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

<table>
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<tr>
<th><strong>Date and Time</strong></th>
<th>Thursday 13th May 2021, (Meeting 87) at 10:00am</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Department of Health, Miesian Plaza, Dublin 2</td>
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<tr>
<td><strong>Chair</strong></td>
<td>Dr Tony Holohan, Chief Medical Officer, DOH</td>
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**Members via videoconference**
- 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
- Dr Siobhán Í N 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
- Ms Yvonne O’Neill, National Director, Community Operations, HSE
- Mr Fhelim 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
- Dr Darina O’Flanagan, Special Advisor to the NPHET
- Dr 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 Colm Henry, Chief Clinical Officer, HSE
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
- Mr Liam Woods, National Director, Acute Operations, HSE
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications
- Prof Mary Horgan, President, RCPI
- Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)
- Dr Siobhán O’Sullivan, Chief Bioethics Officer, DOH;
- 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

**In Attendance**
- Ms Laura Casey, NPHET Policy Unit, DOH
- Ms Aoife Gillivan, Communications Unit, DOH
- Mr Gerry O’ Brien, Acting Director, Health Protection Division
- Ms Pauline White, Statistics & Analytics Unit, DOH
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Ms Sarah Glavey, Health Protection Coordination & Support Unit, DOH

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

**Apologies**
- Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Dr Colette Bonner, Deputy Chief Medical Officer, DOH
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital

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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 Trish Markham, Dr Louise Hendrick, Dr Colette Bonner, and Dr Colm Bergin.

   c) Minutes of previous meetings
   There were no minutes circulated for adoption at this meeting.

   d) Matters Arising
   As the most recent easing of measures only commenced from 10\textsuperscript{th} May, any impact of this phase on the epidemiological situation will take further time to observe and assess. Therefore, the Chair proposed that the NPHET hold its next meeting on 26\textsuperscript{th} May.

The Chair indicated his intention proceed through the agenda in an efficient manner, remarking that substantive discussions regarding future easing of measures would be considered at the NPHET’s meeting on 26\textsuperscript{th} May. With particular regard to item 4(a) Interventions in the community setting, prior to diagnosis of COVID-19, to prevent or minimise progression to severe disease, the Chair indicated that the NPHET would be presented with the HIQA’s findings, but that discussions regarding possible implications for current public health policy would be deferred to 26\textsuperscript{th} May.

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 2,957 cases have been notified in the 7 days to 12\textsuperscript{th} May 2021, which is an 8% decrease from the last NPHET meeting on 28\textsuperscript{th} April when 3,205 cases were notified in the 7 days to 27\textsuperscript{th} April.
   - As of 12\textsuperscript{th} May, the 14-day incidence rate per 100,000 population has increased to 130; this compares with 122 at the last NPHET meeting on 28\textsuperscript{th} April. The 7-day incidence per 100,000 population has decreased to 62, from 67 at the last NPHET meeting.
   - 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, 6\textsuperscript{th} - 12\textsuperscript{th} May compared with the preceding 7 days, 29\textsuperscript{th} – 5\textsuperscript{th} May.
   - The 5-day rolling average of daily cases was 426 on 12\textsuperscript{th} May, compared with 437 on 27\textsuperscript{th} April.
   - Incidence decreased across almost all age groups in the last week, most notably in those aged 13-18 years, 19-24 years, and 75 years and older. While incidence increased in those aged 13-18 years when schools reopened (associated with a much larger increase in referral for testing), it has now stabilised and reduced; there has been a moderate recent increase in incidence in children aged 5-12 years, which has also stabilised, and little change in incidence in children aged 0-4 years.
   - Of cases notified in the past 14 days, 29\textsuperscript{th} April – 12\textsuperscript{th} May, 77% have occurred in people under 45 years of age; and 3% were aged 65 years and older. The median age for cases notified in the same period is 29 years. Incidence in those aged 65 and older is now significantly below the population average. This is likely due in the first instance to reduced social mixing in this group, and now an emerging vaccine effect in the older age cohorts.
   - While 14-day incidence rates remain high across the country, 19 counties have a 7-day incidence as a percentage of the 14-day rate of less than 50%, indicating fewer cases notified in these counties in the last 7 days, 6\textsuperscript{th} - 12\textsuperscript{th} May, compared with the previous 7 days, 29\textsuperscript{th} – 5\textsuperscript{th} May.
   - Of the 6,175 cases reported in the last 14 days, 29\textsuperscript{th} April – 12\textsuperscript{th} May, 2.3% (139) were healthcare workers.
• The Reproduction number (R) is just below 1.0 (range 0.8-1.0), with moderate levels of uncertainty in its estimation. The rate of growth of the disease is currently at 0% to -2%.
• There were 130,697 tests undertaken in the last week (as of 12th May). The 7-day average test positivity rate has decreased to 2.4% on 12th May, a decrease from 2.8% to 27th April as 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 6.7% over the 7 days to 10th May.
• According to Contact Management Programme data (excluding acute, serial, and mass testing in response to outbreaks), 13 counties have a community positivity rate greater than 5%.
• According to Contact Management Programme data from 26th April – 2nd May, where results were available for Test 1, 11.9% (1,053/8,874) were positive. Household close contact positivity rate was 25.5%.
• According to Contact Management Programme data from 19th-25th April, where results were available for Test 2, 4.1% (169/4,105) were positive. Household close contact positivity rate was 11.0%.
• There were 111 confirmed COVID-19 cases in hospital this morning, compared with 153 on 28th April. There have been 11 newly confirmed cases in hospital in the 24 hours preceding this morning.
• There are currently 36 confirmed cases in critical care, compared with 45 on 28th April. There have been 2 admissions in the previous 24 hours.
• To date, there have been 11 deaths notified with a date of death in May. This compares with 85 and 238 deaths notified (to date) with a date of death in April and March, respectively. Of the 11 deaths in May to date, 1 has thus far been associated with a hospital outbreak and 1 has been associated with a nursing home outbreak.
• In total, 72 cases of B.1.351 (variant first identified in South Africa) have been confirmed by whole genome sequencing.
• 28 confirmed cases of P.1 (variant first identified in Brazil) have been identified in Ireland to date.
• 34 confirmed cases of B.1.617.2 (variant first identified in India) have been identified in Ireland to date. This variant has been designated a variant of concern.
• Other variants of note/under investigation that have been confirmed in Ireland to date: 127 B.1.1.318, 33 B.1.525 cases, 15 P.2 cases, 7 B.1.526 cases, 9 B.1.617.1, 6 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 8th May 2021. Week 18 refers to 2nd – 8th May 2021, and data are restricted to cases and outbreaks notified since 29th November 2020.

Healthcare setting outbreaks:
• There was 1 new outbreak notified in acute hospitals in week 18 of 2021. At the end of week 18, there were 14 open clusters, an 18% decrease on week 17.
• There was 1 new cluster notified in nursing homes/community hospitals in week 18, this compares with no new outbreaks in these settings in week 17.
• At the end of week 18, there were 5 open clusters associated with nursing homes, which is the same as the previous week;
• There were no open outbreaks in community hospitals and long stay units.
• There were 25 open clusters associated with residential institutions at the end of week 18, with 3 new outbreaks notified in week 18. The 3 outbreaks notified in week 18 associated with residential institutions related to vulnerable groups and are described in further detail below.
• Within other residential settings at the end of week 18:
  o There were 5 open outbreaks in centres for disabilities.
  o There was 1 open outbreak in a mental health facility.
  o There was 1 open outbreak in a Children’s / TUSLA residential centre.
  o There was 1 open outbreak in an ‘other type’ residential facility.

Vulnerable groups, Irish Traveller Community, Direct Provision & Prison Outbreaks:
• There were 10 new outbreaks reported in vulnerable populations in week 18, compared with 21 in the previous week.
  o There was a decrease in the number of outbreaks in the Irish Traveller Community with 6 new outbreaks in week 18, compared with 16 new outbreaks in week 17; there were 139 open outbreaks at the end of week 18.
  o There was 1 new outbreak in the Roma community in week 18, with 8 open outbreaks.
  o There was 1 new outbreak each in direct provision centres, prisons, or facilities for people with addictions in week 18.
  o There were no new outbreaks in Homeless facilities in week 18, compared with 4 outbreaks in the previous week. There were 6 open outbreaks by the end of week 18.

Outbreaks associated with school children, universities/colleges, and childcare facilities:
• There were 7 outbreaks newly notified in childcare facilities, with 65 open outbreaks remaining by the end of week 18. There were 33 new cases notified in these settings in this week.
• There were 61 outbreaks newly notified associated with school children and/or staff in week 18, with 109 new cases notified in this week. This compared with 29 outbreaks in the previous week.
• There were 2 new outbreaks in university/college/third-level students in week 18, with 14 outbreaks remaining open by the end of week 18.
• Based on the latest data on testing in schools over the period of 2nd–8th May 2021 (week 18), 4,191 tests were completed in 194 primary schools resulting in a 2.3% positivity rate, and 3,327 tests were completed in 101 post-primary facilities resulting in a 0.9% positivity rate. In total, 64 tests were carried out in 7 special education settings with a 3.1% positivity rate and 1,070 tests were completed in 74 childcare facilities resulting in a 4.2% positivity rate.
• The number of cases detected, positivity rates, and numbers of cases associated with outbreaks in schools remains low despite intense oversight and increased testing. It is important to note that detection of a case or declaration of an outbreak in a school does not imply that transmission has occurred in the school setting.

Workplace outbreaks:
• There were 17 workplace outbreaks reported in week 18 across a variety of settings, which is an 11% decrease on the number of outbreaks identified in week 17 (19).
• In total, 6 outbreaks were in commercial settings, 3 were in construction settings, 3 were in office-based settings, 3 were related to food production settings, 1 in manufacturing, and 1 in another workplace setting.

Travel outbreaks:
• There were 9 travel-related outbreaks reported in week 18, which is an increase on the number of outbreaks identified in week 17 (7). There were 68 open outbreaks by the end of this week.

The NPHET noted that the epidemiological situation in Ireland remains concerning but is currently stable. Disease incidence is high, but stable, with significant variability and uncertainty. Recent transient increases in incidence in children and adolescents now appear to be stabilising. Community test positivity remains elevated but is reducing. GP test referrals for those aged 18 years and under, having increased through April and into early May, decreased again over recent days.

The numbers of confirmed cases in hospital and ICU continue to decrease slowly. The numbers of deaths related to COVID-19 are static or reducing slowly. Markers of population mobility have continued to increase, noting the impact of the May bank holiday on recent trends. The mean number of close contacts per adult confirmed case is relatively stable (approximately 2.7). The Reproduction number (R) is just below 1.0 (range 0.8-1.0), with moderate levels of uncertainty in its estimation. The Growth rate in daily case numbers is currently estimated at 0% to -2% per day.
The NPHET noted that the current epidemiological picture is one of controlled stability. The Chair thanked the DOH, the HPSC, and the IEMAG for the update.

3. Review of Existing Policy
There were no matters discussed under this item.

4. HIQA Expert Advisory Group

a) Interventions in the community setting, prior to diagnosis of COVID-19, to prevent or minimise progression to severe disease.

The HIQA presented the paper “Advice to the National Public Health Emergency Team: COVID-19 - Interventions and health-related factors that prevent infection or minimise progression to severe disease, 12th May 2021”, for noting.

The HIQA assessed 50 studies for the paper, these included 4 controlled trials which considered Ivermectin and 46 cohort studies. The following risk factors were identified in the cohort studies:

- Overweight and or obesity (34 studies)
- Smoking (25 studies)
- Vitamin D status (10 studies)
- Physical activity (seven studies)
- Alcohol consumption (five studies)
- Processed meat consumption (one study)

Arising from its findings, the HIQA’s advice to the NPHET was as follows:

With respect to interventions prior to a diagnosis of COVID-19 aimed at the prevention or reduction of progression to severe disease:

- The evidence identified and included in this review does not currently support the use of any pharmaceutical intervention outside of well conducted, well-regulated clinical trials.
- In particular, prophylactic use of ivermectin should not be recommended outside of well-designed, regulated clinical trials as the benefits and harms are not yet clear when taken prior to a diagnosis of COVID-19 to prevent or reduce progression to severe disease.
- No evidence was identified for non–pharmaceutical interventions.
- There is currently insufficient evidence to support the use of Vitamin D supplementation aimed at preventing or reducing the severity of COVID-19. However, national guidance on Vitamin D supplementation should continue to be followed, particularly for those who are housebound with limited and or no sunlight exposure.
- A large number of COVID-19 clinical trials are ongoing. Additional evidence will therefore continue to be reported both for novel interventions and those identified in this review. Consistent with current requirements:
  - As there are potential harms associated with all interventions, including non-pharmaceutical interventions, they must have a robust safety profile, and be subject to appropriate governance, before they can be recommended for widespread use in the community setting. This is important given the serious risks of harm associated with unproven interventions.
  - If effectiveness evidence does emerge, all current due processes will be required, including with respect to potential reimbursement of drugs provided within the publicly funded healthcare system.
  - Availing of the COVID-19 vaccine, when offered it, continues to be the most effective measure to prevent serious illness due to COVID-19.
  - Public health messaging on the benefits of engaging in healthy behaviours should continue. In general, maintaining a healthy weight, not smoking, engaging in physical activity, moderating alcohol consumption, good nutrition and being Vitamin D sufficient have beneficial effects on general health and may reduce the risk of poor outcomes from COVID-19.
  - Public health messaging should endeavour to empower individuals to take ownership of their own health, while recognising that due to health inequalities not everyone has the same opportunity or
capacity to be healthy. Public health initiatives should therefore continue to focus on addressing any such inequalities.

The Chair thanked the HIQA for its advice and reiterated that the findings would be tabled for discussion at the next meeting of the NPHET to allow time for them to be reviewed by Members and for any policy implications to be identified and considered.

5. Future Policy
   a) Vaccination
      i. Vaccination Programme Update

The HSE presented “COVID-19 Vaccination Programme Report, NPHET Update – 11th May 2021”, for noting. Key points are summarised as follows:

- 1,880,625 vaccines administered to 10th May.
- Over 1,375,000 people have now received the first dose of their vaccine (as of 10th May).
- Week of 26th April delivered the highest level administered in a week to date at over 201,000.
- The highest daily number of vaccinations given was recorded last week at over 45,000.
- Front line healthcare workers (HCWs) are substantially complete for Dose 1. The HSE has implemented a pathway for new healthcare workers requiring vaccination. 260,146 Dose 1 vaccines administered to 10th May.
- Over 771,000 vaccines have been administered by GPs to over 70s as of 10th May. This includes over 459,000 first doses. This includes over 311,000 second doses administered to over 70s. The HSE has substantially completed all Dose 1s for over 70s. A pathway has been put in place for anyone emerging who does not have a GP.
- GPs and hospitals will continue to administer to very high-risk people with the current plan for this cohort to be substantially complete (Dose 1) in mid to late May. The majority of hospitals have completed their vaccinations in this cohort.
- GPs have commenced administering to high-risk people and this will continue to ramp up over the coming weeks. GPs are the primary vaccination channel for the high-risk cohort.
- For the 60-69 age group there are 269,923 people vaccinated as of 10th May.
- The online registration system opened for people aged 50 - 59 years on 4th May. The total registered to date across all age cohorts is 369,148.
- The HSE has completed the update to the operation plan following NIAC’s recommendations. The plan is based on adherence to Government’s age-based sequencing policy - maximising pace of the safe and effective vaccination of the population; maximising usage of all available vaccines in Q2; avoiding using only a small portion of available Janssen and minimising operational complexity.

The HSE further noted that the National Ambulance Service (NAS) has been operating a 7-day service to work through the vaccination of those over 70 years, who are housebound and new referrals for this service continue to be scheduled. Particular attention was drawn to the Vaccination Programme for socially vulnerable groups, comprising members of the Irish Traveller community, Roma communities, and the homeless. The aim of the programme is to provide a bespoke vaccination pathway ensuring accessibility, suitability, optimal engagement, and participation for the administration of the COVID-19 vaccines to the target population. The HSE noted that services are reporting high levels of vaccine hesitancy amongst the Roma population in Dublin; work is ongoing to inform harder-to-reach populations about the benefits of vaccination.

The NPHET acknowledged the huge work accomplished thus far HSE colleagues with the rollout of vaccination through mass-vaccination centres and welcomed the progress made to progress the Vaccination Programme for socially vulnerable groups.

The following key points were raised in the ensuing discussion:

- It was queried whether the age denominator could be provided in the Vaccination Programme updates to the NPHET in order to determine the percentages of people vaccinated per age cohort. It was further
queried whether information available through the Local Electoral Areas (LEAs) could assist with determining the numbers vaccinated in those areas.

• With regard to HCWs, the question of whether a plan is in place for vaccinating, harder to access groups within this cohort was raised. It was also questioned whether there is a plan in place for non-vaccinated HCWs.
  o The HSE confirmed that it is taking a non-mandatory, non-coercive approach in conjunction with individual risk assessments. This is in line with the HIQA recommendation to employ a stepwise ladder approach.

• It was raised that many socially vulnerable groups do not have a GP linked to them and, as such, the progress of the vaccination rollout to these groups could be hindered.
  o The HSE noted that work is underway to address this issue and any suggestions or recommendations from Members are welcome. The HSE assured the NPHET that every effort is being made to bring the vaccine to people.

• The high level of uptake was noted by many Members, with the HSE noting that although the uptake percentage may seem implausibly high, the level of resistance that had previously been feared has not been observed thus far. In particular, the HSE noted that among older age groups, there was enormous uptake and very little reported evidence of refusal of vaccines or appointments recorded as ‘Did Not Attend’.

• It was raised that there are individuals in the high-risk cohort who remain to be vaccinated, while the 50-59 age cohort are now eligible to register for vaccination.
  o The HSE noted that work was undertaken to identify those in the high-risk cohort as quickly as possible through the hospital system and GPs, and while work is in progress to ensure harder to access individuals in this cohort are vaccinated, delaying the ongoing rollout in the 50-59 age cohort in order to fully complete vaccination of high-risk individuals would have a negative impact on the Vaccination Programme’s progress overall.

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

ii. HPRA Vaccine Safety Update
The HPRA provided a verbal update on the national reporting experience for COVID-19 vaccines, for noting.

The next report will be published on the HPRA website on 20th May and will be provided to the NPHET for tabling at the next meeting. An update on vaccines under assessment by the EMA was also provided.

The NIAC noted that an update was published on 12th May regarding the Janssen vaccine and cases of Thrombosis with Thrombocytopenia Syndrome (TTS) in the US. The NIAC further noted that while the gender difference with regard to TTS in the US appears striking with 82% of cases in female patients, it is not certain that this will continue to be the case.

In the ensuing discussion, the following key points were raised:
• It was queried whether there are numbers available with regard to the Guillain-Barré signal being investigated by the EMA Pharmacovigilance Risk Assessment Committee (PRAC).
• With regard to vaccine failure, it was noted that no true cases of such have been reported. The ECDC has established a formal data collection system to collect information from all confirmed outbreaks in nursing home settings, where residents have been fully vaccinated. It was noted that such cases are likely to be linked to a high burden of infection in these settings at the commencement of vaccination rollout and not ‘vaccine failure’.
• Many Members noted the importance of having a case definition for vaccine failure going forward.

The HPRA agreed to provide additional information post-meeting on points raised by the NPHET Members.

The NPHET thanked the HPRA, the NIAC, and other contributors for their input and noted same.
\textit{b) Future Measures - Update} \\
The Chair noted that the NPHET meeting scheduled for 26\textsuperscript{th} May will focus primarily on epidemiological readiness to progress the planned further easing of public health measures in June. Consideration will also be given at this meeting to remaining measures not included in the phased reopening over May and June.

6. Communication Update  

The DOH and the HSE presented “\textit{Agenda Item 6 – Communications Update: 13\textsuperscript{th} May 2021}”, for noting.

The Quantitative Tracker, the nationally representative sample of 2,200 people conducted on behalf of the DOH by Amárach Research on 10\textsuperscript{th} May 2021 shows that:

- The level of worry is at 5.4/10, back to the levels seen last summer.
- Concern for the health of family and friends and the economy are now the highest source of worry.
- The majority, 67\% now believe the worst of the pandemic is behind us, 10\% believe it is happening now, and 7\% believe it is ahead of us.
- 35\% think Ireland is returning to normal at about the right pace, 26\% think it is too quick, and 24\% too slowly.
- People are disengaging from COVID-19 related news.

With regard to the Vaccine Quantitative Tracker:

- 51\% of the population know someone in their immediate social circle who has had COVID-19.
- 87\% (70\% definite, 17\% probable) say they will get the COVID-19 vaccine when it is offered to them.
- 44\% say they have concerns around the vaccine: 35\% are worried about side effects of the vaccine while 26\% are worried about the long-term effects on health.
- GPs are the most trusted source of information on the vaccine for 75\% of the population, followed by the HSE (53\%), the DOH (51\%) and Pharmacists (43\%).

The Social Activity Measure (ESRI/DOT) for the period 20\textsuperscript{th} April to 27\textsuperscript{th} April shows that:

- There were further increases in mobility and social activity during this period. The proportions of the population who attended their workplace (34\% during the previous week; 18\% the previous day), another person’s home (37\% and 12\%), and used transport (53\% and 28\%) were the highest seen since tracking began at the end of January.
- There was a substantial increase in social visits to homes, mainly driven by people who are vaccinated: 26\% of vaccinated people had a close contact in the previous day, vs 21\% of non-vaccinated.
- Older people had the largest increase in close contacts during April, mostly due to social visits to homes. Among younger people, greater numbers going to work was a larger factor. However, the chance that workers who attend work on a given day experience a close contact has remained relatively stable at around or just below 50\% – it is simply that more people are going to work.
- There are changing patterns in the drivers of behaviour. Overall worry about the virus has fallen further and remains a strong predictor of behaviour, but somewhat less so than in previous weeks. This may reflect the influence of vaccination (and perhaps expectation of vaccination), which is increasing the social activity of people who, until now, have engaged in little social interaction during 2021.
- The perceived coherence of the restrictions and how people trade off the burden of restrictions against preventing the spread of COVID-19 both continue to influence behaviour. However, as restrictions are lifted, the influence of the former has grown stronger and the latter somewhat weaker.

The DOH advised that from an operational perspective there are two key messages for students; Leaving Certificate students are advised not to congregate or attend end-of-year parties and third-level students are reminded of the role they play in maintaining low disease incidence.

The HSE updated the NPHET on ongoing communications campaigns. The vaccine campaign is now calling the 50-59 age cohort for online registration and a new campaign, #ForUsAll, has been introduced. A vaccine booklet addressing vaccine hesitancy is being developed with delivery to households planned from the first week of June.
The Chair thanked the DOH and the HSE, and the NPHET noted same.

7. Meeting Close
   a) Agreed Actions
      There were no actions arising from the meeting.

   b) AOB
      i. Updated Contact Tracing Guidance
         The HPSC advised that contact tracing guidance has been updated in conjunction with the Contact Management Programme. The updated guidance will be published on the HPSC website in the coming days.

         No other matters were raised during AOB.

   c) Date of next meeting
      The next meeting of the NPHET will take place Wednesday 26th May 2021, at 10:00am via video conferencing.