



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

16th September 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 ahead of the further easing of restrictions on September 20th, and the following key points were noted:

Please note that since 2nd September 2021, the reported epidemiology of COVID-19 as it relates to COVID-19 cases, associated deaths, and outbreaks is based on notifications to the Computerised Infectious Disease Reporting (CIDR) system.

- A total of 8,966 cases have been reported in the 7 days to 15th September 2021 (cases to midnight 14th September), which is a 12% decrease from last week when 10,207 cases were notified in the 7 days to 8th September, **and a 30% decrease from the last NPHE meeting on 25th August when 12,751 cases were reported in the 7 days to 24th August 2021.**
- As of 15th September, the 14-day incidence rate per 100,000 population has decreased to 402; this compares with 458 a week ago and compares with 526 reported at the last NPHE meeting on 25th August.
- Nationally, the 7-day incidence/100,000 population as a proportion of 14-day incidence/100,000 population is 47%, demonstrating that there have been less cases in the last 7 days compared with the preceding 7 days.
- The 5-day rolling average of daily cases is 1,212 as of today, which is a 14% decrease from 1,407 week ago (8th September) and a 33% decrease from that reported at the last NPHE meeting (1,814).
- Of the 19,155 cases notified in the past 14 days to midnight 14th September 2021, 76% have occurred in people under 45 years of age; and 8% were aged 65 years and older. The median age for cases notified in the same period is 26 years. Disease incidence was highest in the 5–12-year-old age group following a significant increase in testing in this age group recently.
- Of the 9,365 cases reported in the latest epi-week (Week 36 ending 11th September 2021), 3.9% (364) were healthcare workers and 3.3% (306) were determined to be travel-related. Additional data on Health care worker status and transmission source for COVID-19 cases is currently sourced using data collected from the COVID Care Tracker (CCT).
- Over the seven days 8th – 14th September, there have been 170,191 laboratory tests reported in community, private and acute laboratories, this compares with 147,080 laboratory tests in the previous 7 days (1st – 7th September), a 16% increase. The 7-day positivity rate in the community was 8%.

- From the 8th -14th September, there were c. 149,495 community referrals. Overall, total referrals have increased by 24% in comparison to the same time-period last week. From the 6th – 12th September, the group with the largest number of referrals was the 0-14-year-old age group. The detected rate for the 0-14-year-old age group is 6%.
- According to the Contact Management Programme (CMP), from 6th - 12th September 2021, the total number of close contacts was 29,262, an increase of 10% compared with 26,400 the previous week. The average number of cases managed per day increased from 3,771 to 4,180.
- The mean number of close contacts per case (excluding cases with zero close contacts) for the week ending 12th September was 2.6, an increase from 2.3 for the week ending 5th September.
- There were 290 confirmed COVID-19 cases in hospital this morning, compared with 332 last week on 9th September, and with 323 on the morning of the last NPHET meeting on 25th August. There have been 37 newly confirmed cases in hospital in the 24 hours preceding this morning.
- There are currently 67 confirmed cases in critical care as of this morning, compared with 54 last week on 9th September, and with 56 on the morning of the last NPHET meeting on 25th August. There were 2 new admissions in the previous 24 hours.
- Of the 301 COVID-19 patients admitted to ICU between 1st April and 11th September 2021, vaccination status was known for 288 patients. Of those where vaccination status is known, 84 had received either one or two doses of vaccine, and 57 received all recommended doses of vaccine before admission to ICU. In total, 51 patients had an epidemiological date 14 days or more after receiving all recommended doses of vaccine.
- As of 15th September 2021, there have been a total of 5,179 COVID-19 related deaths notified in Ireland. This is an increase of 24 notified deaths since the previous weekly update on 8th September. To date, 45 deaths have been notified which occurred in September ,67 in August, 18 in July, and 17 in June.
- In total, 6,783 cases of Delta (B.1.617.2), 77 cases of Beta (B.1.351) and 32 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), 73 Eta (B.1.525), 15 Zeta (P.2), 11 Iota (B.1.526), 7 Epsilon (B.1.429), 4 Lambda (C37), 4 Mu (.1.621 & B.1.621.1), 246 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 98.4% in week 36.

Outbreaks and associated cases are based on those reported up to midnight on 11th September 2021. Week 36 refers to 5th – 11th September 2021.

Healthcare setting outbreaks:

- There were 4 new nursing home outbreaks with 24 confirmed linked cases and 2 community hospital/long-stay unit outbreaks with 6 confirmed linked cases reported in week 36.
- There were 10 new acute hospital outbreaks with 30 confirmed linked cases reported in week 36.
- There were 9 new outbreaks reported in residential institution settings (6 in centres for disabilities, 1 in a mental health facility and 2 in non-specified residential facilities) with 30 confirmed linked cases in week 36.
- There were 4 new outbreaks in 'other healthcare services' with 10 linked cases in week 36.

Vulnerable Groups/ Key Populations outbreaks:

- There were 10 new outbreaks reported involving members of the Irish Traveller community in week 36 with 50 linked cases.

- There were 2 outbreaks associated with the Roma community with 15 confirmed linked cases reported in week 36.
- There were 2 outbreaks associated with clients of mental health facilities reported in week 36 with 6 linked cases.

Outbreaks associated with school children and childcare facilities:

- There were 22 outbreaks newly reported in childcare facilities in week 36.
- There were 40 outbreaks reported in schools in week 36 (34 in primary schools, 3 in post-primary schools and 3 in special education schools) with 191 confirmed linked cases.
- There were 3 new university/college outbreaks in week 36.

Workplace outbreaks:

- There were 14 workplace outbreaks reported in week 36 across a variety of settings. Of these, 2 were in the construction sector, 3 were related to food/meat production and processing settings, 5 in other types of workplaces (including office, commercial, manufacturing, health and dental and defence/justice/emergency services) and 4 were in “not-specified” workplace types.

Outbreaks associated with hospitality settings:

- There were 3 outbreaks reported related to hotels in week 36.
- There were 3 outbreaks associated with restaurant/café settings reported in week 36 and 5 associated with a public house.

Other Locations:

- The remaining 50 outbreaks in week 36 were across a number of other locations:
 - 2 related to social gatherings;
 - 3 associated with religious/other ceremony;
 - 8 related to retail outlets;
 - 1 related to personal grooming services;
 - 7 extended family outbreaks;
 - 27 private house outbreaks;
 - 2 in ‘other’ location.

Disease incidence across the country remains high but has stabilised and is recently showing an overall downward trend. There has been a surge in the demand for testing, matching levels last seen in early January, particularly in the cohort of primary school aged children, with incidence now highest in those aged 5-12 years old. The high incidence in this age cohort is more likely representative of greater case ascertainment than an increase in the overall incidence. Other age groups are showing signs of stabilisation and there has been a decrease in the incidence of those aged 16- 24 of approximately 60% compared with early August. These trends, and in particular the impact of the return to school and the opening of the third level sector, will continue to be monitored closely over the coming weeks.

The growth rate of cases is currently estimated as decreasing at approximately 2% per day. The total number of confirmed cases of COVID-19 in hospital has also been decreasing at approximately 1.5% per day, while the total number of confirmed cases in ICU has remained largely stable. There continues to be low mortality relative to the number of COVID-19 cases. While the majority of infections are occurring largely in the young, unvaccinated population, the current force of infection is resulting in a significant number of infections in older, vaccinated people. At the same time, the number of outbreaks notified in settings with vulnerable populations, such as Nursing Homes, has increased in recent weeks and this is being closely monitored.

Ireland's COVID-19 Vaccination Programme continues to make significant progress. As of 14th September, 88% of those aged 16 years and over are now fully vaccinated, with 90% having received at least one dose (includes partially vaccinated and J&J). Vaccine uptake and completion has been very high in all age groups (ranging from 81% completion in those aged 16-49 years, through to 95% completion in those aged 50-69, to an almost universal vaccination, in those aged 70 and over. However, vaccination has been offered to younger people relatively recently, and many younger cohorts have yet to receive their second dose. Those aged 16-29 years, given their high levels of social contact and partial vaccination, have the potential to sustain a large wave of infection until such time as this cohort achieves very high levels of immunity. Fortunately, uptake in younger cohorts has been very high by international standards.

Policy Recommendations

The NPHET adopted the recommendations within HIQA paper "Reduction of the minimum age for the application of mask wearing requirements and recommendations - updated advice 24th September", noting no substantive change to current guidelines and recommends that there should be no reduction in the minimum age for requirements and recommendations with respect to mask use in the community. In making this recommendation the NPHET acknowledged that the potential benefits of a requirement or recommendation for children to wear face masks must outweigh concerns regarding potential harms associated with face mask use, the NPHET noted that the evidence for the additional benefits of face mask use in younger age groups is of low certainty and benefits are likely to be small in the context of an existing suite of mitigation measures.

The NPHET also considered recommendations from HIQA on rapid antigen testing for screening or surveillance of asymptomatic individuals to limit transmission of SARS-CoV-2, noting that there is uncertainty regarding the effectiveness of rapid antigen detection tests (RADTs) for screening in asymptomatic individuals (who have no known or suspected exposure to SARS-CoV-2) to limit the transmission of SARS-CoV-2. Furthermore, where RADTs are being considered for screening asymptomatic populations, these should be considered as an additional public health measure, rather than a replacement for known mitigation measures. A negative antigen test result in this population should not be viewed as a 'green light' to engage in activities that would otherwise be considered as high risk for transmission.

On this basis the NPHET recommends that any decision to use RADTs in screening asymptomatic populations should consider the following factors:

- Prevalence of SARS-CoV-2 infection in specific populations
- Proportion of the population that have adequate immunity
- Type and number of close contacts
- Public health measures in place
- The vulnerability of the population involved
- The modality of test delivery
- Resource implications
- Ethical considerations

In the context of this highly transmissible variant, it is unlikely that vaccination alone, even at the high levels of vaccine coverage that we have now achieved, will bring the effective reproduction number below 1 such that we will achieve suppression of the disease. This means that through this coming autumn and winter, possibly in the face of high levels of infection, we will remain dependent upon public understanding and buy-in to the basic public health measures in order to minimise opportunities for this virus to transmit.

However, notwithstanding these requirements for ongoing adherence to basic public health advice, particularly with regard to rapid self-isolation when symptomatic, it is now timely, given the proximity to achievement of the transition criteria as set out by NPHET on the 25th August, to give consideration to the ongoing approach to the public health management of cases and contacts, subject to the achievement of those transition criteria.

In this regard, with respect to the public health management of cases and contacts as we approach and achieve the transition criteria the NPHET recommends a systematic stepwise as follows:

Step1:

Subject to an assessment of the impact of the return to education on the epidemiological profile of the disease, and not prior to September 27th;

- Automatic contact tracing of close contacts in childcare facilities and primary education to be discontinued (not including special education facilities);
- Testing of asymptomatic close contacts in childcare facilities and primary education to be discontinued (not including special education facilities), with a focus instead on clinically relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds;
- Children <13yrs who are identified as close contacts in childcare, educational settings, special education settings or other non-household settings and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;
- Children <13yrs who are identified as household close contacts in household settings will still be required to restrict movements and get tested, regardless of symptomatic status;
- Public health advice remains that any child <13yrs with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school or to socialise until 48 hours after resolution of symptoms.

Step 2:

Subject to the achievement of the transition criteria as agreed by NPHET on 25th August:

- automatic contact tracing of all close contacts to be discontinued (public health guidance, including in relation to vulnerable groups, should be developed in this regard);
- automatic testing of all close contacts to be discontinued, with a focus instead on clinically relevant disease rather than infection and a transition to testing for public health surveillance and, where indicated, on public health or clinical grounds (public health guidance, including in relation to vulnerable groups, should be developed in this regard);
- people who self-identify or who are identified through risk assessment as close contacts and who are asymptomatic will no longer be required to restrict movements, unless indicated on public health grounds;

Step 3:

Subjective to favourable epidemiological assessment and not less than four weeks following step 2:

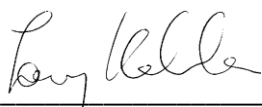
- testing of people with symptoms should evolve to focus on testing on public health or clinical grounds;

The above recommendations are premised on

- public health advice remaining that people with symptoms consistent with COVID-19 should rapidly self-isolate and not attend school/college/workplaces or to socialise until 48 hours after resolution of symptoms. A robust communications campaign will be required in this regard;
- a reorientation and continued enhancement of our surveillance capacities & systems to identify outbreaks, including across primary care and the acute hospital systems, with a particular focus on rapid identification and management of outbreaks in vulnerable groups, & monitor trends in the disease profile nationally and regionally;
- a continued strengthening of our genomic sequencing capacities to ensure the prompt identification and investigation and management of new variants, including sequencing of all travel-related cases;
- a continued monitoring of the potential for and impact of waning immunity and prompt and robust implementation of booster programmes in line with NIAC advices.

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 Tony Holohan

Chief Medical Officer

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