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

**Date and Time**
Thursday 8th April 2021, (Meeting 83) at 10:00am

**Location**
Department of Health, Miesian Plaza, Dublin 2

**Chair**
Dr Ronan Glynn, Deputy Chief Medical Officer, DOH

**Members via videoconference**
- Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)
- Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)
- Dr John Cuddihy, Interim Director, HSE HPSC
- Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)
- Dr Cillian de Gascun, Laboratory Director, NVRL
- Dr Máirín Ryan, 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 Lorraine Doherty, National Clinical Director Health Protection, HSE
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Ms Yvonne O’Neill, National Director, Community Operations, HSE
- Mr Phelim Quinn, Chief Executive Officer, HIQA
- Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI
- Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
- Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
- Dr Darina O’Flanagan, Special Advisor to the NPHET
- Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH
- Ms Deirdre Watters, Communications Unit, DOH
- Dr Colm Henry, Chief Clinical Officer, HSE
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA
- Mr Liam Woods, National Director, Acute Operations, HSE
- Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications
- 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

**‘In Attendance’**
- Ms Laura Casey, NPHET Policy Unit, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Mr Gerry O’ Brien, Acting Director, Health Protection Division
- 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
- Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH
- Ms Sheona Gilsenan, Senior Health Data Analyst R&D & Health Analytics Division, DOH
- Ms Aoife Gillivan, Communications Unit, DOH
- Dr David Hanlon, National Clinical Advisor and Group Lead Primary Care, HSE

**Secretariat**
- Dr Keith Lyons, Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Ms Fiona Tynan, DOH

**Apologies**
- Dr Breda Smyth, Director of Public Health Medicine, HSE
- Dr Siobhán Ní Bhriain, Lead for Integrated Care, HSE
- Prof Mary Horgan, President of the Royal College of Physicians of Ireland (RCPI)
- Dr Catherine Fleming, Consultant Physician in Infectious Diseases, UCHG; Co-Lead National Infectious Diseases Programme, HSE

---

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
   Verbal pause and none declared.

b) Apologies
   Apologies were received from the following NPHET Members: Dr Breda Smyth, Dr Catherine Fleming, Prof Mary Horgan, and Dr Siobhán Ní Bhriain.

c) Minutes of previous meetings
   The minutes of the 11th and 18th March 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 3,506 cases have been notified in the 7 days to 7th April, which is a 6% decrease from last week when 3,736 cases were notified in the 7 days up to 31st March.
   - As of 7th April, the 14-day incidence rate per 100,000 population has decreased to 152; this compares with 161 on the same day last week, 31st March. The 7-day incidence per 100,000 population has decreased to 73, from 78 on the same day last week, 31st March.
   - Nationally, the 7-day incidence as a proportion of 14-day incidence is 48%, demonstrating that there have been more cases in the last 7 days, 1st – 7th April, compared with the preceding 7 days, 25th – 31st March.
   - The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January 2021 to 430 on 7th April. The 5-day average has decreased from 509 a week ago.
   - Incidence rates are decreasing across most age groups, with recent stabilisation of incidence amongst children.
   - Of cases notified in the past 14 days, 25th March – 7th April, 73% have occurred in people under 45 years of age; and 7% 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, 19 counties have a 7-day incidence as a percentage of the 14-day rate of less than 50%, indicating fewer cases notified in these counties in the last 7 days, 1st – 7th April, compared with the previous 7 days, 25th – 31st March.
   - Of the 7,220 cases reported in the last 14 days, 25th March – 7th April, 2.2% (160) were healthcare workers.
   - The best estimate of the reproduction number (R) is is close to, or just below, 1.0 (range 0.7-1.1). 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 110,994 tests undertaken in the last week (as of 7th April). The 7-day average test positivity rate has decreased to 2.9% on 7th April, which is down from 3.3% on the same day last week, 31st 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 was at 8.4% over the 7 days to 5th April.
   - According to Contact Management Programme data, 8 counties have community positivity rates (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%.
   - According to Contact Management Programme data from 22nd – 28th March, where results were available for Test 1, 14.8% (1,475/9,935) were positive. Household close contact positivity rate remains at 31%.
   - According to Contact Management Programme data from 15th – 21st March, where results were available for Test 2, 3.9% (181/4,670) were positive. Household close contact positivity rate was 9.6%.
• A range of data suggest that mobility is increasing, although caution is warranted in interpretation of compliance with population measures, especially given the influence of the Easter period.
• There were 226 confirmed COVID-19 cases in hospital this morning, compared with 274 on 1st April. There have been 11 newly confirmed cases in hospital in the 24 hours preceding this morning, 8th April.
• There are currently 55 confirmed cases in critical care, compared with 63 on 1st April. There have been 2 admissions in the previous 24 hours.
• To date, there have been 205 deaths notified with a date of death in March. This compares with 819 and 1,351 deaths notified (to date) with a date of death in February and January, respectively. Of the 205 deaths in March to date, 40 have thus far been associated with hospital outbreaks and 35 have been associated with nursing home outbreaks. There have been 10 deaths notified in April to date.
• In total, 43 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing. This is an increase of 12 since the last NPHET meeting on 29th March.
• 19 confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date. This is an increase of 7 since the last NPHET meeting on 29th March.
• Other variants of note/under investigation that have been confirmed in Ireland to date: 16 B.1.525 cases, 5 B.1.526 cases, 14 P.2 cases, and 2 B.1.1.7 with E484K mutation.

The outbreak data below are based on outbreaks and associated cases notified since 29th November 2020. Week 13 refers to 28th March – 3rd April 2021. It should be noted that a significant number of outbreaks in week 13 (66) were late notifications of outbreaks from before 1st March 2021.

Healthcare setting outbreaks:
• There were 10 new outbreaks notified in acute hospitals in week 13 of 2021; as of the end of week 13, there were 38 open outbreaks in these settings.
• There was 1 new outbreak notified in nursing homes/community hospitals in week 13, this compares with 2 new outbreaks in these settings in week 12.
• At the end of week 13, there were 41 open outbreaks associated with nursing homes compared with 54 in the previous week.
• There are 12 open outbreaks in community hospitals and long stay units compared with 17 at the end of week 12.
• There were 81 open outbreaks associated with all residential settings at the end of week 13, with 14 new outbreaks notified in week 13. Of these, 12 occurred in homeless facilities and are further detailed in the vulnerable groups section below.
• Within other long-term residential settings at the end of week 13:
  o There were no new outbreaks in centres for disabilities; there were 36 open outbreaks in centres for disabilities compared with 47 in week 12.
  o There were no new outbreaks reported in mental health facilities and there were 4 open outbreaks in these settings at the end of week 13.
  o There were no new outbreaks reported in Children’s / TUSLA residential centres with 4 open outbreaks at the end of the week.
  o There was 1 outbreak reported in ‘other’ residential settings.

Vulnerable groups, Travelling Community, Direct Provision, and Prison Outbreaks:
• There were 25 new outbreaks reported in vulnerable populations in week 13.
• There was a decrease in the number of outbreaks in the Irish Traveller community, with 7 new outbreaks in week 13, compared with 21 new outbreaks in week 12; there were 165 open outbreaks at the end of week 13.
• There were 6 outbreaks in the Roma community in week 13 with 12 open outbreaks.
• There have been no new outbreaks in Direct Provision centres, prisons, or facilities for people with addictions in week 13.
• There have been 12 outbreaks in homeless facilities in week 13, compared with 1 outbreak the previous week. There were 13 open outbreaks by the end of week 13.
Outbreaks associated with school children, universities/colleges, and childcare facilities:

- There were 17 outbreaks newly notified associated with childcare facilities, with 86 open outbreaks remaining by the end of week 13. There were 67 new cases notified in these settings in week 13.
- There were 44 outbreaks newly notified associated with school children and/or school staff in week 13, with 74 new cases notified in this week. This compared with 48 outbreaks in this setting in the previous week.
- There were no new outbreaks in university/college/third-level students in week 13, with 56 outbreaks remaining open by the end of week 13.
- Based on the latest data on testing in schools over the period of 21st – 27th March 2021 (week 12), 5,427 tests were completed in 193 primary schools (a 73% increase on week 11). This resulted in a 1.7% positivity rate; 872 tests were completed in 51 post-primary facilities, resulting in a 2.5% positivity rate; and 239 tests were carried out in special education settings with a 4.2% positivity rate. Overall, mass testing in the schools setting returned a positivity rate of 1.9%.
- 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.

Workplace outbreaks:

- There were 23 workplace outbreaks reported in week 13 across a variety of settings, which is a 92% increase on the number of outbreaks identified in week 12 (12).
- When broken down by category, 10 outbreaks were in commercial settings, 4 were in construction settings, 4 were related to food production settings, 3 were in manufacturing settings, 1 was in an office-based setting, and 1 was in another setting.

The Acting Chair thanked the DOH, the HPSC, and the IEMAG for their respective updates and invited the NPHET Members to consider same.

The NPHET noted that epidemiological situation in Ireland appears to be stable or potentially improving. Disease incidence, while still high, is stable or decreasing. However, it is noted that there is currently significant uncertainty due to the potential effect of the Easter period on factors such as patterns of test referrals, along with a range of other disease indicators.

The NPHET further observed that numbers of confirmed cases in hospital and ICU have continued to reduce. Indicators of population mobility, including attendance in workplaces, have risen over recent weeks, acknowledging, however, the need for some caution in interpretation of these indicators in respect of population adherence to the public health measures due to the influence of the Easter period. The reproduction number (R) is uncertain. The level of close contact in the population remains constant, with the average number of close contacts per adult confirmed case at 2.6. The epidemiological situation as described is stable but with significant uncertainty attached and will continue to be closely monitored by the NPHET over the coming days and weeks.

i. Update on Disease profile in Children

The HPSC presented “COVID-19 in Children and Data on Schools and Childcare Facilities 2021 – 5th April 2021”, for discussion. The key points are summarised as follows:

- Since March 2020, there have been 33,655 cases of COVID-19 in the 0–18-year-old population. This represents 2.9% of the 0-18 years population.
- The importance of on-site education has been discussed nationally and internationally, and schools have been recognised as the last places which should close in the pandemic, and the first places that should re-open. The significant negative consequences and long-term effects of school closures on children, with accompanying lack of psycho-social, holistic, and health-care opportunities has been documented both here in Ireland, and internationally.
• Since schools and child-care facilities re-opened in Ireland, Public Health teams across the country have responded to all cases of COVID-19 notified to them, who were in school within their infectious time period. A Public Health Risk Assessment is undertaken, close contacts are identified and excluded, and organised for swift onward COVID-19 PCR testing. These tests are flagged and batched for swift testing and batched reporting, to enable further Public Health decisions to be rapidly determined and implemented. An assessment of the particular risks identified in that setting is undertaken and recommendations to prevent further cases and spread are made.
• This process has highlighted that schools, with correct recommendations and mitigation measures in place, are a low-risk setting. All staff and families who are part of the broader school community should abide by the national public health measures recommended at that time, to ensure they can remain low-risk settings.
• Since week 6 2021, 164 outbreaks have been reported associated with schools and childcare facilities. This reflects the level of COVID-19 activity in the community and the increased transmissibility of the B.1.1.7 variant (UK variant), which is now the dominant SARS-CoV-2 variant in Ireland.
• 82 outbreaks have been associated with school pupils and staff. Evidence of transmission within the school environment has not been identified in many of these outbreaks.
• In general, these outbreaks are small with 94% of outbreaks (77) having <10 cases linked to the outbreak. This likely reflects the success of current public health control measures in containing these outbreaks.
• 82 outbreaks have been associated with childcare facilities (CCFs). The majority of CCF outbreaks also involved a small number of cases, 77% of outbreaks (63) had <10 cases linked to the outbreak.
• The impact of the UK variant has been considered since schools returned, with slightly wider exclusions having been made, especially in the post-primary sector. The close contact positivity rate has remained stable post-Christmas, in-line with what was identified pre-Christmas for school facilities. A doubling of close-contact positivity has been identified in the CCF sector, dominated by some larger outbreaks. Sustained work has been undertaken within the sector to ensure better understanding and compliance with Infection Prevention and Control measures, and a change to recommendations with regard to more routine use of face-coverings in this sector by staff members.

The paper also noted a summary of close contact positivity, as follows:
• Primary sector - 3% before Christmas; 2.1% post-Christmas.
• Post-primary sector -1.9% before Christmas; 1.9% post-Christmas.
• SEN sector - 3.6% before Christmas; 3.4% post-Christmas.
• CCF sector - 4.5% before Christmas; 9.2% post-Christmas.

Pre-Christmas, in school settings, approximately 14% of close contact exclusions made were staff members; 86% were students. Close contact positivity data were equivalent. Since the phased re-opening, approximately 10% of exclusions have been staff; 90% students. Close contact positivity data are equivalent.

To continue to ensure that schools and CCFs remain low-risk settings and continue to be available for on-site education, the paper recommended the following:
1) No person should present to a facility if they, or a household member, have signs or symptoms of COVID-19, until results of COVID-19 tests are known. No-one should attend if they have been designated a close contact.
2) Schools should implement mitigation measures required as laid out in the ‘return to school’ documents, e.g. distancing, hygiene, face coverings, building ventilation etc.
3) Public Health swiftly responding to cases to identify close contacts, assess whether an outbreak is ongoing, and implement necessary control measures to rapidly contain the outbreak.

The Acting Chair thanked the HPSC for its presentation and invited observations from the Members. The following points were raised:
• A review of the relevant epidemiological data carried out by the IEMAG in relation to children is reassuring and indicates that the recent return to in-person education has been associated with
moderate and transient increases in incidence amongst children, mostly explained by changes in testing due to high levels of vigilance and oversight leading to increased case ascertainment.

- It was also queried whether a more detailed assessment of the vaccination status of HCWs can be included in reports. On this point, it was noted that the process to link the CIDR and COVAX systems is underway and should be operational in the coming weeks.

The Acting Chair thanked the Members for their observations and noted that while significant uncertainty remains, many indicators appear to be promising. The impact of the return to school, particularly following the Easter break, will continue to be kept under close review but processes in place continue to provide reassurance that schools continue to be low-risk settings.

3. Review of Existing Policy

a) International Travel

The DOH provided an update on International Travel, incorporating an update from the Expert Advisory Travel Group (EAGT).

The DOH updated the NPHET on the Mandatory Hotel Quarantine system that is now in place, noting that the system has been designed to be scalable and that further countries will potentially be added to the list of designated states. The DOH informed the NPHET that there will be a time window before such decisions become fully applicable in order to ensure that people are aware of the system in place and can either cancel their travel plans or, if intending to travel, are able to fulfil the legal requirement that Mandatory Hotel Quarantine must be reserved and paid for prior to travel into Ireland. The DOH also noted that there is an appeal process in place, should a person wish to challenge the quarantine requirement as it applies to them. The DOH informed the NPHET that, broadly speaking, the introduction of the quarantine requirement has led to a reduction in international travel.

The Chair of the EAGT informed the NPHET that the EAGT was established in March on the Minister’s request. The Group’s Terms of Reference are to develop a risk-informed approach to the categorisation of countries, provide any other advice on travel that the Group deemed necessary, and to make this advice available to the CMO/ACMO. The Chair of EAGT drew particular attention to the strict criteria for entry contained in the European Union (EU) Recommendation 2020/912 on the temporary restriction of non-essential travel into the Schengen area. The Group further noted that as new VOCs began to emerge, the EU introduced a further level to the ‘traffic light’ system, dark red. Taking all of this into consideration, the EAGT made a number of recommendations with regard to the enforcement of home quarantine, adoption of European Union (EU) Recommendation 2020/912, and whole-genome sequencing. The EAGT noted that recommendations for additions to the list of designated states are based on three criteria:

1. Countries with known VOCs.
2. Very high-incidence countries.
3. High-incidence countries with two and a half times the Irish rate.

The Acting Chair thanked the DOH and the Chair of the EAGT for their updates and invited the NPHET Members to give their observations on same.

In the ensuing discussion, it was raised that incoming unaccompanied minors are being catered for by TUSLA or parents/guardians and are being monitored by local Public Health Departments, a system which is reportedly working well. However, it was highlighted that further attention may need to be directed to quarantine arrangements for persons seeking international protection on arrival.

The NPHET also recognised the significant work carried out by DOH colleagues and others involved in the cross-Government process of quickly standing up the Mandatory Hotel Quarantine system.

Action: With respect to international travel, mandatory quarantine, and the management of variants of concern (VOC), the NPHET reiterated its ongoing significant concerns regarding the potential risks posed
by the importation of VOCs and, in noting legal advice available to the Government which advises that a mandatory hotel quarantine regime should be targeted towards the highest risk States, endorses the methodological approach taken by the Expert Advisory Travel Group (EAGT) with regard to the designation of States as highest risk, and recommends that:

A. measures be taken to ensure that those travelling from non-designated states, and who are subject to home quarantine, are adhering to that quarantine and are availing of a PCR test at ‘Day 5’, post arrival in Ireland;
B. the HSE and the HIQA to examine whether a single test at ‘Day 5’ post arrival in Ireland remains the most appropriate approach to testing for those travelling from non-designated states, who are subject to home quarantine;
C. whole genome sequencing be undertaken on all confirmed cases linked to travel, whether from non-designated or designated states;
D. any necessary resources are identified and directed towards supporting the robust implementation of the updated public health guidance with regard to the management of probable or confirmed cases and contacts linked to VOCs;
E. with regard to non-EU states, in line with a recommendation of the EAGT, that ongoing consideration be given to the adoption of the approach set out in European Union (EU) Recommendation 2020/912 on the temporary restriction on non-essential travel into the EU.

b) Updated Guidance on COVID-19 Assessment and Decision-Making Pathway for Primary School Children.
The HSE presented the paper “Recommendations in relation to COVID-19 Assessment and Testing Pathways for Children: March 2021” to the NPHET, for decision.

The paper set out the latest advice of the HSE’s National Clinical Programme for Paediatrics and Neonatology Review Group concerning the COVID-19 assessment and decision-making pathway for primary school children, namely:
1) that the existing current guidance remains appropriate and fit for purpose;
2) that parents, doctors, and teachers are in general following this guidance, and that this should be encouraged;
3) that on-going adherence to public health and infection control measures should be encouraged;
4) that the evolving situation should be kept under close review, mindful of the epidemiological complexities;
5) that there may be merit in increased surveillance data to identify the circulating viruses amongst this population.

The relevant HSE group will reconvene in three weeks’ time to review the evolving situation and emerging evidence. This time interval will provide an opportunity to monitor infection during, and after the Easter holiday school break.

The NPHET thanked the HSE for its presentation and endorsed the paper, noting no substantive change to existing guidance.

Action Point: The NPHET endorsed the advice of the HSE’s Review Group concerning the COVID-19 assessment and decision-making pathway for primary school children, noting no substantive change to existing guidance.

4. HIQA Expert Advisory Group
a) Mask Wearing in Children
The HIQA presented the paper “Advice to the National Public Health Emergency Team: Reduction of the minimum age for the application of mask wearing requirements and recommendations – Update: 8th April 2021”, for decision.
The purpose of the HIQA report was to provide an update on advice previously submitted to the NPHET on 3rd March on the policy question: “Should the minimum age for the application of mask wearing requirements and recommendations be reduced?”

The HIQA noted that, in the context of limited research evidence regarding a number of key factors to inform this policy question, the advice is informed by the HIQA COVID-19 Expert Advisory Group (EAG), which was reconvened on 6th April 2021 for clinical and technical interpretation of the research evidence. In addition to a number of presentations on issues relating to the above policy question, a representative of the National Parents Council also addressed the EAG, highlighting comments, queries, and concerns on behalf of parents nationwide.

Arising from the findings of this discussion, the HIQA provided the following advice to the NPHET:

- There was a general consensus among EAG members that, as of 6th April 2021, there should be no change in the minimum age for requirements and recommendations with respect to mask use in the community.
- The potential benefits of a requirement or recommendation for children to wear face masks must outweigh concerns regarding potential harms associated with face mask use.
- Based on the Irish epidemiological data in March 2021, there is reassurance that the package of mitigation measures in place in primary schools appear to be effective in minimising transmission. Any additional benefit associated with requiring children to wear face masks in this context is likely to be small.
- With regard to public understanding of mitigation measures, there is a need for reassurance on the lack of evidence of any significant physical harms associated with face mask use.
- Ongoing monitoring is required with respect to the epidemiological situation in children and the effectiveness of current risk mitigations measures in place in primary schools.
- Consideration should be given to proactively collecting representative data on parents’ and children’s attitudes and concerns with respect to face mask use. Such data could be used to help inform future policy development.
- As per previous advice, communication with parents needs to reinforce the need to adhere to current public health advice, including the need to avoid wider school or after-school interactions (for example, after school playdates).
- Given the ongoing evolving situation regarding community-level transmission, this advice should be kept under review and should be informed by national and international surveillance data and relevant evidence from the literature. It should be clearly communicated to the public that evolving evidence may result in changes to the current recommendations.
- Given the ongoing evolving situation regarding community-level transmission, this advice should be kept under review and should be informed by national and international surveillance data and relevant evidence from the literature. It should be clearly communicated to the public that evolving evidence may result in changes to the current recommendations.

The Acting Chair thanked the HIQA for its advice, noting no substantive change to current guidelines.

**Action Point: The NPHET adopted the recommendations within the HIQA paper “Reduction of the minimum age for the application of mask wearing requirements and recommendations-update”, noting no substantive change to current guidelines.**

**b) HCWs not taking vaccination**

The purpose of the HIQA papers was to provide advice to the NPHET on the following policy question: "What policies, mitigation actions or initiatives have been implemented internationally relating to healthcare workers who do not avail of COVID-19 vaccination that could be considered by the Irish Health Service?"

The HIQA’s advice paper was informed by research evidence developed by the HIQA’s COVID-19 Evidence Synthesis Team and with interpretation of the evidence from the HIQA’s COVID-19 Expert Advisory Group (EAG).

Arising from the findings, the HIQA provided the following advice to the NPHET:

- Only two policy or guidance documents, both from the UK, relating to healthcare personnel who do not avail of COVID-19 vaccination (due to contraindication or refusal), were identified. As COVID-19 vaccination programmes progress globally, it is anticipated that more policies will be developed.
- All healthcare personnel should be strongly encouraged and facilitated to avail of COVID-19 vaccination as soon as they are eligible. Given the substantial challenges experienced by healthcare workers during the pandemic, the model of ‘encourage and support’ should be maintained to ensure ongoing positive work environments.
- When developing policy for healthcare personnel who do not avail of COVID-19 vaccination, careful consideration should be given to the following:
  - mechanisms of facilitated decision-making (for example, one-to-one conversations with line managers or trusted peers)
  - risk assessments and mitigation strategies (for example, ongoing testing and use of PPE, redeployment)
  - data collection (for example, vaccine uptake and declination rates, and reasons for refusal, across health and social care settings)
  - legal and ethical issues (for example, autonomy and confidentiality).
- Policy could be based on the ‘intervention ladder’ and the ‘least restrictive alternative’ principle. This means that the first step of the ladder may involve providing evidence-based information to healthcare personnel in a supportive manner, with greater levels of intervention at each subsequent step, such as one-to-one conversations, ongoing testing and use of PPE. Higher rungs of the ladder may involve interventions such as redeployment to a lower risk area. Mandatory vaccination would sit at the top of the ladder as the most intrusive step. The higher the rung on the ladder at which the policy maker intervenes, the stronger the justification has to be.
- Clear guidance should be provided to employers on how to undertake one-to-one conversations with healthcare personnel to encourage vaccine uptake. Supports and tools should be made available to line management and trusted peers to enable these conversations to be successful, taking into consideration the wide range of settings in which health and social care workers operate.

The Acting Chair thanked the HIQA for its advice and invited the NPHET Members to discuss same. Key points in the discussion were as follows:

- Members agreed it is important to consider the level of risk at any one time in the particular setting when utilising the ‘intervention ladder’ approach (for example, greater risk when community transmission is high).
- The importance of the setting was also discussed with regard to certain vulnerable populations (for example, nursing home residents) seen to be a greater risk from unvaccinated healthcare workers. Additionally, in some settings redeployment may not be a viable option (for example, in General Practice).
- It was emphasised that while risk profile and contextual factors are important, fundamental to the ‘intervention ladder’ approach is taking the least restrictive approach first.
- It was brought to the NPHETs attention that the ‘intervention ladder’ approach has been successful in the United Kingdom.
- Ethical issues were discussed with a focus on the balancing of rights between healthcare workers and patients, recognising that healthcare workers have a duty of care to protect patients.
The Acting Chair thanked the HIQA for its presentation and the NPHET endorsed the HIQA’s recommendations.

**Action Point:** The NPHET endorsed the recommendations within the HIQA paper “Advice to the National Public Health Emergency Team: Policies relating to healthcare personnel who do not avail of COVID-19 vaccination: an international review: 8th April 2021”, to take an ‘intervention ladder’ approach utilising the principle of the least restrictive alternative to further encourage vaccine uptake and reduce hesitancy.

c) **Immunity & Risk of Reinfections with COVID-19**

The HIQA presented the paper “Advice to the National Public Health Emergency Team: Duration of immunity (and protection from reinfection) following SARS-CoV-2 infection: 7th April 2021”, for discussion. The paper was accompanied by a report titled “Evidence Summary- Duration of protective immunity (protection from reinfection) following SARS-CoV-2 infection: 7th April 2021”, submitted for discussion.

The purpose of the HIQA papers was to provide updated advice to the NPHET on the policy question: “How long does protective immunity (that is, prevention of antigen or RT-PCR confirmed reinfection) last in individuals who were previously infected with SARS-CoV-2 and subsequently recovered?”

The HIQA outlined that it conducted an evidence synthesis which comprised of a systematic search of databases to identify cohort studies that estimated the risk of reinfection over time and input from the COVID-19 Expert Advisory Group (EAG).

On the basis of the findings of this evidence synthesis, the HIQA provided the following advice to the NPHET:

- The updated evidence summary identified 11 cohort studies on the risk and relative risk of SARS-CoV-2 reinfection over time. Across studies, the total number of PCR- or antibody-positive participants at baseline was 615,777. The median follow-up of individuals within studies was 4.4 months (range of medians: 1.8 to 7 months). 9 of the 11 included studies followed participants for ≥7 months, 6 for ≥8 months, 5 for ≥9 months and 3 for ≥10 months. Reinfection was a rare event (median PCR-confirmed reinfection rate: 0.27%, range: 0% to 1.1%), with no study reporting an increase in the risk of reinfection over time.
- The data remain limited in certain populations, such as in children, the elderly, individuals with comorbidities, the immunocompromised and vaccinated populations. In addition, there is considerable uncertainty surrounding protective immunity against new variants of concern.
- Current policies assume a period of presumptive immunity of 6 months post-infection.
- No specific changes to policies regarding the duration of presumptive immunity following natural infection are advised at this time.
- Consideration must be given to the practicalities and feasibility of any changes to policy arising out of amendments to the duration of presumptive immunity.
- The body of evidence relating to protective immunity is emerging at a fast pace and should be kept under review. Future policy changes should be informed by the international evidence in addition to national surveillance data.

The HIQA noted that this evidence synthesis provides greater confidence in the previous advice to extend the period of presumptive immunity from 3 months to 6 months and that this advice will be kept under review as new evidence emerges.

The Acting Chair thanked the HIQA for its work on this question. The NPHET noted that while the emerging evidence is favourable in terms of the period of presumptive immunity following natural infection of SARS-CoV-2, there is not yet sufficient evidence to extend this beyond the current period of 6 months. Regarding emerging evidence relating to vaccine or naturally induced immunity, the NPHET requested that the HPSC review contact tracing guidance with regard to designation of close contacts.
Action Point: The NPHET requests that the HPSC update contact tracing guidance with regard to designation of close contacts in light of emerging evidence regarding vaccine and naturally induced immunity.

5. Future Policy
   a) Vaccination
      i. Joint Update on Vaccination
The HSE presented a joint update on the rollout of the National COVID-19 Vaccination Programme. Key points made were as follows:

- Approximately 1,000,000 vaccine doses in total will have been administered through the Vaccination Programme by 11th April.
- Residents of Long-Term Residential Care Facilities are currently receiving their second vaccine dose.
- Vaccination of healthcare workers is now substantially complete; the online registration portal for healthcare workers was closed on this basis last Friday, 2nd April and arrangements will be made for vaccination of new entrants.
- Vaccination of the over 70s age group is well underway, with 280,000 fully vaccinated, representing over half of this cohort.
- The National Ambulance Service is providing a special vaccination service for those who are housebound.
- Those, who are deemed ‘very high risk’ in the 16-64 age group (cohort 7) are proving more challenging to identify. The HSE is working with hospitals, the disability sector, and GPs to identify people in this group, with a view to scheduling vaccination appointments.
- Given the difficulties that have arisen in identifying all those falling within the ‘very high-risk’ group, a decision was made to merge this group with the ‘high-risk’ group (cohort 4), in the interest of generating efficiencies in rollout and maximum utilisation of vaccine supplies.
- A stand-alone vaccination project is being developed for vulnerable groups (Homeless, Travellers, those living in Direct Provision etc.).
- In April, vaccination of people aged 65-69 years will commence (approx. 180,000 people) through mass vaccination clinics.
- 37 mass vaccination clinics will soon be operational; 18 are currently operating.
- After the vaccination of those aged 65-69 years, the rollout will proceed down through the age cohorts, in accordance with the NIAC’s Prioritisation Framework.
- An increase in the ‘did not attend’ (DNA) rate has been detected in recent weeks. It is unclear whether this is due to vaccine hesitancy following the recent developments regarding the AstraZeneca vaccine.
- Referral pathways are in place for vaccination teams should any of the reported rare side-effects arise in the course of their work.
- The HSE further noted that the NIAC will be meeting on 9th April to consider the Irish position in light of the EMA’s latest advice concerning the AstraZeneca vaccine.

The Acting Chair thanked the HSE for presenting the joint update and invited observations from the NPHET Members. The following key points were made:

- The NPHET queried how many people by age-bands and cohorts have been vaccinated to date (i.e. uptake and denominator data).
- The NPHET queried whether the HSE would be in a position to extend/scale up the rollout of the Vaccination Programme in line with vaccine supply, for example, the provision of 24-hour mass vaccination centres.
- The HSE responded that the only restriction to rollout at present is vaccine supply and people not presenting for vaccination. Vaccine rollout will be extended as needed to keep pace with supply.
- The NPHET queried how the HSE is managing the vaccine rollout given that Ireland does not have unique identifiers for the population.
- The HSE responded that this challenge will become less of an issue as the Programme moves into age-band rollout; it is difficult to misrepresent your age.
- The NPHET queried whether guidance will be provided for individuals, who experience side-effects, in particular on whether they should be administered a second vaccine dose.
• The NPHET queried whether the position of healthcare workers, who are partially vaccinated remains the same as those who are unvaccinated.
• The HSE confirmed that only those who have received two doses (in circumstances where two doses are required) are considered fully vaccinated.
• The NPHET queried whether there was anything further that the HSE could do to ensure that reserve lists are maintained in accordance with the current advice on same.
• In response, the HSE confirmed that it has issued very clear advice on reserve lists and expects all those involved in the administration of vaccines to adhere to this protocol.
• The NPHET queried whether vaccine hesitancy has arisen in those who have already received one dose of the AstraZeneca vaccine.
• The HSE responded that it is too early in the Programme to ascertain the level of vaccine hesitancy for those who have received one dose.

The Acting Chair thanked the NPHET Members for their observations and noted the need for vaccine uptake and denominator data. Accordingly, the Acting Chair requested that the HSE develop a reporting template providing hard data on uptake by age, gender, occupation, etc. The Acting Chair added that this data should be brought to the NPHET on a regular basis to inform discussions.

ii. 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 22nd April and monthly thereafter.

The HPRA also referred to the European Medicines Agency (EMA) review 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, outweigh the risks of side effects, but has recommended an update to the product information to indicate that these events have been very rarely reported. Additional studies and amendments to ongoing studies have also been requested to investigate these side effects, and potential risk factors. AstraZeneca will circulate a letter to healthcare professionals, describing the side effects, and to ensure awareness of the signs and symptoms. The HPRA has published a statement on its website and will continue to engage with the NIAC, and relevant stakeholders.

The Chair of the NIAC confirmed that the NIAC is monitoring developments with regard to the AstraZeneca vaccine very closely. It is engaging with the HPRA and the HIQA in relation to risk assessments.

The NPHET noted the communications challenges presented by the recent reports regarding the AstraZeneca vaccine, in particular in the context of disparity in decision making and data collection across Europe. The importance of consistent evidence-based messaging to the public was emphasised in this regard.

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

b) Updated Guidance: Variants of Concern — Contact & Case management

The paper detailed the current public health guidance in relation to variants of concern (VOCs) and noted the following key points:
• VOCs are caused by mutations in SARS-CoV-2 viruses which have adverse public health consequences. These consequences include an increase in transmissibility, or virulence, or a decrease in the effectiveness of vaccines, treatments, diagnostic assays, or other public health measures. The World Health Organization (WHO) currently defines three VOCs: B.1.17, B.1.353, and P.1.
• The public health management of incoming travellers from ‘designated states’, also known as ‘high-risk’ countries, who have SARS-CoV-2, known as persons under investigation, is comprised of the following measures:
o Mandatory hotel quarantine.
  o PCR testing.
  o Comprehensive flight contact tracing.

- The Public Health management of persons with a probable or confirmed VOC associated with international travel is as follows:
  o Establishment of an outbreak control team.
  o Epidemiological investigation of the case, and identification of exposures in the 14 days prior to diagnosis.
  o International notification to other countries by the HPSC National IHR Focal Point and EWRS Contact Point, and further local or flight contact tracing, if required.
  o Cases who, within the 14 days prior to onset of COVID-19, have had exposure to someone in their household, workplace, or with another close contact who has travelled from- or through any high risk ‘designated states’ (or former ‘category 2’ countries) in the last month are managed in the same way as travel-associated cases.

- The Public Health management of persons with a probable or confirmed VOC not associated with travel is as follows:
  o Establishment of an outbreak control team.
  o Identification of exposures in the 14 days prior to diagnosis.
  o Wider testing of workplace or other epidemiologically-linked community, with use of diagnostic screening using PCR-based assays for positive cases and sequencing of screening assay positive cases.
  o Wider diagnostic screening using PCR-based assays as indicated by initial epidemiological investigation, including surge testing where indicated.

In response to a request for clarification from the Acting Chair, the HPSC stated that the requirement for contacts of contacts of PUI and VOCs to restrict movements was removed on the basis that experience to date demonstrated that this cohort posed relatively little risk compared to the administrative burden in identifying same.

The HPSC further confirmed that a pop-up centre has been established in Naas, which will serve as a evaluating model for future centres, where there is a VOC identified that requires rapid investigation.

The HPSC clarified for the NPHET’s information that under the legislative framework:
- Unaccompanied minors (i.e. those under 18 years of age) can be quarantined at home if their guardian (parent or approved representative e.g. school) can supervise their quarantine. They quarantine at home in a similar way to the conditions in the hotel and they are subject to the ‘Day 0’ and ‘Day 10’ tests. They can exit from quarantine if both tests are ‘not detected’. In these circumstances, testing is undertaken in the home by the National Ambulance Service.
- Where a person arrives in the State wishing to apply for international protection or requests not to be returned to their country of origin due to fear of persecution, serious harm etc., they self-isolate in accommodation arranged by the Minister for Children, Equality, Disability, Integration and Youth.

The Acting Chair thanked the HPSC for its paper and the NPHET noted same. The Acting Chair then reiterated that the necessary resources are identified and directed towards supporting the robust implementation of the updated public health guidance with regard to the management of probable or confirmed cases and contacts linked to VOCs.

6. Communication Update
The DOH and the HSE presented “NPHET - Communications Update: 8th April 2021”, for noting.

The quantitative tracker up to 5th April reveals:
- The level of worry at 5.9/10, has fallen back to levels last seen in early December, with concern for the health of family and friends, the economy, and prolonged restrictions now the highest source of worry.
• The majority, 44%, now believe the worst of the pandemic is behind us, 29% believe it is happening now, and 11% believe it is ahead of us.
• 41% now think Ireland is returning to normal too slowly (27% the pace is a bit too slow, 14% think the pace much too slow), 37% think we are returning to normal at about the right pace. 16% think the pace is too quick.
• People are disengaging from COVID-19 related news.

The latest Social Activity Measure (ESRI/Department of the Taoiseach) for the week commencing 26th March reveals:
• Mobility and social activity increased further over recent weeks. While increases in workplace activity were small, visits to locations associated with social activity, including to collect take-away food, increased more substantially. There was a steady rise in visits to shops.
• People met with more individuals from outside their household and there was an increase in close contacts between people. The most substantive change was in social visits to homes. 23.8% of the population either had a visitor to their home or visited another home the day before the study. Almost half of these (11.5%) were social visits (i.e. not professional, care or childcare related), up from 5.0% six weeks previously.
• Three psychological factors predict risky behavior – worry, perceived consistency of restrictions, and prevention-burden trade-off.

The Quantitative Tracker – Vaccine Module demonstrates that:
• 52% of the population know someone in their immediate social circle, who has had COVID-19.
• 86% (71% definite, 15% probable) say they will get the COVID-19 vaccine when it is offered to them.
• 41% say they have concerns around the vaccine. 31% are worried about side effects of the vaccine, 22% worried about the long-term effects on health.
• GPs are the most trusted source of information on the vaccine for 71% of the population, followed by the HSE (49%), Department of Health (48%), and Pharmacists (42%).

An update was provided to the NPHET on the following campaigns that are currently underway and in development:
• HSE Vaccine Radio advertisement calling those 70 years and over and people with certain high-risk conditions to be vaccinated during April and May.
• Young Adults campaigns, including the establishment of ‘SciComm Collective’ – a group of young science communicators who communicate the virus and the vaccine to their peers via social media.
• A vaccine booklet to include how to self-isolate/restrict movements.

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

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

   b) AOB
The HSE presented “Impact of Vaccination on Healthcare Workers Availability for Work: 8th April 2021” for discussion and decision.

At the request of the NPHET, the HSE had reviewed relevant policy and guidance for healthcare workers, who are fully vaccinated, with regard to close contact status and return to work for the medically vulnerable, who have been cocooning.

The HSE firstly noted:
• There is also growing evidence of the effectiveness of vaccine in preventing infection. There is also evidence that vaccination reduces viral load in those who become infected.
• It is important to emphasise that all healthcare workers need to maintain a high standard of infection prevention and control practice in all aspects of their work even when fully vaccinated.

• Individuals are considered fully vaccinated for COVID-19 as follows:
  o 15 days after the second AstraZeneca dose;
  o 7 days after the second Pfizer-BioNTech dose;
  o 14 days after the second Moderna dose.

Against the above outlined background, the HSE made the following recommendations:

• Healthcare workers aged 70 years and older, who are fully vaccinated and with no medical conditions that places them at high risk of severe disease, may return to work including frontline patient care when fully vaccinated subject to a brief Occupational Health risk assessment.

• Healthcare workers, who are fully vaccinated with medical conditions that place them at high risk of severe disease but are not immunocompromised, may return to work including frontline patient care when fully vaccinated subject to an Occupational Health risk assessment.

• Healthcare workers, who are excluded from work because they are pregnant or immunocompromised must continue to stay away from work at present. This is subject to ongoing review.

• Healthcare workers, who are fully vaccinated and who are exposed to an infectious case of COVID-19 and are identified as contacts need not restrict their movements and may continue to work including frontline patient care when fully vaccinated unless specific circumstances apply as follows:
  o Known contact with person in whom infection with variant of concern is known or suspected;
  o The person is known to have a medical condition or to be on treatment that is expected to compromise the ability of their immune system to respond to vaccination (see above);
  o A public health or occupational health risk assessment has identified other specific grounds for concern.

The paper also included a recommendation regarding healthcare workers, who are fully vaccinated meeting with other healthcare workers, who are also fully vaccinated or with healthcare workers in the 6 months after COVID-19 infection in settings where patients (service users) are not present. The NPHET concluded that it was not in a position to accept this recommendation at this time, given the importance of maintaining consistency in public messaging around social settings in all workplaces in the community.

The Acting Chair thanked the HSE for its paper and the NPHET endorsed same, subject to the incorporation of agreed revisions.

Action: The NPHET endorsed recommendations within the HSE paper “Impact of Vaccination on Healthcare Workers Availability for Work” subject to the incorporation of agreed revisions.

c) Date of next meeting

The next meeting of the NPHET will take place Thursday 15th April 2021, at 10:00am via video conferencing.