



National Public Health Emergency Team – COVID-19

Meeting Note – Standing meeting

Date and Time	Thursday 22 nd October 2020, (Meeting 60) at 10:00am
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference	<p>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 Prof Colm Bergin, Consultant in Infectious Diseases, St James’s 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 Ms Yvonne O’Neill, National Director, Community Operations, HSE Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Darina O’Flanagan, Special Advisor to the NPHE 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 Ms. Fidelma Browne, Interim Assistant National Director for Communications, HSE Mr Liam Woods, National Director, Acute Operations, HSE</p>
‘In Attendance’	<p>Mr David Keating, Communicable Diseases Policy Unit, DOH Ms Laura Casey, Policy and Strategy Division, DOH Mr Gerry O’ Brien, Acting Director, Health Protection Division Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion) Ms Sheona Gilsean, Senior Health Data Analyst R&D & Health Analytics Division, DOH Mr Ronan O’Kelly, Health Analytics Division, DOH Dr Heather Burns, Deputy Chief Medical Officer, DOH Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Ms Niamh O’Beirne, National Lead for Testing and Tracing, HSE</p>
Secretariat	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Mr Liam Robinson, DOH
Apologies	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH; Dr Matthew Robinson, Specialist Registrar in Public Health, DOH; Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH; Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Dr Lorraine Doherty, National Clinical Director Health Protection, HSE



1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Apologies

Apologies were received for Dr Ronan Glynn and Mr Colm Desmond. Dr Michael Power provided apologies for the first half of the meeting.

c) Matters Arising

The Chair reiterated that the NPHE's advice and recommendations must be treated with utmost confidentiality in order to preserve the integrity of the process, by which the Minister and the Government consider such advice. Several Members of the NPHE echoed this sentiment, stressing the importance of using only the agreed and established communication channels. There was consensus that the release of information regarding the NPHE's processes, advice, or recommendations outside of these channels undermines the NPHE's work and inhibits the ability of Members to discuss issues in a constructive and open manner.

In order to guard against these occurrences, the NPHE agreed to undertake a review of its processes including measures around attendance, document sharing, confidentiality, security and cybersecurity procedures, and risk management procedures.

(i) Update 3rd level students

The DOH updated the NPHE on the supports provided by the DOH and the HSE to the Higher and Further Education sector in the development of their sectoral guidance in relation to COVID-19, including effective implementation of Public Health measures across Ireland's 3rd-level institutions.

Engagement is ongoing between the HSE and the Department of Higher and Further Education, Research, Innovation and Science (DHFERIS), supported by the DOH, to define the optimal management of students who live in university-owned or privately-owned student accommodation and need to self-isolate. Further information is required regarding outbreaks of COVID-19 linked to the Higher and Further Education setting to date. This information will inform the NPHE in supporting the Higher and Further Education sector towards optimal implementation of Public Health guidance to provide a safe environment for students and staff.

The HPSC agreed to prepare a report on outbreaks of COVID-19 linked to the Higher and Further Education sector to date for consideration by the NPHE at its next meeting.

The NPHE thanked the DOH for its update and welcomed the HPSC's proposal to provide further epidemiological data on outbreaks linked to the Higher and Further Education sector.

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 53,422. There have been 8,231 cases notified in the 7 days up to 21st October, compared with 5,683 in the 7 days up to 14th October, a 46% increase;
- Case numbers have been growing exponentially with a daily growth rate of 5-8% per day;



- The 5-day average of cases is currently 1,205 cases per day; the 5-day average was 946 per day on 15th October;
- The current 14-day incidence per 100,000 population is 303. The 14-day incidence rate was 207 per 100,000 population on the 15th October and 92 per 100,000 population on 1st October;
- The current 7-day incidence is 173 cases per 100,000 population. The 7-day incidence rate was 119 per 100,000 population on 15th October and 52 per 100,000 population on 1st October;
- 511 cases have been reported in healthcare workers in the fortnight to 20th October 2020. This represents 3.7% of all cases over the period;
- 1,868 deaths due to COVID-19 have been notified to date; 57 of these have occurred in the month of October; 35 deaths occurred in the month of September;
- Of the 57 COVID deaths in October to date, 23 have been in residents of nursing homes;
- The 7-day average positivity rate has increased from 4% on 8th October to 7% as of 21st October. A total of 112,016 tests were undertaken in the 7 days to 21st October;
- The current estimate of the reproduction number (R) is 1.3 – 1.4;
- The current 7-day incidence in Northern Ireland is 361 per 100,000 population as of 20th October.

Demographic and Location Trends

- 69% of cases notified between 8th – 21st October have occurred in people under 45 years; the median age for cases notified for the same period is 31 years;
- Incidence in older age groups is increasing with 8% of cases notified between 12th -18th October in the 65 years and over age group. The 14-day incidence in those aged 65 years and older has increased from 131.0 per 100,000 population on 15th October to 190.3 per 100,000 population on the 22nd October.

Hospitalisations

- As of 8am 22nd October, there were 305 confirmed cases in hospital, with 21 admissions in the previous 24 hours. At the same time on 15th October, there were 238 COVID-19 patients in hospital with 17 new admissions in the preceding 24 hours. On 1st October, there were 122 patients in hospital;
- In the 7 days up to 21st October, there has been an average of 19 new admissions per day. The number of confirmed COVID-19 patients requiring critical care on 21st October was 35, with 3 new admission in the previous 24 hours. On the 14th October, there were 30 COVID-19 patients in critical care.

Clusters and Modes of Transmission

- 647 additional new clusters were notified in the week to 3rd October. There are 2,999 open clusters nationally. Of these, 37 open outbreaks are associated with nursing homes and 27 open outbreaks are associated with hospitals;
- There is widespread community transmission of the disease with extensive evidence of widespread secondary/tertiary spread.

The NPHE acknowledged that a time lag exists between incidence rates in younger people and those in older age cohorts. This effect has been observed internationally and results in a delay in the onset of hospitalisations and ICU admissions. This delay may negatively impact the public's perception of the seriousness of pandemic resulting in reduced adherence to public health measures.

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

The HPSC presented “COVID-19 Outbreaks – update for NPHE 20th October 2020”. The key points were as follows:



Overview of Outbreaks

- Since 1st March 2020, there have been 5,590 outbreaks notified to the national infectious disease surveillance system (CIDR);
- In the 7 days to midnight on 17th October, there were 649 outbreaks notified: 71% (461) occurred in private houses; 46 occurred in schools; 19 occurred in vulnerable groups; 18 occurred in workplaces; 7 occurred in childcare facilities; 6 occurred in nursing homes/community hospitals.

Updates and Epidemiological findings for Nursing Home Outbreaks:

- In the week to 17th October, there were 6 new nursing home and community hospital/long-stay unit outbreaks;
- A total of 58 outbreaks in nursing homes and community hospitals/long-stay-units were notified between 1st July – 17th October 2020. Of these, 33 outbreaks remain open, with 451 associated cases: 167 associated healthcare worker/staff cases, 177 associated client cases, 107 cases where healthcare worker status was unknown;
- Of the open outbreaks, 7 include only healthcare worker/staff cases and 16 include both healthcare worker/staff and clients; for others, the case mix is unknown;
- Of the 33 deaths notified in nursing homes and community hospitals/long-stay-units between 1st July and 19th October, 91% (30) were over 75 years.

Updates on outbreaks associated with school children and staff, and in outbreaks in Childcare Facilities (CCF):

- In total, there were 118 outbreaks associated with school children and staff notified up to midnight 17th October 2020;
- Since the 12th October, there have been 38 new outbreaks associated with school children and staff, with 69 cases linked; 17 of these outbreaks had 2 or more linked cases.
- There have been 36 outbreaks associated with childcare facilities up to midnight 17th October;
- There is a total of 127 cases linked to these outbreaks, 28 of these outbreaks have 2 or more linked cases;
- Since 12th October, there have been 5 new outbreaks associated with children and staff in childcare facilities, with 16 cases linked to these outbreaks.

Outbreaks in Direct Provision Centres

- Since 29th September 2020, there were no new outbreaks notified in direct provision centres;
- 7 of the outbreaks notified since 1st July remain open, with 42 linked cases and 2 hospitalisations but no ICU admissions or deaths.

Outbreaks in other groups: Irish Travellers, Homeless, Roma

- Between 20th September – 20th October, there were 31 recorded outbreaks in the Irish Traveller Community with 594 linked cases and an additional 110 associated sporadic cases;
- Of these cases, 26 were hospitalised and 4 were admitted to ICU; there was 1 death.
- In the week up to 18th October 2020, there were 17 new outbreaks notified;
- As of 17th October, there were 16 outbreaks in the Roma and Homeless populations notified since the start of the pandemic, with a total of 109 linked cases; 3 of these outbreaks remain open;
- There were no new outbreaks amongst the Roma and Homeless populations recorded in the week to the 18th October.

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

- 3 additional outbreaks were reported in the week to midnight 19th October 2020 involving 12 new cases;
- 18 cases occurred in the last 14 days, and 10 of these within the 7 days to midnight 19th October;
- 13 outbreaks in this sector notified since 1st July 2020 remain 'open', with 127 confirmed cases linked to these outbreaks.



Acute Hospital Outbreaks

- As of midnight 19th October, there has been a total of 135 acute hospital outbreaks notified;
- Of these outbreaks, 25 remain open with 152 linked cases and 4 ICU admissions. There were 11 associated deaths;
- Between 12th October and midnight 19th October, there were 2 new acute hospital outbreaks with 3 linked cases.

Hospitality and Social Settings

- Between 30th August – 17th October, there were 205 outbreaks associated with hospitality and social settings with 1271 linked cases;
- Of these, 94 outbreaks were ‘community outbreaks’, 35 were a result of social gatherings, 28 occurred in a restaurant/café, 19 were as a result of sporting activity, and 16 were in public houses.

(i) *International update*

The DOH presented “COVID-19 situation in European region and selected countries (England, Belgium, France, Italy, Germany): NPHEP Presentation 22nd October 2020”, providing an overview of the epidemiological data and variety of COVID-19 restrictive measures recently taken in the selected countries. The following trends were noted amongst countries in the European Region:

COVID-19 in Europe – epidemiology overview:

- As per the weekly epidemiological update with data received by WHO from national authorities, as of 18th October 2020, the weekly number of cases and deaths increased by 25% and 29%, respectively, in comparison with the previous week.
- The European region reported the greatest proportion of new cases globally (38%, 927,433);
- The WHO Regional Director highlighted that the European region is currently reporting over 3 times more cases per day compared to the April 2020 peak, with hospital admissions increasing, although the number of daily deaths remains five times lower than in April;
- France, the UK, Russia, the Czech Republic, and Italy continue to report a high incidence of new cases; Taken together, these 5 countries represent over half of all reported cases in the last week in Europe;
- As of 21st October, the Czech Republic had the highest 14-day incidence per 100,000 (975.8), followed by Belgium (867.2), Netherlands (574.4), France (441.7), and Slovenia (370.6); Ireland ranks 13th in Europe (270.8);
- The UK has the 7th highest 14-day incidence in Europe at 348.7, as of 21st October;
- The majority of the countries in the region self-characterise their current transmission pattern as community transmission;
- In England, overall cases number and positivity continued to increase in Week 39 – with highest case rates in 20 – 29-year olds.

The DOH concluded the presentation by stating:

- Many countries in Europe are experiencing a resurgence of COVID-19 with high levels of uncontrolled community transmission in a substantial proportion;
- Increasing incidence is driven primarily by infection rates among younger age groups, however, cases are increasingly occurring in those aged over 65 years;
- Many countries in Europe, and other regions, are observing increasing hospitalisations, ICU admissions and deaths related to COVID-19;
- A range of significant restrictions are increasingly being implemented in countries as control of the disease is lost and community transmission increases.



The NPHEP thanked the DOH for its presentation and noted that Ireland's recent reintroduction of Level 5 restrictive measures was broadly in line with actions taken across the European Region. The NPHEP concluded that it would be helpful to liaise further with international colleagues, with a view to gaining a better insight into epidemiological data presented.

3. Review of Existing Policy

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

The HSE presented the paper *"Testing and Tracing NPHEP Paper, 22nd of October"*. The data presented were as follows:

- Over the past 7 days, 13th– 19th October 2020, there have been 115, 271 swabs taken for COVID-19 testing. Over 73, 988 of these were taken in the community; 21,521 swabs were taken in acute settings;
- The remaining 19,762 swabs taken were taken as part of the serial testing programmes of employees in meat and food production plants, and staff in residential care facilities for older persons;
- From 13th - 19th October there were 111,688 tests completed;
- From 13th– 19th October, a total of 27, 726 calls were made in the Contact Tracing Centres. A total of 4,884 of these were Call 1s, which involves the communication of a detected result. A total of 22,842 calls were completed relating to contact tracing;
- Between 13th - 19th October, the average number of close contacts per case was 4.4;
- Between 13th – 19th October, in the community, the median time for community referral to appointment was 0.8 days. 94% 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 the 13th – 19th October was 3.8 days;
- The 3.8-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 4,762 on the week from 6th - 12th October;
 - The calls are becoming more complex as contact tracers are at times 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 must then take place the next morning;
- A process is currently in operation to support all ongoing schools testing including childcare facilities. As of 20th October, 544 schools have had/are having some testing completed as a consequence of a public health risk assessment. From the 544 schools that had mass tests, there have been an additional 355 detected cases identified over and above original cases. 13,289 students and teachers have been involved in mass testing;
- The HSE plans to recruit an initial 800 contact tracers and then review the requirement. 600 people have already completed the interview process, 230 have started working to date and 60-70 new staff are expected to start on a weekly basis over the coming period.

In response to the high numbers of people testing 'detected' for COVID-19 over the weekend of 16th October, and in a continued effort to maintain effective turnaround times for contact tracing, the HSE has asked a limited number of people to alert their own close contacts of their detected result. This step is being taken to ensure that each person receives information as quickly as possible so they can take steps to protect others from infection. People who received notification by SMS of a detected COVID-19 result between 16th – 18th October, will, from 21st October, receive a second text message which can be forwarded to their close contacts.



In response to the HSE's account of actions taken over the weekend of 16th October, the General Practice member of the NPHEt asked that, for the future, additional attention be given to enhanced consultation with general practitioners through the Irish College of General Practitioners so as to facilitate the support of general practitioners for the national testing and tracing programme.

The HSE also presented the "*National Public Health Emergency Team (NPHEt) Close Contact Report 12th to 18th October*". This report covers close contacts of cases of COVID-19 identified for the period 12th-18th October 2020. The data presented were as follows:

- For the week 12th- 18th October 2020, 19, 337 close contacts, and 2,281 complex contacts were created on the COVID Care Tracker (CCT);
- This represents a 27% and 18% increase on the previous week, respectively.
- 12th - 18th October saw an increase in the number of educational institutions recorded as complex from 314 to 583 (46% increase);
- The number of hospitals with recorded complex contacts rose from 126 to 150 (19% increase);
- The number of social venues recorded as complex contacts decreased slightly, from 382 to 343 (10% decrease);
- Between 12th- 18th October, the highest number of close contacts occurred in the household (8,152), followed by social circumstances (4,718).

b) Serial Testing in Nursing Homes

The HSE presented the paper "*Serial Testing of all staff in Residential Care Facilities (Older People): 19th October 2020*," outlining the serial testing programme for COVID-19 delivered to staff in long-term residential care facilities (LTRCFs) for older people to date, including outcomes, level of detected cases identified, and key findings and recommendations for the NPHEt's consideration.

Summary of Cycle 3 Results:

- The 3rd cycle of the serial testing programme ran from 14th September to 13th October 2020. This programme involved testing of all staff in LTRCFs for COVID-19 once a fortnight, for 4 weeks.
- In the 3rd cycle, 85,976 staff were referred, and 61,423 staff from 569 LTRCFs for older persons were tested. This amounts to a 71.4% participation rate from the total number of staff referred for testing.
- 61,423 test results were received.
- A total of 261 tests had a 'SARS-CoV-2 detected' result; 2 of these tests were from previously detected cases in LTRCFs. 259 new 'SARS-CoV-2 detected' cases were identified across 125 LTRCFs.
- 109 (42%) of these cases were detected during the first fortnight of testing.
- 150 (58%) were detected during the second fortnight of testing.
- There was a total of 972 contacts identified from the 259 'SARS-CoV-2 detected' cases identified during this cycle of testing.
- A difference between the three cycles of serial testing was observed. Both Cycle 1 and Cycle 2 reflected the geographical distribution of cases, with a preponderance of positive cases in the East of the country. Results of Cycle 3 show an increase in the number of positive cases detected across all areas of the country.

HSE's Key Considerations for Future Testing:

Targeted Improvement in Uptake: With the increasing levels of detected cases across all Community Health Organisations (CHOs) there is an urgent need to increase the level of uptake of serial testing in all LTRCFs for older persons. Cycle 3 saw a slight improvement in uptake from 69% to 71%. LTRCFs should aim to have 100% of their staff tested in each fortnightly cycle. To support this, the HSE are working with Nursing Homes Ireland (NHI) undertaking a target approach for improvement in facilities where low uptake is currently visible. If required, additional support will be provided to these facilities to improve the uptake rate.



Frequency of Testing: The HSE recommend continuing to complete fortnightly testing of staff in all LTRCFs for older persons. This fortnightly cycle ensures Public Health teams can initiate any mass testing required in LTRCFs in between the fortnightly testing timetable allowing management of any potential outbreaks.

The HSE confirmed that Cycle 4 of the testing programme commenced on October 14th and will continue until 10th November.

Following the HSE's presentation, the NPHET expressed concern over the approximately 70% testing uptake rate for LTRCF staff in the most recent serial testing programme and noted the need for renewed efforts to improve uptake.

The DOH reported that an update was provided to the Nursing Home Expert Panel Implementation Oversight Group (IoT) on 21st October by the HSE, in which it was noted that uptake of serial testing was in the order of 70% and that there continued to be a small number of staff identified as attending work while symptomatic. The IoT agreed to follow these matters up with both the HSE and NHI.

The NPHET thanked the HSE for its update. The NPHET further requested that the HSE raise its concern regarding low uptake with the serial testing programme with all LTRCFs immediately, explore the reasons behind this low uptake, and report back to the NPHET at its next meeting. The NPHET also requested that the HSE consider and report back on whether residents in LTRCFs should be included in the serial testing programme once again, given the trajectory of the disease.

c) *Prioritisation Framework for responding to clusters in different settings*

The HSE presented the paper "*Departments of Public Health, COVID-19 Priority Work Streams-A modified Delphi approach: 20th October 2020*", submitted to the NPHET by the Office of the Clinical Director of Health Protection on behalf of the Directors of Public Health nationwide. Key points in the paper were as follows:

- The increase in cases of COVID-19 has placed significant strain on the 8 regional Departments of Public Health. Referrals into Public Health Departments through the complex cases identified by the Contact Management Programme are increasing in number and complexity on a daily basis.
- Whilst there were significant staff redeployments to assist with the first wave of the COVID-19 pandemic, staffing levels have not returned to first-wave levels and permanent staffing within Departments of Public Health are stretched and fatigued.
- To ensure a robust response can be maintained to the areas in most need throughout the second wave of the pandemic, the regional Departments of Public Health participated in a prioritisation exercise to reach agreement on the areas of greatest and significant clinical priority for health protection teams.

The NPHET thanked the HSE for its presentation and the Directors of Public Health for the well-conducted piece of work. The NPHET endorsed the proposed list of clinical priorities for health protection teams and requested that resources be appropriately directed to meet these priorities.

d) *Guidance on the use of visors*

The HPSC presented the paper "*Efficacy of visors compared with masks in the prevention of transmission of COVID-19 in non-healthcare settings: 20th October 2020*", summarising the current evidence and international guidance regarding the efficacy of visors/face shields compared with masks/face coverings in the prevention of transmission of COVID-19 in non-healthcare settings.



The paper reached the following conclusions:

- Good quality evidence that allows for the assessment of differences in the degree of protection afforded by surgical masks, cloth face covering and visors against droplet transmitted infection is lacking.
- There is a general consensus that cloth face coverings are preferred to visors. Some authoritative international guidance recommends against use of visors alone.
- There is also a body of evidence and opinion that visors offer a significant degree of protection against droplet exposure compared with no face covering.
- Any protective effect from any of these items is dependent on the item being of good quality, well-designed, and properly worn.
- None of these items of PPE should be considered as a substitute for the other Public Health measures of limiting contacts, maintaining social distance, appropriate respiratory etiquette and effective hand hygiene.

The paper made the following recommendations:

- In non-healthcare settings, when considering the options of cloth face coverings compared with visors, expert opinion and international guidance generally favours cloth face coverings.
- There is a rationale and laboratory evidence in particular for favouring cloth face coverings over visors where the wearer is at a higher level (standing) than those potentially exposed at a lower level (sitting).
- However, there is evidence that visors do reduce exposure to droplets and are recognised as a usable alternative to cloth face coverings in situations where use of a cloth face covering is not practical. Where cloth face coverings are used it should be of multiple layers of suitable fabric and correctly applied.
- Where visors are used, they should cover the entire face (above the eyes to below the chin and wrap around from ear to ear) and be correctly applied.

The NPHEt endorsed the recommendations set out in the paper and requested that the DOH build the recommendations into its ongoing communications work.

Action: The NPHEt agreed that, based on the available evidence, visors are not recommended for use in most settings, while recognising they may be a useable alternative to cloth face coverings in some limited defined circumstances, specifically:

- **People with breathing difficulties;**
- **Anyone who is unconscious or incapacitated;**
- **People who are unable to remove masks/face coverings without help;**
- **Anyone with special needs who may feel upset or very uncomfortable wearing the mask/face covering;**
- **In settings where people who are hard of hearing or deaf are being dealt with.**

4. Future Policy

The NPHEt noted that Level 5 restrictions remain in place and that no further recommendations for additional public health restrictive measures were required at present. A brief discussion focused on policy objectives that could collectively be progressed with the relevant stakeholders over the course of October and November to strengthen the system of public health defences in advance of the anticipated easing of restrictive measures thereafter. Further detailed discussions are planned for upcoming NPHEt meetings. The critical importance of joint communications work both during the Level 5 period and afterwards was also underlined.



5. Advice from HIQA

a) *Period of restricted movement for those exposed or potentially exposed to COVID-19*

HIQA presented advice on the question *“Is there a rationale upon which to reduce the current period of restricted movement for close contacts from 14 days? If so, how will any change in guidance intersect with the current testing protocol (that is, a PCR test on day zero and a PCR test on day seven)?”*

HIQA provided the following advice to the NPHE:

- Should a change to the current strategy be implemented, of the options assessed, at a population level, the use of ‘Day 0’ and ‘Day 10’ rRT-PCR tests with end of restricted movements on receipt of a ‘not detected’ result from the ‘Day 10’ test, would present the largest incremental benefit (in terms of reduced person-days in restricted movements) and lowest incremental risk (in terms of infectious person-days in the community) relative to current standard practice in Ireland.
 - Per 1,000 close contacts, this scenario infers a reduction of 1,690 (95% CI -2,340 to -929) person-days in restricted movement with an increase of two (95% CI -12 to 11) infectious person-days in the community.
 - In Ireland, for the week 14th – 20th October, there were 8,097 cases. Assuming an average of 6 close contacts per case, this would equate to a reduction of approximately 82,100 person-days in restricted movement and an increase of 97 infectious person-days in the community.
- Scenarios involving an end of restricted movements on receipt of a ‘not detected’ result from a ‘Day 7’ RT-PCR test are associated with greater benefit, but with a marked increase in risk.
 - Per 1,000 close contacts, this scenario presents a reduction of 2,512 (95% CI -3,362 to -1690) person-days in restricted movement with an increase of 38 (95% CI 21 to 59) infectious person-days in the community.
 - In Ireland, for the week 14th – 20th October, there were 8,097 cases. Assuming an average of 6 close contacts per case, this would equate to a reduction of approximately 121,832 person-days in restricted movement and an increase of 1,846 infectious person-days in the community.
- Scenarios that adopt a ‘Day 10’ test in lieu of the current ‘Day 7’ test are associated with an increase in the total number of tests conducted (approximately 55 tests per 1,000 close contacts). This increase is due a higher proportion of individuals eligible for a second test because of the longer interval between it and the ‘Day 0’ test.
- Consideration should be given to what constitutes an acceptable level of risk relative to current practice in the context of the current and future disease trajectory, possible broader public and mental health considerations, and the capacity to resource essential services. Additionally, the impact that any change would have on the current Test and Trace processes in Ireland should be taken into account.
- When considering a reduction in duration of restricted movements based on testing, attention needs to be paid to the impact on certain groups such as vulnerable individuals or those in high-risk settings, in which the associated residual risk of onward infection may not be acceptable.
- There is an urgent need for a communication strategy that clarifies the rationale for the first and second tests, the implications of a ‘not detected’ first test result, and the importance of ongoing adherence to all aspects of COVID-19 public health guidance.
- Should a change in the current strategy be implemented, the duration of restricted movements would be contingent on completion of all testing requirements. That is, should an individual not present for testing, they should continue to restrict their movements for the full 14-day duration.

During the discussion, the NPHE considered whether there had been a change in the guidance from the ECDC or WHO and noted that, while some international countries had changed the period for restriction of



movement, there had been no change in the basic evidence. The Chair proposed that the NPHEt accept and endorse HIQA's advice; no change should be made to the recommended period for restricting movements. It was also noted that the importance of the 14-day period should be reiterated to the public, with particular regard to those who live with symptomatic or confirmed cases. This proposal was endorsed by the NPHEt.

b) Advice to NPHEt on the immune response to SARS-CoV-2 infection.

HIQA presented advice to the NPHEt on "*Duration of immunity and reinfection following SARS-CoV-2 infection.*" The paper addressed the following questions:

- What is the rate of reinfection in individuals who recovered from a laboratory-confirmed SARS-CoV-2 infection?
- What is the duration of immunity in individuals who recover from a laboratory-confirmed SARS-CoV-2 infection?

HIQA provided the following advice to the NPHEt:

- Reinfection with SARS-CoV-2, although rarely documented, is possible. Therefore, all infection prevention and control procedures and recommendations, including hygiene and physical distancing, should apply to those who have recovered from a SARS-CoV-2 infection as immunity from reinfection cannot be assumed.
- Anti-SARS-CoV-2 IgG and neutralising antibody seropositivity is maintained in most individuals for 2-6 months post-infection. However, further research is required to establish the relative importance of antibody-mediated immunity and the levels (titres) necessary to prevent reinfection. Further research is also required on cell-mediated immunity, including B- and T-cell responses.
- Clear and accessible communication regarding the potential for waning immunity and the risk of reinfection is important.

The Chair proposed that the NPHEt accept and endorse the above advice, noting that relevant members should consider whether this guidance has any implications for contact tracing, the return to work for healthcare workers and serial testing programmes. This proposal was agreed to by the NPHEt.

6. Communications Update

The DOH and HSE presented the joint update "*NPHEt – Communications Update – 22nd October*".

According to the Quantitative Tracker, the nationally representative sample of 1,770 people, conducted on behalf of the Department of Health on 19th October 2020, revealed the following:

- The level of worry stands at 6.8/10, similar to the level of worry expressed in April.
- The appetite for stronger policy responses continues to grow and is now higher on some measures than at the peak of the pandemic in April. For example, 73% of respondents believe there should be more restrictions.
- There is some evidence of growing concern about the wider impact, both socially (isolation, loneliness) and economically.

Some key insights from the qualitative tracker, talking to young adults, mature adults and parents with children living at home, reveals:

- We are now in a period of maximal COVID difficulty, awaiting a workable vaccine.
- Signifiers of control are valuable means of keeping morale during this most difficult phase of the COVID journey. There is a need to empower people with a sense of control once again during this next phase.
- While mature adults (50-69 years) experience loneliness, this is compensated for by an increased sense of control (e.g. who is coming in/out of their homes).



- Young adults require a more positive and human discourse, with their peers being the predominant source of inspiration for any behaviour change.
- There is a pattern of apportioning misplaced shame/blame on individuals who contract COVID-19. Any judgment of others should focus on risky behaviours which can be controlled.

An update was also provided on ongoing and upcoming communications work:

- The informal Youth Taskforce led by the Department of An Taoiseach with assistance from DOH and HSE will work over the coming weeks to develop communications solutions to empower young adults to adhere to public health advice.
- The HSE launched its “Bubbles” campaign, predominantly targeted at young people, which creates a visual reminder of the protection we can share when we follow public health actions, and how easy it can be the lost.
- The HSE is considering the rapid launch of a campaign to reinforce public knowledge and understanding on the need for self-isolation and restriction of movements for close contacts of cases and individuals awaiting the result of a COVID-19 test.

The Chair welcomed these updates and reaffirmed the need for clear public messaging on the importance of the public adhering to guidance on self-isolation and restriction of movements. The NPHET restated the importance for public communications to incorporate perspectives on public behaviours regarding adherence to the challenging but crucial practices of self-isolation and restriction of movements particularly in the context of the long-term future strategy for living with COVID-19.

7. Meeting Close

a) Agreed actions

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

b) AOB

(i) Face Covering Regulations

The NPHET endorsed a further extension of the regulations for use of face coverings in indoor public areas and on public transport.

The NPHET also considered that specific messaging relating to the Halloween period should be factored into communications over the coming days and will be looking to advice from the DOH communications team on this matter.

The NPHET further discussed the issue of return to play for sports and considered whether further guidance or support could be offered to make this return as safe as possible for all individuals involved.

c) Date of next meeting

The next meeting of the NPHET will take place Thursday, 29th October 2020, at 10:00am via video conferencing.