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

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<tr>
<th>Date and Time</th>
<th>Thursday 25th November 2021, (Meeting 96) at 10:00</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 via videoconference
- 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 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 Ni Bhriain, Lead for Integrated Care, HSE
- Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
- 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
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- Dr Colm Henry, Chief Medical Officer, HSE
- Ms Deirdre Watters, Communications Unit, DOH

### ‘In Attendance’
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Dr Jeanette McCallion, Clinical Assessor, HPRA
- Ms Laura Casey, NPHET Policy Unit, DOH
- Ms Sinead O’Donnell, Communications Unit, DOH
- Mr Ronan O’Kelly, 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
- Mr Vincent Colgan, Office of the Chief Medical Officer, 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 Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
- Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI
- Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA
- Mr Phelim Quinn, Chief Executive Officer, HIQA

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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 Dr Eibhlín Connolly, Dr Elaine Breslin, Prof Mark Ferguson, Dr Máirín Ryan, and Mr Phelim Quinn.

   c) Minutes of previous meetings
   The minutes of 11th November 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
   No matters were raised under this agenda item.

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:

   • A total of 31,109 cases have been reported in the 7 days to 24th November 2021 (cases notified to midnight 23rd November), which is a 3% increase from last week when 30,206 cases were reported in the 7 days to 17th November, and a 13% increase from the last NPHET meeting on 11th November when 27,443 cases were reported in the 7 days to 10th November 2021.
   • As of 24th November, the 14-day incidence rate per 100,000 population has increased to 1,288; this compares with 1,210 a week ago, and compares with 952 reported at the last NPHET meeting on 10th November. The 14-day incidence rate, at 1,288 per 100,000, is 84% of its highest value to date (1,531 in January 2021).
   • Nationally, the 7-day incidence/100,000 population as a proportion of 14-day incidence/100,000 population is 51%, demonstrating that there have been more cases in the last 7 days compared with the preceding 7 days.
   • The 5-day rolling average of daily cases is 4,665 as of today, which is an 11% increase from 4,210 a week ago (17th November) and a 113% increase from that reported at the last NPHET meeting on 10th November (3,714).
   • Of the 61,315 cases notified in the 14 days to midnight 23rd November 2021, 70% have occurred in people under 45 years of age; and 8% were aged 65 years and older. Incidence has risen across all age groups and is highest in those aged 5-12 years. The impact of recent booster vaccination on those aged 80 and over is evident and is beginning to become apparent in those aged 75-79 years; these are the only age groups in which incidence is declining.
   • Of the cases reported in the 14 days to 24th November 2021, 1.1% (692) were healthcare workers.
   • From 17th – 23rd November, there have been approximately 206,256 laboratory tests reported in community, private and acute laboratories. The 7-day test positivity rate in the community was 19.5%.
   • Testing rates are very high in those aged 12 and under, at approximately 800 tests per 100,000 children per day. This means that case ascertainment in this age group will be elevated in comparison to older age groups.
   • The Test and Trace system is now operating at surge capacity and is under severe pressure. Overall, total referrals have increased by 10% in comparison to the same time-period in the previous week.

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2 Agenda items reordered in the minutes for readability and to more closely reflect the running order of the meeting.
report that there have been delays in getting an appointment for self-referrals in most areas of the country.

- According to the Contact Management Programme (CMP), from 15th – 21st November 2021, the total number of close contacts was 60,109, an increase of 8% on 55,603 in the previous week. The average number of cases managed per day increased from 4,242 to 4,653, an increase of 10% over the same time period.
- For close contacts created the week ending 7th November, Test 1 results were available at the time for 5,665 close contacts; 1,314 (23.2%) of these had a positive result. Test 2 results were available for 1,501 close contacts, 165 (11%) of these had a positive result.
- The highest proportion of close contacts testing positive by circumstances of contact was amongst household contacts (52%). For the 2,356 household close contacts created the week ending 7th November, 32.5% (765) had a positive result.
- The mean number of close contacts per case (including cases with zero close contacts) for the week ending 21st November was 2.2, a decrease from 2.4 the previous week (week ending 14th November).
- Rapid antigen testing of close contacts who are fully vaccinated and have no symptoms is ongoing since 28th October. As of 25th November, the HSE report that the numbers of close contacts referred through this pathway is increasing with an average of 3,868 tests dispatched daily for the previous 7 days, an increase of 20% on the previous week. In total, 22,747 antigen test results have been reported by close contacts – 15,118 “not detected”/negative antigen results and 7,629 “detected”/positive antigen results, with 4,403 cases confirmed on PCR testing.
- There were 598 confirmed COVID-19 cases in hospital this morning, compared with 643 last week on 18th November, and with 543 on the morning of the last NPHET meeting on 11th November. There have been 73 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 126 confirmed cases in critical care as of this morning, compared with 118 last week on 18th November, and with 97 on the morning of the last NPHET meeting on 11th November. There were 8 new admissions in the 24 hours preceding this morning.
- Of the 626 COVID-19 patients admitted to ICU between 1st April and 20th November 2021, 233 had received either one or two doses of vaccine and 181 were considered to be fully vaccinated (had an epidemiological date 14 days or more after receiving all recommended doses of vaccine). Of the 232 cases admitted to ICU in October and November, 117 (50%) were unvaccinated, 7 (3%) were partially vaccinated, and 99 (43%) were fully vaccinated.
- As of 24th November 2021, there have been a total of 5,652 COVID-19 related deaths notified in Ireland. This is an increase of 43 notified deaths since the previous weekly update on 17th November. To date, 112 deaths have been notified which occurred in November 2021, 198 deaths in October, 175 in September, and 84 in August. Deaths are increasing very slowly at approximately 7 per day or 200 deaths per month. This may increase, given the very high case counts, though booster vaccination of older age groups may mitigate against this.
- Over the period 1st August 2021 to 20th November 2021, 166 out of 507 (32.7%) COVID-19 related deaths were in people who were not fully vaccinated (including those who had an epidemiological date less than 14 days after receiving all recommended doses of vaccine).
- There were 89 hospital acquired COVID-19 cases in the week ending 14th November, compared with 37 in the previous week. There were 436 laboratory confirmed cases in hospital staff in the week ending 14th November, compared with 326 in the previous week.
- In total, 77 cases of Beta (B.1.351) and 33 cases of Gamma (P.1) have been confirmed through whole genome sequencing in Ireland as of 22nd November 2021.
- Other cases of variants of interest that have been confirmed in Ireland as of 22nd November 2021: 247 B.1.1.318, 4 Lambda (C.37), and 4 Mu (B.1.621). There have been 123 confirmed cases of the AY.4.2 Delta sublineage.
- According to a recent CSO analysis on the current employment status of COVID-19 cases notified up to 13th November 2021, 14-day incidence rates were increasing in workers across every sector of employment in the economy. The highest 14-day incidence rates were observed in the following employment sectors: ‘Accommodation and Food Service Activities’, ‘Administrative and Support Service
Activities’, ‘Construction’ and ‘Public Administration & Defence’. These data do not indicate that cases were linked to workplace outbreaks or that infection acquisition occurred in these settings.

- A range of mobility data suggest that mobility across a range of settings remain at or close to levels observed pre-pandemic.

Outbreaks for week 46 are based on those reported up to midnight on 20th November 2021. Week 46 refers to 14th – 20th November 2021.

In Week 46, there were a total of 124 COVID-19 outbreaks notified. It should be noted that regional Departments of Public Health are prioritising Public Health Risk Assessments and outbreak investigations in settings that have the greatest clinical need or would benefit most from public health intervention. For this reason, outbreaks in some settings may be underestimated. Detail on outbreaks in prioritised settings:

**Healthcare setting outbreaks:**
- There were 5 new nursing home and 3 new community hospital/long-stay unit outbreaks notified in week 46. A total of 28 cases were linked to outbreaks in these settings in week 46.
- There were 8 new acute hospital outbreaks notified in week 46, with a total of 23 cases linked to outbreaks in acute hospital settings.
- There were 24 new outbreaks reported in residential institution settings (16 in centres for disabilities, 2 in prisons, 1 in a homeless facility, 1 in a children’s/TUSLA residential centre, 1 in a mental health facility, 1 in a direct provision centre, and 2 in other/not specified residential centres) in week 46. A total of 54 cases were linked to outbreaks in these settings in week 46.
- There were 16 new outbreaks in ‘other healthcare services’ (10 among clients of day services, 1 among clients of homecare services and 5 among other healthcare services). A total of 20 cases were linked to outbreaks in these settings in week 46.

**Outbreaks associated with school children and childcare facilities:**
- There were 6 outbreaks newly reported in childcare facilities in week 46 with a total of 19 cases linked to outbreaks in childcare settings in week 46.
- There were 24 new outbreaks associated with schools notified in week 46 (14 in primary schools and 10 in special education schools). A total of 43 cases were linked to outbreaks associated with schools in week 46.

**Workplace outbreaks:**
- There were 10 new outbreaks associated with workplaces (4 associated with meat/other food processing and 6 in ‘other’ workplace settings) reported in week 46. A total of 70 cases were linked to open workplace outbreaks in week 46.

**Additional details are available in relation to outbreaks in vulnerable groups and key populations:**
- There were 7 new outbreaks reported involving members of the Irish Traveller community in week 46 with 21 cases linked.
- There was 1 outbreak associated with the Roma community with 1 confirmed linked case in week 46.

COVID-19 incidence across the country is very high. Incidence grew rapidly in late October and early November, after which case counts have increased at a slower rate. Incidence has increased across all adult age groups except those aged 75 years and older and is highest in children aged 5-12 years old. The high incidence in this age group is driven by very high levels of infection in adults, primarily through household and community transmission, along with the fact that children under 12 are not vaccinated. Analysis by single year of age shows a steep, increasing age gradient in incidence in children, with the incidence in the 9-to 11-year-old age group three times higher than that in the 0- to 4-year-old age group. Despite the high incidence in children aged 5 to 12 years it should be noted that the risk of severe disease remains very low, with risk of hospitalisation in this age group lower than any other age cohort. The impact of recent booster vaccination for those aged 80 and over is clear and is beginning to become apparent in those aged 75-79 years, with
these being the only age groups in which incidence is declining. Growth rate of cases is uncertain but has reduced over the last 10 days and is now close to zero, though at a very high level of incidence. Demand for testing is higher than it has been at any point in the pandemic and continues to increase. All pillars of the testing pathway are now operating at maximum capacity. Test positivity has rarely been higher, although appears to be stabilising across all age groups in recent days. Testing rates are very high in those aged 12 and younger, at approximately 800 tests per 100,000 children per day. This means that case ascertainment in this age group is elevated in comparison to older age groups in the population.

The number of COVID-19 cases currently in the community and in hospitals continues to place a very substantial additional burden on delivery of non-COVID care across the wider health system, noting also that these pressures are likely to increase over the course of the winter period. Both the total number of confirmed cases and the average number of newly confirmed cases per day in hospital are high. The number of confirmed cases in ICU and requiring mechanical ventilation is also high. Given the recent trajectory in terms of the disease profile, these indicators of severe disease may increase further in the coming weeks and will require ongoing close monitoring. Deaths per day are increasing very slowly at approximately 7 per day, or 200 deaths per month. This may increase, given the very high case counts, though booster vaccination in older persons may mitigate against this. There continues to be a significant number of outbreaks reported in settings with vulnerable populations.

In summary, the overall epidemiological situation is concerning. Ireland remains vulnerable to a further deterioration in the disease profile depending on a number of factors, including levels of social contact in the coming weeks and over the festive period, adherence to basic public health protective measures and levels of immunity across the population.

The HPSC reported that the Influenza-like Illness (ILI) rate was 28.1 per 100,000 in week 46, compared with 16 per 100,000 the previous week. While this is above baseline, it is considered a reflection of SARS-CoV-2 and RSV transmission. There has been 1 confirmed case of Influenza A notified up to week 46. The strain is a slight mismatch compared with the vaccine strain, but reasonably good cross cover is likely. A further 2 laboratory confirmed cases of Influenza AH3 have been notified thus far for week 47. In relation to RSV, 490 confirmed cases and 192 hospitalisations were notified in week 46, a decrease from 510 confirmed cases and 236 hospitalisations the previous week. Levels of RSV remain high and there have been 3 RSV outbreaks since the beginning of October. With regard to COVID-19, the HPSC noted that 46% of those hospitalised are not fully vaccinated. Of those who are hospitalised, 24% are aged between 15 and 49 years. During the current wave (from 27th June 2021 to present), 19 pregnant women have been admitted to ICU. Of these, 18 were not vaccinated and 1 was partially vaccinated. The HPSC noted that the HSE National Immunisation Office is engaged in ongoing work to raise awareness of the importance of vaccination during pregnancy.

The Chair of the IEMAG informed the NPHET that as the positive impact of booster vaccinations takes effect at a population-level, the proportion of people aged 65 years and older who are hospitalised is falling and the proportion of 19–64-year-olds who are hospitalised is growing. Among those aged 80 years and over, the risk of being infected over the previous 14 days has fallen to approximately one third of the risk of those aged 65–75, due to the early booster vaccination of those over 80 years. With regard to children, incidence is very high in the 5-11 age cohort. There is a steep incidence gradient between ages 5-11, with incidence increasing with age. This may be due to greater ascertainment as older children are more likely to present for testing, but also may be a genuine difference in biological susceptibility as older children may have more biologically mature airways receptor expression than younger primary school students. There is relatively low incidence in the 12-18 age cohort. This is associated with vaccination of this cohort, mask wearing practices in secondary schools, and differences in the pattern of social mixing are also important, contrasting incidence in 13–18-year-olds with the higher incidence in 19–24-year-olds. Incidence among 12–18-year-olds increased dramatically during the school mid-term break, suggesting increased social mixing at this time. While it has been suggested that incidence in primary school aged children increased at the point at which automatic contact tracing in schools stopped, the data instead confirms that incidence increased over the course of Summer 2021 due to the Delta variant driving the force of infection in the 13-24 age cohort. Just as the force of infection was declining with vaccination in this age group, restrictions were eased in late September and
social mixing increased which created a new increase in force of infection from the adult population as a whole.

With regards to modelling, the Chair of the IEMAG informed the NPHET that the current modelling uses the homogenous population SEIR model, calibrated to 9th November 2021, with levels of social mixing held constant. This represents a baseline scenario where nothing changes (social mixing does not decrease as a public reaction to high case numbers and public health advice, nor does social mixing increase over the festive period). The level of infection-induced immunity in the population is unknown. In the optimistic scenario, where the level of undetected infection in the community is high, the model projects approximately 6,000 cases per day peaking at the end of November. If the level of undetected infection is low, the pessimistic scenario projects a peak of approximately 12,000 cases per day. The Chair of the IEMAG confirmed that the data are currently tracking slightly below the optimistic scenario while cautioning that the models are dynamic and influenced by changes in public behaviour. Regarding hospitalisations, these data have fluctuated over the previous months however hospitalisations appear to be falling in the past few days. These data had been tracking just under the optimistic scenario and are hopefully departing from this now, however, this trend has not been replicated in terms of critical care. Revised model runs will be completed next week and will take into account any changes to the growth rate and R number in the previous week, as well as increased intergenerational mixing over the Christmas period.

The Chair thanked the DOH, the HPSC, and the IEMAG for their inputs and invited comments and observations from the NPHET Members, summarised thematically below:

**Epidemiology data:**
- A number of Members queried if it is possible to examine hospital admissions, ICU admissions, and deaths by length of stay, age, disease epidemiology, vaccine received in primary series, and presence/absence of comorbidities. This information may help inform what the future burden on the hospital system due to COVID-19 might be, and enable improved targeting of boosters, PCR testing and emerging therapies to appropriate cohorts, once available. The HPSC confirmed that these data are currently being reviewed.
- It was suggested that while booster vaccination is undoubtedly having an impact on the reducing case numbers in older people, older people are also more likely to have changed their behaviour and reduced their social contacts as a result of the high daily case numbers.
- Members acknowledged that it is important to differentiate between the incidence of infection in children and the burden of disease in children. However, the upward trajectory of incidence in children is a concern and while we are not seeing an impact on hospitalisations due to this, further measures to limit transmission in this age group may be required.

**IEMAG modelling:**
- It was queried how the level of social mixing variable was held constant. In response, the Chair of the IEMAG explained that the level of effective social contact for the period 27th October 2021 – 9th November 2021 was determined and held at a constant. It was acknowledged that this is an underestimate of the level of social mixing that will occur over the Christmas period and more complex intergenerational mixing will be included in future model runs using the age-cohorted model. However, Members acknowledged that the period from 27th October 2021 – 9th November 2021 encompasses the October mid-term break where there is greater intergenerational mixing than a two-week period during the school term, hence this period may be broadly indicative of what may occur over the Christmas period.
- It was queried if there are any plans to re-run the Study to Investigate COVID-19 Infection in People Living in Ireland (SCOPI) to determine the level of infection acquired immunity in the population. The HPSC confirmed that the next phase of SCOPI is about to commence. There are also plans for a blood bank seroprevalence study in collaboration with the Irish Blood Transfusion Service and a seroprevalence study among children by Temple Street Children’s Hospital.
Impact on Acute Care:

- The HSE outlined that preliminary data for the week ending 21st November 2021 shows that:
  - The number of hospital-acquired infections among acute hospital staff has decreased to about 300. It is hoped that this may reflect an early effect of booster vaccination of healthcare staff.
  - The number of hospital-acquired infections among patients has decreased by close to 50% since the previous week, however this measure tends to fluctuate, and it is too early to say if there is a trend.

- The need to activate surge capacity is having a major impact on other hospital services and staff morale. Approximately 50% of ICU capacity is being utilised for the care of COVID-19 cases and this is impacting on scheduled care. The HSE reported that work is ongoing to identify additional surge capacity, however, emphasised that prevention of further transmission and infection in the community is of greatest importance at this time.

- The DOH and the HSE are examining the potential to expedite the Strategic Plan for Critical Care. Over 77 million euro has been provided for 2021 and 2022 to complete Phase 1 and commence Phase 2 of this plan. Significant progress has been made on Phase 1, while work is commencing to implement Phase 2. Staff recruitment remains a challenge, and discussions around how best to support and, if possible, expedite recruitment are ongoing.

- It was highlighted that although resources have been allocated for substantial outreach ICU services, some hospital sites have reported challenges in advertising and filling these posts.

- The capacity for treating certain patients outside the ICU setting using non-invasive ventilation, where clinically appropriate, was queried. The HSE confirmed that approximately 300 people are receiving non-invasive ventilation treatment in non-ICU wards, with roughly half being treated for COVID-19.

- It was noted that vaccination is having a considerable impact on reducing the conversion of COVID-19 cases into admissions to hospital and ICU. A disproportionate number of people admitted to hospital and ICU are unvaccinated, and many of the vaccinated patients in these settings have been admitted to hospital for the treatment of recurring health issues. Recent CSO data was noted as indicating that people remain unvaccinated for different reasons and circumstances, including those who are marginalised for social, mental health, and language reasons. This highlights the need for ongoing efforts to communicate with these groups to avail of COVID-19 vaccination. Work is ongoing in this regard with Communications Leads at Hospital Group-level, and through a detailed media campaign in various languages.

- Members reiterated that those who are not vaccinated are highly likely to become infected over the coming months given the current high force of infection. Given the morbidity, mortality, and significant additional strain this could place on the health system, this underscores the importance of encouraging the unvaccinated to avail of vaccination and continue to adhere to NPIs.

Test and Trace System:

- It was recognised that access to PCR testing is a challenge at present due to high demand for testing. It was queried whether a positive antigen test should be considered a confirmed case without the need for PCR testing, to reduce stress on the Test and Trace system.

- The DOH reported that as per the latest HSE Contact Management Programme report, for close contacts created the week ending 7 November, 14,953 were referred for antigen testing. Of these, a confirmatory PCR test result has so far been identified for 242 close contacts, 176 (72.7%) of these tests were positive. The DOH also reported that as per the latest HSE Test and Trace update (25 November), a total of 80,823 test kits have been sent to fully vaccinated asymptomatic close contacts since the programme commenced (28 October). In total, 22,747 test results have been reported by close contacts – 15,118 negative antigen and 7,629 positive antigen, with 4,403 cases confirmed on PCR testing.

- Work is ongoing between DOH and HSE in relation to the procurement of antivirals and monoclonal antibody medicines.

Variants of Concern:

- Members noted the importance of having regular updates at NPHET on emerging variants of concern.

- The NVRL updated the NPHET that between 1,200 – 1,500 are being sequenced per week and these data are published fortnightly by the HPSC. While no cases of the recently reported B.1.1.529 variant have
been identified in Ireland to date, a handful of cases have been identified worldwide and this will continue to be monitored. We do not yet have information on the characteristics of this new variant (i.e., transmissibility, disease severity, impact on vaccine effectiveness). It has not been designated a VOC or VOI at this time. However, the reported characteristics of the variant, would appear to be a cause for concern.

The Chair thanked Members for their inputs to the discussion. While it is important to address challenges around hospital and surge capacity, the Chair stated that prevention of disease transmission in the first instance continues to be the priority. The Chair noted the recent reintroduction of restrictive measures by some European states in this regard.

3. Communications

a) Communications update
The DOH and the HSE presented a joint update on communications campaigns that will run for the coming weeks and over the Christmas period.

The DOH and HSE emphasised at the outset that communications work aimed at reducing socialisation is very challenging in the current environment given that all social venues have been permitted to reopen, albeit with some protective measures remaining in place.

Campaigns in the run up to the festive period will focus on the need for clear and consistent messaging focusing on the key public health messages of:
  o take up your vaccine/booster as soon as it is offered;
  o self-isolate and get a PCR test if you have symptoms;
  o wear your mask;
  o wash your hands well and often;
  o prioritise and reduce the number of people you meet;
  o meet outdoors where possible, when indoors, open windows and ventilate;
  o avoid crowds.

Amárach Public Opinion Tracker 22nd November:
Feedback regarding older adults:
• 6 in 10 have reduced the number of people they plan to meet between now and Christmas.
• More than 4 in 10 of older adults have already cancelled social events/reappraised their decisions on socialisation.

Focus Group feedback regarding young adults:
• Young adults still want to socialise, and so we need to focus on solutions and what they can do. Tone is important.
• Messaging ‘keep your gang small and your presents massive’ is seen as festive, light-hearted, hopeful, and encouraging.

The Chair thanked the DOH and HSE for their joint presentation and invited observations from the NPHET Members, summarised as follows:
• The communications campaigns were welcomed.
• It was stressed that there is a risk of unintentionally ‘othering’ certain vulnerable cohorts or reducing social cohesion in our society with population-level messaging regarding vaccination. Care should be taken to avoid this. Messaging at population level should not focus on those who have not taken up the vaccine; these cohorts are better targeted through subtle local campaigns in a range of languages.
• The inclusion of positive messaging with regard to what has been achieved by the public over the course of the pandemic to date should be considered, for example, achievements made with regard to protecting vulnerable persons in long-term residential care.
The Chair thanked the DOH and the HSE for their joint update and the NPHET noted same.

5. Existing Policy

a) Minimum age for the wearing of face masks
The Chair invited the DOH to give a presentation to inform and guide a discussion on the minimum age for the wearing of face masks. In his introductory remarks, the Chair also noted the NPHET’s related discussion and resulting advice to support families and young children in staying safe, as recorded under item 4(a) below.

The DOH outlined the following considerations:

Current Position:
- Masks are mandatory for those aged 13 and over on public transport and across a number of public settings.
- Face coverings are not recommended for children under the age of 13 unless they are in secondary school.
- Some children under 13 may choose to wear one. They may also be asked when attending a hospital clinic or GP surgery.

Background:
- The Expert Advisory Group (EAG) has discussed the question “Should the minimum age for the application of mask wearing requirements and recommendations be reduced?” on three occasions between February and August 2021.
- The most recent review recommended that, following consideration of the harm-benefit ratio, the minimum age for mask wearing should remain unchanged. However, ongoing monitoring was advised with respect to the epidemiological situation in children and the effectiveness of existing risk mitigation measures in place in primary schools.
- Epidemiological situation as of 23rd November:
  - 14-day incidence is 1287.6 per 100,000.
  - 17.2% of cases were in those aged 5 to 12 years.
  - Incidence is highest in those aged 5 to 12 years, and particularly the 9- to 12-year-old age group.

International Guidance:
- ECDC: Masks are not recommended for pupils in primary schools (<12 years).
- CDC: Masks are recommended for children aged 2 years and older.
- WHO: For children between 6 and 11 years of age, a risk-based approach should be applied to the decision to use of a mask.

Evidence review:
- Schools are not a driver of infection, with lower odds of infection in educational settings compared to community and household settings.
- Studies directly evaluating the isolated effectiveness of mask wearing in children are limited.
- A small number of studies found that mask mandates in schools have been associated with lower incidence of SARS-CoV-2 infection, however, as other NPIs were often in place, it is difficult to determine the independent impact of mask wearing.

Benefits vs. Harms:
- Potential Benefits:
  - Reduction in transmission of COVID-19 (or other respiratory infections) to children.
  - Overall reduction in transmission of COVID-19, which also benefits children.
  - Avoid need to isolate/restrict movements (school attendance).
  - Reduced burden of morbidity and mortality.
• Potential harms:
  o Potential issues relating to anxiety or stigmatising of those exempt from mask wearing.
  o Possible reduced tolerance to wearing masks for long duration.
  o Possible increased difficulties with caring for mask and increased touching of face.
  o Challenges with small, soft ears, glasses, and elastic for face coverings.
  o Potential challenge for those from socioeconomically vulnerable areas or households in obtaining or caring for masks.

The DOH outlined key areas for discussion, as follows:
• Consideration of a reduction in the minimum age recommendation for mask wearing, with exemptions as appropriate, as a temporary, interim measure, recognising the potential roll-out of the vaccination programme in the 5- to 11-year-old age group.
• Consideration of paediatric mask availability, and potential provision for those from lower socioeconomic backgrounds.
• Guidance should continue to emphasise the importance of other mitigation measures.

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 Point below. Key points raised in the discussion are summarised as follows:
• There was widespread support for extending the minimum age for mask use to children aged 9 years, noting that children of this age are capable of wearing masks effectively with good instruction and correct guidance. In school settings, this should encompass pupils from 3rd class and up in order to include those in classes who may not yet be 9 years old.
• It was recalled that the HIQA advice on this issue was based on the epidemiological situation at the time (16th September), and that the advice stated that should there be a change in epidemiology, a consideration of change in position would be warranted.
• Some Members noted previous reservations around extending the minimum age for mask wearing but supported extending the minimum age to 9 years with due consideration of the current epidemiological context. On this point, Members wished for messaging to explicitly state that this position has not been reached on foot of changing evidence in the efficacy of masks, but rather the high levels of transmission that need to be reduced.
• The importance of consultation with children and parents in the decision making behind the resulting advice was raised.
  o In response to this point, it was noted that discussions with the EAG did involve parental representatives.
• The importance of being mindful of those children who may be stigmatised for mask wearing, or for those who may face difficulties in doing so, was reiterated.
• With regard to yet undiagnosed developmental issues that may render mask wearing problematic for a child, it was noted that teachers could monitor for concerning patterns of behaviour and bring same to the attention of parents/guardians.
• Regarding implementation, it was highlighted that the legal mechanisms pertaining to mask wearing will need to be reviewed should the minimum age be extended. This raised concerns regarding mandating for a requirement in respect of children where they are not under the direct supervision of a parent or guardian, and it was asserted that it may be best for this extension to be advisory in nature.
• It was agreed that the formal review of the recommendations should take place in mid-February 2022.
• Further points raised: compliance; supply; engagement with colleagues in the Department of Education and representatives from the educational setting; need for careful messaging - children should not feel they are to blame for the current epidemiological situation.

Following the above discussion, the NPHET reached the consensus view detailed in the Action Point below. A reservation was expressed about the advice to be provided, noting that undoing the advice would be difficult.
The Chair thanked Members for their inputs and contributions to the discussion, noting that the recommendations will be communicated to the Minister in the usual manner for due consideration by Government.

Action: Having considered advice provided to the NPHET by the HIQA Expert Advisory Group with respect to the minimum age for the application face masks and coverings on 16th September and the current high incidence rate in children aged 5-12 years, the NPHET recommends subject to the development of appropriate guidance (on a temporary basis, subject to review in mid-February 2022) the wearing of face masks/coverings by children:

- aged 9 years and over on public transport, in retail and other indoor public settings as currently required for those aged 13 and over, with exemptions as appropriate; in third class and above in primary school.

b) Health System Preparedness


The NPHET noted the sustained pressure being seen across the health system, with continuing high case numbers suggesting that this pressure will continue for some time to come. The significant challenge this pressure presents to the continued delivery of healthcare, with a number of hospitals already curtailing the delivery of scheduled care in order to cope with rising numbers of COVID patients, was emphasised.

The current situation and ongoing intensive management across the health system was discussed, including:

- Critical care units are currently running at close to full capacity on an ongoing basis, with some hospitals already using surge capacity, and 130 COVID-19 patients receiving care in ICU as of 23rd November. The Critical Care Major Surge Working Group is meeting regularly to manage the situation.
- Approximately 300 patients are currently receiving advanced respiratory support in a ward setting, with these patients having higher acuity and dependency than usual ward patients.
- The scope to redeploy staff to support critical care is reduced when compared to earlier waves of the pandemic, particularly in the context of the need to care for high numbers of seriously ill patients on wards. Staff are more fatigued now than at any stage in the pandemic to date, with limited capacity to take on additional responsibilities.
- Emergency Department attendances and admittances have increased compared to the previous two years, with increasing presentations contributing to increased pressure on hospital capacity.
- The number of patients on waiting lists has risen significantly over the course of the pandemic, with additional impact to come from the further cancellation of elective procedures currently being seen.
- The number of open outbreaks in hospitals has risen from 27 in the week ending 19th September to 55 in the week ending 14 November. Cases of hospital-acquired COVID-19 and new laboratory confirmed cases in hospital staff are also continuing to increase.
- The safety net arrangement with the private hospitals is still in operation and is being used currently. The HSE has advised that in the last week, 1,417 bed days in the private sector have been used and this is rising. The year-to-date bed day usage is 60,000.
- Primary care waiting lists are rising across the sector, with the total number of patients waiting for assessment or treatment across the four main primary care therapies (speech and language therapy, occupational therapy, physiotherapy, and psychology) now reaching 131,595.
- While the rollout of the Vaccination Programme in residential care settings is having a positive impact, the continued risk of transmission and outbreaks remains, particularly in nursing homes, where currently nearly 10% are in outbreak.
- The current rate of community transmission is having a very significant impact on the levels of COVID-related absence amongst staff with the resulting challenges in maintaining levels of service.
The NPHET agreed there is evidence of unmet patient need with scheduled care curtailment across the acute hospital system. COVID patient hospitalisations are displacing non-COVID patient scheduled care and unscheduled care access. The HSE Safety Net intervention operates to mitigate this. The continuing high levels of community transmission are likely to result in continuing high numbers of hospitalised COVID patients for some time to come with ongoing impact on timely access of patients to required care in acute hospitals.

c) Testing on admission
The HSE confirmed that a directive has been sent to all hospitals to test all patients for SARS-CoV-2 at point of admission. The HSE will seek assurances that this directive has been implemented by all sites.

The HSE also provided an update on the national SARS-COV-2 test and trace system with reference to the paper “Test and Trace: NPHET Update – 25th November 2021”, circulated to Members in advance of the meeting. Key points made were as follows:

- The Test and Trace system is now operating at surge capacity and is under severe pressure. Further demands on the testing system in recent weeks, due to clinical referrals and close contacts, has led to delays in accessing the testing services.
- Additional surge capacity has been put in place through private agreements, utilization of the Defence Forces, new community swabbing recruitment campaigns and engagement with private healthcare providers. This will bring in an additional 3,000 tests per day.
- All pillars of the testing pathway are operating at maximum capacity (referrals, swabbing, laboratory testing and contact tracing).
- The median end to end TAT for a detected result in the Community is now 2.7 day.
- In the past week, 206,256 laboratory tests were completed, this is the highest volume of lab tests completed to date in a 7-day period.
- Community referrals have increased by 10% in comparison to the same time-period last week.

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

4. Future Policy
a) Ongoing management of COVID 19
The Chair invited the DOH to give a brief presentation with a view to orienting an initial NPHET discussion to assess the impact of current public health measures and to give consideration to potential ways to further strengthen our response to COVID-19 over the coming period, if required. The Chair confirmed that the NPHET would continue its deliberations and provide its finalised advice to the Minister for Health after its next meeting planned for early December. The key points in the DOH’s presentation were as follows:

- An overview of public health measures that became effective from 19th November;
- A summary of the latest advice of the ECDC of 24th November (17th Rapid Risk Assessment) on response options;
- A summary of public health measures recently introduced in other EU Member States;
- Key considerations including: the current epidemiological situation and modelling projections, vaccination and booster programmes, population behaviour, increased socialisation associated with Christmas and New Year, and potential additional pressures on the health service, including in relation to influenza;
- Proposed areas for discussion included: overall strategy for the winter period; under what circumstances would further measures be required; what measures should be considered and the timing of further measures, if necessary.

The key points from the discussion were as follows:

Public Health measures
• Members recognised the precariousness of the current epidemiological situation, and that data over the coming week would give an indication of the impact of recently introduced public health measures, and whether further measures might be advisable to Government.

• Notwithstanding the high levels of vaccination in the population, attention was drawn to relatively worse disease metrics, including numbers of hospitalisations and admissions to ICU due to COVID-19, being observed at present compared to other periods during the pandemic. Members noted the difficulty in comparing these periods given the complexity in deciphering the changing relationship between disease incidence and harm.

• The increased socialisation and intergenerational mixing observed during the festive period in 2020, and the subsequent impact thereof on the epidemiological situation in early 2021, gives cause for concern with regard to the upcoming festive season. Reference was also made to the increased level of socialisation over the recent Halloween period. Uncertainty around the extent to which booster vaccinations for older and more vulnerable cohorts will have been completed in the lead up to the festive period is also of key concern.

• Regarding the management of the COVID-19 response going forward, a sustainable, medium-term, and evidence-based approach for the winter period was favoured over a ‘circuit breaker’ type response. This approach should prioritise the strengthening of existing measures in the first instance.

• The NPHET agreed the need to continue the policy of communicating with the public the importance of reducing their social contacts. This has been strongly emphasised by the NPHET for some weeks. It was noted that more targeted measures designed to limit social contacts might be required if the epidemiological situation does not improve.

• Members reiterated that consideration should be given to the extension of the application of the COVID Pass to all settings where there is high risk of transmission, through close contact or other activities, not yet covered by the current regime.

• Members suggested that further advice and measures might be required in relation to international travel, noting recreational travel is likely to increase over the festive period.

• The NPHET re-emphasised its core priorities of protecting public health and the most vulnerable and protecting the priority public services of health and social care, education and childcare. In particular, Members underscored the need to reduce the burden on the health system and to avoid closures in the education sector like those seen early in 2021. It was stressed that these priorities have not changed, and if the epidemiological situation does not improve, further measures may be required to protect same.

• It was noted that NPHET advice would continue to be communicated with regard to the NPHET’s stated values and priorities, and with reference to the Ethical Framework for Decision Making in a Pandemic.

• If further measures are required, Members noted the importance of coherence and cross-sectoral alignment for enabling clear, effective communications and supporting broad adherence to such measures.

• It was noted that a longer-term strategy is important to consider in due course, once concerns with regard to the immediate epidemiological situation have been addressed.

Vaccination and Boosters

• The NPHET strongly emphasised the importance of expediting the roll-out of the booster vaccination programme to the greatest extent possible.

• The need for continued efforts to increase vaccine uptake in marginalised and hard to reach groups was emphasised. The importance of targeted interventions that take due care not to unintentionally lead to the ‘othering’ of those who do not avail of a COVID-19 vaccine was underlined, in particular with regard to the maintenance of social cohesion.

• It was noted that there was significant uncertainty in relation to the impact that flu will have over the coming months. Strengthened messaging targeted at improving flu vaccine uptake was noted as one important measure that should be pursued with the aim of relieving strain on the health system over the winter period.

Hospital Infrastructure
The challenge of resourcing and delivering both COVID and non-COVID care in parallel over the past 20 months was raised. Notwithstanding the ongoing work to improve certain sites, these parallel pathways of care have largely operated using pre-pandemic hospital infrastructure. It was noted that pre-existing deficits in hospital infrastructure would have to be addressed in the long-term given that cases of COVID-19 hospitalisation can be expected for some time into the future.

Noting the discussions under item 3(b), the NPHET agreed that efforts should continue to focus on preventing the spread of COVID-19 in the community to the greatest extent possible to avoid further increasing the pressures being experienced across all parts of the health system. The uncertainty around the scale of the impact of seasonal influenza on the population this winter, particularly among older and more vulnerable cohorts, further underscores this need.

The Chair thanked the Members for their engagement in the initial discussion and confirmed that there would be a further discussion at its next meeting with a view to providing finalised advice to the Minister.

Advice to support families and young children in staying safe
The NPHET discussed the provision of advice to support families and young children in staying safe over the coming period with a view to reducing risk of disease transmission, including advice on reducing and prioritising discretionary activities and social contacts. Key points made in the discussion are summarised below:

- the NPHET recognised the very significant impacts that previous social and economic restrictions have had on families and children to date.
- a core priority of the NPHET throughout the pandemic has been to protect the continued operation of the education and childcare sector, recognising its importance to the health and development of children.
- we are currently experiencing very high incidence in children aged 5-12 years of age, and as such it is important to take steps to interrupt chains of transmission to protect our core priorities.
- a steep, increasing age gradient in incidence in children was noted, with the incidence in the 9-to 11-year-old age group three times higher than that in the 0- to 4-year-old age group.
- it was stressed that care should be taken in messaging to avoid creating the impression that children are the drivers of transmission. It was also stressed that messaging should seek to differentiate between infection and burden of disease.
- it was stressed that care should be taken in messaging to avoid creating the impression that children are the drivers of transmission. It was also stressed that messaging should seek to differentiate between infection and burden of disease.
- Despite the high incidence in children aged 5 to 12 years it should be noted that the risk of severe disease remains very low, with risk of hospitalisation in this age group lower than any other age cohort.
- it was underlined that parents, guardians, and those with responsibilities for children need to be supported in making good decisions.
- the point was emphasised that the purpose of this advice should be to reduce transmission as much as possible.
- the importance of after-school activities to children’s health and wellbeing was emphasised and it was noted that such activities are controlled environments, i.e. protective measures are in place.
- it was felt that parties and play-dates could continue to take place safely if held outdoors.
- the importance of the speedy roll-out of the booster vaccination programme was emphasised, to protect older persons in the context of expected intergenerational mixing during the festive season.

Action Point:
The NPHET proposed that:
- for at least the next two weeks, indoor community gatherings should be avoided for children aged 12 and younger; examples of which include communions or similar events, nativity performances, and other comparable indoor seasonal events. In addition, sleepovers and indoor birthday parties and playdates should be avoided, although the later may take place outdoors and should ideally be kept to small numbers.
• Having considered advice provided to the NPHET by the HIQA Expert Advisory Group with respect to the minimum age for the application face masks and coverings on 16th September and the current high incidence rate in children aged 5-12 years, the NPHET recommends subject to the development of appropriate guidance (on a temporary basis, subject to review in mid-February 2022) the wearing of face masks/coverings by children:
  o aged 9 years and over on public transport, in retail and other indoor public settings as currently required for those aged 13 and over, with exemptions as appropriate;
  o in third class and above in primary school.

6. Vaccination update
   a) Vaccine Safety Update
      The HPRA provided a verbal update on the national reporting experience for COVID-19 vaccines.

      Monitoring of the safety of the approved COVID-19 vaccines continues nationally and within the EU network/EMA. Overall, no new safety issues have been identified from national reports since the last update to NPHET. The 13th HPRA safety update was published on HPRA’s website on 4th November, and HPRA plans to publish the next safety update on 9th December 2021.

      The NPHET noted the EMA’s approval of the Comirnaty vaccine for children aged 5 – 11 years on 25th November 2021.

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 on Thursday 2nd December.