National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Thursday 20th January 2022, (Meeting 100) at 10:00
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference[1]	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Prof Philip Nolan, Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) Dr Cillian de Gascun, Laboratory Director, NVRL Dr Mary Favier, Past president of the ICGP, COVID-19 advisor Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway Ms Rachel Kenna, Chief Nursing Officer, DOH Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion) Dr Máirín 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 Ní Bhriain, 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 Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE
'In Attendance'	Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Ms Sinead O'Donnell, 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 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
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Ms Fiona Tynan, Ms Emily Kilroy, Mr Ivan Murphy, Mr Liam Robinson
Apologies	Dr Colette Bonner, Deputy Chief Medical Officer, DOH Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital

[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 Colette Bonner and Dr Colm Bergin.

c) Minutes of previous meetings

The minutes of 6th January had been circulated to the NPHET in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.

d) Matters Arising

In his opening remarks, the Chair noted that the meeting would focus substantially on the discussion under Item 5(a) Future Policy and highlighted that any recommendations arising from this discussion on the ongoing management of COVID-19 would draw significant attention from the public and the media. The Chair emphasised that the NPHET's role is to provide evidence-based recommendations and to make clear the accompanying rationale for such decisions and underlined the importance of taking some time to hear all contributions in this regard.

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:

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 80,216 confirmed cases have been reported in the 7 days to 19th January 2022 (cases notified to midnight 18th January 2022), which is a 49% decrease from last week when 157,357 cases were reported in the 7 days to 12th January, and a 41% decrease compared to the 7 days to 5th January 2022 when there were 136,960 cases reported.
- From Friday 14th January 2022, individuals can register a positive antigen test result and upload details of their close contacts to a portal on the HSE website. Data on the number of positive antigen results uploaded to the portal the previous day are reported daily. A total of 25,635 positive antigen results were reported in the five days from 15th to 19th January, with 5,295 positive results reported on 19th January. All antigen test results are self-reported and not subject to validation.
- As of 19th January 2022, the 14-day incidence rate (PCR) per 100,000 population is 4,989; this compares with 6,181 a week ago, which was the highest incidence rate during the pandemic so far (12th January), and 4,450 at the last NPHET meeting on 5th January 2022. Incidence rates are likely to be underestimates. While incidence remains high, it is rapidly decreasing.
- Nationally, the 7-day incidence per 100,000 population as a proportion of 14-day incidence per 100,000 population is 34%, demonstrating that there have been considerably fewer cases identified through laboratories in the last 7 days, 13th – 19th January 2022, compared with the preceding 7 days, 6th – 12th January 2022.
- The 5-day rolling average of daily cases (PCR) is 8,849 as of 19th January, this is a 62% decrease from a peak of 23,432 on 10th January, and a 54% decrease from that reported on 5th January (19,259).

- The test positivity rate in public health laboratories (49.5%) remains high, but it is rapidly reducing; importantly, test positivity in hospital laboratories (13.4%), which is a biased but more stable sample of the population, is also reducing.
- From 12th January to 18th January 2022, there have been approximately 196,661 laboratory tests reported in community, private, and acute laboratories, which is down 28% from 272,308 at the last NPHET meeting (6th January). The 7-day test positivity rate in the community has significantly decreased from 60.5% at the last NPHET meeting to 55.2%.
- The Test and Trace system had been operating at surge capacity until the past weekend, when there was a significant drop in overall demand for testing.
- According to the Contact Management Programme (CMP), from 9th January – 16th January 2022, the total number of close contacts was 144,007, a decrease of 31% on 208,048 in the previous week. The average number of cases managed per day decreased from 23,544 to 16,214, a decrease of 31% over the same time period.
- For close contacts created the week ending 2nd January 2022, PCR Test 1 results were available at the time for 44,169 close contacts; 21,972 (49.7%) of these had a positive result. PCR Test 2 results were available for 3,721 close contacts, 581 (15.6%) of these had a positive result.
- The mean number of close contacts per case (including cases with zero close contacts) for the week ending 16th January was 1.9, an increase from 1.8 the previous week (week ending 9th January). The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 16th January was 2.0, an increase from 1.8 the previous week.
- There were 896 confirmed COVID-19 cases in hospital this morning, compared with 1,011 last week on 13th January, and 941 at the last NPHET meeting on 6th January. There have been 120 newly confirmed cases in hospital in the 24 hours preceding this morning. There has been an average of 122 newly confirmed cases in hospital per day over the last 7 days.
- As of 18th January, 56% of hospitalised cases were categorised as hospitalised for COVID-19, with the remaining 44% categorised as asymptomatic COVID-19 cases and potentially infectious.
- As of 18th January 2022, age breakdown of hospitalised cases: 374 (34%) aged 80 and older, 335 (30%) aged 65-79, 176 (16%) aged 50-64, 196 (18%) aged 15-49, and 27 (2%) aged 0-14 years old.
- According to the latest HSE data on hospitalisations and vaccinations, as of 18th January, 61% of hospitalised COVID-19 cases were fully vaccinated. Of these, 63% were recorded on COVAX as having received a booster/additional dose
- There are currently 89 confirmed cases in critical care as of this morning, compared with 92 a week ago (13th January 2022). There were 7 new admissions to critical care in the 24 hours preceding this morning. Of the 89 cases in critical care this morning, 61 were invasively ventilated.
- There has been a reduction in the absolute number of patients whose primary reason for admission to ICU was COVID-19, from a peak of 126 on 23rd November 2021, to 73 as of 18th January 2022.
- According to HSE data as of 18th January 2022, where vaccination status was known, 49% of COVID-19 cases in ICU were fully vaccinated, of whom 55% were recorded as having received a booster/additional dose.
- As of 18th January, 189 patients were in receipt of non-invasive ventilation/Continuous Positive Airway Pressure (CPAP) or High-Flow Oxygen in non-critical care settings, of whom 66 patients were COVID-19 cases.
- There continues to be a significant number of cases of hospital acquired infection (note this is based on data to the week ending 9th January 2022). There were 207 hospital acquired COVID-19 infections in the week ending 9th January 2022, compared to 137 in the week ending 2nd January, and 39 in the week ending 26th December.
- There has been a high number of laboratory confirmed COVID-19 cases amongst hospital staff (note this is based on data to the week ending 9th January 2022). There were 2,407 laboratory confirmed COVID-19 infections in hospital staff in the week ending 9th January 2022, compared to 2,266 in the week ending 2nd January, and 971 in the week ending 26th December.
- As of 19th January 2022, there have been a total of 6,087 COVID-19 related deaths notified in Ireland. This is an increase of 52 notified deaths since the previous weekly update on 12th January 2022. To 19th

January, 66 deaths have been notified which occurred in January to date, 196 in December 2021, 246 in November, and 224 deaths in October.

- As of 18th January 2022, S gene target failure (SGTF) data (a proxy for Omicron) indicate that approximately 97% of new cases in Ireland are due to the Omicron variant (based on laboratory specimen date of 16th January).
- According to the latest whole genome sequencing data in relation to B.1.1.529 (Omicron), as of 19th January, 2,227 BA.1 (Omicron), 4 BA.2 (Omicron), and 1 BA.3 (Omicron) cases had been confirmed in Ireland.
- 16 laboratory confirmed influenza cases were notified in week 2 2022 (10th-16th January 2022). There were 8 laboratory confirmed hospitalised influenza cases notified in week 2. In the 2021/2022 season to week 2 2022, notified laboratory confirmed influenza hospitalised cases have been predominately influenza A (not subtyped)/influenza A(H3), with the remainder influenza B.
- Respiratory Syncytial Virus (RSV) notifications in week 1 2022 (3rd-9th January): 45 RSV cases (37.8% aged 0-4 years; 26.7% aged ≥65 years) were notified during week 1 2022; 21 of these cases were reported as hospital inpatients (47.6% aged 0-4 years; 28.6% aged ≥65 years). As of week 1 2022, rhinovirus/enterovirus and other respiratory viruses continue to circulate, with coinfections of respiratory viruses reported.
- The SARS-CoV-2 positivity rate from sentinel GP COVID-19 referral specimens tested by the NVRL decreased from 61.6% in week 1 2022, to 51.2% in week 2.
- As of 19th January 2022, approximately 55% of the population aged 35-44 years, 44% of those aged 25-34 years, and 37% of those aged 18-24 years have received a booster/additional vaccine dose.
- A range of mobility data indicate that mobility across a number of settings increased significantly following the Christmas and New Year period.

Outbreaks for week 2 (9th– 15th January) are based on those reported up to midnight on 15th January 2022.

In Week 2, there were a total of 198 COVID-19 outbreaks notified. Due to the high case numbers, there may be a delay in reporting of outbreaks to the national surveillance system (CIDR) and the linking of cases to outbreaks. In addition, regional Departments of Public Health are currently prioritising Public Health Risk Assessments and outbreak investigations in settings that have the greatest clinical need or would benefit most from public health intervention. For this reason, outbreaks in some settings may be underestimated.

<u>Healthcare setting outbreaks:</u>

- There were 57 new nursing home and 4 new community hospital/long-stay unit outbreaks reported in week 2. The case range of these outbreaks was 5-47 cases. As of 19th January, there were 142 outbreaks in nursing homes and community hospitals reported in weeks 51 of 2021 to week 2 of 2022 (midnight 15th January 2022). There were 1,939 cases aggregately associated with these outbreaks, of which there were disaggregate data available on 413 cases. Of the 413 linked cases, 20 were hospitalised (4.8%) and 9 have died (2.2%). To note, there may be a lag in occurrence/notification of deaths for more recent cases. Availability of disaggregate data will increase as linkage of cases continues on CIDR.
- There were 33 new acute hospital outbreaks reported in week 2, with a range of 0-19 cases.
- There were 70 new outbreaks reported in residential institution settings (44 in centres for disabilities, 5 in direct provision centres, 5 in mental health facilities, 5 in children's/TUSLA residential centres, 3 in centres for persons with addictions, 3 in centres for older people, 2 in homeless facilities and 1 in a prison) in week 2, with a range of 1-33 cases.
- There were 12 new outbreaks in 'other healthcare services' (4 among clients of home care services, 5 in day services for people with disabilities, 2 among clients of mental health facilities and 1 in 'other' healthcare services), with a range of 0-5 cases.

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

- There were 3 new outbreaks associated with schools notified in week 2 (1 in a post-primary school and 2 in a special education school), with a range of 0-6 cases.

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

- There were 15 new outbreaks reported involving members of the Irish Traveller community in week 2, with a range of 0-6 cases.
- There were 2 new outbreaks reported involving members of the Roma community in week 2, with fewer than 5 cases.

In summary, the current epidemiological profile of COVID-19 provides a broadly positive outlook. While incidence data may be considered incomplete, a range of data indicate that incidence is high but rapidly reducing. Case counts are now estimated to be decreasing at a rate of 6% per day.

While there continues to be a significant number of outbreaks notified in vulnerable settings such as nursing homes, to date, available data including reports from public health teams, indicate that the burden of severe health outcomes appears reduced compared to previous waves of infection. There continues to be a significant number of hospital-acquired infections reported, though the clinical impression is that most cases of hospital-acquired COVID-19 are not severe and many are asymptomatic. Significant impact from COVID-19 on staffing levels has been observed across all areas of the health and social care system in recent weeks but this impact is beginning to decline as levels of infection in the community reduce.

Modelling

The IEMAG provided a presentation on the current modelling projections. The level of infection and force of infection in the population are past a peak and declining rapidly, and the demand for hospital treatment of more severe infection is also starting to decline.

The incidence of infection detected through PCR testing and self-reported antigen testing is an underestimate of the true incidence. Reasonable estimates of the extent of under-ascertainment are available, and at peak there were approximately 2-3 additional infections for each infection detected or reported. It is clear now that all markers of incidence are decreasing. This profile of incidence fits with the model scenarios generated at the onset of the Omicron surge.

It appears that Omicron evades immune protection from infection, at the higher end of the range of assumptions used in these models, and as such the number of detected infections has tracked the more pessimistic scenarios in terms of case numbers. However, vaccine protection against severe disease is well maintained, and the successful acceleration of the booster vaccination programme has increased this protection. This, along with Omicron being intrinsically somewhat less likely to progress to severe disease, means that serious adverse outcomes and mortality were much less than expected. This protection was graduated, in that vaccination greatly reduced hospitalisation once infected and further reduced admissions to critical care and mortality.

The number of hospital admissions per 1,000 reported cases has fallen from 15 admissions per 1,000 cases in November 2021 to 7 admissions per 1,000 cases now; prior to vaccination, in January 2020, it was 35-50 admissions per 1,000 cases. Furthermore, throughout the pandemic, approximately 12% of hospital admissions have progressed to require admission to intensive care; in recent weeks this has dropped to 5%. As a result, the number of people in hospital is following the more central scenario (and decreasing as expected within those scenarios) and the number of people admitted to critical care has only increased marginally in association with the surge of Omicron infection.

Force of infection is decreasing rapidly, but it is likely that the rate of decrease will slow, and there may be a period ahead where levels of infection increase again. As case numbers and numbers in hospital decline and the threat recedes, population mobility and social contact will increase, creating additional opportunities for viral transmission, a process which may be accelerated by an increase in social contacts following the relaxation of restrictions. Infections and detected cases may then stabilise or start to increase.

The HPSC referred to the data on Nursing Home outbreaks, as noted above under Healthcare Setting Outbreaks, and informed the NPHET that this data aligns with feedback received from Public Health department colleagues who have noted that the disease in Nursing Homes and Long-term Residential Care Facilities (LTRCFs) is much milder than seen in previous waves.

The HSE informed the NPHET that the biggest issue facing the HSE at the moment is staff absences due to COVID requirements, with the resulting pressures causing greater disruption to the provision of services. As the harm from Omicron infection has reduced, maintaining services to clients, particularly in nursing homes and long-term residential settings has become difficult.

The NVRL gave a brief update on the current assessment by colleagues in the UK Variant Technical Group. The key points are summarised as follows:

- While the BA.1 strain of Omicron is currently the dominant strain, many countries are reporting a rise in BA.2, notably Denmark, Sweden, and Singapore.
- Preliminary data indicate that BA.2 has a significant growth rate of 2.1 per week and is likely to be more transmissible than BA.1. For these reasons, the UK are going to declare BA.2 a Variant Under Investigation (VUI). However, the NVRL emphasised that this will be primarily for academic reasons in order to learn more about the variant and obtain greater surveillance information.
- From an epidemiological perspective, decreased fatality rates are being observed in Nursing Homes and care settings in the context of Omicron. Disease prevalence has decreased across all age groups but not in children. The UK is also tying prevalence to socio-economic index, with disease prevalence being highest in 10–19-year-olds in the most deprived areas and in 0–9-year-olds in the least deprived areas.
- There is no difference in the risk of hospitalisation for children with Omicron compared with Delta. This is potentially linked to the fact that most children are not vaccinated but it's also possible that Omicron's enhanced infectivity means that children's reduced susceptibility is not as much of a factor in the current context.
- With regard to waning immunity, UK studies show that there is 25% protection against infection with Omicron 90 days post-booster dose.
- There is an updated Risk Assessment expected from the UK's Health Security Agency tomorrow, 21st January 2022, which will note confidence in the reduced serial interval for Omicron compared with Delta.

The Chair thanked the DOH, the HPSC, the IEMAG, the HSE, and the NVRL for their respective inputs, noted the very encouraging epidemiological situation, and invited comments and observations from the NPHET Members. Key points raised are summarised below:

<u>General Discussion</u>

- The NPHET Members welcomed the latest epidemiological data as very encouraging and confirmed that it aligns with the reported experience of front-line healthcare workers recently.
- Members stressed that although a milder disease is associated with the Omicron variant, Ireland's current positive situation must also be attributed to the level of vaccine protection across the population.
- The unprecedented work of the HSE, GPs and pharmacies in quickly rolling out the booster vaccination programme in response to the onset of the Omicron wave and thereby significantly protecting people was acknowledged.
- It was stressed that testing strategies should remain flexible and rapidly adaptable to changes in the epidemiological situation (i.e. have the ability to scale up and down as needed). It was agreed that it is now appropriate to consider an updated testing and broader public health response strategy to complement the proposed transition in approach and it was noted that this had already been the subject of some consideration by NPHET last September. Members also considered if the current approach to testing and surveillance in hospitals remains appropriate going forward.
- It was noted that comprehensive surveillance and whole genome sequencing will remain important for early detection of the presence of a new variant, to enable the following of epidemiological trends and to guide containment measures.

- In the medium term, there will also need to be ongoing strengthening of the broader public health response such that rigorous and timely application of any necessary contact tracing and control measures can be applied to rapidly contain and limit spread where necessary in the event of future threats.

Nursing Homes/Long-Term Residential Care Facilities (LTRCFs)

- It was raised that in light of the improved epidemiological situation, it is timely to review visitation policies for nursing homes and LTRCFs, given that these policies contributed to the isolation of older people throughout the pandemic.
- The AMRIC clarified that current guidance clearly articulates that visitation to nursing homes and LTRCFs should be permitted with appropriate mask wearing and physical distancing requirements based on local risk assessment and advice from IPC teams. However, non-implementation of the guidance has been an issue. The application of guidance varies in practice. The majority of nursing homes are not HSE operated.
- The Chair reassured Members that this matter would be discussed under item 5(a).

Acute Hospitals

- While Members noted the significance of the decoupling of ICU admissions from hospitalisations, it was emphasised that the Omicron wave sustained the pressure on hospital capacity and had a negative impact on the provision of non-COVID care. Approximately 20% of all hospital admissions with COVID-19 received advanced respiratory support and the remaining were placed on ventilation, which displaced and disrupted the provision of non-COVID care.
- The NPHET stressed that the impact of the pandemic on the health system has been significant. The importance of a continued focus on health service resilience was emphasised, including in particular the ongoing strengthening of health system capacity across the spectrum of public health and community and hospital services to ensure the system is adequately prepared for future surges in activity. This includes critical care and isolation capacities, and the continuation of appropriate support for non-COVID care in a COVID environment.
- The HSE noted that there is a strong commitment for a plan regarding ICU capacity. Further noting that staffing remains challenging.
- The DOH noted that there is a Government approved, fully funded strategic plan in place for ICU development in 2022, with Phase 2 of the plan expected to be operationalised as soon as possible.
- It was also raised that as we move from a primary focus on COVID care, attention must be retained on the long-standing deficits that were exposed during the pandemic. There must be a sustained focus on health service preparedness as a whole.

The Chair thanked Members for their contributions, stressed that the pandemic is not over, and reiterated that there should be a sustained focus on the issues highlighted during the discussion with regard to preparedness for the future, namely: robust public health surveillance and response capacities including testing, contact tracing, surveillance and sequencing capacities, as well as ICU and hospital capacity. The Chair underscored that we must be better prepared for future challenges and that surveillance capacities will be important going forward.

3. HIQA – Expert Advisory Group

a) Omicron emerging evidence – update

The HIQA presented the paper *"Update of international public health agency assessments of the evidence in relation to the Omicron (B.1.1.529) variant: 19th January 2022"*, for noting.

The HIQA commenced a rolling summary of the scientific evidence on Omicron on 6th December 2021, with the most recent report, based on included scientific information available as of 4th January 2022, submitted to the NPHET for noting at the meeting of 6th January. A further update was requested in advance of today's NPHET meeting, 20th January. Information for this update was collated up to 18th January 2022 from the following agencies and/or authorities: European Centre for Disease Prevention and Control (ECDC), Norwegian Institute of Public Health (NIPH), Statens Serum Institut (SSI) (Denmark), South African National Institute for Communicable Diseases (NICD), UK agency websites, including UK Health Security Agency

(UKHSA), US Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO). Updated information was provided under the following headings:

- Transmissibility and Transmission;
- Virulence;
- Immune escape, and vaccine efficacy and effectiveness;
- Treatment efficacy and effectiveness;
- 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 *"International epidemiological data in relation to the Omicron (B.1.1.529) variant: 19th January 2022"*, for noting.

Information for this report was collated on 17th January 2022. In addition to summarising epidemiological reports by the ECDC and WHO, epidemiological metrics, primarily with respect to COVID-19 cases, hospitalisations, and deaths, were collated for Denmark, South Africa, and the UK. These countries were selected due to the dominance of the Omicron variant within these countries as of mid-December 2021.

The HIQA also presented the paper *"Rolling review of International Public Health Guidance in relation to the Omicron variant (B.1.1.529): 19th January 2022"*, for noting.

This paper provided an update to the information presented at the NPHET meeting on 6th January 2022, highlighting any updates to the following measures which were reviewed for changes:

- 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 the NPHET noted same.

4. Communications

a) Communications Update

The DOH and the HSE presented *"Communications Update: 20th January 2022",* 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 17th January 2022, shows that:

- The level of worry is down slightly to 5.5/10, similar to levels seen in May 2021;
- 65% do not want more restrictions, 23% do;
- 55% of the population think Government reaction to the current outbreak is appropriate, 20% think it insufficient, 21% think it too extreme;
- 25% visited hospitality last week. They report COVID-19 Certificates were checked by sector as follows: 85% in cafés, 87% in restaurants, 78% in pubs;
- Of those asked for a COVID-19 Certificate, approximately one third were also asked for photo ID: 31% in cafés, 48% in restaurants, 39% in pubs;
- 13% of adults had symptoms they thought might be COVID-19 in the last week;
    - 27% of all those with symptoms arranged PCR test;

    - 50% of all those with symptoms self-isolated;
- 35% of all adults took an antigen test for COVID-19 last week (vs 56% on 3rd January 2022); 5% were positive, 95% were negative;
- 88% of people with symptoms took an antigen test (14% were positive), 27% without symptoms also took an antigen test (1% were positive);
- Of those with symptoms who took an antigen test and received a negative result, 20% arranged a PCR test;
- Of those with symptoms who took an antigen test and received a negative result: 42% self-isolated.

The DOH and the HSE advised that the following media campaigns regarding COVID-19 are on air:
1. HSE: Symptoms & testing.
2. HSE: COVID-19 Vaccines and booster invitations.

The DOH also presented the ESRI paper *"Update on COVID-19 Behavioural Science Data: 11th January 2022*", for noting.

The update provided an analysis of recent behavioural data, mainly focused on the Social Activity Measure (SAM) conducted by the ESRI's Behavioural Research Unit for the Department of the Taoiseach and the Amárach Tracking Survey undertaken for the Department of Health.

The key findings were as follows:
- There were large declines in social activity in January 2022 compared to December 2021.
- There is a high proportion of people isolating or restricting movements.
- There has been a rise in precautions taken at home, work and in hospitality venues.
- Overall support for the public health effort remains stable.
- There is evidence for short-term caution and long-term optimism.
- The proportion of people who have taken or intend to take the booster has risen steadily since October.
- Parents remain split on whether to allow their child to take the vaccine.
- The majority of people (60%) said that they themselves experienced or they know someone personally who has experienced mild symptoms of COVID-19. One-in-six experienced or know someone personally who has experienced severe or long-lasting symptoms.

The Chair thanked the DOH and HSE for their updates and invited contributions from NPHET Members, summarised as follows:
- It was acknowledged that while these data are somewhat outdated (from the week up to 11th January 2022), they nevertheless provide useful perspectives on current public behaviours.
- It was noted that these data illustrate that the restrictions resulted in reduced social contact which helped to protect vulnerable people. There was a significant wave of infection in younger and less vulnerable people, however, there was a much smaller effect on older and more vulnerable people due to changes in behaviours.

The Chair thanked Members for their contributions and noted same.

5. Future Policy

a) Ongoing management of COVID-19

The DOH presented a proposal for discussion on the ongoing management of COVID-19 in relation to the continuation of public health measures and broader strategy for COVID-19 over the medium term, which was informed by a series of small group discussions it held with NPHET Members over the previous week. The proposal had regard to the advice provided by the NPHET in August 2021 which set out a path for the removal of the majority of remaining public health measures underpinned by a transition, in broad terms, from a focus on regulation and population wide restrictions to a focus on public health advice, personal judgement, and personal protective behaviours.

The Chair thanked the DOH for its presentation and Members for their engagement with preparatory work on the proposal. The Chair noted the encouraging epidemiological situation and reported impacts, which the NPHET could take substantial assurance from. The Chair expressed the view that the NPHET could approach the measures currently in place on the basis that the situation is optimistic in terms of Omicron while being mindful that the pandemic is not over, that certain cohorts remain vulnerable and merit particular attention, and that there is a need to focus on what measures must remain in place, with a view to ensuring our response remains agile and flexible, with an ability to respond rapidly and appropriately to any emerging threat. The Chair stressed that the NPHET would need to provide a firm public health rationale for the retention of any measures. The Chair noted that any recommendations arising from the discussion would have potential implications for the healthcare system and that the DOH would work closely with the HSE as needed in this regard.

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

Discussion on Public Health Measures

- The NPHET noted there is now clear evidence that, in comparison to previous variants, Omicron is associated with a significantly reduced population level of severe disease despite continuing high levels of transmission. The NPHET noted that we are in this much improved situation as a result of the population's engagement with the vaccination programme, and the booster programme in particular, and the high levels of adherence to public health measures combined with the relatively reduced virulence of the Omicron variant.
- The NPHET confirmed that it is of the view that the current profile of the disease in Ireland and the available evidence and experience of Omicron internationally now allows for a fundamental change in the management of COVID-19.
- The NPHET Members confirmed that there is no longer a continuing public health rationale for the majority of the public health measures that are currently in place and therefore advised that certain measures could now be removed (captured in Action Point below), accepting that a period of time will be necessary to make the required legislative changes and give due notice to sectors.
- Members concluded that a limited number of measures should be retained until 28th February (captured in Action Point below), at which point all children between the ages of 5 and 11 years will have had the opportunity to complete their primary course of vaccination. These measures should be reviewed in advance of 28th February.
- There was some discussion on the merits of a more phased easing of measures in order to allow for an assessment of the impact before advancing to the next stage but, on balance, Members agreed that measures could be eased more quickly than in previous phases of the pandemic, while retaining some phasing as agreed.
- Notwithstanding the proposed transition in the overall approach to the public health management of COVID-19 and the high levels of vaccination achieved across the population, the NPHET agreed that there will continue to be an ongoing need for some public health measures to reduce the risk of transmission (captured in Action Point below). It was also noted that communications should continue to highlight the importance of everyone continuing to play their part in limiting transmission so that we can ease pressure on our healthcare system and limit disruption and staff absence across all sectors.
- The NPHET also stressed that while the approach to managing COVID-19 will be underpinned by individual risk assessment and personal judgement, it will be important that there are focused communications and initiatives to inform and empower individuals to assess risks and appropriately re-engage with social activity, return to the workplace, and resume other aspects of their lives.
- The NPHET noted that, as seen in other countries with similar experiences with Omicron, the removal of social and economic restrictions will result in increased opportunities for the virus to transmit and may lead to an increase in disease incidence, including in children, many of whom have not yet had the opportunity to be vaccinated. The harm arising from any such increase in incidence will need to be kept under close review.

- The NPHET agreed that as we move forward into a new phase of managing the pandemic, there should continue to be a focus on our core priorities of protecting those most vulnerable to the severe impacts of COVID-19, protecting health and social care, education, and childcare services. There will also need to be a continuing focus on Long COVID.
- There were differing views on whether the requirement for COVID Passes should be removed. Some members were in favour of maintaining the Pass citing the following reasons:
    - the COVID pass has likely provided reassurance to vulnerable populations in engaging in social activities;
    - It provides a reminder to people, particularly those who are unvaccinated, that they need to remain cautious about exposing themselves to higher risk environments;
    - While not the intended purpose of the Pass, it could potentially assist in increasing booster uptake and general communications in relation to the importance of vaccination.
- However, on balance, it was agreed that the requirement should be removed as part of the proposed package of measures being lifted for the following reasons:
    - The Pass in its current form has diminishing utility as a protective measure in light of the fact that vaccine effectiveness against symptomatic infection wanes over time and is significantly reduced against Omicron as compared to Delta. The impact of primary vaccination against onward transmission of the Omicron variant is not yet clear but appears to be less than with Delta, which is less than with Alpha.
    - While the effectiveness of the Pass could be improved by requiring a booster vaccination, this may limit a significant portion of the population from accessing services and this wasn't deemed a proportionate measure given the current epidemiological profile of the disease.
    - More generally, there are likely to be practical difficulties with continuing with the Pass arrangement as it would have to continuously recognise evolving vaccine policy and evidence on the impact of vaccines and infection on immunity.
    - It was noted that evidence on the COVID Pass as a behavioural incentive for primary vaccination/boosters is mixed. Those who have not accepted vaccination to date are unlikely to be persuaded to do so by a continued requirement for the COVID Pass.

<u>Future Planning</u>

- The NPHET recognised the uncertainty of the future trajectory of the disease and noted that the global public health risk remains very high. While the Omicron variant is spreading rapidly across the world, the evolution of SARS-CoV-2 is expected to continue, and Omicron is unlikely to be the last Variant of Concern; the emergence of new variants with increased levels of transmissibility, immune escape and/or virulence remains a risk both nationally and globally, particularly in the context of continued high levels of infection and differences in vaccine supply and uptake globally. Therefore, it cannot fully rule out the reintroduction of measures in the future and we must continue to ensure the response is agile and flexible, with an ability to respond rapidly and appropriately to any emerging threat.
- Members emphasised that it is highly likely that cases of COVID-19 will increase again next winter and that it is important to prepare for this.
- The need to prepare for future pandemics by embedding the learnings acquired over the course of the COVID-19 pandemic into standard procedures across all sectors was also stressed.
- As already discussed under Item 2(a), Members reiterated the importance of comprehensive surveillance, flexible testing strategies and ongoing strengthening of the broader public health response (captured in Action Point below).
- It was noted with concern that a unified outbreak management IT system has not been put in place yet. It was also acknowledged that a cohesive and informative early warning system would play an important role in future outbreak management and that creative solutions are needed in this regard.
- It was suggested that, rather than the focus remaining on case numbers, it should now shift to metrics such as the number of deaths, hospital and ICU admissions and the numbers receiving oxygen as key measures of the severity of the disease.

- The recent availability of therapeutics for COVID-19 and the benefits these will confer in the treatment of COVID-19 was noted.
- Members were mindful that the personal application of rapid testing by members of the public may become more normalised in future as testing is developed for a range of illnesses and that it would be important to educate the public to ensure that testing is implemented correctly, with appropriate clinical and regulatory oversight.
- It was raised that the pandemic has shone a light on how inequalities in our society make us vulnerable as a whole. Increasing our resilience to future health threats will require that these inequalities be addressed.

Vaccination and Boosters

- The NPHET noted that those who remain unvaccinated are susceptible to severe illness with Omicron and efforts should continue to encourage everyone to complete their primary and booster programme of vaccination.
- The NPHET was conscious that although all children will have had the opportunity to receive a vaccine by the end of February, it does not necessarily mean that all of them will have received it. It was noted that vaccine uptake has been lower in children than in adults to date.
- The NPHET was informed that the WHO is assessing if there would be a benefit in shortening the booster interval from 6 months to 4-6 months and that the ECDC has proposed a 4-month interval.
- It was raised that the US and the UK have shortened the interval between COVID-19 infection and eligibility for a booster dose, and whether this should be considered.
- The NPHET recognised the importance of continuing the global vaccination effort.

Healthcare

- The NPHET highlighted the importance of maintaining a continued focus on health service resilience, including in particular: ongoing strengthening of health system capacity across the spectrum of public health and community and hospital services, including critical care and isolation capacity; and a continued focus on infection prevention and control measures in healthcare settings (detail captured in Action point below).
- The NPHET, while accepting that there will be broader operational and staffing considerations, reiterated its previous advice that there are no longer any public health reasons for a curtailment of health services such as community day services; and limiting visiting in health care facilities, including nursing homes, where arrangements should be informed by national IPC guidance and IPC assessments at facility level.
- It was raised that as there is now reliable data to show that case numbers are not translating into hospitalisations at the rate anticipated, the focus must now turn to non-COVID care and to those patients who have time critical needs. There is an urgent need to address waiting lists and to mitigate the harm caused by the delay in patients presenting for treatments as a result of the COVID-19 restrictions.
- It was noted that although the metrics show a decrease in the burden of disease, there is still a significant burden on the health services and ICUs in particular due to COVID-related staff absenteeism.
- The potential for serious COVID-19 related illness to occur in the unvaccinated population was noted with concern, including in those deemed 'fit and healthy'; this would continue to place an added burden on healthcare services.
- NPHET Members considered that existing backlogs in the health services have been worsened by the cessation of certain services and procedures over the course of the pandemic and the potential for long-COVID to increase the burden on health services in the future. This further underlined the need for an ongoing strengthening of health service capacity.
- NPHET Members were conscious that due to the impact of COVID-19, increased levels of morbidity and mortality would continue to be observed for some time after the end of the current wave.
- NPHET Members stressed the importance of retaining current provisions in the health services, such as the contracting of private hospitals for certain services, which provide necessary extra capacity. Due to the impact of COVID-19, the health service is under significant strain and will continue to be for some time after the pandemic has subsided.

- Just as antivirals for high-risk patients are recommended during waves of influenza, so too should antivirals and other therapeutics for COVID-19 be targeted at high-risk, community-based patients during surges of COVID-19.
- NPHET Members were cognisant of the risk posed by other pathogens that were suppressed by the public health measures implemented during the pandemic, but that now may begin to transmit more freely as restrictions ease and cause a wave of illness.
- It was stressed that it would be important to temper messaging outlining the burden COVID-19 has on the health system with clear communication that care is continuing, and that people should not be hesitant about seeking treatment.
- Messaging will also need to manage the public expectations with regard to the resumption of curtailed health services, as some time will be required before many services can fully return.

Supporting the public in making the transition

- Members were cognisant that life for the public has become increasingly medicalised over the course of the pandemic, with the use of medical PPE and self-testing now part of everyday life. It was queried how this medicalisation of life would fit with the broad transition in approach to COVID-19 and whether the public would require support in that regard. Members noted in this regard that there is a significant cohort in the population who might feel some trepidation about the easing of restrictions, this could include the vulnerable, those who suffer from COVID-related anxiety and those working in healthcare. It will be important to clearly communicate the reasoning behind these decisions and lay out a clear plan which details how to progress safely to the next phase.
- The NPHET discussed the need to strengthen clinical supports for members of the public who are suffering from mental health issues as a result of the pandemic. It will also be important to adopt a population based approach to managing anxiety and mental health, such as supporting cultural events that promote physical and mental health and wellbeing.

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 the Government in the usual manner.

Action Point:

The following remain critical components of our collective response and ongoing communication in relation to COVID-19 and will need to be retained and reviewed on a periodic basis:

- **Clear guidance and communication with the public** on the evolving disease profile and a cultural shift towards embedding individual and collective personal behaviours to mitigate against COVID-19 and other respiratory infections;
- A renewed and sustained focus on the importance of rapid **self-isolation** if symptomatic (even if fully vaccinated/boosted) or if diagnosed with COVID-19;
- Continued promotion of **vaccination against COVID-19 in line with evolving national strategy** and **seasonal influenza vaccination;**
- Continued wearing of masks, practicing of physical distancing and avoidance of crowded environments based on **individual risk assessment**, and adherence to basic hand and respiratory hygiene;
- **Sector specific measures** to ensure a safe environment including in relation to the promotion of rapid self-isolation when symptomatic, appropriate use of face masks, physical distancing, hand and respiratory hygiene, ventilation and signage;
- Continuing engagement with and support for global vaccination and surveillance initiatives;
- In line with evolving strategies, ongoing robust **public health surveillance and response capacities** including testing, contact tracing, surveillance and sequencing capacities for COVID-19;
- The impact of the pandemic on the health system has been significant. It is important that a continued focus on **health service resilience** is maintained, including in particular:

- ongoing **strengthening of health system capacity** across the spectrum of public health and community and hospital services, to ensure the system is adequately prepared for future surges in activity. This includes critical care and isolation capacities, and the continuation of appropriate support for non-COVID care in a COVID environment.
- a continued **focus on infection prevention and control measures** in healthcare settings, including appropriate mask wearing and physical distancing requirements based on local risk assessment and advice from IPC teams, given the ongoing requirement to provide care for both COVID and non-COVID patients and the need to protect both patients and staff.

While the above measures must be maintained, the NPHET is of the view that there is no longer a continuing public health rationale for the majority of the public health measures that are currently in place and therefore advises that the following measures can now be removed (accepting that a period of time will be necessary to make the required legislative changes and give due notice to sectors):

- Guidance in relation to household visiting
- Early closing time for hospitality and events
- Capacity restrictions for outdoor events
- Capacity restrictions for indoor events. This would also apply to weddings.
- Sectoral protective measures e.g.:
  - formal requirements for physical distancing in general (2m)
  - physical distancing requirements in hospitality (table service, 1m between tables, 6 per table etc.)
  - seated only at indoor events
  - pods of 6 for indoor activities
  - COVID pass requirement across all domestic venues/activities
  - requirement to maintain contact details
- Restrictions on nightclubs
- Public health advice to work from home allowing a return to physical attendance in workplaces on a phased basis appropriate to each sector

In addition, the NPHET, while accepting that there will be broader operational and staffing considerations, reiterated its previous advice that there are no longer any public health reasons for:

- A curtailment of health services such as community day services
- Limiting visiting in health care facilities, including nursing homes, where arrangements should be informed by national IPC guidance and IPC assessments at facility level.

While advising the removal of the above measures, the NPHET advises, that the following remaining measures should be retained until the 28th February, at which point all children between the ages of 5 and 11 years will have had the opportunity to complete their primary course of vaccination:

- Requirements for mask wearing in all settings where currently regulated for;
- Protective measures in primary and secondary schools;
- Current advice for those with symptoms, cases and close contacts as announced by Government on 12th January 2022. These will be reviewed in advance of 28th February.

6. Vaccination Update

a) Vaccine Safety Update

The HPRA provided a verbal report on the national reporting experience for COVID-19 vaccines. No new safety issues have been identified from national reports since the last update to NPHET. A report will be published on the HPRA website on 20th January (Report #15) which includes more details regarding the type and nature of reported reactions. The next report will be published on 17th February 2022.

7. Meeting Close

a) Agreed actions

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

b) AOB

No matters arose for discussion under this item.

In his closing comments, the Chair suggested that the NPHET meet once again on the 17th February with the purpose of assessing the epidemiological situation and the impact of the NPHET's latest recommendations. The Chair confirmed that he would call a NPHET sooner if needed. The Chair finally asked that confidentiality be maintained and reminded Members that the Cabinet would meet on 21st January to consider the NPHET's advice.

c) Date of next meeting

The next meeting of the NPHET is scheduled to take place week commencing 17th February.