An Roinn Sláinte
Department of Health

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

Date and Time	Friday 24th April 2020 (Meeting 25) 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 Dr Lorraine Doherty, National Clinical Director, Health Protection, HSE Dr Cillian de Gascun, Laboratory Director, NVRL and Expert Advisory Group (EAG) Chair Dr Darina O'Flanagan, Special Advisor to the NPHET Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Ronan Glynn, Deputy Chief Medical Officer, DOH Dr Alan Smith, Deputy Chief Medical Officer, DOH Dr Siobhan O'Sullivan, Chief Bioethics Officer, DOH Mr David Walsh, National Director, Community Operations, HSE Dr Mary Favier, President, Irish College of General Practitioners (ICGP) Mr Phelim Quinn, Chief Executive Officer, HIQA Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Mr Paul Bolger, Director, Resources Division, DOH Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Ms Kate O'Flaherty, Head of Health and Wellbeing, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Breda Smyth, Public Health Specialist, HSE Mr Colm Desmond, Assistant Secretary, Corporate Legislation Mental Health Drugs Policy and Food Safety, DOH Dr Máirín Ryan, Deputy Chief Executive and Director of Health Technology Assessment, HIQA Dr John Cuddihy, Interim Director, HSE HSPC Prof Philip Nolan, President, National University of Ireland, Maynooth Ms Elaine Breslin, Clinical Assessment Manager, HPRA *(alternate to Ms Jeanette Mc Callion, HPRA)* Ms Marita Kinsella, NPSO, DOH Mr Tom McGuinness, Assistant National Director, Office of Emergency Planning, HSE Mr David Leach, Communications, HSE Dr Eibhlin Connolly, Deputy Chief Medical Officer, DOH
Apologies	Dr Colm Henry, Chief Clinical Officer, HSE Dr Siobhan Ni Bhriain, Lead for Integrated Care
In Attendance	Ms Deirdre McNamara, Office of the Chief Clinical Officer, HSE Mr David Keating, Communicable Diseases Control Policy Unit, DOH

	Ms Laura Casey, Health Systems and Structures Unit, DOH Mr Colm Ó Conaill, Policy and Strategy Division, DOH Ms Sarah Treleavan, NPSO, DOH Mr David Keating, Communicable Diseases Policy Unit, DOH Ms Aoife Gillivan, Communications Unit, DOH Ms Sarah Treleavan, NPSO, DOH Mr Ronan O'Kelly, Statistics and Analytics Service, DOH Ms Sheona Gilsenan, Statistics and Analytics Service, DOH
Secretariat	Ms Rosarie Lynch, Ms Sarah Murphy, Ms Susan Reilly, Ms Linda O'Rourke, Mr John Harding, Ms Liz Kielty, NPSO, DOH,

1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Minutes of previous meeting(s)

The Secretariat advised that further minutes were being prepared and will be circulated to the NPHET members for review, feedback and agreement via email. It was noted that all immediate actions are agreed during the NPHET meetings and are communicated by letter to the relevant parties after each meeting in order that the actions can be progressed.

c) Matters Arising

There were no matters arising.

2. Epidemiological Assessment

a) Update on National Data

(i) Health Protection Surveillance Centre (HPSC)

The HPSC presented an update on the national epidemiological data, including information on ICU admissions and information on infections in healthcare workers. It was noted that the highest number of cases remained in the East of the country.

More detailed information was presented on clusters of infections in long-term residential care and acute hospital settings. The HPSC clarified that, in terms of national reporting on cases, it is not currently possible to differentiate the number of cases occurring in nursing homes settings from the total number of cases in the general community, which would add understanding of that sector.

In addition, NPHET noted that the ability to differentiate for reporting purposes test results relating to staff members of residential healthcare settings separately from the results of residents would also be important in understanding transmission. The HPSC clarified that the Departments of Public Health receive test results in respect of residential healthcare settings as aggregated data and that efforts were underway to manually differentiate the data to identify residents and staff separately.

NPHET also discussed the epidemiological data with regard to healthcare workers (HCWs) and the need for further analysis to better understand the profile of infection in this cohort. The HPSC advised that surveillance is showing the proportion of positive results seen in healthcare workers is just over one quarter of the total number of cases (bearing in mind they are a priority group under the current case definition).

The Department of Health (DOH) advised that the issue of infection rates amongst healthcare workers was discussed at a recent meeting with members of the Health Service Executive (HSE) Board as a matter of significant and ongoing priority for the HSE.

In addition, work is underway to more accurately capture this category by the inclusion of a new field on the Computerised infectious Disease Report (CIDR) information system. It was noted that international experience shows that capturing data such as place / setting of work and ethnicity are important additional data fields. The HPSC updated that it has requested the HSE to expand the data fields being considered in the next iteration of the CRM system. The HPSC is also examining other data sources (e.g. Occupational Health, Health Information Quality Authority (HIQA) outbreak data, National Incident Management System (NIMS)) to see if these offer additional insights. It was noted that, where there is reason to believe that infection in a healthcare worker is nosocomial, then the usual procedures should be followed, which may include reporting on the NIMS system.

(ii) Department of Health (DOH)

DOH also provided an overview of data compiled on the basis of the HSE daily reports and the HPSC data received. The following analysis was noted:

- the data showed an increase in the number of referrals for community testing in the preceding days, and it was acknowledged that this was likely due to the increased testing underway in the long term residential healthcare facilities, as the community structures were being used as part of this enhanced testing;
- an increase in the number of tests conducted by the National Ambulance Service and the numbers of appointments offered in the testing clinics was observed;
- the wait for testing appeared to increase and clarity from HSE was awaited to understand this;
- the number of new patients admitted to hospital over the last few days has been declining;
- the median number of contacts identified from contact tracing is now 2.5 (mean number is 2.8).

b) International Assessments

The publication of the *Rapid Risk Assessment: Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK– ninth update* by the European Centre for Disease Prevention and Control (ECDC) was brought to the attention of the NPHET. It was acknowledged that this would be important in the context of the discussion on agenda item 6(c).

c) Modelling Report

The Chair of the Irish Epidemiology Modelling Advisory Group (IEMAG) provided an update and advised that results from the tests processed in Germany had now been used to recalibrate the model. This gives about 500 to 600 positive test results per day since the beginning of the month (with a dip due to testing constraints for the period when there was a shortage of reagent).

Of note, the data show that the number of people in the population who tested positive rose rapidly from mid to late-March and then there starts to be a decline in the number of positive cases across the population. In comparison, the data for the nursing home settings indicate that the disease entered these settings approximately 10 to 14 days later than in the general population (i.e. towards end March).

With regard to healthcare workers, the epicurve is similar to that seen in the general population (noting a weekend effect).

The data show that the total number of cases per day, as well as the hospital-based indicators of Intensive Care Unit (ICU) occupancy and the number of hospitalised cases, have been decreasing since early to mid-April. It was also noted that the numbers of deaths reported has been relatively stable over the last two weeks. While it is likely that the growth rate of the number of infections is stable since the start of April, the enhanced testing in the long-term residential healthcare facilities will provide further data to update the model.

NPHET noted that it would be useful to consider trends in Ireland and to compare them with those seen elsewhere (acknowledging differences in testing, definitions and data approaches).

d) GeoHive dashboard

The NPHET noted this shared initiative from the IEMAG and the HPSC and the work ongoing to progress a shared dashboard. It was agreed that the final product would be very welcome.

e) Update on planning for Prevalence Studies

Following on from updates at previous meetings, the HPSC advised that the sampling frame for the sero-prevalence survey was being agreed at the moment, engagement continues on a North-South approach and it was hoped to commence the study by the end of May.

3. Expert Advisory Group (EAG)

The Chair of the EAG advised that there were no recommendations to bring to the attention of the NPHET arising from the EAG meeting of Wednesday 23 April. Instead the Chair advised that the EAG had been examining the following matters:

- an occupational medicine approach to the management of asymptomatic healthcare workers in Residential Care Facilities (RCF)/Long Term Care Facilities (LTRCs) in whom (RNA) is detected was reviewed and agreed;
- it was agreed that healthcare workers in RCF/LTCFs who yield an indeterminate result should be retested to inform the appropriate course of management for those individuals;
- testing algorithms/pathways were reviewed in light of the change to the infection prevention and control precautions (i.e. face masks) and approved.

4. Review of Existing Policy

a) Personal Behaviours & b) Social Distancing

No updates were noted under this agenda item.

c) Sampling, Testing, Contact Tracing and CRM Reporting

Given the interdependencies, it was agreed that agenda items 4(c) 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 Chair advised of a recent meeting of the DOH with the HSE CEO and the Lead for Sampling, Testing, Contact Tracing and CRM Reporting.

At the meeting, the HSE advised that the key elements across the testing pathway are now in place, the component processes are being streamlined (e.g. text facilities for confirmation of results and multiple collections of specimens across the day) to reduce turnaround times and capacity is being increased in these processes. The HSE has advised of target projected testing capacity as follows:

Date	**Number of tests**
27th April 2020	10,000 per day
5th May 2020	12,000 per day
18th May 2020	15,000 per day

This would include active surveillance of contacts supported by ongoing development of the CRM.

It was noted that this increased capacity has provided assurance that there was scope to consider reviewing the case definition with a view to broadening it out (as has been previously discussed at the NPHET meeting on 17th April 2020).

Case Definition

In light of the update above, and following on from the previous discussions, the NPHET considered whether changes were required to the current case definition. It was noted that changing the case definition in the coming days would allow for the impact and effects of any change to be monitored and quantified and a better understanding of the transmission dynamics of the disease before any changes in the public health measures come into place. It was also acknowledged that the enhanced testing programme in the long-term residential healthcare facilities was still ongoing.

A deliberative paper entitled "*Changing the Case Definition, 23rd April 2020"* was presented and an overview was provided of the current and prevailing case definition.

There was discussion on what change(s) could be made and the timeliness of such change(s). The NPHET considered the following:

- the importance of aligning the demand for testing and contact tracing arising as a result of the change of case definition with the capacity available to avoid the emergence of a backlog;
- the opportunity afforded by the time between now and when public health social distancing measures might be changed to operationalise a new definition in the current context;
- the need for timeliness across the sampling to reporting pathway;
- the Influenza Like Illness (ILI) rate in the community and how this might impact on the demand for testing;

- the need for a 'lead in' time to allow communication and preparatory work to be complete before implementation, including engagement and effective communication with the GPs;
- in the context of increased demand, maintaining focus on priority groups within the criteria to be included in the new definition.

On the issue of retaining the continued focus on priority groups for testing within a new case definition, the NPHET recalled that the rationale for adopting the priority groups in the current case definition was in line with the ECDC (*Rapid Risk Assessment – 6th update, 12th March 2020*) which had advised that priority groups for testing will need to be established in the event of a large number of tests being performed, potentially overwhelming testing capacity. ECDC had advised that certain groups should be considered for priority testing.

NPHET noted that a widening of the case definition at this point in the pandemic would provide an opportunity to:

- promote identification of cases;
- enable better management and follow up of cases to slow and break the chain of transmission;
- further inform the transmission dynamics of COVID-19 in Ireland;
- inform evidence-based and data driven decision-making.

The NPHET discussed the importance of ensuring that the HSE had sufficient time to work through the impact of and prepare for implementation of the proposed change of case definition.

It was agreed that the NPHET would recommend the adoption of the clinical aspects of the current ECDC case definition while retaining the prioritisation categories for testing which are currently in place. The NPHET agreed to keep the matter of the case definition under review.

Action: The NPHET recommends adopting the ECDC case definition (clinical aspects) which provides that laboratory testing for COVID-19 should be performed for suspected cases according to the following criteria:

a) a patient with acute respiratory tract infection (sudden onset of at least one of the following: cough, fever, shortness of breath) AND with no other aetiology that fully explains the clinical presentation;
OR

b) a patient with any acute respiratory illness AND having been in close contact with a confirmed or probable COVID-19 case in the last 14 days prior to onset of symptoms;
OR

c) a patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease (e.g., cough, fever, shortness breath)) AND requiring hospitalisation (SARI) AND with no other aetiology that fully explains the clinical presentation.
AND
Falls into one of the existing categories for priority testing laboratory testing.

The NPHET recommends retention of the current prioritisation categories for testing in the revised case definition and for implementation on a date to be agreed for week commencing 27th April 2020. The HSE to update the relevant guidance and algorithms and publish these online.

d) Public Health advice implications

No updates were taken under this agenda item.

e) Impact of COVID-19 and non COVID-19 on mortality

The importance of robust, timely and comprehensive reporting of mortality data was discussed and, in particular, the ECDC advice to Member States contained in its most recent *Rapid Risk Assessment Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK– ninth update* (23 April 2020) that data on numbers of COVID-19 related deaths and trends in deaths are important indicators when phasing out social distancing measures.

In relation to mortality reporting, the NPHET recalled its decision of Friday 17th April 2020 at which it agreed to adopt the WHO definition of mortality of 11th April 2020 which includes confirmed and probable cases.

The NPHET was advised that the ECDC had also endorsed the WHO guidance of 11th April 2020 *"which for surveillance purposes defines a death due to COVID-19 as a death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death. A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of pre-existing conditions that are suspected of triggering a severe course of COVID-19."* The ECDC further advised that the *"[u]se of this definition and inclusion of deaths among probable cases will provide a more complete assessment of the impact of the pandemic and allow for more comparable data across Member States."*

NPHET was informed that the ECDC also advised Member States to report deaths that occur both in hospital and long-term care settings, and that, unlike some other EU countries, this is currently already done in Ireland.

The HPSC outlined the terminology currently in use, which provides for reporting under two categories: (a) possible / probable and (b) confirmed. A probable death is a death where a laboratory test has not been done but where a doctor believes a death is associated with COVID-19.

Arising from this guidance, NPHET agreed that probable deaths from COVID-19 should be included as part of the statistics to report a COVID-19 related mortality statistic, which allows for a more complete assessment of the pandemic and more comparable data across Member States.

With regard to actions to encourage the timely notification of deaths, DOH advised that it had written to the Department of Employment Affairs & Social Protection and the Irish Association of Funeral Directors. The HPSC also confirmed that it had written recently to all medical practitioners concerning

death notification and certification processes. This was intended to provided clarity on definitions and encouraged timely notification.

The NPHET agreed that the definition of COVID-19 mortality, in line with the ECDC guidance issued on 23rd April 2020, should be used.

Action: The NPHET recommends a change to the WHO case definition for COVID-19 mortality, as endorsed by the ECDC in its recent publication "Rapid Risk Assessment - *Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK– ninth update*" and as outlined in recent HPSC correspondence to all medical practitioners concerning death notification and certification processes. For surveillance purposes this defines a death due to COVID-19 as a death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death.

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

(a) Residential Care Settings

i. *Census of mortality long-term residential care settings*

Following on from the very preliminary update on the census of mortality in long-term residential care settings, presented at the last meeting (21st April 2020), a further update was presented. It was emphasised that this information remains preliminary as it is still undergoing validation.

The update included information received as at 4pm on 23rd April 2020 and was exclusive of the results for mental health facilities. Up to that point there had been an 89.6% response to this census by older people and disability centres registered with HIQA.

The preliminary data indicate that an increase in mortality started to be observable in residential care facilities from about mid-March onwards. Mortality in the disability centres has remained low.

It was observed that these preliminary data are in line with those expected when compared with both the modelling estimates and the NF02 reports of deaths made by registered centres to HIQA.

The collaboration between HIQA, the Mental Health Commission and DOH on this initiative was noted. This initiative has been important in adding to the understanding of the disease in these settings, in providing assurance that there is not an excess of unreported mortality and in providing an assurance regarding the completeness of mortality reporting processes in long-term residential care settings.

HIQA advised of the publication of their *Assessment framework of the preparedness of a DCOP (Designated Centres for Older People) centre for a COVID-19 outbreak* on 21st April 2020 and that the monitoring programme was due to start the week commencing Monday, 27th April 2020. In advance of this, the relevant information had been forwarded to the centres. This programme aims to support those centres that are currently free from COVID-19 to prepare for an outbreak of COVID-19 and put in place the necessary contingency plans.

(b) Acute Hospital Settings

DOH provided an update regarding ongoing enhanced measures in acute hospitals to reduce the risk of COVID-19 outbreaks in acute hospitals, following the decision of NPHET at its meeting on 31st March 2020.

NPHET was advised that DOH had been engaging with the HSE, in particular, in relation to measures regarding healthcare workers and a new strategic approach regarding the procurement and the supply of personal protective equipment.

It was noted that efforts are ongoing to improve the physical environment in hospitals and that there will be a particular challenge with respect to ICU capacity to cope with demand for both COVID and non-COVID care. Proposals in relation to infrastructure and ICT are being examined. Furthermore, specific measures are being scoped in relation to South Southwest Hospital Group and the University of Limerick Hospital Group.

HIQA's work in relation to the infection prevention and control self-assessment tool for Hospital Groups was noted and the issue of whether a similar exercise could be carried out in respect of private hospitals was being examined.

NPHET was also advised that the COVID-19 Antimicrobial Resistance and Infection Control (AMRIC) team was meeting that day and that infection prevention and control measures for other non COVID-19 infections continue to be monitored and addressed.

6 Future Policy

(a) Case definition

This agenda item was taken with agenda item 4(c) above.

(b) Use of masks by the general public

The discussion of face masks was deferred to the next meeting.

(c) Review of current Public Health Measures – phasing

A short paper summarising international approaches to the reduction of the current public health social distancing measures had been circulated for information. The work of the Department of Foreign Affairs & Trade and HIQA in regularly compiling information from different countries regarding the implementation and easing of restrictive measures was acknowledged.

Two international governments have published formal plans (US and Scotland) and these are both high level and principle-based plans. Media reports and information from countries have provided feedback on approaches being adopted in those countries that have indicated their general approach to exiting the current restrictive measures.

In general, it was noted that there were differing approaches being adopted across different countries, however, some general themes observed from countries' approaches were as follows:

- different number of weeks between phasing of reduction of measures;

- diverse approaches to the use of facemasks among the public i.e. voluntary versus mandatory;
- different arrangements were being put in place by countries for the reopening of retail and return to work with many countries planning for small retailers to return in the earlier phases, while 'on site' workplace resumption was often planned by countries for the mid to end of their exit plans;
- there is a focus in many exit plans on reopening workplaces where it is difficult to work from home in earlier phases rather than on a sector basis;
- in some countries, under education measures, students in exam years were being prioritised for return to school in earlier phases, also consideration was being given to smaller children;
- mostly mass gatherings across countries would not be permissible until the very end of countries' exit plans;
- many countries are indicating that they intend to retain travel restrictions in place for a considerable period of time;
- even within countries, at individual state or province level, different approaches to easing restrictions was evident;
- Italy, Portugal and France are expected to publish their national plans this week.

The work that has been ongoing at the NPHET to develop a public health-led risk-based framework approach to reducing the social distancing measures is taking on board the thinking from other countries, and the approach is in line with that being adopted in other jurisdictions.

While there is information in the public domain about those countries that are lifting their restrictive measures, it was noted that there is a dearth of information about countries that are not lifting or proposing to lift restrictions at this point, such as the United Kingdom and countries where their pandemic timeline is more aligned with Ireland's.

DOH presented an updated version of the deliberative paper discussed at the NPHET meeting of 21st April. The purpose of this work is to assist the NPHET in being able to provide timely and structured public health advice to Government on an approach to how the current restrictive measures could be eased. The NPHET noted that an overarching framework page had now been placed on the document to provide context and the paper had been slightly modified to reflect international experience and NPHET feedback.

The NPHET considered that the measures included at each phase are illustrative. Based on the status of the disease at the point where each phase is due to be evaluated, these measures would then be evaluated as candidates for consideration by NPHET for recommendation to Government.

Furthermore, the NPHET was of the view that, as the social distancing measures are reduced, there will be an increase in social interaction in society. This will inevitably carry with it a risk of increased transmission. Consequently, there can be no assurance that it is safe to reduce the social distancing measures. Any reduction of measures should be done bearing in mind the public health risks. It was agreed that this should be incorporated into the draft paper.

The NPHET agreed that it would continue its consideration of this work at the next meeting on Tuesday 28th April.

d) Guidance for workplaces - proposal

This issue was not discussed due to time constraints.

e) Travel considerations

The NPHET agreed that it would have a further discussion on travel considerations and matters relating to self-isolation and quarantine at its next meeting on Tuesday 28th April.

f) Ad Hoc

There were no items for discussion under this agenda item at the meeting.

7. Risk Register

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

8. Communications Planning

There were no items for discussion under this agenda item the meeting.

9. Meeting Close

a) Agreed Actions

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

b) AOB

There were no items under this agenda item for the meeting.

c) Date of Next Meeting

The next meeting is scheduled for Tuesday, 28th April at 10am via video conference.