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

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<tr>
<th><strong>Date and Time</strong></th>
<th>Thursday 16th December 2021, (Meeting 98) at 10:00</th>
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<tr>
<td><strong>Location</strong></td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td><strong>Chair</strong></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, Maynooth and 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 / 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  
- 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 Máirin Ryan, Deputy Chief Executive and Director of HTA, HIQA  
- 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 Bhríain, Lead for Integrated Care, HSE  
- Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)  
- Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)  
- Prof Mary Horgan, President, RCPI  
- 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 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 Clinical Officer, HSE  
- Ms Deirdre Watters, Communications Unit, DOH

### In Attendance
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH  
- Dr Robert Conway, Specialist Registrar, DOH  
- Ms Aoife Gillivan, Communications Unit, DOH  
- Ms Ruth Barrett, NPHET Policy Unit, DOH  
- Ms Laura Casey, NPHET Policy Unit, DOH  
- Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH  
- Mr Ronan O’Kelly, Health Analytics Division, DOH  
- Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE  
- 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 Vincent Colgan, Office of the Chief Medical Officer, DOH  
- Mr Stephen Donnelly, T.D., Minister for Health (joined briefly to address NPHET Members)

### Secretariat
- Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Liam Hawkes, Ms Fiona Tyman, Ms Emily Kilroy, Mr Liam Robinson, DOH

### Apologies
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital  
- Prof Phelim Quinn, Chief Executive Officer, HIQA  
- Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH  
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway

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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 Catherine Fleming, Prof Colm Bergin, Mr Greg Dempsey, and Mr Phelim Quinn.

   c) **Minutes of previous meetings**
   The minutes of 25th November and 2nd December 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, in his opening remarks, the upcoming retirement of NPHET Member Mr Phelim Quinn, CEO of the HIQA. The Chair expressed thanks on behalf of the NPHET to Mr Quinn for his hard work and dedication during his long career. The Chair confirmed that a letter would be prepared on behalf of the NPHET thanking Mr Quinn for his work in the context of the COVID-19 response in particular.
   - Regarding the management of proceedings, the Chair asked that Members treat discussions as confidential, adding that no Member is entitled to share details of the meeting until such time as the Minister has been briefed and the Government has also been briefed. The Chair noted that breaches in confidentiality cause very substantial difficulty, undermine efforts and cause confusion for the public. The Chair stressed that such actions undermine trust and confidence in our collective ability to lead people through the pandemic. The Chair reiterated in the strongest terms his call for confidentiality.
   - The Minister for Health, Mr Stephen Donnelly, T.D., briefly joined the meeting at approximately 11:00. The Minister thanked Members for their ongoing support to both him and the Government since the onset of the pandemic. The Minister acknowledged that many Members had taken on the additional responsibilities of being on the NPHET alongside their usual frontline and senior decision-making roles in other parts of the health service. The Minister expressed his thanks to the NPHET as a group for making its analysis and advice available to him on an ongoing basis and assured Members of the Government’s continued support. The Chair thanked the Minister for taking time out of his busy schedule to address Members and wished him a Happy Christmas on behalf of the NPHET.

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 29,595 confirmed cases have been reported in the 7 days to 15th December 2021 (cases notified to midnight 14th December), which is a 10% decrease from last week when 33,003 cases were reported in the 7 days to 8th December, and a 5% decrease compared to the last NPHET meeting on 2nd December when there were 31,751 cases reported.
   - As of 15th December, the 14-day incidence rate per 100,000 population is 1,315; this compares with 1,360 reported a week ago and 1,320 at the last NPHET meeting on 2nd December. The 14-day incidence rate, at 1,314 per 100,000, is 86% of its highest value to date (1,531 in January 2021).
   - Nationally, the 7-day incidence per 100,000 population as a proportion of 14-day incidence per 100,000 population is 47%, demonstrating that there have been fewer cases in the last 7 days (reporting between 9th – 15th December), compared with the preceding 7 days, (reported 2nd – 8th December).
- The 5-day rolling average of daily cases is 4,294 as of today, a 4% decrease from that reported at the last NPHET meeting on 2nd December (4,475).
- Of the 62,598 cases notified in the 14 days to midnight 14th December 2021, 75% have occurred in people under 45 years of age; and 5% were aged 65 years and older.
- Of the cases reported in the 14 days to 15th December 2021, 0.5% (336) were healthcare workers.
- From 8th – 14th December, there have been approximately 206,996 laboratory tests reported in community, private, and acute laboratories. It is noted that Storm Barra caused a two-day reduction in demand for testing during the relevant time period. The 7-day test positivity rate in the community has increased from 17.4% last week to 20.0%.
- The demand for testing has fallen significantly in those aged 12 years and under.
- Test positivity is stable or falling across most age groups but has increased in recent days in those aged 19-24 years.
- All parts of the testing pathway are operating at close to maximum surge capacity (referrals, swabbing, laboratory testing, and contact tracing).
- According to the Contact Management Programme (CMP), from 6th – 12th December 2021, the total number of close contacts was 56,402, a decrease of 10.6% on 63,121 in the previous week. The average number of cases managed per day decreased from 4,653 to 4,384, a decrease of 9% over the same time period.
- For close contacts created the week ending 28th November, Test 1 results were available at the time for 15,962 close contacts; 3,348 (21.0%) of these had a positive result. Test 2 results were available for 3,535 close contacts, 428 (12.1%) of these had a positive result.
- The highest proportions of close contacts testing positive by age group were amongst those aged 5 to 12 (30.0%), 65 to 74 (29.6%) and 0 to 4 (28.8%).
- The mean number of close contacts per case (including cases with zero close contacts) for the week ending 28th November was 2.0, a decrease from 2.2 the previous week (week ending 12th December). The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 12th December was 3.0, a decrease from 3.1 the previous week.
- There were 443 confirmed COVID-19 cases in hospital this morning, compared with 532 last week on 9th December. The effect of booster vaccination is seen in a decreasing percentage share of those cases admitted to hospital being aged 65 years and older.
- There have been 50 newly confirmed cases in hospital in the 24 hours preceding this morning. There has been an average of 54 newly confirmed cases in hospital per day over the last 7 days. Of the 1,272 COVID-19 cases (aged 12 and over) in November who were hospitalised and where vaccination status is known, 281 (22%) were unvaccinated and 956 (75%) were considered to be fully vaccinated (had an epidemiological date 14 days or more after receiving all recommended doses of vaccine).
- The number of cases of hospital acquired infection has remained lower compared to previous weeks but continues to be of concern. There were 25 hospital acquired COVID-19 infections in the week ending 5th December 2021, compared to 21 in the week ending 28th November, and 47 in the week ending 21st November.
- There has been a continued reduction in the number of cases in acute hospital staff though there are still significant numbers being reported. There were 175 laboratory confirmed cases in hospital staff in the week ending 5th December 2021, compared to 250 in the week ending 28th November, and 324 in the week ending 21st November.
- There are currently 108 confirmed cases in critical care as of this morning, compared with 115 last week on 9th December. There were 6 new admissions to critical care in the 24 hours preceding this morning. Of the 157 COVID-19 cases (aged 12 and over) in November that were admitted to ICU and where vaccination status is known, 71 (45%) were unvaccinated and 79 (50%) were considered to be fully vaccinated (had an epidemiological date 14 days or more after receiving all recommended doses of vaccine).
- As of 15th December, there have been a total of 5,835 COVID-19 related deaths notified in Ireland. This is an increase of 47 notified deaths since the previous weekly update on 8th December. To 15th December, 57 deaths had been notified which occurred in December 2021, 217 in November 2021, 211 deaths in October and 178 in September. Deaths per day are at approximately 6 per day, or 180 deaths per month.
• Over the period 27th June to 4th December 2021, 253 out of 690 (36.7%) notified 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).

• On 26th November 2021, the WHO designated the variant B.1.1.529 a variant of concern (VOC) on the basis of advice from the WHO’s Technical Advisory Group on Virus Evolution. The variant has been given the name Omicron. As of 16th December 2021, 39 cases of Omicron have been confirmed through whole genome sequencing (WGS) in Ireland. As of 16th December, S gene target failure (SGTF) data (a proxy for Omicron) indicate that approximately 27% of new cases in Ireland are due to the Omicron variant (based on laboratory specimen date of 14th December).

• SARS-CoV-2 WGS capacity has been increased by 33% over the last fortnight and the HPSC is working to further increase capacity for sequencing at six ‘spoke’ hospitals in the first quarter of 2022.

• According to a recent CSO analysis on the current employment status of COVID-19 cases notified up to 27th November 2021, the highest 14-day incidence rates were observed in the following employment sectors: ‘Accommodation and Food Service Activities’, ‘Administrative and Support Service Activities’, ‘Public Administration and Defence’ and ‘Construction’. These data do not indicate that cases were linked to workplace outbreaks or that infection acquisition occurred in these settings.

• Five laboratory confirmed influenza cases - four influenza A (not subtyped) and one influenza B cases - were notified to HPSC during week 49 of 2021; bringing the season total to 15 laboratory confirmed influenza cases notified during weeks 40-49 of 2021. Notified influenza cases in Ireland during the 2021/2022 season to date have predominately been associated with influenza A in those aged ≤65 years. In the European region, influenza activity remains low, however it has increased, and is predominately associated with influenza A(H3). Respiratory syncytial virus (RSV) continues to circulate in Ireland. Rhinovirus/enterovirus and other respiratory viruses also continue to circulate, with coinfections of respiratory viruses reported.

• A range of mobility data suggest that mobility across a number of settings remains at or close to levels observed pre-pandemic with a small decrease in activity levels in recent days, noting however the recent likely impact of Storm Barra on population mobility.

Outbreaks for week 49 (5th – 11th December) are based on those reported up to midnight on 11th December 2021.

In week 49, there were a total of 164 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 such as healthcare settings. For this reason, outbreaks in some settings may be underestimated. Detail on outbreaks in prioritised settings:

Healthcare setting outbreaks
There were 13 new nursing home and 5 new community hospital/long-stay unit outbreaks reported in week 49. A total of 43 cases were linked to open outbreaks in these settings in week 49.

• There were 5 new acute hospital outbreaks reported in week 49 with a total of 10 cases linked to open outbreaks in acute hospital settings in week 49.

• There were 29 new outbreaks reported in residential institution settings (9 in centres for disabilities, 7 in direct provision centres, 6 in mental health facilities, 4 in children’s/TUSLA residential centres, 2 in prisons, and 1 in a homeless facility) in week 49. A total of 71 cases were linked to open outbreaks in these settings in week 49.

• There were 12 new outbreaks in ‘other healthcare services’ (10 among clients of disability day services, 1 among clients of homecare services and 1 among clients of a mental health facility). A total of 15 cases were linked to open outbreaks in these settings in week 49.

Outbreaks associated with school children and childcare facilities
• There were 9 outbreaks newly reported in childcare facilities in week 49, with a total of 13 cases linked to open outbreaks in childcare settings in week 49.
• There were 37 new outbreaks associated with schools notified in week 49 (22 in primary schools, 13 in special education schools and 2 in a post-primary school). A total of 25 cases were linked to open outbreaks associated with schools in week 49.

**Workplace outbreaks**
• There were 3 new outbreaks associated with workplaces (2 associated with food/meat processing and 1 in ‘other’ workplace settings) reported in week 49. A total of 70 cases were linked to open workplace outbreaks in these settings in week 49.

**Additional details are available in relation to outbreaks in vulnerable groups and key populations**
• There were 13 new outbreaks reported involving members of the Irish Traveller community in week 49, with 21 cases linked to open outbreaks in this group in week 49.
• There were 3 new outbreaks reported involving members of the Roma community in week 49, with 2 cases linked to open outbreaks in this group in week 49.

The epidemiological assessment as presented should be considered within the context of the significant additional public health threat posed by the Omicron variant. As of 16th December 2021, 39 cases of Omicron have been confirmed in Ireland through whole genome sequencing. S-gene target failure data (SGTF; proxy for Omicron) indicate that the prevalence of Omicron has risen rapidly in Ireland over recent days, with the latest data indicating that approximately 27% of new cases are due to the Omicron variant.

COVID-19 incidence across the country is high, and while it has reduced in recent days, the situation remains fragile given the very high case volumes. Daily growth rate of cases is currently estimated at -0.5 to -1% per day, with the effective reproduction (R) number at just below 1.0. The demand for testing and incidence in children aged 5-12 years has fallen significantly. The impact of recent booster vaccination in reducing disease incidence in those aged 65 years and over is clear. The effect of booster vaccinations is also seen in a decreasing percentage share of those cases admitted to hospital being aged 65 years and older. The demand for testing remains very high and test positivity has stabilised at a high level. Test positivity is stable or falling across most age groups but has increased in recent days in those aged 19-24 years old. All parts of the testing pathway are operating at close to maximum surge capacity (referrals, swabbing, laboratory testing, and contact tracing).

While there has been a recent reduction in the number of confirmed cases in hospital and ICU, these levels remain high overall, and particularly in terms of occupancy in ICUs which are operating to full capacity. The high number of COVID-19 cases currently in the community and in hospitals continues to place a significant burden on a range of care being delivered to the greatest extent possible by dedicated staff and services across the wider health and social care system. It is critical that the ongoing significant impact from COVID-19 is considered within the wider context of the anticipated increasing burden on health and social care services over the course of the winter period (for example, due to the circulation of respiratory viruses such as influenza), and also, in terms of the significant threat posed by Omicron.

COVID-19 mortality is at approximately 6 deaths per day, or 180 deaths per month. This may rise further, given the high case counts and risk from Omicron, though booster vaccination 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 in Ireland remains concerning and delicately balanced. The key core public health priorities, which include the protection of vulnerable groups, the provision of care across all areas of the health and social care system, as well as education and childcare, remain vulnerable to a further significant deterioration in the disease profile. This risk depends on a number of factors, including levels of social contact over the coming days and weeks, adherence to basic public health protective measures and levels of immunity across the population, and the potential for significant impact from the recently identified Omicron variant which is already circulating at significant levels in the community and rapidly increasing.
Modelling
The IEMAG gave a detailed presentation on its modelling for COVID-19. The key points made are as follows:

- It remains difficult to model the possible impact of the Omicron variant on levels of infection and severe illness with SARS-CoV-2. The emerging data from, for instance, South Africa, Denmark, and the United Kingdom suggest that the growth rate and speed at which Omicron can spread is greater than early estimates, and this means that the level of infection may exceed that anticipated in our earlier scenario models.
- The rapid spread of Omicron is likely due both to its ability to evade the immunity conferred by vaccination and prior infection and being intrinsically more transmissible; the relative contribution of these two mechanisms is unclear.
  - If Omicron spreads rapidly largely because it evades the immune defenses against infection, assuming the immune mechanisms protect against severe disease, we will see larger numbers of milder infections, and fewer of these people will require hospital or critical care.
  - Conversely, if Omicron spreads because it is simply more transmissible, a larger fraction of infected people will become seriously ill.
  - Given that we do not know, this increases the uncertainty in any estimates of how numbers of people infected might translate into requirements for hospital and critical care.
- A wide range of scenarios, using assumptions based on the limited data currently available, have been examined. These scenarios show that as Omicron becomes dominant, which is likely to happen over the coming week, the risk of a surge in disease is very high, and any such surge is amplified by increased effective social contact over the Christmas period. It should be noted that the level of infection is such that at peak, between 2% and 5% of the population could be infected, and between 6% and 25% of the population could be a close contact of an infected person.
- The consequences of this for essential services and the wider economy are significant. The risk of excess demand for healthcare is difficult to estimate but is considered very high. This will be increased further if the level of infection-induced immunity in the population is lower (or if Omicron evades immunity from prior infection with other variants).
- More optimistic scenarios show 8,000-10,000 cases per day, 500-750 people requiring general hospital care, and 150-250 people requiring critical care, or 650-1,000 people in total in hospital at peak.
- The more pessimistic scenarios show in excess of 20,000 cases per day, over 1,500 people requiring general hospital care, and in excess of 400 people requiring critical care, or more than 2,000 people in total in hospital overall at peak.

The NVRL gave a brief update on the current assessment by colleagues in the UK of the characteristics of the Omicron (B.1.1.529) variant of concern, summarised as follows:

- Initial data do not indicate significant differences between the serial intervals of the Omicron and Delta variants, however, more data on the Omicron variant are required.
- A sample of Omicron cases indicates that the median cycle threshold (CT) values have been slightly higher in the days following infection as compared with Delta cases. However, these data contrast with the national trend whereby overall CT values appear to be more similar. Thus, it is too early to determine whether there are significant differences in peak viral load in cases infected with the Omicron vs Delta variants.
- Regarding immune escape, early data suggest that recipients of the two-dose AstraZeneca vaccine schedule who receive a Moderna mRNA booster are better protected than those who receive a Comirnaty booster, but these data are provisional. Those who have received an AstraZeneca booster vaccine do not appear to be conferred with additional protection over the primary course.
- Early, provisional neutralisation data suggest that those infected with Delta who have also been vaccinated may have greater protection against Omicron than those who are vaccinated alone.
- The early data regarding the duration of protection provided by booster vaccines against the Omicron variant is concerning, indicating that the additional protection conferred by booster vaccines against infection appears to wane almost certainly after 10 weeks, and perhaps as early as 5-9 weeks post booster.
• Data from Imperial College London indicate that the risk of reinfection may be 5 times greater with the Omicron variant as compared with the Delta variant. If these data are accurate, and applied to the healthcare worker population as an example, this cohort’s protection from reinfection would reduce from approximately 85% for the Delta variant to approximately 19% for the Omicron variant.

• It may be difficult to definitively prove whether the Omicron variant is more transmissible than Delta. In vitro studies indicate that Omicron still utilises human ACE2 receptor to infect cells. One early study from Hong Kong has indicated that the Omicron variant replicates faster than Delta in the bronchus, but not in the lung. It has been speculated that this may indicate that the virus is adapting to enhance its evolutionary fitness, with this possible change in the virus’s make-up causing the virus to become more transmissible, but less severe than other variants. Further data are required to confirm or refute these hypotheses.

• Notwithstanding the above, the likelihood of a household cluster with the Omicron variant as compared with Delta is increased threefold; however, this likelihood is reduced if the index case has had a booster vaccine.

• While we are still awaiting more definitive data, there are now plausible biological mechanisms that could explain how Omicron could be more transmissible than Delta, if indeed that transpires to be the case. While theoretically Omicron could be less transmissible than Delta, given its capacity for immune evasion, it is difficult to reach the reported growth rate of 0.3-0.4/day without some inherent transmissibility advantage as well.

• Early data do not suggest that the current antiviral therapies in use will be any less effective against the Omicron variant.

The Chair thanked the DOH, IEMAG, and the NVRL for their respective inputs and invited contributions from the NPHET Members, summarised as follows:

General Discussion
• It was suggested that in communications around ongoing public health measures, it is important to outline clearly whether the goal is to protect the healthcare system, manage overall number cases, or both.

• Given that approximately 27% of cases in Ireland are estimated to be infected with the Omicron variant of concern, the ongoing utility of travel restrictions designed to curb the introduction of this variant of concern was queried. The DOH confirmed that these travel-related measures are being coordinated at EU level, and that the early indications are that these restrictions may be altered soon. It was also suggested that the existing testing requirements for inbound travellers to Ireland should be maintained given that many people may return to Ireland for the Christmas period to socialise with elderly parents/relatives.

• It was queried how Christmas socialisation was being factored into the models, with Members noting that Christmas 2020 saw an extremely high level of socialisation in the population. In this regard, the IEMAG confirmed that the ‘Christmas + 20% increase in socialisation’ scenario was highly pessimistic and looking increasingly unlikely based on current estimates of population-level socialisation. However, these highly pessimistic scenarios have been excluded in previous model runs and are included to give an indication of how sensitive these models are to changes in population-level socialisation.

Monitoring and Surveillance
• It was queried whether an urban vs rural difference is being observed in the dispersal of Omicron, as has been the case in the UK. The HPSC confirmed that 18 of the confirmed cases of Omicron have been in Dublin, with the remainder dispersed across a number of counties, indicating a relatively widespread dispersal of the VOC.

• Attention was drawn to data from the HSE’s Contact Management Programme indicating the low proportion of individuals with positive antigen tests subsequently confirmed as positive for COVID-19 by PCR testing. Notwithstanding the reduced specificity that may be associated with self-testing/self-reporting, it was suggested that this specificity was substantially lower than that observed in the HSE
antigen test validation report and in previous similar studies, such as the UniCov Study, and potential differences in data capture and the robustness of the denominator may be influencing factors.

- The DOH highlighted that the latest CMP report shows that, for close contacts created in the week ending 28th November, 23,516 were referred for antigen testing. Of these, a confirmatory PCR test result was identified for 1,124 close contacts. In total, 765 (68.1%) of these PCR tests were positive.

- The HPSC outlined that thus far, there have been 15 lab-confirmed cases of influenza in Ireland. 5 of these have been confirmed in the past week, with 2 children having been hospitalised with the virus. At present, the influenza-like-illness (ILI) indicator is not reliable due to biases in health-seeking behaviour in the population. Increases in rates of influenza have recently been observed across Eastern Europe. Cases of Respiratory Syncytial Virus (RSV) appear to have plateaued, but it should be noted that a later, ‘second peak’ has been observed with in previous years with RSV. The Chair noted the need to pay close attention to developments concerning these other circulating viruses, along with the ongoing monitoring of SARS-CoV-2.

**Vaccination**

- It was noted that persons who are unvaccinated continue to be overrepresented in terms of requiring hospital and critical care treatment for COVID-19 as compared with vaccinated persons. If this population continues to refuse vaccination, it was suggested that the pandemic will be characterised by very different impacts on these two sections of the population placing a differentiated burden on the health system. It was queried how this feature was factored into the IEMAG’s models. The IEMAG confirmed that there remains significant uncertainty regarding the degree to which unvaccinated, previously infected individuals are protected against the Omicron variant. Thus, there is significant uncertainty around the potential impact of this coming wave on the health service.

- It was outlined that HSE Public Health West had administered 60 new primary vaccinations in a highly vulnerable, marginalised population in the past week. This underscores the importance of having bespoke, culturally sensitive clinics for specific cohorts to avail of vaccination.

- It was noted that the epidemiological situation as compared with Winter 2020 was different due to the impact of COVID-19 vaccination. The IEMAG confirmed that the impact of vaccination is included in its modelling scenarios and explains why some of the scenarios show extremely high daily case counts with more moderate increases in hospitalisation and ICU admissions by comparison. If the Omicron variant is a less virulent virus than previous strains, this may result in less demand for hospital and ICU care, however, it is too early to determine if this is the case.

- The proportion of the population who had already received their booster vaccination, and how this fed in to modelling scenarios was queried. The IEMAG confirmed that the models accounted for approximately 90% of people over 75 years being vaccinated, 54% of those aged 50-64, and 33% of those aged 50-55. Approximately 99,000 booster doses have been administered to immunocompromised persons.

- While accepting the high degree of uncertainty in these models, it was noted that modelling data for the relative risk of severe infections over time could give cause for cautious optimism. If optimistic modelling assumptions materialise, including the positive impacts of booster vaccinations, protection against symptomatic infection wanes/is reduced due to the enhanced transmissibility of the Omicron variant to a greater extent than protection against severe infections. Thus, risk of severe infection decreases while risk of milder symptomatic infections increases, resulting in a relatively stable risk of severe disease. The IEMAG elaborated that in this scenario, given that the majority of older age cohorts have received their booster vaccination, age cohorts in the middle of the vaccination schedule (50–70-year-olds) are most severely impacted by the Omicron wave, underscoring the importance of speedy and comprehensive rollout of booster vaccinations for this cohort.

**Health System Impacts**

- In contrast to December 2020, there is now increased COVID-19 hospitalisation demand and increased non-COVID scheduled care demand, and that managing these competing demands is a significant challenge for the health service. It was noted with concern that, based on the modelling projections outlined, and the current total numbers of COVID and non-COVID patients in ICU, general ICU capacity
would be surpassed in most scenarios. This would confirm the hypothesis that the Omicron wave could have a disproportionate impact on demand for critical care in particular.

- Implementation of additional surge capacity in critical care units will entail redeploying staff from other areas. However, the scope to redeploy staff to support critical care is reduced when compared to earlier waves of the pandemic, particularly given the need to care for high numbers of seriously ill patients on wards and the ramping up of the booster vaccination campaign. Recently, the impact of COVID-19 is already evident in some hospitals, where there has been decreased delivery of scheduled and unscheduled care.

- It was noted that the recent stabilisation in cases in hospital and ICU may be partly due to the largest portion of cases being in younger people. Identifying whether this trend remains consistent during the Omicron wave will be important in this regard.

- It was queried whether reliable data on hospitalisations due to the Omicron variant were available to inform the NPHET’s deliberations, noting the first case of the variant may have been in Ireland as early as November 2021. The IEMAG and NVRL suggested that it was still too early to determine the likely impact of the Omicron variant on hospitalisation and ICU rates in Ireland.

- Given the impact of booster vaccinations on healthcare workers, it was suggested that the period of mandatory isolation for this cohort, if they test positive for COVID-19, should be reviewed by the HIQA’s Expert Advisory Group in the future. It was suggested that reducing this period of mandatory isolation could have a positive impact on staffing levels, which may become strained as cases among healthcare workers increase due to Omicron.

The Chair thanked Members for their contributions and noted their importance to deliberations under item 6(a) on the ongoing management of COVID-19.

(i) Update impact of disease - nursing homes and LTRCFs

The DOH provided an update on the impact of COVID-19 in nursing homes and community hospitals. Key points are summarised below.

On account of the disproportionally high COVID-19 morbidity and mortality among residents in long-term residential care facilities (LTRCFs) for older people, the Irish COVID-19 Vaccination Programme prioritised vaccination of staff and residents in these facilities. Vaccinations commenced in late December 2020, and the Booster COVID-19 Vaccination Programme commenced in the week beginning 4th October 2021.

Key epidemiological points from the experience so far in nursing homes and community hospitals include:

- Overall, there have been 842 COVID-19 outbreaks in nursing homes and community hospitals.
- 1,330 of 18,625 laboratory confirmed outbreak cases have been hospitalised (7.1%).
- 2,203 deaths have been reported among confirmed outbreak cases in these settings (11.8%).
- The percentage of cases 65 years or older who died among cases linked to outbreaks notified in wave 4 was 11.2%, compared to between 17.0% and 24.2% in previous waves.
- Large peaks occurred in the number of outbreaks in wave 1 (72 outbreaks in a single week) and wave 3 (57 outbreaks in a single week).
- The COVID-19 Vaccination Programme commenced in earnest in January 2021 and within a few weeks there was a marked reduction in outbreaks and cases.
- The median outbreak size, the median outbreak duration, the median number of deaths per outbreak and the median outbreak case fatality among those 65 years and over has reduced since the commencement of the Vaccination Programme.
- In Wave 4, the number of linked cases of all ages peaked at 226 cases in week 35, followed by a sharp decline from week 43 (week beginning 24th October 2021) to just 36 linked cases in week 49. This is likely due to administration of the booster vaccine which commenced for residents in the week beginning 4th October (week 40).

Since this meeting, a review of sequence data has identified 12 cases of omicron between 25th and 30th November.
Across wave 4, 58% (1,390/2,414) of linked cases were 65 years and older – this was lower in weeks 44-46 at 41%, and likely reflects the earlier implementation of the booster vaccine for residents compared to staff at these facilities.

In Wave 4, the number of deaths per week (by date of death) peaked in week 39 with 18 deaths, followed by a reduction from week 44. This decline in the weekly number of deaths follows the administration of the booster vaccine which commenced for residents in week 40.

The Chair thanked the DOH for its presentation and the NPHET noted same.

3. Existing Policy
   a) Health System Preparedness
The DOH and the HSE presented the paper “Impact of COVID-19 on the Health Service: 16th December 2021” for noting. They key points were as follows:

- Sustained pressure is being seen across the health system. Across hospitals there is high demand for both COVID-19 and non-COVID care.
- Critical care units are continuing to run at very close to full capacity (109 adult COVID-19 patients on 14th December, with 291 critical care beds occupied in total), with high numbers of patients (270-280) receiving advanced respiratory support on a ward setting. In comparison to the same period in 2020, there is now an increased COVID-19 hospitalisation demand and increased non-COVID scheduled care demand, and managing these competing demands is a significant challenge for the health service.
- Implementation of additional surge capacity in critical care units will entail redeploying staff from other areas. However, the scope to redeploy staff to support critical care is reduced when compared to earlier waves of the pandemic, particularly given the need to care for high numbers of seriously ill patients on wards and the ramping up of the Booster Vaccination Programme. At the same time, critical care staff and staff being redeployed are experiencing exhaustion and stress, as indeed are frontline workers in other parts of the system. The current rate of community transmission is having a very significant impact on the levels of COVID-19 related absence amongst staff with the resulting challenges in maintaining levels of service. Approximately 5,000 staff are currently absent across the system.
- Increased Emergency Department admissions are intensifying existing pressure on general hospital capacity, with limited numbers of vacant beds being seen across the system. Furthermore, the HSE CEO’s direction to hospitals in relation to the prioritisation of unscheduled, COVID-19 and urgent time-sensitive care has now been extended beyond its initial two-week period. As a result, scheduled care has now been impacted for a number of weeks. The ongoing curtailment of scheduled care is highly likely to impact the ability of the acute hospital system to deliver elective care between now and year end and is impacting on the ability of hospitals to meet patient needs. Delivery of time-critical services, such as cancer surgeries, may also be challenging in the context of limited theatre and critical care access, and the redeployment of staff. The HSE and the Department are in discussions with the private hospitals in relation to extending the Safety Net arrangement in 2022.
- Primary care and wider community services remain under pressure. Redeployment of staff to support the Booster Vaccination Programme will further impact on service delivery. In light of the urgent need to accelerate the pace of administration of boosters, GPs have agreed to provide additional vaccination clinics over the coming weeks. Notwithstanding the urgent necessity for this, it will impact on the routine delivery of care in GP settings and may therefore have an impact on Emergency Departments and on likelihood of hospital admission. While the rollout of the Booster Vaccination Programme in residential care settings is having a positive impact, the continued risk of transmission and outbreaks remains.

The DOH and HSE concluded that the above points combined, illustrate a system under significant strain with limited capacity to respond to any additional increases in COVID-19 activity.

The Chair thanked the DOH and HSE for their joint update and invited comments from NPHET Members. The following points were raised:

- Members emphasised that at this time in 2020, delivery of scheduled care was curtailed to allow the system to focus on urgent, time-sensitive, and COVID care. However, currently the delivery of scheduled
care is continuing in so far as possible, which affects the health system’s capacity to provide COVID-19 care and meet the needs of non-COVID patients. The continued implementation of the Strategic Plan for Critical Care, noted by Government in December 2020, will be essential to ensure that critical care capacity expands to the current and future demand.

- Negotiations are ongoing with private hospitals to extend the Safety Net arrangement and retain the additional capacity that they provide to the HSE.
- Concern was voiced that as GPs are deployed to assist with the Booster Vaccination Programme, they will only have capacity to deal with urgent care requests in the general practice setting. This may lead to increased presentations and admissions at Emergency Departments, further increasing the demand for hospital care.

4. HIQA - Expert Advisory Group
   a) Update on Omicron VOC


In its rolling summary of the evidence in relation to the Omicron variant of concern (VOC), the HIQA identified emerging evidence published internationally in relation to Omicron and presented it under the following headings:

- Transmissibility and Transmission;
- Virulence;
- Immune escape;
- Treatment efficacy;
- Test accuracy;
- Overall assessments of risk and impact.

The HIQA noted that the report does not present a review of the conduct of the included research, nor the validity of the findings, and, as such, this report does not make conclusions regarding the evidence. The report aims instead to provide a snapshot of the current findings relating to Omicron, as reported by the study authors, as they emerge. It also noted that studies and assessments emerging in the following days may present information that supersedes the contents of the report.

In the second paper presented, the HIQA provided a rolling review of international public health guidance in relation to Omicron. The HIQA provided a summary of changes to public health measures, being advised or taken internationally, from 26th November 2021, when the Omicron variant was declared a variant of concern.

The HIQA noted that changes to public health measures reflect efforts to mitigate the ongoing risks posed by the Delta variant as well as the threat posed by Omicron and that the public health measures adopted by countries to limit the spread of COVID-19 are constantly changing.

The Chair thanked the HIQA for its presentation and the NPHET noted same.

5. Communications
   a) Communications update

The DOH and the HSE presented “Communications Update: 16th December 2021”, for noting.

The Quantitative Tracker, a nationally representative sample of 1,600 people conducted on behalf of the Department of Health by Amárach Research on 13th December 2021, shows that:

- The level of worry has seen a slight decline over the past two weeks, now at 5.6, similar to levels seen in April this year;
- 44% do not want more restrictions, 41% do;
• 51% of the population think government reaction to the current outbreak is appropriate, 35% think it insufficient, 14% think it too extreme;
• 42% visited hospitality last week. They report COVID passes checked by sector to be: 84% in cafés, 84% in restaurants, 72% in pubs;
• At the end of November, 60% said they were ‘happier to have a much quieter Christmas than usual this year’ (55% under 35) this has now firmed up to 81% who say they are ‘planning to have a quiet Christmas this year’ (71% under 35);
• 72% have reduced the number of people they plan to meet between now and Christmas because of the recent increase in COVID cases (64% under 35).

The DOH and HSE also advised that the following campaigns are currently on air:
• HSE: Thank you – stay at home if you have symptoms;
• HSE: Heads Up - Keep protecting yourself and others from COVID-19;
• HSE: COVID-19 Vaccines and booster invitations;
• DOH: Young Adults – reduce your contacts;
• DOH/GIS: Antigen campaign;
• GIS: Asses your risk – Risk, Venue, Symptoms & People.

The DOH confirmed that antigen testing and availing of a booster does when it’s offered have now been incorporated into the ‘layer up’ campaign.

The DOH also presented a summary of the most recent behavioural research findings from the ESRI, captured in item 6(a) below.

6. Future Policy

a) Ongoing management of COVID 19

With a view to orienting the planned discussion on the ongoing management of COVID-19, and in light of the recent emergence of the Omicron variant of concern (VOC), the Chair first invited the DOH to supplement the information already provided by the HIQA by providing a summary of recently published international guidance related to Omicron. Key points summarised as follows:

• During the past week, the EU’s Health Security Committee (HSC) (8th December), the WHO (10th December) and the ECDC (15th December) have published updated position papers with regard to the emergence of Omicron.
• The WHO noted that the overall risk related to Omicron is very high with preliminary evidence suggesting potential immune escape against infection and high transmission rates, which could lead to further surges with severe consequences.
• The EU’s HSC highlighted the need for a precautionary approach and highlighted a number of crucial public health measures – to be implemented as a multi-layered approach – including increasing testing capacities and enhanced contact tracing measures. It further noted that timely reinforced implementation of non-pharmaceutical interventions (NPIs) is now more important than ever and emphasised the importance of avoiding the occurrence of possible ‘super-spreader events’, such as sport events, concerts, and large gatherings.
• The ECDC’s updated Rapid Risk Assessment (RRA) (15th December) noted that the possibility of further spread of Omicron is very high, with the potential impact of that spread also deemed to be very high, resulting in an assessment that the overall risk to public health from Omicron is very high.
• The RRA noted the ECDC’s serious concerns with regard to the preliminary reports of significant growth advantage and potential immune escape versus Delta. It further noted that community transmission is already ongoing in the EU/EEA, with further rapid increases in Omicron cases expected in the next two months and concluded that Omicron’s increased transmissibility and resulting exponential growth of cases will rapidly outweigh any benefits of a potentially reduced severity.
• The RRA concluded that it is very likely that Omicron will cause additional hospitalisations and fatalities, in addition to those already expected with Delta and cautioned that these fatalities will only be observed
with delay after the Omicron variant has become dominant. In light of these concerns, the ECDC observed that:

- Strong and immediate reductions in contact rates are required to avoid a high spike in Omicron cases and to keep the COVID-related health and mortality burden manageable in the short term, even with immediate acceleration of vaccine rollout. This is particularly relevant given the upcoming period that usually involves intergenerational mixing across different households, with the risk of super-spreading events.
- Without reduction of contact rates through the implementation of NPIs and increased booster vaccination, levels of transmission could rapidly overwhelm EU/EEA healthcare systems.
- Given the impending probable dominance of Omicron, NPIs need to be further strengthened without delay, including avoiding large public or private gatherings, encouraging use of face masks, reducing contacts between groups in social or work settings, teleworking, expanded testing and strong contact tracing.
- Immediate planning should be considered to increase healthcare capacity to treat the expected higher number of cases. Hospital surge capacities should be re-assessed according to emerging epidemiological data on the severity of Omicron.
- Testing of individuals with symptoms, irrespective of their vaccination status, together with isolation of those testing positive, continues to be important in limiting the spread of SARS-CoV-2.
- Vaccination remains a key component of the multi-layered approach needed to reduce the impact of Omicron.
- Risk communication activities remain vital.

The Chair invited the DOH to summarise the public health measures currently in place and to present a range of possible additional measures with a view to facilitating an in-depth discussion and formulation of NPHET advice on the matter for the Minister and Government ahead of the festive period and for the weeks thereafter.

The DOH summarised existing measures and presented a range of possible additional measures for consideration. The DOH noted that these measures are targeted primarily at settings with potential for the biggest impact on disease transmission in the coming weeks, including potential super-spreading events, with the aim of reducing the overall volume of social contacts at a societal level.

The Chair thanked the DOH for its presentation and invited the DOH’s Communications Team to present a summary of the most recent behavioural research findings from the ESRI. Key points summarised as follows:

- While the public’s initial response to the recent wave of cases was slow, there has now been a substantive behavioural response.
- The magnitude of behavioural change is not particularly large, with most SAM indicators changing by 10-20%. However, because social contact would typically increase in this period leading up to Christmas, the degree of commitment to change is perhaps more substantive.
- Close contacts have now reduced by approximately 20%, partly due to people working from home, but also because people are taking more care both at work and during visits to other homes. Unsurprisingly, however, close contacts in hospitality venues have increased since early October.
- The greater contribution in behavioural response comes not from meeting fewer people but from being more careful when meeting people, and these observations apply also to those who are most socially active.
- While the public has become significantly more worried over the past two months, there is little sign yet that the Omicron variant has increased that further. Encouragingly, SAM data records a positive trend in willingness to take the booster vaccine. Consistent with feeling protected by the vaccine, people have become more worried about the health system than about friends, family or themselves catching COVID-19.
- Differences in behaviour by age group are much smaller than is reflected in public commentary. However, younger people are becoming more disaffected.
Most people in Ireland are broadly supportive of the public effort, with a second and growing group that is not. This trend is driven by younger adults. Low self-reported wellbeing by young adults is an important factor in this trend.

The Chair thanked DOH colleagues for their respective inputs. With a view to focusing the planned discussion on the ongoing management of COVID-19, the Chair commenced the discussion by asking whether any NPHET Members would make the case for continuing with the public health measures already in place, without any modifications. It was agreed that some further measures, additional to those agreed on 2nd December, are now required. The NPHET discussion proceeded on this basis. The additional public health measures, as endorsed by the NPHET Members, are captured in the Action Points section below. Key points raised in the discussion are summarised thematically below.

Adherence to basic public health measures
- Due to the emergence of the Omicron variant, the NPHET emphasised the importance of individuals and families adhering to basic public health measures in the weeks ahead. It was agreed that this would be emphasised in the letter to the Minister.
- In addition, the NPHET stressed that the emergence of the Omicron variant requires a renewed and enhanced emphasis by all sectors and organisations on ensuring widespread compliance with, and adherence to, measures which will protect the public and employees. Again, it was agreed that this would be emphasised in the letter to the Minister. The NPHET also emphasised the importance of continued clear and targeted communications over the coming period and noted the various communications campaigns that are underway.

The need for additional measures
- Members expressed their broad support for additional public health measures beyond those agreed on 2nd December, noting the importance of reducing social interaction and minimising contacts in the least impactful way to society and the economy, where possible.
- Members emphasised that in order to attenuate the worst effects of the coming wave, particularly as the Omicron variant becomes dominant, the current rate of infection must be kept under control.
- The NPHET was cognisant of the very significant impact that the pandemic, adherence to public health advices, and restrictive measures have had on individuals, families, communities and businesses in Ireland. The NPHET recognised the significant efforts being made across society to follow current public health advice including reducing levels of social mixing and the sacrifices that this entails. However, given the scale of cases projected as the Omicron variant becomes dominant in the days ahead, it was stressed that it is unlikely to be sufficient to protect against the expected surge in infection levels.
- It was stressed that renewed efforts must be made to ensure that all tools at our disposal (vaccines and boosters, PCR and antigen testing, NPIs) are optimised to the greatest extent possible.
- The importance of a continuing focus on the guiding principles of solidarity, fairness, and proportionality in considering additional public health restrictions was highlighted.
- It was stressed that solidarity has been a hallmark of the Irish response to COVID-19. It was noted that the collective national effort in which people have acted in mutual support of each other has allowed us to protect our healthcare services and educational opportunities for children to the greatest extent possible. These actions have undoubtedly saved many lives. Members emphasised the importance of acknowledging the public’s efforts and achievements thus far.
- The NPHET noted that in its most recent correspondence of 2nd December, it expressed its significant concern in relation to the potential trajectory of COVID-19 over the coming weeks with three key risk factors identified – the impact of the Omicron variant; increased social mixing over the Christmas and New Year period; and the impact of influenza and other respiratory illnesses. It was emphasised that each of these factors constituted a real but as yet unquantifiable risk to the management of COVID-19, and that taken together in the context of an already significant burden of disease and force of infection, they had the capacity to present serious challenges in the weeks ahead.
The NPHET noted the advice of the ECDC and others that even if the Omicron variant results in less severe infection, the increased transmissibility and resulting exponential growth of cases will rapidly outweigh any benefits of a potentially reduced severity. This is likely to place considerable burden on our healthcare system and may also have very disruptive effects in terms of workforce sustainability across healthcare (including the Vaccination Programme and impacts on IPC practices), the education and childcare systems, and other essential services.

It was also noted that an additional risk associated with a significant increase in caseload due to the emergence of the Omicron variant is that a proportion of those infected with SARS-CoV-2 may experience significant longer-term sequelae, so-called ‘long COVID’. According to the WHO, while the precise number of people affected with longer term sequelae after acute COVID-19 remains unknown, published reports indicate that approximately 10-20% of people diagnosed with COVID-19 experience lingering symptoms for weeks to months following acute infection.

Members drew attention to the potential impact that a further deterioration in the epidemiological situation could have on the NPHET’s core priorities of protecting the most vulnerable and priority public services of health and social care, education and childcare. The following related points were noted:

- The current strain on the health system, from GPs through to primary care, community care, and critical care;
- The challenge posed by the absence of key workers from the health workforce;
- Unsustainable ICU projections;
- The importance of keeping education and childcare open.

The NPHET acknowledged that additional measures will impose a further burden on certain sectors and also on society more generally. It was acknowledged that the proposed measures are intended to reduce the volume of social contacts, particularly in higher risk settings which present super-spreader opportunities and those that involve inter-household and intergenerational mixing.

It was felt that the risk associated with not immediately intervening was too high, given the speed at which our health system could become overwhelmed. The ICU projections were noted as concerning and not sustainable.

Members noted that without additional public health measures, we would likely experience a sharp peak in cases, and while cases may decrease quickly from this peak, the magnitude of the increase could potentially overwhelm the healthcare system, and result in significant associated staff absenteeism across essential services due to illness. It was stressed that it is necessary to take steps to spread these infections out over a longer period of time, i.e. ‘to flatten the curve’.

It was noted with concern and some frustration that enforcement of and compliance with existing measures remains imperfect.

The NPHET reflected on whether enough has been done to optimise and enforce the measures currently in place for sectors before progressing with closures, such as adequate social distancing and more stringent implementation of the COVID Pass cross-checked with ID. It was recalled that the NPHET has previously recommended increased enforcement of existing measures. The conclusion was reached that an approach of stressing better enforcement in the absence of additional measures would be insufficient to flatten the curve at this point in time.

**Hospitality and organised indoor events/gatherings**

With regard to the proposed earlier closing time for hospitality and organised indoor events/gatherings from 5pm daily, the following points were made by Members:

- Some Members noted that the early closing time may appear arbitrary, however, it was emphasised that the measure itself is targeted and the purpose is clear: to reduce socialisation in higher risk settings. On balance, it was felt that a 5pm closing time would provide a clear cut-off point and a distinction between day- and night-time trade. It was noted that communications should clearly state that this measure is focussed on reducing the opportunities for the virus to spread and ultimately reducing the overall risk of infection at a societal level.

- While there was agreement ultimately on the advice as set out in the Action Points, there were differing views expressed during the discussion. Some Members voiced concern about the 5pm closing time for the hospitality sector. Various reasons were cited for this. Some felt that the imposition of strict measures
of this type was disproportionate by international comparison, others favoured a later closing time and stressed that 5pm closure would preclude some families from engaging in evening time festive events (pantos etc.) to the detriment of social cohesion, while others were of the opinion that the focus should be on reducing capacity within venues rather than limiting trading hours.

- Members noted the importance of hospitality settings in providing an opportunity to socialise and the impact this has on wellbeing, in particular for those at risk of isolation and that this needs to be factored into considerations.
- On balance, it was felt that this measure is consistent with messaging to reduce social contacts while allowing for a level of personal responsibility and risk assessment.
- Consensus was reached on the proposal as set out within the Action Points below. It was agreed that the situation would be kept under close review by the NPHET and any advice, if adopted by Government, would be subject to review should new evidence emerge in the intervening period.

**Household gatherings**

- Members did not favour additional restrictions on households.
- It was felt that any further restrictions in this regard would be disproportionate, given the overall efforts by the public to alter their behaviours in recent weeks to bring Delta transmission below 1.
- Members supported strong communications around safe household gatherings. People should try to reduce their contacts as much possible in the days and weeks ahead. Keep groups small and try to meet the same people regularly rather than meeting people from multiple different households. Visits to private homes should be kept to a maximum of three other households, recognising the need for some flexibility depending on individual circumstances. In general, people are advised to keep gatherings small and to take particular cognisance of protecting those aged 50 years and older and those with underlying conditions who may not yet have received their booster vaccine. Those who are meeting regularly with people from other households should regard this as high risk and should therefore consider using antigen tests twice weekly and before they socialise with others (including immediately prior to gatherings over the Christmas and New Year period).

**The Education sector**

- It was agreed that no changes to the school holidays should be recommended at this time, given the priority of maintaining continued access to education and the protective measures already in place in schools and other educational settings.
- The NPHET recalled the closure of schools across the country from January 2021 to March 2021, as a result of a sharp deterioration in the epidemiological situation following last year’s festive period. The need for immediate action now on additional public health measures to avoid having to take such drastic measures once again after the festive period was reiterated.

**Healthcare workers**

- It was queried whether anything further could be done to support healthcare workers.
- It was stressed that modelling for healthcare workers is needed for the coming weeks. It was noted with concern that large numbers of healthcare workers are unable to attend work at present and that a number of GP practices have had to close due to staff shortages in recent weeks. The protection of the country’s healthcare workforce was emphasised as a key consideration regarding the imposition of further measures.

**Other measures**

- Members agreed that there should be an appropriate limit on the number of attendees at weddings if they are to proceed. The higher risk of transmission and potential for super spreading events in the context of the Omicron variant informed the NPHET’s considerations in this regard.
- Members agreed that it be recommended to limit attendance at organised outdoor events/gatherings to 50% capacity or 5,000 attendees (whichever is the lower number), along with robust protective measures including mask wearing.
• In relation to the COVID Pass system, and acknowledging the impact of Omicron, it was noted that NPHET will give consideration to the application of expiry dates for primary vaccination and the inclusion of booster doses in the COVID Pass for domestic use at a forthcoming meeting. It was noted that there are ongoing discussions at EU level on these matters in relation to the Digital COVID Certificate (DCC) and travel.

• It was noted that operational and logistical work is ongoing regarding the application of a medical exemption to the COVID Pass system for those who cannot fulfil vaccine requirements. Members acknowledged that this is a significant issue for the small group of people concerned.

• It was noted that the NPHET will discuss the issue of mandatory vaccination at a later date and this discussion will be facilitated by a forthcoming paper from the DOH on the relevant ethical and legal considerations pertaining to this topic.

Vaccination and boosters
• Members underscored the importance of those who are eligible for a first, second or booster dose, availing of it as soon as it is available to them.

• Members expressed concern about waning immunity and the as yet uncertain duration of protection provided by booster vaccination with regard to the Omicron variant. Concern was expressed that if emerging evidence is found to be correct, those who are most at risk may need an additional booster dose in a number of weeks’ time. It was stressed that emerging data should be kept under very close review.

• It was stressed that care should be taken when interpreting emerging international data regarding the potential waning of immunity post booster vaccination. It was asserted that it would be imprudent to suggest on this basis that further measures would not be worthwhile at this time even if the data were to show that booster immunity wanes at a quicker rate than the primary course of vaccination. On this point, it was stressed that vaccination and booster vaccination remain crucially important.

• It was noted with concern that there is a risk that vaccination could lead to complacent behaviour with regard to NPIs. This risk should be borne in mind in targeting communications.

Testing
• It was stressed that people who have recovered from COVID-19 should be tested on admission to hospital given the potential for reinfection in the context of Omicron.

• The HSE confirmed that advice had been given that those who had recovered from COVID-19 in the past 9 months should no longer be exempted from a requirement for testing on admission to hospitals on a HSE-ARMIC teleconference on 15th December. The text for hospital guidance in this regard is currently being updated.

Whole-genome sequencing
• The importance of whole-genome sequencing was stressed, noting Denmark’s investment in same and its resultant greater available data on Omicron. It was suggested that sequencing capacity in Ireland should be increased and should focus on the hospital population.

• The NVRL confirmed that - given the current caseload, and in keeping with ECDC guidance, the available sequencing capacity would allow the surveillance programme to detect a novel variant at a prevalence of 1% in the population. As the prevalence of s-gene target failure was 0.3% in October and November and had increased to 12% over the past 10 days. The NVRL confirmed that the HPSC would be in a position to provide details of Ireland’s first Omicron case by date of sequence.

• Notwithstanding the above, the NVRL informed Members that in light of the time of year with reduced working days, and likely staff absences due to illness, with support of other labs already engaged with the national testing programme, whole-genome sequencing capacity has been increased by 33% since the last NPHET meeting on 2nd December. This is intended primarily to introduce resilience into the surveillance programme. Capacity is available to hospital cases as necessary and these cases can be
prioritised. The HPSC is also working with the assistance of EU funding to build up whole-genome sequencing capacity at 6 acute hospital labs within the first quarter of 2022.

Communications

- The NPHET noted the various communications campaigns that are currently underway as summarised by the DOH.
- Members emphasised the need for communications to be specific, clear, and targeted, noting the importance of consistency and coherency to facilitate the public’s compliance with measures.
- Members expressed the need to stress unity, social cohesion, and promote solidarity in messaging and to thank the Irish public for the sacrifices they have made.
- It was stressed that communications should seek to maximise adherence to NPIs and optimise utilisation of all other tools at our disposal (PCR testing, antigen testing, masks etc.).
- The need for clear messaging outside vaccination centres was highlighted, in particular concerning eligibility for vaccination.
- It was stressed that communications should address any lack of awareness in the general public regarding what is facing them in the coming weeks. The public needs to understand what is meant by flattening the curve in terms of protecting both the health system and essential services. Presenting to the public the various modelling scenarios in terms of impact on the health system and education sector was noted as important in this regard.
- It was emphasised that communications should address the unhelpful narrative that has arisen in recent days that the Omicron variant is less pathogenic; it must be stressed that sufficient evidence is simply not yet available to reach such a conclusion. It was acknowledged that messaging around this issue is complex.
- The DOH confirmed in response to a query that antigen testing has now been incorporated into the ‘layer up’ campaign.

Timing of measures

- The NPHET agreed that recommended measures should commence as soon as possible but no later than midnight on Sunday 19th December, subject to Government decision and with due regard for requisite legislative or regulatory amendments.
- The NPHET noted that the measures recommended on 2nd December were to remain in place until 9th January 2022, however, with due regard for the points noted during today’s discussion, and particularly the uncertainty regarding the virulence of Omicron and the peak in infections expected in the middle third of January, the NPHET agreed that the recommended measures should remain in place until 30th January 2022.
- Given the current uncertainty regarding the trajectory and characteristics of the Omicron variant and in line with the procedural value of responsiveness, it was deemed important that public health advice would be kept under close review, with the potential for revising advice should further evidence become available.

The Chair thanked the NPHET Members for their contributions, confirmed that a consensus had been achieved, and that the NPHET’s agreed recommendations would be communicated to the Minister for Health and Government in the usual manner.

Action Point:

For the reasons cited above, and in line with advice outlined above from ECDC, WHO and the EU Health Security Committee, the NPHET strongly advises the continued adoption of a proactive and precautionary approach. In addition, the NPHET recommends the early introduction of additional measures to slow down the spread of the Omicron variant while the booster programme advances, and its full impact can take effect.

Given the likely magnitude and speed of Omicron transmission over the coming weeks, the objective of the measures below is to protect the most vulnerable and to flatten the curve of this projected wave to
protect the core functioning of essential services by minimising synchronous absenteeism (i.e. large numbers of people missing from the workplace at the same time) in particular in health and social care, education and childcare systems.

The NPHET acknowledges that additional measures will impose a further burden on certain sectors and also on society more generally. The measures outlined below are intended to reduce the volume of social contacts, especially in higher risk settings which present super spreader opportunities and those that involve inter-household and intergenerational mixing. The NPHET recommends that the following additional measures should be considered by Government:

- **All restaurants and bars, excluding take-away or delivery services, should close at 5pm. This should also apply to hotel restaurants and bars, except for overnight residents.** These reduced operating hours will significantly lessen the substantial volume of high-risk social contact taking place in these settings. The NPHET recognises that closing hospitality at 5pm will result in some element of displacement of socialisation into private households. However, this displacement is likely to result in substantially less social contact overall than would occur in restaurants and bars operating as they do at present. All existing legal requirements and guidelines applicable to restaurants and bars should be fully implemented during these reduced hours.
- **There should be no indoor events, including entertainment, cultural, community and sporting events, after 5pm in line with advice above for the hospitality sector.** In relation to events happening earlier in the day, **attendance should be limited to 50% of venue capacity or 1,000 attendees, whichever is the lower.** There should also be strict application of the full range of protective measures. In particular, the reduction in attendance should be used to maximise physical distancing in venues (i.e. attendees should not be seated together in a portion of the venue), and masks should be worn during performances.
- **Attendance at outdoor events, including entertainment, cultural, community and sporting events, should be limited to 50% of venue capacity or 5,000 attendees, whichever is the lower.** In addition, there should be robust implementation of the full range of robust protective measures, including mask wearing.
- **There should be an appropriate limit on the number of attendees at weddings if they are to proceed.** The higher risk of transmission and potential for super spreading events with Omicron should inform these considerations.
- The NPHET reiterated its advice on workplaces that **employers should accommodate employees to work from home where their attendance on site is not essential.**
- **Full implementation of all previously advised protective measures across all sectors, including retail, public transport and religious services.**
- In the coming days, **specific public health advices will be provided to support people in gathering safely over the Christmas/New Year period.** This will cover the range of advices set out earlier, including that people may consider the use of an antigen test in advance of visiting other households over the coming weeks.

- **Restricted movement advice for all close contacts** (regardless of primary vaccination status) should be enhanced as follows:
  - For those that have received a booster (effective from one week after receiving the booster dose): Restrict movements for 5 days with 3 antigen tests.
  - For those that have not received a booster (including those not fully vaccinated): Restrict movements for 10 days. The HSE will be asked to consider the most appropriate testing schedule for this cohort.

  It was noted that there are specific arrangements already in place for healthcare workers that are close contacts and that this will continue.
- **No changes are advised in relation to school holidays.**

The NPHET advises that these measures should be implemented as soon as possible, and in any event no later than midnight on Sunday, 19th December. The NPHET recommended that the above measures remain
in place until January 30th, however given the current uncertainty regarding the trajectory and characteristics of the Omicron variant and in line with the procedural value of responsiveness, it was deemed important that public health advice would be kept under close review, with the potential for revising advice should further evidence become available.

7. Vaccination update

a) Vaccine Safety Update

The HPRA provided a verbal update 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 9th December (Report #14) which includes more details regarding the type and nature of reported reactions. The next report will be published on 20th January 2022. The HPRA also provided a brief update on the work that is ongoing at EMA on treatments for COVID-19.

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

8. Meeting Close

a) Agreed actions

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

b) AOB

The Chair referenced correspondence from the Minister for Health received on 15th December, noting that the NPHET had discussed and agreed on the specific issues outlined by the Minister as priorities.

The Chair restated his opening message regarding the importance of maintaining confidentiality post-meeting on the NPHET’s discussion in general and the agreed action points in particular. The Chair reiterated that the Minister of Health and Government should be briefed on the outcomes of today’s meeting without external speculation.

The Chair acknowledged the work of the Department of Health’s NPHET Policy and NPHET Secretariat Units in supporting the functioning of the NPHET.

The Chair wished those in attendance a happy and peaceful Christmas, thanking everyone for their support throughout the year.

c) Date of next meeting

The next meeting of the NPHET is scheduled to take place on 6th January 2022.