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

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Wednesday 28th April 2021, (Meeting 86) 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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</tbody>
</table>

Dr Ronan Glynn, Deputy Chief Medical Officer, DOH  
Dr Kevin Kelleher, Assistant National Director, Public Health, HSE  
Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)  
Dr Cillian de Gascun, Laboratory Director, NVRL  
Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA  
Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital  
Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE  
Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH  
Dr Mary Favier, Immediate past president of the ICGP, Covid-19 advisor  
Dr Michael Power, Consultant in Anaesthetics / Intensive Care Medicine, Beaumont Hospital  
Ms Rachel Kenna, Chief Nursing Officer, DOH  
Ms Tracey Conroy, Assistant Secretary, Acute Hospitals Policy Division, DOH  
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  
Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH  
Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH  
Dr Breda Smyth, Public Health Specialist, HSE  
Dr Kathleen MacLellan, Assistant Secretary, Social Care Division, DOH  
Ms Deirdre Watters, Communications Unit, DOH  
Dr Elaine Breslin, Clinical Assessment Manager, HPRA  
Mr Liam Woods, National Director, Acute Operations, HSE  
Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway  
Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications  
Prof Mary Horgan, President, RCPI  
Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)  
Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;  
Mr Colm Desmond, Assistant Secretary, Corporate Legislation, Mental Health, Drugs Policy and Food Safety Division, DOH  
Dr Anna-Rose Prior, Consultant Microbiologist, Tallaght University Hospital  
Dr Martin Cormican, HSE National Antimicrobial Resistance and Infection Control (AMRIC)  
Dr John Cuddihy, Interim Director, HSE HPSC  

### Members via videoconference

Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI  
Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH  
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Dr John Cuddihy, Interim Director, HSE HPSC

### '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  
Ms Aoife Gilivian, Communications Unit, DOH  
Dr Desmond Hickey, Deputy Chief Medical Officer, DOH  
Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH  
Ms Sarah Gleave, Health Protection Coordination & Support Unit, DOH  
Ms Sheona Gillesen, Senior Health Data Analyst R&D & Health Analytics Division, DOH  
Mr Aaron Rafter, NPHET Policy Unit, DOH

### Secretariat

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

### Apologies

Dr Colm Henry, Chief Clinical Officer, HSE  
Dr Darina O’Flanagan, Special Advisor to the NPHET

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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 Colm Henry and Dr Darina O’Flanagan.

c) Minutes of previous meetings
   The minutes of 15th 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
   The Chair emphasised the need for confidentiality around NPHET deliberations. The Chair also reminded Members that care must be taken to allow NPHET recommendations to be communicated in an appropriate manner, adding that the ability of the NPHET to do this is undermined if inaccurate and incomplete information is shared with the public prematurely.

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 3,205 cases have been notified in the 7 days to 27th April 2021, which is a 23% increase from the last NPHET meeting on 22nd April when 2,612 cases were notified in the 7 days to 21st April.
   • As of 27th April, the 14-day incidence rate per 100,000 population has increased to 122; this compares with 113 at the last NPHET meeting. The 7-day incidence per 100,000 population has increased to 67, from 55 at the NPHET meeting on 22nd April.
   • Nationally, the 7-day incidence as a proportion of 14-day incidence is 55%, demonstrating that there have been more cases in the last 7 days, 21st – 27th April, compared with the preceding 7 days, 14th – 20th April.
   • The 5-day rolling average of daily cases has increased from 376 on 21st April to 437 on 27th April.
   • Incidence is increasing or stable across all age groups with the largest increases observed in those aged 13-18, 19-24 and 25-39 years. While incidence has increased in those aged 13-18 years since schools reopened (associated with a much larger increase in referral for testing), there has been very little change in incidence in those aged 0-12 years.
   • Of cases notified in the past 14 days, 14th – 27th April, 73% have occurred in people under 45 years of age and 5% were aged 65 years and older. The median age for cases notified in the same period is 31 years. Incidence in those aged 65 years and older is now significantly below the population average. This is likely due first to reduced social mixing in this age group in recent weeks and an emerging vaccine effect in the older age cohorts.
   • While 14-day incidence rates remain high across the country, 13 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 compared with the previous 7 days.
   • Of the 5,831 cases reported in the last 14 days, 14th – 27th April, 2.6% (151) were healthcare workers.
   • The best estimate of the reproduction number (R) is 1.0-1.2. The rate of growth of the disease is currently at 0% to +2%.
   • There were 118,454 tests undertaken in the last week (as of 27th April). The 7-day average test positivity rate remains stable at 2.8% on 27th April, the same rate observed at the last NPHET meeting.
   • Excluding acute, serial, and mass testing in response to outbreaks, the community test positivity rate has decreased since the last NPHET meeting; the rate was at 7.5% over the 7 days to 25th April.
• According to Contact Management Programme data, only 2 counties have a community positivity rate (excluding acute, serial, and mass testing in response to outbreaks) greater than 10%; 17 counties have a community positivity rate greater than 5%.
• According to Contact Management Programme data from 12th-18th April, where results were available for Test 1, 14.6% (788/5,415) were positive. Household close contact positivity rate was 31.0%.
• According to Contact Management Programme data from 5th-11th April, where results were available for Test 2, 6.7% (133/1,972) were positive. Household close contact positivity rate was 11.5%.
• As of the morning of 28th April, there were 153 confirmed COVID-19 cases in hospital, compared with 176 on 22nd April. There have been 17 newly confirmed cases in hospital in the 24 hours preceding the morning of 28th April.
• As of 28th April, there are currently 45 confirmed cases in critical care, compared with 48 on 22nd April. There have been 2 admissions in the previous 24 hours.
• To date, there have been 63 deaths notified with a date of death in April. This compares with 232 and 868 deaths notified (to date) with a date of death in March and February, respectively. Of the 63 deaths in April to date, 15 have thus far been associated with hospital outbreaks and 4 have been associated with nursing home outbreaks.
• In total, 71 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 from Brazil) have been identified in Ireland to date.
• Other variants of note/under investigation that have been confirmed in Ireland to date: 20 B.1.525 cases, 15 P.2 cases, 8 B.1.617, 6 B.1.526 cases, 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 24th April 2021. Week 16 refers to 18th – 24th April 2021 and data are restricted to cases and outbreaks notified since 22nd November 2020.

Healthcare setting outbreaks:
• There were 3 new outbreaks notified in acute hospitals in week 16 of 2021. At the end of week 16, there were 22 open clusters, a 15% decrease on the 26 open outbreaks in week 15.
• There were no new clusters notified in a nursing home in week 16; this compares with 1 new outbreak in week 15. There was 1 new cluster notified in community hospitals/long-stay units in week 16.
• At the end of week 16, there were 11 open clusters associated with nursing homes, remaining stable from week 15.
• There were 6 open outbreaks in community hospitals and long-stay units in week 16.
• There were 32 open clusters associated with all specified residential institutions at the end of week 16. There were 5 outbreaks in these settings notified in week 16, one of these outbreaks was a late notification from an outbreak in February.
• At the end of week 16, in the following specific residential institution settings:
  o 2 outbreaks were notified in centres for persons with disabilities. There were 11 open outbreaks compared with 15 in week 15.
  o There were 2 open outbreaks in mental health facilities, the same number that remained open at the end of week 15.
  o There was 1 open outbreak in Children’s / TUSLA residential centres, compared with 4 in week 15.

Vulnerable groups, Irish Traveller Community, Direct Provision, and Prison Outbreaks:
• There were 10 new outbreaks reported in vulnerable populations in week 16.
  o There were 8 new outbreaks associated with the Irish Traveller community notified in week 16, which is a decrease from 10 in week 15; there were 137 open outbreaks at the end of week 16.
  o There were no new outbreaks in the Roma community in week 16, with 13 open outbreaks.
  o There were 2 new outbreaks in Direct Provision Centres in week 16, the same as the number notified in week 15. There were 10 open outbreaks by the end of week 16.
  o There were no new outbreaks notified in homeless facilities in week 16. There were 4 open outbreaks by the end of week 16, a 43% decrease from week 15.
Outbreaks associated with school children, universities/colleges, and childcare facilities:

- There were 54 outbreaks associated with school children, universities/colleges, and childcare facilities.
- There were 22 outbreaks newly notified in childcare facilities, a 100% increase on the previous week, with 64 open outbreaks remaining by the end of week 16. There were 43 new cases notified in these settings in week 16.
- There were 31 outbreaks newly notified associated with school children and/or staff in week 16, with 82 new cases notified in this week. This compared with 5 outbreaks in week 15.
- There was 1 new outbreak associated with university/college/third-level settings/students in week 16, with 14 outbreaks remaining open by the end of week 16.

Based on the latest data on testing in schools over the period of 18th-24th April 2021 (week 16), 2,795 tests were completed in 109 primary schools resulting in a 2.4% positivity rate and 1,810 tests were completed in 70 post-primary facilities resulting in a 2.5% positivity rate. In total, 34 tests were carried out in special education settings with an 8.8% positivity rate, however it should be noted that this was from a small number of tests carried out in these settings. In total, 1,179 tests were completed in 61 childcare facilities resulting in a 4.4% positivity rate.

- The number of cases detected, positivity rates, and the number of cases associated with outbreaks in schools remains 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 9 workplace outbreaks reported with 64 cases notified in week 16 across a variety of settings, a decrease from 16 identified in week 15. Of these, 3 were in construction settings with 48 cases notified, 3 in manufacturing, 1 was related to food production settings, 1 in an office-based setting, and 1 in Defence/Justice/Emergency services settings.

Modelling Projections:
The IEMAG presented its current modelling projections to the NPHET. The IEMAG noted that there are significant uncertainties in relation to the relative transmissibility of the B.1.1.7 variant, the level of vaccine effectiveness and the level of vaccine deployment and uptake. These make it challenging to model the likely course of SARS-CoV-2 infection and significant COVID-19 disease over the coming months. The possible scenarios generated by models vary widely depending upon the assumptions made. The following key conclusions were drawn from current modelling projections:

- A phased re-opening in May and June 2021, with an emphasis on outdoor activity, is considered low-to-medium risk.
- A premature re-opening, especially one involving close indoor contact, remains very high risk over the coming 8 weeks.
- The medium-term position, with greater indoor social contact remains very uncertain, and depends heavily on assumptions used in the model, in particular regarding the increased transmissibility of the B.1.1.7 variant. Before the IEMAG can model with any reasonable degree of utility what might happen with wider reopening and indoor social contact later in the summer, further national and international data is required, and the actual impact of the phased re-opening in May and June, along with the parallel Vaccination Programme, must be observed.

It was noted that the projections and risk analyses are based on assumptions on vaccine uptake and speed of deployment. It was also noted that there is an assumption that non-pharmaceutical interventions (NPIs), e.g., reduced contacts, physical distancing, face coverings, hygiene, and ventilation, will remain in place in some form unless and until herd immunity is achieved through vaccination.

The Chair thanked the DOH, the HPSC and the IEMAG for their inputs and invited observations from the NPHET Members, noting that a substantive discussion on future public health measures would take place later in the meeting under item 5(a).
The NPHET noted that the epidemiological situation in Ireland remains concerning but is currently stable, or potentially disimproving. The recent increase in incidence is most marked in those aged 13-18, 19-24 and 25-39 years. In contrast, incidence in those aged 65 years and older is now significantly below the population average. This is likely due, in the first instance, to reduced social mixing in this group in recent weeks, along with an emerging vaccine effect in the older age cohorts. Markers of population mobility continue to increase, with presence in the workplace, and reduced time spent at home, now at levels seen in early September 2020. The mean number of close contacts per adult confirmed case is relatively stable (approximately 2.6), although there has been a recent increase in overall numbers of both close and complex setting contacts.

While there is significant evidence of the protective effect from vaccination in those who have been immunised, Ireland remains vulnerable in the coming weeks as the wider population is not yet protected through vaccination. As such, the situation remains finely balanced and any increase in close contact represents a significant risk.

Key points raised included:

- The utility of hospital admissions data was noted with regard to assessing the epidemiological situation, in particular data on the geographic location of those hospitalised, the profile of those admitted and their length of stay.
- The NPHET noted a number of recent workplace outbreaks that have involved a younger age cohort that is highly mobile and does not appear to adhere stringently to NPIs (e.g. mask wearing and social distancing). Efforts are ongoing to work with employers to reinforce and promote these measures in the workplace. Greater accountability on the part of employers to prevent workplace outbreaks was also emphasised.
- It was reiterated that vaccination alone will not control COVID-19 in the months ahead and that there needs to be continued focus on other measures, including adherence to public health measures, testing, and robust outbreak management. It was noted that there are currently 13 walk-in test centres in operation, with plans to open further centres in train, and that the HSE is also developing an online portal for self-referral for testing.
- It was noted that there is significant work ongoing to reach out to vulnerable and hard-to-reach population cohorts. It was also noted that while significant progress is being made, all vulnerable groups and older age cohorts are not yet fully vaccinated and there is a continuing need for caution until there is a wider level of protection across the population.

The Chair thanked the Members for their valuable observations, noting their relevance to the planned discussion on future measures under item 5(a).

3. Review of Existing Policy
   a) Update on Contact Tracing Guidance


The HPSC outlined that the document summarises interim recommendations for changes to contact tracing guidance with respect to asymptomatic close contacts (excluding healthcare workers), who are fully vaccinated. The guidance has been informed by:

- The ECDC Technical Report “Interim guidance on the benefits of full vaccination against COVID-19 for transmission and implications for non-pharmaceutical interventions”.
- The ECDC Technical Report “Risk of SARS-CoV-2 transmission from newly infected individuals with documented previous infection or vaccination”.

5
The CDC Science Brief “Background Rationale and Evidence for Public Health Recommendations for Fully Vaccinated People” and CDC “Interim Public Health Recommendations for Fully Vaccinated People”.

Following a brief discussion, the Chair proposed that the guidance as drafted be accepted as interim guidance, with the HPSC to further update the NPHET on how the guidance could apply to previously infected and partially vaccinated individuals at its next meeting. This was agreed by the NPHET.

Action: The NPHET endorses interim recommendations for changes to contact tracing guidance with respect to asymptomatic close contacts (excluding healthcare workers) who are fully vaccinated. Persons who are fully vaccinated should continue to adhere to all general public health advice. Persons who are fully vaccinated and who are identified as close contacts of a case of COVID-19, need not: (1) restrict their movements or (2) be tested, unless specific circumstances apply as follows:

1. Known contact with a case of COVID-19 in which the case is a Person Under Investigation, probable or confirmed variant of concern. In this situation the close contact should be managed as a close contact of a VOC.
2. If the person’s immune system response to vaccination could be compromised due to either a known medical condition or being on immunosuppressive treatment, they should be treated as a close contact - offered two tests and advised to restrict their movements. If there is any uncertainty as to whether the close contact has a medical condition or takes a treatment that would result in a sub-optimal response to vaccination, they should also be advised to restrict their movement and contact their treating physician who can advise if these recommendations apply to them.
3. A public health or occupational health risk assessment has identified other specific grounds for concern, e.g., outbreak setting.
4. The close contact develops symptoms of COVID-19, in which case they need to immediately self-isolate and be referred for one test. If the test result is negative, they can discontinue self-isolation once they are symptom free for 48 hours.

b) Update on behavioural research from ESRI

The DOH presented the ESRI Research Note “Summary of Behavioural Evidence: April 2021”, for noting. The research note summarises updated evidence from a number of behavioural studies.

The findings are arranged by the following research questions:

1. How does the behavioural response compare to previous stages of the pandemic?
2. What social activities have changed in recent weeks?
3. How has overall social contact changed in recent weeks?
4. What are public expectations for the easing of restrictions?
5. What are public opinions on the current level of restrictions and re-opening?
6. Do the public intend to take the COVID-19 vaccine?

The DOH noted that findings show that people have been steadily leaving their homes more and more since the end of January 2021. People are now leaving their homes more than in the period prior to Christmas and more than they have at any point since the beginning of September 2020. While this might give some cause for concern in relation to the spread of the virus, it is important to understand that this measure does not indicate what activities people are leaving their homes to undertake. In particular, better weather may mean that much of the increased activity relative to the period prior to Christmas is concentrated outside rather than inside.

The findings also suggest that people’s individual level of worry about the virus is strongly and consistently associated with their behaviour. The level of worry and self-reported compliance has now fallen to its lowest level since Summer 2020, with a particularly steep fall in recent weeks. Importantly, the decline is not driven by people abandoning the guidelines but rather reflects the reality that more and more people are gradually ‘pushing the boundaries’ on measures currently in place, as evidenced by the fact that people who were previously reporting compliance at 7-out-of-7 are now more likely to respond with a 6, or even a 5. It remains
the case that very few give a lower score. The DOH noted that previous work has shown that the perceived coherence of the restrictions is important for maintaining compliance.

Overall, there has been a clear increase in multiple kinds of social activity in recent weeks. Of most concern is the increase in social visits to homes, which generally do not involve protective behaviours. On a positive note, however, the upward trend in risky home visits levelled off towards the end of March, perhaps reflecting the focused messaging on the need to avoid indoor interhousehold mixing earlier in March.

The ESRI found that the majority (53%) of the public still believe the general approach to reopening is appropriate, however a growing minority (23%) think that the reaction of the Government is too extreme. The population appears to expect a slow reopening, with the majority expecting a further easing of restrictions in May but expecting it to be at least 9 months before all restrictions are eased.

There is a high level of acceptance among the public for the COVID-19 vaccine, with over 80% of the population saying they will take the vaccine when offered. Concerns are mostly about the possible side effects. There is indication that the recent information and public debates in relation to possible blood clots have had an impact on public perceptions and perhaps intentions, however these effects are small in comparison to the rising trend in willingness to take the vaccine that has occurred since before Christmas.

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

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

5. Future Policy
   a) Future Measures
The Chair noted the considerable progress that has been made in reducing infection levels since the peak of the recent wave of infection as a result of the widespread commitment and adherence by the public to the range of public health measures in place since the start of the year. The Chair further noted the significant progress being made in relation to the rollout of the Vaccination Programme, especially for those who are most vulnerable to the severe impacts of COVID-19. The protection provided by vaccination is already changing the relative risk profile at a population level and will continue to do so over the coming weeks and months as a greater proportion of the population is vaccinated.

The Chair also noted that, in the interim, it will be important to communicate how public health measures and other non-pharmaceutical interventions (NPIs) such as testing will complement the Vaccination Programme instead of being replaced by it. The Vaccination Programme will be most effective while working in tandem with NPIs to drive down transmission. It was cautioned that a 4th wave of infection is still possible. Therefore, it is vital that all measures are taken to reduce the likelihood of this occurring or to, at least, mitigate its impact.

The Chair remarked that we are entering a transition period where the focus of controlling the pandemic will move gradually from legal provisions and enforcement powers towards an emphasis on guidance and empowering the public by providing advice on safe behaviours. In this regard, good communications will be vital as messaging becomes more nuanced. Messaging will shift from what cannot be done to what can safely be done, and, potentially, there will need to be different guidance for those who have been vaccinated compared to those who are unvaccinated.

The Chair invited the NPHET Members to consider whether, in the current epidemiological context, the appropriate conditions have been met to facilitate progressing with the easing of public health restrictive measures. The Chair noted the increasing level of uncertainty in relation to the trajectory of the disease as you move through the projection period and suggested that advice at this stage should focus on the immediate upcoming period; any further easing of measures beyond June should be discussed at a later date.
The Chair invited the DOH to give a short presentation to facilitate and guide the discussion. This included a summary of the key points from the discussion at the previous meeting (22nd April), the criteria in the Government Plan and the measures noted in the Plan for consideration in May. Based on the previous week’s discussion, it was proposed that:

- Advice should cover the period May and June with two phases of easing of restrictions and a suggested period of 4 weeks between phases to ensure adequate time to assess impact.
- A number of inherently high-risk activities should not be implemented in this timeframe – these will be subject to further consideration at a later date. This includes:
  - Indoor hospitality (restaurants, bars, nightclubs, casinos).
  - Indoor team/group sports including matches, training and exercise classes.
  - Mass gatherings/events (including spectators) – indoors and outdoors.
  - Advice to work from home unless absolutely necessary to be on site continues.
  - Advice to avoid non-essential international travels continues.
- A summary of the remaining measures that should be subject to consideration for the period of May and June was outlined.

The Chair proceeded to invite all Members to give their views on both the proposed general approach and timeframe for advice and on each of the specific areas that had been outlined. The key points made, and recommendations agreed during the ensuing discussion are outlined below.

**Discussion**

- There was agreement that advice should cover the period of May and June, acknowledging that it was too difficult to provide certainty beyond that point at this time. It was also agreed that there should be two phases of easing over the period.
- There was agreement that the following could proceed in Phase One - phased return of non-essential retail, personal services by appointment, cultural attractions and libraries and resumption of in-person religious services.
- The risk of indoor congregation in shopping centres was highlighted and it was agreed that, as was the case previously, measures should be in place to prevent congregation. It was agreed that Government is best placed to decide on the exact phasing for the reopening of non-essential retail.
- It was agreed that the numbers permitted to attend funeral and wedding services should be increased to 50 in Phase One to align with the recommencement of in-person religious services. It was noted that this should apply to the service element only. In the case of funerals, pre and post related events should not take place. In the case of weddings, it was agreed that the limit of 6 guests at indoor wedding receptions should be retained in Phase One while 15 could be permitted at outdoor wedding receptions. This should increase to 25 in Phase Two. While it did not form part of the final agreed advice, there was a suggestion that testing of guests be considered in future, using either antigen tests or walk in testing centres, so as to enable greater numbers to attend wedding receptions. It was also agreed that it should be advised that other religious ceremonies such as communions and confirmations should not take place at this time.
- It was agreed that organised outdoor gatherings of up to 15 people should be permitted in Phase One. Indoor gatherings and events could not be recommended over the period.
- It was agreed that in Phase One, outdoor training should be permitted for all age groups with a max. 15 persons per pod. Members agreed that it could be recommended that in Phase Two, gyms, swimming pools and leisure centres reopen, and that guidance be updated to include the wearing of face coverings in these facilities. Also in Phase Two, outdoor sports matches can recommence without spectators. Members highlighted that it will be important that sectoral bodies and sporting organisations ensure that the return of matches does not lead to linked socialisation activities before or after matches given the known risks related to these activities.
- It was agreed that numbers on public transport should increase to 50% capacity in Phase One. Transport companies should ensure that all appropriate protective measures including ventilation, social distancing, mask wearing and hygiene measures, are in place are adhered to.
• With regard to social gatherings, it was agreed that in Phase One:
  o Indoor visits (without masks or social distancing) should be permitted in private homes for vaccinated people from up to 3 households.
  o Indoor visits (without masks or social distancing) should also be permitted between vaccinated people with one household of unvaccinated people who are not at risk of severe illness.
  o It was noted that guidance has been developed and published by the HPSC in relation to visiting and this will now be updated in light of the above recommendations. It is important to note that visiting should not take place if a person has symptoms of COVID-19.
  o In addition, an increased number should be permitted to meet outdoors (in gardens or public spaces) and it was agreed that this number should be 3 households or a maximum of 6 people from any number of households. The addition of 6 people from any number of households was considered appropriate to better facilitate young adults and single person households in meeting. It was also recommended that children not be counted in this number.

• In Phase Two, indoor visits in private homes between two households should be permitted for everyone.
• In relation to hospitality, it was agreed that it be recommended that in Phase Two, outdoor service in restaurants and bars resume with a limit of 6 people per table. New guidance should be developed to facilitate the resumption of outdoor hospitality. Paid accommodation services including self-catering, hotels, B&Bs, hostels should be permitted to reopen as part of Phase Two with services limited to guests/residents. Hostels will need to risk assess the safety of communal room-sharing arrangements.
• Members then discussed the resumption of inter-county travel. While there were some concerns in relation to removing travel restrictions in addition to allowing the agreed broad range of activities to recommence, on balance, Members supported the resumption of inter-county travel in Phase One. Members noted the necessity of the public adhering to public health guidelines when undertaking inter-county travel.
• Having reached agreement on its recommendations, the Chair proposed that Phase One commence on 10th May to allow further time to fully assess the current epidemiological situation. The Chair further proposed that Phase Two commence no sooner than 7th June to allow sufficient time to assess the impact of Phase One on the epidemiological situation. The NPHET agreed to the proposed time frames and emphasised that progression to Phase Two will be contingent on the epidemiological situation at the time.
• The NPHET also agreed that the vaccine bonus measures applying to those who are vaccinated, should apply equally to those that have had COVID-19 in the last six months.

The Chair thanked the NPHET Members for their contributions and informed Members that this advice would be conveyed to Government following the meeting.

**Action:** The NPHET advises that:

1. Subject to there being no significant deterioration in the epidemiological situation, the following measures can be implemented from 10th May:
   - Increase in the numbers permitted to meet outdoors for social/recreational purposes, including in private gardens – to a maximum of either:
     - A group of 3 households.
     - A group of 6 people from any number of households (children aged 12 or younger do not count towards the limit of 6).
   - For gatherings in private gardens, it is important that congregation indoors is avoided, and masks should be worn if using indoor facilities.
   - Small organised outdoor gatherings permitted with a maximum attendance of 15 people.
   - Outdoor training for adults can recommence, in pods of a maximum of 15 people.
   - Phased reopening of non-essential retail. Measures should be taken to prevent congregation in shopping centres.
   - Reopening of personal services by appointment.
   - Reopening of galleries, museums, and other cultural attractions where people are non-stationary (for general admittance, not indoor events).
• Reopening of libraries (for lending services, no access to reader spaces/PCs).
• Recomencement of in-person religious services in line with existing guidance.
• Increase in the numbers attending funeral services to 50. This relates to the service only. Pre and post related events should not take place.
• Increase in the number of guests attending wedding services to 50. This relates to the service (both religious or civil) only. The number of guests attending a wedding celebration/reception should remain at 6 for indoor gatherings and 15 for outdoor gatherings.
• It is advised that other religious ceremonies such as communions and confirmations should not take place at this time.
• Inter-county travel can resume. It is essential that people adhere to all public health measures when travelling inter-county.
• Increase in numbers on public transport, up to 50% of normal capacity. Transport companies should ensure that all protective measures are taken to ensure the safe increase in passenger numbers.

The NPHET advises that these measures shouldn’t be implemented until 10th May. This is in recognition of the current uncertainty in relation to the trajectory of the disease and will allow a further period of time to properly assess the situation.

2. No sooner than 7th June, the following measures can be implemented:
• Outdoor sports matches can recommence (no spectators). It will be important that sectoral bodies and sporting organisations ensure that the return of matches does not lead to linked socialisation activities before or after matches.
• Gyms, swimming pool, leisure centres can reopen. Guidance should be updated to include the wearing of face coverings in these facilities.
• Outdoor services in restaurants and bars can recommence. It is recommended that there is specific sectoral guidance developed to ensure the safe reopening of these services, including in relation to ensuring social distancing between groups, patrons remaining seated, table service only, mask wearing when not seated, keeping of contact details and safe controls around the use of indoor facilities. It is also recommended that individual groups should be limited to a maximum of 6 people.
• Accommodation services including hotels, B&Bs, self-catering and hostels can reopen. Indoor restaurant and bar services must be restricted to guests/residents. Hostels will need to risk assess the safety of communal room-sharing arrangements.
• The numbers of guests attending a wedding celebration/reception can increase to 25.
• Visiting indoors in private homes – visitors from one other household can be permitted.

The NPHET emphasised that the progression to this phase of measures will be fully contingent on the epidemiological situation at the time. A full assessment of the position at the start of June will be necessary before these measures can be implemented.

3. There can be a further extension to the vaccine dividend, applying from 10th May, as follows:
• Indoor private home visiting can be permitted (without masks or social distancing) in the following cases:
  o Those that are fully vaccinated may visit with other fully vaccinated people, providing there are no more than 3 households present.
  o Those that are fully vaccinated may visit with unvaccinated people from a single household, provided that they are not at risk of severe illness.
• Guidance has been developed and published by the HPSC in relation to visiting in these circumstances and will now be updated in light of the above recommendations. It is important to note that visiting shouldn’t take place if a person has symptoms of COVID-19.
• It was also agreed that these measures will be applicable to those who have had a PCR confirmed COVID-19 infection in the previous 6 months.

4. There are a number of other higher-risk activities that shouldn’t be implemented over the coming two months. This includes:
   • Indoor hospitality (restaurants, bars, nightclubs, casinos).
   • Indoor team/group sports including matches, training and exercise classes.
   • Mass gatherings/events (including spectators), both indoors and outdoors with the exemption of those mentioned above.
   • Advice to work from home unless absolutely necessary to be on site continues.
   • Advice to avoid non-essential international travels continues.

These will be subject to further consideration at the end of June. It is further advised that any easing of measures at that stage should be no sooner than 4 weeks after 7th June.

5. As advised last week, revised guidance for visitation in long term residential care facilities was published last week. This should be reflected in the Framework for Restrictive Measures.

b) Vaccination

i. Vaccination Update

The HSE presented the paper “COVID-19 Vaccination Programme Report, Week Ending 25th April 2021”, for noting. Key updates were as follows:

• 1,385,753 vaccines have been administered up to 24th of April.
• Over 987,000 people have now received the first dose of their vaccine.
• Week of 12th April delivered the highest weekly vaccines administered in a week at over 141,000.
• Front line healthcare workers are substantially complete for dose one and the HSE are completing any people registered on the portal and ensuring an ongoing process for new staff or student placements, 254,267 Dose 1 vaccines administered to 24th April.
• Over 657,000 vaccines have been administered by GPs to over 70s as of 24th April. This includes over 214,000 second doses administered to over 70s. GPs have done superb work in a supply constrained environment with the over 70s. They will substantially complete all Dose 1s for over 70s later this week, with a small mop up next week (less than 5%).
• The HSE have implemented a small call centre to contact all outstanding GP referrals for housebound patients to provide reassurance and to ensure they can still receive the vaccine. In addition, the NAS are increasing the capacity of this service from Monday to accelerate this programme.
• GPs and hospitals will continue to administer to very high-risk people when vaccines become available with the current plan for this group to be substantially complete Dose 1 in mid to late May.
• The HSE have successfully launched the online registration system to the public for appointments for 65 - 69 years olds last week, with approximately 150,000 people registered to date. The HSE commenced administration through vaccination centres this week with 46,567 completed as of 24th April.
• The HSE opened the on-line registration system for those aged 60-64 years on Friday, 23rd April, with first appointments to commence around two weeks later.
• The HSE is awaiting guidance from the NIAC on the use of COVID-19 vaccine Janssen® and changes to dose interval for Vaxzevria® and the Pfizer-BioNTech vaccine. The HSE will update the plan based on any recommendations. These decisions will have a significant impact on the operational plan.
• The increased supply from Pfizer is currently being updated.

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

ii. Vaccine Safety Update
The HPRA provided a verbal update on the national reporting experience for COVID-19 vaccines and referred to the HPRA Safety Update Report (Update #6) published on its website on 22nd April.

The HPRA also updated the NPHET regarding the European Medicines Agency’s (EMA) ongoing reviews of authorised COVID-19 vaccines, and vaccines that are in the pipeline for assessment.

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

iii. **Vaccine dividend following one dose of the COVID-19 Vaccine Vaxzevria®**

The DOH presented the paper “Vaccine Dividend following One Dose of the COVID-19 Vaccine Vaxzevria®, 28th April 2021”, for decision.

The DOH reminded the NPHET that a series of measures have been introduced over the past month that permit those who have completed their full vaccine regimen to derogate from specified public health measures. These ‘vaccine dividend’ measures have been introduced in recognition of the decreased risk of developing serious disease once fully vaccinated, as well as the importance of a vaccine dividend in maintaining momentum in the ongoing rollout of the Vaccination Programme.

The DOH outlined recent developments regarding a single-dose of the vaccine Vaxzevria® (previously COVID-19 vaccine AstraZeneca), including:

- In its advice to the CMO on 26th April, it was also noted by the NIAC that 3 weeks after one dose of Vaxzevria®, levels of protection are comparable to that after one dose of COVID-19 vaccine Janssen® and this protection persists for at least 12 weeks.
- Pooled analysis of 4 randomised clinical trials have demonstrated that vaccine efficacy against symptomatic COVID-19 after a single standard dose of Vaxzevria® was 76.0% (59.3–85.9) from Day 22 to Day 90 after vaccination. Modelling analysis indicated that protection did not wane during the initial 3-month period. Similarly, antibody levels were maintained during this period with minimal waning by Day 90.
- This compares to an efficacy of 76% against severe-critical COVID-19, 14-days post vaccination with COVID-19 Vaccine Janssen® in randomised, double-blind, placebo-controlled phase III trial.
- A single dose of Vaxzevria® has also been found to be 94% effective in reducing COVID-19 related hospitalisations 28-34 days post-vaccination.

The DOH noted that the longer dosing interval of the vaccine Vaxzevria®, as compared to the mRNA vaccines and Janssen®, could act as a disincentive for people to accept vaccination with Vaxzevria®, which could in turn impact negatively on vaccine rollout nationally. In this regard, the DOH proposed that public health guidance relating to those who are fully vaccinated, with the exception of that relating to foreign travel, will be applicable to those 4 weeks (28 days) after having received a first dose of Vaxzevria®. In making this proposal, the DOH stressed that it would remain essential that individuals continue to receive their full course of vaccination notwithstanding the applicability of this guidance.

The Chair thanked the DOH for its presentation and invited observations from the Members. Key points made were as follows:

- The need for ongoing recognition and understanding that the situation around COVID-19 vaccines is dynamic and continues to evolve was noted.
- In response to queries regarding whether individuals who have completed a single-dose of Vaxzevria® would be derogated from measures applied to close contacts of confirmed cases, the DOH confirmed that derogations from being a close contact would only apply to those who had fully completed the two-dose regimen of Vaxzevria®.
- There was consensus around the need to ensure that individuals who receive the Vaxzevria® vaccine experience a ‘dividend’ to maintain the momentum of the Vaccination Programme. Members noted in particular the fact that individuals who have received a single dose of the Vaxzevria® vaccine show similar levels of efficacy to the Jannsen® vaccine after 3-4 weeks, while acknowledging that differences in the
impact of variants on the respective vaccines, and the possibility of having to receive ‘booster’ doses, are yet to be fully understood.

- How the Vaxzevria® vaccine is framed in public communications will be important, with Members noting the need to incentivise the public to avail of this vaccine, if offered to them, while being clear that a second dose will be required to ensure maximum immune protection.
- The possible implications for communications around the mRNA vaccines were raised. Members queried whether individuals who had received a single dose of mRNA vaccine might question why they should not be entitled to a ‘dividend’ before completing their two-dose regimen. The NIAC explained that this would not be appropriate given the apparent shorter duration of immunity induced by mRNA vaccines.

The Chair thanked the DOH for its work noting the strong public health rationale for the paper’s recommendations. The Chair proposed the paper’s recommendations for endorsement. These were endorsed by the NPHET.

In concluding the discussion, the Chair expressed thanks on behalf of the NPHET to the NIAC and its Chair. The NIAC was commended in particular for its work in interpreting data from the EMA and other international authorities regarding the Janssen® vaccine and translating this into clear advice for the DOH and Government in recent days.

**Action:** The NPHET endorsed the proposal that public health guidance relating to those who are fully vaccinated, with the exception of that relating to foreign travel, will be applicable to those 4 weeks (28 days) after having received a first dose of Vaxzevria®. The NPHET however clarified that it is essential that individuals continue to receive their full course of vaccination notwithstanding the applicability of this guidance.

6. **Communication Update**

The DOH gave a brief update on Communications for COVID-19. In summary:

- The risk profile of the population has changed as the Vaccine Programme has advanced. People know the risks associated with COVID-19; we now need them to empower themselves to use the public health advice to risk assess their behaviours and decide appropriately.
- It is envisaged the content and tone of communication in this new phase of the pandemic will be quite different. The most efficient way to manage communication of the public health advice at this stage in the pandemic is to tailor it to cohorts. Whereas before, citizens were told what the rules were and what they should avoid doing, this new phase is one of responsible empowerment.
- New targeted public health messaging will speak to what citizen cohorts can do safely and responsibly, in a spirit of mutual trust, which fully respects the dangers of the virus. This new messaging approach from the Department of Health will be embraced as a signal of adult-to-adult, mature communication with an Irish population that now has over a year’s experience of the virus and is well versed in its safety parameters.

The Chair thanked the DOH for this update and the NPHET 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**

No matters were raised under this item.

**c) Date of next meeting**

The next meeting of the NPHET will take place Thursday 13th May 2021, at 10:00am via video conferencing.