National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Monday 18th October 2021, (Meeting 94) at 14:00
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference[1]	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Prof Philip Nolan, Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) Dr Cillian de Gascun, Laboratory Director, NVRL Dr Mary Favier, Past president of the ICGP, COVID-19 advisor Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Ms Rachel Kenna, Chief Nursing Officer, DOH Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Dr Colette Bonner, Deputy Chief Medical Officer, DOH Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital Ms Yvonne O'Neill, National Director, Community Operations, HSE Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Dr Breda Smyth, Public Health Specialist, HSE Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion) Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway 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 Liam Woods, National Director, Acute Operations, HSE Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC) Dr John Cuddihy, Interim Director, HSE HPSC Dr Darina O'Flanagan, Special Advisor to the NPHET Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications Mr Phelim Quinn, Chief Executive Officer, HIQA
'In Attendance'	Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Ms Aoife Gillivan, Communications Unit, DOH Ms Laura Casey, NPHET Policy Unit, DOH Ms Lyndsey Drea, Communications Unit, DOH Ms Sinead O'Donnell, Communications Unit, DOH Mr Ronan O'Kelly, Health Analytics Division, DOH Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH Dr Trish Markham, HSE (Alternate for Tom McGuinness) Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH Ms Pauline White, Statistics & Analytics Unit, DOH Ms Elizabeth McCrohan, Statistics and Analytics Unit, DOH Mr Aaron Rafter, NPHET Policy Unit, DOH
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Ms Fiona Tynan, Mr Liam Robinson, DOH
Apologies	Dr Lorraine Doherty, National Clinical Director Health Protection, HSE Dr Kevin Kelleher, Assistant National Director, Public Health, HSE Dr Colm Henry, Chief Clinical Officer, HSE Ms Deirdre Watters, Communications Unit, DOH

[1] References to the HSE in NPHET minutes relate 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 Dr Kevin Kelleher, Ms Deirdre Watters, Dr Colm Henry, and Dr Lorraine Doherty.

c) Minutes of previous meetings

The minutes of 16th September 2021 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 Chair noted that managing the next phase of the response would be the key matter for discussion, in particular whether we can safely proceed with the planned transition in approach to the public health management of COVID-19 on 22nd October, having due regard to the transition criteria as agreed on 25th August.

2. Epidemiological Assessment

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:

Epidemiological Update

- A total of 12,206 cases have been reported in the 7 days to 18th October 2021 (cases to midnight 17th October), which is a 22% increase from last week when 9,998 cases were notified in the 7 days to 11th October, and a 36% increase from the last NPHET meeting on 16th September when 8,966 cases were reported in the 7 days to 15th September 2021**.**
- As of 18th October, the 14-day incidence rate per 100,000 population has increased to 466; this compares with 395 a week ago and compares with 402 reported at the last NPHET meeting on 16th September.
- Nationally, the 7-day incidence/100,000 population as a proportion of 14-day incidence/100,000 population is 55%, demonstrating that there have been more cases in the last 7 days, 11th to 17th October compared with the preceding 7 days, 4th to 10th October.
- The 5-day rolling average of daily cases is 1,736 as of today, which is a 10% increase from 1,578 a week ago (11th October) and a 43% increase from that reported at the last NPHET meeting on 16th September (1,212).
- Of the 22,204 cases notified in the past 14 days to midnight 17th October 2021, 64% have occurred in people under 45 years of age; and 13% were aged 65 years and older. With relatively even levels of vaccination across all age groups, the median age of cases (36 years) is approaching the median age of the population (38 years) indicating that risk of infection is evenly distributed across the population.
- Of the 9,533 cases reported in the latest available epi-week (Week 40 ending 9th October 2021), 5.0% (472) were healthcare workers and 2.0% (188) 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).
- From 7th – 13th October, there have been approximately 142,356 laboratory tests reported in community, private, and acute laboratories**.** The 7-day test positivity rate in the community was 12%.
- From 8th – 14th October, there were c. 114,049 community referrals. Overall, total referrals have increased by 6% in comparison to the same time-period last week. From 7th – 13th October, the group

with the largest number of referrals was the 4-12-year-old age group. The detected rate for the 4-12-year-old age group is 9.4%.

- According to the Contact Management Programme (CMP), from 4th – 10th October 2021, the total number of close contacts was 23,473, an increase of 16% on 20,240 the previous week. The average number of cases managed per day increased from 1,279 to 1,530, an increase of 20%.
- Of the 17,210 close contacts with self-reported vaccination status recorded, 55.7% (9,583) were fully vaccinated and considered to be significantly protected, an increase from 51.9% the previous week.
- The mean number of close contacts per case (including cases with zero close contacts) for the week ending 10th October was 2.4, the same as the previous week (week ending 3rd October).
- There were 482 confirmed COVID-19 cases in hospital this morning (18th October), compared with 400 last week on 11th October, and with 290 on the morning of the last NPHET meeting on 16th September. There have been 42 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 73 confirmed cases in critical care as of this morning (18th October), compared with 75 last week on 11th October, and with 67 on the morning of the last NPHET meeting on 16th September. There were 5 new admissions in the 24 hours preceding this morning.
- Of the 402 COVID-19 patients admitted to ICU between 1st April and 9th October 2021, 123 had received either one or two doses of vaccine, and 82 had an epidemiological date 14 days or more after receiving all recommended doses of vaccine.
- As of 10th October 2021, there have been a total of 5,306 COVID-19 related deaths notified in Ireland. This is an increase of 26 notified deaths since the previous weekly update on 6th October. To date, 35 deaths have been notified which occurred in October 2021, 136 in September, 73 in August, 20 in July, and 17 in June.
- There were 54 hospital acquired COVID-19 cases in the week ending 3rd October, compared with 21 in the previous week. The substantial increase in hospital acquired cases of COVID-19 in the week ending 3rd October related to a large degree to two large acute hospital outbreaks that together account for over half of the reported cases.
- In total, 77 cases of Beta (B.1.351) and 32 cases of Gamma (P.1) have been confirmed through whole genome sequencing in Ireland as of 15th October 2021.
- Other cases of variants of interest under investigation that have been confirmed in Ireland as of 15th October: 245 B.1.1.318, 7 Epsilon (B.1.429), 4 Lambda (C.37), 4 Mu (B.1.621), 2 B.1.1.7 with E484K mutation and 2 A.27.
- TaqPath S-gene PCR target results by specimen week show that the prevalence of S-gene positivity (proxy for Delta) was 98.4% in week 36.

Outbreaks and associated cases for week 40 are based on those reported up to midnight on 9th October 2021. Week 40 refers to 3rd to 9th October 2021. Additional data for week 41 (10th – 16th October 2021) are included for healthcare settings and vulnerable populations.

<u>Healthcare setting outbreaks:</u>

- There were 13 new nursing home outbreaks with 123 confirmed linked cases and 1 community hospital/long-stay unit outbreak with 3 confirmed linked cases reported in week 40. There were also 13 nursing home outbreaks reported in week 41.
- There were 10 new acute hospital outbreaks with 37 confirmed linked cases reported in week 40. There were 13 new outbreaks reported in week 41 with 52 linked cases.
- There were 5 new outbreaks reported in residential institution settings (2 in centres for disabilities, 1 in a homeless facility, 1 in a prison, and 1 in a women/ children's refuge facility) with 16 confirmed linked cases in week 40. There were 10 new outbreaks reported in residential institution settings in week 41; they were all in disability settings with 43 linked cases.
- There were 7 new outbreaks in 'other healthcare services' with 15 linked cases in week 40.

<u>Outbreaks associated with school children and childcare facilities:</u>

- There were 2 outbreaks newly reported in childcare facilities in week 40.

- There were 3 outbreaks reported in schools in week 40 (2 in primary schools and 1 in a special education school) with 15 confirmed linked cases).

Workplace outbreaks:

- There were 19 workplace outbreaks reported in week 40 across a variety of settings. Of these, 4 were in the construction sector, 5 were related to food/meat production and processing settings, 8 in other types of workplaces (including office, commercial, manufacturing, health and dental and defence/justice/emergency services) and 2 were in 'not-specified' workplace types.

Outbreaks associated with hospitality settings:

- There were 3 outbreaks associated with a public house, 1 with a guesthouse/B&B, and 1 associated with restaurant/café settings reported in week 40.

Other locations:

- The remaining 111 outbreaks in week 40 were across a number of other locations:
    - 3 related to social gatherings**;**
    - 1 associated with religious/other ceremony;
    - 1 related to retail outlets;
    - 11 extended family outbreaks;
    - 83 private house outbreaks;
    - 9 in community outbreaks; and
    - 1 associated with travel.

Additional details are available in relation to outbreaks in vulnerable groups and key populations:

- There were 19 new outbreaks reported involving members of the Irish Traveller community in week 40 with 87 linked cases. There were 10 outbreaks in this group in week 41;
- There were 2 outbreaks associated with the Roma community with 15 confirmed linked cases reported in week 40;
- There was 1 outbreak associated with the homeless community with 2 confirmed linked cases in week 40;
- There was 1 outbreak in clients of mental health services with 2 linked cases in week 40;
- There was 1 outbreak in third-level students with 9 confirmed linked cases in week 40;
- There was 1 outbreak in a direct provision centre in week 41.

Disease incidence across the country is high and increasing. The national 7-day average of daily cases has increased from 1,258 two weeks ago, to 1,744 as of today (18th October), while the 14-day incidence per 100,000 population has increased from 378 to 466 over the same time period. Incidence is increasing across all age groups including those aged 65 years and older. Demand for testing remains high, and is increasing, and test positivity is also increasing across all age groups, with the exception of those aged 0-4 years.

The total number of confirmed cases of COVID-19 in hospital has increased over the last four weeks and was 482 as of this morning, while the number of daily admissions and newly confirmed cases in hospital has increased to an average of 56 per day. Cases in hospital are growing at +2.3% (range +1.9% to +2.8%) per day. In addition, the number of COVID-19 cases in ICU and the number requiring mechanical ventilation have increased. There is currently an average of 5 COVID-19 admissions to ICU per day. Deaths related to COVID-19 are relatively constant at approximately 5 per day. Further, in recent weeks there has been a significant number of outbreaks reported in settings with vulnerable populations, such as nursing homes, as well as a recent increase in hospital acquired infections and this continues to be closely monitored.

With relatively even levels of vaccination across all age groups, the median age of cases (36 years) has increased over recent weeks and is approaching the median age of the population (38 years) indicating that risk of infection is evenly distributed across the population.

The July 2021 wave of Delta infections caused a subsequent increase in numbers of COVID-19 cases in hospital. However, in September, numbers in hospital increased before an increase in cases. This is because the age mix of cases changed in September, with a greater proportion of cases in older people more likely to require hospital care with longer lengths of stay. The full effect of the recent increase in cases on numbers in hospital will be seen over the next few weeks.

The number of hospital admissions per 1000 cases ranged from 30 to 50 prior to the implementation of the national Vaccination Programme, to a low of about 20 hospitalisations per 1000 cases in July 2021 when older adults and those at higher risk of hospitalisation were vaccinated and most cases were aged under 35 years. However, this ratio has increased again to approximately 35 admissions per 1000 cases now that young adults are vaccinated, and cases are more evenly distributed across age groups.

In summary, the epidemiological situation in Ireland indicates a worsening disease profile with the future trajectory very uncertain.

Modeling update

The Irish Epidemiological Modelling Advisory Group (IEMAG) gave an update on its COVID-19 modelling projections.

The NPHET was reminded of the detailed set of scenario models at the end of August which examined how the disease might spread in different age groups.

Given that over 90% of adults are fully vaccinated, a key determinant of the spread of infection is the extent to which unvaccinated children transmit the virus. The models examine two fundamental scenarios, one where it is assumed that children and adults are equally likely to become infected and to transmit the virus, and one where it is assumed that children under 12 years of age are 50% as likely to transmit the virus as adults (low child transmission).

Within these scenarios, the models looked at a progressive increase in effective social contact in September and October 2021:

- a *conservative* scenario, where effective social contact at the end of October 2021 is similar to that seen in December 2020, but with the population maintaining basic non-pharmaceutical measures (such as self-isolating when symptomatic, good respiratory and hand hygiene, and masks in crowded settings) sufficient to interrupt about 30% of potential transmissions; and
- a *pessimistic* scenario where effective social contact at the end of October 2021 reverts to pre-pandemic levels with few or no effective mitigation measures.

The IEMAG outlined that 'effective social contact' in these models is an estimate not only of the level of close social contact, but also the risk of transmission associated with those contacts, including the effectiveness of non-pharmaceutical interventions, and the changing risk of social contact in the winter compared to the summer.

The actual case counts, numbers in hospital, and numbers requiring critical care have, since the end of August 2021, followed relatively closely the 'low child transmission' scenario. This accords with the international evidence that, at a population level, children transmit SARS-CoV-2 less effectively than adults. However, since early October 2020, case counts are following the more pessimistic scenario in terms of effective social contact, albeit about a week later than in the models, as has the number of people in hospital.

If we continue to track this pessimistic scenario, daily case counts are likely to increase to a peak of between 2,500 and 3,000 cases per day in the course of November, with approximately 170,000 additional cases between now and the end of the year. If this occurs, we could expect a peak of 800-1,000 people in hospital in late November, of whom 150-200 would require critical care, with approximately 2,000 new admissions to hospital and over 300 admissions to ICU between now and the end of the year.

The HPSC gave a brief overview of the breakdown of confirmed COVID-19 cases by vaccination status (unvaccinated vs fully vaccinated (breakthrough infection)), noting the significant breakthrough infections observed in hospitalised cases and deaths:

- Of the confirmed cases reported 12/09/21 – 09/10/21, 21% were unvaccinated, while 25% were breakthrough infections;
- Of the hospitalised cases reported 12/09/21 – 09/10/21, 25% were unvaccinated, while 40% were breakthrough infections;
- Of the ICU cases reported 01/04/21 – 09/10/21, 69% were unvaccinated, while 20% were breakthrough infections;
- Of the deaths reported 01/04/21 – 09/10/21, 46% were unvaccinated, while 42% were breakthrough infections.
- In addition, the HPSC outlined that 6.9% of breakthrough infections had occurred among healthcare workers.

The Chair thanked the DOH, the HPSC, and the IEMAG for their contributions and invited comments and observations from Members, summarised as follows:

- Members acknowledged the concerning and very uncertain epidemiological outlook.
- Members, noting the latest ECDC Rapid Risk Assessment of 30th September, stressed that vaccination remains the most important protective measure that an individual can take to prevent serious infection with COVID-19. Members also acknowledged that even in countries with high vaccination coverage like Ireland, a high disease burden is possible due to potential waning of vaccine effectiveness or low levels of natural immunity. Ireland's high vaccination uptake alone will not therefore lead to a suppression of cases of COVID-19 at a population level in the absence of other important measures, such as non-pharmaceutical interventions.
- Members noted that incidence was increasing almost uniformly across age groups, while waning immunity would be expected to affect older age groups earlier; they queried the implication of same for the IEMAG's models with respect to hospitalisations, ICU admissions etc.
- The IEMAG confirmed that we can be confident that vaccine protection is remaining strong against severe outcomes, but we are less confident regarding its effect on transmission. The IEMAG clarified that hospital-acquired infections are not factored into the models. The IEMAG view is that current increases in incidence are primarily due to increased effective social contact rather than waning immunity, but this is a complex issue. On the one hand, vaccination is playing a very large role in suppressing force of infection. If vaccine protection were suddenly lost, we would expect at least 8000 cases per day within one generation time. Conversely, small changes in population immunity, such as waning immunity, could have significant effects on the trajectory in the coming weeks. The IEMAG further outlined that approximately 300,000 people remain unvaccinated against COVID-19 in Ireland, creating a significant potential for substantial increases in hospitalisations and admissions to ICU into the winter months.
- Noting the recent decision to stop automatic contact tracing of children in schools, Members queried whether analyses had been undertaken on possible increases in household clusters of infection and if there was any link with children attending school. The HPSC outlined that nationally, there had recently been 2 outbreaks in schools with significant case numbers reported in each case. Generally, outbreaks in schools have not been observed to be associated with resultant significant increases in family/household transmission.
- Members queried whether further data on the vaccination status of COVID-19 positive, close contacts of a confirmed case were available. The HPSC confirmed that significant proportions of COVID-19 positive close contacts of a confirmed case reported that they were not fully vaccinated.
- It was also queried whether a demographic breakdown was available on the number of breakthrough infections occurring in those who are asymptomatic close contacts of a confirmed case of COVID-19. The HPSC outlined that these data were difficult to attain given the current testing and contact tracing guidance does not require asymptomatic fully vaccinated close contacts to get tested.
- Members expressed concern regarding the 13% of close contacts of a confirmed case who, despite being fully vaccinated and asymptomatic, tested positive for COVID-19 following a PCR test. Concern around the potential for this cohort to transmit infection further was raised, with a particular concern in relation

to healthcare workers, particularly given the current policy of not automatically testing asymptomatic fully vaccinated close contacts of confirmed cases.

- The NPHET was informed that the majority of breakthrough infections in ICU are occurring predominantly in patients who have high-grade immunosuppression.
- Members advised that, if the numbers of confirmed cases being treated in hospitals and in ICUs continue to increase, this is likely to impact the health system's ability to deliver certain scheduled care activities. In this eventuality, consideration would have to be given to curtailing some scheduled care activities in order to meet the care needs of COVID-19 cases in hospital and ICU.
- It was suggested that the potential use of new and emerging drugs for COVID-19 could be considered in future, as an additional protective measure for healthcare workers if appropriate, noting the disruption to delivery of services when healthcare workers are required to self-isolate. Use of such drugs for this cohort, in addition to patients who at higher risk of severe complications from COVID-19, would be subject to evidence-based advice.
- Members queried whether surveillance capacity existed to ensure that Whole-Genome-Sequencing was being undertaken for hospital outbreaks around the country. In response, the NVRL confirmed that this capacity was available to be deployed when requested by a particular site, and that new and emerging mutations of the Delta variant continue to be monitored. In addition, NPHET was informed of the recent (EU) HERA Incubator Funding secured by the HPSC to develop a national SARS-CoV-2 sequencing (hub & spoke) network in Ireland.
- The HSE AMRIC raised the issue of the growing numbers of Hospital Acquired Infections (HAIs) of COVID-19. There were 107 HAIs of COVID-19 in the two-week ending 10th October (54 week ending 3rd and 53 week ending 10th). Vaccination status of cases is not collected but clinical accounts from the hospitals indicate that cases are increasingly among those who are fully vaccinated. Clinical impression is that pre-existing infrastructural deficits in hospitals, such as the dependence on large multi-patient wards in several sites, is strongly associated with transmission of COVID-19 once introduced in the hospital setting. Sequencing data from one hospital continues to support the understanding that typically a COVID-19 outbreak occurs in one area of the hospital, IPC measures are taken to successfully close this outbreak down, but then COVID-19 (different virus sequence) is reintroduced causing a problem in another part of the hospital.

The Chair thanked Members for their contributions, noting their relevance to the planned discussion on managing the next phase of the COVID-19 response.

3. Existing Policy

a) Impact of COVID-19 on the Health Service

The DOH and the HSE presented the paper *"Impact of COVID-19 on the Health Service – 18th October 2021"* to the NPHET for noting.

The NPHET noted the paper. The Chair confirmed that a future discussion on the paper could take place, if required

4. Future Policy

a) Future Public Health policy

The Chair introduced this agenda item on managing the next phase of the COVID-19 response by confirming that the main purpose of the discussion would be to consider whether we could safely proceed with the planned transition in approach to the public health management of COVID-19 on 22nd October, having due regard to the agreed transition criteria. The Chair recalled in this regard, the NPHET's advice of 25th August and invited the DOH to briefly summarise same in order to facilitate the discussion.

The DOH gave a short presentation on the public health restrictive measures that remain in place currently, the changes proposed for implementation on 22nd October in the Government's Plan, and the criteria for

transition in approach from a focus on regulation and population-wide restrictions to a focus on public health advice, personal judgement, and personal protective behaviours, as agreed by the NPHET on 25th August.

The DOH further highlighted the current situation with regard to restrictive measures across EU Member States and the UK and noted the key points from the latest ECDC Rapid Risk Assessment (16th Update, 30th September). The ECDC's RRA states that it expects that countries with high vaccination coverage could experience a manageable disease burden at current contact rates, but this disease burden would increase if contact rates increased further. Moreover, even in countries with high vaccination coverage, a high disease burden is possible due to potential waning of vaccine effectiveness or low levels of natural immunity. In particular, it assesses the risk for unvaccinated people in the general population and for vulnerable populations regardless of their vaccination status as being moderate or high to very high risk. The ECDC recommend the following continuing measures at a population level:

- increase vaccine coverage – with particular focus on hard-to-reach population groups;
- continuation of NPIs such as the use of face masks, improved ventilation in closed spaces and physical distancing measures;
- risk communication activities with a focus on the role of COVID-19 and influenza vaccines, the role of basic NPIs, and targeted messaging to vulnerable groups regardless of vaccination status of the importance of adhering to NPIs;
- continuing high levels of prevention and preparedness are required in the educational system;
- continuing importance of COVID-19 surveillance systems and genomic sequencing of samples.

The DOH suggested the key areas for the NPHET discussion, as follows:

- Should the reopening/further opening of remaining sectors proceed – nightclubs, indoor and outdoor events.
- Should the COVID Pass be retained/strengthened for hospitality sector and potentially extended to other sectors/areas.
- Should sectoral protective measures be continued, e.g. physical distancing, masks, ventilation, hand and respiratory hygiene, self-isolation.
- Should the full return to workplaces proceed.
- Should proposed changes to the Public Health Management of cases/contacts proceed as per the NPHET advice of 16th September regarding Step 2 and the automatic contact tracing and testing of close contacts.

The Chair thanked the DOH for its presentation and opened the discussion to the NPHET Members. The NPHET's detailed recommendations made on foot of the discussion are captured in the Action Points section below. Key points raised in the discussion are summarised as follows:

Social and Economic Restrictions

- The NPHET concluded that the epidemiological situation has deteriorated and is now uncertain and precarious.
- The NPHET further concluded the transition criteria for facilitating the removal of the majority of the public health measures that remain in place have not yet been met.
- In the context of deteriorating disease profile, increasing hospital and critical care admissions, and continued sustained pressure on the provision of non-COVID health and social care services, Members agreed that the easing of restrictions should not proceed on 22nd October as had previously been planned.
- Members considered recommending a full pause on the easing of remaining economic restrictions, with a further review in 3-4 weeks' time. However, it was felt that there is unlikely to be a sufficient improvement in the disease profile over the short term and, therefore, Members did not believe it tenable that any pause now would result in a further easing of measures in November.
- Members agreed that implementing or reintroducing restrictions is not required at this time. However, the NPHET cautioned that the reintroduction of measures in the future cannot be fully ruled out and that the national response must remain agile and flexible, with an ability to pivot rapidly and respond to any

emerging threat. The NPHET reiterated its position that, based on past experiences, we cannot predict with certainty the future trajectory of the disease and emphasised the importance of continued monitoring in this regard.

- The NPHET stressed that the progressive de-escalation of public health restrictions to date has been cautious, gradual, and phased, with - crucially - sufficient time between phases to assess the impact. This approach has been critical to ensuring the protection of those most vulnerable and the protection of health and social care, education, and childcare services.
- The majority of Members supported the re-opening of the remaining areas of the hospitality, entertainment and night-time economy, but agreed that given the infection level it would be critical that robust protective measures were in place, including the wide and robust implementation of the COVID Pass. The importance of developing or updating guidance, as appropriate, by the relevant sectors was emphasised. A number of Members expressed reservations about additional re-opening as it may increase virus transmission notwithstanding updated guidance and other measures proposed.
- Members further supported maintaining the range of public health protective measures currently in place across sectors, including the appropriate use of masks, physical distancing, ventilation, and mitigation measures; the NPHET does not foresee these being removed until at least February 2022.
- Members acknowledged that young adults would be those most impacted should the sectors that remain to be opened stay closed for a further period (e.g. nightclubs). Many noted that this would be disproportionate due to the high level of vaccination and lower risk of severe illness with COVID-19 infection in this cohort.
- Members stressed that vaccination alone, even at Ireland's very high uptake rates, will not alone suppress transmission, and there needs to be a re-invigorated emphasis on the continuing requirement for basic protective measures and personal behaviours.
- Members also noted that healthcare settings are a higher risk, more vulnerable setting and must therefore be subject to higher standards/enhanced measures.

COVID Pass

- There was general consensus on the continued use and expansion of the COVID pass system. It was noted however that the COVID Pass system should only be retained for as long as its utility can be justified.
- It was further noted that many other EU Member States have retained COVID Pass type systems. However, other Member States also have provisions in place for those who, on medical grounds, are unable to complete their vaccination programme and it was suggested that alternative options, such as a medical exemption certificate or negative PCR/Antigen Test, be introduced for those individuals in Ireland.
- It was agreed that the Rapid Testing Expert Advisory Group should be requested to examine the potential role and feasibility of rapid testing as a component of the COVID pass for those for whom, on medical grounds, it has not been possible to get fully vaccinated.
- It was noted that some EU Member States require a COVID Pass for visitation in healthcare settings and there was a discussion on whether this should be recommended in Ireland. Many Members emphasised the importance of protecting patients and that this would provide a further mechanism for doing this. However, some Members expressed reservations on the basis that individuals have a profound moral right to see their loved ones and that a requirement for the COVID-pass for people proposing to come to see them would limit that right. On balance, Members agreed that, subject to operational feasibility, the COVID Pass should be a requirement for visitation to healthcare settings but there should be a provision for exemptions on compassionate grounds.
- The NPHET also noted the results of the recent Social Activity Measure (SAM) study from the ESRI which suggests that, notwithstanding the efforts of many businesses to adhere to sectoral guidelines, the COVID Pass has not been appropriately implemented across the hospitality sector in its entirety. Members expressed that compliance with the COVID Pass should be reviewed and strengthened, along with the other protective measures currently recommended for the hospitality sector and should be implemented widely and robustly across hospitality and for indoor events.

Vaccination

- It was stressed that the primary goal of the Vaccination Programme is to prevent against severe infection and the vaccines continue to be very effective at doing that.
- It was acknowledged that there is ongoing work and initiatives to promote vaccine uptake in hard to reach and vulnerable populations.
- Members supported the ongoing vaccine booster campaign.
- Many members highlighted the impact that the redeployment of unvaccinated healthcare staff is having on the healthcare system, both with regard to waiting times for patients and staff working hours.

Testing, Contract Tracing, Surveillance

- The NPHET noted that planning for a transition from mass scale SARS-CoV-2 testing would be predicated on achievement of the transition criteria. Given that these criteria have not been met, the NPHET recommended on balance, that the current approach to the public health management of contacts and cases be maintained, i.e. should not proceed to Step 2 as proposed in the NPHET letter of the 16th September. In coming to this conclusion, the NPHET noted the reservations of some Members regarding the value of the current processes in the context of the extensive social mixing currently taking place. The NPHET's detailed advice in this regard is captured in the Action Points section below.
- Given the level of infection in asymptomatic fully vaccinated close contacts as noted in the earlier discussion and current high prevalence of disease, the NPHET also recommended that, subject to operational feasibility, HSE should also implement a programme of COVID-19 antigen testing (with PCR confirmation of positive cases) for people who are identified as fully vaccinated close contacts of a confirmed case and who do not have any symptoms. Full details of this recommendation are captured in the Action Point section below.
- The NPHET recognised that all sectors of society will now be open and, as such, some individuals will engage in activities and behaviours which are higher risk. In this context, the NPHET recommended that the Rapid Testing Expert Advisory Group be requested to provide a view as to the potential utility of voluntary self-testing by asymptomatic individuals who plan to engage in such high-risk behaviours and activities.

Communications:

- In the context of the highly transmissible Delta variant, many Members remarked on the importance of public understanding and buy-in to basic public health measures in order to minimise COVID-19 transmission as much as possible, given that vaccination alone, even at the high levels of vaccine coverage now achieved, will not bring the effective reproduction number below 1 such that we will achieve suppression of the disease. In this context, the NPHET noted the results of the most recent SAM study in relation to mitigative behaviours. The NPHET's recommendation in this regard is captured in the Action Point below.
- Members concurred that the focus of communications should be on reminding people of the importance of being vigilant regarding non-pharmaceutical interventions (NPIs) and basic public health measures that we may have begun to set aside, rather than seeing current behaviour as non-compliance.
- The importance of policy coherence with respect to decisions and messaging around limitations on social mixing and other measures intended to reduce the spread of COVID-19 was emphasised.

Working from home:

- The importance of working from home in containing the spread of infection throughout the pandemic was emphasised. The NPHET's detailed recommendation on this point is captured in the Action Points section below.

The Chair thanked Members for their contributions to a robust and valuable discussion and noted that the NPHET's advice and recommendations would be communicated to the Minister in the usual manner for due consideration by Government.

Action Points: The NPHET recommends that on balance:

Social and Economic Restrictions

- **the easing of public health restrictions on 22nd October as previously planned should not proceed as envisaged.**
- **the remaining aspects of the hospitality, entertainment and night-time economy sector can reopen only with the full range of protective measures in place and the wide and robust implementation of the COVID-19 pass. In this regard, guidance should be developed or updated as appropriate by the relevant sectors.**
- **the range of public health protective measures currently in place across sectors should remain, including the appropriate use of masks, physical distancing, ventilation, and mitigation measures; the NPHET does not foresee these being removed until at least February 2022.**

Sector-specific Guidance

- **sector specific guidance and protocols with regard to hospitality, cultural and sporting events be reviewed, and strengthened where necessary, such that there is assurance with regard to institution and maintenance of high levels of basic infection prevention and control standards including in relation to promotion and facilitation of hand and respiratory hygiene, ventilation, and protection of employees and patrons.**

COVID Pass

- **compliance in relation to implementation of the COVID Pass be reviewed and strengthened, along with the other protective measures currently recommended for the hospitality sector.**
- **the COVID pass be implemented more widely and robustly than is currently the case, including in hospitality and for indoor events.**
- **subject to operational feasibility, that the COVID pass be adopted as a requirement for visitation to healthcare settings with a provision for exemptions on compassionate grounds.**
- **the Rapid Testing Expert Advisory Group be requested to examine the potential role and feasibility of rapid testing as a component of the COVID pass for those for whom, on medical grounds, it has not been possible to get fully vaccinated.**

Working from Home

- **The return to the workplace should continue to be phased and cautious and the NPHET continues to recommend that all who can work from home should continue to do so. All other protective measures currently in place, as set out in the Work Safely Protocol, should continue to be adhered to by workplaces, employers, and employees. In particular, there is a need for an ongoing partnership approach between employers and employees to ensure that the importance of self-isolating when symptomatic is understood, communicated and facilitated, such that employees are not disincentivised to identify themselves as symptomatic and stay at home where appropriate.**

Testing and Contact Tracing

- **The NPHET has previously outlined that planning for a transition from mass scale SARS-CoV-2 testing would be predicated on achievement of the criteria as set out above. Given that these criteria have not been met, the NPHET recommends that the current approach to the public health management of contacts and cases be maintained. In addition, given the high and increasing incidence of disease in the community, the NPHET has further recommended that, subject to operational feasibility, the HSE should implement a programme of COVID-19 antigen testing (with PCR confirmation of positive cases) for people who are identified as fully vaccinated close contacts of a confirmed case and who do not have any symptoms.**
- **The NPHET recommends that the Rapid Testing Expert Advisory Group be requested to provide a view as to the potential utility of voluntary self-testing by asymptomatic individuals who plan to engage in such high-risk behaviours and activities.**

Communications

- **The NPHET recommends that continuing efforts are made across all sectors to ensure clear guidance and communication with the public on the need for a cultural shift towards embedding individual and collective strategies to mitigate against COVID-19 and other respiratory infections. This should involve a strengthening of the ongoing co-ordinated approach to communications across Government and relevant agencies, ensuring a consistent and coherent message across Government, Department of Health, the NPHET, the HSE, and relevant agencies and sectors. As part of this, it is essential that workplaces, the retail sector, public transport operators, sporting and cultural organisations, and other public facing sectors review and, where necessary, refresh their messaging, signage, and their provision of hand sanitiser.**

Vaccination

- **there is a focus on increasing vaccination uptake in hard to reach and vulnerable populations, including a potential booster programme, to mitigate further risks to the healthcare system, which may be impacted by influenza and other respiratory viruses across the winter period.**

The NPHET cautions that the re-imposition of public health restrictive measures may be warranted should the application of the above measures not have sufficient effect on the profile of disease. In this regard, compliance with basic public health measures by the general public and across sectors will be critical.

b) Autumn/Winter COVID-19 surveillance strategy

The HPSC presented the paper *COVID-19 Surveillance and Reporting Strategy for Ireland*" for noting and feedback.

The paper outlined the national COVID-19 surveillance system objectives for the next phase of the pandemic and the surveillance systems and initiatives through which these objectives will be met; these systems will be modified as necessary according to the latest ECDC COVID-19 Surveillance Guidance. The paper also noted that HPSC epidemiological reporting will move to a weekly basis with the report produced in dashboard format, incorporating data from the surveillance elements outlined in the paper, including the Wastewater Surveillance Programme, the National Whole Genome Sequence (WGS) Surveillance Programme, SARI Surveillance etc. Monitoring and reporting of vaccine uptake will also continue, with a focus on areas or groups with lower vaccination rates. Participation in ECDC coordinated vaccine effectiveness studies in primary care, acute hospitals and healthcare workers will also continue.

The Chair thanked the HPSC for its presentation and encouraged Members to provide their feedback to the HPSC. The NPHET noted the paper.

5.HIQA - Expert Advisory Group

a) Risk of re-infection with COVID-19

The HIQA presented the paper *"Advice to the National Emergency Team: Duration of immunity (protection from reinfection) following SARS-CoV-2 infection- 14th October 2021"* to the NPHET for preliminary consideration.

The Chair confirmed that a future discussion on the paper will take place once Members have had an opportunity to fully consider the recommendations made therein.

6.Vaccination update

a) Vaccine Safety Update

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 October 7th (Report #12) which includes more details regarding the type and nature of reported reactions. The next report will be published on 4th November.

HPRA also provided a brief update on review of COVID-19 treatments at the European Medicines Agency (EMA).

7. Meeting Close

a) Agreed actions

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

b) AOB

No matters arose for discussion under this item.

c) Date of next meeting

The next meeting of the NPHET is scheduled to take place the week commencing 8th November (date tbc).