National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Thursday 8th October 2020, (Meeting 58) at 10:00am
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Dr Kevin Kelleher, Assistant National Director, Public Health, HSE Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG) Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA Dr John Cuddihy, Interim Director, HSE HPSC Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Dr Siobhán O'Sullivan, Chief Bioethics Officer, DOH Dr Colette Bonner, Deputy Chief Medical Officer, DOH Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Darina O'Flanagan, Special Advisor to the NPHET Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Dr Breda Smyth, Public Health Specialist, HSE Ms Yvonne O'Neill, National Director, Community Operations, HSE Dr Lorraine Doherty, National Clinical Director Health Protection, HSE Mr Tom McGuinness, Assistant National Director for Emergency Management, HSE Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Colm Henry, Chief Clinical Officer, HSE Mr Liam Woods, National Director, Acute Operations, HSE Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE
'In Attendance'	Dr Matthew Robinson, Specialist Registrar in Public Health, DOH Mr David Keating, Communicable Diseases Policy Unit, DOH Ms Laura Casey, NPHET Policy Unit, DOH Mr Gerry O' Brien, Acting Director, Health Protection Division Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion) Ms Aoife Gillivan, Communications Unit, DOH Mr Ronan O'Kelly, Health Analytics Division, DOH Dr Heather Burns, Deputy Chief Medical Officer, DOH Dr Des Hickey, Deputy Chief Medical Officer, DOH Ms Deirdre McNamara, Quality & Patient Safety, HSE (Alternate for Dr. Colm Henry) Ms Niamh O'Beirne, National Lead for Testing and Tracing, HSE
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Robinson, Mr Liam Hawkes, DOH
Apologies	Mr Paul Bolger, Director, Resources Division, DOH Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital Ms Sarah Treleaven, CMO Division, DOH

1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Minutes of previous meetings

The minutes of the 24th September 2020 had been circulated to the NPHET in advance of the meeting. These were agreed and formally adopted by the NPHET.

c) Matters Arising

The Chair reiterated his thanks to the NPHET members and to DOH colleagues for coming together on Sunday, 4th October, to facilitate the important work carried out in making the NPHET's advice available to Government, in line with the concerning change in the epidemiology of the disease nationally. The Chair added that the NPHET's findings and subsequent recommendation that arose from this meeting required early, serious, and confidential discussion. The Chair stated that the content leaked to the media on the evening of the 4th October precipitated a series of events, which ultimately prevented the NPHET's recommendation from receiving the confidential consideration that it deserved. The Chair stressed that whoever was responsible for that leak does not share the NPHET's objectives for dealing with the COVID-19 pandemic.

The Chair confirmed that the NPHET would continue to make its conclusions and findings available to the Minister for Health in the usual way, in line with its Terms of Reference. Over recent days, there has been significant engagement befitting the current situation and the Chair expressed that he had received reassurance from the Department of the Taoiseach that each government department will be involved in the country's response to the pandemic. The Chair noted that he was reassured by the substantial response that can already be perceived across government, the media, and general public.

In the interest of maintaining public confidence, the Chair respectfully requested that NPHET members respect the importance of planned and timely communication with the media, explaining that unplanned communication does not serve the objectives of the group. In this regard, attention was drawn to the advisory, and coaching supports that can be provided by the Department of Health's Press Office team to members, should they feel that they require it in carrying out their NPHET-related work.

Reflecting on the Chair's comments, the NPHET agreed that there is a critical need for renewed focus on risk management, with particular regard to the confidential nature of NPHET recommendations prior to consideration by Government. The NPHET also confirmed that it was timely to review the governance procedures within the NPHET Secretariat, with a view to ensuring that the NPHET's recommendations and advice are communicated securely to the relevant parties.

2. 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:

Cases and Deaths

- The number of confirmed cases stands at 39,584;
- A total of 90,332 tests were undertaken in the 7-days to 8th October.
- A total of 3,436 cases have been notified in the 7 days to 8th October, compared with 3,072 in the 7 days to 4th October;
- As of 8th October, the 7- and 14-day incidences are 72 and 124 per 100,000 population, respectively; these compare with 7- and 14- day incidences of 66 and 108 per 100,000, respectively to 4th October;
- As of 8th October, the 5-day average of reported cases is 508; this compares with a 5-day average of 462 cases on 4th October;
- As of 8th October, the 7-day incidence is 72.2 cases per 100,000 population. The 7-day incidence rate was 66.8 per 100,000 population on 1st October;
- The 7-day average positivity rate has increased from 3% on 30th September to 4% as of 7th October;
- 9,434 cases (24% of all cases) were associated with healthcare workers; 397 cases were reported in healthcare workers in the fortnight to 6th October;
- 1,816 deaths due to COVID-19 have been notified to date; 8 of these have occurred in the month of October; 34 deaths occurred in the month of September;
- As of 8th October, the estimate of the reproduction number (R) is 1.2. It was estimated to be between 1.2 and 1.4 in the week to 7th October.
- Northern Ireland is experiencing a large number of confirmed cases, with a 7-day incidence of approximately 235 per 100,000 population.

Demographic and Location Trends

- 66% of cases notified in the past 14 days have occurred in people under 45 years;
- The median age for all cases remains stable; the median age for cases notified in the past 14 days is 33 years;
- Incidence in older age groups is increasing with 10% of cases notified in the last 7 days in the over 65 age group;
- The 14-day incidence in those aged 65 years and older has increased from 67.3 per 100,000 population on 3rd October to 92.9 per 100,000 population on 7th October;
- 23 counties have an increasing 14-day incidence rate at present as compared to their rates in the week to 7th October.

Hospitalisations

- As of 8th October, there are 159 confirmed cases in hospital with 17 admissions in the previous 24 hours, compared with 134 on 4th October;
- There are currently 27 confirmed cases in critical care, compared with 22 on 4th October;
- In the fortnight to 7th October, 397 cases have been reported in healthcare workers;

Clusters and Modes of Transmission

- 492 additional new clusters were notified in the week to 3rd October 2020. There are 2,083 open clusters nationally; The vast majority of open clusters continue to be associated with private households (1,628 of the 2,083 clusters);
- In the fortnight to 6th October, 57% of all cases in recent days have arisen as a result of close contact with a confirmed case. A further 38% of cases are linked with community or possible community transmission.

(i) Update on outbreaks – Nursing homes, workplaces, vulnerable groups

The HPSC presented *"Epidemiological Summary of Outbreaks for NPHET, 8th October 2020."* The key points were as follows:

Overview of Outbreaks

- Since the start of the pandemic, there have been 4,443 outbreaks notified to the national infectious disease surveillance system;
- In the 7 days to midnight 5th October, there were 492 outbreaks notified, 80% (395) of them occurred in private houses.

Updates and Epidemiological findings for Nursing Home Outbreaks:

- In the week to midnight on 5th October, there have been 11 new nursing home and community hospital/long-stay unit outbreaks, with 86 linked confirmed cases; there were 34 additional cases linked to outbreaks reported previously;
- 3 outbreaks in nursing homes and community hospitals/long-stay units were closed since 29th September 2020;
- A total of 47 outbreaks in Nursing Homes and 3 in a Community Hospital/Long-Stay-Unit were notified between 1st July and 5th October 2020. Of these, 29 outbreaks remain open, with 299 associated cases: 112 associated HCW/staff cases, 111 associated client cases, 76 cases where HCW status unknown;
- Of the open outbreaks, 6 include only HCW/staff cases and 17 include both HCW/staff and clients, for others the case mix is unknown.

Updates on outbreaks associated with school children and school staff:

- In total there were 55 outbreaks associated with school children and staff notified up to midnight 5th October 2020;
- Since 29th September, there have been 18 new outbreaks associated with school children and staff with 28 linked cases, 9 of these outbreaks had more than one linked case.

The HPSC emphasised that while outbreaks may be described as associated with school children and staff, this does not necessarily imply that these have arisen as a consequence of transmission within the school setting.

Outbreaks in Childcare Facilities (CCF)

- There have been 19 outbreaks associated with CCFs up to midnight 5th October;
- There is a total of 57 cases linked to these outbreaks, 13 of these outbreaks have 2 or more linked cases;
- Since the 29th September, there have been 8 new outbreaks associated with children and staff in CCFs with 11 cases linked to these outbreaks.

Outbreaks in Direct Provision Centres

- Since 29th September 2020, there were no new outbreaks notified;
- There have been 6 new cases linked to existing outbreaks in Direct Provision Centres;
- 8 of the outbreaks notified since the 1st July remain open; there were 42 cases linked to these outbreaks, 2 of these cases were hospitalised; the outbreaks range in size from 2-12 cases.

Outbreaks in other groups: Irish Travellers, Homeless, Roma

- Since 29th September, 4 new outbreaks in the Irish Traveller community with 32 linked cases were notified;
- There were 4 additional cases linked to previously reported outbreaks;

- As of midnight 5th October, there were 16 outbreaks in vulnerable populations notified since 1st July 2020 that remain open; there have been 101 confirmed cases linked to these outbreaks. 4 of these cases were hospitalised, 1 was admitted to ICU and there were no deaths.

Outbreaks in Meat Plants, Food Processing Plants and Wholesale Florists

- 3 additional outbreaks were reported since 29th September 2020 involving 9 new cases;
- 47 cases occurred in the last 14 days, 14 of these within the 7 days to 5th October;
- There are 13 outbreaks in this sector notified since 1st July 2020 that remain open, with 117 confirmed cases linked to these outbreaks; two cases (1.7%) were hospitalised; there were no ICU admissions or deaths among these cases.

Outbreaks in the Construction Sector

- Between 1st July and 29th September, there were 11 outbreaks notified that remain open; there are 41 cases linked to these outbreaks;
- There were no hospitalisations, ICU admissions or deaths associated with these cases.

Acute Hospital Outbreaks

- As of midnight 5th October 2020, there have been a total of 126 acute hospital outbreaks notified;
- Of these outbreaks, 106 are closed and 20 remain open;
- Between 28th September and midnight 5th October, there were 9 new acute hospital outbreaks with 28 linked cases;
- During this time there were 2 additional cases linked to previously reported outbreaks.

The NPHET noted that the increase in cases in healthcare workers predated the increase in hospitalisations, which would indicate that healthcare workers are contracting virus in the wider community and bringing it into the hospital setting, rather than becoming infected in the course of their work.

The NPHET acknowledged the fact that the spread of the disease across the population has changed over the course of the pandemic and is now more heavily concentrated in younger age cohorts, particularly those aged 19-24 years. It was noted that while this shows older people have been successful in protecting themselves from the virus, a high incidence within the general population will diminish their ability to do this in the future, and a reduction in community transmission is required to protect this population.

3. Nursing Homes

The DOH presented *"Nursing Homes Paper - Current Situation: Provided to NPHET 8th October 2020"* on the work carried out to date with regard to the management of COVID-19 in nursing homes

The DOH further outlined that oversight mechanisms for reporting to the Minister for Health on the implementation of the prioritised operational recommendations made in *"The COVID-19 Nursing Home Expert Panel's Report"*, are now in place. The NPHET noted that responsibility for the implementation of the report's 86 recommendations lies with individual nursing homes, the HSE, HIQA, NTPF and the Department of Health, as appropriate. An interagency approach is in operation with significant supports, guidance and regulatory oversight being provided to nursing homes by the HSE and HIQA. In addition to the supply of PPE to all nursing homes by the HSE, 26 COVID-19 response teams are in place, providing multi-disciplinary support across the CHOs to individual nursing homes.

The NPHET acknowledged the significant work carried out to date and stated that the implementation and oversight mechanisms contained in the report are satisfactory, with a clear assignment of responsibility for each recommendation.

The NPHET further emphasised the importance of continuing the programme of fortnightly serial testing for staff in nursing homes as a proactive protective measure.

The NPHET noted with concern that recent trends demonstrate an increasing number of COVID-19 cases and clusters in residents of nursing homes and staff working in these settings. The NPHET emphasised that reducing overall community transmission is an essential prerequisite to protecting those living and working in nursing homes against COVID-19.

Finally, the NPHET stated the need for more data sources on the epidemiology of COVID-19 in all nursing homes beyond serial testing data. By considering the results of serial testing data in parallel with other sources, more proportionate and targeted interventions in individual nursing homes could possibly be enabled. In this regard, the NPHET requested that the HPSC conduct future analyses on:

- *The comparative level of infection rate within the nursing home population (per serial testing, plus non-serial testing outbreaks) compared with the over 65 age cohort in the community;*
- *The trend in positivity rates over time, combined with the overall testing population proportions in order to understand the link between increased detection alongside increased infection;*
- *This should be combined with information on whether serial testing was being carried out in the period;*
- *The representation of the percentage of nursing homes where outbreaks/positive cases are taking place compared to total number of nursing homes in the State.*

4. Future Policy

a) Overarching approach to testing for COVID-19 and Influenza in community & acute settings

The HPSC presented *"Guidance for SARS-CoV-2 and influenza testing – Winter 2020/21: V2.3 07/10/2020"*, containing the recommendations of a subgroup of the National COVID-19 Testing Strategy Group, convened to consider the options for SARS-CoV-2 testing/influenza testing for the winter, in settings including nursing homes, residential care facilities, work places, hospital settings, and primary care.

The guidance provides detailed recommendations on:

- determining when influenza viruses are circulating in Ireland in the context of COVID-19 pandemic;
- when testing for SARS-CoV-2 or Influenza or both should occur.

The NPHET thanked the HPSC for its report and requested assurance that this guidance has been communicated and implemented across the health system. The NPHET stressed that it is essential that all patients undergo a SARS-CoV-2 test, whether they are being admitted for scheduled care or for acute treatment.

Action: The NPHET endorses the HPSC's *"Guidance for SARS-CoV-2 and influenza testing – Winter 2020/21"* and seeks assurance from the HSE this guidance has been communicated and implemented across the health system

5. Review of Existing Policy

a) Sampling, Testing, Contact Tracing, and CRM Reporting

The HSE presented the paper *"Testing and Tracing updated for NPHET, 8th of October"*. The data presented were as follows:

- Over the past 7 days, 29th September 2020 – 5th October 2020, there have been 89,543 swabs taken for COVID-19 testing. Over 53,338 of these were taken in the community; 18,412 swabs were taken in acute settings;

- The remaining 17,793 swabs were taken as part of the Serial Testing programmes of employees in meat and food production plants, and residents and staff in Direct Provision Centres;
- From 5th September - 5th October there were 366,601 tests completed – that is 73,880 tests per million of population, the 4th highest rate across EU countries of >2 million population;
- Between 29th September – 5th October, a total of 18,124 calls were made in the Contact Tracing Centres. A total of 3,439 of these were Call 1s, which involves the communication of a detected result. A total of 14,685 calls were completed relating to contact tracing;
- Between 29th September – 5th October, the average number of close contacts per case was 5;
- Between 29th September – 5th October, the median end-to-end turnaround time for not detected tests in the community setting was 1.8 days;
- Between 29th September – 5th October, the median end-to-end turnaround time for detected tests in the community was:
    - 2.80 days from referral to completion of Call 1 (patient informed);
    - 3.25 days from referral to completion of the final Call 3 (contact tracing complete and close contacts referred for tests);
- Between 29th September – 5th October, the median time for community referral to appointment was 0.7 days; 95% of GP referrals were provided with a swabbing appointment the same day or next day;
- The median time to complete all calls for contact tracing, from 29th September – 5th October was 1.8 days, showing an improvement of 0.3 days to complete all calls in comparison to the preceding 7 days;
- The time to complete all calls of 1.8 days is high due to a number of factors:
    - There is an increase in the number of calls being made;
    - The calls are becoming more complex as contact tracers are met with frustration from those who are receiving the close contact calls;
    - Some laboratory results are received late in the evening and informing patients of a detected result takes place the next morning;
- Between 29th September – 5th October, the combined median time from swab to lab result for community and acute settings was 27 hours;
- Cycle 3 of serial testing of healthcare workers in Residential Care Facilities for older persons continued from 16th September. As of 6th October, there has been 43,488 tests carried out with 138 cases detected. This represents a detected rate of 0.32%;
- A process is currently in operation to support all ongoing schools testing including childcare facilities. As of 6th October, 252 schools have had/are having some testing completed as a consequence of a Public Health Risk Assessment. From the 252 schools that had mass tests there have been an additional 112 detected cases have been identified over and above original cases. 5,890 students and teachers have been involved in mass testing;
- The vast majority of cases are in the primary sector rather than secondary schools.

The NPHET was informed that, as of 5th October, there are 34 testing centres in operation, with an additional 3 pop-up testing sites also in operation. The continued deployment and operation of pop-up testing centres is part of the HSE's long-term testing strategy. The HSE also outlined that concerted efforts are underway to recruit additional staff for swabbing and contact tracing. The NPHET stressed the importance of maintaining the capacity and capability to respond that has been built over the course of the pandemic. Even as case numbers drop, the ability to rapidly deploy resources will be vital in ensuring that COVID-19 remains controlled at a low level in the population.

The HSE also presented the "*National Public Health Emergency Team (NPHET) Report 28th September to 4th October".* This report covers close contacts of cases of COVID-19 identified for the period 28th September - 4th October 2020. The data presented were as follows:

- For the week 28th September – 4th October 2020, 11,665 close contacts, and 1,565 complex contacts were created on the COVID Care Tracker (CCT);
- This represents a 10% and 28% increase on the previous week, respectively.
- 5th – 8th October saw an increase in the number of educational institutions recorded as complex from 229 to 315 (38% increase);
- The number of hospitals with recorded complex contacts rose from 57 to 104 (82% increase);
- Between 28th September – 4th October, the highest number of close contacts occurred in the household (4,256), followed by social circumstances (3,134).

Concerns about the increase in complex cases were raised. It was understood that some frontline practitioners are reporting a significant increase in reported close contacts. Should this be found to be the case nationally, a prioritisation process may need to be implemented for contact tracing.

The HSE highlighted that the proportion of complex cases to routine cases has increased. This presents a risk for Public Health Departments that manage complex cases as demands may increase beyond available capacity. The bulk testing protocol and ongoing public health alignment initiatives are designed to mitigate this risk.

6. Advice from HIQA (incorporating EAG)

a) Rapid Health technology assessment of alternatives to laboratory based real-time RT-PCR to diagnose current infection with SARS-CoV-2

HIQA presented advice to the NPHET on *"Rapid health technology assessment (HTA) of alternatives to laboratory-based real-time RT-PCR to diagnose current infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)*".

Accounting for WHO advice regarding diagnostic testing, the NPHET requested that HIQA undertake a rapid health technology assessment (HTA) of alternative diagnostic testing methods to laboratory-based real-time RT-PCR for the detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). HIQA presented several key findings from the HTA, which included the following:

- Broadly, RT-PCR remains the recommended test for the detection of SARSCoV-2 internationally and is recognised as the reference standard;
- In some countries, including Australia, Spain and the US, approved rapid antigen detection tests (RADTs) may be used in certain clinical contexts for the detection of SARS-CoV-2 in symptomatic individuals; this usage depends on factors such as the performance and availability of the test, and time since symptom onset.

Based on the key findings from the HTA, HIQA's advice to the NPHET is as follows:

- Alternative approaches for the detection of current infection with SARS-CoV-2 should be considered to enhance COVID-19 prevention and control; efficient processes with accurate and reliable rapid tests would facilitate timely clinical management and public health measures;
- In high-throughput laboratory settings, sample pooling strategies could be expanded to increase rRT-PCR testing capacity within existing resources. The following circumstances have been identified as potentially suitable for pooling of samples:
    - Specimens collected for the purpose of serial testing of asymptomatic individuals in at-risk settings (for example, nursing homes, healthcare workers, food processing facilities, vulnerable communities);

    - Specimens collected from patients as part of pre-admission precautions prior to elective procedures.
- Adoption of alternative approaches to testing requires consideration of factors including clinical performance (sensitivity and specificity), turnaround time, and ease of use. Exact specifications should be outlined for what constitutes a suitable test for each relevant purpose in the Irish setting, similar to the guidance issued by the WHO;
- Variability in performance within individual technologies and devices precludes a class-based endorsement of specific technologies such as rRT-LAMP and rapid antigen detection tests;
- Hospital-based laboratories have validated and adopted a range of simplified rapid RT-PCR tests. These tests offer comparable accuracy and facilitate prompt clinical decision-making. These devices typically have limited throughput, however, can be subject to supply chain shortages, and therefore should be reserved for high priority clinical circumstances;
- Near-patient testing, including the use of rapid antigen detection tests (RADTs), has the potential to expand test capacity, reduce test turnaround times and improve access. However, RADTs which are available or currently in development show lower sensitivity than that observed with rRT-PCR. Reported sensitivity varies significantly across brands, and there is a lack of performance data in asymptomatic populations. Investment is therefore required to perform clinical validation studies in the Irish setting. Potential opportunities identified for validation include:
    - Supplementing central laboratory capacity for the diagnosis of symptomatic patients early in the course of infection;
    - Serial testing for the prevention of outbreaks in at-risk settings (for example, nursing homes, healthcare workers, food processing facilities, vulnerable communities);
    - Testing for the investigation and management of outbreaks (for example, in university settings).
- Tests which demonstrate satisfactory performance, following clinical validation in the Irish setting, will support the ongoing development of a cohesive national strategy that ensures the right tests are undertaken in the right people at the right time for the right purpose;
- The introduction of near-patient testing must be within the context of a supporting quality management system. Such a system would support the quality assurance, governance, training and reporting requirements essential to delivering a safe and effective service;
- A coordinated multi-agency response is needed to mitigate potential risks associated with testing performed outside of the publicly funded national Test and Trace programme. This should include multilateral communication with stakeholders, including members of the public and private providers.

The NPHET expressed support for the HTA and raised the issue of external pressure to respond to questions regarding rapid testing in certain settings and contexts, and comparisons with international practices. The NPHET reiterated that, while antigen testing may be suitable for use in certain contexts, it is not a replacement for RT-PCR. The NPHET requested a paper detailing what tests have been validated and what progress has been made so far. The NPHET concluded that more work needs to be done in consideration of the settings that may be appropriate for antigen testing and procurement logistics, noting that a future policy decision will need to be reached on this matter.

7. Communications

The Department of Health presented, *"NPHET – Communications Update 8th October."*

According to the quantitative tracker, the nationally representative sample of 1,770 people conducted on behalf of the Department of Health on 5th October 2020 revealed the following:

- The level of worry is increasing, now standing at 6.8/10, similar to that expressed in April. The main sources of worry are primarily, health system overload, the health of family and friends, and the economy;

- 52% think the worst of the pandemic is ahead, the highest level reported since April;
- 63% think there should be more restrictions, similar to reports in March;
- 52% now think Ireland is trying to return to normal too quickly, with 34% thinking the pace is 'about right'.

The Communications Team informed the NPHET that the Department of Health is currently undertaking ethnographic research among young adults to understand the reasons behind the low levels of compliance in this age group, and to identify possible solutions, with the aim of enabling young adults to live and socialise safely within the public health guidelines. The final results of the study are due on 16th October, however, some key insights to date include:

- Young adults, in particular, are suffering from COVID-19 restrictions through a lack of social outlets, variety and the opportunity to meet new people and create friendships, with particular regard to the university experience;
- Young adults feel it is unfair to be vilified by the media for the rise in cases and feel that COVID-19 is a waiting game with no end in sight, and the absence of hope being a difficult burden.

The Communications Team update the NPHET on a Youth Taskforce (working title) that launches on 9th October with a meeting between the Department of Health, HSE, GIS, Spunout, USI, NCYI, and BelongTo. Additionally, an advertising campaign specifically aimed at the 15-29 age group will launch in the week 12th – 16th October. Work to engage Irish influencers, in an unpaid capacity, is ongoing.

8. Meeting Close

a) Agreed actions

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

b) AOB

a) 3rd-Level Medical/Clinical Practical's

The NPHET discussed the matter of facilitating healthcare students in higher and further education to attend necessary on-site activities such as practical tuition, simulation exercises, and training. There was consensus that these activities form an essential part of healthcare students' educational training and are necessary to ensure that relevant professional/regulatory requirements are met in order to allow vital healthcare professionals to complete their training and enter the health workforce. It was agreed that these activities be facilitated to continue with the appropriate protective measures in place.

Action: The NPHET recommended that healthcare students in higher and further education (including allied health disciplines) should be facilitated to attend on site, with appropriate protective measures in place, for any clinical placements, simulation exercises or training, laboratory practice or practical examinations that are necessary to meet professional or regulatory requirements.

b) Halloween

The NPHET agreed to give further consideration to the Halloween period at its next meeting.

c) Visors

The HPSC agreed to update its advice regarding the use of visors for approval by the NPHET at its next meeting.

d) *ICU Capacity*

The NPHET was updated on current ICU capacity in terms of existing/available capacity and surge/potential capacity:

- Existing adult public critical care capacity = 280 (+17 TBA);
- Potential adult private critical care capacity 46 - not accessible at this time to public patients;
- Potential additional surge capacity +70 (additional to 280) = 350.

The NPHET was advised that in order to bolster surge capacity significant staff redeployment, cessation of certain scheduled care activities and direct access to private hospital ICU capacity would be required.

c) Date of next meeting

The next meeting of the NPHET will take place on Thursday 15th October 2020, at 10:00am via video conferencing.