphy of University College Dublin for their extraordinary work in developing the models which have continued to provide invaluable insight throughout the pandemic.

c) Date of next meeting

The next meeting of the NPHET is provisionally scheduled to take place on Thursday 14th October.