

National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Thursday 6 th January 2022, (Meeting 99) at 10:00
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference¹	<p>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH</p> <p>Prof Philip Nolan, Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)</p> <p>Dr Cillian de Gascun, Laboratory Director, NVRL</p> <p>Dr Mary Favier, Past president of the ICGP, Covid-19 advisor</p> <p>Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital</p> <p>Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital</p> <p>Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH</p> <p>Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway</p> <p>Ms Rachel Kenna, Chief Nursing Officer, DOH</p> <p>Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH</p> <p>Dr Colette Bonner, Deputy Chief Medical Officer, DOH</p> <p>Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH</p> <p>Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)</p> <p>Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI</p> <p>Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA</p> <p>Ms Yvonne O’Neill, National Director, Community Operations, HSE</p> <p>Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH</p> <p>Dr Breda Smyth, Public Health Specialist, HSE</p> <p>Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE</p> <p>Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)</p> <p>Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)</p> <p>Prof Mary Horgan, President, RCPI</p> <p>Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;</p> <p>Mr Liam Woods, National Director, Acute Operations, HSE</p> <p>Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital</p> <p>Dr John Cuddihy, Interim Director, HSE HPSC</p> <p>Dr Darina O’Flanagan, Special Advisor to the NPHET</p> <p>Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications</p> <p>Dr Lorraine Doherty, National Clinical Director Health Protection, HSE</p> <p>Dr Colm Henry, Chief Clinical Officer, HSE</p> <p>Ms Deirdre Watters, Communications Unit, DOH</p>
‘In Attendance’	<p>Dr Desmond Hickey, Deputy Chief Medical Officer, DOH</p> <p>Ms Aoife Gillivan, Communications Unit, DOH</p> <p>Ms Sinéad O’Donnell, Communications Unit, DOH</p> <p>Ms Ruth Barrett, NPHET Policy Unit, DOH</p> <p>Ms Laura Casey, NPHET Policy Unit, DOH</p> <p>Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH</p> <p>Mr Ronan O’Kelly, Health Analytics Division, DOH</p> <p>Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE</p> <p>Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH</p> <p>Ms Pauline White, Statistics & Analytics Unit, DOH</p> <p>Ms Elizabeth McCrohan, Statistics and Analytics Unit, DOH</p> <p>Mr Vincent Colgan, Office of the Chief Medical Officer, DOH</p>
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Mr Liam Hawkes, Ms Fiona Tynan, Ms Emily Kilroy, DOH
Apologies	

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

No apologies were received for this meeting.

Minutes of previous meetings

The minutes of 16th December 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.

c) Matters Arising

In his opening remarks, the Chair wished Members a happy New Year, briefly referred to the continued close monitoring of the epidemiological situation, and noted the public health measures the Government had put in place until 30th January 2022. The Chair confirmed that the NPHET would meet in advance of this date to provide updated advice to the Minister on what measures might be required into the future.

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 current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing.

Due to anticipated large volumes of case numbers over the current period, from 22nd December 2021, the daily case number reported has been based on positive SARS-CoV-2 results uploaded to the HSE COVID Care Tracker the preceding day. These data are provisional and do not represent notified cases. The data presented were as follows:

- A total of 136,960 confirmed cases have been reported in the 7 days to 5th January 2022 (cases notified to midnight 4th January 2022), which is an 83% increase from last week when 74,931 cases were reported in the 7 days to 29th December 2021, and a 363% increase compared to the week prior to the last NPHET meeting on 16th December 2021 when there were 29,595 cases reported.
- As of 5th January 2022, the 14-day incidence rate per 100,000 population is 4,450 (its highest value to date); this compares with 2,342 a week ago, and 1,315 in the week prior to the last NPHET meeting on 16th December 2021. The 14-day incidence rate, at 4,450 per 100,000, is 2.9 times higher than the highest level observed in January 2021 (1,531 in January 2021).
- Given the 7-day cumulative incidence of 2,876 per 100,000, allowing for constraints on testing and undetected infections, the likely population prevalence of active SARS-CoV-2 infection is 5.7%-9.6%; between 1 in 10 and 1 in 20 of the population are likely to be infected.
- Nationally, the 7-day incidence per 100,000 population as a proportion of 14-day incidence per 100,000 population is 65%, demonstrating that there have been considerably more cases in the last 7 days, 30th December 2021 – 5th January 2022, compared with the preceding 7 days, 23rd – 29th December 2021.
- The 5-day rolling average of daily cases is 19,259 as of today, a 349% increase from that reported at the last NPHET meeting on 16th December (4,294).
- Of the 124,682 cases notified in the 14 days to midnight 4th January 2021, 79% have occurred in people under 45 years of age; and 4% were aged 65 years and older. Incidence is high across all age groups, and while lower and rising more slowly in older age groups, incidence exceeds that seen in December 2020, and in most age groups is higher than at any time in the pandemic.
- The positivity rate in public health laboratories is markedly elevated (60%). The positivity rate in hospital laboratories (19%) is also exceptionally high, higher than at any point since April 2020 when it was 20-25%.

- From 29th December 2021 – 4th January 2022, there have been approximately 272,308 laboratory tests reported in community, private, and acute laboratories. The 7-day test positivity rate in the community has significantly increased from 17.4% at the last NPHET meeting to 60.5%.
- Test positivity is increasing across all age groups, with test positivity rates greater than 50% in those aged 5-54 years. Test positivity has also increased in those aged 65 years and older in recent weeks.
- The Test and Trace system is now operating at surge capacity and is under severe pressure. The demand for testing has been particularly high amongst those aged 19-44 years. Clinical prioritisation is in place to ensure that those most in need receive access first. The HSE has increased testing capacity to 650,000 tests per week. PCR testing capacity is at 300,000 per week and antigen testing capacity has increased to 350,000 per week.
- According to the Contact Management Programme (CMP), from 27th December 2021 – 2nd January 2022, the total number of close contacts was 229,113, an increase of 123% on 102,754 in the previous week. The average number of cases managed per day increased from 9,200 to 18,367, an increase of 99% over the same time period.
- For close contacts created the week ending 19th December 2021, PCR Test 1 results were available at the time for 12,281 close contacts; 2,426 (19.8%) of these had a positive result. PCR Test 2 results were available for 2,274 close contacts, 407 (17.9%) of these had a positive result.
- The mean number of close contacts per case (including cases with zero close contacts) for the week ending 2nd January was 2.6, an increase from 2.4 the previous week (week ending 26th December). The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 2nd January was 3.3, an increase from 3.1 the previous week.
- There were 941 confirmed COVID-19 cases in hospital on the morning of 6th January, compared with 619 last week on 30th December, and 443 at the last NPHET meeting on 16th December.
- There have been 153 newly confirmed cases in hospital in the 24 hours preceding this morning. There has been an average of 139 newly confirmed cases in hospital per day over the last 7 days. According to the latest HSE data on hospitalisations and vaccinations, as of 29th December, only 49% of hospitalised COVID-19 cases were fully vaccinated.
- There are currently 90 confirmed cases in critical care as of this morning, compared with 88 last week on 30th December 2021. There were 6 new admissions to critical care in the 24 hours preceding this morning. According to HSE data as of 28th December 2021, only 40% of COVID-19 cases in ICU were fully vaccinated.
- As of 4th January, 219 patients were in receipt of non-invasive ventilation/Continuous Positive Airway Pressure (CPAP) or High-Flow Oxygen in non-critical care settings, of whom 100 patients were COVID-19 cases.
- The number of cases of hospital acquired infection continues to be of concern. There were 36 hospital acquired COVID-19 infections in the week ending 26th December 2021, compared to 45 in the week ending 19th December, and 17 in the week ending 12th December.
- There has been a significant increase in laboratory confirmed COVID-19 cases amongst hospital staff. There were 704 laboratory confirmed COVID-19 infections in hospital staff in the week ending 26th December 2021, compared to 269 in the week ending 19th December, and 179 in the week ending 12th December. As of 4th January 2022, there were over 6,300 staff across acute hospitals and the National Ambulance Service absent due to COVID-19 (e.g. positive tests/symptoms, close contacts).
- As of 5th January 2022, there have been a total of 5,952 COVID-19 related deaths notified in Ireland. This is an increase of 40 notified deaths since the previous weekly update on 29th December 2021. To 5th January, 157 deaths had been notified which occurred in December 2021, 230 in November, 217 deaths in October, and 179 in September. The number of deaths per day appears stable; notification of deaths may be delayed over the holiday period.
- 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).
- As of 4th January 2022, S-gene target failure (SGTF) data (a proxy for Omicron) indicate that approximately 96% of new cases in Ireland are due to the Omicron variant (based on laboratory specimen date of 2nd January); this compares with 27% at the last NPHET meeting on 16th December 2021. As of 25th December 2021, 718 cases of Omicron have been confirmed through whole-genome sequencing (WGS) in Ireland.

- 14 laboratory confirmed influenza cases, 12 influenza A (1 AH3 and 11 A not subtyped), and 2 influenza B were notified to HPSC during week 51 of 2021. No laboratory confirmed influenza cases were notified during week 52 of 2021. 37 laboratory confirmed influenza cases have been notified during the 2021/2022 season (weeks 40-52 of 2021): 31 influenza A (25 influenza A-not subtyped and 6 influenza A(H3)) and 6 influenza B. There were 55 RSV notifications in week 52 of 2021, compared to 207 RSV notifications in week 51 of 2021. Influenza and RSV notifications data for weeks 51 and 52 should be interpreted with caution as reporting and testing levels were impacted over the Christmas and New Year holiday period. It is possible RSV notifications may increase in the following weeks.
- A range of mobility data suggest that mobility across a number of settings decreased significantly over the Christmas and New Year period.
- As of 5th January 2022, approximately 78% of those aged 60-64 years, 68% of those aged 50-54 years, and 49% of those aged 40-44 years have received an additional booster dose.
- COVID-19 mortality has remained relatively stable. It should be noted there has been a recent increase in outbreaks reported in settings with vulnerable populations and this is being closely monitored.

Outbreaks for week 52 (26th December 2021 – 1st January 2022) are based on those reported up to midnight on 1st January 2022.

In week 52, there were a total of 44 COVID-19 outbreaks notified. Due to the extended Christmas weekend in week 52, and the surge in case numbers, there may be a delay in reporting of outbreaks to the national surveillance system (CIDR). Therefore, the number of outbreaks reported for week 52 may be an underestimate. In addition, due to a technical issue and reduced processing over the extended weekend, the processing time of case notifications on CIDR has increased.

Healthcare setting outbreaks:

- There were 7 new nursing home outbreaks and 1 new community hospital/long-stay unit outbreak notified in week 52. The case range of these outbreaks was 1-17 cases. According to preliminary data for week 53 (week beginning 2nd January), there have been 19 nursing home outbreaks and 3 community hospital outbreaks notified to 5th January.
- There were 8 new acute hospital outbreaks notified in week 52, with a range of 2-5 cases. According to preliminary data, there have been 16 new hospital outbreaks notified in the epidemiological week beginning 2nd January.
- There were 22 new outbreaks reported in residential institution settings (12 in centres for disabilities, 2 in direct provision centres, 2 in mental health facilities, 2 in children's/TUSLA residential centres, 2 in homeless facilities, and 3 in 'not specified' facilities) in week 52, with a range of 2-8 cases. According to the latest preliminary data for week 53 (week beginning 2nd January), there were 17 new residential institution outbreaks notified to 5th January.
- There was 1 new outbreak in 'other healthcare services' in week 52.

Outbreaks associated with school children and childcare facilities:

- There was 1 outbreak newly reported in a childcare facility in week 52.
- There were 2 new outbreaks associated with schools notified in week 52 (1 in a primary school and 1 in a special education school), with a range of 0-4 cases.

The current epidemiological assessment indicates that the recent increase in incidence and hospitalisation has not as yet translated into increased critical care admissions or mortality, with potential contributory factors including the age profile of recent cases, the protection conferred by immunity (both vaccine-induced and natural) in preventing or delaying progression to severe disease, and lower intrinsic virulence of Omicron compared with previous variants.

In summary, the overall epidemiological situation in Ireland continues to give rise for concern, noting however, some initial positive indications in terms of markers of disease severity which will continue to be closely monitored over the coming days and weeks. This summary shows that the profile of the disease, over the past three weeks, is broadly in keeping with the modelling projections presented to the NPHE at its

meeting of 16th December 2021. The NPHET agreed, therefore, with the exception of those outlined in the Action Point under agenda item 4(a) below, that the measures the Government has put in place until 30th January 2022 should be maintained until that date, and that no additional measures are indicated at this time.

The HPSC informed the NPHET that there have been 12 confirmed cases of influenza, with 10 cases of influenza A, and 2 cases of influenza B notified. The HPSC noted the number of influenza AH3 cases as the subtype is known to predominantly affect older adults in terms of disease severity and risk of hospitalisation. The HPSC also noted that 715 COVID-19 referrals were reported through the GP Sentinel surveillance system last week. SARS-CoV-2 positivity was 6% in week 50 (13th – 19th December 2021). However, this increased to 50% in week 51 (20th – 26th December 2021), and over 60% in week 52 (27th December 2021 – 2nd January 2022).

Modelling

The IEMAG confirmed Omicron's anticipated path to dominance since the last NPHET meeting of 16th December and noted that case numbers are in line with its model's more pessimistic projections. The IEMAG stated that it is difficult to estimate when the peak of this wave will be reached but it is expected that it will be a shorter spike than that experienced in preceding waves. The IEMAG stressed that it is still too early to tell how case numbers will translate into hospitalisations, although there are some grounds for optimism; more time will be required to discern the impact. The IEMAG cautioned that we must remain cognisant of the delays between the increase in cases and the subsequent increase in hospitalisations, as observed in previous waves. At present, hospitalisations are tracking a central scenario outside critical care, with cases coming 4-5 days later than estimated. Cases in critical care are tracking well below the optimistic scenario but such delays may also be a factor in this regard. The IEMAG stated that the models predict that cases will decrease to 10,000 per day by the end of January; however, this assumes that people will continue to limit their social contacts. If people increase their contacts, the peak of the wave could spread out over time.

The AMRIC noted a significant change in recent data, with an increase in the number of COVID-19 cases in acute hospital staff, with over 1,800 acute hospital staff diagnosed with COVID-19 in the week ending 2nd January, with some sites not yet reported. While it is difficult to determine where these infections are acquired, the clinical sense is that most of this infection is related to high levels of community transmission rather than workplace exposure.

The HSE informed the NPHET that staff absences, with an estimated 8,000-9,000 absences expected to be reported in the coming days, are impacting the provision of hospital services. The HSE also noted that there is some variation in how some COVID-19 related hospital data are captured and characterised by the different hospital groups. The HSE confirmed that work is currently underway to improve the recording system so that a more accurate picture of COVID-19 in hospitals can be obtained.

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. The key points are summarised as follows:

- Animal studies appear to support the assertion that Omicron is less virulent than preceding variants, with fewer symptoms, less weight loss, and a quicker drop in viral load reported.
- There is evidence from different labs to suggest that Omicron is very capable of replicating more efficiently than other SARS-CoV-2 lineages in the upper respiratory tract and nasal epithelium, but not as efficiently in lung tissue, which provides a plausible narrative as to why it could be more transmissible yet causing milder illness (although this is yet to be confirmed).
- Omicron has changed the mechanism by which the virus enters host cells, potentially giving up some of its pathogenicity for increased transmissibility. However, further data is needed to confirm this.
- Based on contact tracing data in the context of Omicron, UK colleagues are noting that while the median serial interval is slightly reduced – 3.5 days to 3.1 days – it is marginal, and no significant change has been observed in the mean. However, there are limitations to the data as cases within the first two days are excluded (household contacts).

- Of note, despite the reduced median, a higher variance is being observed with Omicron. This means that if RNA remains detectable after 7 days, then those cases are more likely to be Omicron.
- UK colleagues have noted that it is becoming increasingly challenging to define a COVID-specific symptomatology, with symptoms no longer specific enough to distinguish from other respiratory viruses. For example, they report a significant reduction in the number of cases reporting anosmia/ageusia.
- While there has been some evidence that the growth advantage of Omicron can be attributed to vaccine escape, the virus also has an infectivity advantage. However, infectivity does not necessarily equate with transmissibility. There is currently an absence of definitive evidence of a transmissibility advantage for Omicron from laboratory studies; it will be some time before the reasons for Omicron's growth advantage can be elucidated.

The Chair thanked the DOH, the HPSC, the IEMAG, the HSE, and the NVRL for their respective inputs and invited comments and observations from the NPHET Members, key points raised are summarised below:

General Discussion

- The NPHET noted the emerging encouraging data that Omicron may be a milder disease than Delta at individual level, while cautioning that more time is needed to have confidence in this regard.
- It was queried whether it would be possible to model expected cases (infection and hospitalisations) to mid-February 2022 at this point in time. In this regard, it was noted that various therapeutics will become available over the coming weeks, but supplies will be limited at the outset and priority groups will need to be identified; modelling will assist with this process.
- It was noted that the experience of clinicians in recent weeks appears to support assertions that infection with Omicron results in a milder disease. On this point, it was noted that there is some emerging evidence that the symptomatology of the disease has changed with Omicron, becoming milder with a quicker turnaround time and less oxygen dependency.
- It was noted that as children and students return to school and third-level education after the Christmas break, having engaged in activities associated with the break, transmission is likely to increase over January. It is essential that messaging on the importance of booster doses is reinforced for students and for those travelling abroad.
- It was noted that GPs have reported a substantial reduction in demand for testing referrals from patients over the past week; this change coincided with the change in testing criteria. GPs are also reporting a notable change in the age profile of COVID-19 patients, with increasing numbers from older age cohorts presenting, a potential impact of intergenerational mixing over the Christmas period. GPs are seeing less patients who are very sick from COVID-19. There is some concern among GPs that people may decrease their adherence to NPIs and public health measures as the message that Omicron is a milder form of COVID-19 becomes embedded; communications will need to address this risk.

Hospitalisations

- With regard to hospital admissions, it was noted that the experience on the ground appears to indicate that of the patients who are admitted with COVID-19, COVID-19 is incidental for approximately half of those admissions, i.e. COVID-19 is not the primary reason for admission. If patients have been vaccinated prior to admission, their COVID symptoms appear to be less severe, with quicker turnaround times, and less need for oxygen support.
- Members highlighted that an analysis of the data on COVID-19 hospitalisations in the context of the Omicron variant is necessary.
- The need for age-specific hospitalisation data was also noted. Attention was drawn to emerging international reports on paediatric hospitalisations and it was emphasised that this should be closely monitored over the coming months given that younger children remain unvaccinated, and that the Omicron variant may be capable of causing significant levels of infections in younger age groups, particularly in those aged 0-4 years. On this point, however, it was highlighted that reports from UK suggest that the increase in paediatric hospitalisations in school age children is more likely to be a

reflection of increased community transmission than the likelihood of Omicron causing greater hospitalisation in children.

- With regard to ICU admissions, a comparison was drawn between the rates of change in ICU admissions from last year to this year. On 4th January 2021, there was a net positive change of 20 ICU admissions per day; we are not seeing such figures now.
- It was noted that the UK has not seen an upswing in ICU admissions, which is reassuring given that the UK is tracking 1 to 2 weeks ahead of Ireland in this current wave.
- To further inform future decision making and allow for better interrogation and analysis of hospital admissions with COVID-19, it was agreed that a report will be prepared with input from the HSE and Department of Health in advance of the next NPHEt meeting. This will allow for a better understanding of the severity of the Omicron variant, the impact of vaccination and boosters, and other important measures of the impact of COVID-19 on the health system.

Testing

- Concern was raised that the difficulties in providing a clinical case definition for the Omicron variant may impact on testing capacity. In this regard, it was stressed that testing capacity will need to be preserved for those who would benefit from therapies that are due to become available in the coming weeks (i.e. those at severe risk for disease progression). The non-specificity of COVID-19 symptoms in the older population in particular was highlighted in this context.
- It was noted that hospitals are continuing to actively detect cases of hospital-acquired COVID-19. At present, the clinical impression is that severe disease is rare in vaccinated patients who acquire COVID-19 within the hospital setting.
- The increased burden on resources with regard to active case-finding and resulting infection prevention and control management in hospitals in the context of the current transmission rate was emphasised. There is a significant shortage of lab personnel within hospitals at present to manage the current onerous testing requirements. It was suggested that a longer-term plan for COVID-19 testing and contact management should be considered if emerging data confirms that infection with Omicron leads to less severe cases.
- Concern was expressed that whole-genome sequencing is not carried out in the context of healthcare worker community acquired COVID-19.
- It was noted that the approach to surveillance is currently being considered at EU level. The WHO is also giving consideration to this matter.
- It was noted that the ECDC is expected to publish updated guidance on the public health management of cases and contacts in the coming days. Updated advice will be provided to the Minister thereafter as appropriate.
- It was queried whether the pathogenicity of Omicron would change the modality of diagnostic testing and whether an alternative testing methodology would be suitable in this context.
- With regard to antigen testing, it was noted that the Minister had accepted a recommendation from the CMO that antigen testing results be accepted in their own right without the need for confirmatory PCR testing. It was noted that it will take some time for this change to be operationalised by the HSE. It was clarified that a dual reporting system is intended. PCR testing will be preserved for higher risk groups and for those who may be suitable for COVID-19 therapies.
- It was noted that the inclusion of QR codes on antigen tests would be useful for tracking purposes. However, it was also noted that, given the growing demand for these tests, this may be difficult to achieve at manufacturing sites.

The Chair thanked Members for their contributions and noted the NPHEt's conclusion that while the early data are encouraging, more time will be required before the NPHEt will be in a position to provide updated advice. The Chair confirmed that emerging evidence will continue to be monitored closely for another two weeks, at which point the NPHEt will reconvene to provide updated advice to the Minister on public health measures in place.

3. HIQA – Expert Advisory Group

a) Omicron Emerging Evidence – Update

The HIQA presented the paper *“Update on international public health agency assessments of the evidence in relation to the Omicron (B.1.1.529) variant: 5th January 2022”*, for noting.

The paper provided an update to the rolling summary of scientific evidence in relation to Omicron which the HIQA had presented to the NPHEt on 16th December 2021. The update, due to time constraints, was limited to identifying and summarising assessments of the scientific evidence as published by public health agencies and authorities between 15th December 2021 and 4th January 2022. The update was presented under the following headings:

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

The Chair thanked the HIQA for its update and the NPHEt noted same.

b) International Responses to Omicron – Update

The HIQA presented the paper *“Rolling review of International Public Health Guidance in relation to the Omicron variant (B.1.1.529)”*, for noting.

The HIQA noted that changes in public health measures are being advised or taken internationally following the identification of the Omicron variant. The report provided a summary of all changes to mitigating measures from 26th November 2021, when the Omicron variant was declared a variant of concern. Changes to public health measures reflect efforts to reduce the ongoing risks posed by the Delta variant as well as the threat posed by Omicron.

The HIQA gave an overview of the key changes in international public health guidance observed up to 4th January 2022 since the previous version of its summary paper dated 15th December 2021. Due to time constraints, only the below seven measures were systematically reviewed for changes in this updated version:

- Social or mass gatherings;
- Schools and any other measures for children such as out-of-school activities;
- Business activities;
- Culture, leisure entertainment;
- Changes in infection, prevention and control measures;
- Face coverings;
- COVID Pass.

The Chair thanked the HIQA for its update and invited contributions from NPHEt Members, summarised as follows:

- It was commented that Ireland appears to be in a similar ‘holding’ position to other jurisdictions at present. Data analysed in the next fortnight will give greater clarity as to the true impact of the Omicron variant in terms of cases, hospitalisations, ICU admissions and deaths.
- When analysing the guidance in other countries, it was queried whether the term ‘fully vaccinated’ should be interpreted as having completed only a primary vaccination schedule, or as having completed a primary vaccination schedule and received a booster vaccine. The HIQA clarified that ‘fully vaccinated’ in this report means having completed only a primary vaccination schedule. It was noted that it is likely that Ireland is ahead of other countries in its booster vaccination rollout. Therefore, a universal change in the definition of ‘fully vaccinated’ to include booster vaccination may yet take some time.

The Chair thanked Members for their contributions and noted same.

4. Existing Policy

a) Use of Facemasks in the Context of Omicron

The DOH summarised previous advice as endorsed by the NPHET on 2nd December 2021 on the use of face masks and highlighted a number of significant interim developments and considerations regarding the recent spread of the Omicron variant, including: emerging international consensus on the protection offered by higher grade masks and updated AMRIC guidance of 23rd December regarding the use of respirator masks in respect of healthcare workers in patient facing roles and in respect of patients in hospitals. The DOH then outlined proposed changes to the existing face mask guidance for the NPHET's consideration.

Key points raised in the discussion are summarised below. The advice, as endorsed by the NPHET Members, is captured in the Action Point below.

- Some Members voiced concern about the proposed change in advice with regard to the use of respirator masks by the general public on the basis that:
 - a view that the evidence did not support the use of respirator masks by the general public as a useful intervention and that it would involve considerable cost was expressed
 - respirator masks can be difficult wear correctly; and fit testing is advised for their use particularly in healthcare and other occupational settings. Many wearers report that respirator masks are uncomfortable to wear for long periods of time and, therefore, may not be suitable for prolonged use by the general public. Experience to date in the healthcare setting is that respirator masks are poorly tolerated by some patients, particularly those with respiratory or cardiovascular conditions.
 - respirator masks do not work as effectively for people with facial hair - if respirator protection is required for people with facial hair, they need to be advised to use a powered air purifying respirator.
 - A change in advice may be difficult to implement and could exacerbate current face mask procurement challenges. The need to protect face mask supplies for frontline healthcare workers and vulnerable cohorts was particularly stressed. The costs associated with implementation of the proposed advice should also be considered.
 - Advising the use of respirator masks at this time could send a discordant message to the public, may unduly increase levels of anxiety, and may not be merited in the context of what appears to be a milder variant. It was questioned whether there is sufficient evidence to support the change in advice at this time.
 - The focus of advice should remain instead on the proper use of medical face masks with a provision that people are not precluded from using a respirator mask on the advice of their healthcare provider.
- The majority of Members supported the change in advice with regard to respirator masks on that basis that:
 - The risk we are managing has changed. The Omicron variant may result in less severe disease at the individual level but its effect on society is more severe due to its growth advantage. The use of respirator masks is merited in this context.
 - International bodies are increasingly recommending the use of respirator masks.
 - Fit testing of respiratory masks may not be necessary for the general public. While strict criteria around fit testing is necessary for use in high-risk settings such as hospitals, guidance can be provided to the public on how to fit check these masks for general use.
 - People should be afforded a choice of mask; the recommendation would not be mandatory. The advice could be reframed to make this choice clearer.
 - Procurement challenges is a separate issue to whether the use of respirator masks or medical grade masks should be recommended on public health grounds for certain cohorts.
- Members also stressed that targeted communications on the range of masks available on the market and their proper use should accompany the updated advice.
- Members acknowledged that the HSE should be afforded a period of time for operational planning to implement the updated advice.

Action Point:

While emphasising that respirator and medical grade facemasks must, in the first instance, be prioritised for use by healthcare workers and those in healthcare settings, and recognising that the HSE will need time to operationalise this advice, the NPHE recommends that:

- **Guidance and messaging should clarify that:**
 - all types of masks, including cloth masks, can significantly reduce community transmission if properly constructed, well fitted, and appropriately worn;
 - medical grade and respirator masks, if properly worn, offer greater protection than cloth masks;
 - anyone who wishes to wear a medical grade or respirator mask instead of a cloth mask should do so, so long as whichever mask they choose is well-fitting and worn properly.
- The HSE should develop targeted communications in line with international models to provide appropriate information and clear messaging to communicate and promote adherence to the current public health guidance on facemasks.
- As an additional form of protection for the wearer, individuals in medically vulnerable cohorts and older age groups (those 60s years and over) are currently advised to wear a medical grade mask when in crowded outdoor spaces or confined indoor spaces, including on public transport and in retail and healthcare settings. Some of these people may prefer to wear a respirator mask. When properly fitted and worn, a respirator mask may provide a higher level of protection against inhaling virus that may be valuable for people at higher risk.
- Ideally a respirator mask or, alternatively, a medical grade mask (not a cloth mask) should be worn by anyone:
 - with a confirmed COVID-19 diagnosis during their infectious period, OR
 - who has symptoms suggestive of COVID-19, OR
 - who is a household contact of a confirmed COVID-19 case, OR
 - visiting a healthcare setting or when visiting those who are vulnerable to COVID-19 in any setting.

5. Communications

a) Communications Update

The DOH and the HSE presented “Communications Update: 6th January 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 3rd January 2021, shows that:

- The level of worry remains at 5.8, similar to levels seen in March and April this year;
- 45% do not want more restrictions, 42% do;
- 45% of the population think government reaction to the current outbreak is appropriate, 40% think it insufficient, 15% think it too extreme;
- 26% visited hospitality last week. They report Covid passes checked by sector to be: 80% in cafés, 92% in restaurants, 75% in pubs;
- 56% of adults took an antigen test for COVID-19 last week (vs 27% on 20th December);
 - 87% of people with symptoms took an antigen test, 43% without symptoms also took an antigen test;
 - 13% were positive, 87% negative;
- 29% of adults had symptoms they thought might be COVID-19 in the last week;
 - 31% of all those with symptoms arranged PCR test, 60% self-isolated;
 - 87% with symptoms took an antigen test, 28% of these were positive and 97% of these isolated;
 - 13% with symptoms did not take an antigen test and 33% of them isolated;
- Of those with symptoms who took an antigen test and received a negative result, 18% arranged a PCR test, 51% self-isolated.

The DOH and HSE also advised that the following media campaigns regarding COVID-19 are on air:

1. HSE: Symptoms and testing;

2. HSE: COVID-19 Vaccines and booster invitations;
3. DOH: Young Adults – reduce your contacts;
4. GIS: Asses your risk – Risk, Venue, Symptoms and People.

The HSE added that longer-term communications planning for COVID-19 public health guidance and vaccination is ongoing, with particular focus on test and trace and boosters.

The Chair thanked the DOH and HSE for their updates and noted same and invited contributions from NPHEM Members, summarised as follows:

- The effectiveness and clarity of the GIS 'RSVP' campaign over the Christmas period was noted by Members.
- Members noted that the anticipated availability of effective therapeutics for treating COVID-19, while a positive development, will require clear communications around the specific utility of COVID-19 therapeutics as well as the need for ongoing commitment to the full suite of public health guidance.
- The need to communicate the benefits of vaccination and precisely what vaccines are designed to achieve was stated. While COVID-19 vaccines may not prevent milder upper airway infections, their effectiveness at preventing severe disease and deaths, as originally designed, should be highlighted on an ongoing basis to prevent the undermining of the vaccination campaign.

The Chair thanked Members for their contributions and noted same.

6. Vaccination Update

a) Vaccine Safety Update

The HPRC 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 NPHEM. A report was published on the HPRC website on 9th December 2021 (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 HPRC also provided a brief update on the work that is ongoing at EMA on treatments for COVID-19.

The Chair thanked the HPRC for its update and the NPHEM noted same.

7. Meeting Close

a) Agreed actions

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

b) AOB

The following points were raised under any other business:

- Members welcomed the news that updated Digital COVID Certificates will be issued to those who have received an additional vaccine dose over the coming week.
- Members noted once again that the ECDC is expected to publish updated guidance on the public health management of cases and contacts in the coming days. The Chair confirmed that this will be reviewed, and updated advice will be provided to the Minister accordingly.
- 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.

In his closing remarks, the Chair confirmed that the NPHEM intends to meet again on 20th January to give further consideration to, in addition to the usual agenda items, more detailed information on hospitalisation and the approach to managing the pandemic in the weeks and months ahead on the assumption that the early indicators of Omicron transmission and impact are maintained.

c) Date of next meeting

The next meeting of the NPHE is scheduled to take on 20th January.