# National Public Health Emergency Team — COVID-19

## Meeting Note – Standing meeting

**Date and Time**: Monday 29th March 2021, (Meeting 82) at 09:00am  
**Location**: Department of Health, Miesian Plaza, Dublin 2  
**Chair**: Dr Ronan Glynn, Deputy Chief Medical Officer, DOH

<table>
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<th>Members via videoconference¹</th>
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| 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  
| Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital  
| Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE  
| Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH  
| Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor  
| 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  
| Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI  
| Dr Colette Bonner, Deputy Chief Medical Officer, DOH  
| Ms Yvonne O’Neill, National Director, Community Operations, HSE |  
| Mr Phelim Quinn, Chief Executive Officer, HIQA  
| Dr Darina O’Flanagan, Special Advisor to the NPHET  
| Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH  
| Dr Breda Smyth, Public Health Specialist, HSE  
| Ms Deirdre Watters, Communications Unit, DOH  
| Dr Colm Henry, Chief Clinical Officer, HSE  
| Mr Liam Woods, National Director, Acute Operations, HSE  
| Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway  
| Ms Fidelma Browne, Interim Assistant National Director for Communications, HSE  
| Prof Mary Horgan, President, RCPI  
| Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)  
| Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;  
| Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH  
| Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital  
| Dr Elaine Breslin, Clinical Assessment Manager, HPRA  
| Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)  

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| Ms Laura Casey, NPHET Policy Unit, DOH  
| Ms Ruth Barrett, NPHET Policy Unit, DOH  
| Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH  
| Ms Sheona Gillesen, Senior Health Data Analyst R&D & Health Analytics Division, DOH  
| Dr Trish Markham, HSE (Alternate for Tom McGuinness)  
| Mr Gerry O’ Brien, Acting Director, Health Protection Division  
| Ms Aoife Gillivan, Communications Unit, DOH  
| Mr Ronan O’Kelly, Health Analytics Division, DOH  
| Dr Desmond Hickey, Deputy Chief Medical Officer, DOH  
| Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH |  

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<td>Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Ms Fiona Tynan, Mr Liam Robinson, DOH</td>
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| Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH;  
| Dr Lorraine Doherty, National Clinical Director Health Protection, HSE |  

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¹ References to the HSE in NPHET minutes relates to the staff of the HSE present at NPHET meetings and not the HSE Board which is the HSE in law unless otherwise stated.
1. Welcome and Introductions

a) Conflict of Interest
The president of the RCPI declared a potential conflict of interest given her involvement in pro bono work for the IRFU and GAA on the safe return to play in the context of COVID-19.

b) Apologies
Apologies were received from the following NPHET Members: Dr Kathleen MacLellan and Dr Lorraine Doherty.

c) Minutes of previous meetings
The minutes of 25\textsuperscript{th} February 2021 and 4\textsuperscript{th} March 2021 had been circulated to the NPHET in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.

d) 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 3,992 cases have been notified in the 7 days to 28\textsuperscript{th} March, which is a 3\% increase on the previous 7 days to 21\textsuperscript{st} March in which there were 3,864 cases.
- As of 28\textsuperscript{th} March, the 14-day incidence rate per 100,000 population has increased to 165; this compares with 155 on the 21\textsuperscript{st} March and 148 at the last NPHET meeting on 18\textsuperscript{th} March. The 7-day incidence per 100,000 population has increased to 84 from 81 on the 21\textsuperscript{st} March, and 77 at the last NPHET meeting on 18\textsuperscript{th} March.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 51\%, demonstrating that there have been more cases in the last 7 days to 28\textsuperscript{th} March compared with the preceding 7 days to 21\textsuperscript{st} March.
- The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10\textsuperscript{th} January 2021 to 620 on 28\textsuperscript{th} March. However, the 5-day average has increased from 588 on 21\textsuperscript{st} March, and from 481 at the last NPHET meeting on 18\textsuperscript{th} March. To note, daily incidence is currently twice what it was in early December 2020, and approximately 50 times what it was in late June 2020.
- Incidence has increased in those aged 0-12 years over the four weeks to 28\textsuperscript{th} March (noting it is not clear to what extent this is due to increased infection, increased ascertainment, or both), though this may have stabilised in the last week.
- Of cases notified in the 14 days to 27\textsuperscript{th} March, 74\% have occurred in people under 45 years of age; and 8\% were aged over 65 years. The median age for cases notified in the same period is 32 years.
- While 14-day incidence rates remain high across the country, 14 counties have a 7-day incidence as a percentage of the 14-day rate of more than 50\%, indicating more cases notified in those counties in the last 7 days to 28\textsuperscript{th} March compared with the preceding 7 days to 21\textsuperscript{st} March.
- Of the 7,834 cases reported in the last 14 days to 27\textsuperscript{th} March, 3\% (202) were healthcare workers.
- The best estimate of the reproduction number (R) is 1.0–1.3. The rate of growth of the disease is continuing at 0\% to +2\%. R is uncertain and difficult to estimate at this time.
- There were 119,565 tests undertaken in the last week (as of 27\textsuperscript{th} March). The 7-day average test positivity rate has decreased to 3.6\% on 28\textsuperscript{th} March, which is down from 4.0\% on the same day last week and from 3.8\% on 18\textsuperscript{th} March. However, it is noted that a recent increase in test referrals (potentially due to factors such as heightened vigilance around education and childcare as well as testing of asymptomatic persons) may be diluting the positivity rates in recent days.
• 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 10% over the 7 days to 26th March, which is a decrease from 12% observed on 15th March before the last NPHET meeting, noting the point made previously about the potential for dilutionary effect in relation to test positivity at the moment.
• According to contact management programme data, 9 counties have community positivity rates (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%. Over the seven-day period, 19th-25th March, demand for testing in the community increased by 19.3%.
• According to contact management programme data from 8th-14th March, where results were available for Test 1, 20.1% (1,283/6,375) were positive. Household close contact positivity rate remains at 34%.
• According to contact management programme data from 1st-7th March, where results were available for Test 2, 5.7% (148/2,607) were positive. The household close contact positivity rate was 9.5%.
• There were 331 confirmed COVID-19 cases in hospital this morning, 29th March, compared with 345 on 18th March; this is a 4% decrease since the last NPHET meeting. There have been 19 newly confirmed cases in hospital in the 24 hours preceding this morning.
• There are currently 68 confirmed cases in critical care, compared with 82 on 17th March. There have been 6 admissions in the previous 24 hours.
• To date, there have been 167 deaths notified with a date of death in March. This compares with 803 and 1,371 deaths notified (to date) with a date of death in February and January, respectively. Of the 167 deaths in March to date, 28 have thus far been associated with hospital outbreaks and 31 have been associated with nursing home outbreaks.
• In total, 31 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing.
• 12 confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date.
• Other variants of note/under investigation confirmed in Ireland to date: 15 B.1.525 cases, 5 B.1.526 cases, 13 P.2 cases, and 1 B.1.1.7 with E484K mutation.

It should be noted that in week 12, (21st - 27th March 2021), a significant number of outbreaks (92), were added that related to cases notified before 1st March. Outbreaks and associated cases are based on those notified up to midnight on 27th March 2021 and since 22nd November 2020.

Healthcare setting outbreaks:
• There were 6 new outbreaks notified in hospitals in week 12 of 2021 (week ending 27th March 2021).
• As of the week ending 27th March, 37 hospital outbreaks remained open. There have been 508 cases linked to these open outbreaks.
• There were 2 new outbreaks notified in nursing homes/community hospitals in week 12; this compares with 2 outbreaks in these settings in week 11 (week ending 21st March 2021).
• By the end of week 12, 54 outbreaks in nursing homes remained open. There are 17 open outbreaks in community hospitals and long-stay units.
• There are currently 87 open clusters associated with all residential institutions with 6 new outbreaks notified in week 12, of which 4 were in Direct Provision centres (also mentioned in vulnerable groups section).
• Within other residential institutions at the end of week 12:
  o There were 2 new outbreaks in centres for disabilities; there were 47 open outbreaks in centres for disabilities.
  o There were no new outbreaks reported in mental health facilities and there were 4 open outbreaks in these settings.
  o There were no new outbreaks reported in Children’s/TUSLA residential centres with 4 open outbreaks.

Outbreaks associated with educational settings and childcare facilities:
• There were 49 notified outbreaks associated with school children and/or school staff in week 12 with a range of between 1-14 linked cases. Over the period of 14th – 20th March 2021, 3,142 tests were completed in 120 primary schools resulting in a 2.7% positivity rate and 817 tests were completed in 52 post-primary facilities resulting in a 1.8% positivity rate. The number of cases detected, positivity rates, and numbers of cases associated with outbreaks in schools remain low despite intense oversight and increased testing. It is important to note that detection of a case or declaration of an outbreak in a school does not imply that transmission has occurred in the school setting.

• There were 19 outbreaks newly notified in childcare facilities in week 12 with a range of between 0-9 linked cases per outbreak. Over the period of 14th – 20th March 2021, 1,236 tests were completed in 71 childcare facilities resulting in a 9.6% positivity rate.

Vulnerable groups, Travelling Community, Direct Provision, and Prison Outbreaks:
• There were 30 new outbreaks reported in vulnerable populations in week 12.
• There remains a high number of Irish Traveller outbreaks with 21 new outbreaks in week 12, compared with 42 new outbreaks in week 11.
• There were 4 new outbreaks notified in Direct Provision centres in week 12.
• There has been 1 outbreak in a Homeless facility in week 12, 1 outbreak in the Roma community, and 1 outbreak in other vulnerable populations (emergency accommodation).

Workplace outbreaks:
• There were 12 workplace outbreaks reported in week 12 across a variety of settings, which is a reduction on the number of outbreaks identified in week 11 (19).

The Acting Chair thanked the DOH, the HPSC, and the IEMAG for their respective inputs and invited comments from the NPHET Members, requesting that observations on future measures for responding to COVID-19 be reserved for the substantive discussion planned under the Future Policy item to follow (see Section 5 below).

The NPHET noted its concern at the current epidemiological situation in Ireland, which remains precarious. Disease incidence has plateaued at a high level and may now be increasing. Community test positivity rates, which had previously been reducing, have flattened at persistently elevated levels over recent weeks. Of particular concern, there continues to be a significant disease burden on the acute healthcare system. The NPHET noted that the high level of infection significantly increases the risk associated with any increase in social contact and reproduction number. There is a high risk of a fourth wave of infection in the coming weeks if public health measures are relaxed too quickly.

i. EU Comparison Data

The DOH presented the paper “Comparative analysis of European COVID-19 epidemiological situation focusing on severe health outcomes (hospitalisations, critical care, and mortality): 28th March 2021”, for noting.

The paper included a summary and analysis of the epidemiological situation in Ireland and Europe from spring 2020 to March 2021 under the following headings:
• Epidemiological situation in Ireland and Europe, spring 2020 to November 2020.
• Epidemiological situation in Ireland and Europe, December 2020 to March 2021.
• Risk of variants of concern to the European region.
• Disease incidence in Ireland and the EU/UK.
• Hospitalisations in Ireland and the EU/UK.
• ICU admissions in Ireland and the EU/UK.
• Mortality in Ireland and the EU/UK.
• Disease indicators in Ireland relative to current EU averages.
The DOH concluded that notwithstanding a recent stalling in progress, Ireland has achieved significant viral suppression since the beginning of 2021, particularly in the context of the highly dominant and transmissible B.1.1.7 VOC. However, the disease profile remains of serious concern across Europe, with many countries experiencing high and increasing incidence, hospitalisations, critical care admissions, and mortality. The precariousness of the situation in many countries is compounded by the increasing threat of VOCs, the residual burden of disease on healthcare systems, and the relatively low coverage of vaccination across populations in the EU at this time.

The current, very challenging experience of most other countries in the EU highlights the progress made in Ireland to control viral transmission and disease impact since the beginning of the year; yet also, in the context of low levels of immunisation coverage in the population and the dominance of the highly transmissible B.1.1.7 VOC (and threat of other VOCs), the high risk to Ireland of a further very significant surge of infection and resultant morbidity and mortality, as well as potential impacts on public health priorities.

The Acting Chair thanked the DOH for its paper and the NPHET noted same.

ii. Modelling Report
The Chair of the IEMAG presented the paper “IEMAG input to NPHET: Report 29th March 2021”, for noting.

The paper outlined the effects of COVID-19 variants and immunity on the reproduction number (R) and included an analysis of the likely impact of the Vaccination Programme on levels of infection and severity of disease. The findings were presented as follows:

Current epidemiological position:
- While the available data on vaccine efficacy and effectiveness, and the projected timeline of the vaccination programme offer hope for a very considerable improvement in our position within a matter of weeks, the epidemiological position is precarious, and any significant change in the public health interventions and controls that are currently limiting the spread of the virus is very high risk.
- The position is precarious for two reasons:
  - First, the level of infection is high; at a 5-day average case count of 620 cases per day and a 14-day cumulative incidence of 165 per 100,000, it is approximately twice that experienced in early December 2020, and 50 times that in late June 2020.
  - Second, the dominance of the more transmissible B.1.1.7 variant means that, for similar levels of close social contact, viral transmissions, and effective reproduction number ((R_{eff}) will be 30%-70% greater than in 2020.
- The high level of infection significantly increases the risk associated with any increase in social contact and reproduction number. If reproduction number increases, the number of new infections per day will rise very quickly from this high baseline.

The impact of vaccination on risk:
- Vaccination will significantly and quickly reduce risk over a short period of time from May 2021 to August 2021. It will radically reduce mortality when those over 70 years are fully vaccinated but will have a smaller effect on hospitalisation and critical care until the wider adult population, especially vulnerable adults and those aged 50-69 years, are protected by vaccination.
- This smaller effect on hospitalisation is due to the relationship between age and risk. While the risk of dying is low for those under 65 years old, the risk of hospitalisation and admission to ICU remains significant in younger age groups; therefore, the protection of those aged 70 years and over through vaccination will greatly reduce mortality but will have a lesser effect on numbers hospitalised and admitted to ICU.
- It is important to note that the subsequent phases of the Vaccination Programme, as they protect other older adults before younger cohorts, should quickly further suppress the numbers of severe infections,
that is, the proportion of cases hospitalised will fall, and the number of cases hospitalised will fall faster than the total number of infections and cases as vaccination continues.

Reproduction number: the effect of variants and immunity:
• It is important to note that the full impact of B.1.1.7 has been experienced in Ireland only since the end of January 2021 and the very high levels of transmission seen in late December 2020 were primarily associated with other lineages (mainly the B.1.177 or ‘Spanish’ variant). The prevalence of B.1.1.7 was low (less than 20%) until late December 2020, and less than 50% as case numbers peaked in early January 2021. There is a clear impact of B.1.1.7 becoming dominant in January 2021; as prevalence increases from 60% to 90%, it becomes more challenging to suppress transmission, and in mid-January the rate of decline of infection decreases, from -7 to -10% per day in early January, to -3 to -5% per day in subsequent weeks. The high reproduction numbers 1.8-2.5 measured in late December 2020 were primarily associated with wild-type virus, not B.1.1.7.
• The IEMAG noted that when comparing the risks of levels of social mixing now (March 2021) and over the coming months with those which applied in 2020, it is important to take into account not just the increased transmissibility of the B.1.1.7 variant, but also changing levels of immunity in the population. The very large numbers of infections which have occurred over three waves of disease mean that perhaps half a million people will have conferred some level of immunity in addition to the increasing proportion of the population protected by vaccination.
• These considerations, taken together, mean there is a different relationship between close social contact, viral transmission, and effective reproduction number now compared to that which applied throughout 2020, and this relationship will change further over the coming months as vaccination further reduces risk.

Modelling the effect of vaccination:
• The IEMAG explored the possible interaction between increased levels of social mixing over the coming months with increasing protection afforded by vaccination. The IEMAG advised that there is a critical window over the next 8 weeks, where any significant increase in indoor social mixing is likely to lead to a significant additional wave in the range of that experienced in October 2020 or January 2021. Conversely, delaying any increase in close social contact for 4-8 weeks significantly reduces the risk profile.
• A delay in any increase in social mixing also greatly reduces the risk of severe disease and the projected demand for hospital care. A delay of 4 weeks reduces any surge in healthcare demand, and a delay of 8 weeks almost eliminates any surge, because the majority of vulnerable adults are protected by vaccination.
• The IEMAG emphasised that in all the scenarios modelled, vaccination is associated with continuing controls on viral transmission through non-pharmaceutical interventions (reduced contacts, physical distancing, face coverings, hygiene, and building ventilation) and such measures will need to remain in place in some form unless and until herd immunity is achieved through vaccination.

The Acting Chair thanked the Chair of the IEMAG for the presentation and invited observations from the NPHET Members. The following key points were raised:
• Members queried whether the models account for other factors such as unknowns, variants, vaccine avoidant variants, and the potential for Public Health Departments to carry out increased testing and retrospective contact tracing.
  o The IEMAG advised that it has not yet included the possibility of vaccine resistant variants in its models, but it would be able to account for this issue should it need to in future. Regarding other factors, the IEMAG informed the NPHET that it relies on a homogeneous model as it is much more robust under the current circumstances. Should case numbers drop to significantly lower levels, it may become more feasible and beneficial to model individual behaviour and this could be carried out at that point.
• The HSE enquired if it would be possible to see county-level data in order to ascertain if there are any notable discrepancies in incidence between counties.
  o The IEMAG advised that the stochasticity of these data do not allow for an accurate comparison at this time, with incidence rates fluctuating significantly as a result of outbreaks within counties.

The Acting Chair thanked the Chair of IEMAG for the paper and the NPHET noted same.

iii.  Report from HPSC WGS Group
The HPSC and the NVRL presented the paper “Summary of COVID-19 virus variants in Ireland: 22nd March 2021”, for noting.

The paper summarised whole genome sequencing and epidemiological data for COVID-19 cases that have been sequenced in Ireland between week 41 of 2020 (4th October 2020) and week 10 of 2021 (13th March 2021). The data presented were as follows:
• No variants of concern (VOCs) were identified in Ireland prior to week 51 of 2020.
• Cases of 3 variants of concern (VOC) have been identified in Ireland since then; UK VOC (B.1.1.7), South African VOC (B.1.351), and 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.
• The first case of the UK VOC (B.1.1.7) was identified in Ireland in week 51 of 2020. Transmission of this variant is now widespread in Ireland. Of cases sequenced in week 9 of 2021, 91% were found to be infected with the B.1.1.7 variant.
• The South African VOC (B.1.351) was first identified in Ireland in a case with a specimen date in week 52 of 2020 (week starting 19th December). A total of 26 COVID-19 cases have been confirmed to have been infected with this variant in Ireland to date.
• To date, the Brazilian VOC (P.1) has been confirmed in 9 cases of COVID-19.

Comparison of B.1.1.7 (the UK variant) and non-variants of concern:
• The age profile of cases sequenced from week 51 to date and found to be the UK variant (B.1.1.7), was slightly younger (median: 38 years, mean: 39 years) than those found not to be infected with variants of concern in the same time period (median: 40 years, mean: 42 years), but the overall age distributions were quite similar.
• After adjusting for age, there was no statistically significant difference in hospital admissions, ICU admissions, or deaths in cases with the B.1.1.7 variant compared to cases not infected with variants of concern.

Focus on the emerging variants of concern and variants of interest (excluding variant B.1.1.7):
• The South African VOC (B.1.351) was first identified in Ireland in a case with a specimen date in week 52 of 2020 (week starting 19th December).
• A total of 26 COVID-19 cases have been confirmed to have been infected with the South African VOC (B.1.351) in Ireland to date. Of these, 9 had a history of international travel, 4 were infected through contact with a case who had travelled outside Ireland, 8 were reported to be contacts of 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. 23 of these cases are associated with 14 outbreaks, most of which were family clusters.
• To date, the Brazilian VOC (P.1) has been confirmed in 9 cases of COVID-19. 5 were part of two separate outbreaks involving families who had travelled from Brazil. 2 further cases are reported to be contacts of confirmed cases but are not currently linked to an outbreak on the CIDR system, and the remaining 2 cases were associated with travel.

The Acting Chair thanked the HPSC and the NVRL for the presentation and invited the NPHET Members to provide their observations on the data presented. The following observations were made:
• Notwithstanding the recent operationalising of mandatory quarantining facilities for people travelling from high-risk ‘Category 2’ countries, the NPHET acknowledged the ongoing risk posed by international travel.
• Several Members noted with concern the ongoing risk posed by the emergence of new variants across Europe. The NPHET underlined the need to continue to monitor the issue of new and emerging variants closely on an ongoing basis, noting the risks that these variants could pose to the successful rollout of the Vaccination Programme. In this regard, the NPHET noted ongoing developments to strengthen Ireland’s surveillance systems, including a wastewater surveillance programme.

The Acting Chair acknowledged the ongoing risk posed by new and emerging variants, noting that these variants will continue to arise. This ongoing risk underscores both the need for caution surrounding international travel and the need to keep levels of transmission low.

The Acting Chair thanked the HPSC and the NVRL for this update and the NPHET noted same.

3. Review of Existing Policy
   a) Update on Testing Strategy
The HSE presented “Testing and Tracing: 29th March”, for noting. The paper outlined the five key initiatives commencing under the testing strategy, namely:
• Source investigation/backward tracing.
• Alternative referral pathway for testing.
• Approach to antigen testing pilot in schools/third level.
• Testing at quarantine sites.
• Self-isolation and restricted movement support.

The paper also noted that the overall testing report shows that demand for community testing has increased, driven by the 0-13 and 20-40 age cohorts. The paper further provided details of the testing programmes currently in place for each of the following settings: nursing homes, mental health facilities, disability facilities, food production facilities, education, and childcare.

The HSE also noted that the newly established ‘walk-in’ testing centres for the asymptomatic are experiencing high numbers of young attendees. Messaging needs to clearly state the purpose of the testing centres in order to maintain the integrity of the symptomatic GP referral system.

It was also highlighted that Public Health Departments regularly carry out source investigations, despite the general perception that this is not the case.

The Acting Chair thanked the HSE for its update and requested that the HSE bring the first full week of data from the ‘walk-in’ testing centres to the NPHET on Thursday, 1st April.

The NPHET thanked the HSE for this update and noted same.

b) Update on Non-COVID Services
The DOH and the HSE presented “Update on Non-COVID Care: 29th March 2021”, for noting.

The paper outlined that the level of COVID-19 has been shown over the past year to be a key determinant of the level of healthcare that can be delivered and of the associated risk to patients, service users, and healthcare workers. The widespread level of the virus in January and February 2021 resulted in significant impact on the delivery of non-COVID care including the deferment of all but essential time-critical elective care in our hospitals and pausing/reduction of some community services in order to meet the highest priority needs in residential, community, and home delivered services. The number of COVID-19 patients in hospital and critical care remains high and in the case of critical care, at levels greater than the peak of the second wave. The health system is faced with the challenge of resuming non-COVID care, while simultaneously continuing to provide care for a cohort of patients with COVID-19.
The DOH and the HSE emphasised that in essence, the system is currently extremely fragile. Any further increase in cases would lead to an intensely difficult period for primary, acute, and social services, which have not yet recovered from the third wave and are paralleling the rollout of a substantial national vaccination programme. Staff are exhausted and in need of some respite from the challenges of working in a COVID environment for an extended period of time. Any additional curtailment of the delivery of scheduled care would further exacerbate the already high waiting lists for non-COVID care.

In the ensuing discussion, it was noted that the impact on Child Health services must be assessed in particular going forward. It was also noted that if there is an increase in case numbers, there will be significant displacement of non-COVID care in General Practice.

The Acting Chair thanked the DOH and the HSE for this update and the NPHET noted same.

c) Current Knowledge of Long-COVID

The paper summarised the emerging evidence in relation to the longer-term effects of infection with SARS-CoV-2, noting the following terminology:
- Post-Acute COVID: Symptoms for up to 12 weeks following known infection with SARS-CoV-2.
- Long COVID/Post-Acute Sequelae of COVID (PASC): Symptoms after 12 weeks of known infection. ‘Long COVID’ is a term coined by social media and PASC is the terminology used by the National Institute of Health Sciences (NIH).

The paper concluded that while the evidence base is limited to date, a small number of studies are available and are reporting a high level of residual effects in hospitalised patients lasting for more than 3 months, noting that studies may be limited by responder bias.

The long-term impact of post-COVID syndromes on the working-age population is not well-understood but it may be very significant. A drop in quality of life including greater difficulty doing usual activities and increases in anxiety, depression, and pain is reported. It is also reported that outcomes are significantly worse in working-age females than males.

Most studies show that fatigue, cough, headache, sleep disturbance, and joint/muscle pain are the most predominant symptoms. It may well be that there are two distinct clinical entities emerging:
- Those with severe infection requiring hospitalisation, who have required rehabilitation and have a prolonged recovery course.
- Those whose initial infection did not require hospitalisation but have prolonged debilitating symptoms.

The paper noted that it is becoming clearer that underlying pre-morbid conditions do not appear to predict prolonged symptoms in any group and the only currently-known predictor in the hospital group is invasive ventilation. Experience from other post-viral syndromes suggest potential for serious and negative impact on the mental health of those affected.

A healthcare worker case report demonstrated the variability and fluctuating nature of symptoms that have been described as part of the post-COVID sequelae.

The Acting Chair thanked the HSE for this update and the NPHET noted same.

d) Behavioural Insights Update
The DOH presented the ESRI Research Note “Summary of Behavioural Evidence: March 2021”, for noting. The research note summarises recent evidence from a number of behavioural studies. The findings are arranged by the research questions below:
- How has social activity changed under Level 5 restrictions?
- How is behaviour related to close contacts?
- How well are people following public health guidelines?
• What factors drive more risky behaviour?
• How is personal wellbeing holding up?
• What are public expectations for restrictions?
• What is the public’s opinion on re-opening?
• Do the public want the COVID-19 vaccine?

The DOH noted that findings under the above questions show that social activity has increased in recent weeks with an increase in indoor social visits to other households, a trend being driven by a small minority of people. The study also demonstrated that the majority of people are supportive of the overall approach and remain compliant with measures and advice.

The ESRI found that reduced fear regarding COVID-19 is an important factor in increased social activity. The ESRI did not find a significant association between fatigue and non-adherence to restrictions and most of the population are willing to act in the public interest. There is no strong relationship between behaviour and socio-demographic group, age, or gender. Engagement in risky behaviour is based on an individual’s psychology and is an attitudinal characteristic, which cannot be predicted by age, geographic location, or socio-demographic background.

With regard to wellbeing, data shows that the third wave has had a detrimental impact, in particular among younger adults. Positive emotions in February were at the lowest since March 2020, and negative emotions are now at their highest since the onset of the pandemic.

The population appears to expect a slow reopening, with the majority expecting some easing in April but expecting it to be at least 9 months before all restrictions are eased. The majority still believe the general approach to reopening is appropriate or should be more cautious, but there is a growing minority that believe it should be quicker.

There is a high level of acceptance among the public for the COVID-19 vaccine and concerns are mostly about the possible side effects.

The Acting Chair thanked the DOH for this update and the NPHET noted same.

4. HIQA Expert Advisory Group
No matters arose for discussion under this item.

5. Future Policy
a) Future Measures for Responding to COVID-19
The DOH presented the paper “NPHET Advice on Future Measures: 29th March”, for discussion. The paper was informed by the NPHET discussion on future measures of 18th March and set out key informing considerations in relation to the two aspects under consideration – (1) advice in relation to the easing of measures, and (2) potential changes in guidance for those that are fully vaccinated.

The Acting Chair thanked the DOH for the paper. The Acting Chair referenced presentations from earlier in the meeting, noting the precarious nature of the current epidemiological picture, the fragility of recent progress until greater vaccine coverage affords more widespread protection among the population, and the modelling projections which outlined the benefits that a further 4-8 weeks of caution can bring. The Acting Chair also reaffirmed the NPHET’s core priorities, namely protecting the most vulnerable and the full restoration of health and social care services, education, and childcare. The Acting Chair also referenced discussions from the last meeting, and the general consensus on the need for some easing of measures with a focus on outdoor activities.

The NPHET held a substantive discussion on future measures and key points included the following:
• The NPHET acknowledged the precariousness of the current epidemiological position, noting that progress in suppressing the disease had plateaued and transmission levels may now even be increasing. While acknowledging the hard-earned progress in suppressing the disease since January 2021, and the significant efforts of the public in achieving this, it was agreed that the currently high case count requires a cautious approach to any reopening to prevent any further waves of infection. It was also noted that the four conditions as set out in the Government Plan, *The Path Ahead*, had not been met. Members expressed the importance of communicating the fragility of the epidemiological profile observed at present.

• Members noted the significant hope offered by the modelling projections. While the modelling underscored the need for an extremely cautious approach in the near term, it also provided a time frame for when restrictions could be eased more broadly. It was noted that this would help in communicating the overall approach to the public and the positive protective effect that vaccines will have.

• The NPHET acknowledged the enormous impact that this protracted period of restrictions is having across society and growing levels of fatigue among the public. Members stressed the importance of decisions being perceived as coherent and underpinned in evidence to support adherence levels.

• There was broad agreement on the need to protect the gains of the previous three months and importantly to continue to protect the ongoing resumption of the core priority services of health, education, and childcare in the context of any easing of restrictions. The need to protect the health service from any future surges of COVID-19 was reemphasised.

• While there were some differing views on the extent to which measures could be eased and the appropriate timeline for this easing, there was general consensus that the headroom for easing of measures in the near term was relatively limited and the focus should be on low-risk outdoor activities to improve overall wellbeing and to maintain majority support for public health measures. It was noted that permitted activities should not be limited to sporting activities and should consider other areas of interest for the public.

• The NPHET considered the easing of the 5km rule and agreed that it should be eased in the context of enabling people to do more outdoors, more safely. Members agreed that the allowing of within-county travel only could place arbitrary limits on individuals living along border areas and proposed a more nuanced arrangement which would permit domestic travel within an individual’s county or within 20 kilometres from their place of residence.

• The NPHET deliberated as to whether sports for underage children should be reintroduced. While acknowledging the important developmental benefits of their participation in sport, there was consensus that return to sport for underage children should be delayed until May, noting the paramount need to ensure the full return of education in the interim period. The NPHET will be in a better position to assess the epidemiological impact of the return of education later in April and will continue to monitor this situation closely.

• There was also some discussion of a potential limited reopening of some aspects of retail, but this did not have widespread support at this time. It was also acknowledged that there was regional variation in case numbers and incidence, however given the fluctuating and uncertain epidemiological position, it was considered appropriate to continue to apply measures on a national basis at this time.

• Members noted that communications accompanying any announcement should emphasise the need for continuing safe behaviours outdoors, including social distancing, and the need for individuals to continue to keep their number of social contacts low on an ongoing basis. It was also noted that communications should emphasise the need for continued public buy-in and adherence to all measures over the Easter period, in particular in relation to interhousehold and/or intergenerational mixing.

• The NPHET also gave consideration as to whether it is appropriate at this time to provide revised guidance to those who are fully vaccinated. It was noted that the level of vaccine coverage was still low and that there still is not full evidence in relation to the impact of vaccines on transmission, the period of vaccine-induced immunity, and the risk of reinfection, as well as the impact of variants on vaccine effectiveness. It was also noted that to date, only a small number of countries have issued differentiated advice for those who are fully vaccinated.
Notwithstanding the above, the NPHET agreed that it was appropriate to provide for a limited relaxation of measures for individuals, who are fully vaccinated. Individual benefits derived from vaccination were noted as important incentives to maintain momentum in the ongoing roll-out of the vaccination programme.

It was emphasised that messaging around the benefits fully vaccinated individuals should enjoy must be managed carefully to ensure that individuals understand what ‘fully vaccinated’ means and the circumstances within which any benefit would apply. Specific guidance will be required in this regard.

Members raised the issue of regional variation in case numbers of COVID-19, and the implications of this for releasing restrictions. While the data currently show that transmission is high in most regions, more detailed regional data will be prepared for the NPHET’s next meeting.

The Acting Chair thanked the Members for their contributions and the following recommendations were proposed and endorsed by the NPHET:

**Action Point: Public Health Measures**

- **Level 5 measures should be extended for a further period of time.** This should be reviewed again at the end of April, once there has been time to assess the impact of the full return of in-school education on 12th April.

- **There should be no relaxation of measures before the full return of in-school education on the 12th April.**

- **There should be a limited relaxation of measures in April focused on improving societal wellbeing and quality of life.**

  - **From 12th April:**
    - Two households can meet up with one another outdoors for social or recreational purposes (this does not include private gardens). Any meetings outdoors should be safe, with continued practicing of social distancing and other safe behaviours. Masks should be worn in crowded outdoor spaces.
    - Travel restrictions can be relaxed to enable travel within own county or within 20km of residence if crossing county boundaries (the latter (20km) should only be adopted if deemed to be operationally enforceable).

  - **From 26th April:**
    - Outdoor sports facilities can reopen (e.g. golf courses and tennis courts, other facilities as appropriate). Activities should take place between a maximum of two households. Facilities including club houses and any indoor facilities (e.g. changing rooms, showers, kitchens, meeting rooms), apart from essential toilet facilities, must remain closed. There should not be any return to team sports or training activities.
    - Outdoor visitor attractions can reopen (i.e. zoos, open pet farms, heritage sites, but not amusement parks) – indoor areas, should remain closed and hospitality should only be open for take-away services. Robust protective measures, including appropriate capacity limits, should be in place.
    - Recognising the significant impact of restrictions on funeral services, maximum attendance at funerals can increase to 25 on compassionate grounds. Given the known transmission risks associated with funerals, it is essential that this measure is fully complied with and that all necessary protective measures are taken. It is also essential that linked gatherings do not take place before or after funeral services.

- **Consideration will also be given to the phased return of non-contact outdoor training, starting with under 13s in May.**

- **New guidance has issued in relation to visiting in long-term residential care facilities which will provide the framework for visiting in these facilities over the coming months. It is therefore no longer deemed necessary to include visiting under the Framework for Restrictive Measures.**

- **No further relaxation of measures should take place over the coming month.**

- **All those working from home should continue to do so.**
Advice for those that are fully vaccinated:

• Current guidance for those most vulnerable to the severe impacts of COVID-19 (the over 70s and the medically vulnerable) should be aligned with that for the general population. This means that when they are fully protected from vaccination, they can be advised that they may:
  o Use public transport for essential purposes.
  o Go to shops.
  o Meet up with one other household outdoors for exercise.
  o These cohorts should continue to work from home where possible and if this is not possible, they should talk to their employer.
  o They must also continue to follow Level 5 restrictive measures along with the rest of the population and continue normal protective measures.

• Those who are fully vaccinated may visit with other fully vaccinated people (from one other household only) indoors without wearing masks or staying 2 metres apart. The HPSC will develop guidance in this regard.

• The HSE should review relevant policy and guidance for healthcare workers, who are fully vaccinated including with regard to close contact status and return to work for the medically vulnerable, who have been cocooning.

• All communications in relation to these measures should clearly emphasise when full vaccination is achieved. While this will differ for the different vaccines, full protection is generally not in place until 2 weeks after the second dose of a two-dose vaccine.

b) Vaccination

i. Update on Vaccination Programme

The HSE presented the paper “Update on Vaccination Programme: 24th March”, for noting. The key points were as follows:

• The milestone of 600,000 vaccines administered was reached on Friday 12th March. 689,5810 vaccines administered to 22nd March; a total of 503,147 people have now received the first dose of their vaccine.

• Recommencement of AstraZeneca COVID-19 vaccinations for the new high-risk groups and front-line healthcare workers (HCWs) on Saturday 20th March, with a continued ramp-up in vaccinations of these groups.

• Vaccination of dose 1 for front-line HCWs is substantially complete with 218,989 dose 1 vaccines administered to 22nd March. The portal for front-line HCWs will be closed this week (week ending 4th April).

• Vaccination of the very high-risk cohort commenced in Irish hospitals in March, and it is anticipated that the vaccination of this very high-risk group will be completed for dose 1 early in May. In parallel, with the vaccination of the very high-risk cohort, work is ongoing to identify the larger cohort of high-risk patients, whose vaccination will commence in May following completion of the very high-risk cohort.

• In addition, during April, it is intended to commence vaccination for those within the age 65-69 years and non-frontline HCW cohorts. Plans for these groups will be finalised over the next week (week ending 11th April).

• Over 195,000 vaccines have been administered by GPs to the over 70s as of 22nd March. The HSE is continuing to administer vaccines to housebound patients through NAS and the over 70s in the hospital setting.

• 13 vaccination centres are now operational. However, current cohorts have a greater focus on GP and hospital-based delivery, and this will continue into April. Other Vaccination Centres will be ready for operations during April in preparation for greater utilisation in May and beyond.

The Acting Chair thanked the HSE for its update and the NPHET noted same.

ii. Prioritisation Framework

The DOH and the NIAC presented the paper “COVID-19 Vaccine Allocation Strategy: 29th March”, for decision.
The DOH informed the NPHET that following the receipt of updated recommendations from the National Immunisation Advisory Committee (NIAC), it was being proposed that the COVID-19 Vaccine Allocation Strategy would be updated. The DOH reminded the NPHET in this regard that the Vaccine Allocation Strategy was designed to be agile and responsive to changes in evidence on an ongoing basis, noting the NIAC’s recommendation endorsed by the NPHET in February to alter the allocation strategy and to prioritise those deemed to be at very-high and high-risk of severe disease and death from COVID-19 for vaccination. Given the planned expansion of the vaccine rollout in Q2, on foot of increased vaccine supply, it was deemed timely to re-examine the remaining groups in the vaccine allocation framework to facilitate planning and ongoing operational allocation requirements.

The NIAC presented the results of its evidence reviews and deliberations to the NPHET. In summary:

- The NIAC, having completed an evidence review, concluded that while there is encouraging evidence emerging to suggest that vaccines can interrupt transmission of the virus, at the current time there is insufficient evidence to justify adopting a strategy which would be primarily aimed at reducing transmission. Thus, the objective of the Vaccination Programme to protect those most at risk of serious disease and death as a result of COVID-19 remains valid.
- Following an evidence review conducted by the NIAC, no occupational group emerged as being at higher risk of severe disease or death from COVID-19, independent of age and other co-morbidities.
- The international and national evidence is unequivocal that hospitalisation and death as a result of COVID-19 increases with age. In line with the primary goal of the Vaccination Programme, the NIAC considered that the adoption of an age-based approach to vaccination would facilitate a more rapid deployment of vaccine and, by extension, should protect the greatest number in the shortest time.
- The NIAC considered, with the support of a HIQA evidence review, those who meet the criteria of living and/or working in conditions which make social distancing difficult and identified members of the Traveller and Roma communities as well as people who are homeless, as at higher risk of severe disease from COVID-19, and on that basis recommended these groups receive priority for vaccination. It was suggested by the NIAC that other groups identified in the HIQA report be considered for vaccination on equity grounds. The joint paper brought by the DOH and the NIAC, recalls that equity is a central pillar of the vaccine allocation strategy and notes that many of the groups identified by the HIQA suffer health inequities arising from social, economic, and structural disparities that contribute to differences in their health outcomes compared to the general population. Thus, it was proposed that in addition to the groups identified by the NIAC as being at increased risk of severe disease or death, residents of accommodation centres for international protection applicants and programme refugees, prisoners, and those in detention centres, addiction service users, residents of women’s refuges, undocumented migrants, and sex workers should be included in the priority group ‘people aged 16-64 years living or working in crowded settings’. The point was made that there would be a requirement for a targeted and collaborative approach for each of the groups to ensure accessibility, suitability, and optimal engagement in the Vaccination Programme. It was proposed that this group be vaccinated in parallel with those aged 64 years and younger.
- Further analysis of the data related to maternal and foetal outcomes during, and post COVID-19 is warranted to inform recommendations for vaccination of pregnant women not already identified for prioritisation (healthcare workers and those with very-high- and high-risk conditions). This is being addressed as a matter of urgency.
- It was noted that currently no COVID-19 vaccine has been authorised for use in children under 16 years, although clinical trials are ongoing. Any emerging evidence will be kept under review by the NIAC.

On foot of these considerations, it was recommended to alter the Vaccine Allocation Strategy so that:
1. Residents of long-term residential care facilities aged 16-64 years should be vaccinated directly after people aged 16-64 years, whose underlying condition puts them at a high risk of severe disease and death.

2. Vaccination should then proceed on an age-based basis, starting with the oldest adults first i.e. those aged 64 years and proceeding in descending order in ten-year cohorts.

3. In parallel with the above group, members of the Traveller and Roma communities, people who are homeless, residents of accommodation centres for international protection applicants and programme refugees, prisoners and those in detention centres, addiction service users, residents of women’s refuges, undocumented migrants, and sex workers, should be prioritised for vaccination.

The Acting Chair thanked the NIAC and the DOH for their work and invited Members to discuss the recommended updates to the Vaccine Allocation Strategy. Key points made were as follows:

- The NPHET welcomed and endorsed the updated recommendations. Members commented positively on the operational simplicity that the Vaccination Programme rollout would derive from the change, noting that the speed with which vaccines are distributed will be of utmost importance once supply is up-scaled.

- Members queried the use of 10-year age-bands, as opposed to the 5-year age-bands used for older cohorts. The NPHET agreed that 10-year age-bands allowed for more flexibility and operational simplicity in the rollout of the Vaccination Programme. Some Members raised the difficulties associated with identifying which groups aged 16-64 years should be included in the category of ‘people aged 16-64 years living or working in crowded settings’, and whether younger members of these cohorts could be characterised as more at risk compared to older members within this age cohort in the general population. The DOH reminded the NPHET that the purpose of the HIQA evidence review was to identify groups who met the criteria for inclusion into this group based on national and international evidence. It was noted that there was likely an under ascertainment of risk of severe outcomes in a number of the groups identified, given limitations in case data and/or population estimates and that equity considerations were also being taken into account. Members noted the positive impact that the change would have for vulnerable groups most at risk to the adverse consequences of COVID-19.

- The NPHET noted that specific pathways for availing of vaccination may be required for harder-to-reach cohorts in the category of ‘people aged 16-64 years living or working in crowded settings’. Specifically, bespoke vaccination centres and the use of single-dose vaccines may be required, subject to supply and operational circumstances. The HSE confirmed that planning for this requirement is underway.

- Members acknowledged that there may be disappointment in certain sectors regarding the proposed changes to the Vaccine Allocation Strategy. The NPHET affirmed that the proposed changes to the Vaccine Allocation Strategy meet the goal of equitable vaccination rollout and noted the importance of speed over specificity as supplies increase.

The NIAC and the DOH thanked contributors to this work including the HSE and DOH Social Inclusion, the HIQA, and the DOH Statistics and Analytics Team.

The Acting Chair thanked the NIAC, the DOH, and other contributors for this important evidence-based piece of work, noting its emphasis on equity in healthcare. The Acting Chair proposed the updated recommendations on vaccine allocation for endorsement. The NPHET endorsed same.

Action: The NPHET endorses the paper from the Department of Health and the National Immunisation Advisory Committee which sets out an updated prioritisation of groups for vaccination. The NPHET considers this updated ranking appropriate on the basis of currently available data and will continue to keep this under review.

iii. HPRA Vaccine Safety Update
This item was deferred to the next meeting of the NPHET.

The HSE informed the NPHET that it would present an update on the integration of the COVAX and CIDR systems at the next NPHET meeting.

6. Communication Update
Due to time constraints, it was agreed that the DOH would present its communications update at the next meeting of the NPHET.

7. Meeting Close
a) Agreed actions
The key actions arising from the meeting were examined by the NPHET, clarified, and agreed.

b) AOB
In response to a previous query about the vaccination rollout on Tory Island, the Chief Nursing Officer (DOH) assured the NPHET that all those eligible for vaccination at this time have been vaccinated in line with the national Vaccination Programme. The Acting Chair thanked the Chief Nursing Officer for this update.

The HPSC provided a brief update on the progress of the Wastewater Surveillance programme, which has begun sampling at 3 plants and will roll-out to a further 65 plants from mid-April. The Acting Chair thanked the HPSC for its update and requested a formal update on the programme once it becomes fully operational.

c) Date of next meeting
The next meeting of the NPHET will take place Thursday 1st April 2021, at 10:00am via video conferencing.