An Roinn Sláinte
Department of Health

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

Date and Time	Friday 1st May 2020 (Meeting 27) at 10am
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference	Dr Kevin Kelleher, Assistant National Director, Public Health, HSE Mr Liam Woods, National Director, Acute Operations, HSE Mr David Walsh, National Director, Community Operations, HSE Dr Darina O'Flanagan, Special Advisor to the NPHET Dr Colm Henry, Chief Clinical Officer (CCO), HSE (10am to 11am) Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group Dr Lorraine Doherty, National Clinical Director, Health Protection, HSE Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group Chair Mr David Leach, Communications, HSE Dr Mary Favier, President, ICGP Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Michael Power, Consultant in Anaesthetics/Intensive Care Medicine, Beaumont Hospital Dr Máirín Ryan, Deputy Chief Executive and Director of Health Technology Assessment, HIQA Prof Colm Bergin, Consultant Physician in Infectious Diseases, St James's Hospital Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Dr Alan Smith, Deputy Chief Medical Officer, DOH Dr Eibhlin Connolly, Deputy Chief Medical Officer, DOH Dr Siobhan O'Sullivan, Chief Bioethics Officer, DOH Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Mr Paul Bolger, Director, Resources Division, DOH Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Breda Smyth, Public Health Specialist, HSE Ms Kate O'Flaherty, Head of Health and Wellbeing, DOH Ms Marita Kinsella, Director, NPSO, DOH Dr John Cuddihy, Interim Director, HSE HPSC Mr Tom McGuinness, Assistant National Director, Office of Emergency Management, HSE Dr Jeanette McCallion, Medical Assessor, HPRA Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE
'In Attendance'	Ms Laura Casey, Health Systems and Structures Unit, DOH Mr David Keating, Communicable Diseases Policy Unit, DOH Mr Colm Ó Conaill, Policy and Strategy Division, DOH Ms Sarah Treleavan, NPSO, DOH Ms Sheona Gilsenan, Statistics and Analytics Unit, DOH
Secretariat	Ms Rosarie Lynch, Ms Sarah Murphy, Ms Susan Reilly, Ms Linda O'Rourke, Mr John Harding, NPSO, DOH.

1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Minutes of previous meeting(s)

The Department of Health (DOH) updated that minutes up to and including the NPHET meeting of the 14th of April have been published on the DOH website. Preparation of minutes from other meetings in April continues and when finalised, they will be circulated to NPHET members for feedback and agreement. The "*National Public Health Emergency Team (NPHET) for COVID-19: Governance Structures*" has also been published on the DOH website.

The Chair also recalled that all actions continue to be agreed by the NPHET in real time at the end of each meeting and are communicated by letter to the Minister for Health and the Health Service Executive (HSE), as appropriate, on that same day.

c) Matters Arising

No matters arising were noted.

2. Epidemiological Assessment

In the interests of time, it was agreed that this agenda item would be taken as part of agenda item 6 in the discussion of the review of the current public health measures and the epidemiological indicators of disease progression.

The Health Protection Surveillance Centre (HPSC) noted that mortality data now includes confirmed, probable and possible deaths.

3. Expert Advisory Group

The Chair of the Expert Advisory Group (EAG) gave an update on the discussions at the most recent meeting of the Group (29th April).

It was noted that the EAG advice in relation to the wearing of face masks in the community by asymptomatic individuals would be considered under agenda item 6 b).

Regarding the other matters from the EAG meeting of 29th April, the Chair outlined the following recommendations:

(i) the EAG had reviewed the proposal presented by HSE National Clinical Advisors and Group Leads in relation to the restart of routine non-COVID-19 care in the acute hospitals and recommended its submission to NPHET;

(ii) in relation to healthcare workers with a history of COVID-19 infection who have completed 14 days of self-isolation and whose illness has resolved, but who have then been retested as part of the nursing home screening - these staff can work if they are well even if they receive a positive COVID-19 test as part of the screening. This is likely to be non-viable virus material, rather than active infection, and there is no evidence that these individuals pose an infection risk;

(iii) in relation to those patients whose illness has resolved, but in whom SARS-CoV-2 RNA remains detectable after 14 days, EAG recommends that infection prevention and control (IPC) precautions should be kept in place for another 7 days and then removed provided the patient has no symptoms consistent with ongoing COVID-19 infection. No further retesting is required as the risk of spreading infection is extremely low after this time period.

By way of background in relation to the EAG recommendation (i) above, it was noted that, as part of the restrictive public health measures necessary to control the spread of COVID-19, on 27 March, NPHET had recommended that all non-essential health services be postponed. A proposal and interim guidance has been developed by the HSE National Clinical Advisor Group Lead for Acute Care to restart non-urgent acute care and this proposal and interim guidance is supported by the Acute Hospitals Preparedness Subgroup and now, based on the recommendation above, by the EAG. The NPHET agreed that this recommendation would be for substantive discussion at the NPHET meeting on Tuesday 5th of May.

In relation to the EAG recommendation (ii) above regarding healthcare workers, it was clarified that this applied to healthcare workers in all healthcare settings and not just nursing home settings. This clarification was accepted.

Action: The NPHET accepted the advice from the Expert Advisory Group (EAG) of 29th April 2020 in relation to:

a) the proposal from the HSE Acute Hospitals to restart routine non-COVID-19 care in acute hospitals and this matter will be considered further by the NPHET on 5th May 2020;

b) In relation to healthcare workers (HCWs) with a history of COVID-19 infection who have completed 14 days of self-isolation and whose illness has resolved, but who have then been retested as part of an enhanced testing programme in a healthcare facility: these staff can continue to attend work if they are asymptomatic even if they receive a test result which suggests the persistence of SARS-CoV-2 RNA in the sample taken as part of this enhanced testing programme. The HPSC is to update its guidance and the HSE is to implement accordingly.

c) In relation to those patients whose illness has resolved, but in whom SARS-CoV-2 RNA remains detectable after 14 days, the EAG recommends that infection prevention and control (IPC) precautions should be kept in place for another 7 days and then removed provided the patient has no symptoms consistent with ongoing COVID-19 infection. No further retesting is required,

as the risk of spreading infection is extremely low after this time period. The HPSC is to update its guidance and the HSE is to implement accordingly.

4. Review of Existing Policy

a) Sampling, Testing, Contact tracing and CRM reporting

Given the interdependencies, it was proposed and agreed that agenda items 4 a) on Sampling, Testing, Contact Tracing and CRM Reporting and 6 a) on Case Definition would be discussed together as one agenda item.

Sampling, Testing, Contact Tracing and CRM Reporting

The HSE provided an update on testing and testing capacity noting that the National Ambulance Service (NAS) had conducted an estimated 40,000 tests in the previous week with a further 10,000 tests being carried in community locations. The HSE expected that capacity for 15,000 tests per week would be in place by the 18th May, with increasing automation to assist in improving contact tracing processes.

Updated Case Definition

DOH presented a paper to NPHET on the current case definition and the data emerging from the COVID-19 Community Tracker, developed by GP Buddy in conjunction with Trinity College Dublin and Irish College of General Practitioners (ICPG).

An update was provided to the NPHET regarding the change in case definition, agreed by the NPHET meeting of the 24th of April, which went live on 28th of April 2020. Data from the COVID-19 Community Tracker show that the change in case definition has not resulted in a significant increase in the number of patients been referred for testing. Based on these data and the expected trajectory of testing capacity, moving from 10,000 a day to 15,000 day over the next 3 weeks, it was noted that widening the case definition to remove the existing restriction on testing to priority groups, was within the available testing capacity.

The impact of the enhanced testing programme currently running in long-term residential healthcare settings (LTRCs) on the operational capacity to support any proposed changes to the case definition was noted.

Feedback from GPs in community settings on the working of the current testing pathway was provided by the ICGP, noting that rate-limiting steps appear to still exist across waiting times for testing and tracing.

The following was proposed to the NPHET:

(i) The removal of the priority testing categories;
(ii) The revised case definition to become operational on Wednesday 6th May 2020;
(iii) The implementation of immediate actions to prepare for these changes, including–

- HPSC to update algorithm,

- HSE to communicate the decision to the ICGP,
- ICGP to communicate the change in case definition to its members.

The Chair noted that the current capacity appeared to be able to support a change in case definition but if this is not the case, this would need to be addressed as a matter of urgency. The HSE agreed to provide a further update to the NPHET of Tuesday the 5th of May on the status of the enhanced testing programme in LTRC and will work to assure operational capacity is in place to support the change in case definition. It was also noted that as part of testing strategies, consideration should be given to the testing of certain category of workers based on the nature of their work and bearing in mind their social interactions and accommodation arrangements, in an effort to interrupt the chain of transmission within those communities.

Action: **The NPHET recommends the removal of the requirement to fall into a priority group from the current case definition (last updated on 24th April 2020). The target date for implementation is from 6th May 2020 or such further date that is deemed more operationally feasible and agreed with the HSE in the interim. The HPSC is to update the relevant guidance and algorithms and the HSE will communicate the decision taken today with the Irish College of General Practitioners (ICGP) and commence the preparations necessary for implementation.**

b) Use of face masks – update

It was agreed that this would be discussed under Agenda item 6 b)

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

a) Residential Healthcare settings

DOH provided a brief update on the continued focus LTRCs with the ongoing implementation of NPHET actions and recommendations remaining a priority for the HSE's COVID-19 response.

b) Acute Hospital settings

DOH provided a brief update on the bilateral engagement between DOH and the HSE in relation to the implementation of agreed actions, noting the ongoing progress to date in working to address outstanding issues regarding infection prevention and control.

Due to time constraints it was agreed that more detailed updated on the response to COVID-19 in long-term residential healthcare and acute hospital settings would be provided at the NPHET meeting on 5th May.

6. Future Policy

a) Case definition

This was discussed under agenda item 4 a) above.

b) Review of current Public Health measures – phasing

c) Disease indicators (and Agenda item 2 Epidemiological Assessment)

In light of the interdependencies, Agenda item 6 b) and 6 c) were discussed together.

Public health framework approach in providing advice to Government regarding the reduction of the social distancing measures

The NPHET continued its work in relation to the development of a public health framework approach in providing advice to Government regarding the reduction of the social distancing measures. The document incorporated the feedback from previous meetings and written inputs received from NPHET Members. The framework aims to provide clear, risk-based and responsive public health advice to inform Government as part of its decision-making process in changing the restrictive measures over time. The NPHET noted that this work would now become part of the Government's Roadmap for exiting from the current public health restrictive measures due to be published shortly, but that in the Roadmap, Government would be addressing other wider economic and societal matters.

The NPHET agreed that it should be a living document, subject to regular review, the measures contained within it are intended to be indicative, providing a menu of possible options for NPHET to consider at each 3-week review point when providing public health advice to Government regarding the adjustment of social distancing measures. The framework is intended to be applied flexibly, so that it would be open to the NPHET, at any point in time, not to recommend measures or to recommend measures from later phases depending on the prevailing disease circumstances.

Action: The NPHET approved its Public Health Framework Approach in providing advice to the Minister for Health and Government regarding the reduction of social distancing and other measures introduced in response to COVID-19 for adoption and publication. This Framework will be used as the basis of informing the ongoing decision-making of the NPHET as it makes its advice to Government regarding any future changes to social distancing and other public health measures.

Disease indicators (and Agenda item 2 Epidemiological Assessment)

Agenda item 2 Epidemiological Assessment was also discussed under this agenda item.

DOH set out a draft key disease indicators to be used in monitoring the status and progression of COVID-19 in Ireland, which would enable the NPHET to make judgements and upon which it could base its recommendations and advice to Government regarding future public health and social distancing measures. The indicators are in three categories: epidemiological; health system; and contact tracing.

While it was acknowledged that there are a range of other indicators and metrics that are also important, it was noted that the draft disease indicators are not intended to be a comprehensive performance measurement tool, which would not responsive or adaptive enough to changes in the evolving nature of the disease to make rapid decisions about the necessary response. Instead the draft indicators are intended to provide key pieces of information of importance to allow understanding of

the disease situation, in order that judgements can be made regarding calibrating the public health response and the adjustment of the public health measures.

NPHET considered that the draft disease indicator framework provided an appropriate basis to assess the current status of the disease and noted that the indicators and thresholds will evolve over time, as understanding of the disease evolves and in line with evidence.

The social distancing and public health measures introduced to date have shown a clear impact in suppressing the transmission of COVID-19 with collective efforts now resulting in measurable improvements in the progression of COVID-19 in Ireland. The reproduction number of the virus (R_0) has now fallen below 1, with indications being that it is now between 0.5 and 0.8.

Noting the ongoing epidemiological assessment, in summary, Ireland's current position was as follows:

i. the number of confirmed cases stands at 20,612 (with an average of 414 cases notified per day over the past 5 days; +359 yesterday);
ii. 740 confirmed cases in hospital today;
iii. the number of confirmed COVID-19 patients requiring critical care today is 103, with a further 20 patients suspected of having COVID-19 also in critical care;
iv. 371 number of clusters in residential care facilities to date;
v. the number of confirmed cases in residential care facilities stands at 4,590 of which 3,679 are in nursing homes (with an average of 194 cases notified per day over the past 5 days; +227 yesterday);
vi. 5,684 cases are associated with healthcare workers (+116 yesterday);
vii. there have been 1,232 deaths recorded to date, with 43 notified yesterday.

There were continuing concerns expressed however about the ongoing extent of COVID-19 disease in the community and regarding specific burden still being experienced in the residential care settings. NPHET also noted from the current assessment that COVID-19 related occupancy levels in hospitals and ICU settings, though decreasing, remained at high levels. Concerns continued to exist in relation to the transmission profile of COVID-19 amongst healthcare workers and the burden of mortality, particularly in vulnerable groups.

The NPHET also noted the European Centre for the Prevention of Disease Control (ECDC) updated *Rapid Risk Assessment: Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK– ninth update* from the 23rd April and its assessment that:

- *The risk of severe disease in the EU/EEA and UK is currently considered low for the general population in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced and/or maintained at low levels. The risk of severe disease in the EU/EEA and UK is currently considered* ***moderate*** *for the general population in areas where appropriate physical distancing measures* <u>*are not in place*</u> *and/or where community transmission is still high and ongoing.*

- *The risk of severe disease in the EU/EEA and UK is currently considered **moderate** for populations with defined factors associated with elevated risk for COVID-19 in areas where appropriate physical distancing measures are in place and/or where community transmission has been reduced or maintained at low levels. The risk of severe disease in the EU/EEA and UK is currently considered **very high** for populations with defined factors associated with elevated risk for COVID-19 in areas where appropriate physical distancing measures are not in place and/or where community transmission is still high and ongoing.*

- *The risk of resurgence of sustained community transmission in the EU/EEA and the UK is currently moderate if measures are phased out gradually and accompanied by appropriate monitoring systems and capacities, with the option to reintroduce measures if needed, and remains **very high** if measures are phased out without appropriate systems and capacities in place, with a likely rapid increase in population morbidity and mortality.*

- *The reduction in the rate of incident reported cases in many EU/EEA Member States is almost certainly due to the introduction of stringent control measures. However, a progressive strategy to phase out measures, where an increasing proportion of the population returns to work, could mitigate the risk of significant upsurges, and maintain incidence at a rate within hospital capacity and allow monitoring systems to identify the need for re-introduction of specific measures if there is a sharp resurgence.*

- *If control measures are to be lifted, conscious efforts to protect the vulnerable and careful choices by all in their interactions with others will help to moderate the increased risk of transmission.*

NPHET also noted the preliminary work undertaken by the Health Information Quality Authority (HIQA) comparing Ireland's epidemiological information with that of a number of other countries. Even from this preliminary work it was evident that certain countries that had announced lifting of measures before Ireland were ahead of Ireland in terms of the peak and timeline of their outbreak.

Given consideration of the available data and disease indicators, in conjunction with updated ECDC risk assessment, the NPHET agreed not to recommend the easing of current public health restrictions at that time and instead that restrictions should be recommended for extension for a further two weeks.

Action: The NPHET today considered the public health measures currently in place (previous recommendations of 12th, 24th and 27th March and 10th April refer). Arising from the discussion at the meeting, the NPHET recommends the extension of the current public health measures; with this extension effective until midnight on Sunday, 17th May 2020.

Consideration of potential measures for recommendation to Government

A discussion took place regarding whether, in the intervening period before 17 May 2020, there were any social distancing measures that could be recommended to Government for change, on the basis that they would not significantly increase the overall public health risk associated with COVID-19.

The NPHET continued to acknowledge the extent to people across society have been exceptional in complying with the restrictions and this has enabled Ireland to reduce the level of disease. NPHET members, however, were also very conscious of the impact that the social distancing measures have had on people's lives.

(i) 'Stay at home'

In particular, the NPHET discussed recommending to Government that the "stay at home" exercise restriction could be increased from 2km to 5km as this would maintain the existing public health objective of minimising the risk of the disease spreading quickly to different parts of the country, but would enable people to enjoy different exercise routes within their locality.

(ii) Cocooning

The NPHET also discussed in detail the issue of cocooning for those aged 70 years and over and the medically vulnerable. The NPHET noted that in light of their higher risk of infection, for their safety those cocooning should continue to be advised to cocoon, but should they now wish to leave their homes to engage in exercise and activities outdoors, they should be advised how to do so safely. This would include continuing to adhere to strict social distancing, keeping 2 metres from other people, complying with appropriate guidance regarding maintaining a 'no touch' approach and hand hygiene on returning home. It was also considered that guidance should be developed for the rest of the general public on how to maintain social distancing in order to assist in keeping those aged 70 years of age and over, and the medically vulnerable safe.

(iii) Face-coverings

In relation to the wearing of face masks in the community by asymptomatic individuals, EAG Chair provided an update regarding the outcome of the EAG meeting on 29th April at which it recommended the following:

a. In order to limit or prevent the (inadvertent and unintentional) transmission of SARS-CoV-2 from the (asymptomatic or pre-symptomatic infected) wearer to others (i.e. source control), individuals should wear medical face masks in settings in which physical distancing cannot be maintained. These circumstances would include public transport, shops, and other indoor congregated spaces;
b. Guidance be made available to the public explaining the appropriate use of a medical face mask i.e. how to apply, remove, and safely dispose of same;
c. Communications advice be requested as to how best to communicate this guidance to the public;

d. Consideration be given to how this recommendation – if accepted – can be implemented in an equitable manner - requiring individuals to purchase their own masks could exacerbate health inequalities.

In making this recommendation, the EAG stressed–

- that the public should be advised that medical face masks and respirator masks should be prioritised for healthcare workers,
- that this recommendation can only be made if sufficient confidence exists in the availability of medical face masks for the foreseeable future,
- mask wearing represents only one part of a suite of measures used to prevent the spread of COVID-19 in the community. Hand hygiene and physical distancing remain the priorities, and the EAG strongly caution that poor adherence to the existing recommendations on hand hygiene and physical distancing would have the potential to reverse any gains that might be achieved with the use of face masks.

Furthermore–

- the wearing of latex/nitrile gloves is not recommended as these may, if worn inappropriately for long periods, lead to an increased risk of transmission of SARS-CoV-2; regular hand hygiene is preferred,
- due to a lack of evidence of effectiveness, and the potential risk of harm, the EAG does not recommend the use of cloth masks.

NPHET discussed the use of face coverings in the community and noted the limitations around evidence in the area. In particular NPHET noted the caveat on the EAG's advice that its recommendation can only be made if sufficient confidence exists in the availability of medical face masks for the foreseeable future.

There was a discussion on the need to increase indigenous supply of all grades of masks, including medical grade masks, but that it was important that the wearing of the face coverings in the community should not impact on the supply of masks for healthcare workers.

Applying a precautionary principle, the NPHET agreed that the use of face coverings in the community should be implemented as part of the reduction of public health social distancing measures in certain circumstances and preparatory work should commence, such as the development of guidance for the public on how to make and correctly use face coverings and ensuring that necessary supplies of suitable non-healthcare grade face coverings are available. NPHET agreed to progress further at its meeting on Tuesday 5th May.

Action: NPHET has agreed that the following measures are appropriate for recommendation to Government, as it is considered that they will not significantly increase the overall public health risk associated with the disease:

(i) the 'stay at home' restriction now be expanded geographically to cover an area within 5km from the home rather than the current restriction of 2km;

(ii) continue to advise those aged over 70 years of age and over and the medically vulnerable of the importance of remaining cocooned for their safety, however, should they now wish to leave their homes to engage in exercise and activities outdoors, they should continue to adhere to strict social distancing, keep 2 metres from other people, comply with appropriate guidance regarding maintaining a 'no touch' approach and hand hygiene on returning home. Guidance will also be developed for the general public on how to maintain social distancing and assisting keeping those aged 70 years of age and over, and the medically vulnerable safe;

(iii) The use of face coverings in the community will be implemented as part of the reduction of public health distancing measures, and work will now be progressed to ensure that supplies are available, bearing in mind the need to ensure necessary availability of medical grade masks for use by healthcare workers. Guidance will be developed in relation to the correct and appropriate use of such face coverings and further recommendations on this matter will be considered by the NPHET.

d) Travel Considerations

Due to time constraints, it was agreed that this item would be carried over for discussion at a later meeting.

e) Ad Hoc

There were no items under this agenda item for today's meeting.

7. Meeting Close

a) Agreed actions

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

b) AOB

A brief discussion took place in relation to NPHET processes, particularly as the NPHET starts to move into its next phase. It was noted by the Chair that the initial phase, in terms of public health emergency response, was likely to transition to the next phase of the disease in the near future, and there may be a need to make adjustments going forward to allow for a more sustainable process that could respond to the requirements of the NPHET over what is likely to be an extended period of time. The Chair suggested that consideration be given to taking stock of the NPHET process at the meeting on the 5th of May.

c) Date of next meeting

The next meeting will take place on Tuesday 5th May 2020 at 10am via video conferencing.