



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

<b>Date and Time</b>	Thursday 15 <sup>th</sup> October 2020, (Meeting 59) at 10:00am
<b>Location</b>	Department of Health, Miesian Plaza, Dublin 2
<b>Chair</b>	Dr Tony Holohan, Chief Medical Officer, DOH
<b>Members via videoconference</b>	<p>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  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  Dr Lorraine Doherty, National Clinical Director Health Protection, HSE  Ms. Fidelma Browne, Interim Assistant National Director for Communications, HSE</p>
<b>‘In Attendance’</b>	<p>Mr David Keating, Communicable Diseases Policy Unit, DOH  Ms Laura Casey, NPHET Policy Unit, DOH  Mr. Robert Mooney, NPHET Policy Unit, DOH  Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)  Ms Emily de Grae, NPHET Policy Unit, DOH  Ms Ruth Barrett, NPHET Policy Unit, DOH  Ms Sheona Gilsean, Senior Health Data Analyst R&amp;D &amp; Health Analytics Division, DOH  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</p>
<b>Secretariat</b>	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Robinson, Mr Liam Hawkes, DOH
<b>Apologies</b>	Dr Matthew Robinson, Specialist Registrar in Public Health, DOH, Mr Paul Bolger, Director, Resources Division, DOH, Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital, Mr Gerry O’ Brien, Acting Director, Health Protection Division



## 1. Welcome and Introductions

### a) *Conflict of Interest*

Verbal pause and none declared.

### b) *Minutes of previous meetings*

The minutes of 1<sup>st</sup> October 2020 had been circulated to the NPHE in advance of the meeting. These were agreed, subject to minor amendments, and formally adopted by the NPHE.

### c) *Matters Arising*

The CHAIR noted the Government decision of 14<sup>th</sup> October that the counties of Cavan, Donegal, and Monaghan will be placed at Level 4 under the Plan for Living with COVID-19, from midnight on 15<sup>th</sup> October. Cavan, Donegal and Monaghan will remain at Level 4 until Tuesday 10<sup>th</sup> November, at which point the situation will be reviewed by the Government.

The rest of the country will remain at Level 3. However, due to the deteriorating epidemiological situation across the country, the Government has decided to increase restrictions nationwide within Level 3, with particular regard to limiting visits between households.

The CHAIR added that he had not yet seen the text of the decisions taken but that Regulations would follow shortly. The CHAIR asked the NPHE members to be aware of these decisions taken by Government in proceeding with the NPHE agenda, as planned.

## 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

- As of 15<sup>th</sup> October, the number of confirmed cases stands at 46,429;
- A total of 6,382 cases have been notified in the seven days up to the 14<sup>th</sup> October, compared with 3,514 in the previous seven days, an 82% increase;
- The 5-day average of cases is currently 946 cases per day; the 5-day average was 508 per day on 8<sup>th</sup> October and 411 per day on 1<sup>st</sup> of October;
- As of 15<sup>th</sup> October, the current 14-day incidence per 100,000 population is 207. The 14-day incidence rate was 92 per 100,000 population on 1<sup>st</sup> October and 108 per 100,000 population on 4<sup>th</sup> October;
- The current 7-day incidence is 119 cases per 100,000 population. The 7-day incidence rate was 67 per 100,000 population on 1<sup>st</sup> October and 72 per 100,000 population on 8<sup>th</sup> October;
- 9,756 cases (22% of all cases) were associated with healthcare workers; 493 cases were reported in healthcare workers in the fortnight to 13<sup>th</sup> October 2020;
- 1,838 deaths due to COVID-19 have been notified to date; 30 of these have occurred in the month of October; 33 deaths occurred in the month of September;
- A total of 101,270 tests were undertaken in the seven days to 15<sup>th</sup> October. The 7-day average positivity rate has increased from 4% on 8<sup>th</sup> on the October to 6% as of 14<sup>th</sup> October;
- The positivity rate yesterday, 14<sup>th</sup> October, was 7.9%;
- The current estimate of R is 1.4.

#### Demographic and Location Trends

- 68% of cases notified in the past 14 days have occurred in people under 45 years;
- In the past fortnight, to 13<sup>th</sup> October, 493 cases have been reported in healthcare workers.
- The median age for cases notified from 30<sup>th</sup> September up to midnight 13<sup>th</sup> October 2020 is 32 years;



- Incidence in older age groups is increasing with 9% of cases notified between 7<sup>th</sup> October – 14<sup>th</sup> October in the over 65 age group;
- The 14-day incidence in those aged 65 years and older has increased from 92.9 per 100,000 population on 7<sup>th</sup> October to 125.0 per 100,000 population on the 14<sup>th</sup> October; many counties are seeing large increases in incidence – 25 out of 26 counties have seen more cases in the 7 days up to 14<sup>th</sup> October than in the 7 days up to 7<sup>th</sup> October.

#### Hospitalisations

- As of 8.00am on 15<sup>th</sup> October, there were 238 confirmed cases in hospital, with 17 admissions in the preceding 24 hours. On Thursday 8<sup>th</sup> October, there were 159 COVID-19 patients in hospital, with 17 new admissions in the preceding 24 hours. On 1<sup>st</sup> September, there were 36 patients in hospital.
- Over the last week (7<sup>th</sup> October – 14<sup>th</sup> October), there has been an average of 19 new admissions per day. The number of confirmed COVID-19 patients requiring critical care yesterday evening (14<sup>th</sup> October) was 30, with 1 new admission in the previous 24 hours. Last Wednesday 7<sup>th</sup> October, there were 27 COVID-19 patients in critical care.

#### Clusters and Modes of Transmission

- 522 additional new clusters were notified in the week to 3<sup>rd</sup> October 2020. There are 2,475 open clusters nationally; The vast majority of open clusters continue to be associated with private households (1,906 of the 2,475 clusters); 99 open outbreaks are associated with workplaces;
- There are currently 21 open clusters in acute hospitals. Of these, 8 clusters were notified in the week leading up to Saturday 10<sup>th</sup> October; In the fortnight to 13<sup>th</sup> October, 50% of all cases in recent days have arisen as a result of close contact with a confirmed case. A further 46% of cases are linked with community or possible community transmission.

The most recent data modelling carried out by the IEMAG shows that:

- Based on data up to 10<sup>th</sup> October, the best estimate of effective reproduction (R) for the country is now 1.4. This is likely to be at, or slightly greater than, 1.0 in Dublin and between 1.6 – 1.8 in the rest of the country. Modelling shows that, were current trends to continue, between 1,800 (current R = 1.4) and 2,500 (if R increases to 1.6) cases will be notified per day by 31<sup>st</sup> October;
- Based on the current demographic profile of cases, for every 1,000 confirmed cases, there will be approximately 30 – 40 hospitalisations, with 4 – 5 people admitted to critical care, and 3 - 4 deaths. However, were the age profile to change, such that the profile of cases reflects the demographic profile of the general population, modelling shows that for every 1,000 confirmed cases, there will be approximately 40 – 50 hospitalisations, with 6 – 7 people admitted to critical care, and 5 – 6 deaths;
- Based on the current trajectory and profile of cases (and not accounting for the potential impact of measures announced by Government on 14<sup>th</sup> October), modelling shows that there will be 450 – 600 people in hospital and 80 – 110 people in critical care by 31<sup>st</sup> October;
- Were R to be reduced to 0.5 for a period of three weeks, this would be expected to reduce daily case numbers to between 250 – 300 cases per day by the end of that period. However, modelling estimates that a release of measures at that point (with R returning, for example, to 1.4), would very likely result in a rapid re-escalation in the disease trajectory and impact, such that approximately 1,000 cases per day would be expected by the middle of December 2020;
- Were R to be reduced to 0.5 for a period of six weeks, this would be expected to reduce daily case numbers to between 50 – 100 cases per day by the end of that period, following which, a release of measures (with R returning to 1.4) would be expected to result in cases not going above 300 cases per day until early January 2021.

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

The HPSC presented “Epidemiological Summary of Outbreaks for NPHE, 15th October 2020”. The key points were as follows:



### Overview of Outbreaks

- Since the start of the pandemic, there have been 4,957 outbreaks notified to the national infectious disease surveillance system (CIDR);
- In the 7 days to midnight 10<sup>th</sup> October, there were 522 outbreaks notified: 67% (352) occurred in private houses; 25 occurred in schools; 23 occurred in workplaces; 15 occurred in childcare facilities; 12 occurred in Nursing Homes/ Community Hospitals.

The HPSC noted its concern that large outbreaks were occurring in key settings such as nursing homes and among vulnerable populations. It assured the NPHE that extensive outbreak control measures are in place.

### Updates and Epidemiological findings for Nursing Home Outbreaks:

- In the week to Monday 12<sup>th</sup> October, there have been 7 new nursing home and community hospital/long-stay unit outbreaks, with 11 linked confirmed cases;
- There were 121 additional cases linked to outbreaks reported previously;
- 2 outbreaks in nursing homes and community hospitals/long-stay units were closed since 6<sup>th</sup> October 2020;
- A total of 53 outbreaks in Nursing Homes and 3 in Community Hospitals/Long-Stay-Units were notified between 1<sup>st</sup> July – 12<sup>th</sup> October 2020. Of these, 33 outbreaks remain open, with 422 associated cases: 159 associated HCW/staff cases, 179 associated client cases, 84 cases where HCW status unknown;
- Of the open outbreaks, 7 include only health care worker/staff cases and 18 include both HCW/staff and residents; for others, the case mix is unknown.

### Updates on outbreaks associated with school children and school staff:

- In total, there were 80 outbreaks associated with school children and staff notified up to midnight 12<sup>th</sup> October 2020;
- Since the 6<sup>th</sup> October, there have been 26 new outbreaks associated with school children and staff, with 39 linked cases; 9 of these outbreaks had 2 or more linked cases;
- 6 further cases have been linked to previously notified outbreaks.

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 31 outbreaks associated with CCFs up to midnight 12<sup>th</sup> October;
- There is a total of 101 cases linked to these outbreaks, 8 of these outbreaks have 2 or more linked cases;
- Since 6<sup>th</sup> October, there have been 12 new outbreaks associated with children and staff in CCFs, with 34 cases linked to these outbreaks.

### Outbreaks in other groups: Irish Travellers, Homeless, Roma

- Since 6<sup>th</sup> October, 7 new outbreaks in the Irish Traveller community, with 56 linked cases, were notified;
- There were 155 additional cases linked to previously reported outbreaks.
- As of 13<sup>th</sup> October, there were 21 outbreaks in vulnerable populations notified since 1<sup>st</sup> July 2020 that remain open; there have been 306 confirmed cases linked to these outbreaks, 19 of these cases were hospitalised, 3 were admitted to ICU and there were no deaths.
- 5 recent 'open' Irish Traveller outbreaks have more than 20 cases linked to each (range 23-83). A national OCT for outbreaks in the Irish Traveller population has been convened.

### Outbreaks in Meat Plants, Food Processing Plants and Wholesale Florists



- 21 cases occurred in the last 14 days, and 14 of these within the 7 days to 12<sup>th</sup> October;
- 11 outbreaks in this sector notified since 1<sup>st</sup> July 2020 remain 'open', with 120 confirmed cases linked to these outbreaks.

#### Acute Hospital Outbreaks

- As of midnight 12<sup>th</sup> October 2020, there has been a total of 134 acute hospital outbreaks notified;
- Of these outbreaks, 109 are closed and 25 remain open;
- Between 6<sup>th</sup> October and midnight 12<sup>th</sup> October, there were 8 new acute hospital outbreaks with 30 linked cases;
- During this time there were 17 additional cases linked to previously reported outbreaks.

### **3. Review of Existing Policy**

#### **a) Update on Critical Care Capacity**

The DOH presented the paper "*National Public Health Emergency Team: Acute Hospitals Preparedness Critical Care Capacity, Department of Health-HSE Joint Paper: 15<sup>th</sup> October 2020*", with a view to providing clarity on the critical care capacity experience of the past 6 months, the current situation, and future planning in this area. The key points in the paper are summarised below.

The National ICU Audit reported that Ireland has 6.0 critical care beds per 100,000 population (including private hospitals) compared with the European average of 11.5 per 100,000. Significant efforts have been made in recent months to enhance and increase critical care capacity as much as possible, including the work of the Acute Hospitals Preparedness Subgroup of NPHE. ICU is a system of care that requires trained available nurses, trained available doctors and appropriate equipment, notably a supply of ventilators and oxygen to deliver effective patient care. Considerable progress has been made to enhance this system of care over the past six months, including the provision of additional training and equipment.

In January 2020, baseline critical care capacity was 255 beds as reported by the Critical Care Bed Capacity Census published in September 2019. The HSE reports that between 280 and 285 beds are now open, with the number of beds open on any given day subject to fluctuation as a result of available staff and other operational considerations. 31 additional ICU beds have been opened since March 2020. In relation to the Winter Plan and critical care, 17 critical care beds are referenced. Of these, 11 are those beds already funded in March but not yet open. These are included in the Winter Plan as they represent additional capacity coming on stream.

The National Clinical Programme in Critical Care has been clear that while clinical risk remains at an acceptable level up to surge levels of around 350, beyond this level, standards of care cannot be maintained, with a resulting impact on patient outcomes. A strategic plan is being submitted to Minister for Health that envisages an increase of 26 beds to bring permanent critical care capacity to 321 by the end of 2021, with a further 12 beds coming onstream in 2022 bringing total capacity to 333. The first part of the plan has been advanced with the provision of a €52m investment in Budget 2021, and will allow the DOH to build and strengthen critical care capacity across Ireland.

The NPHE thanked the DOH for its update, the considerable work achieved to date in the provision of critical care and welcomed the implementation of the strategic plan.

#### **b) Update on Acute Hospital Preparedness**

The DOH presented "*National Public Health Emergency Team, Acute Hospitals Preparedness Joint Department of Health-HSE Update: 15<sup>th</sup> October 2020*", reviewing the preparedness of Ireland's acute hospital system for the 2020-2021 winter period, in light of the unprecedented challenges posed by the COVID-19 pandemic. The key points in the paper were as follows:



- The available capacity in Ireland’s hospitals will need to be used as effectively and efficiently as possible to manage the response to COVID-19, alongside the resumption and continuation of non-COVID services to the greatest extent possible;
- The first peak of COVID-19 infections occurred in an environment in which most scheduled care was cancelled and a significant reduction in patients presenting to hospital was observed. The current situation is more complicated:
  - Scheduled care has now resumed, with significant backlogs being seen in many services;
  - Staff, who had previously been redeployed to assist with caring for patients with COVID-19 have returned to their posts;
  - The number of patients presenting to emergency departments and injury units has returned to pre-COVID levels, presenting difficulties in terms of patient cohorting and physical distancing in emergency departments;
  - Hospital occupancy rates are back at pre-COVID levels and are well-above the recommended 85%;
- These factors all combine to create an extremely challenging environment for the acute hospital sector over the coming months. While additional capacity will be created wherever possible, ultimately the focus must be on reducing the levels of the virus circulating in the community.

The DOH drew the NPHE’s attention to Appendix 1 of the paper, which sets out detailed information on the current situation in acute hospitals, including early lessons in the Covid-19 response.

In its discussion, the HSE stressed that Ireland now has an acute system that is operating close to capacity. Attention was further drawn to the impending influenza season, the severity of which cannot yet be determined. The HSE added that staff absences, primarily due to illness or COVID-19 isolation/cocooning requirements, are also impacting the system. The discussion also highlighted the equally diminished capacity within the community care setting, and that ‘elective care’ is often misinterpreted as optional, and use of the term ‘scheduled care’ is more appropriate to highlight that such services are extremely important.

The NPHE also expressed its concern in relation to health system capacity and noted the significant pressures across all areas of the health service as we enter the winter period, which has traditionally been the most challenging for the system. The NPHE noted that ongoing consideration is being given to how public health resources can be best prioritised to ensure that those most vulnerable to the disease are protected.

### **c) Overview of approaches taken internationally**

The DOH presented “COVID-19 situation in European region and selected countries (Israel, Sweden, the Netherlands, England, and Northern Ireland): NPHE Presentation 15<sup>th</sup> October 2020”, providing an overview of the epidemiological data and variety of COVID-19 restrictive measures taken in the selected countries in recent months. The following trends were noted amongst countries in Europe:

#### COVID-19 in Europe – epidemiology overview:

- In the week to 11<sup>th</sup> October 2020, Europe had the highest weekly incidence of COVID-19 cases since the beginning of the pandemic with almost 700,000 new cases reported;
- As of 11<sup>th</sup> October 2020 the weekly incidence in cases and deaths increased by 34% and 16% respectively in comparison with the previous week;
- The COVID-19 situation is deteriorating in many European countries – with increasing cases (including in older age groups), hospitalisations, ICU admissions, and deaths;



- By the end of week 40 (4<sup>th</sup> October 2020), the 14-day case notification rate for the EU/EEA and the UK was 130.6 (country range: 24.0-319.3) per 100,000 population. The rate has been increasing for 77 days;
- The UK, France, the Russian Federation, and Spain account for over half of all new cases reported in the region (355,455, 51%);
- The majority of the countries in the region self-characterise their current transmission pattern as community transmission.
- Increasing incidence is driven primarily by infection rates amongst younger age groups, however, cases are increasingly occurring in those aged over 65 years;
- Restrictions are increasingly being reintroduced in countries as control of the disease is lost and community transmission spreads.

#### **d) Review of Level 3 Measures**

The Chair, in his introductory remarks, outlined that Level 3 measures have been in place in Dublin since 19<sup>th</sup> September, in Donegal since the 26<sup>th</sup> September, and across the country since the 7<sup>th</sup> October. The Government decision of 14<sup>th</sup> October, in which enhanced Level 3 measures will be implemented nationally, and with Level 4 measures to come into effect in Cavan, Donegal, and Monaghan was also noted. The Chair requested that the NPHET commence its review of Level 3 measures by assessing the impact that current restrictions are having on the trajectory of the disease. In this regard, the Chair invited the DOH and the IEMAG to present available data on public adherence to the current measures.

The DOH presented data for traffic levels on key routes, daily traffic flow, Google Mobility Ireland data, and credit card and ATM transactions.

The NPHET noted the following with respect to available mobility data:

- Between 27<sup>th</sup> September and 11<sup>th</sup> October, there has been no significant change in daily traffic flow at selected points in the national network; a slight decrease can be detected in recent days;
- Available Google Mobility data, between 26<sup>th</sup> September and 10<sup>th</sup> October, shows no significant percentage change from its baseline;
- Between 28<sup>th</sup> September and 12<sup>th</sup> October, there has been no significant change in overall public transport daily passenger numbers;
- There has been no significant change in people travelling to places of work since the summer months, only a slight decrease can be detected since 3<sup>rd</sup> October;
- There has been no significant change in credit card and ATM transactions since June;
- There has been no significant change in visits to grocery shops and pharmacies since June.

The IEMAG presented data on movements into, out of, and within selected counties, concluding that, while there is a strong impression that movements have reduced since the implementation of Level 3 measures, the reduction is far less than that observed in March/April of this year and is unlikely to be sufficient to achieve the necessary impact.

In the subsequent discussion, with due regard for the epidemiological data presented, the NPHET members noted that while it was still too early to assess the full impact of the Level 3 measures imposed, they were not satisfied by the evidence available that the measures are having the degree of impact required.

It was noted that since 4<sup>th</sup> October, all key indicators of disease transmission and severity show further significant signs of deterioration, with widespread community transmission evident across the country. The growth rate of the disease has also accelerated. Furthermore, the number of cases and the number of hospitalisations are increasing faster than the exponential growth predicted by modelling. The picture is one of a rapidly deteriorating disease trajectory nationally that could potentially compromise our ability to protect the core priorities. Several NPHET members voiced concern that the burden infection will fall



disproportionately on the most vulnerable in our society. In that regard, the NPHEP noted the rising number and scale of outbreaks in nursing homes and within the Irish Traveller community. It also noted the rising number of outbreaks in hospitals.

The NPHEP also expressed its concern for the capacity of the health system as the winter period approaches. With influenza season yet to fully take hold and occupancy rates now back at pre-COVID levels, there is an increasing risk that hospitals in particular will have difficulties in meeting demand in the coming days and weeks, which will inevitably impact the provision of scheduled non-COVID care as a consequence.

The Chair then asked the NPHEP members whether they thought a further period of time should be allowed at Level 3, which would enable a more thorough assessment of whether the Level 3 measures currently in place are sufficient.

During the subsequent discussion, the NPHEP considered whether the Level 3 measures already in place could be sufficient if given more time to fully take effect. Some members felt that with full compliance and enforcement, Level 3 could potentially be sufficient. However, accounting for the current profile and trajectory of the disease, modelling projections, the level of demand across the health system, the NPHEP, on balance, concluded that delaying escalation would pose too great a risk. Such a delay would put the overriding priorities of protecting the most vulnerable, and continuing health and education services at too great a risk.

The NPHEP concluded that Public Health restrictive measures must be increased in the short-term to bring the disease back under control and to mitigate the increases in hospitalisations and deaths.

The Chair then asked the NPHEP members to consider whether Level 4 could be recommended:

During the discussion, the NPHEP noted that the majority of restrictions with direct economic impacts are proscribed within Level 4. Level 5 will however reduce social activity significantly as people will be required to stay within 5km of their residence, as opposed to within their county. It was noted that schools and childcare services are expected to remain open at Level 5, in contrast to the restrictions implemented in March. Essential work, including construction work, will also continue in Level 5.

The NPHEP proceeded to consider whether Level 4 measures would be sufficient to suppress the virus to the extent necessary, with some members asserting that Level 4 restrictions may be a more proportionate response accounting for the level of restrictions currently in place. However, given the immediate need to protect the key priorities, and the risk associated with failure to achieve this, the NPHEP reached the consensus that a recommendation to implement Level 5 measures is both necessary and proportionate. The potential impact of restricting non-essential travel to within 5km of home, if appropriately adhered to, carried significant weight in the NPHEP's discussions. It was noted that Level 5 differs from the previous stay at home measures introduced in March as schools and childcare will remain open, and therefore the impact of Level 5 would be more difficult to predict.

The NPHEP noted that all triggers for an escalation to Level 5 of the *"Resilience and Recovery 2020-2021: Plan for Living with COVID-19"* continue to be met, as was the case on 4<sup>th</sup> October. The NPHEP specifically noted the following:

- There is high and rapidly increasing disease incidence, with all indicators of viral transmission escalating rapidly in addition to widespread community transmission;
- There are multiple clusters with secondary and tertiary spread, and cases in LTRCFs are increasing rapidly.
- There has been a significant and rapid increase in both admissions to hospital and admissions to critical care. There is deep concern among the clinical community that hospital and critical care capacity will deteriorate significantly over the coming weeks, with, at a minimum, consequential impact on the provision of scheduled non-COVID services;



- It is evident that the capacity to undertake robust and timely contact tracing is now constrained;
- Despite being an indicator which lags substantially behind disease incidence and caseload notification, deaths are now also increasing.

Attention was drawn to the impact that the restrictive measures imposed in March/April had on vulnerable groups, such as those living on their own, people with mental illness, and those living in nursing homes. The NPHET confirmed that supports and very clear communications would be needed to ensure that such groups continue to have access to the family and community supports that they require in line with the ethical framework. It was also suggested that some consideration should be given to allowing visitors from one other household in the case of single person households.

The NPHET acknowledged that the only strategy that would effectively bring the resurgence of disease back under control is a set of very strict population-level public health measures that would reduce the effective reproduction number to approximately 0.5 for at least six weeks. The question was raised: what is the cost of delaying such an intervention by a number of weeks? The IEMAG model scenarios show that the cost of delay is much less than the cost of failing to achieve adequate suppression ( $R = 0.5$ ) over the six week period: for instance an  $R$  of 0.7 would not give sufficient suppression, and cases would be back up to 1000 per day within 6 weeks of the release of strict public health measures. This leads to the conclusion that a short delay to ensure that measures are appropriately co-ordinated and implemented is better than immediate but poorly implemented action. Nonetheless at this level of disease, delay has cost. A two-week delay with  $R$  at 1.4 before successfully introducing measures to bring  $R$  to 0.5 is projected to lead, approximately, to an additional 24,000 cases, close to 1,000 hospitalisations, 140 admissions to ICU and 120 deaths.

In conclusion, the NPHET recommended that the Government apply Level 5 measures, as provided for in *“Resilience and Recovery 2020-2021: View the Plan for Living with COVID-19”*, across the country for a period of 6 weeks, subject to periodic review. The NPHET again advised that it believes schools should remain open during this period of restrictions. The NPHET members stressed the importance of explaining and communicating the data, evidence, and rationale underpinning its recommendation to enable appropriate consideration by Government. The Chair reminded those present once again of the need for confidentiality and the importance of planned communication.

The NPHET also considered the post-Level 5 period, in which restrictive measures could once again be eased. A number of areas were highlighted that will require planning and development over the coming period to support the easing of restrictions at the appropriate time. Further enhancement and investment in the State’s public health response system was highlighted as one such area, as ensuring that there is sustainable capacity to quickly identify, respond to, and manage cases and outbreaks will be essential when restrictions are lifted. The NPHET also confirmed that it would consider the future strategic response to the pandemic over the coming weeks, while continuing to monitor the trajectory of the disease within Level 5.

**Action: The NPHET recommends, in line with the *“Framework for Restrictive Measures in Response to COVID-19”*, the implementation of Level 5 public health restrictive measures nationally for a period of 6 weeks, with ongoing review.**

#### **e) Sampling, Testing, Contact Tracing, and CRM Reporting**

The HSE presented the paper *“Testing and Tracing updated for NPHET, 15<sup>th</sup> of October”*. The data presented were as follows:

- Over the past 7 days, 6<sup>th</sup>– 12<sup>th</sup> October 2020, there have been 103,254 swabs taken for COVID-19 testing. Over 64,137 of these were taken in the community; 21,010 swabs were taken in acute settings; The remaining 18,107 swabs taken 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 6<sup>th</sup>– 12<sup>th</sup> October, a total of 22,984 calls were made in the Contact Tracing Centres. A total of 4,798 of these were Call 1s, which involves the communication of a detected result. A total of 18,186 calls were completed relating to contact tracing;
- Between 6<sup>th</sup> - 12<sup>th</sup> October, the average number of close contacts per case was 5.2;
- The median time to complete all calls for contact tracing, from the 6<sup>th</sup> – 12<sup>th</sup> October was 2 days;
- The 2-day median completion time is due to a number of factors:
  - There is an increase in the number of calls being made, with an increase of 4,860 on the week from 29<sup>th</sup> September- 5<sup>th</sup> October;
  - 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;
- Cycle 3 of serial testing of Healthcare workers in Residential Care Facilities for older persons continued from 16<sup>th</sup> September. As of 13<sup>th</sup> October, there has been 59,226 tests carried out with 226 cases detected. This represents a detected rate of 0.38%;
- Cycle 2 of serial testing of food production facilities has commenced on 12<sup>th</sup> of October for a 4-week cycle. To date, cycle 2 has carried out 416 tests with 3 detected cases. This represents a detected rate of 0.72%;
- A process is currently in operation to support all ongoing schools testing including childcare facilities. As of 13<sup>th</sup> October, 364 schools have had/are having some testing completed as a consequence of a Public Health Risk Assessment. From the 364 schools that had mass tests there have been an additional 172 detected cases have been identified over and above original cases. 8,606 students and teachers have been involved in mass testing;

The HSE informed the NPHET that as of 12<sup>th</sup> of October, patients who receive a COVID-19 detected result, will receive a text message to inform them of their result where a valid mobile number has been provided. This improvement to the current process and will result in a reduced turnaround time, ensuring individuals are notified as soon as possible. The national contact tracing centre will be in contact with those in receipt of a positive result to provide clinical guidance and to carry out relevant contact tracing as per the normal end to end process.

The HSE also presented the “*National Public Health Emergency Team (NPHET) Report 19<sup>th</sup> May – 11<sup>th</sup> October*”. This report covers close contacts of cases of COVID-19 identified for the period 19<sup>th</sup> May - 11<sup>th</sup> October 2020. The data presented were as follows:

- Of the close contacts that had a Day 0 test since 19<sup>th</sup> May 2020, 10% were positive for SARSCoV2;
- Of these close contacts that had both Day 0 and Day 7 tests, 2.6% of those who had initially tested negative were found to be positive on Day 7;
- The week of the 5<sup>th</sup> – 11<sup>th</sup> October saw an increase in the number of social venues recorded as complex contacts from 285 to 382 (34% increase);
- The number of hospitals with recorded complex contacts rose from 104 to 126 (21% increase);
- Between 5<sup>th</sup>– 11<sup>th</sup> October, the highest number of close contacts occurred in the household (5,719), followed by social circumstances (4014).

**f) Update: Monitoring of COVID-19, Influenza and RSV by the sentinel GP network**

The HPSC provided a verbal update on the monitoring of COVID-19, Influenza, and RSV by the sentinel GP network. Collaboration has taken place with a number of organisations and planning has gone well. The HPSC confirmed that the programme will include RSV, Influenza, and COVID-19 and is on track to commence at the beginning of November 2020.



The NPHET thanked the HPSC for its update and noted that the influenza-like illness (ILI) rate is far lower than it was in early 2020.

#### 4. Future Policy

##### a) **Consolidated Paper on Testing Strategy**

The Office of the Clinical Director of Health Protection presented, “SARS-CoV-2: A Testing Strategy Approach”. The paper provided an overview of the current testing strategy and capacity in Ireland and highlighted certain sub-groups of the population that are at increased risk of contracting and/or transmitting COVID-19.

The paper detailed the current approach to testing these sub-groups, the proposed future approach to testing, and the rationale behind the proposal. It was proposed that the HSE convene a working group to review currently available antigen tests and how they might be usefully deployed within clinical and non-clinical settings by the HSE, in the context of a testing strategy for the COVID -19 pandemic.

Members of the NPHET expressed support for the establishment of such a working group, however, the NPHET agreed that there is necessary outstanding work to be completed prior to a decision on the adoption of the paper and requested that the paper be finalised and returned to the NPHET in the coming weeks.

##### b) **Flight Transmission and Casual Contact Tracing**

The HSE presented, “Proposal to rationalise flight contact tracing for COVID-19 in Ireland – recommend cessation of casual contact tracing on flights.” The paper highlighted the difficulties involved in flight manifest extraction (boarded passenger details), following a confirmed COVID-19 case on board in the current context.

The following recommendations/options to consider were highlighted:

1. Reconsider casual contact tracing – revert to close contact tracing only-radius of 2 seats around case;
2. Transmission risks on-board are being mitigated internationally (reduced crew/passenger interaction, reduced occupancy, mandatory face coverings). Clear advice for most incoming travellers is to restrict movement and there are reports of in-flight transmission. Therefore, further study of yield (close flight contacts becoming cases) is recommended to assess whether flight close contact tracing is sustainable, and that effort is proportionate to yield;
3. Improve electronic data gathering.

It was additionally noted that, in all situations, the Public Health risk assessment may change the approach to any flight.

This paper was circulated to members for consideration in advance of the meeting. On the basis that all members were satisfied with the recommendations noted above, further discussion was not required. The NPHET agreed to the recommendations in this paper.

**Action: The NPHET endorses the HPSC’s proposal to rationalise flight contact tracing for COVID-19 in Ireland and recommends its implementation.**

##### c) **Visiting Guidance Framework – RE: smaller disability facilities**

The HSE presented, “COVID-19 Guidance on visits to and from community housing units for people with disabilities.” The paper sets out guidance to support the providers of Long-term Residential Care Facility services so that management, staff, individuals and relatives can balance the risk of COVID-19, while facilitating visiting in line the Government’s 5 Level Framework.

The paper focuses on “Own-door” Supported Accommodation for individuals and couples, and Community Housing Units. The paper stipulates that own-door accommodation should not be considered a congregated setting and individuals should be supported in following the public health guidance applicable to the general



population, including self-protection measures for those over 70 years old or with extreme medical vulnerability. With regard to Community Housing Units, risk is generally deemed lower than large residential facilities. Individuals can continue to receive one to two nominated visitors or visit their family home (or corresponding house) throughout Levels 1, 2 and 3; if required on critical or compassionate grounds, individuals may continue to receive a nominated visitor or continue to visit their family home (or corresponding house) in Levels 4 and 5, subject to conditions stipulated in the guidance.

This paper was circulated to members for consideration in advance of the meeting. On the basis that all members were satisfied with the guidance detailed above, further discussion was not required. The NPHET agreed to the guidance presented in this paper.

**Action: The NPHET recommends the communication and implementation of the HPSC's guidance on visits to and from community housing units for people with disabilities**

## 5. Communications Update

The DOH presented "*NPHET Communications Update – 15<sup>th</sup> October*".

According to the Quantitative Tracker, the nationally representative sample of 1,770 people conducted on behalf of the Department of Health on 12<sup>th</sup> October 2020 revealed the following:

- The level of worry is increasing, now standing at 6.8/10 similar to the level of worry expressed in April, with the main sources of worry being health system overload, the health of family and friends, and the economy
- 52% think the worst of the pandemic is ahead of us, the highest level reported since April
- 51% think Government reaction to the current outbreak is insufficient.

Qualitative findings were also presented as of 12<sup>th</sup> October which included findings from conversations with pregnant women, young adults, and adults with a parent in a nursing home:

- Citizens are looking for a definition of success, a way of living alongside Covid that balances the needs of the safe behaviours with respect of the virus, oneself and society;
- Restricted visiting of Nursing Homes is causing hardship and alienation for families and residents and increasing the burden on care staff;
- First time mums-to-be should be seen and treated differently, being the most challenged by COVID-19. At the heart of their concern is alone-ness at a time when closeness is so important (partner family, friends);
- The on-going collapse in employment for young people in their twenties should be seen as a mental health challenge, not just an economic one. Remaining active, especially in the absence of social lives and the ability to plan, is a critical part of keeping balanced.

The HSE also gave an update on planned communications activity over the coming weeks:

- A communications campaign for CAMHS which will enlist the help of Irish influencers, in an unpaid capacity, will begin this weekend;
- A Youth Taskforce, led by the Department of the Taoiseach with representatives from young people's organisations (e.g. Spunout, USI, NCYI, and BelongTo), with input from the Department of Health and HSE, is being established.
- A communications campaign for older adults is planned for next month, including the production of an updated household booklet detailing public health advice.

The Chair reaffirmed the importance of ongoing effective public communications as a means of containing the progression of the virus. The NPHET endorsed this view, noting in particular the need for clear cross-sectoral communications on public health advice in the context of any possible future restrictive measures (e.g. advice for students living in higher education/campus settings, visitation guidance for long-term care facilities).



## **6. Meeting Close**

### **a) Agreed actions**

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

### **b) AOB**

#### **(i) Visors**

The HPSC updated the NPHE on their progress in assessing the suitability of the wearing of visors as an infection prevention and control measure. Their early evidence gathering indicates that visors do not sufficiently block droplet transmission by comparison with other types of face coverings recommended for use by the general public (e.g. Surgical Masks, Non-Medical Cloth Face Coverings). The HPSC will present their full findings and recommendations, including the specific and limited circumstances where the use of visors is recommended to continue alongside other infection prevention and control measures, in a paper to the NPHE on 22<sup>nd</sup> October.

#### **(ii) Halloween**

The NPHE discussed the upcoming Halloween period. Noting the concerning epidemiological patterns of the disease and the Government's announcement that from midnight, 15<sup>th</sup> October to 12<sup>th</sup> November, people should have no visitors to their home or garden, with the exception of visits for essential purposes (e.g. family reasons such as providing care to children, elderly or vulnerable people, and in particular those who live alone), there was consensus that traditional Halloween trick or treating activities between households would not be possible. The NPHE agreed that parents and guardians should plan alternate ways to participate in Halloween, which limits interaction to people within their own household.

### **c) Date of next meeting**

The next meeting of the NPHE will take place Thursday 22<sup>nd</sup> October 2020, at 10:00am via video conferencing.