



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

<b>Date and Time</b>	Thursday 18 <sup>th</sup> March 2021, (Meeting 81) at 10:00am
<b>Location</b>	Department of Health, Miesian Plaza, Dublin 2
<b>Chair</b>	Dr Ronan Glynn, Deputy Chief Medical Officer, DOH
<b>Members via videoconference<sup>1</sup></b>	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 Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA Dr John Cuddihy, Interim Director, HSE (HPSC) Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital Ms Rachel Kenna, Chief Nursing Officer, DOH Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, 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 Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH Dr Darina O'Flanagan, Special Advisor to the NPHE Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH Ms Deirdre Watters, Communications Unit, DOH Dr Colm Henry, Chief Clinical Officer, HSE Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion) Mr Liam Woods, National Director, Acute Operations, HSE Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications Prof Mary Horgan, President, RCPI Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC) Dr Siobhán O'Sullivan, Chief Bioethics Officer, DOH; Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)
<b>'In Attendance'</b>	Ms Laura Casey, NPHE Policy Unit, DOH Mr Ronan O'Kelly, Health Analytics Division, DOH Dr Robert Mooney, NPHE Policy Unit, DOH Dr Trish Markham, HSE (Alternate for Tom McGuinness) Dr Desmond Hickey, Deputy Chief Medical Officer, DOH Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH
<b>Secretariat</b>	Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Mr Liam Hawkes, Ms Fiona Tynan, Mr Liam Robinson, DOH
<b>Apologies</b>	Dr Breda Smyth, Public Health Specialist, HSE Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI Dr Lorraine Doherty, National Clinical Director Health Protection, HSE Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE Prof Colm Bergin, Consultant in Infectious Diseases, St James's Hospital

<sup>1</sup> References to the HSE in NPHE minutes relates to the staff of the HSE present at NPHE meetings and not the HSE Board which is the HSE in law unless otherwise stated.



## 1. Welcome and Introductions

### a) *Conflict of Interest*

Verbal pause and none declared.

### b) *Apologies*

Apologies were received from the following NPHET Members: Dr Breda Smyth, Dr Lorraine Doherty, Prof Mark Ferguson, and Dr Siobhán Ní Bhriain.

### c) *Matters Arising*

There were no matters arising at the meeting.

## 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:

- A total of 3,646 cases have been notified in the 7 days to 17<sup>th</sup> March, which is a 6% increase on the previous 7 days to 10<sup>th</sup> March in which there were 3,427 cases.
- As of 17<sup>th</sup> March, the 14-day incidence rate per 100,000 population has decreased to 148; this compares with 163 on 10<sup>th</sup> March. However, the 7-day incidence per 100,000 population has increased to 77 from 72 on 10<sup>th</sup> March.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 52%, demonstrating that there have been more cases in the last 7 days, 11<sup>th</sup>-17<sup>th</sup> March, compared with the preceding 7 days, 4<sup>th</sup>-10<sup>th</sup> March.
- The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10<sup>th</sup> January to 481 on 17<sup>th</sup> March. The 5-day average is almost the same as a week ago when it was 488 on 10<sup>th</sup> March.
- Incidence rates increased in those aged 5-64 years between week 9 and week 10 (week ending 14<sup>th</sup> March), in particular, increases were seen in those aged 5-12 years, 13-18 years, 19-24 years, and 25-39 years. This refers to the incidence in the population excluding healthcare workers and long-term residential care (LTRC) settings.
- Of cases notified in the past 14 days from 4<sup>th</sup> to 17<sup>th</sup> March, 72% have occurred in people under 45 years of age; and 9% of cases notified were aged over 65 years. The median age for cases notified in the same period is 31 years.
- While 14-day incidence rates remain high across the country, 15 counties have a 7-day incidence as a percentage of the 14-day rate of more than 50%, indicating more cases notified in the last 7 days, 11<sup>th</sup>-17<sup>th</sup> March, compared with the previous 7 days, 4<sup>th</sup>-10<sup>th</sup> March.
- Of the 7,048 cases reported in the last 14 days from 4<sup>th</sup> to 17<sup>th</sup> March, 3% (242) were healthcare workers.
- The best estimate of the reproduction number (R) is 0.8–1.1. The rate of decline of the disease is continuing at 0% to -3%. R and growth rate are uncertain and difficult to estimate at this time.
- There were 99,088 tests undertaken in the last week. The 7-day average test positivity rate has remained stable at 3.8% on 17<sup>th</sup> March, which is a slight increase from 3.7% on 10<sup>th</sup> March.
- Excluding acute, serial, and mass testing in response to outbreaks, the community test positivity rate has remained stable over the last week; the rate remains high at 12% over the 7 days to 15<sup>th</sup> March, which is the same as the rate observed on 8<sup>th</sup> March.
- According to contact management programme data, 15 counties have community positivity rates (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%. Over the 7-day period, 9<sup>th</sup>-15<sup>th</sup> March, demand for testing in the community increased by 9.2%, the first time there has been an increase in 5 weeks.
- According to contact management programme data from 1<sup>st</sup>-7<sup>th</sup> March, where results were available for Test 1, 21.6% (1,051/4,871) were positive. The household close contact positivity rate was 34%.



- According to contact management programme data from 22<sup>nd</sup>-28<sup>th</sup> February, where results were available for Test 2, 5.4% (150/2,770) were positive. The household close contact positivity rate was 7.9%.
- There were 345 confirmed COVID-19 cases in hospital this morning, compared with 366 on 11<sup>th</sup> March; this is a 6% decrease since the last NPHEM meeting on 11<sup>th</sup> March. There have been 24 newly confirmed cases in hospital in the 24 hours preceding this morning, 18<sup>th</sup> March.
- There are currently 82 confirmed cases in critical care, compared with 92 on 10<sup>th</sup> March. There have been 4 admissions in the previous 24 hours.
- To date, there have been 103 deaths notified with a date of death in March. This compares with 780 and 1,356 deaths notified (to date) with a date of death in February and January, respectively. Of the 103 deaths in March, 17 have thus far been associated with hospital outbreaks and 23 have been associated with nursing home outbreaks.
- In total, 24 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing. Of these, 8 were newly identified in the last week, to 15<sup>th</sup> March.
- 7 confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to 15<sup>th</sup> March. Of these, 3 were newly identified in the last week.
- Other variants of note/under investigation confirmed in Ireland to 15<sup>th</sup> March: 11 confirmed B.1.525 cases, 5 confirmed B.1.526 cases, and 12 confirmed P.2 cases.

It should be noted that in week 9 (7<sup>th</sup>-13<sup>th</sup> March 2021), a significant number of outbreaks (95), were reported that related to cases notified before February. The majority of these related to private household outbreaks. The outbreak data below are based on outbreaks and associated cases notified since 22<sup>nd</sup> November 2020.

#### Healthcare setting outbreaks:

- There were 12 new clusters notified in hospitals in week 10 of 2021, ending 13<sup>th</sup> March (5 were late notifications).
- As of the week ending 13<sup>th</sup> March, 86 hospital outbreaks remained open. There have been 2,515 cases and 354 deaths linked to hospitals outbreaks created in this period.
- There were 3 clusters notified in nursing homes/community hospitals in week 10 (1 of these was a late notification), this compares with 2 outbreaks in these settings in week 9.
- Of all nursing home outbreaks at the end of week 10, 92 remained open. There have been 7,229 cases and 843 deaths linked to nursing home outbreaks created in this period.
- Of all community hospital outbreaks created in the same period, 18 remained open. There have been 613 cases and 38 deaths linked to community hospital outbreaks created in this period.
- There were 5 new outbreaks in residential institutions in week 10.
- There are currently 122 open clusters associated with residential institutions with 12 new outbreaks notified in week 10 (2 of these were late notifications); within these residential institutions at the end of week 10:
  - There was 1 new outbreak in centres for disabilities; this was a late notification of an outbreak; there were 71 open outbreaks in centres for disabilities.
  - There were no new outbreaks reported in mental health facilities and there were 15 open outbreaks in these settings at the end of week 10.
  - There were 2 new outbreaks reported in Children's/TUSLA residential centres with 8 open outbreaks at the end of the week.

#### Outbreaks associated with educational settings and childcare facilities:

- There were 17 new outbreaks notified during week 10 in settings associated with education and childcare facilities or students.
- There were 8 outbreaks notified associated with school children and/or school staff in week 10, with 21 linked cases. There were 19 open outbreaks in school settings at the end of week 10. The number of cases detected, positivity rates, and numbers of cases associated with outbreaks in schools remains low.



- There were 8 outbreaks newly notified in childcare facilities in week 10 with 31 new linked cases. There were 52 open outbreaks in these settings at the end of week 10.
- There was 1 newly notified outbreak associated with third level students in week 10, with 86 open outbreaks associated with this group.

#### Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:

- There were 22 new outbreaks reported in vulnerable populations in week 10.
- There remains a high number of Irish Traveller outbreaks with 15 new outbreaks and 103 linked cases in week 10, compared with 30 new outbreaks in week 9; there were 136 open outbreaks in the Irish Traveller community at the end of week 10. This represents an 5% increase on the number of open outbreaks on the previous week.
- There was 1 new outbreak in a direct provision centre in week 10. At the end of week 10, there were 8 open outbreaks in direct provision centres.
- There were 5 outbreaks notified in homeless facilities in week 10. Currently, there are 78 open outbreaks in these settings.

#### Workplace outbreaks:

- There were 14 workplace outbreaks reported in week 10 across a variety of settings. There were 10 in commercial settings, 1 related to food production settings, 1 in manufacturing settings, 1 in 'other workplace', and 1 in an office.
- There were 150 open outbreaks in workplaces up to the end of week 10.

The NPHE noted that the epidemiological situation in Ireland remains fragile due to a recent stalling of the progress that had been ongoing since the beginning of the year. The number of confirmed cases in hospital and ICU remains above the highest levels seen in wave 2. Daily case counts may have plateaued, highlighting the precariousness of the current situation, particularly in the context of the highly dominant and significantly more transmissible B.1.1.7 variant. The epidemiological situation remains finely balanced and will continue to be closely monitored by the NPHE.

The Acting Chair thanked the Members for their inputs and observations.

#### ***i. 1<sup>st</sup> Report from HPSC WGS Group - sequencing and VOC***

The HPSC and the NVRL presented the paper "Summary of COVID-19 virus variants in Ireland- 12<sup>th</sup> March 2021", for discussion. The report summarised whole genome sequencing and epidemiological data for COVID-19 cases that were sequenced in Ireland between week 41 of 2020 (4<sup>th</sup> October 2020) and week 8 of 2021 (27<sup>th</sup> February 2021). The HPSC noted the following key points in the presentation:

- Cases of 3 variants of concern (VOC) have been identified in Ireland to date; UK VOC (B.1.1.7), South African VOC (B.1.351), Brazilian VOC (P.1).
- 4 variants of interest have also been identified; P.2 (a different variant from Brazil), B.1.525 (variant from Nigeria) B.1.526 (variant from New York) and A.27.

#### UK VOC (B.1.1.7):

- The first case of the UK VOC (B.1.1.7) was identified in Ireland in week 51 2020. Transmission of this variant is now widespread in Ireland. Of cases sequenced in week 8 2021, 87% were found to be infected with the B.1.1.7.
- The age profile of cases sequenced from week 51 to date and found to have the variant B.1.1.7 was slightly younger (median: 40 years, mean: 38 years) than those found not to be infected with variants of concern in the same time period (median: 44 years, mean: 43 years), but the overall age distributions were quite similar.
- Hospital admission rates and case fatality ratios were slightly lower for cases with the B.1.1.7 variant compared to cases who were not infected with variants of concern. This varied slightly by age group, with a higher percentage of cases aged 45-64 years with the B.1.1.7 variant hospitalised compared to



non-variants of concern and a slightly lower percentage of cases in the  $\geq 65$  years age group hospitalised. However, the number of cases who were hospitalised is low and these differences were small and were not statistically significant.

- The percentage of cases with the B.1.1.7 variant, who were admitted to ICU, was similar to that for cases who were not infected with variants of concern.

#### South African VOC (B.1.351):

- The South African VOC (B.1.351) was first identified in Ireland in a case with a specimen date in week 52 2020 (week starting 19<sup>th</sup> December 2020). A total of 21 COVID-19 cases have been confirmed to have been infected with this variant in Ireland to date.
- Of the 21 cases infected with the South African VOC (B.1.351), 11 were related to travel, 5 were contacts of a known cases, 1 was reported to be a healthcare worker who acquired the infection in a work setting, and 4 cases are currently classified as community transmission.
- 17 of these cases are associated with 12 outbreaks, most of which are family clusters linked to travel; 4 of the outbreaks have no further linked cases. No links have been identified between the remaining 4 cases.

#### Brazilian VOC (P.1):

- To date (18<sup>th</sup> March), the Brazilian VOC (P.1) has been confirmed in 7 cases of COVID-19.
- Of the 7 cases infected with the Brazilian VOC (P.1), 5 were part of 2 separate outbreaks involving families who had travelled from Brazil. The remaining 2 cases were reported to be contacts of confirmed cases but are not currently linked to an outbreak on CIDR.

The paper also outlined the structure and objectives of the National SARS-CoV-2 Surveillance and Whole Genome Sequencing (WGS) Programme Steering Group. The group was established in March 2021. The group is a multi-disciplinary expert group tasked with overseeing the design and development of a comprehensive and sustainable national WGS surveillance programme. The group currently meets on a weekly basis. The group has met on two occasions to date (18<sup>th</sup> March) and draft terms of reference have been developed. The group is currently working on the description of an appropriate framework for sampling of cases. This includes agreement on the appropriate mix of samples for the 'routine (proactive) pathway' and the consideration of broad guidance regarding sequencing in outbreak situations and other components of the 'reactive pathway'.

The AMRIC provided a brief update on the efforts that have been made to sequence COVID-19 cases diagnosed in one hospital to date and acknowledged the work of colleagues in the hospital. While the analysis is preliminary, the diversity of sequences observed is consistent with multiple introductions of the COVID-19 virus into the hospital resulting in multiple outbreaks. While the IPC measures in place were effective against managing individual outbreaks, the scale and frequency of additional introductions from multiple sources led to the hospital's IPC measures becoming over stretched in some cases. Initial reports from one other hospital carrying out sequencing exercises suggests a similar picture.

The Acting Chair invited observations from the NPHET Members. The following key points were raised:

- Some NPHET Members raised concerns about the reported community transmission of the variants of concern, in particular B.1.351.
- The NPHET noted that, based on the data sets available, it appears that, to date, the B.1.1.7 variant is not associated with increased mortality or ICU admissions. This will be kept under review.

The Acting Chair thanked the Members for their observations and requested that the HSE bring a paper to the NPHET in the coming weeks on the public health approach to contact management concerning detected variants of concern, setting out any additional requirements that might be warranted.

The NPHET thanked the HPSC and the AMRIC for the presentation and updates provided.



### 3. Review of Existing Policy

No matters were discussed under this item.

### 4. HIQA Expert Advisory Group

#### **a) International review of public health measures and strategies to limit the spread of COVID-19**

The HIQA presented the paper *“Public health measures and strategies to limit the spread of COVID-19: an international review: 16<sup>th</sup> March 2021”*, for discussion. The review is accurate as of 12<sup>th</sup> March. The key points are outlined below:

- Public health measures are currently being applied across all countries included in the review, either nationally, regionally, or a combination of both. Most countries continue to operate at the highest level of their respective risk framework, if applicable. Although the measures that are being applied are largely consistent, there are many differences in the detail between countries. The more prominent differences between countries include how movement is restricted (for example, curfew hours and travelling distances permitted); numbers permitted at gatherings, events, religious services and sporting activities; and the operating hours of businesses allowed to open within the hospitality sector. The situation remains extremely fluid with gradual easing of current restrictions either already commenced or plans for doing so announced in a number of countries. However, further restrictions are also being introduced in some countries ahead of the upcoming Easter holiday period.
- Most countries broadly saw a reversal of the effects of the most recent increase in coronavirus cases from December (2020)/January (2021). However, the latest epidemiological data show an increase in the 14-day incidence rate per 100,000 population over the previous seven days in Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, Sweden, and Switzerland. A small number of countries, including Belgium, Czechia, and Italy, have seen an increase in the 14-day death rate per million population over the previous seven days, while the rate of hospitalisations and admissions to intensive care increased in several countries.
- Each of the included countries have begun vaccinating people against COVID-19. To date, Israel and the UK have had the highest reported number of vaccine doses administered per 100 population of the included countries. Reassuringly, the epidemiological situation in these countries continues to improve; for example, the 14-day incidence rate of new cases per 100,000 population declined on 14 March 2021 by 16.2% and 20.0% over the previous seven days in Israel and the UK, respectively.
- As a national strategy, individuals displaying symptoms consistent with COVID-19 are prioritised for testing in each of the countries included in this review. In Austria, Czechia, Denmark, France, Israel, and Switzerland however, testing is provided for anyone that requests a test, irrespective of the presence of symptoms. High-risk groups based on pre-existing conditions, age or setting are specifically prioritised in the national strategies of ten of the 18 countries. Most countries have expanded testing to include screening of asymptomatic individuals in certain situations. This is mostly aimed at frontline staff and residents of care facilities or healthcare users. For example, serial testing is conducted on staff and or residents in long-term care facilities, while some provide tests to visitors to long-term care facilities. Screening programmes are also being implemented in non-healthcare settings, such as in education settings and critical industries, as well as in areas of high density and in communities and regions with high incidence. With the exception of Austria and Czechia, which made rapid antigen tests available to the general public (anyone aged 10 years or over) through a voluntary free-of-charge mass testing programme over December, population-wide testing has yet to be implemented in any of the other included countries. Portugal, Germany and the UK (all four jurisdictions) have a strategy to implement regional/area wide testing in various community settings including workplaces and schools in the event of an increased incidence.

The Acting Chair thanked the HIQA for its work, noting that the report will inform the NPHE’s upcoming deliberations on national public health restrictive measures.



## 5. Future Policy

### a) *Initial Discussion: Future Measures for responding to COVID-19*

The Acting Chair introduced this item, emphasising that it had been scheduled to afford the NPHE Members an opportunity to hold an initial discussion on possible future measures for responding to COVID-19. The Acting Chair confirmed that the discussion will inform the development of a DOH discussion paper, which the NPHE will deliberate further upon, at its meeting of 25<sup>th</sup> March, with a view to providing updated recommendations for Government ahead of the planned review of public health measures by Government on 5<sup>th</sup> April.

The Acting Chair encouraged all Members to contribute to the discussion and offered three questions to focus their interventions:

- The extent to which certain measures may or may not be feasible from 5<sup>th</sup> April?
- The extent to which a broad plan for the months of April and May might be required?
- The extent to which individuals who are fully vaccinated will need to comply with all aspects of public health guidance?

The DOH presented briefly on the current national context in order to frame the NPHE's discussion. Key features include:

- The national epidemiological situation is uncertain, and the health system remains fragile. Levels of disease and hospitalisation are much higher than when measures were eased previously.
- There is a deteriorating epidemiological picture across the EU, with 'lockdown' measures in place in a majority of countries.
- International advice remains that NPIs should not be eased until incidence is at low levels and there is greater vaccine coverage.
- Vulnerable groups will not be fully protected by vaccination until May/June 2021.
- Levels of fatigue among the population are growing, but the majority are still supportive of the overall approach.
- Acknowledgement that some level of easing may be necessary in the immediate term to maintain public buy-in, general societal wellbeing, and give some indication of what the path forward may be.
- An outline of relevant aspects of the Government's Plan, *The Path Ahead*, and summary of reopening plans for education and childcare sectors.
- An outline of very initial considerations for the areas highlighted in the Government's Plan for potential reopening in April and in relation to advice for the fully vaccinated.

The Acting Chair thanked the DOH for its presentation and invited the NPHE Members to commence their initial discussion. The main points raised are summarised as follows:

#### Precarious Epidemiological Position:

- There was broad acknowledgement that the current epidemiological picture is significantly worse compared to previous stages of the pandemic, where the lifting of restrictions was under consideration. This is compounded by the B.1.17 variant of concern, which is a more transmissible strain of SARS CoV-2, becoming the dominant strain in Ireland in recent months.
- The precariousness of the current epidemiological picture must continue to be to the forefront of the NPHE's considerations, given the real risk of possible rapid deterioration if measures are eased too soon.
- It was also noted that while vaccination of the over 70s cohort will likely result in significantly reduced mortality, it is likely that risk of hospitalisation and admission to ICU will remain high for younger cohorts for some time. The protection afforded to the health service as a whole cannot be guaranteed until these younger cohorts are also vaccinated. These data will be presented to the NPHE at its next meeting to inform its deliberations.



#### Protection of Public Health Priorities:

- The NPHET agreed that the longstanding priorities of protecting the most vulnerable, facilitating the provision of health and social care services, and protecting education and childcare, must continue to underpin its advice to Government.
- Several NPHET Members drew attention to the severe impact of the pandemic on the provision of health and social care services, and the inherent fragility of the sector. Several health services have remained closed since the onset of the pandemic leading to an increase in unmet healthcare needs and an unprecedented backlog in the numbers of people waiting to receive care, increasing the risks of secondary harm.
- The NPHET also drew attention to the significant toll that successive waves of the pandemic have had on staff. Considerations around easing of measures must recognise the ongoing need to protect their wellbeing.
- The NPHET agreed that any further closure of schools would have a very significant negative impact on children and the wider public, noting the protective effects of education on children's mental health and wellbeing. The NPHET was reminded that the reopening of education is still incomplete.
- The NPHET acknowledged the need to continue to communicate effectively with the public the impact of successive waves of the pandemic on the provision of health, social care, and education when voicing caution around the reopening of society.

#### Easing of Public Health Restrictions:

- The NPHET acknowledged the significant toll on the public due to protracted restrictions, as well as their impact on economic and social life. The NPHET is charged with providing objective, evidence-based, and consistent advice to the Government and the public with the overarching aim of protecting public health.
- The importance of ensuring that measures are seen as coherent and proportionate was emphasised, along with the need to continually communicate the rationale underpinning public health measures and the risks that need to be balanced. This is important to ensure the continued buy-in of the public.
- The NPHET acknowledged that due to widespread vaccine-induced immunity, it is likely that, over time, transmission of COVID-19 will no longer be linked as strongly with adverse public health impacts.
- There was consensus that the NPHET approach should continue to be one of caution, but that consideration does need to be given to some easing of measures that are considered low-risk and will improve wellbeing.
- If certain restrictions are to be eased, Members suggested that these should focus on expanding opportunities for outdoor activities and socialisation, including easing of current domestic travel restrictions. The NPHET acknowledged the decreased risk of transmission in outdoor settings, where social distancing is maintained, as well as the improved quality of life and well-being that outdoor activities foster.
- The NPHET acknowledged that robust communications around safe outdoor socialisation will be required if these measures are eased, noting the ancillary risks associated with organised outdoor activities observed towards the end of Summer 2020. Measures to facilitate greater outdoor activities should not be limited to organised sporting activities and should consider the broad range of activities, which can be done safely outdoors.

#### Vaccination:

- The NPHET agreed that future measures should consider what 'vaccine dividend' individuals can expect from being fully vaccinated, noting the apparent high degree of protection afforded by vaccination, as well as the significant toll that the pandemic has had on cohorts vaccinated to date (e.g. older people, those at high-risk of severe disease, and healthcare workers). Aligning advice for the over 70s and medically vulnerable was viewed as an immediate first step.
- The NPHET acknowledged the significant source of hope that vaccines represent for the public. The concept of 'vaccine dividend' is important to support overall vaccination uptake.



- If future measures address what a ‘vaccine dividend’ might comprise, this will require a clear public understanding of when a person is considered ‘fully protected’. Communications should also emphasise that the risks are greatly reduced for those that are fully vaccinated but they are not eliminated entirely.
- The NPHET also acknowledged that the concept of ‘vaccine dividend’ presents some ethical questions. These ethical questions should feature in any considerations of what ‘vaccine dividend’ individuals might derive.
- Notwithstanding the ongoing vaccination roll-out, the NPHET acknowledged that only a limited proportion of the population is vaccinated at present. It also noted that while emerging evidence is positive, a lot of uncertainties still remain in relation to the impact of vaccines on transmission, the length of vaccine-induced immunity, and the impact of variants on vaccine efficacy.

#### A Plan for Easing Measures:

- The NPHET acknowledged the public’s desire for a sense of hope that the end of the pandemic is in sight.
- If significant easing is not possible by the time the NPHET provides its advice to Government, it will be important to provide the public with some sense of ‘direction of travel’ through the coming months. This plan must convey the ongoing balancing of risks that serve to inform public health measures.
- The NPHET acknowledged that certain important changes are already due to take effect, including changes in visitation guidance to long-term residential care facilities.

The DOH thanked the NPHET Members for their comprehensive inputs and confirmed that it would proceed to draft a paper, based on the initial discussion, for the next NPHET meeting on 25<sup>th</sup> March. The Acting Chair further confirmed that several additional papers will be presented at the NPHET’s next meeting to ensure that the NPHET’s deliberations and recommendations on future measures are underpinned by a robust and up-to-date evidence base.

#### **b) Vaccination**

##### **i. HPRa Vaccine Safety Update**

The HPRa provided a verbal update on the national reporting experience for COVID-19 vaccines. The next report will be published on the HPRa website on 25<sup>th</sup> March.

The HPRa also referred to an ongoing investigation by the European Medicines Agency (EMA) into a small number of reports of thromboembolic and thrombocytopenic events in patients, who had recently received the AstraZeneca COVID-19 vaccine. The EMA currently remains of the view that the benefits of the AstraZeneca vaccine in preventing COVID-19, with its associated risk of hospitalisation and death, outweigh the risks of side effects. In the meantime, the administration of the AstraZeneca COVID-19 vaccine in Ireland has been deferred on a temporary and precautionary basis, pending the outcome of this investigation, which is due on 18<sup>th</sup> March 2021.

The Acting Chair thanked the HPRa for its update and reminded the NPHET that a formal update on the vaccination programme would be considered at its next meeting, scheduled for 25<sup>th</sup> March.

#### **6. Communication Update**

The HSE provided an update on ongoing and planned joint communications work with the DOH. Work is ongoing on refreshing the standard advertisements around COVID-19 preventative behaviours. A new advertisement will air on Monday 22<sup>nd</sup> March. The vaccination communications campaign is progressing well, with work continuing in mainstream TV and radio but also over community networks, and with harder to reach groups. The planned vaccine portal is also currently being reviewed from a user point of view. In addition, the Department of the Taoiseach has a new campaign planned regarding protective and preventative behaviours.



## **7. Meeting Close**

### ***a) Agreed actions***

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

### ***b) AOB***

The NPHE recognised that further communications work is needed with regard to vaccine uptake in healthcare workers, particularly those working in long-term residential care settings. The NPHE reiterated the urgent need for a better understanding of vaccine uptake in different settings, with a view to assessing vaccine confidence in those settings and any targeted communications work required. The Acting Chair noting that the NPHE would discuss vaccine uptake in healthcare workers in more detail at its meeting of 1<sup>st</sup> April. The NIAC confirmed that it is currently preparing a vaccination statement aimed at healthcare workers and that it will keep the NPHE apprised of developments in this regard.

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

The next meeting of the NPHE will take place Thursday 25<sup>th</sup> March 2021, at 10:00am via video conferencing.