National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Thursday 17th February 2022, (Meeting 101) 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 Anaesthetist with a Special Interest in Intensive Care Medicine Beaumont Hospital; Clinical Lead National Clinical Programme for Critical Care, HSE Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH 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 Ms Deirdre Watters, Communications Unit, DOH Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE Dr Colette Bonner, Deputy Chief Medical Officer, DOH Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital
'In Attendance'	Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Dr Triona McNicholas, Specialist Registrar in Public Health Medicine, DOH Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH Ms Aoife Gillivan, Communications Unit, DOH Ms Ruth Barrett, NPHET Policy Unit, DOH Ms Laura Casey, NPHET Policy Unit, DOH Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH Mr Ronan O'Kelly, Health Analytics Division, DOH Ms Pauline White, Statistics & Analytics Unit, DOH Ms Elizabeth McCrohan, Statistics and Analytics Unit, DOH
Secretariat	Ms Ruth Brandon, Ms Emily Kilroy, Mr Ivan Murphy, Mr Liam Hawkes, Mr Liam Robinson
Apologies	Dr Colm Henry, Chief Clinical Officer, HSE Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway

[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 Colm Henry and Dr Catherine Fleming.

c) Minutes of previous meetings

The minutes of 20th 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 recalled the NPHET's most recent advice of 20th January and confirmed that the NPHET would proceed as planned to give further consideration to the epidemiological profile of the disease, in particular as it relates to children, and provide advice on the remaining public health measures in place, namely mandatory mask wearing where it is currently regulated for and public health measures in early learning settings, school-age childcare and schools, including physical distancing measures and mask wearing.

2. Epidemiological Assessment

Epidemiological Assessment

a) Evaluation of Epidemiological data: (incorporating National Data Update, Modelling Report, and International Update)

The DOH, the HSE, the HPSC, and the IEMAG provided an overview of the latest epidemiological data regarding confirmed cases, including the current information on hospitalisation, critical care, mortality, sampling, testing, and contact tracing. The data presented were as follows:

- A total of 34,460 confirmed PCR cases have been reported in the 7 days to 16th February 2022 (cases notified to midnight 15th February 2022), which is an 8% decrease from last week when 37,383 PCR positive cases were reported in the 7 days to 9th February.
- Data on the number of positive antigen test results uploaded to the HSE portal the previous day are reported daily. There were 29,309 positive antigen test results reported in the 7 days to 16th February 2022 (positive antigen test results uploaded to the HSE portal in the week to 15th February 2022), which is a 20% decrease from last week when 36,615 positive antigen test results were reported in the 7 days to 9th February.
- As of 16th February 2022, the 14-day incidence rate (PCR) per 100,000 population is 1,509; this compares with 1,497 a week ago, a 1% increase. Incidence rates are likely to be underestimates.
- Nationally, the 7-day incidence (PCR) per 100,000 population as a proportion of 14-day incidence (PCR) per 100,000 population is 48%, demonstrating that there have been fewer cases identified through PCR testing in laboratories in the last 7 days,10th-16th February, compared with the preceding 7 days 9th – 15th February.
- The 5-day rolling average of daily reported cases (PCR) is 4,439 as of 16th February, an 8% decrease from that reported on 9th February (4,803).
- The test positivity rate in public health laboratories (>40%) remains high. The positivity rate in hospital laboratories (11.7%) is high, and unstable, reflecting a high and fluctuating prevalence in the population.
- From 9th February – 15th February, there have been approximately 111,959 laboratory tests reported in community, private, and acute laboratories, which is down 43% from 196,661 at the last NPHET meeting (20th January). The 7-day test positivity rate in the community has significantly decreased from 55.2% at the last NPHET meeting to 47.5%.
- Antigen test kits booked through the HSE Antigen Portal have decreased by 5% in the latest reporting week, in comparison to the previous week. There were 259,948 test kits booked during the week to 15th February, compared to 275,046 in the previous week (2nd February to 8th February 2022).

- According to the Contact Management Programme (CMP), from 6th February – 13th February 2022, the total number of close contacts managed was 92,219, a decrease of 21% on 116,535 in the previous week. The average number of cases managed per day decreased from 16,648 to 13,174, a decrease of 21% over the same time period.
- As of the morning of 17th February, there were 639 confirmed COVID-19 cases in hospital, compared with 595 last week on 10th February, and 896 at the last NPHET meeting on 20th January. There have been 120 newly confirmed cases in hospital in the 24 hours preceding the morning of the 17th February.
- As of 15th February, 52% of hospitalised cases were categorised as hospitalised for COVID-19, with the remaining 48% categorised as asymptomatic COVID-19 cases and potentially infectious. Of hospitalised cases aged 0-14 years old (N=33), 70% were categorised as hospitalised for COVID-19, with the remaining 30% categorised as asymptomatic COVID-19 cases and potentially infectious.
- As of 15th February 2022, age breakdown of hospitalised cases: 260 (36%) aged 80 and older, 206 (28%) aged 65-79, 110 (15%) aged 50-64, 120 (16%) aged 15-49, and 33 (5%) aged 0-14 years old.
- According to the latest HSE data on hospitalisations and vaccinations, as of 15th February, 37% of hospitalised COVID-19 cases were boosted, 28% of hospitalised COVID-19 cases had completed their primary vaccination course and 35% of hospitalised COVID-19 cases had not completed their primary vaccination course.
- As of the morning of the 17th February, there were 58 confirmed cases in critical care, compared with 63 a week ago (10th February 2022). There were 2 new admissions to critical care in the 24 hours preceding the morning of the 17th February. Of the 58 cases in critical care on the morning of the 17th February, 32 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 47 as of 15th February 2022. Of the 20 COVID-19 cases aged 0-18 years old admitted to ICU between 1st January 2022-16th February 2022, the primary reason for admission to ICU was not related to COVID-19 for 10 cases.
- According to HSE data as of 15th February 2022, where vaccination status was known, 43% of COVID-19 cases in ICU were unvaccinated and 56% were fully vaccinated, of whom 41% were recorded as having received a booster/additional dose.
- As of 14th February, 180 patients were in receipt of non-invasive ventilation/Continuous Positive Airway Pressure (CPAP) or High-Flow Oxygen in non-critical care settings, of whom 42 patients were COVID-19 cases.
- As of this morning (17th February), there were 10 COVID-19 patients in the three hospitals of the Children's Hospital Group (Children's Health Ireland). This compares with 15 a week ago (10th February), and a peak of 26 on 10th January.
- There continues to be a significant number of cases of hospital acquired infection (note this is based on data to the week ending 6th February 2022). There were 153 hospital acquired COVID-19 infections in the week ending 6th February 2022, compared to 137 in the week ending 30th January, and 182 in the week ending 23rd January.
- The proportion of cases that are Omicron variant, based on the sample prevalence of S-gene target failure (SGTF) on the TaqPath assay, accounted for approximately 50% of infections by 17th December 2021, and 90% by 25th December 2021. The prevalence of SGTF has recently been reducing in the context of the growth of the BA.2 lineage (Omicron). In total, approximately 60% of current infections are S-gene target negative, suggesting approximately 40% of current infections are BA.2. This is growing at 9.7% (7.5-12%) per day and may be dominant by the last week in February 2022.
- According to the latest whole genome sequencing data in relation to B.1.1.529 (Omicron), as of 16th February, 5,322 BA.1 (Omicron), 1,320 B.A.1.1 (Omicron), 78 BA.2 (Omicron), and 2 BA.3 (Omicron) cases had been confirmed in Ireland.
- 37 laboratory confirmed influenza cases were notified in week 6 2022 (7th-13th February 2022), an increase from 13 in the previous week. There were 13 laboratory confirmed hospitalised influenza cases notified in week 6, compared with 2 in the previous week. In the 2021/2022 season to week 6 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 5 2022 (to 6th February): 25 RSV cases (52% aged 0-4 years; 16% aged ≥65 years) were notified during week 5 2022; 13 of these cases were reported as hospital inpatients (62% aged 0-4 years; 8% aged ≥65 years). As of week 5 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 NVRL decreased from 61.6% in week 1 2022 to 35.3% in week 5 2022. In week 6 2022, the positivity rate increased to 40.0%.
- As of 13th February 2022, approximately 60% of the population aged 35-44 years, 50% of those aged 25-34 years, and 43% of those aged 16-24 years have received a booster/additional vaccine dose.
- As of 17th February 2022, 72% of children aged 12-15 have received their primary course of vaccination. Of those aged 5-11, 23% have received one dose of their primary course of vaccination.

Outbreaks for week 6 (6th – 12th February) are based on those reported up to midnight on 12th February 2022.

In week 6, there were a total of 96 COVID-19 outbreaks notified. Regional departments of public health are currently prioritising the investigation and reporting of outbreaks in settings that would benefit most from Public Health and clinical intervention. Therefore, the number of outbreaks reported in some settings is underestimated.

Healthcare setting outbreaks:

- There were 20 new nursing home and 4 new community hospital/long-stay unit outbreaks created in week 6. The case range of these outbreaks was 2-27 cases.
- There were 15 new acute hospital outbreaks created in week 6, with a range of 1-23 cases.
- There were 25 new outbreaks reported in residential institution settings in week 6 (16 in centres for disabilities, 2 in prisons, 2 in children's/TUSLA residential centres, 1 in direct provision centres, 1 in a mental health facility, 1 in a centre for older people, 1 in a homeless facility and 1 in a 'not specified' facility), with a range of 1-30 cases.
- There were 8 new outbreaks in 'other healthcare services' in week 6 (5 in day services for people with disabilities, 1 among clients of mental health facilities and 2 in other healthcare services), with a range of 2-5 cases.

Outbreaks associated with school children and childcare facilities:

- There were 9 new outbreaks associated with schools notified in week 6 (1 in a primary school and 8 in special education schools), with a range of 2-13 cases.

Outbreaks among vulnerable groups:

- There were 10 new outbreaks among the Irish Traveller Community notified in week 6, with a range of 2-14 cases.
- There was 1 new outbreak in the Roma Community.

In summary, the current epidemiological profile of COVID-19 continues to provide a broadly stable and positive outlook. The total number of confirmed cases in acute hospitals and the number of admissions and newly confirmed cases per day remain stable. Following a recent moderate increase, particularly amongst young adults, the number of infections detected per day (based on PCR and self-reported antigen tests) remains high but has stabilised and may be starting to decrease. The number of detected infections in those aged 0-11 years is reducing, and is stable in those aged 12-15 years.

The November 2021 Delta wave was associated with higher incidence in children compared to vaccinated adults. Given that vaccines offer more limited protection against infection with Omicron, the risk of infection is now more evenly distributed across the population under 50 years of age, with higher incidence currently in the 19–24-year-old cohort. Demand for testing is reducing. Test positivity in public health laboratories remains high (>40%). Test positivity in hospital laboratories is high, and unstable, likely reflecting a high and fluctuating prevalence in the population.

COVID-19 hospitalisations in children

The Omicron wave has been associated with an increase in the number of people hospitalised with, and for, COVID-19, including increased hospitalisations in children. This is in the context of high levels of transmission across the population. The weekly number of children hospitalised with COVID-19 peaked at approximately 150 in early January 2022 and is decreasing. The increase in COVID-19 hospitalisation amongst children during the Omicron wave has not been disproportionate compared to the number of adult cases hospitalised. The proportion of cases hospitalised accounted for by children is marginally higher than during comparable periods in 2021. Data provided by the HSE also indicates that a proportion of recently hospitalised paediatric cases are asymptomatic and receiving care primarily for reasons other than COVID-19. While severe COVID-19 disease requiring hospital care can be experienced in paediatric cohorts, data continue to indicate that this remains uncommon. The Omicron wave has been associated with a small cluster of ICU admissions of children.

Evidence continues to emerge internationally on COVID-19 hospitalisations in children in the context of Omicron. International evidence generally indicates a relatively increased level of paediatric COVID-19 hospitalisation during the Omicron surge, particularly amongst younger children. However, the overall risk of hospitalisation in children remains low, with admissions that do occur generally short, and illness experienced typically not severe.

The HSE confirmed that the number of hospital-acquired infections in Ireland remains significant, though the clinical impression continues to be that many cases are not severe or are asymptomatic. There continues to be a significant number of outbreaks reported in settings with vulnerable populations.

The HPSC confirmed that in the past week to 17th February, there have been 57 influenza notifications via the NVRL. Positivity has increased from 4.4 to 9.9. The HPSC has issued an advisory to clinicians regarding antiviral treatments.

The IEMAG noted that the ratio of hospitalisations to cases amongst children is currently half of that observed, on average, throughout the pandemic (20 admissions per 1000 children). The hospitalisation ratio for children is currently lower than expected despite under ascertainment of cases.

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

- The importance of reinfection data was noted with a view to identifying any patterns or trends emerging regarding variants and informing future vaccination planning going forward. The HPSC confirmed a report on this matter will be available shortly.
- It was noted that although the number of community outbreaks and the levels of positivity within those outbreaks have stabilised at a lower level, there is a significant number of outbreaks in older persons residential facilities. This has a detrimental impact on the movement of residents to and from hospital and on their ability to visit family. The importance of continued monitoring of outbreaks was emphasised.
- Members noted that current data shows that 30% of cases recorded in hospitals are asymptomatic but still infectious. This suggests that the community rate for individuals who are asymptomatic but infectious is likely to be more substantial.
- However, the need for caution when extrapolating information based on the hospitalised population was advised. The HSE outlined that while disease information regarding hospital-acquired COVID-19 has been guided predominantly by clinical impressions in recent weeks, a follow-up exercise is underway to record outcomes at 30 days for patients who contracted COVID-19 while in hospital in the weeks ending January 9th and 16th to give further insight on this issue. It was noted that given the high rates of asymptomatic infection in the population at present, it is likely that people who have unknowingly had an asymptomatic infection in recent months have also received a booster dose recently.
    - It was confirmed that recent COVID-19 infection can in effect act as a booster and increase levels of protection against subsequent infection for some months. Thus, for those with confirmed infection,

booster vaccination is delayed for a minimum of three months post infection. Where an individual who is scheduled to receive a booster, is unsure whether or not they have had an infection i.e., worried that they might have unknowingly had an asymptomatic infection, it is recommended to proceed with the booster vaccination as the benefits outweigh the risks. Serological testing prior to boosting is not indicated.

- It was noted that those currently being admitted to ICU are predominantly those who are unvaccinated with co-morbidities or with high grade immunosuppression. The triple vaccinated high grade immunosuppression admissions seen in 2020/21 are not a marked feature of ICU admissions at present. The number of unvaccinated patients with no co-morbidities admitted to ICU is also now small.
- It was noted that the reconfiguration of ICUs as part of the response to COVID-19 has limited ICU access to non-COVID care patients; this is an ongoing situation. The ongoing implementation of the Strategic Plan for Critical Care, which will increase ICU capacity, was also acknowledged.
- The NPHET also 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, including amongst those aged 5-11 years, in whom uptake to date has been less than 25%. Vaccination against infection remains important to protect children from severe disease, the consequences that can follow infection e.g., multisystem inflammatory syndrome in children (MISC), long COVID, psychosocial and developmental impacts.
- The HSE advised that as well as the mobile and pop-up vaccination clinics that have been in operation for some months, it is also evaluating more options to improve vaccine uptake amongst the 5-11 year old cohorts. These options include allowing parents/guardians to book their own clinics and walk-in clinics where no appointment will be necessary. Additionally, more local pop-up type clinics are also being considered to support improvement in uptake. There is a focus on ensuring adequate information at all stages of the vaccination journey to enable parents/guardians and children and young people to make an informed decision on vaccination for their child/young person.

The Chair thanked Members for their contributions and noted that the discussion on the epidemiological data presented would serve to inform the NPHET's discussion on public health measures under item 5.

3. Review of Existing Policy

a) Update on Long COVID

The HSE presented the paper *"Long COVID Briefing Paper for NPHET: 15th February 2022"*, for noting.

The paper provided an update on the national approach to Long COVID and noted developments in relation to the resourcing and development of an Interim Model of Care (MoC), aimed at addressing the emerging needs of those with prolonged symptoms following infection with COVID-19. The MoC provides a framework for the provision of services spanning General Practice, Community Services, Acute Hospitals and Mental Health Services.

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

4. Communications

a) Communications Update

The DOH and the HSE presented *"Communications Update: 17th February 2022"*, for noting.

The Quantitative Tracker, a nationally representative sample of 1,600 people conducted on behalf of the DOH by Amárach Research on 14th February 2022, shows that:

- The level of worry is down to 4.8, similar to August 2021 and around the lowest level seen throughout the pandemic.
- 75% of the population think the worst of the pandemic is behind us, 4% think it is ahead of us.
- 55% think Ireland is returning to normal at about the right pace, 14% think it too slow and 31% think it too quick.
- 72% say they will continue to social distance in queues and 52% say they will continue to wear a face mask in public.

- 27% of the population say they have tested positive for COVID, 66% know someone in their immediate circle who have tested positive for COVID.
- 58% of those under 35 think they will probably be infected with COVID.
- The main reasons for not getting boosters are:
    - I don't think the booster will make any difference;
    - I have had COVID and have to wait;
    - I feel safe enough as I am already fully vaccinated.
- 30% of adults have taken an antigen test for COVID-19 in the last week, 7% were positive for COVID. Approximately three quarters of those with a positive result registered it on the HSE portal.

Qualitative Data, based on Focus Groups on 7th February, highlighted:

1. The Irish people are in buoyant mood, especially the young who able to embrace living in the active voice again, and actively engage in activities that had been on hold. Most do so with an awareness that although the pandemic has abated, it's not 'over, over' and hence a mindset of caution is appropriate.
2. COVID, its effects diluted by Omicron and the high levels of vaccination, has become a disease which people do not want to transmit to others - rather than one that excites dread in of itself. Antigen testing has proven to be a powerful, pragmatic tool for people to keep this in check.
3. In the opinion of these citizens, Contact Tracing is no longer functioning, and should likely be stepped down. It is intuitive to most, given Omicron's speed of transmission, that contact tracing is an act of personal responsibility.
4. It will take society some time to learn the normalcy of socialising which is acceptable. It may be that 'social proximity consent' develops, whereby the way in which we greet and connect is communicated in a more bespoke manner.
5. Citizens who are booster resistant were also vaccine resistant. The difference is that the case for boosters has not been made for them – and the incentives to take the booster have declined sharply. To make headway with this cohort, benefit-led, evidence-based communication is required.

Campaigns currently on air:

1. HSE: COVID-19 Vaccines and booster invitations;
2. Stay home if symptomatic.

The Chair thanked the DOH and HSE for their joint update and the NPHET noted same.

5. Future Policy

a) Mandatory Vaccination

The DOH presented *"COVID-19 Mandatory Vaccination – Ethical and Human Rights Considerations: 17th February 2022"*, for decision.

The paper outlined the complex ethical and human rights considerations pertaining to this public health policy. Mandatory vaccination policies represent a considerable interference with individuals' liberties and autonomy and as such require strong justification and supporting evidence that the measure will achieve the intended goal, is proportionate to the intended benefit and that no less restrictive measure would be effective.

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

- There was a recognition that there are a variety of reasons underpinning an individual's choice to remain unvaccinated including social and cultural reasons as well as needle phobias.
- The HSE noted its intention to withdraw the requirement for risk assessment for non-vaccinated staff from 1st March as it was no longer considered proportionate given that most patients and staff are vaccinated or have recovered from natural infection or both. In addition, the impact of current vaccines on transmission of the Omicron variant is attenuated as is severity of disease. It was also noted that

treatments have recently become available that reduce the risk of harm to those most vulnerable if they acquire COVID-19 in the healthcare setting.

- It was recognised that the successes Ireland has already achieved in relation to COVID-19 have been largely based upon trust and transparency rather than penalties and enforcement.
- While the discussion on vaccination of healthcare workers (HCWs) involved some differing opinion, the consensus view was that the current 'intervention ladder' approach to vaccination of HCWs remains sufficient and proportionate at this time; a vaccine mandate for HCWs is not recommended at this time. The importance of understanding the number of unvaccinated staff and their reasons for this was also raised.
- It was noted that the NPHET's recommendations (see Action Point below) were formulated with reference to the current epidemiological context. Should the situation change e.g. a more severe variant emerges, there was an acknowledgement that it may be necessary to revisit the issue of mandatory vaccination for healthcare workers given their particular professional and ethical duties. In that context, it was agreed that it would be important to accurately establish the numbers, grades and geographical distribution of HCWs who had received a COVID-19 vaccine. It was considered vital that continued and on-going efforts be made to engage those HCWs who have yet to receive/declined a COVID-19 vaccine to understand the reasons underpinning their hesitancy/declination. This is also relevant for flu vaccine uptake. It was also acknowledged that HCWs have to feel supported by their employer who has an obligation to provide a safe working environment and vaccine mandates may erode the trust relationship.

Action Point:
On balance, in the context of the current epidemiological situation and given the high levels of immunity in the population as a result of vaccination and natural infection, and in light of vaccine waning and vaccine escape in the context of Omicron, the NPHET:

- **does not recommend a population wide vaccine mandate on the basis of necessity or proportionality. It is vital that continued efforts be made to engage, listen with respect, communicate effectively, and offer practical and targeted support to those who have yet to be vaccinated.**
- **does not recommend a vaccine mandate for healthcare workers (HCWs) and considers the current 'intervention ladder' approach as sufficient and proportionate. The NPHET recognises the particular ethical and professional duties of healthcare workers to do no harm and advises that any change in vaccination policy for this cohort would have to be informed by a more complete understanding of COVID-19 vaccine uptake in HCWs, both in health and social care settings. Less intrusive measures must first be shown to be ineffective before more intrusive measures are considered.**

b) Public Health Measures

In introducing this agenda item, the Chair recalled the advice provided by the NPHET at its last meeting of 20th January that the prevailing profile of the disease in Ireland and the available evidence and experience of Omicron internationally allowed for a fundamental change in the management of COVID-19. The NPHET advised that this should entail 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.

Specifically, on 20th January the NPHET advised that there was no longer a continuing public health rationale for the majority of the public health measures that were in place at that time and advised that a range of measures could be removed. It, however, advised that a small number of mandatory requirements should be retained until 28th February, at which point all children between the ages of 5 and 11 years would have had the opportunity to complete their primary course of vaccination. The Chair confirmed that the NPHET would today give further consideration to the remaining mandatory requirements and whether there is a continuing public health rationale for retaining them.

The Chair then invited the DOH to provide a number of short presentations with a view to informing and orienting the substantive discussion.

Advice provided to Minister on future of COVID-19 testing, tracing, and surveillance programme

The DOH updated the NPHET on advice provided to the Minister for Health on the future of the COVID-19 testing, tracing and surveillance programme, in accordance with the transition in approach to the public health management of COVID-19 as recommended by the NPHET on 20th January. The key elements of the advice provided to the Minister were outlined as follows:

- It is now appropriate to transition from a response based on extensive case finding and tracing of infection to reduce transmission towards a response focused on mitigation of the severe impacts of COVID-19, with a continuing requirement to protect those most vulnerable to the severe effects of the disease and those with risk factors for severe disease who may benefit from specific interventions.
- Anyone who has symptoms of COVID-19 or other viral respiratory tract infection should self-isolate until 48 hours after symptoms have substantially or fully resolved.
- While nothing should replace or constrain clinical judgement that a test is required on a particular person in a particular clinical context, henceforth public health indications for testing will differentiate between those at high risk of severe disease who may benefit from early treatment and other people. As such, testing will no longer be needed for clinical or public health purposes for otherwise healthy younger people (<55 years) with symptoms. However, it is recognised that some people may require a test for other reasons for example to support a claim of social welfare payments associated with absence from work. Through a transition period, the HSE will support access to antigen testing for those in this group.
- PCR testing is recommended (through the HSE portal) for the following people with symptoms:
  - Those who have not had a booster vaccination and are aged 55 years and older;
  - Those with a high-risk medical condition;
  - Those who are immunocompromised;
  - Those who live in the same household as a person who is immunocompromised;
  - Those who provide care or support for person they know to be immunocompromised;
  - Those who are pregnant.
- Anyone diagnosed with COVID-19 should follow current guidance (self-isolate for 7 days from date of onset of symptoms, or if asymptomatic, date of first positive test. Exit from self-isolation after day 7 on basis that symptoms have substantially or fully resolved for the final two of those seven days. Anyone exiting at day 7 should continue to adhere to other public health protective measures, including appropriate use of masks, until at least day 10).
- Asymptomatic close contacts do not need to restrict movements; if they develop symptoms, they should self-isolate. Asymptomatic people including close contacts, other than healthcare workers, do not need to have PCR or antigen testing. It is recognised that some asymptomatic individuals may choose to use rapid antigen tests. Any asymptomatic individual who has a positive antigen test result should consider this result definitive and self-isolate. This advice will be reviewed during the transition phase should prevalence decrease.
- For healthcare workers, repeat antigen testing is required if identified as a household close contact, unless they have recovered from COVID-19 in the previous three months.
- Serial Testing in residential care facilities for older people will continue to be offered to these facilities through the transition period until such time as a facility meets set criteria.
- Admission testing of *unscheduled* adult admissions to hospital by laboratory or laboratory supervised near-patient testing. Admission testing of scheduled admissions and transfers to hospital and residential care facilities based on current national IPC guidance and institutional risk assessment.
- Contact tracing will be limited to those contacts readily identifiable as at risk based on individual characteristics or context, public health risk assessment and settings where further transmission is likely and could have a serious impact.
- There will be a requirement to expand and strengthen surveillance programmes including the GP sentinel and SARI programmes and the HSE will develop a comprehensive proposal for a population infection survey.
- Existing sequencing capacity will be strengthened as part of the development of the ECDC supported programme and work will progress to improve turn-around time and integration of sequencing data with epidemiological data.

- A sustainable, permanent Biostatistical Modelling Unit will be established at the HPSC, to enable a smooth transition of knowledge, methodologies, and skills from the IEMAG to the HPSC.

Face masks and children

With a view to orienting the discussion on public health measures in early learning settings, school-aged childcare, primary and secondary schools, the Chair invited the DOH to present on the results of consultation exercises carried out with children, parents, and teachers in relation to the requirement for mask wearing in the 9 to 12 year age cohort.

The DOH outlined the current position regarding face masks in children:

- On 25th November 2021, the NPHET recommended the wearing of face masks/coverings by children aged 9 years and above on public transport, in retail and other indoor public settings as already required for children aged 13 years and over.
- The wearing of face masks/coverings for children in 3rd class and above in the primary school classroom setting was also recommended.
- This measure was introduced on a temporary basis with planned review in mid-February 2022.
- Following its consideration, Government introduced a requirement for those in 3rd class and above in primary schools to wear a mask, excluding those with a medical exemption or complex needs, with effect from 30th November 2021.

The DOH then summarised a range of evidence on the wearing of face masks in children in Ireland, including:

- Current epidemiology (age-specific incidence; age distribution of positive antigen test results);
- Vaccination uptake in children;
- International guidance (ECDC, CDC, WHO);
- Qualitative evaluation involving three separate consultations with primary school pupils, their teachers and their parents.

Public health measures across the EU

The DOH then gave a short presentation on public health measures across EU to further inform the NPHET's discussions. The DOH reported in summary that countries are at different stages of easing restrictions, but the general trend is an easing of public health measures and an overall transition in approach to managing COVID-19. Some countries have removed all legal measures, other countries have removed the majority of restrictions while maintaining some baseline measures such as mask wearing, while another group of countries still have some sectoral restrictions in place e.g. on the hospitality sector.

The DOH reminded Members that on 20th January, the NPHET advised that a small number of mandatory requirements (detailed below) should be retained until 28th February. The focus of the NPHET meeting was to advise on whether these measures could be removed with effect from 28th February as planned, namely:

- Mandatory mask wearing in areas where it is currently regulated for, including public transport, taxis, retail and other indoor public settings, and staff in hospitality settings.
- Public health measures in early learning settings, school-aged childcare, primary and secondary schools, including physical distancing measures such as pods, and mask wearing.

The Chair thanked DOH colleagues for their respective presentations and invited Members' views on whether there was any reason in epidemiological terms not to proceed with the easing of measures as envisaged on 20th January. The discussion is summarised below:

Mandatory mask wearing

- While Members agreed that legal requirements in relation to face mask wearing were no longer warranted, Members also emphasised that face masks should continue to be advised in certain settings.
- Particular attention was given to the wearing of masks on public transport. Members felt that public transport is a setting where physical distancing can be difficult and where those who are more vulnerable

to the severe impacts of COVID-19 do not always have the discretion to avoid. For these reasons, the NPHET agreed that the wearing of masks on public transport should continue to be advised.

- Members also recommended the continuation of mask wearing in healthcare settings in line with evolving national guidance.

Resumption of social activity in residential care facilities and visitation in all healthcare settings

- The NPHET reiterated its previous advice that while accepting that there will be broader operational and staffing considerations, and noting that everyone who accesses healthcare facilities, including nursing homes, should adhere to directions on essential infection prevention and control practices, there is a clear need to make rapid progress on resuming social activity within residential centres and outings for residents, given that there are no longer any public health reasons for not doing so. Members also emphasised the need for reasonable access for family and friends in all healthcare settings including acute hospitals. Current national guidance on infection prevention and control and on access and visiting represents a balanced approach, respecting the need for a degree of caution.
- Acknowledging the progress made by many hospitals, nursing homes and residential care facilities in this regard, Members expressed significant concern that some healthcare facilities continue to apply onerous restrictions that are in excess of national guidance and of any reasonable requirements at this stage. This is impacting negatively on the wellbeing and the rights of patients and residents to share in the resumption of normal social and family life that the wider society is benefiting from.
- The NPHET's detailed recommendation on this matter is captured in the Action Point below.

Protective measures in schools

- While Members agreed that public health measures in schools, including physical distancing measures such as pods, and mask wearing, in early learning settings, school-aged childcare, primary and secondary schools were no longer warranted, Members emphasised the importance of continuing infection prevention and control measures (IPC) including in relation to ventilation, hygiene measures and advice to stay at home if symptomatic. These measures are important for mitigating the spread of COVID-19 but also for mitigating the spread of other viral infections.
- The importance of documenting the learnings that can be garnered from the experience and effectiveness of IPC interventions in schools was noted.
- Members recognised that some children may wish to continue wearing masks and that no child who wishes to do so should be discouraged.
- The NPHET also 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, including amongst those aged 5-11 years, in whom uptake to date has been less than 25%. Vaccination against infection remains important to protect children from severe disease, and the consequences that can follow infection e.g., multisystem inflammatory syndrome in children (MISC), long COVID, psychosocial and developmental impacts.

Ongoing critical components of COVID-19 response

- The NPHET also reiterated its advice of 20th January that the COVID-19 pandemic is not over, levels of infection remain high, a cohort of the population still remain vulnerable to more severe infection and the emergence of new variants with increased levels of transmissibility, immune escape and/or virulence remains a risk both nationally and globally. For these reasons, certain measures will remain critical components of our collective response and ongoing communication in relation to COVID-19 (captured in Action Point below). These measures will need to be retained and reviewed on a periodic basis.
- There will be an ongoing requirement to be able to scale up appropriate responses quickly should they be required and key areas of focus in Ireland over the coming months will likely include surveillance and monitoring of the epidemiological position nationally and internationally, including in relation to current and new variants; modelling of likely disease trajectories and impact; and ongoing assessment and advice on emergent issues in relation to SARS-CoV-2 and other respiratory viruses.
- The ongoing need for sector specific measures was emphasised, based on risk assessments by individual sectors, to ensure a safe environment including in relation to the promotion of rapid self-isolation when

symptomatic, hand and respiratory hygiene, ventilation, signage, and use of face masks and physical distancing if appropriate.

- It was stressed that individual sectors should continue to take responsibility for developing specific public health guidance and operationalising protective measures within their sector, as required.
- The need for ongoing strengthening of health system capacity across the spectrum of public health and community and hospital services was reemphasised. This is important to ensure the system is adequately prepared for future challenges. This includes additional critical care and isolation room capacities in line with the Strategic Plan for Critical Care, and the continuation of appropriate support for non-COVID care in a COVID environment.
- Members noted the importance of consistency in testing arrangements as they are continued.
- The ongoing need for clear advice for household close contacts of confirmed cases of COVID-19 was stated. Given the observed high transmissibility of COVID-19 within households to date, it will be important that household close contacts are empowered with the guidance and information they need to prevent further onward transmission.

Communications

- It was acknowledged that, over the coming period, people will perceive the risk of COVID-19 infection in different ways, depending on their individual medical history and experience of the pandemic to date. For many, the further easing of measures as recommended today will lead to some uncertainty with regard to the adoption of protective behaviours. It will be important that people's individual choices with regard to physical distancing, use of facemasks and other protective measures are respected over the coming period.
- Members suggested that a programme of public health communications should be considered in this regard.
- It was noted that communications should continue to provide a clear rationale for decision-making and should outline to the public the new baseline/new normal.

The Chair thanked Members for their contributions to the discussion and summarised the recommendations made (captured in the Action Point below).

In closing the discussion, the Chair underlined the points made regarding the importance of ongoing hygiene and supportive measures in schools and childcare settings to prevent the transmission of COVID-19 and other viral infections into the future. The Chair also echoed the point made by Members that the removal of mandatory mask-wearing in certain settings should not be interpreted as implying that mask wearing was no longer an important public health measure to be advised in certain situations. The Chair emphasised that there continued to be settings where mask wearing should be encouraged to protect vulnerable people as previously advised by NPHET. The Chair further noted that the HSE will take lead responsibility for framing and communicating updated testing guidance to the public and throughout the health service.

Action Point:

In light of the current profile of the disease in Ireland and the available evidence and experience of Omicron internationally and in line with an overall transition in the approach to managing COVID-19, the NPHET agrees that there is no longer a continuing public health rationale for retaining the remaining legal/formal public health measures and advised that they could be removed with effect from 28th February as planned (while emphasising the advices/measures that remain critical to our ongoing response to COVID-19 as set out in letter of 20th January). This includes:

- **Mandatory mask wearing in all those areas where it is currently regulated for - public transport, retail and other indoor public settings, and certain staff in hospitality.**
- **Public health measures in schools, including physical distancing measures and mask wearing.**

With regard to the resumption of social activity in residential care facilities and visitation in all healthcare settings, the NPHET recommends that:

- **Nursing homes and residential care facilities should move as quickly as possible to restore the activities and social life that provide a stimulating environment within the home for residents.**
- **In acute hospitals, nursing homes and residential care facilities, visiting restrictions that are more restrictive than those specified in national guidelines are not indicated unless there is specific written advice from a Public Health doctor or other appropriate expertise that additional restrictions are required in a specific context for a defined period of time and based on a risk assessment that is reviewed regularly and is publicly available.**
- **As appropriate, regulators should maintain a focus on ensuring visiting arrangements are in place in line with existing legal frameworks and guidance and should report to the Department on concerns of a systemic nature if they are identified.**
- **In all circumstances, including during outbreaks, there must be flexibility to meet the needs of residents and take account of the will and preferences of the residents in the application of limitations on access.**
- **While healthcare facilities will find it necessary to refuse access to people who show evidence of infection or those who will not cooperate with infection prevention and control requirements, this should be very exceptional as most people are happy to work with the facility to keep everyone safe**.

With regard to the critical components of the ongoing collective response and ongoing communication in relation to COVID-19, the NPHET recommends that the following 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 COVID19 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 with a continuing focus on protecting others, and adherence to basic hand and respiratory hygiene;**
- **Sector specific measures, based on risk assessments by individual sectors, to ensure a safe environment including in relation to the promotion of rapid self-isolation when symptomatic, hand and respiratory hygiene, ventilation, signage, and use of face masks and physical distancing if appropriate;**
- **Continuing engagement with and support for global vaccination and surveillance initiatives;**
- **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 challenges. 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 national guidance and 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.**

6. Vaccination Update

a) Vaccine Safety Update

The HPRA provided a verbal update on the national reporting experience for COVID-19 vaccines. No new safety issues have been identified from national reports since the last update to NPHET.

The HPRA published its 16th Report on its website on 17th February which includes more details regarding the type and nature of reported reactions. The next report will be published on the HPRA website on 24th March 2022.

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

7. Meeting Close

a) Agreed actions

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

b) AOB

The Chair stated that notwithstanding the need for continued vigilance, we are now entering a transition phase of the pandemic response. This transition will entail a shift from the emergency type processes and measures of the last two years, while also necessitating the maintenance of high levels of readiness for COVID-19 outbreaks and the emergence of new variants of concern, with significant strengthening of existing disease surveillance systems, along with continued close monitoring of the epidemiological profile of the disease.

The Chair stated that considering the country is moving out of the emergency phase of the pandemic and given the significant mainstreaming of the COVID-19 response, the continuing impact of the vaccination programme, and the programme of work already completed by the NPHET, it is now deemed timely to conclude the work of the NPHET.

The NPHET supported the approach proposed.

The Chair then confirmed that a specific proposal on the appropriate structure and processes for this would be sent to the Minister for Health after the NPHET meeting.

The Chair extended his sincere thanks and gratitude to the Members for their contributions and support in carrying out the important work of the NPHET. Members reciprocated these sentiments to the Chair.