



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

11th March 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 (NPHE). The NPHE reviewed the latest epidemiological data and the following key points were noted:

- A total of 3,427 cases have been notified in the 7 days to 10th March, which is a 24% decrease on the previous 7 days in which there were 4,531 cases.
- As of 10th March, the 7- and 14-day incidence rates per 100,000 population have decreased to 72 and 163, respectively; these compare with rates of 91 and 199 on 3rd March.
- Nationally, the 7-day incidence as a proportion of 14-day incidence is 46%, demonstrating that there have been fewer 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 488 on the 10th March. The 5-day average has decreased by 17% since the last NPHE meeting (591).
- Incidence is decreasing across most age groups except in those aged 65-74 years (+4%). The decrease in incidence is relatively evenly spread across other age groups (20-30%) except in those aged 85+ years which has decreased by over 50% in the latest week. This refers to the incidence in the population excluding healthcare workers and long-term residential care (LTRC) settings only.
- Of cases notified in the past 14 days, 69% have occurred in people under 45 years of age; 18% of cases notified were aged over 65. The median age for cases notified in the same period is 32 years. Among those aged under 45, the highest incidence is in those aged 19-24 years.
- While 14-day incidence rates remain high across the country, 21 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 the 7,739 cases reported in the last 14 days, 5% (330) were healthcare workers.
- The best estimate of the reproduction number (R) is 0.6-1.0. The rate of decline of the disease is continuing at 0% to -5%. R and rate of decline are uncertain and difficult to estimate at this time.
- There were 97,184 tests undertaken in the last week. The 7-day average test positivity rate has decreased to 3.7% on 10th March from 4.2% on 3rd March.
- Excluding acute, serial and mass testing in response to outbreaks, the community test positivity rate has decreased slightly over the last week; the rate remains high at 12% over the 7 days to 10th March, which compares with 13% on 3rd March.
- According to contact management programme data, 15 counties have community positivity rates (excluding acute, serial and mass testing in response to outbreaks) greater than 10%.
- There were 359 confirmed COVID-19 cases in hospital this morning, compared with 460 on 4th March; this is a 22% decrease since the last NPHE meeting. There have been 32 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 89 confirmed cases in critical care, compared with 107 on 4th March. There have been 3 admissions in the previous 24 hours.
- To date, there have been 59 deaths notified with a date of death in March. This compares with 762 and 1,352 deaths notified (to date) with a date of death in February and January, respectively. Of the 59

deaths in March, 9 have thus far been associated with hospital outbreaks and 15 have been associated with nursing home outbreaks.

- In total, 19 cases of B.1.351 (variant first reported in South Africa) have been confirmed by whole genome sequencing. Of these, four were newly identified in the last week.
- Six confirmed cases of P.1 (variant first reported from Brazil) have been identified in Ireland to date. Of these, three were newly identified in the last week.
- Other variants of note/under investigation confirmed in Ireland to date: 7 confirmed B.1.525 cases, 5 confirmed B.1.526 cases, and 11 confirmed P.2 cases.

It should be noted that in week 9, (28th February – 6th March 2021), a significant number of outbreaks (141), were added that related to cases notified before February. The majority of these related to private household outbreaks. The data presented here are based on outbreaks and associated cases notified since 22nd November 2021.

Healthcare setting outbreaks:

- There were 5 new clusters notified in hospitals in week 9 of 2021.
- As of the week ending 6th March, 94 hospital outbreaks remained open. There have been 2,372 cases and 318 deaths linked to hospitals outbreaks created in this period.
- There were 3 clusters notified in nursing homes/community hospitals in week 9 (including 1 late notification), this compares with 6 outbreaks in these settings in week 8.
- Of all nursing home outbreaks at the end of week 9, 104 remained open. There have been 7,227 cases and 844 deaths linked to nursing home outbreaks created in this period.
- Of all community hospital outbreaks created in the same period, 20 remained open. There have been 662 cases and 44 deaths linked to community hospital outbreaks created in this period.
- There were 9 new outbreaks in residential institutions in week 9.
- Of all residential institution outbreaks created in the same period, 103 remained open at the end of week 9. There have been 1,619 cases and 29 deaths linked to nursing home outbreaks created in this period.

Outbreaks associated with educational settings and childcare facilities:

- There were 25 new outbreaks notified during week 9 in settings associated with education and childcare facilities or students.
- There were 10 outbreaks newly notified in childcare facilities in week 9 with 34 new linked cases. There were 73 open outbreaks in these settings at the end of week 9.
- There were 15 newly notified outbreaks associated with third level students in week 9 with 86 open outbreaks associated with this group. The majority of these outbreaks were notified in the West (13).
- There were no outbreaks notified associated with school children and or school staff in week 9.

Vulnerable groups, Travelling Community, Direct Provision & Prison Outbreaks:

- There were 37 new outbreaks reported in vulnerable populations in week 9.
- There remains a high number of Irish Traveller outbreaks with 30 new outbreaks and 119 linked cases in week 9, compared with 23 new outbreaks in week 8; there were 130 open outbreaks in the Irish Traveller community at the end of week 9. This represents an 8% decrease on the number of open outbreaks on the previous week.
- There was 1 outbreak reported in the Roma Community during week 9.
- There was 1 new outbreak in a direct provision centre in week 9. At the end of week 9 there were 9 open outbreaks in direct provision centres.
- There were 4 outbreaks notified in homeless facilities in week 9 (includes 1 late notification). Currently, there are 7 open outbreaks in these settings.
- There was 1 new outbreak in a prison in week 9. At the end of week 9 there were 39 open outbreaks in prisons.

Workplace outbreaks:

- There were 19 workplace outbreaks reported in week 9 across a variety of settings, which is 47% lower than the number of outbreaks identified in week 8, (37). There were 6 in commercial settings, 4 related to food production settings, 3 in manufacturing settings, 3 related to the construction industry, 2 in 'other workplace' and 1 in an office.

- There were 208 open outbreaks in workplaces up to the end of week 9.

In summary, the epidemiological situation in Ireland has continued to improve but progress remains particularly fragile. While we are seeing continued, slow improvement in most disease indicators, incidence across all age groups remains at a much higher level than that observed in late November/early December 2020. In addition, test referrals from general practitioners, which had previously been reducing, indicate a static trend over the last week. Community test positivity is high but slowly reducing. To note, however, 15 counties still have 7-day average community test positivity rates of 10% or greater. The elevated secondary attack rate of the dominant B.1.1.7 variant, continues to present significant challenges to transmission control, with recent data indicating approximately one in four close contacts overall, and one in three in the household setting, have returned a positive result.

Supported by the unwavering commitment of its frontline workers and wider support staff, the health and social care system continues to experience significant pressure in response to the current wave of infection, with ongoing profound curtailment of capacity to deliver a range of scheduled and routine care services. The number of confirmed cases in hospital and ICU, although reducing, is still greater than the highest levels observed during wave 2. Incidence in long-term residential care and healthcare workers has fallen substantially in recent weeks, providing significant evidence for the initial protective impact of the national vaccination programme which continues to be rolled out.

Indicators of mobility continue to drift upwards, although it is noted their interpretation in relation to compliance is limited by the increase in mobility expected on foot of the recent commencement of phased reopening of schools. That said, there is concern that rising mobility, particularly in relation to workplace attendance, may be associated with increased viral transmission in the coming weeks.

We are maintaining suppression of transmission but this is precarious. R may be between 0.6 to 1, with rate of decline between 0 to -5%. However, these indicators are uncertain and difficult to estimate at this time, signaling the need for caution over the coming days and weeks. While there is evidence of protective effect from vaccination of healthcare workers and those living in long-term residential care, the anticipated impact of immunisation on the risk profile of the remaining susceptible population will take a number of months. It is noted that those aged 70 and older are not due to have all received their first vaccine dose until after mid-April, and their second dose until after mid-May, highlighting the particular vulnerability of this group over the coming months.

Visitation to Long-Term Residential Care Settings

The NPHET discussed visitation to long-term residential care facilities (LTRCFs) in the context of the COVID-19 vaccine roll-out in such settings. Given the challenge of balancing protective health measures and normal living within such settings, LTRCF visiting guidance has remained under ongoing review throughout the course of the pandemic.

The NPHET endorsed the HSE's (AMRIC) latest *"COVID-19 guidance on visits to Long-Term Residential Care Facilities (LTRCFs)"*, which contains a number of revisions to the existing visitation guidance in the context of the Framework of Restrictive Measures.

Although the vaccination of LTRCF residents and staff is very well advanced, vaccination does not confer immediate protection. Therefore, the updated guidance particularly emphasises that it is important for staff and residents' families and friends to understand that precautions to prevent the introduction and spread of the virus cannot be reduced immediately after vaccination.

The guidance, therefore, proposes a cautious, incremental increase in visiting at Levels 3, 4 and 5 of the Framework of Restrictive Measures, providing for meaningful contact between residents and their families and friends, with changes placing greater emphasis on the harm associated with visiting restrictions and the rights of residents to maintain meaningful contacts, while also stressing that vigilant, general infection prevention and control (IPC) measures and risk assessment requirements are to remain in place. Key changes to the guidance include:

- Increased frequency of visiting on general compassionate grounds at Levels 3, 4 and 5 of the Framework in the context of a high level of vaccination of residents and staff (to 2 visits with 1 person per week).
- Removal of the limit on duration of visits to 1 hour (unless a limit is required for operational reasons).

- Clarification that residents who have recovered from COVID-19 should be regarded as equivalent to vaccinated residents for 6 months after diagnosis.
- For IPC reasons, all visitors will be asked to wear a surgical mask.

The guidance will come into effect by 22nd March, thereby allowing LTRCFs, residents, and their families and friends time to prepare for the change. A user-friendly document will be developed for residents and families/friends to accompany the guidance. The AMRIC will also consider vaccination requirements for admission to LTRCFs in due course.

The NPHET confirmed its intention to further review the visiting guidance in April, with a view to assessing whether LTRCF visiting restrictions in the context of the Framework of Restrictive Measures can be further eased, with due regard to relevant national and international evidence, available data on the roll-out and uptake of the COVID-19 vaccine in such settings, and the level of disease in the community.

Serial Testing in Long-Term Residential Care Facilities (LTRCFs)

The NPHET also endorsed the Interim Recommendations of the HSE's (HPSC) National Testing Strategy Group on the future approach to Serial Testing in long-term residential care facilities (LTRCFs). This report was provided in the context of the roll-out of the COVID-19 vaccination programme in the sector. The NPHET agreed that there should be no change to the serial testing programme in LTRCFs at this time as a number of concerns need to be addressed, including the provision of clear information on the vaccination status of nursing home staff and data on the possible occurrence of COVID-19 infections post-vaccination. The positivity rate for serial testing in nursing homes, which currently stands at 0.5% (similar to that seen at the end of Summer 2020), also remains a concern. The NPHET confirmed its intention to review serial testing in LTRCFs in April, with a view to not solely considering whether the serial testing programme should continue, but also whether there are alternative testing strategies or surveillance approaches that could be more usefully applied in these settings moving forward.

Update on Critical Care

The NPHET received a joint update from the Department of Health and the HSE on the situation in critical care. It was noted that the situation in critical care units has improved since the update provided to the NPHET on 11th February. However, most units are still having to provide critical care across two areas to accommodate COVID and non-COVID care, with associated increased staffing requirements. Nationally, critical care occupancy is within funded baseline capacity, but it should be noted that there is inter-unit variability with some units still in surge, in particular in the Greater Dublin area.

The levels of disease in the community have continued to decrease, which is very welcome. The effects of this can be seen in a slow but sustained reduction in the number of ICU admissions. A continued focus on preventing resurgence of disease in the community, with resultant impact on health and healthcare requirements, remains the key to reducing demand, alleviating pressure on critical care units and enabling the resumption of scheduled care.

Alongside the immediate service demands, the implementation of the Strategic Plan for Critical Care, supported this year by very significant new development funding of €52m, is a priority for 2021. The HSE has recently established a Critical Care Acute Operations implementation structure. This will allow for a strong, central focus on the implementation of the Strategic Plan for Critical Care and will coordinate and continue the many initiatives underway to develop and strengthen critical care responses for critically ill COVID and non-COVID patients.

The NPHET acknowledged the excellent efforts of HSE colleagues nationally, across hospitals and in the community in managing the critical care surge of recent weeks. It is clear that the intensive focus on increasing critical care surge capacity was successful and our hospitals were not overwhelmed. However, the need to redeploy staff to support critical care surge led to a significant curtailment of the delivery of scheduled care. Alongside that, staff in our hospitals have been working in an incredibly pressurised and difficult environment for many months now and it is anticipated that that environment will remain for some time to come, given the need to address backlogs of scheduled care.

While the situation in critical care units still requires strong, ongoing management and oversight, it is important to focus on long-term improvements in critical care capacity as well. The establishment of the implementation

structure for the Strategic Plan for Critical Care is welcome in this regard, and will allow for oversight of the expansion of critical care capacity to 321 this year and to 446 in the long-term, with simultaneous investment in education initiatives and support services.

The NPHE, 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.

Your 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