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

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<tr>
<th>Date and Time</th>
<th>Wednesday 25th August 2021, (Meeting 92) at 11:00am</th>
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<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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### Members via videoconference
- Prof Philip Nolan, President, National University of Ireland, Maynooth and Chair of the Irish Epidemiological Modelling Advisory Group (IEMAG)
- Dr Kevin Kelleher, Assistant National Director, Public Health, HSE
- Dr Cillian de Gascun, Laboratory Director, NVRL
- Prof Colm Bergin, Consultant in Infectious Diseases, St James’s Hospital
- Dr Siobhán Ni Bhriain, Lead for Integrated Care, HSE
- 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 Colette Bonner, Deputy Chief Medical Officer, DOH
- Prof Mark Ferguson, Director General, Science Foundation Ireland, and Chief Scientific Adviser to the Government of Ireland, SFI
- Mr Fergal Goodman, Assistant Secretary, Primary Care Division, DOH
- Dr Breda Smyth, Public Health Specialist, HSE
- Dr Elaine Breslin, Clinical Assessment Manager, HPRA (alternate for Jeanette McCallion)
- Dr Catherine Fleming, Consultant in Infectious Diseases, University of Galway
- Prof Mary Horgan, RCPI
- Prof Karina Butler, Chair of the National Immunisation Advisory Committee (NIAC)
- Dr Siobhán O’Sullivan, Chief Bioethics Officer, 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
- Dr Colm Henry, Chief Clinical Officer, HSE
- Dr Darina O’Flanagan, Special Advisor to the NPHET
- Ms Fidelma Browne, Head of Programmes and Campaigns, HSE Communications
- Mr Phelim Quinn, Chief Executive Officer, HIQA

### In Attendance
- Dr Conor Teljeur, Chief Scientist, HIQA (Alternate for Máirín Ryan)
- Ms Laura Casey, NPHET Policy Unit, DOH
- Dr Trish Markham, HSE (Alternate for Tom McGuinness)
- Mr Gerry O’Brien, Acting Director, Health Protection Division
- Mr Ronan O’Kelly, Health Analytics Division, DOH
- Dr Desmond Hickey, Deputy Chief Medical Officer, DOH
- Dr Louise Hendrick, Specialist Registrar in Public Health Medicine, DOH
- Dr Robert Conway, Specialist Registrar, DOH
- Ms Lyndsey Drea, Communications Unit, DOH
- Ms Pauline White, Statistics & Analytics Unit, DOH
- Ms Elizabeth McCrohan, Statistics and Analytics Unit, DOH
- Mr Aaron Rafter, NPHET Policy Unit, DOH

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

### Apologies
- Ms Deirdre Watters, Communications Unit, DOH
- Dr Eibhlín Connolly, Deputy Chief Medical Officer, DOH
- Mr Greg Dempsey, Deputy Secretary, Governance and Performance Division, DOH
- Mr Liam Woods, National Director, Acute Operations, HSE
- Dr Lorraine Doherty, National Clinical Director Health Protection, HSE
- Dr Máirín Ryan, Deputy Chief Executive and Director of HTA, HIQA
- Dr Ronan Glynn, Deputy Chief Medical Officer, DOH
- Ms Yvonne O’Neill, National Director, Community Operations, HSE

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

a) Conflict of Interest
Verbal pause and none declared.

b) Apologies
Apologies were received from Ms Deirdre Watters, Dr Eibhlín Connolly, Mr Greg Dempsey, Mr Liam Woods, Dr Lorraine Doherty, Dr Máirín Ryan, Dr Ronan Glynn, and Ms Yvonne O'Neill.

c) Minutes of previous meetings
The minutes of the 17th and 28th June, and the 27th July had been circulated to the Members in advance of the meeting. These were agreed subject to minor amendments and formally adopted by the NPHET.

d) Matters Arising
The Chair, in his opening remarks, stated that the focus of today’s meeting would be on reaching a consensus on the NPHET’s advice to the Minister on managing the next phase(s) of the COVID-19 response, with a view to informing the Government’s Roadmap for further easing of restrictions and overall approach to the management of COVID-19, expected week commencing 30th August.

2. Epidemiological Assessment

In advance of presenting the epidemiological data, the DOH reminded Members that the reported epidemiology of COVID-19 as it relates to COVID-19 cases, associated deaths, and outbreaks is normally based on notifications to the Computerised Infectious Disease Reporting (CIDR) system. The cyber-attack on the HSE on 14th May 2021 has prevented the routine notification of these data to CIDR. As an interim measure, epidemiological case data are based on the information captured by the HSE COVID Care Tracker. Please note that these data do not represent notified cases and have not undergone the data validation procedures undertaken through CIDR. As soon as all COVID-19 surveillance systems are restored, COVID-19 cases and outbreak data will be validated and updated for the relevant period.

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 12,751 cases have been reported in the 7 days to 24th August 2021 (cases to midnight 23rd August), which is a 4% increase from last week when 12,317 cases were notified in the 7 days to 17th August, and a 45% increase from the last NPHET meeting on 27th July when 8,791 cases were reported in the 7 days to 26th July 2021.
- As of 24th August, the 14-day incidence rate per 100,000 population has increased to 526; this compares with 490 a week ago and compares with 333 at the last NPHET meeting on 27th July.
- Nationally, the 7-day incidence/100,000 population as a proportion of 14-day incidence/100,000 population is 51%, demonstrating that there have been more cases in the last 7 days (18th-24th August) compared with the preceding 7 days (11th – 17th August).
- The 5-day rolling average of daily cases is 1,814 as of today, which is a 5% increase from 1,734 week ago (17th August) and a 52% increase from that of 27th July (1,191).
- Of cases notified in the past 14 days (11th – 24th August), 83% 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 25 years. Disease incidence remains highest in the 19–24-year-old age group.
- Of the 25,066 cases reported in the last 14 days (11th – 24th August), 3.7% (925) were healthcare workers and 3.6% (899) were determined to be travel-related.
- Data on COVID-19 cases is currently sourced from an extract from the Covid Care Tracker (CCT). The CCT includes self-reported data on vaccine status (if a person reports having received a vaccine and if so, how many doses). This is self-reported by cases during their contact tracing call and no data is available on the timing of when they received their second dose or other data validation. Caution is therefore required in interpretation of this data. Of the 25,328 cases reported in the last 14 days: 24% reported having
received two doses of vaccine; 16% reported having received one dose of vaccine; 41% reported having not received any vaccine; and the vaccine status was unknown for 19%.

- Over the seven days 17th – 23rd August, there has been 131,893 laboratory tests reported in community, private and acute laboratories, this compares with 137,294 laboratory tests in the previous 7 days (10th –16th August). The 7-day positivity rate in the community was 14%.
- From the 17th – 23rd August, there were 103,806 community referrals. Overall, total referrals have remained stable in comparison to the same time-period last week (0.38% increase). From the 15th – 21st August, the group with the largest number of referrals was the 21-30 year old age group, making up 19.5% of all referrals. The detected rate for the 21-30 year old age group is 16%.
- According to the Contact Management Programme (CMP), from 9th - 15th August 2021, the total number of close contacts was 29,375, a decrease of 6% compared with 30,987 the previous week. The average number of cases managed per day decreased from 4,427 to 4,196.
- The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 22nd August was 3.3, a decrease from 3.4 for the week ending 15th August.
- As of the morning of the 25th August, there were 323 confirmed COVID-19 cases in hospital, compared with 249 on 18th August, and with 142 on the morning of the last NPHET meeting on 27th July. There were 56 newly confirmed cases in hospital in the 24 hours preceding the morning of the 25th August.
- As of the morning of the 25th August there were currently 56 confirmed cases in critical care, compared with 54 on 18th August, and with 27 on the morning of the last NPHET meeting on 27th July. There were 5 new admissions in the previous 24 hours.
- Of the 195 COVID-19 patients admitted to ICU between 1st April and 14th August 2021, vaccination status was known for 185 patients. Of those where vaccination status is known, 45 had received either one or two doses of vaccine, and 18 received all recommended doses of vaccine before admission to ICU. In total, 10 patients had an epidemiological date 14 days or more after receiving all recommended doses of vaccine.
- Of the 165 laboratory-confirmed COVID-19 deaths notified to HPSC with a date of death between 1st April 2021 and 14th August 2021, 158 of these deaths had COVID-19 vaccination data reported. Of these, 68 deaths were reported in persons having received at least one dose of COVID-19 vaccine prior to death and 30 deaths were reported in persons having received all recommended doses of COVID-19 vaccine prior to death. Thirteen COVID-19 deaths were reported in persons with an epidemiological date 14 days or more after receiving all recommended doses of vaccine.
- As of 25th August 2021, there have been a total of 5,092 COVID-19 related deaths notified in Ireland. This is an increase of 18 notified deaths since the previous weekly update on 18th August (5,074). To date, 34 deaths have been notified which occurred in August, 16 in July and 16 in June.
- In total, 6,496 cases of Delta (B.1.617.2), 77 cases of Beta (B.1.351) and 30 cases of Gamma (P.1) have been confirmed through whole genome sequencing in Ireland to date.
- Other cases of variants of note/under investigation that have been confirmed in Ireland to date: 210 Kappa (B.1.617.1), 74 Eta (B.1.525), 15 Zeta (P.2), 11 Iota (B.1.526), 7 Epsilon (B.1.429), 245 B.1.1.318, and 2 A.27.
- Taq-path S-gene PCR target results by specimen week show that the prevalence of S-gene positivity (proxy for Delta) has increased from 90.3% in week 28 to 98.2% in week 31. Outbreaks and associated cases are based on those reported up to midnight on 21st August 2021. Week 33 refers to 15th – 21st August 2021. Due to the cyber-attack on system networks, data are limited to an aggregate summary of outbreaks reported weekly to HPSC.

Healthcare setting outbreaks:

- There were 11 new nursing home outbreaks with 56 confirmed linked cases and 2 community hospital/long-stay unit outbreaks with 15 confirmed linked cases reported in week 33.
- There were 5 new acute hospital outbreaks with 13 confirmed linked cases reported in week 33.
- There were 6 new outbreaks reported in residential institution settings (2 in centres for disabilities, 1 in a prison, and 3 in non-specified residential facilities) with 15 confirmed linked cases in week 33.
Vulnerable Groups/ Key Populations outbreaks:
• There were 9 new outbreaks reported involving members of the Irish Traveller community in week 33 with 47 linked cases.

Outbreaks associated with school children and childcare facilities:
• There were 14 outbreaks newly reported in childcare facilities in week 33.

Workplace outbreaks:
• There were 16 workplace outbreaks reported in week 33 across a variety of settings. Of these, 5 were in the construction sector, 4 were related to food/meat production and processing settings and 7 were in “other” workplace types.

Outbreaks associated with hospitality settings:
• There were 8 outbreaks reported related to hotels in week 33.
• There were 10 outbreaks associated with restaurant/café settings reported in week 33 and 3 associated with a public house.

Other Locations:
• The remaining 30 outbreaks in week 33 were across a number of other locations:
  o 1 related to ‘other healthcare service’;
  o 4 travel-related outbreaks;
  o 2 related to social gatherings;
  o 4 associated with religious/other ceremony;
  o 3 community outbreaks;
  o 5 related to retail outlets;
  o 1 related to other recreation activity;
  o 4 extended family outbreaks;
  o 5 private house outbreaks;
  o 1 in ‘other’ location.

In summary, disease incidence across the country is currently high. Incidence is very high in those aged 19-24 and 13-18 years old; until recently most of the cases in the latter group were in those aged 16-18 years old, but incidence has also started to increase in those aged 13-15 years old. Incidence may be plateauing or starting to decrease in those aged 16-18 and 19-24 years old, though these trends may be influenced by very strong weekend effects. Incidence in children and older adults has increased as the force of infection grows. Incidence in children aged under 12 years old has been lower than other unvaccinated groups, comparable with incidence in vaccinated adults aged 35-64 years old.

Test referrals are at high levels and the 7-day average national test positivity rate has increased. The growth rate of cases is uncertain with the best estimate currently at 0 to 2% per day. The total number of confirmed cases of COVID-19 in hospital has been increasing at 2%-4% per day, while the total number of confirmed cases in ICU has also increased. There continues to be relatively low mortality related to COVID-19 and this is being closely monitored.

The IEMAG shared a range of updated modelling scenarios outlining the potential trajectories the disease could take in the coming months. The models have been revised and updated, based on the experience in recent weeks of the transmission of the Delta variant, the success of the Vaccination Programme, and revised assumptions on the effectiveness of the vaccines in preventing transmission, symptomatic infection, and severe disease. The IEMAG confirmed that while the outlook over the coming days and weeks is very uncertain, it is likely that the situation will get worse before we begin to see an improvement. Revised modelling scenarios calibrated to 11th August 2021 show, for optimistic scenarios, case counts peaking at 2500-3000 cases per day in mid-September, with later peaks in healthcare demand seeing 500-700 people in
hospital and 80-130 people in ICU. Central scenarios show the peak at 3000-5000 cases per day, 750-1300 in hospital and 150-250 people requiring critical care. The IEMAG is conducting additional work to update these scenarios, to further examine the possible effects of school opening, and to provide additional detail on possible scenarios beyond October 2021.

The Chair thanked the DOH, the HPSC, and the IEMAG for their inputs and invited observations from the Members. Key points made were as follows:

- It was noted that the epidemiological situation in Ireland indicates high incidence across the country with an uncertain trajectory. While incidence may start to plateau in the coming weeks, we should expect at least transient increases in incidence with the elevated population mobility and mixing associated with the reopening of schools and higher education.
- The current epidemiological situation is set against a background of the dominance of Delta in Ireland, a variant which is significantly more transmissible and less susceptible to vaccines than previous variants. The increasing incidence of the infection has increased the risk for more vulnerable individuals across all age groups who have either not been vaccinated or who have not been sufficiently protected through vaccination. The growing force of infection is resulting in a significant number of infections in older people who are unvaccinated and in vaccinated older people.
- It was noted that respiratory viruses including influenza ('flu') and respiratory syncytial virus (RSV) may be more impactful than usual over the coming months because as a population we may be more susceptible to these infections given our reduced exposure last winter, as well as differences in the public’s health behaviours. In addition, non-communicable diseases including asthma, COPD and strokes are likely to be exacerbated during the winter and coupled with the resurgence of respiratory infectious diseases will put further pressure on our health system.
- Members agreed that it would be important to communicate effectively to the public that they cannot rely on the vaccine alone to keep themselves safe from infection but that they must continue to apply Non-Pharmaceutical Interventions (NPIs) when appropriate particularly in the coming winter months. Members were conscious of the importance of communicating this message without undermining the public’s confidence in the vaccine. Developing an understanding in the public that those who are vaccinated are less likely to be seriously ill but still capable of transmitting the virus will be key.
- Members noted that a study of healthcare workers (HCWs) in the Netherlands had found that 68% of vaccinated HCWs who suffered a breakthrough infection were found to be hosting infectious virus cultures in comparison to 85% of unvaccinated HCWs. These findings indicate that there is still a significant risk that a vaccinated person can transmit the virus. Therefore, continued practice of NPIs needs to be emphasised.
- It was also noted that many of those who are not yet vaccinated may not be opposed to vaccination but rather are from marginalised communities, many of whom do not speak English as a first language or experience other barriers to access. The contribution of GPs to date in supporting access for marginalised groups was acknowledged with appreciation. Continued emphasis should be placed on innovative public health interventions to support the vaccination of those from marginalised communities.
- Members reflected on whether a focused vaccination drive aimed at those returning to third-level education would be prudent.
- The disproportionate impact that the current wave of cases is having on those who are unvaccinated or who are experiencing waning immunity was noted with concern.
- With regard to hospitalisations, the need to be able to triage vaccinated and unvaccinated patients into separate streams upon admission to hospital was emphasised. The need for prompt identification of patients with high grade immunosuppression who are at high risk of breakthrough infections and ICU admission was also stressed.
  - The HSE confirmed that hospitals have been requested to determine the vaccination status of patients on admission and to protect those who are unvaccinated where possible but that in some cases the infrastructure does not allow for this.
• The HSE confirmed that although testing of asymptomatic fully vaccinated staff and patients in the acute hospital is not required as a routine in current guidance, hospitals are continuing to test asymptomatic people quite extensively, based on risk assessment as per guidance. When new asymptomatic infections of fully vaccinated patients and staff are detected, they are managed as infectious cases.

• The NVRL advised that there is an increasing recognition internationally that certain cohorts of people may require an additional dose of vaccine as part of their primary course in order for them to develop immunity. It is therefore important to differentiate these people from cohorts requiring a booster shot due to waning immunity.

• Regarding duration of hospital stay, it was confirmed that while length-of-stay has become shorter, over time, patient numbers in hospital may accumulate through the current wave if some people have longer stays.

• It was suggested that available data on previous influenza seasons (morbidity, mortality, length-of-stay) could be compared against COVID-19 for comparison purposes over the coming winter.

The Chair thanked the Members for their observations and noted that, while vaccine uptake has been very high to date and will hopefully remain so, there is still a large cohort of the population who remain unvaccinated and consequently vulnerable. The majority of cases occurring are within this unvaccinated cohort and it will be important to emphasise to the public that there are many activities that are now possible which remain unsafe for those who are not vaccinated or who are immunocompromised. It will also be important to communicate that we must continue to apply NPIs post-vaccination so as not to lose control of the disease. The Chair noted future measures would be discussed under item 4(b).

3. HIQA Expert Advisory Group
   a) Advice Re: screening and surveillance of asymptomatic individuals
   The HIQA presented the paper "Advice to the National Emergency Team: Rapid antigen testing for screening or surveillance of asymptomatic individuals to limit transmission of SARS-CoV-2 - 24th August 2021" to the NPHET for preliminary consideration. The Chair confirmed that a future discussion on the paper will take place once Members have had an opportunity to fully consider the recommendations made therein.

   b) Recommended Minimum age for Mask Wearing
   The HIQA presented the paper "Advice to the National Emergency Team: Reduction of the minimum age for the application of mask wearing requirements and recommendations – Update: 24th August 2021" to the NPHET for preliminary consideration. The Chair confirmed that a future discussion on the paper will take place once Members have had an opportunity to fully consider the recommendations made therein.

4. Future Policy
   a) Vaccination update
   The HSE gave a verbal update on progress regarding the national Vaccination Programme. The key points made were as follows:

   • The national COVID-19 Vaccination Programme continues to make significant progress, with 91.4% of adults aged 18 years and over having received one dose and 86.7% of adults now fully vaccinated (data as of 24th August).

   • Vaccine uptake and completion has been very high in older age groups (ranging from 84% completion in those aged 40-44 years, through to 97% completion in those aged 65-69, to almost universal vaccination, 98-99.5%, in those aged 70 and over).

   • 80% of 18-29-year-olds are now partially vaccinated (approximately 500,000).

   • The vaccination registration portal is now open for 16-and 17-year-olds, with 100,000 registrations recorded up to 25th August.

   • Regarding 12-15-year-olds, over 100,000 have received their first vaccine dose to 25th August.

   • 43 vaccination centres continue to operate nationally.
• The HSE is awaiting NIAC advice on boosters and preparations are underway to provide same if needed.
• Geographical vaccination data is now available with regard to county of residence.
• The experience has been that the more vaccination avenues that are opened for people locally, the greater the uptake: walk-in centres, GP clinics etc.
• The HSE Communications team is running local communication campaigns to foster greater uptake in areas of concern.
• Some anti-vaccination campaigns have taken place recently. These campaigns do not appear to be adversely affecting uptake at present. The support provided by members of the public in countering misinformation has been invaluable and very much appreciated.
• Outreach work regarding socially vulnerable groups is continuing with 10,000 vaccinations administrated to 25th August. Bespoke vaccination programmes have been established where needed (e.g. workplaces where employees are largely non-nationals with limited English language proficiency). Directors of Public Health continue to bring socially vulnerable cohorts to the attention of the HSE with a view to providing appropriate avenues for vaccination. A jointly chaired working group continues with its work in coordinating the vaccination of vulnerable employees.
• An updated Infection Prevention and Control checklist will be provided to acute hospitals in the next week. This checklist will include a requirement to establish the vaccination status of patients on admission. If a patient is not vaccinated, the hospital is asked to arrange for vaccination as soon as the person is clinically well enough for vaccination.
• The emergence of a significant social class gradient in the 12-15-year-old cohort is becoming apparent based on feedback from GPs. The HSE is working to address this. For example, consent to vaccination forms for minors require one parent’s signature only.

The Chief Clinical Officer of the HSE acknowledged the contribution of General Practice to the Vaccination Programme, with approx. 2 million vaccines administered by GPs nationally. The speedy vaccination of those aged 70 years and over can be attributed to the intervention of General Practice in particular.

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

(i) Vaccine safety Update
The HPRA provided a verbal report on the national reporting experience for COVID-19 vaccines.

No new safety issues have been identified from national reports since the last update to the NPHET. A report published on the HPRA website on 12th August (Report #10) includes more details regarding the type and nature of reported reactions. The next report will be published on 9th September.

The HPRA also provided a brief update on vaccine review at the EMA. The ECDC and the EMA are developing criteria on the use of booster doses and considerations on boosting with a vaccine different to the one used in the initial vaccination (heterologous boosting). The EMA will review data on booster doses submitted by companies marketing vaccines over the coming weeks.

Ronaprev, a monoclonal antibody combination product (casirivimab/imdevimab, Regeneron) intended for the prevention and treatment of acute COVID-19 infection is undergoing rolling review stage by the EMA, with a formal marketing authorisation application not expected until later this year (2021). The product is subject to a positive opinion from the EMA on the basis of initial data and can be prescribed as an unauthorised medicine. Ronaprev has recently been approved by the UK MHRA.

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

b) Future Planning
In introducing this item, the Chair stated that the purpose of today’s discussion is to finalise and reach a consensus on the NPHET’s advice to the Minister on managing the next phase(s) of the COVID-19 response, with a view to informing the Government’s Roadmap for further easing of restrictions and overall approach to the management of COVID-19, expected week commencing 30th August.
The Chair reminded Members that an initial discussion on the same topic had taken place at the NPHET meeting of 27th July. At that meeting, Members were asked to consider the circumstances and criteria that would facilitate a further easing of the range of public health measures and advices in place and to those that will either need to continue over the medium term or that can be altered, adapted, or removed altogether once those criteria are satisfied. To facilitate a substantive discussion on the matter, the Chair invited the DOH to give a brief presentation on the relevant decision points.

The DOH outlined the current context and summarised a number of important considerations that were captured during the NPHET discussion on 27th July, including: the high level of vaccine uptake; current disease trajectory; ongoing uncertainties in relation to variants, length of post-vaccination and post-infection immunity, long-term health impacts of COVID-19 and the impacts of other respiratory viruses over coming months; ongoing international advice in relation to the importance of NPIs; ongoing core priorities of protecting those most vulnerable to COVID-19, and protecting key public services of health and social care, education and childcare; and approach continuing to be underpinned by core ethical principles, with a view to informing the discussion.

The DOH then set out the points for decision, namely: the proposed criteria for transition in public health approach; proposed measures that will need to be maintained even when the agreed criteria have been met; and measures to be eased once the agreed criteria have been met. The Chair thanked the DOH for its presentation, reiterated that the decision points presented were informed by the NPHET’s preliminary discussion on the 27th July, and invited observations from the Members. Key observations made during the discussion are detailed below.

Decision Point 1 - Proposed criteria for transition in public health approach:
The DOH presented proposed criteria for transition in the public health management of COVID-19 from regulation and population wide restrictions to a focus on public health advice and personal judgement and responsibility. It was noted that an earlier version of the criteria had been presented at the previous meeting and had been further developed following that discussion. The 5 criteria (to be considered collectively), discussed and agreed upon, are captured in the Action Point below. Key points made in the NPHET discussion on Decision Point 1 were as follows:

- There was broad support for the criterion that 90% vaccination uptake should be attained in the population aged 16 years and older in order for the transition to commence, with Members noting that 90% is considered practicable, reasonable, and proportionate. However, a number of queries were raised by Members with regard to:
  - Was health system capacity sufficient to provide for 10% of the population remaining unvaccinated as well as breakthrough infections?
  - The current trajectory of the Vaccination Programme and at what point in time 90% uptake in vaccination is likely to be achieved.
  - Whether it would be appropriate to include those aged 12-15 years in the overall 90% uptake target.
- In response to the above queries, the DOH noted that, based on current vaccination figures, 90% vaccination uptake in those aged 16 years and older is likely to be achieved by mid-September 2021; including the 12-15 years age cohort in this target would extend the time necessary to achieve this goal. Furthermore, it was noted that maintaining the uptake target for those aged 16 years and older is consistent with the general approach to consent in healthcare and, therefore, should not be expanded to include the 12-15 age cohort. Members were keen to stress however that this approach should not be interpreted as meaning that vaccination of the 12-15 age cohort is unimportant.
- With regard to incidence and reproduction number (R), some Members noted that as the virus is very likely to continue to circulate in the long term, they would support transitioning from a focus on overall case numbers to a focus on the harm and impact of COVID-19 infection. Others noted that, while harm will be the primary focus when the disease enters the endemic phase, endemcity has not yet been reached and it is, therefore, too early to move away from our current focus. It was agreed that there should be a criterion on infection levels, but that there shouldn’t be a requirement for R to be below 1.
• There was general agreement that a transition in the overall management of COVID-19 should also involve a change in the public health response strategy. This will require a review of the public health response to COVID-19 to include testing, contact tracing, outbreak management, surveillance and sequencing. This review will inform an agreed plan and prioritisation framework for public health response capacity. It was agreed that the criterion being included on public health capacity will be subject to a review and an agreed plan will be developed.

• As had been discussed earlier in the meeting, it was emphasised that there would need to be clear communications that the achievement of these criteria did not mean that there could be a return to full normality, and that there would need to be a continuation of some NPIs.

• The criteria as presented, with minor amendments, were agreed. These are outlined in the action point below.

Decision Point 2 - Longer term measures:
The DOH presented a draft of proposed longer-term measures that notwithstanding a transition in the overall approach to the public health management of COVID-19, must remain critical components of our collective response and will need to be retained and reviewed on a periodic basis until at least Spring 2022. It was noted that an earlier version of proposed longer-term measures had been presented at the previous meeting and had been further developed following that discussion. These measures, discussed and agreed upon, are captured in the Action Point below. Key observations made during the NPHET discussion on Decision Point 2 were as follows:

• With regard to Health Service Preparedness:
  o IPC measures that have already been implemented should be sustained.
  o Infrastructural change is needed in hospitals to facilitate stronger IPC measures and isolation capacities.
  o A revision of the regulations governing LTRCFs is needed.
  o The need for ongoing strengthening of health system capacity across public health, community and hospital services.

• With regard to non-essential international travel, advice should specify that it relates to those eligible for vaccination.

• The need for a refreshed communications approach was emphasised.

• The proposed measures that should be retained in the longer-term as presented, with minor amendments, were agreed. These are outlined in the action point below.

Decision Point 3 - Measures to be eased once criteria met:
The DOH presented a draft of the measures to be eased once the transition criteria have been met, and notwithstanding ongoing public health advice, that those who have not been fully vaccinated should continue to avoid or exercise very high levels of caution in high-risk environments. The measures, discussed and agreed upon, are captured in the Action Point below. Key observations during the discussion on Decision Point 3 were as follows:

• Members acknowledged that the proposed advice represents a significant shift in our approach. It entails a change from protection at the population level through regulations and restrictions to protection at a personal level.

• It was noted that this move from regulations to personal responsibility and making well-informed individual risk assessments requires a shift in focus to empowering people and highlighting the importance of relational autonomy and interconnectedness. It was suggested that a move from regulations towards personal responsibility should emphasise the importance of personal protection.

• The transition from regulations to guidance will necessitate a renewed approach to engagement and communication with the public. This phase will require the health system and Government to find new ways to keep people informed about COVID-19 and any risks that remain. While this step change will be welcomed by most, and signals progress in our work to respond to COVID-19, it will call for a renewed approach to engagement and communication with the public. It was highlighted that for this new phase of the COVID-19 response, without the parallel track of significant restrictions, and given the fatigue
being seen with the messaging on public health measures, supporting and sustaining the required level of appropriate public health behaviours will be a continuing challenge for all sectors to address.

- Ireland is part of a global community and, as such, global inequalities and differences in response must form a large part of our considerations going forward. COVID-19 will continue to be a global challenge further compounded by an uneven vaccination rollout. International cooperation will be required to facilitate the equitable allocation of vaccines across the world and as a country, we must continue to play our part in ensuring equitable access to vaccines.

- The proposed measures that can be removed once the agreed criteria have been met were agreed as presented. These are outlined in the decision point below.

The Chair thanked the Members for their respective inputs to the discussion and confirmed that, subject to amendments as agreed during the discussion, consensus had been reached on the criteria, measures that can be eased once these criteria have been met, and measures that need to be retained in the longer-term. The Chair proceeded to summarise the NPHET’s position and advice as detailed in the Action Point below.

**Action Point: The public health management of the COVID-19 pandemic has evolved and must continue to evolve in light of changing circumstances and risks. Notwithstanding the current disease profile and continuing uncertainties in relation to the trajectory of COVID-19, and subject to the continued engagement of younger age cohorts with the vaccination programme in the coming weeks, we will attain a level of vaccine coverage within the population which, together with a number of continued protective measures and ongoing robust public health surveillance and response capacities in appropriate settings, will facilitate a transition in our approach to the public health management of COVID-19 in Ireland.**

Accordingly, it is the view of the NPHET that it may be appropriate in those circumstances that the public health management of COVID-19 in Ireland transitions, in broad terms, from a focus on regulation and population wide restrictions to a focus on public health advice and personal judgement and personal protective behaviours. The NPHET advises that the following criteria should be met to enable this transition (balance assessment on a collective basis):

1. At least two weeks having passed from the attainment of at least 90% uptake (completion of vaccination) in the population aged 16 years and older; and
2. A point in time assessment that incidence, reproduction number, growth rate, impact, and progression of infection to severe disease give confidence that we can suppress the infection sufficiently to minimise the harm of disease; and
3. Hospital and critical care occupancy for COVID-19 are reducing and/or reduced to low levels to protect the health service and ensure the continued provision of non-COVID health and social care services, including in the community; and
4. Public health capacities, which will need to be subject to review and an agreed plan, including in relation to testing, contact tracing, outbreak managements, surveillance, and sequencing for COVID-19, will be sufficiently robust to enable the rapid identification, investigation, and management of local or regional outbreaks, outbreaks among vulnerable groups, and the emergence of new variants; and
5. The absence of a new variant of concern with significantly increased potential for one or more of the following: greater transmissibility, increased virulence, or vaccine escape.

Notwithstanding a transition in the overall approach to the public health management of COVID-19, the following must remain critical components of our collective response to COVID-19 and will need to be retained and reviewed on a periodic basis until at least Spring 2022:

- Clear guidance and communication with the public on the evolving disease profile and a cultural shift towards embedding individual and collective strategies to mitigate against COVID-19 and other respiratory infections. This will require a refreshed communications approach;
A renewed and sustained focus on the importance of rapid self-isolation if symptomatic (even if fully vaccinated) or if diagnosed with COVID-19;

Formal requirements for mask wearing in healthcare settings, indoor retail and on public transport;

Continued promotion of vaccination against COVID-19 and seasonal influenza vaccination;

Continued wearing of masks, practicing of physical distancing and avoidance of crowded environments based on individual risk assessment, and adherence to basic hand and respiratory hygiene;

Sector specific measures to ensure a safe environment including in relation to the promotion of rapid self-isolation when symptomatic, and appropriate use of face masks, physical distancing, hand and respiratory hygiene, ventilation, and signage;

Advice that non-essential international travel (by those eligible for vaccination) should only be undertaken by those who are immune (vaccinated or recovered);

In line with evolving strategies, ongoing robust public health surveillance and response capacities including testing, contact tracing, surveillance and sequencing capacities for COVID-19;

Health service preparedness and response to COVID-19 including:
  - sustained focus on and strengthening of IPC measures
  - ongoing strengthening of health system capacity across public health and community and hospital services, including critical care and isolation capacities, continuation of appropriate support for non-COVID care in a COVID environment and the revision of regulations governing the quality and safety of Long-Term Residential Care
  - appropriate physical distancing requirements based on local risk assessment and advice from IPC teams
  - continued strong promotion of vaccine uptake among healthcare workers.

While the above measures must be maintained over the medium term, and notwithstanding ongoing public health advice that those who have not been fully vaccinated should avoid or exercise very high levels of caution in high-risk environments, it is advised that the following measures can be removed when all of the above criteria have been met:

- Formal requirements/mandates for physical distancing;
- Formal advice for mask wearing outdoors and in indoor private settings;
- Limits on numbers that can meet in private homes/gardens;
- Limits on numbers at outdoor events and engaging in sporting activities outdoors;
- Restrictions on indoor sports activities and other indoor leisure/community activities;
- Restrictions on religious or civil ceremonies;
- Certification of immunity or testing as a prerequisite for access to, or engagement in, any activities or events (with exception of international travel);
- Restrictions on high-risk activities (i.e. nightclubs);
- Requirement to work from home allowing a return to physical attendance in workplaces on a phased and cautious basis appropriate to each sector.

In addition, it is proposed that, subsequent to the above criteria being met, it would be appropriate that sectors commence the phased reintroduction of spectators/patrons (without the need for certification of immunity) at indoor cultural and sporting events, with institution and maintenance of high levels of basic infection prevention and control standards including in relation to promotion and facilitation of hand and respiratory hygiene and ventilation. Furthermore, all sectors should review and align sector-specific guidance and protocols such that they are appropriate to the transition in approach to the public health management of COVID-19.

5. Meeting Close
   
a) Agreed actions
The key actions arising from the meeting were examined by the NPHET, clarified, and agreed.
b) AOB
No matters arose for discussion under this item.

c) Date of next meeting
The next meeting of the NPHET is scheduled to take place week commencing 13\textsuperscript{th} September (date tbc).