An Roinn Sláinte
Department of Health

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

Date and Time	Friday 17th April 2020 (Meeting 21) at 10am
Location	Department of Health, Miesian Plaza, Dublin 2
Chair	Dr Tony Holohan, Chief Medical Officer, DOH
Members via videoconference	Dr Kevin Kelleher, Asst. 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 (IEMAG) 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 David Leach, Communications, 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 Dr Máirín Ryan, Deputy Chief Executive and Director of Health Technology Assessment, HIQA Prof Colm Bergin, Consultant 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 (first part of meeting only) Dr Siobhan O'Sullivan, Chief Bioethics Officer, DOH Ms Tracey Conroy, Assistant Secretary, Acute Hospitals 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 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 for Emergency Management, HSE Dr Jeanette McCallion, Medical Assessor, HPRA Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE
'In Attendance'	Ms Judith Martin, In-vitro Devices Manager, HPRA Ms Laura Casey, Health Systems and Structures Unit, DOH Mr David Keating, Communicable Diseases Policy Unit, DOH Mr Colm O'Conaill, Policy and Strategy Division, DOH Ms Sarah Treleavan, NPSO, DOH Ms Sheona Gilsenan, Statistics and Analytics Service, DOH Ms Elizabeth Adams, NPSO, DOH Mr Ronan O'Kelly, Statistics and Analytics Service, DOH Mr Niall Redmond, Services for Older People, DOH Ms Deirdre McNamara. Office of the Chief Clinical Officer, HSE

	Ms Elizabeth Adams, NPSO, DOH
Secretariat	Ms Rosarie Lynch, Ms Sarah Murphy, Ms Susan Reilly, Ms Linda O'Rourke, Mr John Harding, Ms Liz Kielty, Ms Ruth McDonnell, NPSO, DOH

1. Welcome and Introductions

a) Conflict of Interest

Verbal pause and none declared.

b) Minutes of previous meeting(s)

Three sets of minutes went up on the website on Wednesday 15th April, with further sets will go up today 17th. Further minutes are being prepared and will be circulated to the NPHET for review, feedback and approval via email.

c) Matters Arising

i. Health Protection Governance

The HPSC presented a paper "*Current Governance Arrangements for HSE Health Protection Response to CoVid-19 Pandemic"* which was circulated after the last meeting of NPHET (Tuesday, 14th April 2020).

Some key points covered included–

- In March, the public health remit came under the HSE Office of the Chief Clinical Officer,
- The National Clinical Director, Health Protection (NCDHP), Dr Lorraine Doherty, took up post 25th March 2020 and on 2nd April was appointed National Medical Officer of Health and incident lead for the Health Protection Response, reporting to the Chief Clinical Officer,
- Directors of Public Health are now accountable to the NCDHP for delivery of Health Protection areas of work and COVID-19 response,
- The HPSC provides the surveillance function for health protection and currently this role is carried out according to local plans,
- The National Immunisation Office will come under the remit of Health Protection.

The Chair welcomed the update and acknowledged that this new structure builds on the previous good work of the HPSC. In particular, the strengthened links between surveillance and response, and surveillance and outbreak control are welcomed.

It was noted that any further observations of a technical nature could be sent directly to the author if members wished to make comment.

2. Epidemiological Assessment

a**)** ***Update on National Data***

i. HPSC

The HPSC presented an update on the national epidemiological data, including information on clusters of infections in hospitals and long-term residential care settings, and information on infections in healthcare workers. It was noted there was a day-on-day reduction in the level of hospital admissions and ICU admissions and these were tending to plateau and possibly reduce. The NPHET noted that it is likely community transmission now accounts for over half of the cases.

ii. DOH

The DOH also provided an overview of the spreadsheet compiled on the basis of the HSE daily reports and the HPSC data received. In terms of community testing, it was noted that the effect seen over the recent public holiday was now reversing and the number of referrals for testing was increasing. It was also noted that the waiting time for testing was reducing. However, there continues to be a 'waiting list' for referral for testing. Clarity on this is sought from the HSE. Work continues with the HSE to ensure the best data is captured.

b) International Assessments

There were no items of note for the update today.

c) Modelling Report

The Chair of the IEMAG presented an update, with the results from the German tests backdated into the model. These cases are reflected in the epi-curve by date the specimen was collected.

It was noted that when more testing is done, more cases are identified, meaning the testing constraint is an important consideration in interpreting the overall trend.

Given the results of the model, it is likely the epidemic may be shrinking in the community but there is a need to separate this from the long term care facilities (LTCF) to understand the picture more clearly. Consequently, work is now focusing on separating data relating to the community and long-term residential care settings. The IEMAG are aiming to update the model with the further data which may help inform recommendations on public health measures. The importance of available, accurate and real time information to inform the model was agreed by all.

The modelling also showed two different progression behaviours within this pandemic; community (where transmission has reduced) and residential settings (where work is still needed to contain the disease).

Contact tracing capacity also needs to be increased quickly to ensure there is adequate capacity as public health measures are reviewed and reduced. It is was agreed that is was imperative to see, in as close to real time as possible, where these cases are originating and to identify daily cases in long term residential healthcare facilities, in the community and in particular groups e.g. healthcare workers.

d) Update on planning for Prevalence Studies

The HSE provided an update following on from the NPHET decision at the last meeting (Tuesday, 14th April 2020), which was "The HSE is to put in place a coordinated national process for carrying out prevalence surveys across nursing homes and other residential healthcare settings, with a particular focus on detecting COVID-19 infections in these settings, using approaches such as pooled PCR tests of randomised samples taken at these sites in accordance with recommendations of the ECDC."

Separately, the HSE advised that there was work underway in relation to the planning of a national seroprevalence study to estimate population age-specific immunity or past exposure to SARS-CoV-2. Planning had commenced for this sero-epidemiological study, linking in with WHO methodology and a detailed protocol was under development. The NPHET was advised that a working group had been

convened on 5th April with the HPSC linking with colleagues in other jurisdictions to keep abreast of international developments.

A descriptive epidemiological study is also planned for nursing homes to ascertain what additional data are routinely available (other than those from the HPSC and public health departments) and help identify data gaps. The NPHET agreed that priority must continue to be given to long term residential healthcare settings and the Department will liaise with the HSE on this. It was noted that the methodological approach has now moved on from pooled to individual testing as the preferred option.

The HSE further advised of the decision to increase COVID-19 testing in nursing homes for both staff and patients in those homes that have confirmed outbreaks and where a new confirmed case is identified. The NPHET agreed with this approach and considered key aspects should include: communications with families, GPs and relevant organisations; implications for public health teams; and other operational considerations. It was agreed that approach should be finalised and commenced.

3. Expert Advisory Group (EAG)

The Chair of the EAG provided update on the considerations at the latest meeting as follows:

- Care pathways for COVID-19 patients and how should they differ for non-COVID-19 patients e.g. whether screening should be considered – this is to be kept on the agenda for future meetings;
- Healthcare workers and the duration of immunity – the Guidance and Evidence Synthesis subgroup are looking at the evidence on this and the EAG will pursue any applicable advice;
- Supports and funding mechanisms for clinical research on COVID-19.

(HSE considerations in relation to the EAG advice from the last meeting (Tuesday, 14th April 2020) on the issue of wearing of surgical face masks by healthcare workers in clinical settings was taken at agenda item 6.)

The Pandemics Ethics Advisory Group (PEAG) updated in relation to COVID-19 research priorities (which were previously discussed at meetings on 7th and 14th April 2020), that a paper is being prepared setting out a strategic perspective on research priorities on a whole-of-Government basis and there was liaison with the Department of An Taoiseach in this regard. The NPHET subgroups had fed into this paper by submitting their research questions and research priorities.

Arrangements for Ireland's involvement in WHO's SOLIDARITY clinical trial were noted as progressing well. However, the use of the same candidate drugs across clinical trials may result in increased demand for supply of certain therapeutics. It was noted that treating patients within a well-designed clinical trial is the optimal scenario as this ensures that data is collected on the efficacy and safety of therapies, which will contribute to the evidence base for treating patients with COVID-19. That said there may be situations where additional patients might be allowed access key investigational medicines as part of an Expanded Access (or compassionate use) Programme. It was agreed that all opportunities to participate in priority clinical trials and to access therapeutics of interest should be explored and this would be discussed further among a smaller group (to include

the HSE Office of the Chief Clinical Officer, The Chief Bioethics Officer Dr. Siobhán O'Sullivan, Prof. Colm Bergin and Dr. Michael Power).

4. Review of Existing Policy

a) Personal Behaviours

There were no items of note for the update today.

b) Social Distancing

There were no items of note for the update today.

c) Sampling, Testing, Contact tracing and CRM reporting

The current status of sampling, testing, contact tracing and CRM reporting was outlined and discussed. The HSE noted that it was now in a position to expand the testing capability. Current demand was noted as being between 2,000 to 2,500 swabs per day. Capacity currently exceeded demand. Key to the level of demand was the influence of the current case definition. It was noted that widening the case definition would likely increase the number of patients requiring testing, the number of close contacts to be contact traced and subject to active surveillance

The HSE advised that end to end mapping of the process from sampling through to reporting was now complete and provided a good overview of the end-to-end process from GP referral to sampling, laboratory analysis, results issued to contact tracing. A need to build capacity across each stage of the testing process was discussed, with particular attention on ensuring that any rate limiting steps were identified and addressed in as far as possible. Some process improvements were needed in the contact tracing process to ensure that all pertinent contact information was available at each step and these were underway.

There was discussion of a figure of 15,000 tests per day as a reasonable total capacity estimate to deal with likely future demand (including the forthcoming prevalence study and the long term residential care facilities etc) and enable the system to have sufficient capacity to cope with case definition changes, testing of close contacts and any revised plans for targeted/enhanced testing in specific settings. It was noted that the targeted testing programme as discussed under Item 2d for long term residential care centres would also give further information which could inform how capacity can be best directed. It was noted that the operational arrangements with external laboratories to enhance testing capacity was working well. The group agreed on the importance of access to testing across the full week so there is a consistency to the process and the daily data reporting, such that artificial delays generated by weekends, public holidays etc are avoided.

In advance of any change of the current case definition, it was noted that there was a window of opportunity to use the current available capacity to support the targeted testing programme in relation to long term residential care settings as mentioned earlier in the meeting. It was agreed that discussions would continue on amending the case definition at the meeting next week, and to include a lead-in time following any decision, to ensure a reasonable level of confidence that there was sufficient capacity in place to meet the demands created by an expanded and revised case definition.

Contact tracing was discussed, and it was noted that while no resourcing issues are apparent, some process issues arise as well as gaps that exist on how the data gathered was captured and recorded.

Action: In relation to testing for COVID-19:

a) **to facilitate the broadening of the current COVID-19 case definition, the NPHET recommends that the HSE expand testing capacity to 15,000 tests per day i.e. 100,000 tests analysed per week when considered on a seven day a week basis, for a minimum period of 6 months;**
b) **the NPHET requests the HSE to ensure the further development and implementation of processes and capacity across all aspects of the pathway (sampling, testing, contact training and reporting) to meet this expected demand in testing on a real-time basis and in line with the WHO recommendations of 16th April 2020. This work is to include consideration of capacity ceilings, turnaround times, risks, risk mitigation and cost for each aspect of this pathway, as well as a robust system of active surveillance and potential new referral pathways across the continuum;**
c) **prior to the forthcoming change in the current COVID-19 case definition, the NPHET recommends that available testing capacity over the course of the next 7 to 10 days be targeted to support the revised HSE recommendations (16th April 2020) for testing in Long Term Residential Care facilities (LTRCs).**

d) Public Health advice implications

There were no items of note for the update today.

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

Following on from the discussion at previous meetings (7th and 14th April 2020), COVID-19 mortality surveillance was discussed. The DOH presented a paper entitled "*Surveillance of Covid-19 Mortality*".

This outlined the definition of a COVID-19 death developed by WHO (11th April 2020) which states "a COVID-19 death is defined for surveillance purposes 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 disease (e.g. trauma). There should be no period of complete recovery between the illness and death."

Having discussed this new definition with HPSC, the DOH paper proposed that the WHO case definition should now be adopted. This proposal was agreed by all.

Currently, mortality is monitored through:

1. Notified COVID-19 deaths are reported on CIDR,
2. CIDR Outbreak Reporting of all COVID-19 Outbreaks, Outbreak Settings and Deaths linked to Outbreaks,
3. Death Registrations,
4. Notifications to HIQA of unexpected deaths in nursing homes.

A number of actions were noted as being underway to improve the data stream on mortality data and encourage communications between relevant organisations. These included–

- The DOH has written to the Irish Association of Funeral Directors asking that their member firms encourage families who have recently lost loved ones to register deaths early, noting the online system now available; additionally, legislative amendments on this are under consideration,
- The HSE is in the process of writing to all medical practitioners in relation to death certifications and notifications across confirmed, suspect and possible COVID-19 deaths,
- The HSE is working to develop a monitoring system for all online reporting of deaths from across HSE facilities, including long term residential care,
- HIQA collection of mortality data is ongoing in the relevant centres,
- The HPSC (who have been monitoring all-cause excess mortality since 2009) are involved in the EuroMOMO project, in conjunction with the ECDC, to improve reporting processes in the context of COVID-19.

The importance of using available sources of information to aid our understanding of mortality was noted and in particular, understanding across the long term residential care facilities. Also, it was noted that Ireland is very transparent in its mortality reporting when compared with many other countries but that work should continue to ensure improvements are made. The DOH will continue to engage with the HPSC to help analysis, describe and understanding mortality in Ireland.

5. HSE's update to the NPHET further to

a) Residential Healthcare settings

The Chair of the Vulnerable People Subgroup presented an update paper entitled "*Long-term Residential Care (LTRC) - NPHET 18th April 2020*" for consideration. This outlined a set of urgent actions to establish the level of risk related to staff COVID-19 status and patient mortality in light of the increasing number of clusters and deaths in long-term residential centres.

The proposed further actions for all LTRCs and/or nursing homes were:

- *Action 1: Survey of mortality in LTRC.*
  HIQA will support distribution of the survey, which is due to commence today (17th April 2020). Over a short timeframe, the plan is to collect data on the total number of deaths (January 2020 to present), the number of laboratory confirmed COVID-19 deaths (March 2020 to present) and number of possible COVID-19 deaths (March 2020 to present).

- *Action 2: Testing staff in LTRCs/nursing homes.*
  It is proposed to test as many staff over a short period as possible in LTRCs, commencing with nursing homes. This is an action of scale and it is noted that there are over 30,000 staff in nursing homes and is key to confirming whether a nursing home is COVID-19 'free'. This is to take place in the context of the programme of testing discussed earlier in meeting. As agreed at meeting 14th April 2020, the HSE is to put in place a coordinated national process for carrying out prevalence surveys across nursing homes and other residential health care settings, with a particular focus on detecting COVID-19 infections in these settings.

- *Action 3: HIQA publishes and assesses COVID-19 Quality Assurance Regulatory Framework.* This Framework will be designed to ensure that providers are prepared for, and have contingency plans in place for, an outbreak of COVID-19. The Framework will be regulated by HIQA in line with Health Act 2007.

- *Action 4: Urgent implementation of previous recommended actions.* The HSE, HIQA and DOH are in agreement on the need for continued urgent progress of these actions, including the development of an expanded 'Nursing Homes/LTRC settings Actions Tracker' for further monitoring and to build on the work already underway by HSE Community Operations.

It was noted that mental health facilities are also included in residential long term care facilities and the HSE advised that it had been in contact with the Mental Health Commission and similar regulator arrangements were in train.

It was also noted that work continued on the CRM system for the LTRCs and homecare and it was due to be up and running next week.

The NPHET agreed with the expanded approach as outlined. The ongoing importance and collaboration of DOH, HSE and HIQA on this work to improve understanding and response to the requirements of this sector was acknowledged.

Action: The NPHET endorses the proposal from the Department of Health, HIQA and the HSE on a set of immediate additional actions focused on long term residential healthcare settings, to further inform and direct the public health response, which are to include:

a) a survey of mortality is to be conducted;
b) national testing of staff across all settings with an initial widespread approach and thereafter ongoing testing, which may include both staff and patients, to be conducted on a rolling basis;
c) the publication and assessment of a COVID-19 quality assurance regulatory framework for these settings by HIQA;
d) the implementation of previous recommended actions with enhanced reporting through an expanded 'Nursing Homes/LTRC settings Actions Tracker', which is to include the roll out of the Contact Management (CRM) system.

b) Acute Hospitals settings

The Chair of the Acute Hospital Preparedness Subgroup acknowledged the work of HIQA in progressing the self-assessment for Hospital Groups on Infection Prevention and Control and the work of the Hospital Groups in submitting their responses in a timely fashion. The high level preliminary findings were outlined, with a further report to follow at the next NPHET meeting, planned for Tuesday, 21st April 2020.

The preliminary findings identified areas of strength as: clarity on leadership and planning for COVID-19 at site level, availability of access to clinical and infection prevention expertise, implementation of critical infection prevention and control measures, and contingency planning for essential services. Areas were further assurance were required included continuity of access to PPE, cleaning, testing

kits and consumables; and availability of specialist staffing and staffing contingency in some areas. The HSE provided update on engagement of Acute Hospital Operations with the Hospital Groups on these issues, noting the staffing issues and the provision of support and guidance.

6. Future Policy

a) Use of surgical facemasks within healthcare settings

Following from recommendations made by the EAG to NPHET and subsequent discussion (meeting of 14th April), the HSE presented its proposal for the use of surgical facemasks.

Noting the challenges faced in sourcing PPE and the wide range of healthcare settings requiring masks, it was proposed to prioritise on a risk basis. (A similar approach has been used in other jurisdictions).

Discussion identified a number of matters to be considered. These included: further information on current supplies; need for clear understanding and definitions should a risk based approach be used; that masks are not a substitute for other measures; the precautionary principle; international practice; the advice of the Expert Advisory Group; in the event that supply is constrained, the need to prioritise the use of masks amongst healthcare workers; and the need for continuity of supply.

The discussion outlined an approach based on risk assessment, similar to that used by the Public Health England. It was considered that further clarity and specificity were required in the approach outlined by the HSE with an agreement for further engagement with HSE colleagues with a updated for an proposal to be presented at the NPHET meeting, with a view to adoption, planned for Tuesday, 21st April 2020, so that work can commence towards full implementation of the EAG advice.

b) Review of current Public Health measures - phasing

Draft deliberative papers outlining considerations for any future NPHET advice on phased reduction of the social distancing measures currently in place had been considered at the meetings on 10th and 14th April 2020. The DOH gave an overview of a further draft paper, as an iteration of these ongoing considerations by the NPHET.

The following points were noted:

- the important role that solidarity has and will need to continue to play especially as public health measures against spread of COVID-19 are reduced;
- that groups at greatest risk may have specific requirements;
- the need for clear, tailored advice with guidance for the public and sectors of society as the package of measures in place at a given time changes;
- the critical dependencies and assurances that underpin the process;
- that both health and non-health data may be useful sources of information;
- the role of regulation to support compliance and adherence to measures.

The approach was described as a public health led, underpinned by guidance and evidence from the research and findings of international bodies; informed by the experience and learning in other jurisdictions; with priority consideration afforded to those activities which attach the greatest potential risk from a public health perspective.

The suggested approach, in line with international guidance, was a step by step gradual process which would allow sufficient time for consideration of appropriate public health data on disease progression, service testing and tracing capacity and assessments against identified triggers and observed impacts. WHO, ECDC and the EU Commission noted that, it may also be necessary to consider reinstating certain measures in the event of a resurgence in infection. The need for a nuanced approach to regulation in a stepdown process was highlighted with a focus on the requirement for a flexible framework to ensure successful implementation of any suggested process.

It was noted that WHO suggest 2 weeks between changing of measures and the European Commission suggest 4 weeks; it was agreed that whatever period is chosen, it needs to allow sufficient time to assess the impact of the measures on the progress of the disease before moving to further reduce measures.

The NPHET agreed to continue its work in accordance with this overarching direction with further discussions to continue over the coming meetings to ensure due consideration was given across all aspects of any proposed reduction of measures.

c) Travel Considerations

This agenda item was carried over to a future meeting.

d) Ad Hoc

(i) Childcare Considerations

This agenda item was carried over ahead of the delivery of a paper on this issue at the next meeting.

8. Risk Register

This item was carried over on the agenda to a future meeting.

9. Communications Planning

There was no update for today's meeting.

10. Meeting Close

(a) Agreed actions

The actions from the meeting were presented to the group, clarified and agreed.

(b) AOB

i. Following on from the AOB item at Tuesday meeting (14th April 2020), the Chair reminded all that input was welcome in the preparation of a reply.

ii. The DOH updated that the WHO has advised it is developing a surveillance tool for COVID-19 infections amongst healthcare workers. This development was welcomed by the group, noting that healthcare workers are a priority group.

(c) Date of next meeting

The next meeting will take place on Friday, 21st April 2020 at 10am via video conferencing.