An Roinn Sláinte
Department of Health
Office of the Chief Medical Officer

Mr. Stephen Donnelly TD,
Minister for Health,
Department of Health,
Miesian Plaza,
50-58 Lower Baggot Street,
Dublin 2.

18th February 2021
Via email to Private Secretary to the Minister for Health

Dear Minister,

I write further to today's meeting of the COVID-19 National Public Health Emergency Team (NPHET). The NPHET reviewed the latest epidemiological data and the following key points were noted:

- A total of 5,868 cases have been notified in the 7 days to 17th February, which is an 11% decrease on the previous 7 days in which there were 6,607 cases.
- As of 17th February, the 7- and 14-day incidence rates per 100,000 population have decreased to 123 and 262, respectively; these compare with rates of 139 and 312 on 10th February. Incidence rates remain high with incidence levels around 3-4 times greater than observed in early December 2020.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 47%, demonstrating that there have been a lower number of cases in the last 7 days compared with the preceding 7 days.
- The 5-day rolling average of daily cases has decreased from a peak of 6,831 on 10th January to 816 on the 17th February. The 5-day average has decreased by 4% since the last NPHET meeting (848).
- Incidence, although still high, is decreasing across all adult age groups except those aged 24 and younger. Incidence in those aged 85 and older remains elevated but is reducing. In the last 14 days, 12% of cases notified were aged over 65.
- Of cases notified in the past 14 days, 65% have occurred in people under 45 years of age; the median age for cases notified in the same period is 35 years. The incidence in those aged 18 and under has stabilised or increased with greater detection of asymptomatic infections due to the recent recommencement of testing of asymptomatic close contacts. Of note, there has been an increase in incidence in those aged 19-24 which may be due to increased social mixing in young adults.
- While 14-day incidence rates remain high across the country, 16 counties have a 7-day incidence as a percentage of the 14-day rate less than 50%, indicating fewer cases notified in the last 7 days compared with the previous 7 days. Of note in recent weeks, the number of cases in Dublin as a proportion of all cases notified nationally has been increasing, though it remains lower than in earlier phases of the pandemic.
- Of the 12,460 cases reported in the last 14 days, 6.8% (844) were healthcare workers.
- The best estimate of the reproduction number (R) is 0.65 – 0.85. The rate of decline of the disease is continuing at -2% to -4%.
- There were 110,462 tests undertaken in the last week. The 7-day average test positivity rate remains high; the positivity rate has decreased to 5.5% on 17th February from 5.8% on 10th February.
- Excluding serial testing and facility testing in response to outbreaks, the test positivity rate has plateaued over the last week, the rate remains high at 10.4% over the 7 days to 17th February, which compares to 10.5% last week.
- According to contact management programme data, 17 counties have test positivity rates (excluding serial and outbreak facility testing) greater than 10%.

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- There were 771 confirmed COVID-19 cases in hospital this morning, compared with 984 on 11th February; this is a 22% decrease since the last NPHET meeting. There have been 48 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 154 confirmed cases in critical care, compared with 170 on 10th February. There have been 9 admissions in the last 24 hours.
- To date, there have been 470 deaths notified with a date of death in February. This compares with 1,265 and 193 deaths notified (to date) with a date of death in January and December, respectively. Of the 470 deaths in February, 36 have thus far been associated with hospital outbreaks and 212 have been associated with nursing home outbreaks.
- To date, the prevalence of S-Gene Target Failure (SGTF) is 75% (833/1111 samples) for week 4 and 89% (762/860 samples) for week 6 2021. Week 5 SGTF prevalence data (90%, 82/91) should be interpreted with caution as they are provisional and have low sample numbers due to a technical laboratory issue which has since been resolved. Further data will be provided when available. SGTF is a marker for the new B.1.1.7 variant of concern first identified in England in December 2020.
- In total, 11 cases of 501Y.V2 (variant first reported in South Africa) have been confirmed by whole genome sequencing.
- No confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date.

<u>Healthcare setting outbreaks</u>

- There were 12 new clusters notified in acute hospitals in week 6 of 2021.
- As of today, there are 127 open clusters associated with 44 hospitals; there have been 231 deaths and 1,974 confirmed cases linked to these outbreaks. Of these confirmed cases, 39% are related to healthcare workers.
- There were 6 new clusters notified in nursing homes/community hospitals in week 6, this compares with 12 new outbreaks in these settings in week 5.
- There are currently 180 open clusters associated with nursing homes; there have been 721 deaths and 6,241 confirmed cases linked to these outbreaks. Of these cases, 39% of confirmed cases are related to healthcare workers.
- There are 23 open outbreaks in community hospitals and long stay units; there have been 39 deaths and 599 confirmed cases linked to these outbreaks with 51% of these cases recorded as healthcare workers.
- There are currently 194 open clusters associated with residential institutions; there have been 24 linked deaths and 1,617 linked confirmed cases to these outbreaks. Within these residential institutions:
    - there were 7 new outbreaks in centres for disabilities in week 6; there were 106 open outbreaks in centres for disabilities at the end of week 6;
    - there were no new outbreaks in mental health facilities in week 6 and there were 17 open outbreaks in these settings at the end of week 6;
    - there were 2 new outbreaks in Children's / TUSLA residential centres in Week 6 with 8 open outbreaks at the end of the week.

<u>Childcare Facility outbreaks</u>

- There were 5 outbreaks newly notified in childcare facilities in week 6 with 21 new linked cases. There are 73 open outbreaks in these settings at the end of week 6. According to the latest close contact positivity data in this setting from the Contact Management Programme, 11% (56/511) of close contacts (all age groups) in pre-school/creche settings were positive. Of these, 9.1% (35/384) of close contacts who are children (0-12 years) and 16.5% (21/127) of close contacts who are adults aged 18 years and older tested positive.

<u>Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:</u>

- There were 25 new outbreaks reported in vulnerable populations in week 6.
- There remains a high number of Irish Traveller outbreaks with 22 new outbreaks and 82 linked cases in week 6 compared with 22 new outbreaks in week 5; there are currently 103 open outbreaks in the Irish Traveller community. This represents a 26% increase on the number of open outbreaks on the previous week.
- There have been 2 new outbreaks in direct provision centres in week 6. Currently, there are 21 open outbreaks in direct provision centres.

- There has been 1 new outbreak in prisons in week 6. Currently, there are 4 open outbreaks in prisons

Workplace outbreaks

- Workplace outbreaks continue to be notified, with 22 reported in week 6 across a variety of settings, which is lower than the number of outbreaks identified in week 5 (29). There were 9 in commercial settings, 4 outbreaks related to food production settings, 4 in manufacturing settings, and 3 related to the construction industry.
- There were 181 open outbreaks in workplaces up to the end of week 6.

Further relevant information includes:

- The sentinel GP influenza-like illness (ILI) consultation rate has decreased to 18.2/100,000 population in week 6 of 2021, compared to an updated rate of 22.1/100,000 population in week 5 of 2021.
- A range of mobility and compliance data suggest that mobility is increasing, although levels still remain low.
- The number of close contacts captured during the week ending 14th February was 10,616, an 18% decrease from the previous week (12,978).
- The average number of close contacts per adult confirmed case remained below 3.3 until early December 2020, rose to almost 5 on average by 28th December, and then decreased rapidly; while it remains very low, it is increasing slowly (from 2.1 to 2.4 per case).
- Of the 7,155 close contacts created between 1st to 7th February where test results were available, 1,783 (24.9%) were positive. The highest positivity rate, 33.3%, was seen in household contacts.
- As of 17th February, the 14-day incidence per 100,000 population in Northern Ireland was 235; this is 10% less than the 14-day rate in the Republic of Ireland (262 per 100,000 population). The latest 7-day incidence per 100,000 population in Northern Ireland is 110, which is 11% less than the 7-day incidence rate in the Republic of Ireland (123 per 100,000 population).

In summary, Ireland continues to experience a very concerning and precarious epidemiological situation. Incidence is falling but the rate of decline has slowed and daily case counts remain very high. Incidence in older adults is decreasing, while testing of asymptomatic close contacts is inflating ascertainment of asymptomatic cases, with apparent increasing incidence in those aged 18 and younger. Of concern, incidence in young adults aged 19-24 years may be starting to increase. While acknowledging the contribution of the recent recommencement of testing of asymptomatic close contacts, there is some concern that test positivity may be plateauing.

The wider health and social care system continues to experience very significant impact from the current wave of infection. The number of patients with COVID-19 in hospital is reducing but remains very high, with daily COVID-19 hospital admissions now potentially plateauing. The number of COVID-19 patients in ICUs is slowly reducing but remains at a very elevated level. Healthcare-acquired infections and cases associated with long-term residential settings are decreasing. Mortality is very high but may be stabilising.

Indicators of mobility and contact remain low but are drifting upwards, with the average number of close contacts per adult confirmed case now at 2.4. The latest estimate of prevalence of the B.1.1.7 variant of concern (first identified in England) indicates that this lineage now accounts for approximately 90% of cases in Ireland, with its increased transmissibility evidenced by the high attack rates observed in the most recent close contact positivity data. Of notable concern, these data indicate that one in three close contacts of confirmed cases in the household setting are testing positive.

We are maintaining suppression of transmission, but the situation is precarious. Rate of decline in incidence has slowed, with daily growth at -2 to -4%, and halving time at 18-35 days. In addition, the latest estimates indicate that R has increased to 0.65 – 0.85. It is further noted that as a consequence of recent and ongoing high levels of infection, the capacity of our public health response is significantly constrained, with teams in regional departments of public health fully engaged in investigating and managing complex outbreaks across a range of vulnerable groups and settings. This further highlights the need for particular caution. A fundamental concern is that while we continue to suppress transmission, levels of disease remain very high, highlighting the need to consider the epidemiological situation in Ireland as very fragile.

Given the slow increase in reproduction number (R) over recent weeks, our models suggest that, even if the population continues to work to keep R below 1, case numbers will decline more slowly in February and March than they would have had we been able to maintain R between 0.5 and 0.7. We now estimate, if R is maintained between 0.7 and 0.9, which is in itself challenging, that we will have 400-500 cases per day at the end of February

and 200-350 cases per day in the week beginning 15th March 2021. The projections for numbers of people with COVID-19 in hospital at the end of February are at least 500-600 requiring general hospital care and 80-100 requiring critical care, with optimistic projections that these will further decrease to 300-400 people requiring general hospital care and 50-70 in ICU during the third week of March contingent on R staying between 07.-0.9.

Assessment of Current Position and Advice

As a country, we have once again succeeded in significantly reducing infection levels through widespread commitment and adherence to the public health measures over recent weeks. However, the epidemiological situation remains very fragile as we are still experiencing high levels of infection across the country. There remains a considerable risk that we will experience a further wave of infection if public health restrictions are eased before case numbers are reduced to much lower levels and before the vaccine rollout has been significantly advanced. This risk is heightened due to the dominance of the more transmissible B.1.1.7 variant and the risk in relation to other variants of concern (VOCs).

Furthermore, hospital and ICU occupancy levels remain high, with past experience demonstrating that they will fall at a slower rate than infections, resulting in prolonged pressure on the acute hospital system over the coming period. In addition, a difference can be observed in the age profiles of those who have been admitted to hospital and critical care and those who have died (47% of those hospitalised and 69% of those in ICU have been under 70, while only 13% of deaths have been in those under 70), and, as such, it can be anticipated that vaccination will not have as significant an impact on hospitalisations initially as it will on mortality as it will take time for younger age cohorts to be vaccinated.

Overall, our health service remains extremely fragile. While it has managed to withstand the significant demands made of it during the recent period, the high levels of disease required a significant ramp up in surge critical care capacity, redeployment of staff and caused serious and extensive disruption to non-COVID services across the breadth of the health and social care system, the impact of which will be felt for some time. It has also had an enormous impact on health care workers, where fatigue and burn-out continue to be very significant concerns.

There is an understandable level of hope in relation to the potential of vaccines and the impetus that they can bring to a return of "normal" life. Vaccines will of course play a critical role in protecting the population against COVID-19 and will, hopefully, in time be our primary line of defence. However, it will take time before we have a sufficient level of the population vaccinated, and even then, it is not possible to know at this stage what level of protection vaccination will give. While we have just cause to be hopeful that things will improve over the course of the year, it is simply too early to predict what the future trajectory of the disease will be given all the uncertainties and unknowns in relation to variants and vaccine effectiveness and uptake levels. It is vital that as a population we don't drop our guard and we ensure that our overall approach continues to be one that is cautious and sustainable over the immediate, medium and longer term.

Most recent international guidance from the ECDC and WHO urges caution in relation to the ongoing management of COVID-19 and calls for a continuation of the measures that have been deployed over the last year until incidence levels have been reduced to the lowest levels possible, minimising the opportunities for new variants to emerge, and vaccination has reached a critical mass and has been shown to work. In particular, they highlight the risks associated with new variants. In its Risk Assessment of 15th February 2021, the ECDC warns that the epidemiological situation remains of serious concern across the EU/EEA. It notes that there has been an overall decline in incidence over recent weeks as a result of public health restrictive measures, but concludes that the current risk associated with further spread of variants of concern is high-very high for the overall population and very high for vulnerable individuals.

In light of the current epidemiological position, the continuing pressures on our health service, and international advice, the NPHET advises that the approach over the coming months must be one of extreme caution. It is critical that we do not risk the progress we have made over recent weeks, which has come at huge sacrifice to everyone. It is imperative that the focus remains on regaining and maintaining control over the disease and preventing a further wave of infection later in the year, until vaccination can offer a widespread population level of protection. It will be essential that the following are achieved before any significant easing of measures is considered:

(1) Disease prevalence is brought to much lower levels that can be managed and controlled by public health.

(2) Hospital and critical care occupancy are reduced to low levels to protect the health service and allow for the safe resumption of non-COVID care.
(3) The most vulnerable are protected through vaccination.
(4) When these conditions have been met, any easing should be slow and gradual with sufficient time between phases to assess impact and should be subject to rapid response if the epidemiological situation were to deteriorate.

The NPHET, therefore, advises that current restrictions should be extended. Subject to continued improvement in the profile of the disease to the end of February, there should, however, be scope to facilitate the safe return of in-school education and childcare services but this must be on a cautious and phased basis. It is also critical that non-COVID health and social care services are resumed as quickly as possible, subject to national risk assessments. We continue to have an unacceptably high level of disease in the community. It is therefore imperative that we continue to suppress the disease over the coming period, and this will require that all other restrictions remain in place while these services recommence.

It is essential that the return of these core public services isn't interpreted as a signal of wider reopening and that other forms of interaction or mobility are now acceptable or appropriate. All efforts should be made to ensure that the return to in-school education and childcare is associated with a minimum level of linked mobility and the avoidance of inter-household mixing, and that all those working from home continue to do so. There must also continue to be consistent and clear messaging from all sectors in relation to the necessity for continued adherence to public health measures.

The NPHET further notes that it is too early to advise on how and when other restrictions should be eased given current uncertainties. The situation will be subject to ongoing review taking account of the evolving epidemiological situation and available evidence in relation to vaccine deployment, uptake and effectiveness. This will allow a fuller assessment of the status of the disease, including the impact of priority services reopening in the context of the more transmissible variant, and it is envisaged there will be considerably more data in relation to vaccines which will enable more detailed modelling. In parallel, consideration will be given to which measures can be eased safely when it is appropriate to do so, taking account of emerging international and national evidence and experience and with a specific focus on supporting mental health and wellbeing. As previously advised, any easing of measures should be slow and gradual with sufficient time between phases to assess impact and subject to rapid response if the epidemiological situation was to deteriorate.

The NPHET notes that continuing with a cautious approach is consistent with most recent public opinion research which indicates that the vast majority of the population are supportive of measures to protect the population, with 54% reporting that the current Government response is appropriate and 36% saying it is insufficient. 45% believe we are trying to return to normal at about the right pace, with 34% reporting that it is too quick and only 20% reporting it is too slow. It should be noted that these findings may be influenced by views in relation to travel measures.

Finally, it is important to re-emphasise that the adoption and practice of the basic individual behaviours that protect us both individually and as a community remain the most important and effective contribution that we can all make to preventing transmission of the virus. These behaviours will continue to be a core feature of our response for some time to come, these include social distancing, wearing a face mask, hand hygiene, sneeze and cough etiquette, isolating and contacting a GP if symptoms develop, minimising the number of close contacts, and avoidance of crowds and poorly ventilated indoor spaces.

Longer Term Planning

In addition to the above advice, the NPHET also undertook a process of broader consideration in relation to the ongoing response. This has taken account of the key learnings from our experience of the pandemic to date, new parameters such as the emergence of more transmissible variants and the rapidly developing vaccination landscape, new evidence and innovations, and most recent international advice. I attach a paper which sets out NPHET's advice for managing the next phase of the COVID-19 response. This identifies key elements of the response that must be strengthened and improved over the coming weeks to allow for an easing of measures in the medium term, including:

- Increased public health capacity & an enhanced public health response system
- Comprehensive support system for self-isolation/restricted movements

- Enhanced surveillance and modelling capacity & consideration of an expanded role for testing using complementary novel technologies
- Robust and responsive international travel measures
- Continuing strategic investment in research and innovation
- Robust infection prevention and control measures across all sectors, organisations, businesses, and services, including a more explicit focus on ventilation
- Continued supports for long-term residential care settings and other services

The paper also outlines areas for consideration in relation to the longer-term sustainability of the response, specific considerations in relation to health system resilience and transformation and the overall communications strategy. I understand that this advice will form part of considerations across Government over the coming period in relation to our ongoing response to COVID-19.

Vaccination Strategy

The COVID-19 Vaccine Allocation Strategy developed by the National Immunisation Advisory Committee (NIAC) and the Department of Health, was endorsed by the National Public Health Emergency Team (NPHET) and approved by Government on 8th December 2020. The provisional vaccine allocation strategy contained a commitment to keep the priority groups identified under review and to adapt where necessary in light of any new evidence and/or a changing epidemiological situation. Since the publication of the provisional priority listing at the beginning of December, Ireland has experienced increasing disease incidence with extremely elevated case counts as well as the emergence of SARS-CoV-2 variants of concern. In addition, national and international evidence has become available which enables a more detailed examination of specific underlying medical conditions which increase the risk of developing severe disease or dying following infection with SARS-CoV-2.

The NPHET endorsed a joint Department of Health and National Immunisation Advisory Committee (NIAC) paper which set out a re-prioritisation of those individuals with underlying medical conditions which put them at very high or high risk of severe disease or death should they contract the virus. The NPHET considered that the recommendations are consistent with the primary objective of the vaccination campaign to reduce morbidity and mortality which in turn will improve resilience of and protect the healthcare system from being overwhelmed. Targeting individuals with medical conditions known to be associated with severe COVID-19 disease for early vaccination should protect the most vulnerable and reduce hospital and ICU admissions as well as mortality. Accelerating the vaccination of those at very high and high risk of severe disease or death as a result of COVID-19 is also consistent with ECDC advice to Member States in its rapid risk review of February 15th to rapidly roll out vaccination to those populations most at-risk of high morbidity and mortality from COVID-19.

Long-Term Residential Care Settings

The NPHET also discussed visitation to long-term residential care settings (LTRC) in the context of the rollout of the COVID-19 vaccine in such settings. LTRC visiting guidance has remained under ongoing review throughout the pandemic, given the challenge of balancing protective health measures and normal living within such settings. In light of the advanced stage of the rollout of the COVID-19 vaccine in LTRCs for both residents and staff, the NPHET recommended that the AMRIC progress a process for considering the scope and application of LTRC visiting restrictions. This work should be undertaken in the context of the Framework of Restrictive Measures, having regard to relevant national and international evidence, the rollout and uptake of the COVID-19 vaccine in LTRCs, and the level of disease in the community.

The NPHET, of course, remains available to provide any further advice and recommendations that may be of assistance to you and Government in relation to ongoing decision-making processes in respect of the COVID-19 pandemic. As always, I would be happy to discuss further, should you wish.

Yours sincerely,

Dr Ronan Glynn
Deputy Chief Medical Officer
Acting Chair of the COVID-19 National Public Health Emergency Team

cc. Ms Elizabeth Canavan, Department of the Taoiseach and Chair of the Senior Officials Group for COVID-19