An Roinn Sláinte
Department of Health

Framework for Future Decision Making

Department of Health Input:

Status Report on COVID-19

14th May 2020

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Introduction

On May the 1st 2020, the Government published a 'Roadmap for Reopening Society and Business' [1] to ease the COVID-19 restrictions and reopen Ireland's economy and society in a phased manner.

The World Health Organization predicts that the most plausible scenario is recurring epidemic waves interspersed with periods of low-level transmission. Consequently, it will be necessary to reduce the measures in a slow, gradual, stepwise manner. This approach is essential as easing measures too quickly is likely to result in a sudden surge in infections.

The National Public Health Emergency Team (NPHET), on behalf of the health service, supported by the HSE Health Protection Surveillance Centre (HPSC) and the Irish Epidemiological Modelling Advisory Group (IEMAG) has utilised epidemiological data and modelling capability to continuously monitor the evolving impact of the disease on the Irish population, thereby enabling it to advise Government in relation to progress regarding the suppression of virus transmission. There will be close and continuous monitoring by the Department of Health and the NPHET in relation to the progression of the disease through data sources such as: epidemiological data and modelling; incidence of outbreaks in residential settings; testing and contact tracing; and health service capacity and performance. In addition, as the measures are eased it will be important to understand the impact of adherence and compliance in society from wider data sources across Government, such as: market research data; transportation data; data and information on mobility and congregation; An Garda Síochána and other sources.

The Roadmap also sets out that the framework for future decision making, will at all times be underpinned by public health advice.

[1] https://www.gov.ie/en/press-release/e5e599-government-publishes-roadmap-to-ease-covid-19-restrictions-and-reope/

Framework for Future Decision Making

The decision-making framework under the Roadmap for Reopening Society & Business is as follows:

Before each Government consideration of the easing of restrictions, the Department of Health will provide a report to the Government regarding the following on/off trigger criteria:

a) The latest data regarding the progression of the disease
b) The capacity and resilience of the health service in terms of hospital and ICU occupancy
c) The capacity of the programme of sampling, testing and contact tracing
d) The ability to shield and care for at risk groups
e) An assessment of the risk of secondary morbidity and mortality as a consequence of the restrictions.

Risk-based public health advice will be provided on what measures could be modified in the next period. This risk-based public health advice on the introduction, adjustment and change of public health measures is provided by the National Public Health Emergency Team for COVID-19 by letter to the Minister for Health following a meeting of the NPHET in the usual way and accompanies this Report from the Department of Health to Government.

The Government would then consider what restrictions could be lifted, having regard to the advice of the Department of Health as well as other social and economic considerations, e.g. the potential for increased employment, relative benefits for citizens and businesses, improving national morale and wellbeing etc. It is acknowledged that there is also an ongoing possibility that restrictions could be re-imposed and this process will be carried out on an ongoing basis once every 3 weeks.

A) Progression of the Disease

The NPHET considers the following criteria when evaluating the status of the progression of the disease. These criteria will be reviewed on an ongoing basis and will be subject to change as the measures in place are modified.

Criteria
Number of new cases per day
New cases per day
Total confirmed COVID-19 cases in hospital
Trend in daily COVID-19 acute hospital admissions
Hospitalisations as a percentage of newly confirmed cases
Confirmed COVID-19 cases in ICU
Trend in daily ICU admissions of confirmed COVID-19 patients
ICU admissions as a percentage of hospitalised cases
Trend in new clusters in residential care facilities
New cases in residential care facilities
Trend in new cases per day associated with clusters in residential care facilities
Trend in deaths (by date of death)
Number of cases in healthcare workers
Median number of close contacts

The latest data regarding the progression of the disease

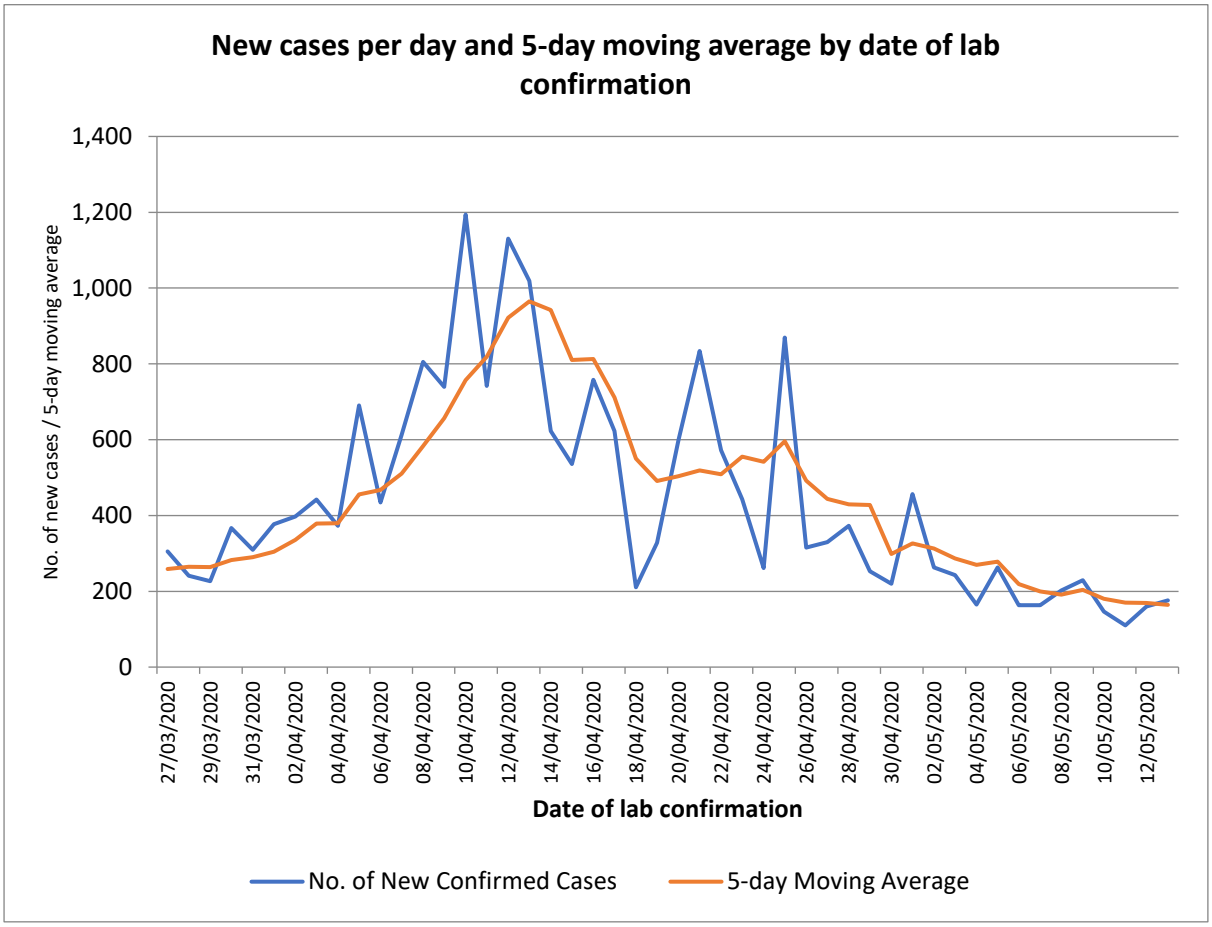
As at 11.00 am on 14th May 2020,

- there have been 23,827 patients with laboratory-confirmed cases of COVID-19.
- this equates to 484 people per 100,000 population having tested positive for COVID-19.
- the largest number of cases reported on a single day was on 23rd April (n=936). This represents a later date of a peak number of cases than is observed in many other European Member States.

Disease incidence

The number of new cases of COVID-19 reported to the Department of Health by the HPSC as lab confirmed on 13th May was 176. This compares with 305 new cases lab confirmed on the 27th March.

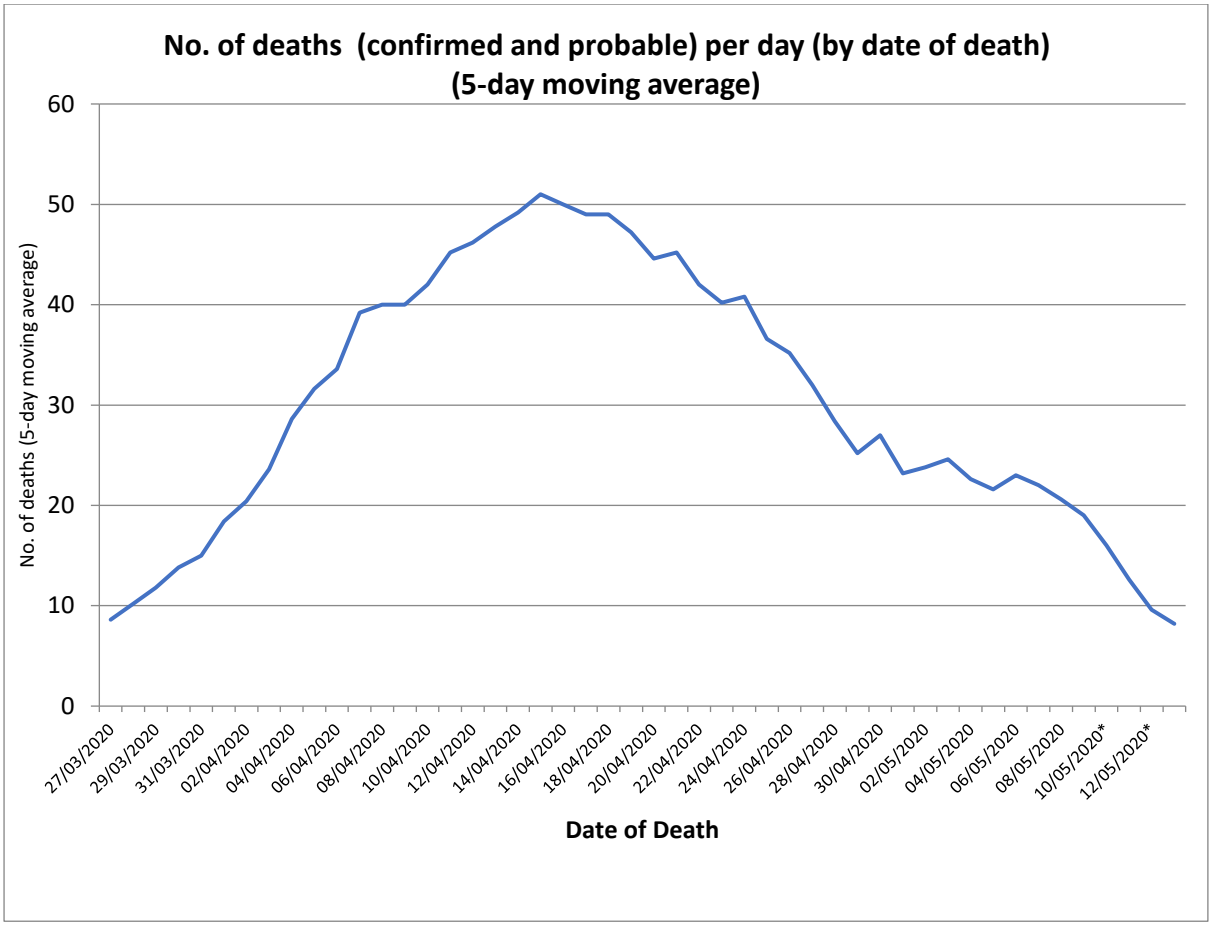
The five-day moving average of new cases to 13th May was 164. This is down from 965 on the 13th of April.



Source: HPSC, Daily CIDR Data Extract

Disease impact

The number of deaths newly reported to the Department by the HPSC at 11.00 on 14th May was 9, bringing the total number of COVID-19 related deaths (confirmed and probable cases) to 1,506. Excluding the most recent three days (to account for delays in reporting of deaths), the five-day moving average of daily deaths, by date of death, was 16 (to the 10th of May). This is down from a peak of 51 on the 15th of April.



Source: HPSC, Daily CIDR Data Extract

* Due to possible delays in notification of deaths, data for the most recent five days should be considered provisional.

Note: For consistency, this chart begins on 27/03/20, however the first COVID-19 related death occurred on 11/03/20. There were a total of 57 confirmed and probable COVID-19 deaths prior to 27/03/20 or with a unknown date of death and not shown in this chart.

COVID-19 hospitalisations

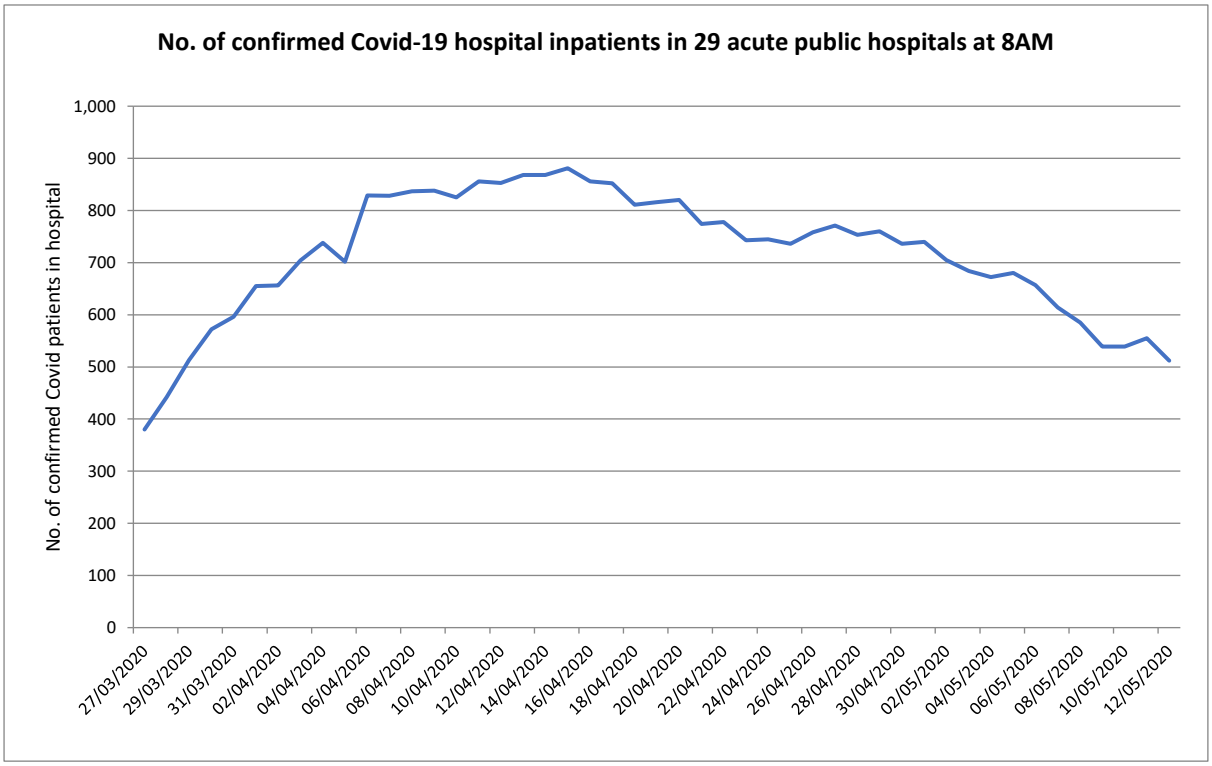
There were 512 confirmed and 412 suspected cases of COVID-19 in hospital as at 08.00 on 12th May, with 67 confirmed and 20 suspected cases in intensive care at 19.00 on 12th May, of whom 51 were ventilated. The five-day moving averages for new admissions of confirmed cases to hospital and to ICU were 16 and 2 cases respectively as of 12th May. For comparison, the number of confirmed cases of COVID-19 in intensive care on the 27th of March was 68.

As of 12th May, the number of confirmed COVID-19 patients in ICU represents 12.9% of all confirmed COVID-19 patients currently in hospital (19% on 27th March). In critical units, there has been a steady decline over the recent weeks of COVID-19 positive patients in these units. On the 1st of May this number dropped below 100 for the first time since the 29th of March, and has continued to fall. As of the 12th May there were 67 such patients in critical care units.

Trends in COVID-19 admissions to hospital

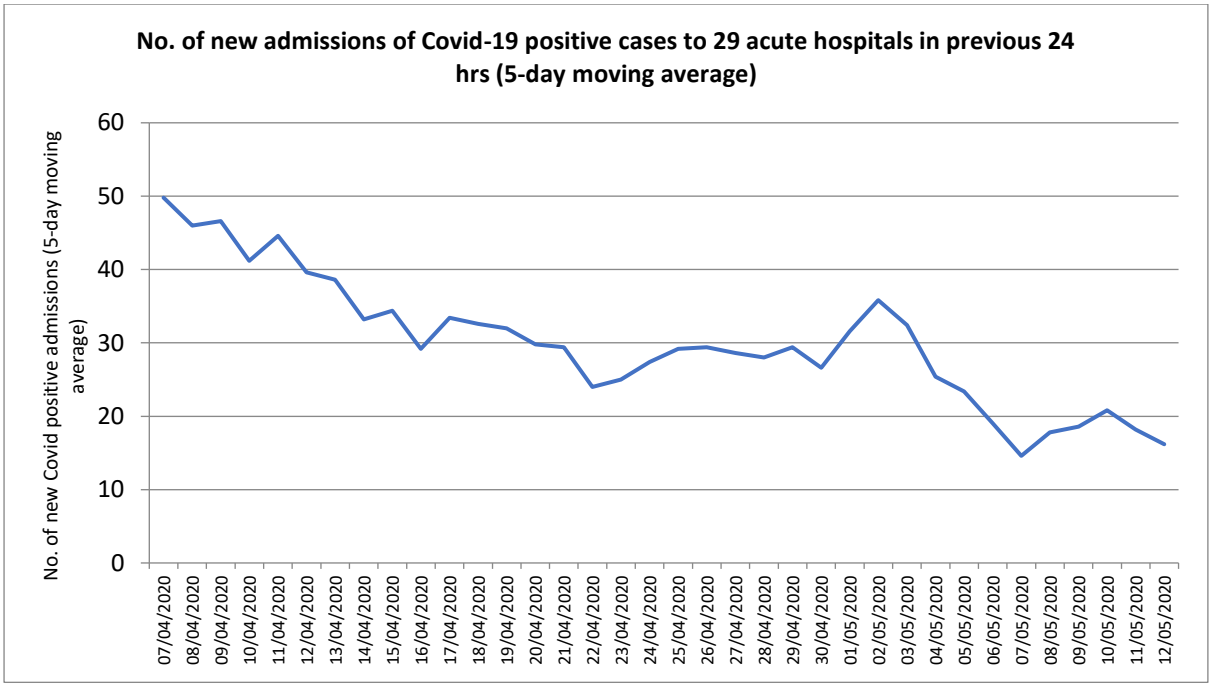
The charts set out below provide an overview of recent trends relating to a range of the key indicators that will be monitored as part of the assessment of capacity in the context of the decision-making framework.

The number of confirmed Covid-19 hospital inpatients per day has been steadily declining in recent weeks. As at 12th May there were 512 hospital inpatients with confirmed diagnosis of COVID-19. This is down from a peak of 881 on the 15th of April.



Source: HSE, SDU, extract from SBAR - 29 Hospitals

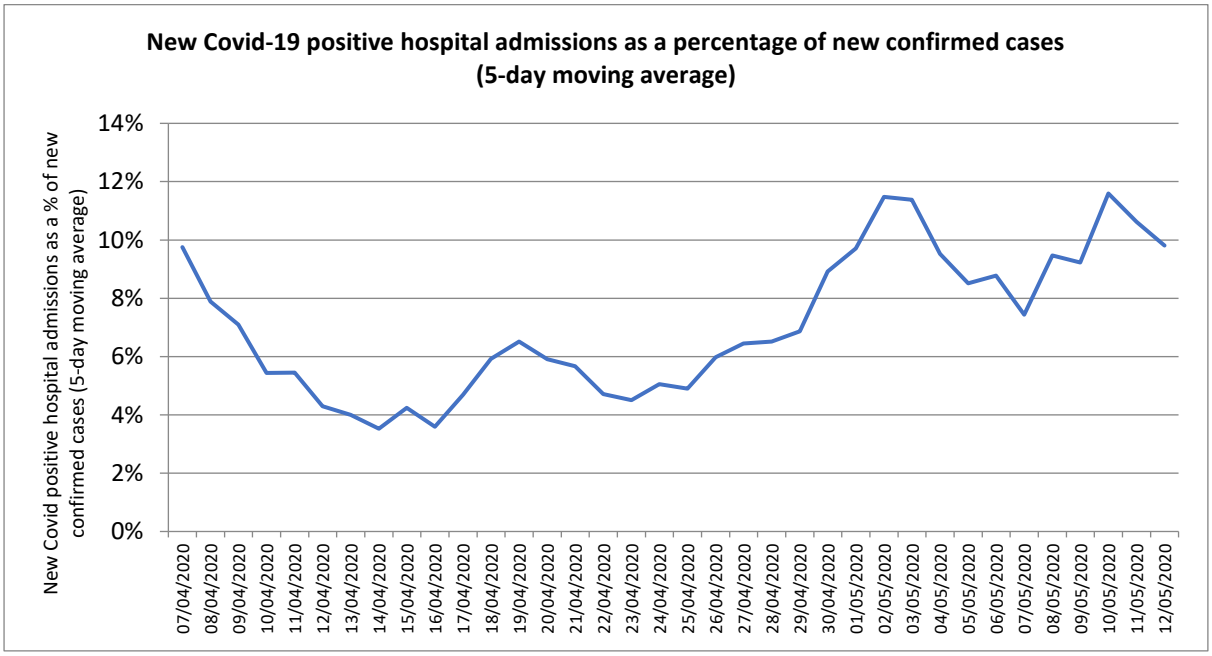
In a similar trend to that of hospital inpatients, the number of new admissions of COVID-19 positive patients to hospital has also been overall trending downward in recent weeks. As measured by a 5-day moving average, there was an average of 16 COVID-19 positive patients daily being admitted to our public hospitals on the 12th of May. This is down from the 5-day moving average of 50 seen on the 7th of April.



Source: HSE, SDU, extract from SBAR - 29 Hospitals

Note: This variable only began to be collected on 03/04/20. Therefore the earliest date that a 5-day moving average can be calculated is 07/04/20

Again using a measure of the average of the previous five days, just under 10% of new confirmed COVID-19 positive patients were also hospitalised as of the 12th of May. This is a rise from the 4% seen on the 16th April.



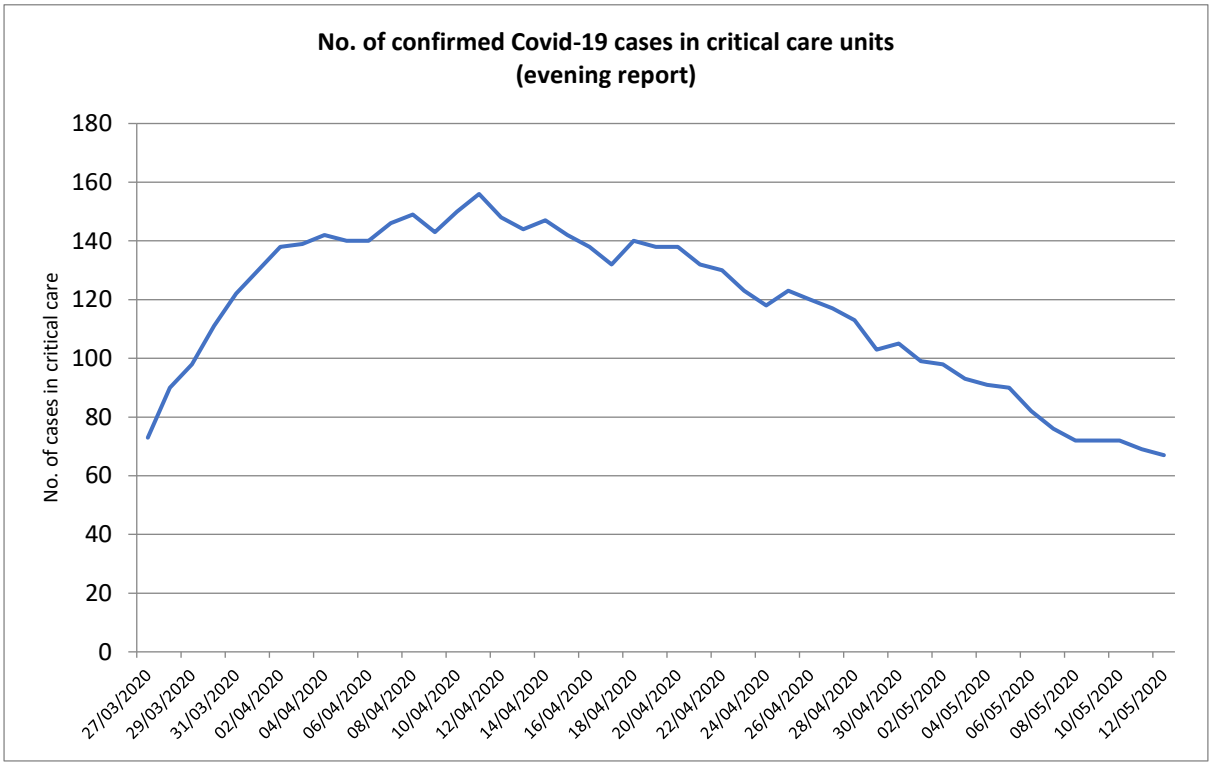
Source: HPSC, Daily CIDR Data Extract; and HSE, SDU, extract from SBAR - 29 Hospitals

Note: Data on new Covid-19 positive admissions only began to be collected on 03/04/20. Therefore the earliest date that a 5-day moving average can be calculated is 07/04/20

Trends in COVID-19 admissions to critical care

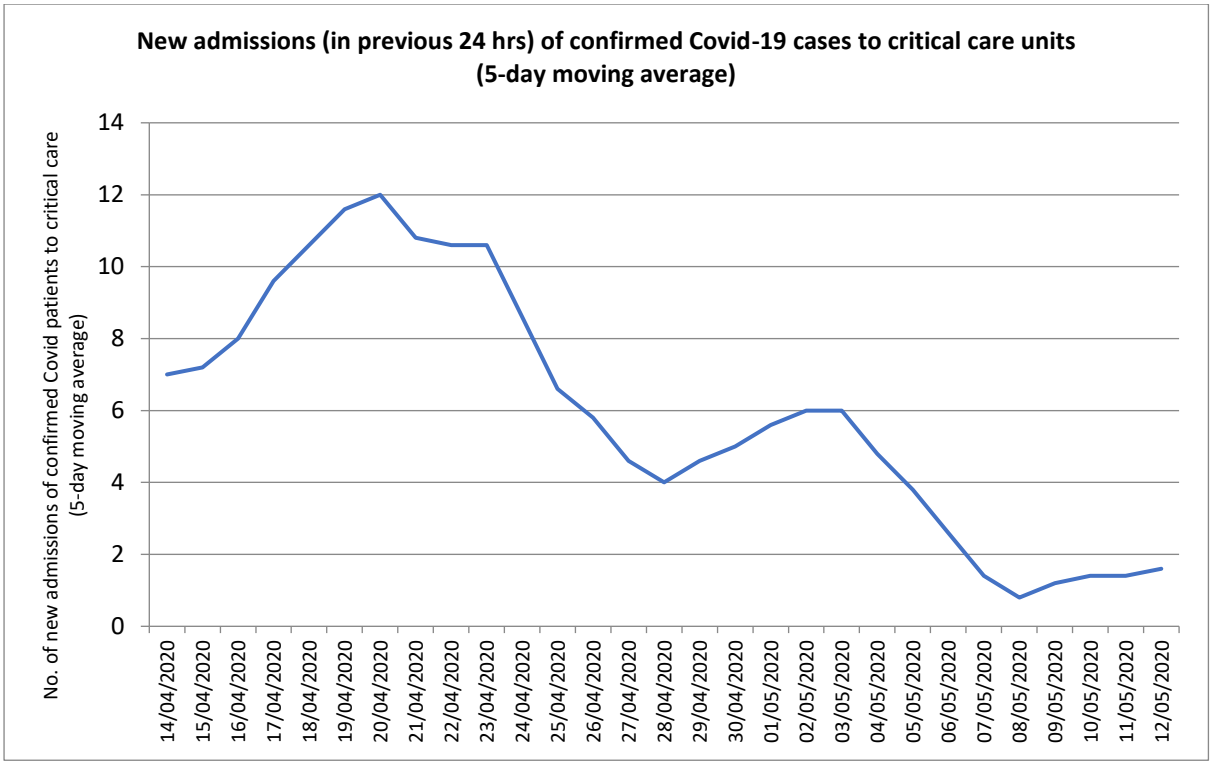
The charts set out below provide an overview of recent trends relating to key indicators on COVID-19 activity in critical care units that will be monitored as part of the assessment of capacity in the context of the decision-making framework.

Based on data available to 11.00 on 13th May, approximately 13% of all confirmed cases to date have been hospitalised, with 1.7% admitted to intensive care. In those who have been hospitalised and admitted to intensive care, 45% and 64% are aged less than 65 years, respectively.



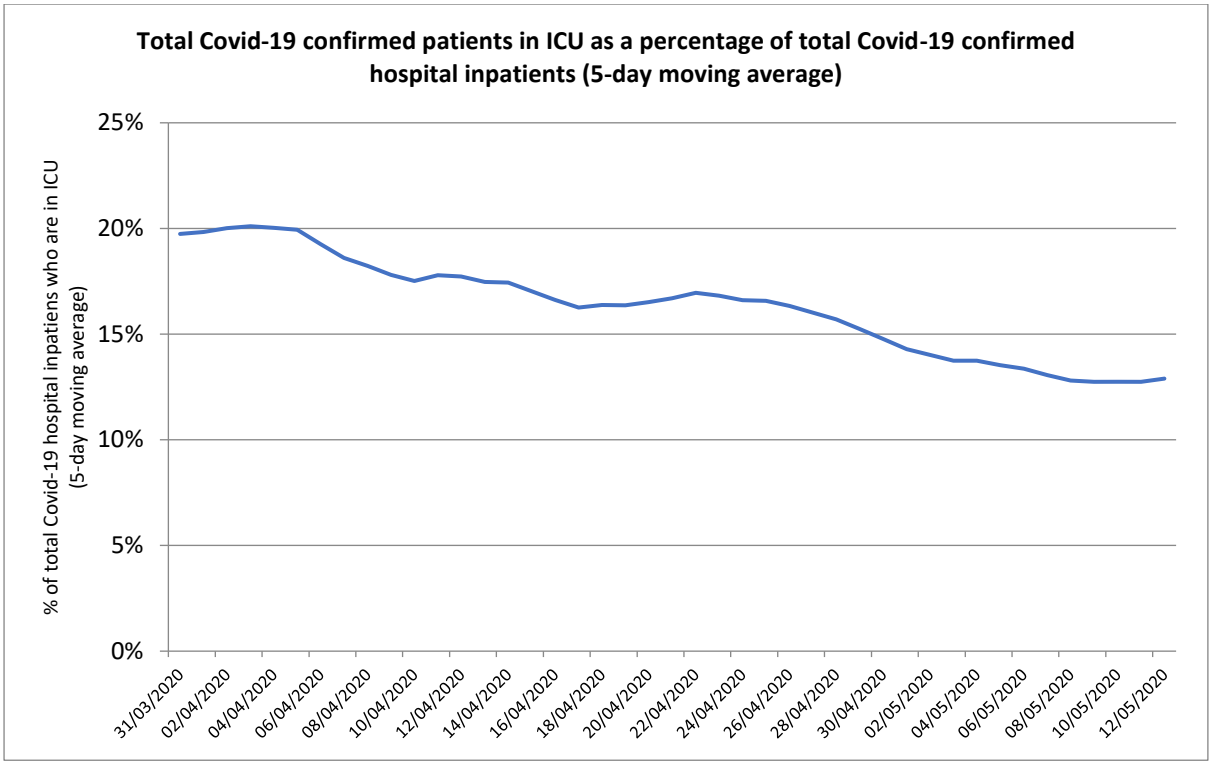
Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals

When considering the impact of new admissions of COVID-19 positive patients it is useful to keep in mind the relatively low numbers per day admitted to these units which can cause an appearance of larger increases/decreases. With this in mind, the 5-day moving average of new daily admissions to critical care units has fluctuated in recent weeks, however, on the 12th of May this stood at an average of 2 patients over the most recent 5-day period. Down from a peak of 12 on the 20th of April.



Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals
Note: This variable only began to be collected on 10/04/20. Therefore the earliest date that a 5-day moving average can be calcuated is 14/04/20

In contrast to the percentage of COVID-19 patients who are hospitalised, the proportion of those COVID-19 confirmed hospitalised patients who needed to be admitted to a critical care unit, as measured by a 5-day moving average, has been steadily falling in recent weeks from 20% on the 2nd of April to 13% on 12th May.

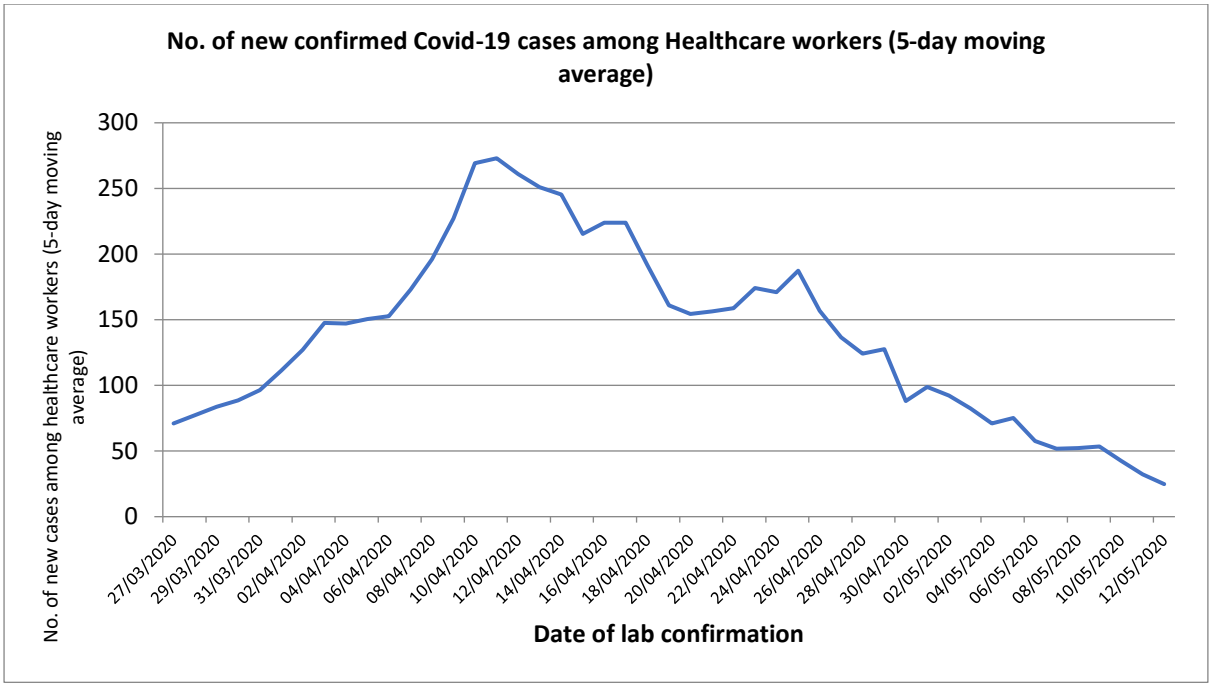


Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals; and HSE, SDU, extract from SBAR - 29 Hospitals

Note: As data from the NOCA ICU-BIS system began on 27/03/2020, the earliest date that a 7-day moving average can be calculated is 31/03/20

Healthcare workers

Based on data available at 11.00, Wednesday 13th May, 30.2% (n=7,056) of all confirmed cases to date have been in healthcare workers. The current number of new cases per day in healthcare workers, expressed as a five-day moving average, is 25. Approximately 0.6% of healthcare workers who have been diagnosed with COVID-19 have been admitted to intensive care and there have been 7 deaths amongst healthcare workers.



Source: HPSC, Daily CIDR Data Extract

Residential Care Facilities

There have been 428 clusters reported to date in Residential Care Facilities, of which 245 have been in nursing homes (as reported by HPSC on 12th May). These clusters have been associated with 5,923 and 4,624 laboratory confirmed cases of COVID-19, respectively. Further detail available in Section D.

Clusters in Other Settings

As of 9th May, the Health Protection Surveillance Centre (HPSC) have identified:

- Five COVID-19 outbreaks in prisons involving 18 cases (all laboratory confirmed), two of which were hospitalised cases and no deaths were reported.
- Three COVID-19 outbreaks involving the Roma community involving 21 cases, seven cases were hospitalised and four cases died.
- Five COVID-19 outbreaks involving the Irish Travelling community have been notified, involving 43 cases, two hospitalisations and no cases died.
- Eight[2] COVID-19 outbreaks were notified in residential facilities for the homeless involving a total of 15 cases, three cases were hospitalised and no cases died.
- Twelve COVID-19 outbreaks in Direct Provision Centres have been notified, involving 149 cases, 12 cases have been hospitalised and no cases have died.

Certain workplaces have also emerged as a concern regarding spread of COVID-19. As of 9th May, cases had been reported in 32 clusters. More up to date data is available for meat processing facilities. As of 13th May there have been 12 COVID-19 clusters in meat processing plants notified; these are associated with 571 laboratory confirmed cases with 12 cases hospitalized. A National

[2] This includes one of the COVID-19 outbreaks involving the Roma community.

Outbreak Control Team has been convened to coordinate the response to this issue. The next update for all such settings will be provided next Tuesday, with data to next Saturday night.

Influenza Like Illness Rate

The influenza like illness rate, as reported to the HPSC, decreased during week ending the 11th May to 12 per 100,000 compared to an updated rate of 19.9 per 100,000 in week ending 3rd May.

Modelling data

The effective reproduction number is currently estimated to be between 0.5 and 0.6.

B) Capacity and Resilience of the Health Service in Terms of Hospital and ICU Occupancy

Context

The initial focus for acute services in the response to COVID-19 was surge capacity, and the continuation of essential time-critical non-COVID care. The trajectory of the disease means there is now an opportunity for increasing provision of non-COVID care including more routine care. Key challenges to be managed will include capacity, infection control and mitigation of risk for patients and healthcare workers.

Hospital occupancy will need to remain at a level that allows for surge capacity to respond to increased demand for COVID care periodically, and the current recommendation is for 80-85%, as opposed to the near 100% occupancy levels prior to the pandemic. Providing non-COVID elective care will require processes and protocols to mitigate risk for patients and healthcare workers. These will have operational implications including on patient flow and throughput. They are described in guidance on risk mitigation which has been developed under the auspices of the Expert Advisory Group and approved in principle by NPHET on 1 May.

The IEMAG subgroup on demand and capacity has developed a predictive model which offers the potential to predict general acute bed and critical care bed demand for different scenarios. Consideration is being given currently to how this can best support capacity planning over the coming weeks and months.

Utilisation of available beds has to be balanced between the needs of COVID-19 patients, emergency admissions and elective procedures and the management of delayed transfers of care. The tables below reflects the Acute Hospital capacity situation of the HSE in the context of the current COVID-19 Pandemic response. This excludes Critical Care Capacity. This data should be understood in the context of the current reduced level of non-urgent elective activity and a reduced level of attendance to and admission from Emergency Departments.

Acute Hospital Bed Capacity

The Table below sets out the current Acute Hospital Bed Capacity as of 14th of May.

Overview of Public Acute Hospital Bed Capacity – 14th May 2020

Public Hospitals	**Beds**
Total In-patient beds	11,907
Minus beds closed for infection control	*-172*
Minus beds closed	*-244*
Subtotal available beds	11,491
Total Surge Capacity	*+2,118*
Total Overall Capacity	14,025
Of which = beds occupied	*12,446*
In-patient beds currently vacant and available (current capacity)	**1,163**

Available beds is the total bed complement less the number of occupied beds, beds not available when they are temporarily closed for reasons such as infection control, maintenance/refurbishment or staffing shortages and beds occupied by delayed transfers of care cases. Over the seven days previous to 14th May, the number of beds available in public hospitals has increased from 1,085 to 1,163 (+78) while the number of beds closed or blocked or decreased from 632 on May 7th to 416 on May 14th.

Private Hospital Capacity

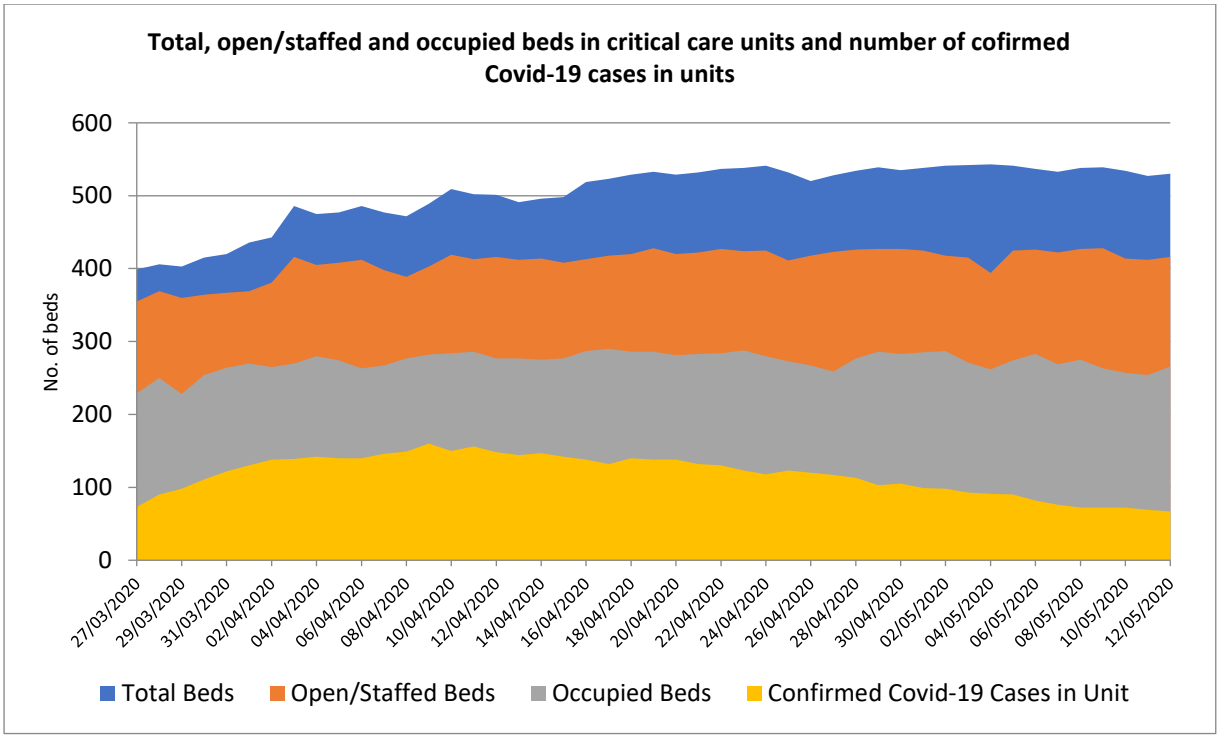
The additional capacity available in private hospitals is set out below. These facilities offer a significant opportunity for delivery of non-COVID care in designated non-COVID environments, in line with recommendations previously approved by NPHET.

Overview of Private Acute Hospital Bed Capacity – 14th May 2020

Private Hospitals	**Beds**
Total In-patient beds	1696
In-patient beds that are vacant	**949**
Day patient beds	569
Day patient beds that are vacant	**364**

Total Critical Care Capacity

Total bed capacity in critical care units in 28 public acute hospitals and five private hospitals is shown below. There is a steady decline in the number beds needed to be occupied by COVID-19 confirmed patients since mid April. This is in contrast to non-COVID-19 confirmed patients whose numbers in critical care have been steadily growing over the last number of weeks.



Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals

C) Capacity of the Programme of Sampling, Testing and Contact Tracing

Overview

Ireland has adopted a robust process of testing, isolation and contact tracing as a key strategy for containing and slowing the spread of COVID-19, as advocated by WHO, ECDC and many countries to "break the chain of transmission".

Sufficient testing capacity will be critical to inform any future public health decisions about (1) the timing of the relaxation of current social distancing measures (2) monitoring the impact of any such decision and (3) responding to any cases detected.

The HSE has been working intensively over the last two months to develop the infrastructure, processes and capacity to ensure we have a system of real-time testing, isolation and tracing, all underpinned by robust information systems.

Huge progress has been made to get us to the current point. There is now capacity across the full testing and tracing pathway for 12,500 tests per day. Turnaround times have improved significantly. In the community, the median turnaround time for referral to contact tracing completed is now 5 days. It is 3 days in hospitals.

The focus is now on delivering the additional capacity to get to 15,000 tests per day and a turnaround time of, on average, 1-3 days from referral to tracing. Process improvements will continue into next week, with a particular focus on reducing turnaround times across the full testing/tracing pathway.

Capacity and Turnaround Time Targets

Date	**Monday, 27 April**	**Tuesday, 5 May**	**Monday, 18 May**
End to End Capacity	10,000 tests a day	12,000 tests a day	15,000 tests a day
Swab to Result	3 days on average	2 – 3 days on average	Average 1 – 2 days
End to End Turnaround Time (referral to results)	15%: 1 – 2 days	15%: 1 – 2 days	20%: 1 – 2 days
	70%: ≤ 5 days	70%: ≤ 5 days	70%: 1 – 3 days
	15%: > 5 days	15%: > 5 days	10%: 4.5 days

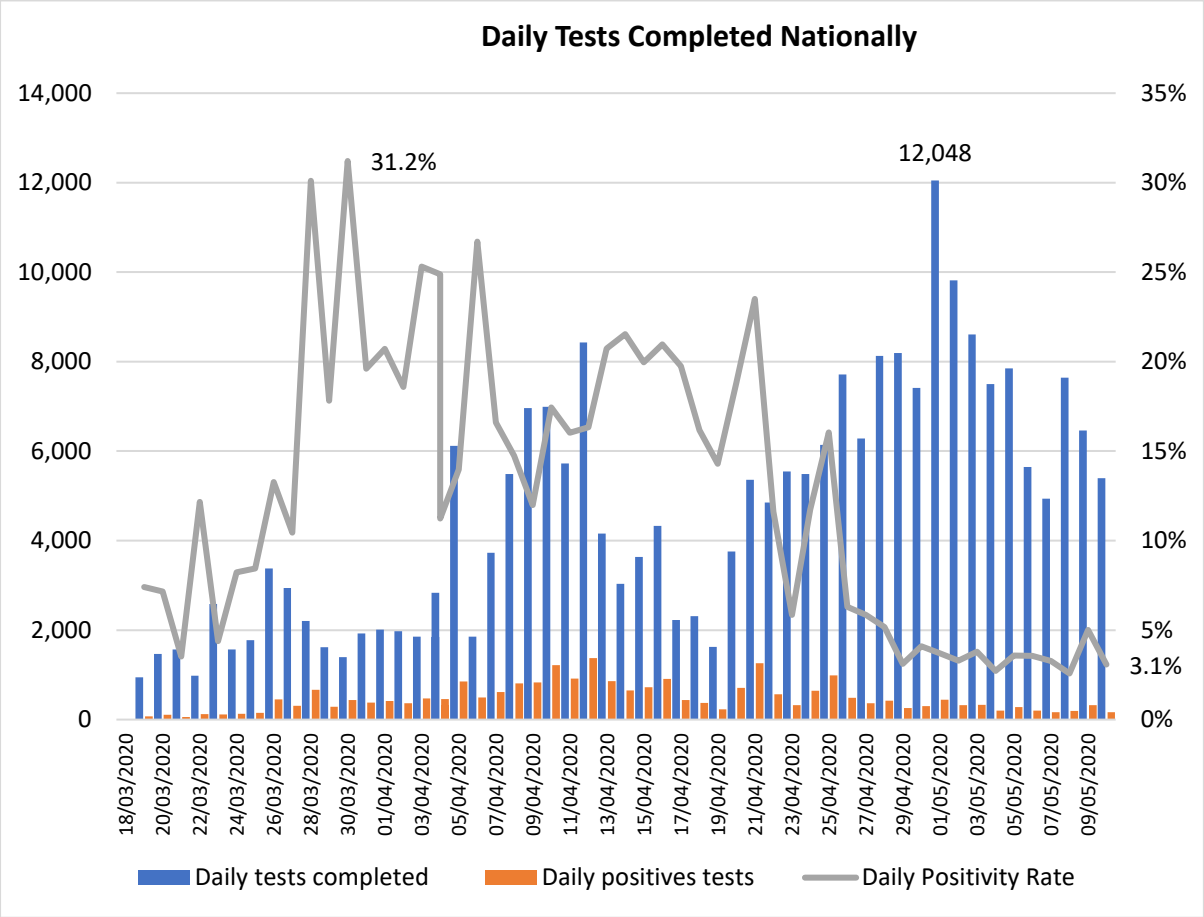
Testing & Contact Tracing – Key metrics for the 5th – 11th May

Referrals and Swabbing

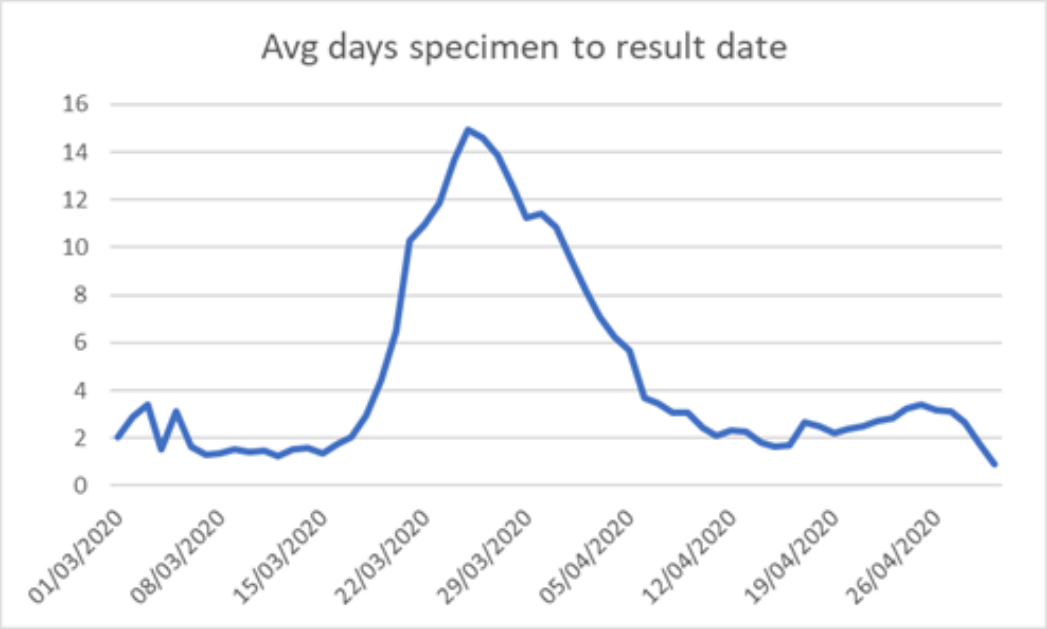
There is capacity in place for 12,500 per day across hospitals, community testing centers and the National Ambulance Service. 35,700 samples were taken in the last week. In the vast majority of community referrals, patients are now receiving same-day or next-day appointments – average time over the past week was 0.6 days. This has improved significantly from a peak of 6 days in mid-March.

Laboratory Testing

Significant progress has been made in securing sustainable laboratory capacity. Capacity now stands at 15,000. Over 45,000 laboratory tests were completed in the last week and the positivity rate fell to 3.1%.

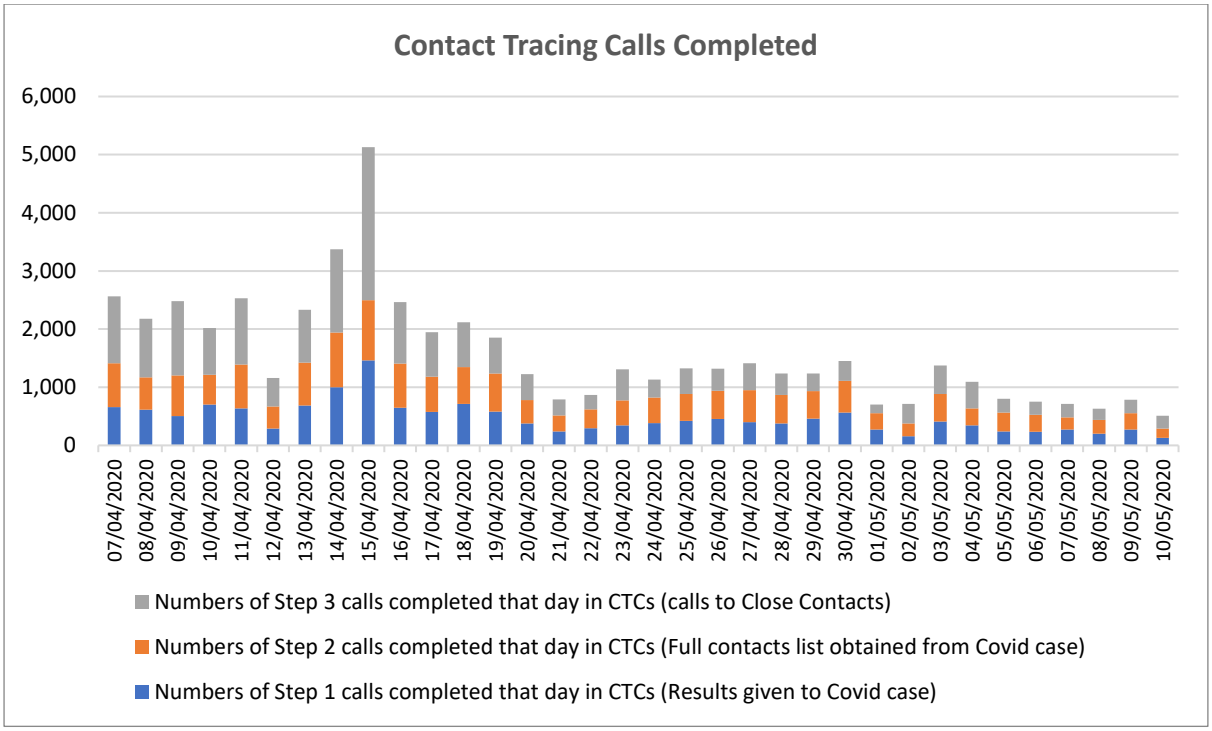


The average turnaround time from sampling (swab taken) to receiving results for loading to the IT system to commence contact tracing is 3.3 days in the community and 0.8 days in hospitals. This has fallen from a peak of over 14 days at end March related to delays in laboratory processing and the development of the known backlog in cases which were processed in Germany.



Contact Tracing / Surveillance

Over 5,100 calls were made across Calls 1, 2 and 3 to communicate positive results and trace close contacts in the past week by the Contact Tracing Centres set up for routine cases. The median turnaround time for contacting individuals to inform them of a positive result is 18 hours for routine cases. Negative results are communicated by text.



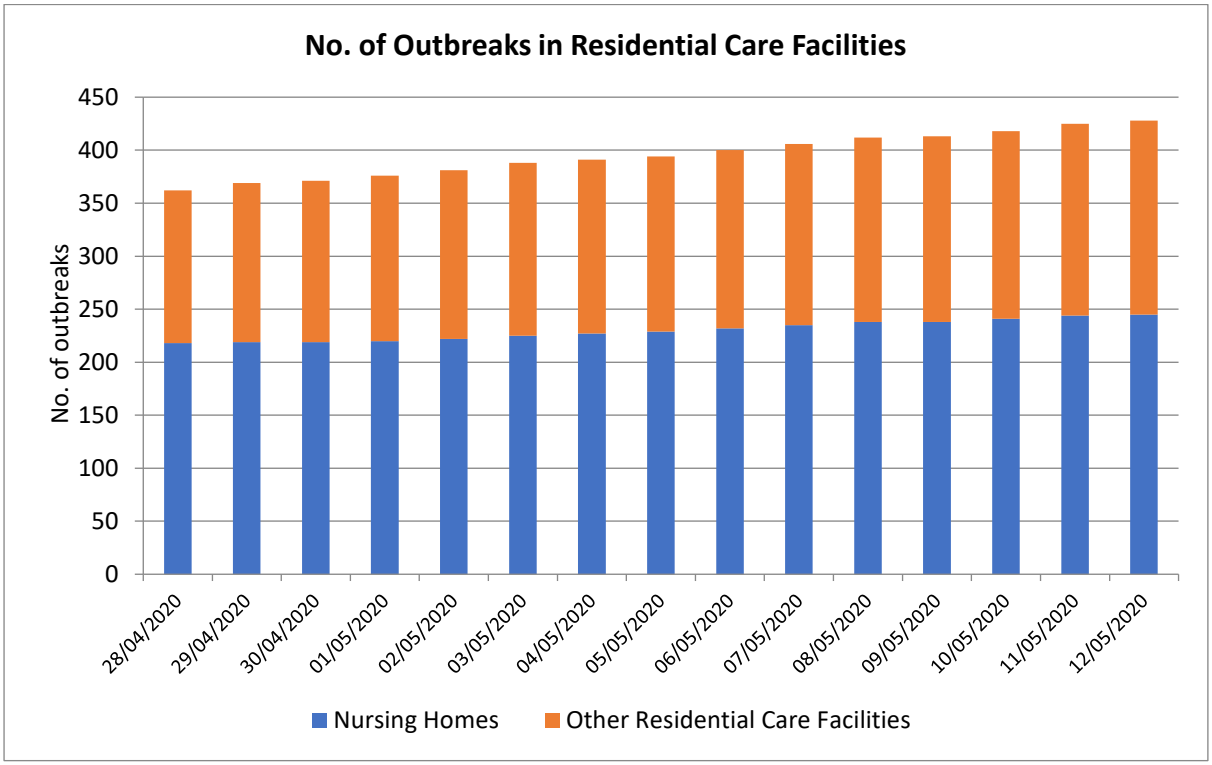
These numbers do not include the extensive work completed by public health, occupational health and environmental health in contacting more complex cases such as healthcare workers and those in congregated settings with their results. The mean and medium number of close contacts has remained very stable in recent weeks, with both generally between 2 and 3. The number of Calls 1, 2, and 3 are outlined below and mirror the trend in number of confirmed cases over the period.

D) Ability to Shield and Care for at Risk Groups

There is growing international evidence that those over 70 years and those people living in long term residential care (LTRC) settings are particularly vulnerable to severe COVID-19 infections and that they are experiencing higher rates of mortality than the general community as a result.

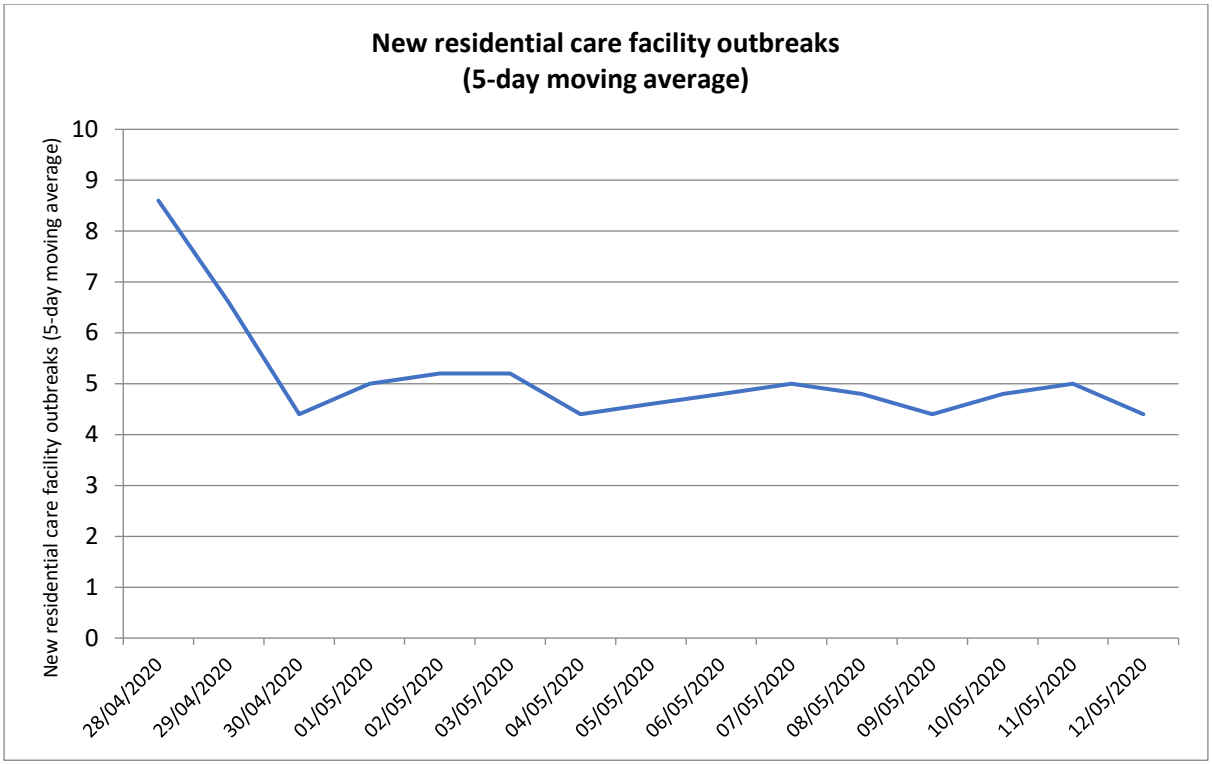
(i) As part of a risk-based approach to protect this group who are most vulnerable to infection and to minimise the risk of spread of disease, the following key indictors must be monitored and utilised to support evidence based, balanced decision making in relation to public health and infection prevention measures in LTRC settings:

- Number of clusters in LTRC settings
- Number of new clusters in LTRC settings
- Number of closed clusters in LTRC settings
- Number of deaths in LTRC settings.

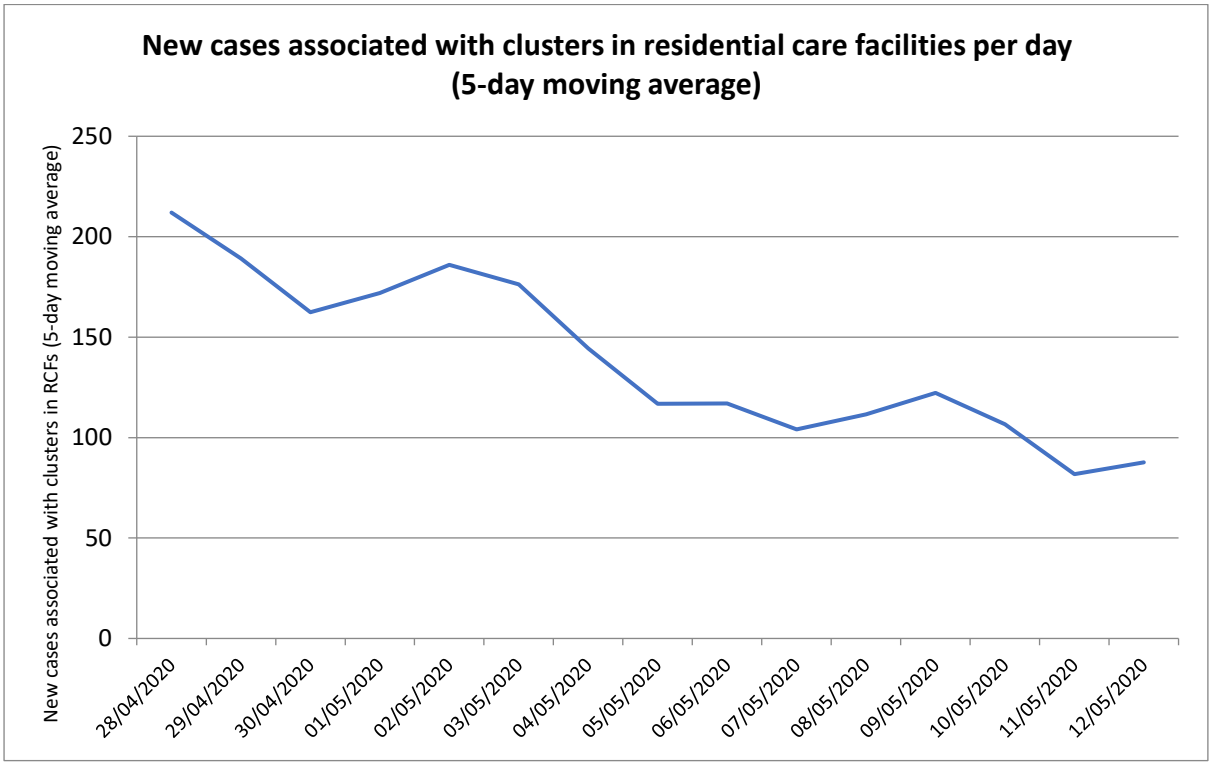


Source: HPSC Daily Outbreak Reports

Note: Other residential care facilities include community hospitals/long stay units and residential institutions (mental health facilities, prisons, direct provision centres)



Source: HPSC Daily Outbreak Reports



Source: HPSC Daily Outbreak Reports

As of the 9th of May 2020, 44 of total notified COVID-19 outbreaks were reported as closed on the HPSC's CIDR system. Among these, eight of the closed clusters were in residential care facilities (three in nursing homes and five in residential institutions). With regard to number of deaths in

LTRC, the Department of Health undertook a census of mortality rates in all registered LTRC settings which is discussed in section E of this report.

(ii) A number of Government Departments have responsibility for services to vulnerable people are provided through a range of settings and are under the remit of a number of Government Departments. Cohorts of people either due to living arrangements or social inequalities are more vulnerable to transmission of COVID-19 for example those in prison and youth detention centres, travellers and Roma; homeless; undocumented migrants and those in direct provision. It should be noted that the policy responsibility for these areas, the establishment of appropriate actions and their implementation remain with the relevant Department as per normal business processes in line with public health guidance. This includes the development of the relevant criteria for supporting these groups during the phased reopening of society and business.

E) Assessment of the Risk of Secondary Morbidity and Mortality.

All-cause excess mortality refers to the number of deaths above expected seasonal baseline levels, regardless of the reported cause of death. As noted by the ECDC in its ninth risk assessment (23rd April 2020), all-cause excess mortality may be a more objective measure of the impact of the pandemic than the cumulative rate of COVID-19, particularly at this time of year when competing drivers (influenza and high/low temperatures) are largely absent. Excess deaths from the COVID-19 pandemic might arise both in those infected (direct effects), as well as those affected (indirectly, not infected) by altered access to health services and reluctance to access health services; the physical, psychological, and social effects of distancing; and economic changes. The data from the European all-cause mortality monitoring system (EuroMOMO) show considerable excess mortality in multiple countries during March and April 2020. For the EuroMOMO network as a whole, from week 10, 2020 and as of week 18, there were 149,447 excess deaths estimated in total, including 137,524 in the age group ≥65 years and 11,573 in the 15-64 years age group. This time period includes part of the influenza season as well as the start of the COVID-19 pandemic.[3]

COVID-19 Excess Mortality

Different countries count deaths in different ways and so the data is not always consistent or comparable at an international level. Unlike Ireland, for example, many other countries are not able to report on deaths in nursing homes or in the community and many just report on laboratory confirmed deaths in hospitals. Some countries do not report deaths which were not directly attributable to COVID-19. In many countries they report completely separately on the registered deaths and are unable to link them with the deaths by place of death such as hospital or nursing home.

In Ireland we can link all these different data streams and provide a breakdown on where these deaths are occurring. It does however mean there can be a lag while all of this work to link data happens and for the notification to reach the HPSC and the Department of Health.

In Ireland, every effort is being made to report on all deaths linked to COVID-19, including

- all clinicians have been written to, to emphasise to them the importance of death certification and notification of deaths,
- outbreak control teams have been asked to ensure that all confirmed or suspected cases in Residential Care Facilities are notified,
- a census of mortality in residential care settings has been undertaken (see above),
- Funeral Directors have been written to, to ask them to encourage families to use the online option for death certification and to submit death certification in a timely manner.

Non-COVID-19 Excess Mortality

Since 2005, HPSC has received weekly mortality data from the General Register Office (GRO) on deaths registered in Ireland during the previous week. These data have been used to monitor all-cause and influenza and pneumonia deaths as part of the influenza surveillance system. Ireland

[3] https://www.euromomo.eu/

participates in the European mortality monitoring group (EuroMOMO) and the HSPC uses their algorithm, A-MOMO, to generate the outputs.

All cause death is an important index to monitor during any pandemic as COVID-19 (like influenza) exacerbates any underlying illness. Therefore, an increase in deaths would be expected from other causes such as strokes and myocardial infarction. In Ireland we have a long period before families are required to register a death - up to 3 months.

The latest excess weekly mortality report, produced by HPSC on data up to Sunday 10 May 2020 (end of week 19), demonstrates a significant excess of deaths (all cause 'pneumonia and influenza' specifically) for weeks 14-16, inclusive. The delay in registration of deaths prevents a more complete and timely analysis of this.

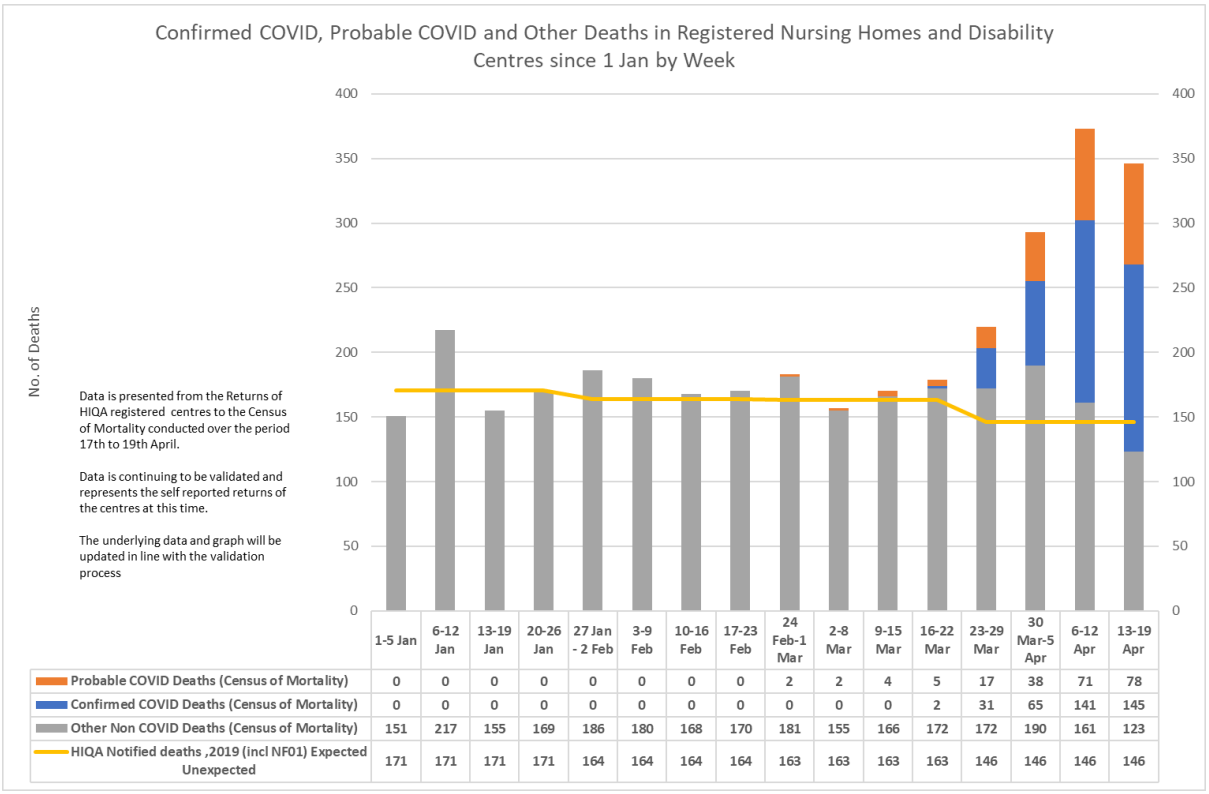
Mortality Census LTRC

In order to enhance the picture of all mortality in LTRC settings, including lab confirmed and probable deaths, and as per NPHET's actions on 17th April 2020, the Department of Health undertook a census of mortality rates in all registered LTRC settings. This census reported 3,367 total deaths having occurred in LTRCs during the period Jan – 19th April 2020 as set out below.

Mortality Census of Long Term Residential Care Facilities
1 Jan – 19 April 2020

	COVID-19 Lab confirmed deaths	COVID-19 Probable deaths	Total COVID-19 deaths	All deaths
Nursing Homes	376	209	585	3,243
Disability	8	8	16	73
Mental Health*	10	4	14	51
Total	394	221	615	3,367

Data was compared between the census of mortality and other sources of mortality data including the Health Information and Quality Authority (HIQA) NF02 notifications and Health Protection and Surveillance Centre (HPSC). It demonstrated that the number of cases matched closely between these sources. The data in the chart below would suggest that excess deaths in this period were COVID-19 related.



	1-5 Jan	6-12 Jan	13-19 Jan	20-26 Jan	27 Jan - 2 Feb	3-9 Feb	10-16 Feb	17-23 Feb	24 Feb-1 Mar	2-8 Mar	9-15 Mar	16-22 Mar	23-29 Mar	30 Mar-5 Apr	6-12 Apr	13-19 Apr
Probable COVID Deaths (Census of Mortality)	0	0	0	0	0	0	0	0	2	2	4	5	17	38	71	78
Confirmed COVID Deaths (Census of Mortality)	0	0	0	0	0	0	0	0	0	0	0	2	31	65	141	145
Other Non COVID Deaths (Census of Mortality)	151	217	155	169	186	180	168	170	181	155	166	172	172	190	161	123
HIQA Notified deaths ,2019 (incl NF01) Expected Unexpected	171	171	171	171	164	164	164	164	163	163	163	163	146	146	146	146

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

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

14th May 2020

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).

Firstly, it is important to acknowledge that the combined efforts and collective action of people across Irish society has changed the trajectory of the COVID-19 epidemic in Ireland. Through high levels of adherence to the public health social distancing measures and the rapid adjustment to new personal and collective hygiene behaviours, people, including the most vulnerable, have been protected from infection and lives have been saved.

You will recall that following the NPHET meeting on 1 May 2020, in light of the NPHET's continued concerns, at that time, regarding the ongoing extent of COVID-19 infection in the population and in residential care settings, in particular, the NPHET recommended the extension of the current public health measures to 17 May 2020.

In the intervening two-week period, further progress has been made in suppressing the transmission of COVID-19. However, a focussed disease control strategy and cautious approach must be pursued as new cases of infection continue to be identified, outbreaks in residential settings and certain workplaces continue to emerge, and the impact of the disease amongst healthcare workers and vulnerable groups remains concerning.

Ireland's situation at the time of consideration by NPHET was as follows:

i. the number of confirmed cases stands at 23,401 (with an average of 165 cases notified per day over the past 5 days);
ii. 458 confirmed cases in hospital today;
iii. the number of confirmed COVID-19 patients requiring critical care yesterday is 64, with a further 20 patients suspected of having COVID-19 also in critical care;

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iv. 6,997 cases (30% of all cases) are associated with healthcare workers;
v. there have been 1,497 deaths recorded to date, with 10 new deaths notified yesterday.

With regard to clusters and outbreaks specifically, NPHET noted–

vi. the total number of clusters in residential care facilities to date has been 432;
vii. the number of confirmed cases in residential care facilities stands at 5,957 of which 4,641 are in nursing homes;
viii. that as of Saturday 9th May, there have been-
- Five COVID-19 outbreaks in prisons involving 18 cases (all laboratory confirmed),
- Three COVID-19 outbreaks involving the Roma community involving 21 cases,
- Five COVID-19 outbreaks involving the Irish Travelling community, involving 43 cases,
- Eight COVID-19 outbreaks notified in residential facilities for the homeless involving 15 cases (one of the COVID-19 outbreaks involving the Roma community),
- 12 outbreaks in Direct Provision Centres, involving 149 cases,
- 32 clusters in workplaces including 12 in meat processing plants, where 571 cases have been notified.

The NPHET also took note of the following:

- the effective Reproduction number is now estimated to be between 0.4 and 0.59;
- the daily positivity rate has been less than 5% each day for the past week;
- the influenza like illness rate (ILI rate) is 12 per 100,000 (i.e. below threshold).

Given the latest national data, as set out above and in the report to Government as provided for in the *Roadmap for Reopening Society & Business*, and the ECDC risk assessment, the NPHET today considered the public health measures currently in place (letters of 12th, 24th and 27th March, 10th April, and 1st May refer).

Arising from the discussion at today's meeting, the NPHET recommends that Government give consideration to the Phase 1 reductions and adjustments of the public health social distancing measures set out in the Appendix to this letter, with effect from 18 May 2020.

Furthermore, as part of this advice to Government in relation to Phase 1 measures, the NPHET now recommends that, where appropriate, members of the public use a face covering (i.e. a non-medical face covering) as an additional hygiene measure, when using busy public transport or when in enclosed indoor public areas such as retail outlets. Appropriate guidance and information for the public is being developed.

Importantly, in giving this advice to Government, the NPHET acknowledged the particular impact that the current pandemic and consequent public health social distancing measures have had on children in our society over the last number of months. The NPHET will give specific consideration to the needs of children and parents in the context of advising Government on options for the easing of restrictions, having regard to the public health risks for children and their families.

In developing this risk-based public health advice to Government in relation to the reduction of the public health social distancing measures which are currently in place, the NPHET has had regard to the following:

- the report to Government prepared by the Department of Health this week in accordance with the decision-making framework provided for in the *Roadmap for Reopening Society & Business* and in particular–
  - the latest data regarding the progression of the disease,
  - the capacity and resilience of the health service in terms of hospital and ICU occupancy, and
  - the capacity of the programme of sampling, testing and contact tracing;

- the most recent ECDC *Rapid Risk Assessment: Coronavirus disease 2019 (COVID-19) in the EU/EEA and the UK– ninth update* (23 April 2020) in which it is stated that the risk of resurgence of COVID-19 remains **moderate**, even if public health measures are phased out gradually and accompanied by appropriate monitoring systems and capacities;

- the Government of Ireland *Roadmap for Reopening Society & Business* published on 1 May 2020 and the NPHET's *Public Health Framework Approach in providing advice to Government in relation to reducing social distancing measures introduced in response to COVID-19*;

- the experiences in some countries internationally, including South Korea, Germany and China, where easing of public health measures has been associated with an increase in cases of COVID-19 infection.

In providing this risk-based public health advice to Government in relation to the reduction of the public health social distancing measures, the NPHET–

- emphasised that it is impossible to predict with certainty what the future trajectory of the COVID-19 disease will be in Ireland. Consequently, it is not possible to provide assurance that it is safe to reduce the public health social distancing measures and stricter measures may have to be reintroduced if a strong upsurge of infection were to occur at some point in the future;

- reiterated the importance of the continued enhancement of the HSE's sampling, testing, contact tracing, surveillance and reporting processes, with a particular focus on reinforcing the public health management of complex cases and clusters, especially among vulnerable populations;

- highlighted the concern that workplaces have the potential to become foci for new clusters of infection as public health measures are eased and emphasised the need for employers, workers and relevant stakeholders to work together to promote adherence to public health guidance and advice appropriate to the relevant sector;

- recommended the slow, gradual, stepwise and incremental easing of some restrictions, as set out, on the proviso that there is a continued strong emphasis on the risks associated with same, the need for robust communication regarding the ongoing presence of the virus within the community

and the consequent importance of individual and societal collective behaviours in preventing its resurgence;

- acknowledges that there are other important considerations for Government with regard to the reduction of measures, such as social and economic considerations, while noting the potential effects of the current measures on the wider health and wellbeing of the population.

The epidemiologic trends and health system impact of COVID-19 will continue to be reviewed on an ongoing basis such that any changes in the overall situation will be detected rapidly. As such, future recommendations and the timing of same will be subject to change based on the transmission patterns of the disease, the trajectory and velocity of change, and the evolving analysis of the impact of COVID-19 on health system capacity.

The NPHET considered that the powers contained in the Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations, 2020 should be updated accordingly and continue to be available for use by the Gardaí for the coming period.

I also wish to bring to your attention that at today's meeting the NPHET recommended the establishment of an expert independent panel (COVID-19 Nursing Home Expert Panel – examination of measures to 2021) which, through examination of the national response to COVID-19 as well as international measures and emerging best practice, will make recommendations to you as the Minister for Health by the end of June 2020 to ensure all protective COVID-19 response measures are planned for, in light of the expected ongoing COVID-19 risk for nursing homes over the next 6-18 months. The Department will revert to you with a proposal in this regard in the coming days.

I enclose a copy of the letter which has been forwarded to the HSE CEO arising from today's NPHET meeting.

The NPHET of course remains available to provide any further advice and recommendations that you or the Government may determine that it requires in order to assist it in making the difficult and complex decisions for which you are responsible.

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

Appendix – NPHET Advice to Government regarding the Phase 1 reductions and adjustments of the Public Health Social Distancing Measures

The NPHET advises that Government may wish to consider the following measures as part of the Public Health Framework Approach to reducing the current public health social distancing measures:

1. **Community Health Measures**

General advice

The general advice that people should take action to protect themselves and others remains broadly the same. Some important updates are being made to the general advice for everyone to take account of the changes now proposed, as the public health measures are lifted in line with Phase 1 of the Public Health Framework Approach. These changes are intended to provide additional guidance to the public.

Everybody should–

- wash hands frequently with soap and water or use an alcohol-based hand rub even if hands are not visibly dirty,
- practice good respiratory hygiene, that is, when coughing and sneezing, cover your mouth and nose with flexed elbow or tissue – discard tissue immediately into a closed bin and clean your hands with alcohol-based hand rub or soap and water,
- maintain social distancing, that is, leave at least 2 metres (6 feet) distance between yourself and other people, particularly those who are coughing, sneezing and have a fever,
- avoid touching your eyes, nose and mouth – if you touch your eyes, nose or mouth with your contaminated hands, you can transfer the virus from the surface to yourself,
- continue to restrict your close contacts to people in your household, but if do meet people from outside your household, keep the number of contacts as small as possible and duration of contact as short as possible, while also maintaining strict social distancing, 2 metres distance, and good personal and respiratory hygiene,
- know, and be very vigilant of, the symptoms of COVID-19. If you think you have symptoms, including flu-like symptoms, self-isolate at home. Do not go to work, meet other people or go out,
- avoid crowded places, assess the risk in the different situations and environments that you are in and respond accordingly,
- as an additional hygiene measure, when using busy public transport or when in enclosed indoor public areas such as retail outlets, the wearing of a face covering (i.e. a non-medical face covering) is recommended, where appropriate,
- people who are aged 70 years of age and over and the medically vulnerable are advised to continue cocooning for their safety, bearing in mind the updated guidance to them from 1 May 2020 that if they wish to leave their homes to engage in exercise and activities outdoors that they should continue to adhere to strict social distancing, keep 2 metres from other people, comply with appropriate guidance regarding maintaining a 'no touch' approach and hand hygiene on returning home.

Stay at Home advice

People should continue to stay at home except in the following circumstances:

- to travel to and from work, or for purposes of work;
- to shop for essential food and household goods;
- to attend medical appointments and collect medicines and other health products;
- for vital family reasons, such as providing care to children, elderly or vulnerable people, but excluding social family visits;
- for farming purposes i.e. food production and/or care of animals;

- to avail of the expanded list of essential retail services as set out under the *Retail, Personal Services and Commercial Activities* heading below;
- to engage in physical exercise within 5km of the home, while adhering to strict 2 metre social distancing.

Small groups meeting outdoors

- Up to 4 people who are not from the same household may meet outdoors (for example a group of individuals from different households, a family group meeting an individual friend or neighbour etc.) In these circumstances it is advised that people maintain 2 metres distance, good personal and respiratory hygiene as well as continuing the apply the general advice of keeping the number of contacts as small as possible and duration of contact as short as possible.

2. **Cultural & Social Measures**

Culture & social

- Outdoor public amenities (e.g. parks, beaches, walks, etc.) may be reopened. These may be accessed by people where they are located within 5 kilometres of the person's home. People should continue to maintain strict social distancing and avoid these locations if crowded. People are encouraged to avoid congregating at these locations and this should be enforced if necessary.

Sport

- Outdoor public sports amenities (e.g. sports pitches, tennis courts, golf courses etc) may be reopened. These may be accessed by people where they are located within 5 kilometres of the person's home. Strict social distancing and personal hygiene should be maintained while using these sports amenities.
- People may engage in outdoor sporting and fitness activities, either individually or in groups of up to 4 where strict personal hygiene is practiced and social distancing can be maintained, In addition, contact should be minimised and the sharing of sports equipment should be minimised and where shared, regularly and effectively cleaned before, during and after use.

3. **Education & Childcare Measures**

- School and college buildings may be reopened for access by teachers and staff for organisation and distribution of learning materials, related activities and essential administration.

4. **Economic Activity (Work)**

- Over and above all of the existing permitted work arrangements, a risk-based and phased approach should be applied to commencing the return to onsite working. On that basis, a phased return to work of outdoor workers (e.g. construction workers, gardeners etc.) should commence.
- Those employers whose workers are returning to work on a phased basis in Phase 1 should consider a range of approaches to manage the total number of workers interacting with each other onsite at work at any one time, such as: having a proportion of workers return initially and increasing over time, shift work, staggered hours etc.
- Anyone who can work from home should continue to do so. This includes essential workers also, whether they work in essential Government, utilities or other services.
- Businesses and organisations reopening should apply the Return to Work Safely Protocol - COVID-19 Specific National Protocol for Employers and Workers published by the Department of Business, Enterprise and Innovation on 8 May 2020, including having a COVID-19 Response Plan in place.
- Additionally, it is important that employers, workers, employment and labour agencies and all stakeholders work together so that workplaces are prepared for the return of workers, and good communication

mechanisms are in place on how workers can protect themselves, other colleagues, customers and everyone around them from infection and how to reduce the risks of workplace outbreaks. Actions may include:

- establishing cleaning stations and making hand sanitisers available for use, implementing appropriate cleaning schedules, waste disposal arrangements, arrangements to encourage social distancing between workers and alternative arrangements where social distancing is not always possible etc.
- communicating the importance of hand and respiratory hygiene, complying with social distancing and maintaining 2m distance while at work and travelling to and from work, as well as avoiding congregating during break times, and while waiting to go "on-site" at work or leaving work etc.

- It is important that employers work proactively, including with authorities and health authorities where necessary, to limit the spread of disease within or connected with the workplace and to mitigate the effects of workplace outbreaks should such occur.
- For workers, it is important that they do not come to work if they have symptoms, including flu-like symptoms, and workers who are contacts of a confirmed or suspected case, should follow public health advice and not come to work until advised otherwise.
- It is also important that employers work with authorities and stakeholders across the sector to share good practices to protect all in society from the risks of infection.

5. **<u>Retail, Personal Services and Commercial Activities</u>**

- Over and above all of the existing permitted retail arrangements, a risk-based and phased approach should be applied to commencing the return of retail, personal services and commercial activities. On that basis, a phased return of retail activities should commence as follows:
  - Retail outlets that are primarily outdoor (e.g. garden centres, farmer's markets, hardware stores etc) may reopen.
  - The following retail outlets listed as essential in the Health Act 1947 (Section 31A – Temporary Restrictions) (COVID-19) Regulations 2020, but which are currently restricted to offering services on an emergency basis, may now open on a fulltime basis:
    - *opticians and optometrists, outlets providing hearing test services, selling hearing aids and appliances;*
    - *retailers involved in the sale, supply and repair of motor vehicles, motorcycles and bicycles and related facilities;*
    - *hardware stores, builders' merchants and stores that provide hardware products necessary for home and business maintenance, sanitation and farm equipment, supplies and tools essential for gardening / farming /agriculture;*
    - *retail sale of office products and services for individuals working from home and for businesses;*
    - *retailers providing electrical, IT and phone sales, repair and maintenance services for home and businesses.*

- Retailers, as employers, should apply the Return to Work Safely Protocol - COVID-19 Specific National Protocol for Employers and Workers published by the Department of Business, Enterprise and Innovation on 8 May 2020, including having a COVID-19 Response Plan in place.
- In addition, retailers should consider a range of approaches to ensure the safe operation of their outlet for their staff and customers and minimise the spread of infection such as:
  - providing cleaning stations and hand sanitiser for use by staff and customers,
  - implementing protective screens and barriers,
  - operating new queueing approaches,
  - limiting the number of customers and staff per store at any one time,

  - increasing store cleaning and hygiene,
  - considering store layout to facilitate social distancing,
  - extending opening hours to reduce crowding,
  - implementing carpark restrictions, etc.
- Retailers, workers and all sector stakeholders should work together so that retail workplaces are prepared for the return of workers and customers and good communications are in place on how workers can protect themselves, other colleagues, customers and everyone around them from infection and how to reduce the risks of workplace outbreaks. Actions may include:
  - implementing appropriate cleaning schedules, waste disposal arrangements, arrangements to encourage social distancing between workers, customers and alternative arrangements where social distancing is not always possible etc.
  - communicating the importance of hand and respiratory hygiene, complying with social distancing and maintaining 2m distance while at work and travelling to and from work, as well as avoiding congregating during break times, and while waiting to enter the retail premises at work etc.
- It is important that retailers, as employers, work proactively, including with authorities and health authorities where necessary, to limit the spread of disease within or connected with the workplace and to mitigate the effects of workplace outbreaks should such occur.
- For workers in retail outlets, it is important that they do not come to work if they have symptoms, including flu-like symptoms, and workers who are contacts of a confirmed or suspected case, should follow public health advice and not come to work until advised otherwise.
- It is also important that retailers work with authorities and other stakeholders across the sector to share good practices to protect all in society from the risks of infection.

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

Mr. Paul Reid,
Chief Executive Officer & Chair HSE National Crisis Management Team (NCMT),
Health Services Executive,
Dr Steevens' Hospital,
Dublin 8,
D08 W2A8.

14th May 2020

Via email to: ceo.office@hse.ie

Dear Paul,

Arising from today's meeting of the COVID-19 National Public Health Emergency Team (NPHET), I wish to bring to your attention, as Chair of the HSE NCMT, the following decisions of the NPHET which are now required to be actioned by the HSE and Health Protection Surveillance Centre (HPSC):

1. The NPHET agreed the HSE HPSC *Epidemiology Report on COVID-19 in Residential Care Facilities (RCF) in Ireland* (14 May 2020) and approved the recommendations contained in the Report.

2. The NPHET accepted the advice of the Expert Advisory Group (EAG) from its meeting of 13 May, 2020 in relation to the following:

   (i) *For those individuals with COVID-19 who have made a complete clinical recovery from their illness, who are at least 14 days from symptom onset, and who have had no fever for 5 days, the requirement for repeat testing, to demonstrate that RNA is not detected, has been removed.*

   (ii) *Immunocompromised individuals with COVID-19 can be moved out of isolation 14 days from onset of symptoms, provided they have made a complete clinical recovery, are symptom-free, and have had no fever for 5 days.*

   The HPSC is to update and publish its guidance and the HSE is to implement accordingly.

3. The NPHET approved the HSE's proposal to undertake a population sero-prevalence study to be carried out by the HPSC and NVRL, in collaboration with the Central Statistics Office and Department of Health, to investigate COVID-19 infection in the Irish population (SCOPI) so as to estimate population age-specific immunity or past exposure to SARS-CoV-2.

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4. NPHET recommends that the HSE should commence the testing of close contacts of confirmed cases of COVID-19 (including asymptomatic close contacts)–

(i) as soon as they are identified as a close contact, and
(ii) on day 7 after their last contact with the index case.

This should occur concomitantly with the commencement of Phase 1 reduction of measures. The HSE is to put in place operational arrangements that include ensuring these testing samples are 'tagged' as close contacts to enable the tracking and reporting of their outcomes through the CRM and CIDR information systems. The HPSC is to update the relevant public health guidance.

For information, the NCMT may also wish to note that the NPHET today recommended the following to Government:

a) Having regard to current epidemiological situation, and latest national data set out in the report to Government as provided for in the *Roadmap for Reopening Society & Business*, the NPHET recommended that Government give consideration to the reduction and adjustment of the public health measures, in accordance with Phase 1 of the *Roadmap*.

b) The NPHET recommended that, where appropriate, members of the public use a face covering (i.e. a non-medical face covering) as an additional hygiene measure, when using busy public transport or when in enclosed indoor public areas such as retail outlets.

c) NPHET recommended the establishment of an expert independent panel (COVID-19 Nursing Home Expert Panel – examination of measures to 2021) which, through examination of the national response to COVID-19 as well as international measures and emerging best practice, will make recommendations to the Minister for Health by the end of June 2020 to ensure all protective COVID-19 response measures are planned for, in light of the expected ongoing COVID-19 risk for nursing homes over the next 6 to 18 months.

Finally, I would like to take this opportunity to thank you and the wider team across the HSE for your ongoing support and work across the health and social care services as we move through the COVID-19 National Public Health Emergency. Officials from this Department have been and continue to be available to work with relevant HSE staff.

Yours sincerely,

Dr Tony Holohan
Chief Medical Officer

cc. Dr Colm Henry, Chief Clinical Officer, HSE
Mr Liam Woods, National Director, Acute Hospital Operations, HSE