



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

Date and Time	Friday 8 th May 2020 (Meeting 29) at 11am
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via Videoconference	<p>Dr Colm Henry, Chief Clinical Officer (CCO), HSE Mr David Walsh, National Director, Community Operations, HSE Mr Liam Woods, National Director, Acute Operations, HSE Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group Chair Dr Darina O’Flanagan, Special Advisor to the NPHE Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Dr Alan Smith, Deputy Chief Medical Officer, DOH Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH Dr Mary Favier, President ICGP Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Prof Colm Bergin, Consultant Physician in Infectious Diseases, St James's Hospital Dr Kevin Kelleher, Assistant National Director, Public Health, HSE Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Mr Paul Bolger, Director, Resources Division, DOH Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Ms Kate O’Flaherty, Head of Health and Wellbeing, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Breda Smyth, Public Health Specialist, HSE Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety, DOH Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA Dr John Cuddihy, Interim Director, HSE HPSC Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group Mr Tom McGuinness, Assistant National Director, Office of Emergency Planning, HSE Mr David Leach, Communications, HSE Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE Dr Jeanette McCallion, Medical Assessor, HPRA Dr Lorraine Doherty, National Clinical Lead, Health Protection, HSE</p>
‘In attendance’	<p>Mr David Keating, Communicable Diseases Control Policy Unit, DOH Mr Colm Ó Conaill, Policy and Strategy Division, DOH Ms Sarah Treleavan, NPSO, DOH Ms Aoife Gillivan, Communications, Corporate Division, DOH Ms Laura Casey, Policy and Strategy Division, DOH Ms Deirdre McNamara, Office of the Chief Clinical Officer, HSE Ms Marita Kinsella, NPSO, DOH Mr Ronan O’Kelly, Statistics and Analytics Unit, DOH Ms Sheona Gilsenan, Statistics and Analytics Unit, DOH</p>
Secretariat	Ms Rosarie Lynch, Ms Susan Reilly, Mr John Harding, Ms Sarah Murphy, Ms Linda O’Rourke, Ms Liz KIELTY, DOH



1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Minutes of previous meeting(s)

The NPHE Secretariat advised that draft meeting notes up to 5th May 2020 are in the process of being finalised and continue to be sent out for review and feedback. It is expected that the finalised meeting notes of these meetings, when finalised by NPHE members, will be published on the Department of Health website.

c) Matters Arising

No matters arising

2. Epidemiological Assessment

a) Key updates on National Data

i) Health Protection Surveillance Centre (HPSC)

The HPSC gave an overview of the national data for COVID-19.

The HPSC also provided an overview of the trends over the past three weeks and focused particularly on the data now available for cases in (i) healthcare workers and (ii) Long Term Residential Care settings (LTRCs). The data showed that the numbers of new cases detected in the general population, as well as among healthcare workers and the LTRCs, have been falling in recent days.

As committed at the last meeting, the HPSC provided a specific update in relation to cases in healthcare workers. Of total confirmed cases, nearly 29% are in healthcare workers. It was noted that they have been prioritised for testing for a significant period. Data on healthcare workers show that the likely source of transmission in over half the cases is nosocomial and where there was close contact with a COVID-19 patient in a healthcare setting. The data showed that the source of transmission was unknown in over 40% of cases and the HPSC advised they are exploring this matter further. Overall, just over 30% of healthcare worker cases are linked to an outbreak, of which 16% are attributed to nursing homes.

The HPSC also provided data for vulnerable populations which show–

- Five outbreaks in prisons with 18 notified cases;
- Three outbreaks involving the Roma community with 21 notified cases;
- Five outbreaks involving Irish Travellers with 36 notified cases;
- 12 outbreaks in Direct Provision Centres with 149 notified cases;
- Eight outbreaks involving homeless settings, though it was noted that there are gaps in data for this group.



In terms of community cases, the HPSC advised that cases in specific workplaces, such as meat processing factories, account for a relatively small proportion of the overall number of cases, though acknowledging that one outbreak, which started a few weeks ago, accounted for a high number of cases. The HPSC advised that of the confirmed cases in Direct Provision Centres, 12 cases were reported as hospital inpatients and there have been no reported deaths.

ii) Department of Health (DOH)

An overview was presented by DOH, compiled from the daily HSE reports and the HPSC data. The hospitalisation data show a steady downward trend over the past month in the number of ICU admissions and the number of ventilated patients. There is still some work to be done to ascertain reliable intelligence in relation to hospital discharges.

The number of laboratory tests continues to increase, and the positivity rate has seen a steady decline since changing the testing regime. Data show that the number of contact tracing calls completed peaked on 15th April, but numbers have declined.

b) *Modelling update*

The Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) advised that the main updates had been covered and there was nothing further of note.

The data presented were discussed by the NPHET and the key points raised included:

- While the data show improving trends in the general population, there was agreement that there is a need to maintain a strong focus on vulnerable groups in the community including those in Direct Provision Centres, prison populations, Traveller Community, Roma Community, the homeless and those availing of homeless services;
- available testing capacity should be mobilised towards increased testing of vulnerable groups and staff working in and/or providing supports to these groups;
- the need for enhanced efforts to communicate effectively with these groups including through a holistic cross-Government public health/social inclusion approach;
- in relation to some of the outbreaks in vulnerable populations as well as in the workplace and among healthcare workers, it was acknowledged that there were a lot of unknown factors that may be relevant in terms of transmission such as shared accommodation, social interactions, work location, and ethnic background;
- the need for more robust data collection and improved completion of all fields on the surveillance forms to identify at risk groups quickly, including capturing data such as ethnicity, occupation, workplace setting, vulnerable group, etc. if appropriate. The HPSC advised that a list of additional fields has been sent to the HSE for inclusion in the CRM and the HPSC is following up to progress implementation.

More broadly, in the context of the work of the NPHET in the coming week in relation to providing advice to Government on reducing public health social distancing measures, it was agreed that there is a need for improved surveillance and intelligence on the progress of the disease, especially amongst vulnerable groups and higher risk workplaces; the need for an enhanced testing



programme; and to have assurances that the current guidance remains appropriate and is being appropriately implemented by the relevant stakeholders.

The NPHET asked the HSE to revert outlining the public health response to address the specific challenges identified amongst vulnerable groups (e.g. persons in direct provision centres, prisons, Roma Community, Irish Travellers, the homeless and others) in relation to managing the transmission of COVID-19 in these settings. This is to include consideration of enhanced surveillance data, the guidance in place and the way this guidance is being complied with.

The HPSC advised that the issues raised in the discussion will be incorporated into its work to prepare an overall testing strategy. They further advised that a preliminary report will be presented to the NPHET next week.

Action: The NPHET recommends that the HPSC review and update the current surveillance form for COVID-19. The HSE is to implement across all relevant settings, including where contact tracing is undertaken.

c) International Assessments

There were no items of note for update at the meeting.

d) Prevalence Studies (SCOPI)

At the request of the HPSC, discussion of this item was deferred until the NPHET meeting of the 15th May.

3. Expert Advisory Group (EAG)

The Chair of the Expert Advisory Group provided a summary of the matters discussed by the EAG at its meeting of 6th May. The Chair updated the NPHET as follows:

(i) Regarding the use of masks or face coverings in the community:

- *Given that many people are already choosing to wear masks, the HPSC will prepare guidance on appropriate mask use in the community which will come back to EAG and NPHET for review;*
- *There has been no change to the EAG advice on mask use in the community at this time.*

The Chair of the EAG advised that HPSC is to prepare guidance on the appropriate and safe use of non-medical grade masks in the community and the EAG will review this guidance and provide its views on same to NPHET. The NPHET welcomed this approach, particularly in the context of recommendation to Government regarding the use of face coverings in the community.

(ii) In the case of an individual with confirmed COVID-19 who has recovered and completed their 14 days of isolation, but who is subsequently a contact of a case of COVID-19–

- *such individuals can be considered immune for 3 months from the onset of symptoms and can continue to work,*



- *such individuals should be advised to be vigilant for symptoms,*
- *such individuals should be re-tested and excluded from work if symptoms develop, given the uncertainty around the development of protective immunity after infection,*
- *in addition to SARS CoV 2, these individuals should be tested for other respiratory viruses to identify a potential alternative diagnosis.*

EAG advised that this recommendation will need to be kept under review as more studies with a longer follow-up on the persistence of antibodies are published.

Regarding its advice in relation to individuals with confirmed COVID-19, who have completed their 14 days of self-isolation and recovered, but who are subsequently a contact of another case of COVID-19 in another individual. The position of the EAG is that the available international evidence shows that there is not a significant risk of reinfection and, as such, individuals can be considered immune for a period of three months following the onset of their original initial symptoms. It was acknowledged that, as the evidence on the nature of the virus continues to evolve and while current research shows that antibodies are detectable out to two months, the position of the EAG will be kept under review. Individuals should remain vigilant for further onset of symptoms even after they recover from the virus and that those who are diagnosed with re-infection may need to be referred for specialist testing. The HPSC agreed to engage with EU colleagues at a forthcoming ECDC meeting in relation to evolving international guidance on these matters.

(iii) Regarding possible reinfection (i.e. someone with a history of COVID-19 who has recovered, but who then develops new symptoms consistent with COVID-19 and has another SARS CoV 2 RNA Detected test)–

- *IPC precautions should be put in place until the diagnosis is clear,*
- *Patients should be tested for a full panel of respiratory viruses to identify a potential alternative diagnosis,*
- *The Ct values of the PCR results for COVID-19 should be reviewed in conjunction with a consultant microbiologist, virologist, or infectious diseases physician,*
- *If reinfection cannot be excluded following the above steps, suspected cases of reinfection should be reported to public health to facilitate contact tracing in accordance with current guidelines.*

The Chair added that the EAG considered that individuals should remain vigilant for further onset of symptoms even after they recover from the virus and that those who are diagnosed with re-infection might need to be referred for more specialist investigation.

(iv) Regarding asymptomatic healthcare workers in whom SARS CoV 2 RNA is detected–

- *healthcare workers in this group should firstly undergo direct questioning regarding possible COVID-19 related symptoms in the pre-test period,*
- *If no symptoms are reported, then the HCW should be excluded for 14 days from the date of the test,*
- *In the case where symptoms consistent with COVID-19 are reported:*



- *If symptoms occurred within 14 days prior to the test, the healthcare worker should be excluded from work for 14 days from the date of onset of symptoms,*
 - *If symptoms occurred more than 14 days prior to the onset of the test, the healthcare worker should be excluded for 14 days from the date of the test.*
- (v) *Regarding patients waiting for dental treatment prior to receiving chemotherapy or to undergoing essential cardiac surgery–*
- *these individuals should be added to the priority list for testing.*

Action: The NPHEAT accepted the advice of the Expert Advisory Group (EAG) arising from its meeting dated 6th May 2020 in relation to–

- a) **individuals with confirmed COVID-19 who have recovered and completed their 14 days of isolation, but who are subsequently a contact of a case of COVID-19,**
- b) **individuals with possible reinfection (i.e. someone with a history of COVID-19 who has recovered, but who then develops new symptoms consistent with COVID-19 and has another SARS CoV 2 RNA detected test), and**
- c) **asymptomatic healthcare workers (HCWs) in whom SARS CoV 2 RNA is detected.**

The HPSC is to update its guidance on these matters and the HSE is to implement accordingly.

3. Review of Existing Policy

a) Personal Behaviours & b) Social Distancing

The DOH provided an overview to NPHEAT of the Department’s ongoing surveys and focus groups to ascertain public opinion and attitudes during the COVID-19 pandemic. Some of the key findings indicate as follows:

- Positive changes among individuals regarding personal hygiene, respiratory etiquette;
- A reduction in the number of individuals staying at home albeit down from a very high compliance rate of over 90%;
- 18% of respondents are already wearing facemasks;
- Compliance with measures is strongly linked to individual responsibility and an anxiety of spreading the virus to another person, particularly a vulnerable person;
- A need for clarity regarding any proposals around the concept of micro-communities in the context of any reduction of social distancing messaging;
- Overall, individuals are preparing for a ‘new normal’ and living in an environment with COVID-19;
- The DOH is amending its communications message, which reflects the findings, to “stay safe, protect each other”.

The NPHEAT also discussed the need to use other data sources to evaluate levels of compliance with the public health measures, particularly as the public health measures are eased, e.g. traffic and transport, mobility and seismology data. These data are expected in the coming days. It was noted that the views of the Behavioural Change Sub-Group of NPHEAT aligned with the findings of the DOH public opinion research.



In relation to the use of face coverings, it was acknowledged that there was a need for careful communications to advise the public on their safe use. Importantly, communication campaigns regarding face coverings will have to emphasise that they are only supplementary to personal hygiene behaviours and ongoing vigilance to recognise symptoms of the virus and to act quickly.

c) Sampling, Testing, Contact Tracing and CRM reporting

The HSE updated the NPHET on progress on rolling out the new end-to-end testing capacity.

The new case definition which became operational on 6th May did not result in any unexpected surge in demand and so there is some spare capacity in the system for additional testing. In this context, the HSE welcomed the increased focus that could be placed on testing in the vulnerable groups.

The capacity of the HSE remains on target to carry out 15,000 tests per day by 19th May 2020. In terms of turnaround times, there has been some improvement with the testing pathway being down to 1-2 days from 3 days. The HSE is putting a target in place to have 70% of test completed in 1-3 days and this includes the entirety of the pathway from sampling, testing through to contact tracing.

The NPHET were advised that contact tracing calls can range from the routine to the more complex. The complex calls are carried out by Public Health Departments. The HSE added that the fully automated contact tracing system is expected to be operational in the week commencing 18th May 2020.

The HSE advised that a GP Helpline is being set up which will allow for direct GP access where patient updates are required. The HSE acknowledged the positive input and support in the community and primary care settings throughout the implementation of the testing programme.

The HSE advised that a paper is being prepared for NPHET by the HSE Lead for the Testing Strategy which will set out the progress to date.

There was a discussion of the ongoing challenges in relation to the CRM and Computerised Infectious Disease (CIDR) systems and the impact of the timely receipt of daily epidemiological data. The HSE was requested to explore potential solutions and indicated that work is ongoing in this regard.

5. HSE's update to the NPHET further to:

a) Residential Healthcare settings

The DOH and the HSE provided a brief update on the work ongoing and advised that the data are showing a decrease in the number of new cases and in the number of active outbreaks in long-term residential care settings.

Work is also ongoing with regard to developing a plan to recommence visiting to residential centres, bearing in mind the public health risks. It is expected that the proposed approach will recommend



very gradual changes to the visiting restrictions given the challenges involved. A paper is in preparation for NPHE with a view to it being submitted at the end of next week.

i) Update on the HIQA monitoring programme

HIQA presented a paper on its regulation of health and social care services during the COVID-19 public health emergency. The paper sets out the approach taken by HIQA in order to provide a meaningful contribution to the national response to COVID-19 in its interactions with DOH and the HSE. To facilitate timely exchange of information and escalation of risk, HIQA outlined that it created five distinct referral and monitoring pathways. Furthermore, HIQA developed an Infection Control Hub, a Contact Tracing Centre, and directed its Health Technology Assessment (HTA) team and other relevant staff to support the NPHE, the EAG and the HPSC in the development of relevant HTA and evidence summaries.

HIQA outlined that, in terms of regulatory activities, it has issued seven regulatory notices to providers across March and April. These have reduced the number of mandatory notifications and have facilitated an easier system to ensure the timely return of data on number of residents and staff with suspected or confirmed cases of COVID-19, and the number of unexpected deaths in each centre. In addition, HIQA has facilitated a one-day turn around registration process to expedite the opening of new residential beds.

The NPHE welcomed the ongoing work of HIQA, the assurances to the NPHE as a result of the regulatory work undertaken by HIQA, and the ongoing collaboration with the DOH and HSE. It was suggested that HIQA start to examine the preparation of guidance, in particular, to address the isolation of residents and the psycho-social impact this has on individuals, in preparation for the easing of public health measures.

b) Acute Hospital settings

The DOH advised that there continues to be ongoing engagement with the HSE including through the NPHE Acute Hospital Preparedness Sub-group and there are currently no issues which need to be brought to the attention of NPHE.

The DOH advised that feedback has been received on the HIQA Report on public hospital infection prevention and control preparedness for COVID-19 and a final copy of the report and accompanying letter from HIQA will be circulated to NPHE members following the meeting.

6. Future Policy

a) Non-urgent, non-acute care

DOH spoke to the paper “*Community Capacity and Resumption of Community Services (Post-COVID-19) - Proposal to establish a Community Capacity Working Group*” and advised that meetings have taken place, including with the HSE to establish the proposed Working Group.

NPHE was advised that the purpose of the Working Group will be to develop a high-level plan for the phased resumption of services and associated capacity requirements for the community. This



plan will be operationalised having due regard to the advice of the Office of the Chief Clinical Officer of the HSE and the need to achieve an integrated approach between acute and non-acute services.

It was acknowledged that the resumption of community services should be based on sound clinical advice and prioritisation regarding re-commencement of services. It was also acknowledged that a whole-of-community approach should be taken, and that there should be cross-health sector alignment of measures. It was requested that this process consider screening and issues related to discharges from hospital. In addition, there is a need to ensure the continuation, in the next phase, of the positive reforms and innovation which have arisen through this crisis e.g. community hubs, response teams, ICT.

b) Travel Considerations

DOH presented a draft deliberative paper on travel matters and consideration of restrictions on arriving overseas passengers on public health grounds. In the paper, DOH presented an overview of international approaches to travel restrictions which range from voluntary through to a prohibition on travel. However, it was noted that a number of countries have started lifting their public health social distancing measures which could potentially see a resumption of international travel. Therefore, it is timely to review if Ireland's current approach is appropriate or in need of strengthening.

DOH also clarified at the outset that Ireland's current policy and legislative framework, as well as membership of the EU and Common Travel Area, mean that a ban on non-essential travel cannot be considered.

The NPHE's overall considerations were as follows:

- NPHE had a significant concern that, as the number of cases of COVID-19 declines (after the extreme efforts of, and impact on, everyone in society), there is a considerable risk that Ireland will see an increase in infection, including as a result of imported cases due to non-essential overseas travel;
- NPHE emphasised that travel restrictions are even more important as Ireland starts to lift its restrictive measures because more people will be moving about in society and there will be greater opportunities for spread of infection;
- NPHE noted the advice from international organisations and the experience of other countries that are ahead of Ireland in time, in terms of the progress of the disease and easing of their restrictive measures. Indications from some countries suggest that the number of cases have started to increase again, including because of importation of cases;
- A concern was also noted regarding international non-essential travel by Irish residents and the need for this to be discouraged. It was recognised that non-essential international travel could result in two specific risks: a) the risk of Irish residents returning to Ireland from non-essential international travel with infection contracted in another country; and b) the risk (though



hopefully lower now) of transmission of infection from Ireland to other countries as those countries lift restrictive measures;

- Overall, the NPHE was of the view that the principal public health objective should be to eliminate, in as far as possible, all non-essential overseas travel and to require a period of mandatory quarantine for people arriving into Ireland from overseas. There is a risk of importation of cases from overseas which could contribute to an upsurge in infection. These measures would minimise this risk and, as a result, lessen the likelihood of Ireland having to reimpose public health social distancing measures, which are highly disruptive to social and economic activity;
- NPHE noted that testing and temperature screening at airports and ports could not provide an adequate solution, though it was acknowledged that new technology developments in the future could inform a review of this position;
- NPHE considered that non-essential travel from non-EEA countries should be restricted, subject to certain exemptions (including Irish citizens and residents);
- NPHE considered possible approaches to self-isolation, and came to the view that persons arriving into Ireland from overseas should be mandatorily required to undertake a period of self-isolation for 14 days at a designated facility (subject to appropriate exemptions), rather than on the basis of an individual's own self-declared plan. It was considered that this approach—
 - has the greatest deterrent value in dissuading non-essential travel,
 - will be comparatively easier to oversee in terms of compliance rather than trying to verify each individual's own plan at a location of their choosing;
- NPHE also considered that the current voluntary "*Public Health Passenger Locator Form*" should be made mandatory and it was clarified that this could be provided for in Regulations under the *Health Act, 1947*;
- In coming to this position, the NPHE stressed the need for careful consideration of the operationalisation of this approach to ensure the following concerns would be addressed:
 - that necessary exemptions are provided for, including travel for essential purposes;
 - the provision of facilities of adequate quality in terms of capacity, safety, comfort of individuals required to isolate, at the possible cost of the individual;
 - that all human rights obligations are taken account of in the arrangements put in place;
 - a comprehensive programme of communications is developed to inform residents and prospective travellers to Ireland of the travel restrictions in place and the requirements on the part of the individual should they choose to travel to Ireland from overseas.

Action: NPHE recommends that the necessary whole-of-Government work is undertaken to allow for a Government decision on the introduction of a range of more stringent requirements related to travel from overseas to include



- a. mandatory completion of the *Public Health Passenger Locator Form* by all persons arriving into Ireland from overseas;
- b. restriction of non-essential travel from all countries other than EEA countries and the UK (with exemptions to include Irish citizens or residents);
- c. a mandatory regime of self-isolation for 14 days at a designated facility for all persons arriving into Ireland from overseas (with limited exemptions to include supply chain workers and those in transit to other jurisdictions, such as Northern Ireland);
- d. a programme of public communication designed to deter all non-essential travel should be put in place.

NPHET recognised that preparatory work including in relation to regulatory, operational and communications measures will be required to give effect to any decision the Government may make having regard to this public health advice. In addition, it will be essential to ensure clear messaging through coordinated public communications.

c) Ad Hoc

The DOH referred to the timelines of the Government's "*Roadmap for Reopening Society & Business*" and the lifting of measures and proposed that the NPHET allocate time at its meeting of Tuesday 12th May for substantive discussion on this matter.

It was agreed that both the Government's "*Roadmap for Reopening Society & Business*" and the NPHET "*Public Health Framework Approach in providing advice to Government in relation to reducing social distancing measures introduced in response to COVID-19*" will be circulated to NPHET members following the meeting by way of reminder and preparation.

The NPHET reiterated that in providing public health advice, that the advice cannot be considered to be risk-free and in relation to requests from other organisations for input regarding the lifting of measures, the NPHET can provide no assurance that easing any set of restrictions will be safe in terms of the risk of infection.

The HPSC advised the NPHET that they are receiving a substantial number of queries from organisations seeking detailed sector-specific protocols and advice. It was noted that the NPHET's role is to provide public health advice to Government and that the HPSC provides public health guidance. NPHET agreed that sectors or organisations should be advised to apply the general public health advice and guidance and to engage with the relevant Government Departments, regulatory bodies and sector bodies within their sector.

Action: The NPHET recommends that Government Departments, regulators, State Bodies and organisations across society should commence preparation of appropriate guidance and planning as part of the process of easing of the current public health restrictions.

7. NPHET processes

The DOH spoke briefly to the paper "*NPHET for COVID-19 Process - Proposal for NPHET to carry out a "Take Stock" process to prepare for moving into the next phase of COVID-19 disease management.*"



The timing of the stock take also coincides with the progression of the disease into a new phase and broadly reflects the approach to date, i.e. the NPHEt adapting its processes to respond to the demands for public health advice and direction within the health service.

This piece of work will also aim to inform proposals for sustainable arrangements to be put in place to respond to the disease in the medium term. The process will include engagement with the NPHEt Subgroups as well as members of the NPHEt to receive feedback on how NPHEt might evolve and a review of administrative processes.

It was agreed that the DOH will submit a paper to the NPHEt on the 22nd May with the results of the stock taking exercise.

8. Meeting Close

a) Agreed Actions

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

b) AOB

i. Occupational Health paper

Due to time constraints, it was agreed to defer discussion of the “HSE Workplace Health and Wellbeing Unit - Update 27th April” to a later NPHEt meeting.

ii. Date of Next Meeting

It was agreed that next week’s meetings will be arranged for Tuesday 12th May and Thursday 14th May both to start at 10am.