### National Public Health Emergency Team – COVID-19

**Meeting Note – Standing meeting**

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<thead>
<tr>
<th>Date and Time</th>
<th>Thursday 22nd April 2021, (Meeting 85) at 10:00am</th>
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<tbody>
<tr>
<td>Location</td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td>Chair</td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
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<td>Members via videoconference</td>
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<tr>
<td>Dr Ronan Glynn, Deputy Chief Medical Officer, DOH</td>
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<td>Dr Kevin Kelleher, Assistant National Director, Public Health, HSE</td>
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<td>Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)</td>
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<td>Dr Cillian de Gascun, Laboratory Director, NVRL</td>
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<td>Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA</td>
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<td>Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital</td>
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<td>Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE</td>
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<td>Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH</td>
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<td>Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor</td>
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<td>Ms Rachel Kenna, Chief Nursing Officer, DOH</td>
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<td>Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH</td>
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<td>Dr Lorraine Doherty, National Clinical Director Health Protection, HSE</td>
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<td>Ms Yvonne O’Neill, National Director, Community Operations, HSE</td>
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<td>Mr Phelim Quinn, Chief Executive Officer, HIQA</td>
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<td>Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI</td>
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<td>Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH</td>
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<td>Dr Darina O’Flanagan, Special Advisor to the NPHET</td>
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<td>Dr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH</td>
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<td>Dr Breda Smyth, Public Health Specialist, HSE</td>
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<td>Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH</td>
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<td>Ms Deirdre Watters, Communications Unit, DOH</td>
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<td>Dr Colm Henry, Chief Clinical Officer, HSE</td>
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<td>Dr Elaine Breslin, Clinical Assessment Manager, HPRA</td>
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<td>Mr Liam Woods, National Director, Acute Operations, HSE</td>
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<td>Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway</td>
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<td>Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications</td>
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<td>Prof Mary Horgan, President, RCPI</td>
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<td>Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)</td>
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<td>Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;</td>
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<td>Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH</td>
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<td>Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital</td>
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<td>Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)</td>
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<td>Dr John Cuddihy, Interim Director, HSE HPSC</td>
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**In Attendance**

| Ms Laura Casey, NPHET Policy Unit, DOH |
| Ms Ruth Barrett, 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 Pauline White, Statistics & Analytics Unit, DOH |
| Ms Aoife Gillivan, Communications Unit, DOH |

**Secretariat**

| Ms Ruth Brandon, Mr Ivan Murphy, Ms Emily Kilroy, Mr Liam Hawkes, Ms Fiona Tynan, Mr Liam Robinson, DOH |

**Apologies**

| Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital; |
| Dr Colette Bonner, Deputy Chief Medical Officer, DOH |

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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
      Verbal pause and none declared.

   b) Apologies
      Apologies were received from Dr Colette Bonner and Dr Michael Power.

   c) Minutes of previous meetings
      The minutes of 29th March and 8th April 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
      In his opening remarks, the Chair, Dr Tony Holohan, expressed his gratitude to Dr Ronan Glynn for the excellent work carried out as Acting Chair of the NPHET during his recent leave of absence. The Chair also thanked the Members of the NPHET for their hard work and dedication, particularly since the beginning of the year. The Chair further noted that the NPHET’s efforts have, along with the support of the public, brought the country to a good position, in relative terms, where attention can now be turned to the next steps for our public health measures and the path forward for the country.

      The Chair reiterated the importance of confidentiality to NPHET meetings and reminded the Members of the requirement to preserve the integrity of the process by which the NPHET provides its advice to the Minister for Health and the Government.

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 2,612 cases have been notified in the 7 days to 21st April 2021, which is a 7% decrease from last week when 2,814 cases were notified in the 7 days to 14th April.
      • As of 21st April, the 14-day incidence rate per 100,000 population has decreased to 113; this compares with 132 on the same day last week, 14th April. The 7-day incidence per 100,000 population has decreased to 55, from 59 on the same day last week, 14th April.
      • Nationally, the 7-day incidence as a proportion of 14-day incidence is 48%, demonstrating that there have been fewer cases in the last 7 days, 15th – 21st April, compared with the preceding 7 days, 8th – 14th April.
      • The 5-day rolling average of daily cases has decreased from 388 a week ago to 376 on 21st April.
      • Incidence is stable or decreasing across all age groups. The sharp decrease in incidence in those aged 75 years and older is likely due, at least in part, to the protective effect of vaccination.
      • Of cases notified in the past 14 days, 8th – 21st April, 73% have occurred in people under 45 years of age; and 6% were aged 65 years and older. The median age for cases notified in the same period is 32 years.
      • While 14-day incidence rates remain high across the country, 12 counties have a 7-day incidence as a percentage of the 14-day rate of greater than 50%, indicating more cases notified in these counties in the last 7 days, 15th – 21st April, compared with the previous 7 days, 8th – 14th April.
      • Of the 5,402 cases reported in the last 14 days, 8th – 21st April, 3.1% (165) were healthcare workers.
      • The best estimate of the reproduction number (R) is close to or just below 1.0, with high levels of uncertainty in its estimation (range 0.7-1.1). The rate of growth of the disease is continuing at 0% to -2%.
      • There were 106,029 tests undertaken in the last week (as of 21st April). The 7-day average test positivity rate has increased slightly to 2.8% on 14th April, which is up from 2.7% on the same day last week, 7th April.
• 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 8.3% over the 7 days to 19th April.
• According to Contact Management Programme data, only 4 counties have a community positivity rate (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%. 21 counties have a community positivity rate greater than 5%.
• According to Contact Management Programme data from 5th – 11th April, where results were available for Test 1, 21.9% (878/4,014) were positive. The household close contact positivity rate has increased to 31.6% since last week.
• According to Contact Management Programme data from 29th March – 4th April, where results were available for Test 2, 3.8% (146/3,858) were positive. The household close contact positivity rate was 9.1%.
• There were 176 confirmed COVID-19 cases in hospital this morning, compared with 184 on 15th April. There have been 19 newly confirmed cases in hospital in the 24 hours preceding this morning, 22nd April.
• There are currently 48 confirmed cases in critical care, compared with 51 on 15th April. There have been 5 admissions in the previous 24 hours, 21st – 22nd April.
• To date, 22nd April, there have been 47 deaths notified with a date of death in April. This compares with 224 and 866 deaths notified (to date, 22nd April) with a date of death in March and February, respectively. Of the 47 deaths in April to date (22nd April), 13 have thus far been associated with hospital outbreaks and 3 have been associated with nursing home outbreaks.
• In total, 68 cases of B.1.351 (variant first identified in South Africa) have been confirmed by whole genome sequencing.
• 27 confirmed cases of P.1 (variant first identified in Brazil) have been identified in Ireland to date.
• Other variants of note/under investigation that have been confirmed in Ireland to date (22nd April): 17 B.1.525 cases, 15 P.2 cases, 6 B.1.526 cases, 3 B.1.617, 2 B.1.429, and 2 B.1.1.7 with E484K mutation.

Outbreaks and associated cases are based on those notified up to midnight on 17th April 2021. Week 15 refers to 11th April – 17th April 2021 and data are restricted to cases and outbreaks notified since 22nd November 2020.

Healthcare setting outbreaks:
• There were 5 new outbreaks notified in acute hospitals in week 15 of 2021. At the end of week 15, there were 26 open clusters, a 13% decrease on week 14.
• There was 1 new cluster notified in a nursing home in week 15 (although the linked cases were identified prior to week 15); this compares with no new outbreaks in week 14. There were no new clusters notified in community hospitals/long-stay units in week 15.
• At the end of week 15, there were 11 open clusters associated with nursing homes compared with 21 in the previous week; this represents a decrease of just under 50%.
• There were 8 open outbreaks in community hospitals and long-stay units in week 15.
• There were 41 open clusters associated with all residential institutions at the end of week 15. There were no new outbreaks in this setting notified in week 15.
• At the end of week 15, in specific residential institution settings:
  o There were 15 open outbreaks in centres for disabilities, compared with 22 in week 14.
  o There were 2 open outbreaks in mental health facilities, compared with 3 at the end of week 14.
  o There were 4 open outbreaks in Children’s / TUSLA residential centres, compared with 5 the previous week.

Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:
• There were 14 new outbreaks reported in vulnerable populations in week 15.
  o There were 10 new outbreaks associated with the Irish Traveller community notified in week 15, which is the same as in week 14; there were 151 open outbreaks at the end of week 15.
  o There was 1 outbreak in the Roma community in week 15, with 13 open outbreaks.
  o There were 2 new outbreaks in Direct Provision Centres in week 15, compared with none in week 14. There were 9 open outbreaks by the end of week 15.
There was 1 outbreak notified in homeless facilities in week 15. There were 7 open outbreaks by the end of week 15.

Outbreaks associated with school children, universities/colleges, and childcare facilities:
- There were 11 outbreaks newly notified in childcare facilities, with 70 open outbreaks remaining by the end of week 15. There were 26 new cases notified in these settings in week 15.
- There were 5 outbreaks newly notified associated with school children and/or staff in week 15, with 10 new cases notified in this week. This compared with 14 outbreaks in the previous week.
- There were 2 new outbreaks associated with university/college/third-level settings/students in week 15, with 20 outbreaks remaining open by the end of week 15.
- Based on the latest data on testing in schools over the period of 11th – 17th April 2021 (week 15), 535 tests were completed in 31 primary schools resulting in a 2.2% positivity rate and 206 tests were completed in 18 post-primary facilities resulting in a 0.5% positivity rate. In total, 127 tests were carried out in special education settings with a 1.6% positivity rate. In total, 869 tests were completed in 42 childcare facilities resulting in a 4.0% positivity rate.
- The number of cases detected, positivity rates, and numbers of cases associated with outbreaks in schools remain low despite intense oversight and 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 16 workplace outbreaks reported in week 15 across a variety of settings, a decrease from 18 identified in week 14. Of these, 7 outbreaks were in commercial settings, 3 were in construction settings, 3 were related to food production settings, 1 in manufacturing, 1 in an office-based setting, and 1 in another workplace setting.

The Chair thanked the DOH, the HPSC, and the IEMAG for their updates and invited observations from the NPHET Members.

The NPHET noted that the epidemiological situation in Ireland remains concerning but is currently stable or improving. Disease incidence, while still high, is stable although there is a level of uncertainty given case counts in recent days, especially given the 617 cases notified today (22nd April), along with any potential impact over the coming weeks due to the easing of measures that occurred from 12th April.

The numbers of confirmed cases in hospital, confirmed cases in ICU, and deaths are stable or decreasing. While some indicators of mobility have been increasing, levels of close contacts in the population have continued to hold constant. We have observed the significant impact of vaccination in protecting healthcare workers and older persons in long-term residential care facilities and we are beginning to see the early effects in those aged 75 years and older in the community. While there is strong evidence of the protective effect from vaccination in those who have been immunised, the population is largely not yet protected. As such, the situation remains fragile and any increase in close contact represents a significant risk.

It was also noted that the HSE has established a National Oversight Group for Variants of Concern in collaboration with health service colleagues in Northern Ireland. The group is preparing a report for the DOH Expert Advisory Travel Group (EAGT) at present. One of the group’s primary concerns is where those applying for international protection isolate or quarantine on arrival.

The Chair thanked the Members for their contributions and noted that their observations on the epidemiological situation would inform the NPHET’s planned deliberation on future measures, placed at item 5(a) on the agenda.

3. Review of Existing Policy
a) Updated Visitation Guidance for LTRCFs
The HSE (AMRIC) presented the paper “COVID-19 Guidance on visits to Long-Term Residential Care Facilities (LTRCFs) V2.1: 20th April 2021”, for decision.

The guidance document aims to support providers in fulfilling their obligations by giving guidance to management, staff, residents, and relatives to balance the risk of COVID-19, while facilitating visitation. The guidance, therefore, provides for increased contact between residents and their families and friends, with changes placing greater emphasis on the harm associated with visiting restrictions and the rights of residents to maintain meaningful contacts, while also stressing that vigilant, general infection prevention and control (IPC) measures, and risk assessment requirements are to remain in place.

The revised visitation guidance continues to build on learnings from the positive impact of the vaccine rollout nationally and internationally and will provide enhanced opportunity for visiting in nursing homes and other LTRCFs as we continue to see the benefits from the vaccine rollout across the community.

Although the situation in nursing homes and other LTRCFs has greatly improved, the guidance notes that there is a continued risk of introduction of infection, even with a high level of vaccination. There is a particular concern about the possibility of introducing a new variant, against which the vaccine may be less effective. Therefore, caution remains appropriate. Notwithstanding this, the experience of recent months gives confidence that visiting can now be managed safely at all Government Framework levels. Therefore, the level of visiting in the guidance is no longer directly linked to the level of the Framework of Restrictive Measures in effect. In continuing the incremental approach towards a more normalised situation, visiting is now being framed as routine visiting rather than visiting on general compassionate circumstances. The level of visiting is, however, dependent on the level of vaccination amongst residents in a LTRCF, risk assessment, and the HSE’s (AMRIC) guidance.

The paper contained the following key changes:
- Routine indoor visiting in the absence of a high level of vaccination of residents (to 2 visits by 1 person per week).
- Routine indoor visiting in the presence of a high level of vaccination of residents (to 4 visits by 2 people per week).
- Routine visiting in the context of an outbreak when appropriate control measures are in place and the situation has stabilised (to 1 visit by 1 person per week).

The guidance will come into effect on 4th May, thereby allowing LTRCFs, residents, and their families and friends time to prepare for the change.

The Chair thanked the HSE (AMRIC) for its work and invited the NPHET Members to share their observations. Key points made by the Members were as follows:
- It was suggested that messaging that promotes exercise and activity for older people and others who have been shielding should be incorporated into the communications around the guidance. The HSE confirmed that outdoor visiting is encouraged in the guidance and that the recently updated general for long term residential care facilities place an emphasis on the resumption of social activities, where possible, in nursing homes.
- As noted on 11th March, a user-friendly document should be developed for residents and families/friends to accompany the guidance.

Action: The NPHET endorsed the HSE’s (AMRIC) latest “COVID-19 Guidance on visits to Long-Term Residential Care Facilities (LTRCFs) V2.1: 20th April 2021” to facilitate the further easing of visiting restrictions in long-term residential care facilities in the context of COVID-19 vaccine uptake in such settings. The NPHET noted that operationalisation of same for applicable facilities will take a week (4th May).
4. HIQA Expert Advisory Group

a) Public health measures and strategies to limit the spread of COVID-19

The HIQA presented the paper “Public health measures and strategies to limit the spread of COVID-19: an international review – 20th April 2021”, for discussion. The review focused on the national response to COVID-19 in 19 countries that were identified by the NPHET as being in a similar phase of pandemic response as Ireland and is accurate as of 16th April 2021. The key points are outlined below:

- Public health measures are currently being applied across all countries included in this review, either nationally, regionally or a combination of both. Most countries continue to operate at the highest level of their respective risk framework, if applicable. Although the measures that are being applied are largely consistent, there are many differences in the detail between countries. The more prominent differences between countries include how movement is restricted (for example, curfew hours and travelling distances permitted); numbers permitted at gatherings, events, religious services, and sporting activities; and the operating hours of businesses allowed to open within the hospitality sector. The situation remains extremely fluid with gradual easing of current restrictions well underway in some countries, particularly in those with high levels of vaccination coverage. However further restrictions have been reintroduced regionally or nationally in some countries as a result of deteriorating epidemiological indicators.

- Most countries broadly saw a reversal of the effects of the most recent increase in coronavirus cases from December (2020)/January (2021). However, the latest epidemiological data shows an increase in the 14-day incidence rate per 100,000 population over the previous seven days in Germany, the Netherlands, Portugal, Spain, and Sweden. A small number of countries, including Austria, Germany, Norway, and Sweden, have seen an increase in the 14-day death rate per million population over the previous seven days, while the rate of hospitalisations and admissions to intensive care increased in several countries. Each of the included countries have begun vaccinating people against COVID-19. To date, Israel and the UK have had the highest reported number of vaccine doses administered per 100 population of the included countries. Reassuringly, the epidemiological situation in these countries continues to improve; for example, the 14-day incidence rate of new cases per 100,000 population declined on 18th April 2021 by 30.2% and 22.2% over the previous seven days in Israel and the UK, respectively.

- As a national strategy, individuals displaying symptoms consistent with COVID-19 are prioritised for testing in each of the countries included in this review. In Austria, Czechia, Denmark, England, France, Germany, Portugal, and Israel, however, testing is provided for anyone that requests a test, irrespective of the presence of symptoms.

- High-risk groups based on pre-existing conditions, age or setting are specifically prioritised in the national strategies of 12 of the 19 countries. All countries have expanded testing to include screening of asymptomatic individuals in certain situations. This is mostly aimed at frontline staff and residents of care facilities or healthcare users. For example, serial testing is conducted on staff and or residents in long-term care facilities, while some provide tests to visitors to long-term care facilities. Screening programmes are also being implemented in non-healthcare settings, such as in education settings and critical industries. Two countries have implemented population wide testing while nine countries have a strategy to implement regional or community wide testing in a range of settings including workplaces and schools in the event of an increased incidence or in high-risk communities. Testing based on either unsupervised self-test (sample and test processing by patient) or self-sampling (sample collected by patient, but test processed by trained staff) is in widespread use in eight of the 19 countries included, with a pilot study underway in the Netherlands.

The HIQA acknowledged that although a comprehensive search of international resources was undertaken, it is possible that the sources identified in this review are not current or do not accurately capture all public health measures and strategies that are being undertaken at the present time. It also noted that comparisons of epidemiological data across countries are difficult for a number of reasons, including differences in metrics, definitions and strategies adopted.
The Chair thanked the HIQA for its work, noting that the report will inform the NPHET’s deliberations on future national public health measures, under item 5(a).

5. Future Policy
   a) Future Measures
The Chair outlined that the NPHET’s discussion under this item would serve to frame its deliberations and decisions in relation to the potential easing of public health measures at its next meeting, where it would be required to agree its advice to Government in relation to the coming period.

The Chair noted that the NPHET now had significant cause for hope regarding the possibility of initiating the safe and gradual reopening of certain sectors of society. The rollout of vaccinations, and in particular the protection afforded by vaccinating the most vulnerable cohorts of the population, should now inform considerations in relation to the risk posed by COVID-19 in Ireland. While accepting the provisos and caveats around the limitations of vaccination and the possible impact of new variants, the NPHET should consider the impact of the protection afforded by vaccination both at a collective population level and at an individual level. The recent ECDC guidance (as presented under item 5(b)(i)) is relevant to NPHET considerations in this area.

The Chair also noted that while the return of certain high-risk activities (e.g., mass gatherings, indoor hospitality) remains extremely difficult to plan for, the NPHET can begin to be ambitious in its advice on the types of activities that could return safely in the near-term. The Chair cautioned however, that the risk of reopening too many sectors of society too quickly, and the resulting impact on disease transmission and harm to public health, remains.

The Chair invited the DOH to give a brief presentation to frame the discussion on future measures. This presentation included:
   • Summary of the current position, including scheduled reopening of certain sectors during the month of April.
   • General principles/considerations for reopening and criteria in the Government plan.
   • An overview of the types of activities that fall for consideration.
   • Vaccine Dividend – measures already agreed and areas for further consideration.

The Chair thanked the DOH for this input and opened the discussion to the NPHET Members, stressing that NPHET advice would continue to be provided on a consensus basis, and noted the importance for all Members to contribute to the discussion.

The ensuing discussion can be summarised under a number of broad themes as follows:

Incremental, sustainable return of safe activities:
   • There was consensus around the proposed approach to reopening as outlined by the Chair in his opening remarks.
   • Members agreed that there were no ‘zero harm’ option, noting that both the disease and impact of restrictions have the potential to result in harm. The challenge for the NPHET is to identify the activities that could be recommended to return, which would ensure the greatest public benefit with the least amount of risk.
   • Several Members stated that reopening should proceed on an incremental basis and in such a way that it is sustainable in the long-term across all sectors.
   • There was consensus that the NPHET should strongly consider increasing opportunities for outdoor socialisation, including visits to private gardens, accompanied by clear public health messaging around how this can be done safely. The circumstances that would enable the return of inter-county travel must also be reflected upon.
   • The NPHET agreed that a return of congregated indoor socialisation could not be contemplated until a later date.
**Ongoing need for Non-Pharmaceutical Interventions (NPIs):**

- The NPHET agreed that NPIs would continue to be required for the period ahead. Notwithstanding the increasing impact of population-wide vaccination on disease transmission, daily case numbers remain high and the premature lifting of NPIs would result in significant numbers of hospitalisations and admissions to ICU.
- There was consensus that a 4th wave of cases could not be tolerated, with Members referencing the severe fatigue and fragility across the health system’s frontline since the 3rd wave in January 2021, and the priority of ensuring that schools remain open.
- Members noted the usefulness of the ‘Swiss Cheese’ model when communicating the importance of all NPIs in reducing transmission of COVID-19 and referenced the UK’s recent public communications during its vaccination rollout which emphasised the ongoing importance of NPIs. While vaccination will increasingly become a positive feature of preventing transmission of COVID-19 as part of this model, other NPIs will continue to play a vital role in keeping transmission low in the coming months.
- Members agreed that advice around social distancing must be maintained and stressed that advice for people to work from home, where possible, should be restated.
- Some Members raised the need for continued attention around building ventilation in the context of reopening certain sectors, noting the importance of ventilation in preventing onward transmission as part of a broad suite of public health measures.

**Public Health Communications & Coherency of Measures:**

- The NPHET acknowledged the significant efforts undertaken by the public throughout the past year, noting that the overwhelming majority has adhered to restrictions to protect the core priorities of health and education. It was also noted that the public has a much better understanding now of the risks associated with COVID-19 and public health advice than at the beginning of the pandemic and are better placed to undertake their own risk assessments of situations and activities.
- The NPHET cautioned that anticipatory behaviour within the population is growing, with levels of worry as low as those seen during the summer of 2020. Members suggested the need to ensure that future measures encourage renewed compliance among individuals who may be engaging in anticipatory behaviour at present.
- Members drew attention to the need for measures to have a logical coherence as the relaxing of restrictions proceeds, noting the importance of this for ensuring ongoing public support and adherence. Inconsistencies or perceived inconsistencies in the overall suite of public health guidance may negatively impact on this support and adherence, particularly given the public’s acquired experience on what kinds of behaviours pose the greatest risks to increasing transmission. The perceived inconsistency between permitting outdoor socialisation in a public park but not allowing visits to private gardens was noted.
- The Chair acknowledged that public health messaging would need to evolve as restrictions begin to be relaxed. Messaging at population level will need to transition to the promotion of positive, individual-level public health behaviours as restrictions are relaxed. Certain core messages (e.g. social distancing, mask wearing, hand-washing, the need to maintain R close to 1) will need to be maintained over the coming months.
- The NPHET agreed that a refreshed, cross-governmental communications campaign may be required to educate and empower people around safe socialisation over the coming months. This should include the refreshing of communication tools in public areas such as outdoor parks and recreational facilities. It was also noted that some of the principles that have underpinned the response to date should continue to form part of communications e.g. the importance of solidarity.

**Vaccination:**

- The NPHET noted the significant role vaccination will play in ensuring the safe reopening of society in the long-term at an individual and societal level, while acknowledging the need for caution in approaching this issue given the unknown impacts that new variants of SARS CoV-2 may have.
• Members noted the need for clear public communications around the benefits of vaccination, and that testing positive post-vaccination should not be interpreted as a ‘vaccine failure’. Clear communications around dosage requirements to ensure full vaccination will also be particularly important for those who have had only one dose of a two-dose vaccine.
• The NPHET stressed the importance of having a robust vaccine efficacy surveillance programme in place to support the ongoing reopening of society, noting that work is underway to ensure that this information is provided on an ongoing basis.

Testing:
• The NPHET noted the importance of a continued robust testing programme for COVID-19 as society begins to reopen, including the development of more access pathways to testing (e.g. walk-in centres) and in relation to antigen testing.
• Members noted that the HSE is planning for the launch of a self-referral testing service whereby individuals can book their test online. This was welcomed by Members, noting the empowerment members of the public report by being able to easily avail of a test through walk-in centres.

Measures targeted at specific groups:
• Several Members referenced the need to ensure that older persons who have been fully vaccinated continue to derive benefits as a result that improve their quality of life. Consideration should be given to how activities that many older people normally engage in (e.g., social clubs, bridge clubs) can be safely restarted.
• Consideration should also be given to how religious services might be safely restarted, noting their importance to many older people, while acknowledging the risks that may persist in these settings for those who are not yet protected from COVID-19 through vaccination.
• The NPHET acknowledged the significant impact that the pandemic has had on the lives of younger people, noting the difficulties associated with being isolated and engaging in online learning. Members suggested the need to develop tailored supports for younger people to promote safe socialisation during the summer months.

Alcohol & Individual’s risk behaviours:
• Several Members drew attention to the influence that alcohol can have on an individual’s behaviour and perception of risk when socialising which can, in turn, increase the risk of transmission of COVID-19. In many instances, well-planned events which adhere to public health guidance are followed by unsafe gatherings where guidance is not adhered to.
• Members referenced the need for strong messaging around the contributing role that alcohol can play to the risk of transmission and the possible need for stronger enforcement around alcohol in public settings.

The Chair thanked the NPHET Members for their contributions and briefly summarised the discussion.

The Chair restated Ireland’s success over previous months at being able to ensure the full, safe return of education. Compared to when the NPHET contemplated easing restrictions prior to the summer of 2020, the relative protection afforded to the population through widespread vaccination must be acknowledged, both at population-level and in terms of the dividend experienced by fully vaccinated individuals.

While the detail of the proposed advice to Government in relation to which specific activities should be facilitated to recommence will be discussed and agreed at the next NPHET meeting, the Chair noted the NPHET’s broad consensus from the discussion that a limited number of activities should be facilitated to recommence, and with a particular focus on outdoor activities. The Chair requested that all NPHET Members reflect further individually on the specific activities that should be recommenced over the coming period prior to final discussion of the issue at the next NPHET meeting.

b) Vaccination
i. **ECDC Update – Vaccination Impact**

The DOH presented a review of the ECDC publication “Interim guidance on the benefits of full vaccination against COVID-19 for transmission and implications for non-pharmaceutical interventions- 21st April 2021”, for noting.

Based on the data available, the ECDC review noted the following key points:

- As vaccine efficacy is high for all currently licenced COVID-19 vaccines in the EU/EEA, the likelihood of infection in a fully vaccinated individual following exposure to COVID-19 is assessed to be very low.
- The risk of developing severe disease for a fully vaccinated individual is very low in younger and middle-aged adults with no risk factors for severe disease, and low in older adults or people with underlying risk factors.
- Based on limited evidence, the likelihood of an infected vaccinated person transmitting the disease is very low to low.
- The impact of infection if transmitted by a fully vaccinated person to an unvaccinated contact is low for younger and middle-aged adults and high for older adults or people with underlying comorbidities.
- There is a degree of uncertainty regarding duration of protection provided by vaccination.
- There is uncertainty regarding the possible protection that available vaccines provide against emerging COVID-19 variants.

The ECDC made the following recommendations:

- When fully vaccinated individuals meet other fully vaccinated individuals (very low/ low risk), physical distancing and the wearing of face masks can be relaxed.
  - On this point, the DOH also highlighted, for the benefit of the NPHET, the CDC’s guidance, as follows: Fully vaccinated people can visit with unvaccinated people from a single household, who are at low risk for severe COVID-19 disease indoors without wearing masks or physical distancing.
- When unvaccinated individuals meet fully vaccinated individuals, physical distancing and the wearing of face masks can be relaxed if there are no risk factors for severe disease or lower vaccine effectiveness in anyone present (e.g. older age, immunosuppression, other underlying conditions).
- When contact tracing, health authorities may consider undertaking a risk assessment on a case-by-case basis and subsequently classify some fully vaccinated contacts as low-risk contacts, taking into account the local epidemiological situation in terms of circulating variants, the type of vaccine received, and the age of the contact and the risk of onward transmission to vulnerable persons by the contact.
- Requirements for testing and quarantine of travellers and regular testing at workplaces can be waived/modified for fully vaccinated individuals as long as there is no very low level circulation of immune escape variants (in the community in the country of origin, in the case of travellers).
- In the current epidemiological context in the EU/EEA, in public spaces and in large gatherings, including during travel, non-pharmaceutical interventions (NPIs) should be maintained irrespective of the vaccination status of the individuals.
- Countries considering relaxing measures for fully vaccinated people should take into account the potential for uneven inequitable vaccine access across the population.

The ECDC guidance noted that in settings of high circulation of immune escape variants or if individuals in this category have risk factors for severe disease, regardless of age, the risk will be enhanced, and a relaxation of measures may not be appropriate.

The NPHET agreed that while it remains important to highlight the benefits of the vaccine to those who have received it, it is equally important to communicate its limitations. A vaccinated person may still become infected with COVID-19 and could potentially spread it to others and, therefore, it is important that non-pharmaceutical interventions such as social distancing continue to be practiced while incidence in the community remains high. Caution in this regard is particularly important in acute and residential settings, where there is a particular concern about the possibility of introducing a new variant, against which the vaccine may be less effective.
The NPHET was also cognisant of the fact that research into the duration of immunity provided by the vaccine or post infection remains ongoing.

The Chair thanked the DOH for presenting the ECDC’s update and the NPHET noted same

ii. Update on Vaccination Programme

The HSE gave an update on the national COVID-19 Vaccination Programme. Key points made were as follows:

- Approximately 1.2 million vaccines have been administered, with over 877,000 people having received their first dose.
- Vaccination of the long-term residential care facilities (LTRCFs) sector is substantially complete. The protective effect of vaccination on residents and staff in LTRCFs is evidenced by the significant drops in outbreaks and mortality associated with these settings, as reported through the HPSC.
- The proportion of overall cases occurring among healthcare workers (HCWs) has dropped significantly from 16% in January 2021 to 3%; this is likely due to the protective effect of vaccination. Rates of healthcare worker absenteeism have also decreased significantly since January.
- Cohort 3 of the vaccination prioritisation framework schedule, comprising those aged ≥70 years, will largely finish receiving their first dose next week. Given that mRNA vaccines are being used among this cohort, full vaccination of this cohort is expected to be completed in a month’s time.
- The vaccination of cohorts with one or more of ten underlying conditions placing them at severely high risk of adverse consequences of COVID-19, as specified in the vaccination prioritisation schedule, is ongoing. There are challenges to completing vaccination of this cohort given their dispersal across GP practices, community vaccination centres, disability centres, and long-term mental health facilities. Moreover, implementation of the Vaccination Programme among this cohort has had to adapt to the temporary suspension of the use of the AstraZeneca vaccine for those under the age of 60. During this period, individuals with underlying conditions under the age of 60 were offered mRNA vaccines.
- This week, the vaccination registration portal for individuals aged 60-69 years was opened with significant uptake observed. It is expected that first doses will be fully completed among those aged 65-69 years in the next 3-4 weeks.
- Throughout the rollout, certain groups (e.g. housebound individuals) have required targeted supports to ensure that they can avail of vaccination. Schemes to ensure this have been developed.
- The HSE concluded its summary by reminding the NPHET of the significant operational and logistical challenges entailed in the implementation of the Vaccination Programme. Finally, the HSE thanked the National Immunisation Advisory Committee (NIAC) and the DOH for their ongoing support during the implementation of the Vaccination Programme, particularly in fielding queries from the public and media regarding recommendations on the use of vaccines.

Members queried whether there are data available on rates of refusal/consent to vaccination among each cohort. The HSE outlined that, while refusal/consent data are not available, rates of registration for vaccination among 65–69-year-olds as compared with CSO population estimates, suggest that the great majority of individuals in this cohort wish to receive a vaccine.

The Chair thanked the HSE for its update, and concurred that recent events reinforced the value and necessity of the working processes of the NIAC regarding vaccines. The Chair thanked the Members for their contributions and concluded the discussion on this item.

iii. Vaccine Safety Update

The HPRA provided a verbal update on the national reporting experience for COVID-19 vaccines, stating that the HPRA safety report would be published on the HPRA website on 22nd April and provided to the NPHET at its next meeting.
The HPRA also updated the NPHET regarding the European Medicines Agency’s (EMA) ongoing review of Vaxzevria® (formerly COVID-19 Vaccine AstraZeneca), specifically its review of vaccination data and data on disease epidemiology, to enable authorities to put the risks of Vaxzevria® in the context of the benefits of the ongoing vaccination campaigns. The EMA is also considering available evidence to inform any possible updates to recommendations for the second dose of Vaxzevria® in those who have already received their first dose.

The EMA has concluded that thrombosis with thrombocytopenia occurring in association with COVID-19 vaccine Janssen®, should be listed as very rare adverse reactions of the vaccine, with a warning added to the product information. This information has been published on the EMA website, and a direct healthcare professional communication (DHPC) will also be disseminated.

The NPHET Members queried whether cases of Bell’s palsy post-vaccination were still being reported to the HPRA. The HPRA confirmed that reports were still being received, but the numbers were small and as there was no significant safety concern, it was decided to not continue specific updates to the NPHET, at this point.

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

6. Communication Update

The DOH and the HSE presented “Agenda Item 6 – Communications Update: 22nd April 2021”, for noting.

With regard to the Quantitative Tracker, the nationally representative sample of 2,200 people conducted on behalf of the DOH by Amárach Research on 19th April 2021 has revealed:

- The level of worry is at 5.7/10, back to the levels seen last Summer.
- Concern for the health of family and friends, the economy, and prolonged restrictions are now the highest source of worry.
- The majority, 57% now believe the worst of the pandemic is behind us, 19% believe it is happening now, and 9% believe it is ahead of us.
- 35% think Ireland is returning to normal too slowly, 44% think it is at about the right pace. 21% think it is too quick.
- People are disengaging from COVID-19-related news.

With regard to the Vaccine Quantitative Tracker:

- 53% of the population know someone in their immediate social circle, who has had COVID-19.
- 86% (68% definite, 18% probable) say they will get the COVID-19 vaccine when it is offered to them.
- 44% say they have concerns about the vaccine - 37% are worried about side effects of the vaccine, 23% worried about the long-term effects on health.
- GPs are the most trusted source of information on the vaccine for 72% of the population, followed by the HSE (51%), DOH (50%), and Pharmacists (42%).

The DOH also presented feedback from the qualitative tracker, which included information from focus groups among working parents and in-depth interviews with older people.

With regard to communications campaigns underway, particular attention was drawn to the establishment of the SciComm Collective, a group of young science communicators to communicate information on the virus and the vaccine to their peers via social media. With regard to campaigns in development, a vaccine booklet is being developed.

The NPHET thanked the DOH and the HSE for the above update and noted same.

8. Meeting Close

a) Agreed actions

The key actions arising from the meeting were examined by the NPHET, clarified, and agreed.
b) AOB
There were no matters raised under this item.

c) Date of next meeting
The next meeting of the NPHET will take place Wednesday 28th April 2021, at 10:00am via video conferencing.