An Roinn Sláinte
Department of Health

Framework for Future Decision Making

Department of Health Input:

Phase Two - Status Report on COVID-19

June 25th 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 Organisation 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 and 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:

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 three weeks.

A) Progression of the Disease

The NPHET considers a wide range of information when considering its public health advice to Government. The following criteria are considered 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. These criteria are not viewed in isolation, but rather within the larger situational context.

Criteria:

- Number of new cases per day
- Trend in deaths (by date of death)
- 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
- Clusters and cases in non-healthcare settings
- Number of cases in healthcare workers
- Median number of close contacts

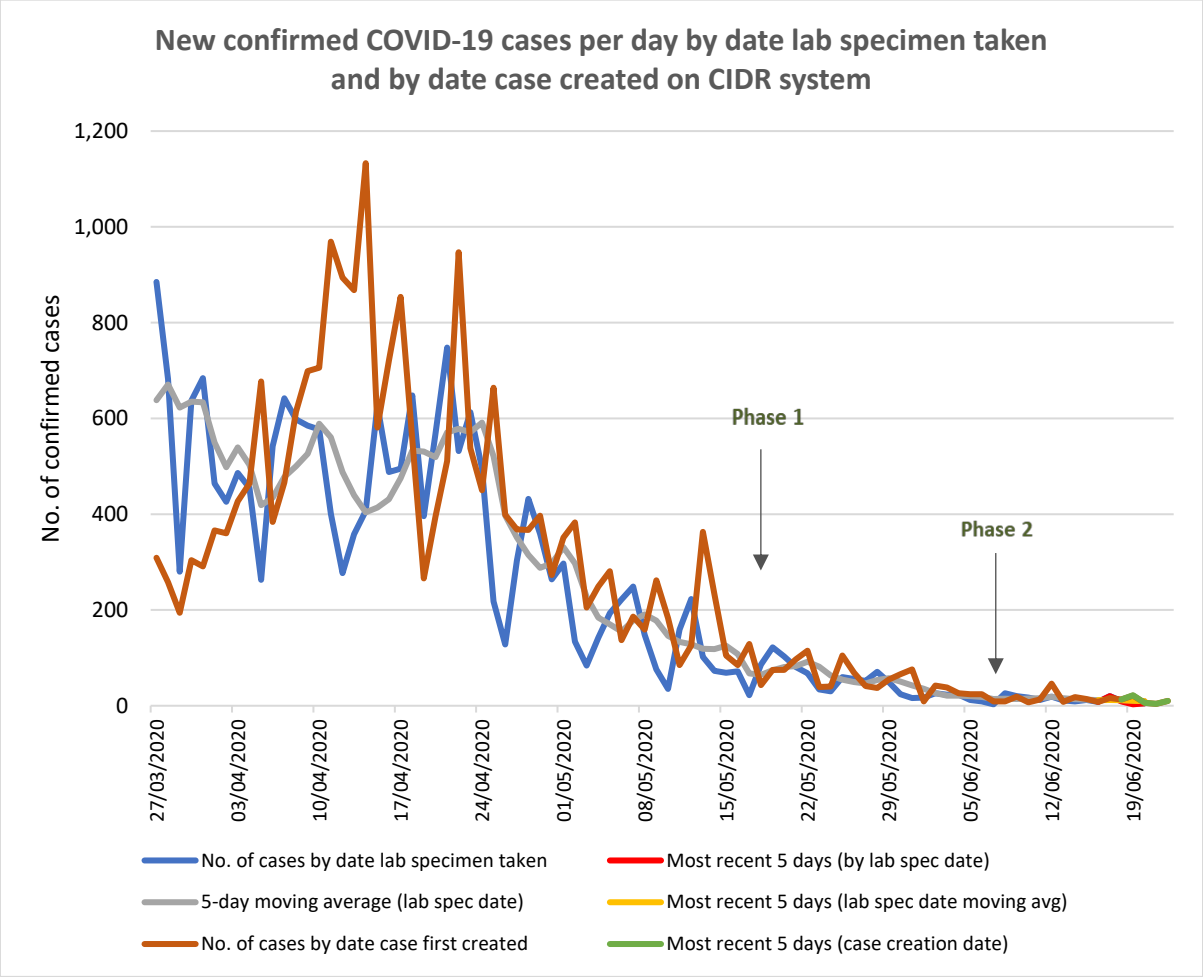
The latest data regarding the progression of the disease

As at midnight on the 22nd of June 2020:

- there have been 25,391 patients with laboratory-confirmed cases of COVID-19.
- this equates to 516 people per 100,000 population having tested positive for COVID-19.
- the largest number of cases notified to the Department of Health by the HSE Health Protection Surveillance Centre (HPSC) 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

As at midnight on the 22nd of June, the five-day moving average for confirmed cases newly reported to the Department of Health was 11. A new case is notified to the Department when it is confirmed they have COVID-19 and would be later than when the person first became ill or was tested. When considering the progression of the disease, considering the date when cases were tested is useful. The latest five-day moving average of new confirmed cases, based on the date the person's lab specimen was taken (for testing), was 10. It must be noted that time lags in data reporting mean that data for the most recent five days should be considered provisional and subject to change. The latest average of 10 cases compares with a peak in the five-day average during the observed period of 671 on 28th March.

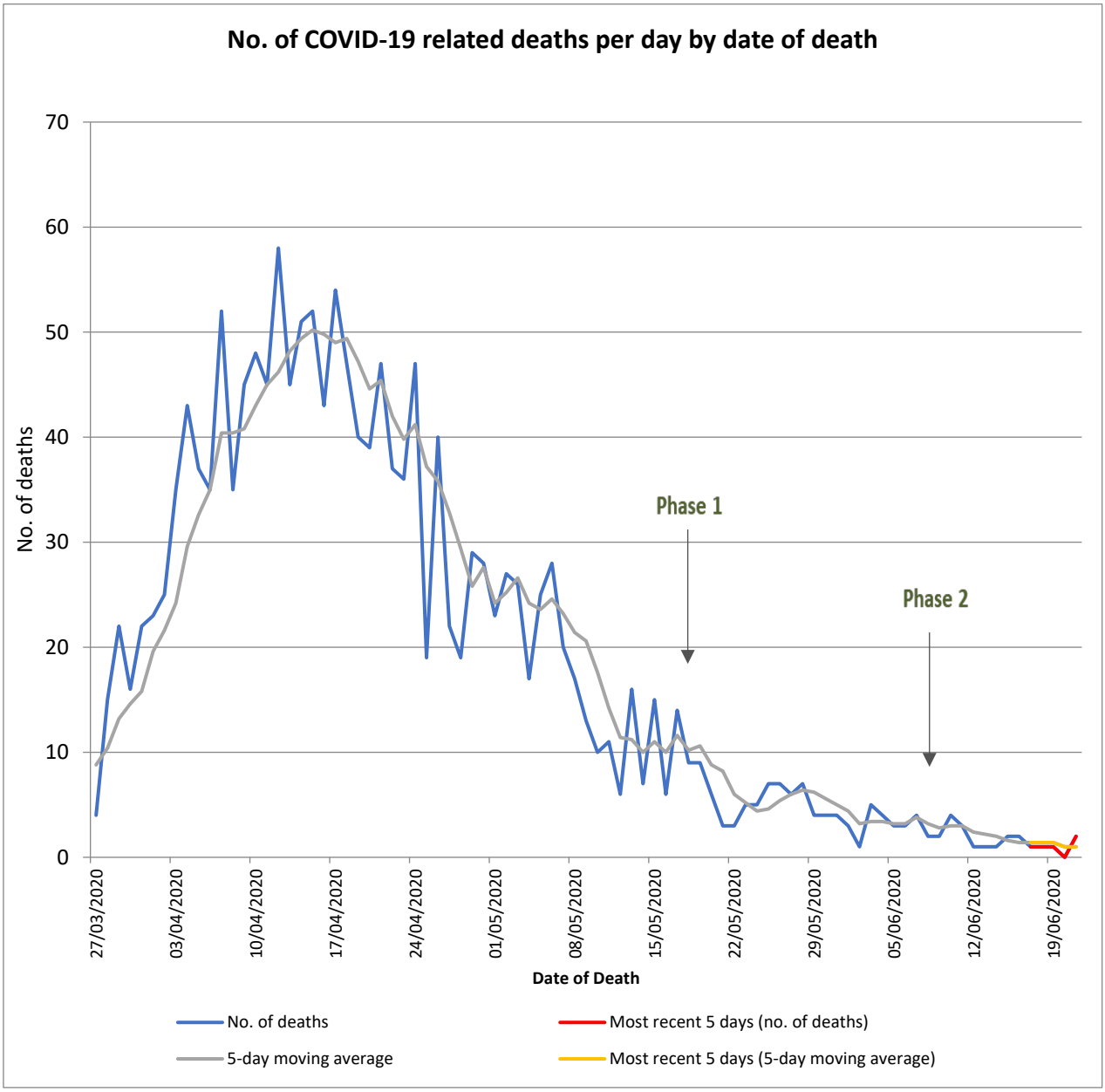


Source: HPSC, Daily CIDR Data Extract
Note: Time lags in data reporting mean that data for the most recent 5 days should be considered provisional and subject to change.

Disease impact

The latest five-day moving average for daily deaths, based on date of death, was 1.

As at midnight on the 22nd of June, the total number of COVID-19 related deaths (confirmed and probable cases) was to 1,720. The peak for new deaths recorded by date of death during the observed period was 58 on the 12th of April. Excluding the most recent five days (to account for delays in reporting of deaths), the five-day moving average of daily deaths, by date of death, was 1.4 (to the 16th of June). This is down from a peak of 50 on the 15th of April.



Source: HPSC, Daily CIDR Data Extract

Note: This includes all COVID-19 related deaths, both lab confirmed and probable.

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 an unknown date of death and not shown in this chart.

Note: Time lags in data reporting mean that data for the most recent 5 days should be considered provisional and subject to change.

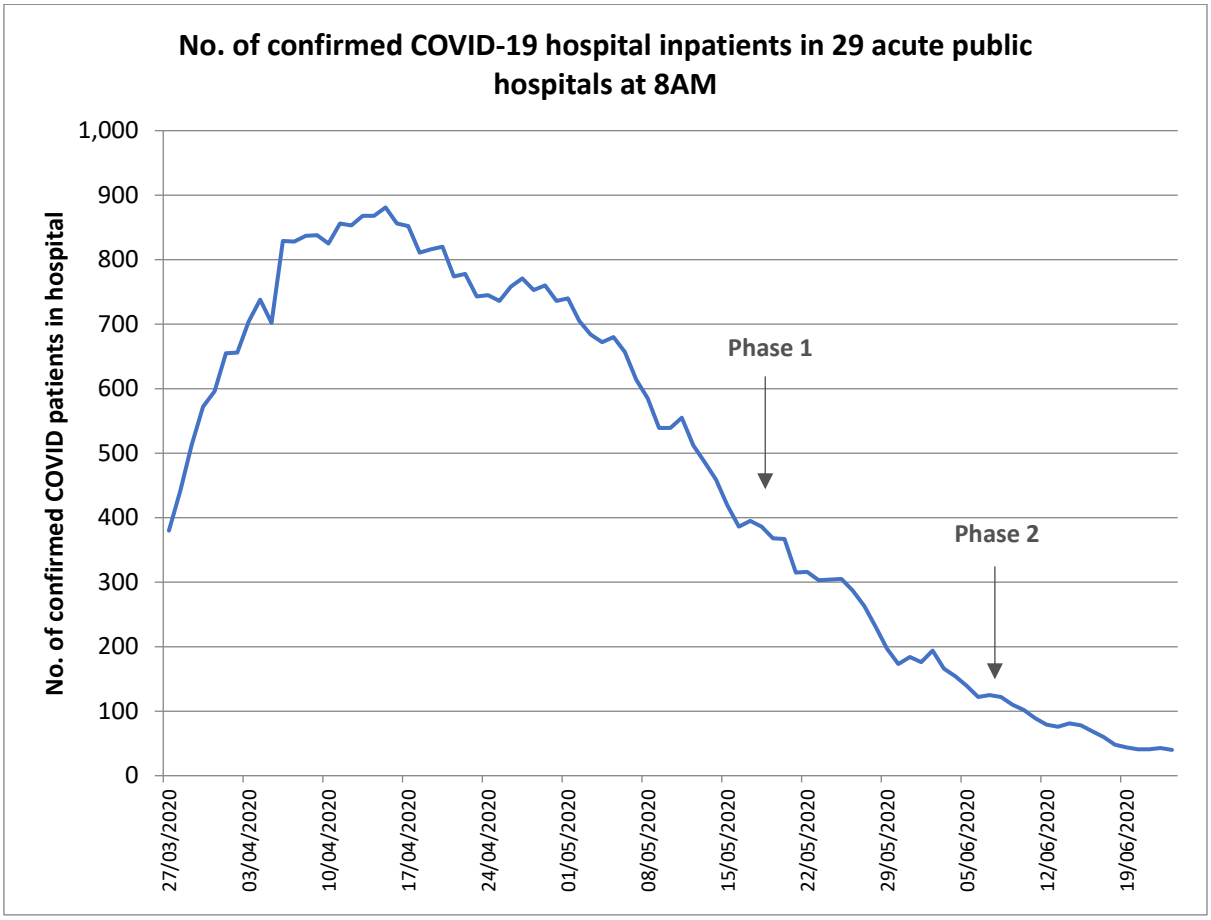
COVID-19 hospitalisations

There were 40 confirmed and 260 suspected cases of COVID-19 in hospital on June 23rd. There were 11 confirmed and 9 suspected cases in intensive care, of whom 11 were ventilated**.** The five-day moving average for new admissions of confirmed cases to hospital was 2 on the 23rd of June. The five-day moving average of new admissions to ICU was 0.2. Based on the latest data available, approximately 13% of all confirmed cases to date have been hospitalised, with 46% of those aged under 65. On the 23rd of June, the number of confirmed COVID-19 patients in ICU represented 36.3% of all confirmed COVID-19 patients currently in hospital. In total, 1.7% of all cases have being admitted to intensive care. Of those in ICU, 63% are aged under 65. The average length of stay in ICU is 15 days,

with 73% of patients discharged to a ward after their stay in critical care with 9% being transferred to a High Dependency Unit or another ICU.

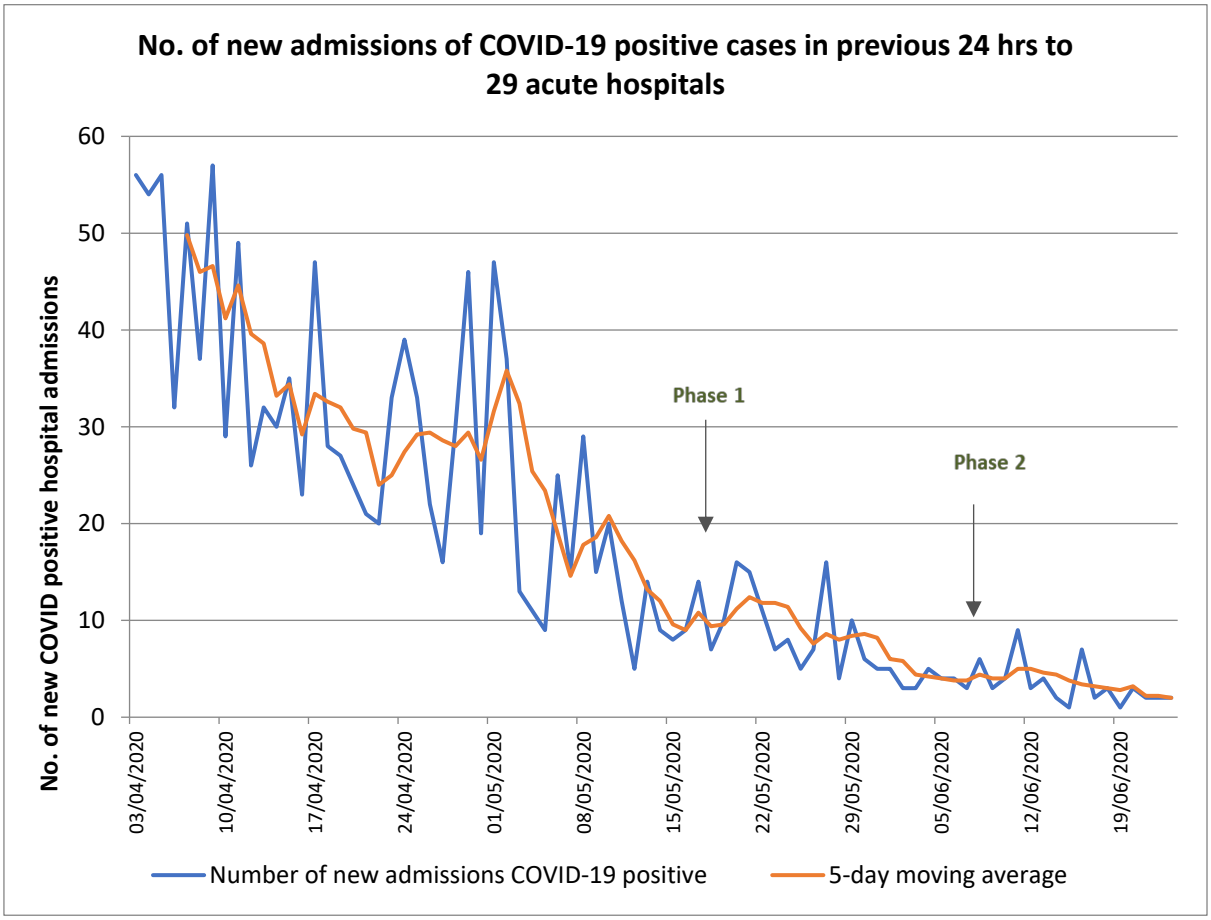
Trends in COVID-19 admissions to hospital

The number of confirmed COVID-19 hospital inpatients per day has been steadily declining in recent weeks. As at 23rd of June, there were 40 hospital inpatients with confirmed diagnosis of COVID-19. This is a 67% decline since the beginning of Phase 2 on 8th June.



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

The number of new admissions of COVID-19 positive patients to hospital has been trending downwards overall in recent weeks. As measured by a 5-day moving average, there was an average of 2 COVID-19 positive patients daily being admitted to our public hospitals over the 5 days ending 23rd June.

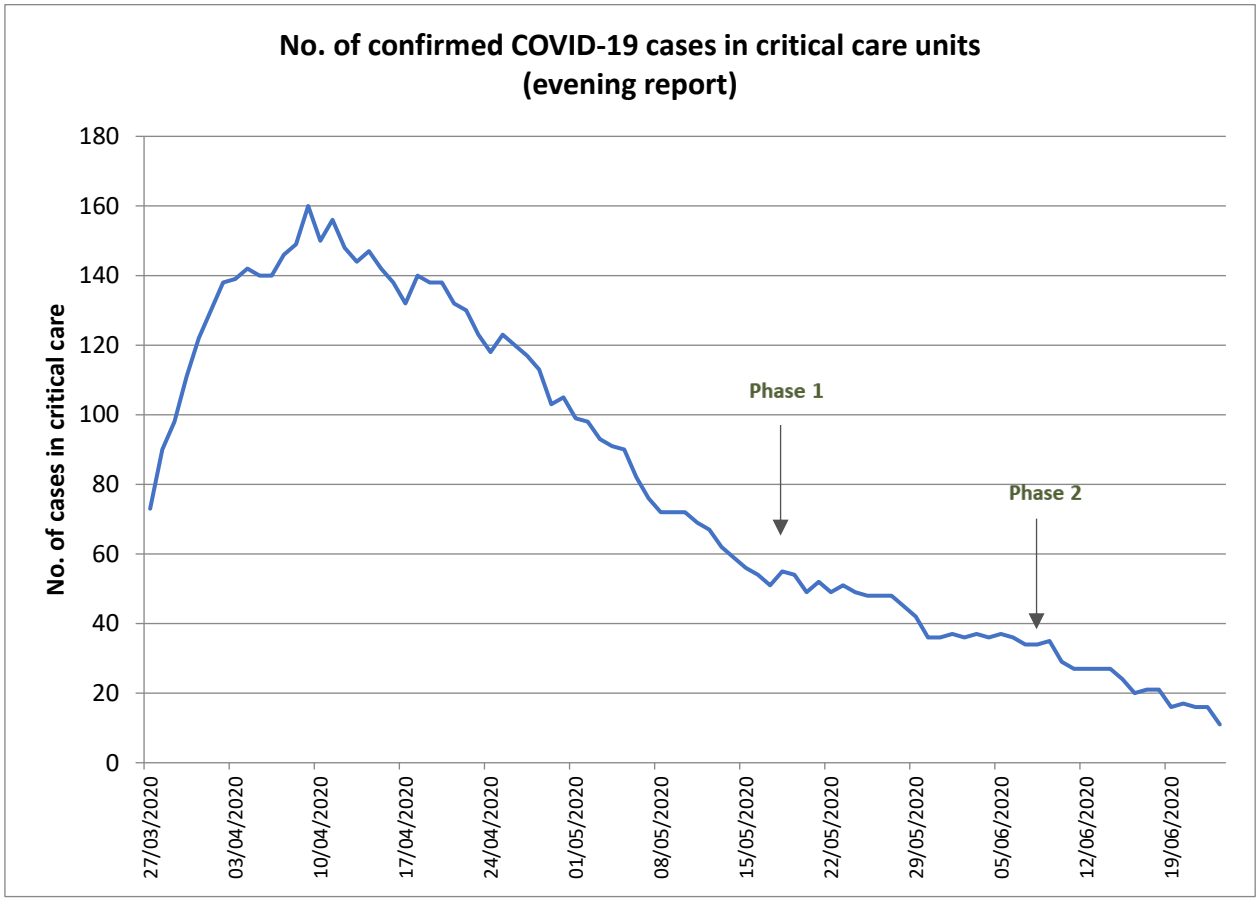


Source: HSE, SDU, extract from SBAR - 29 Hospitals
Note: This variable only began to be collected on 03/04/20. Therefore the earliest date that a 5-day moving average can be calculated is 07/04/20

Trends in COVID-19 admissions to critical care

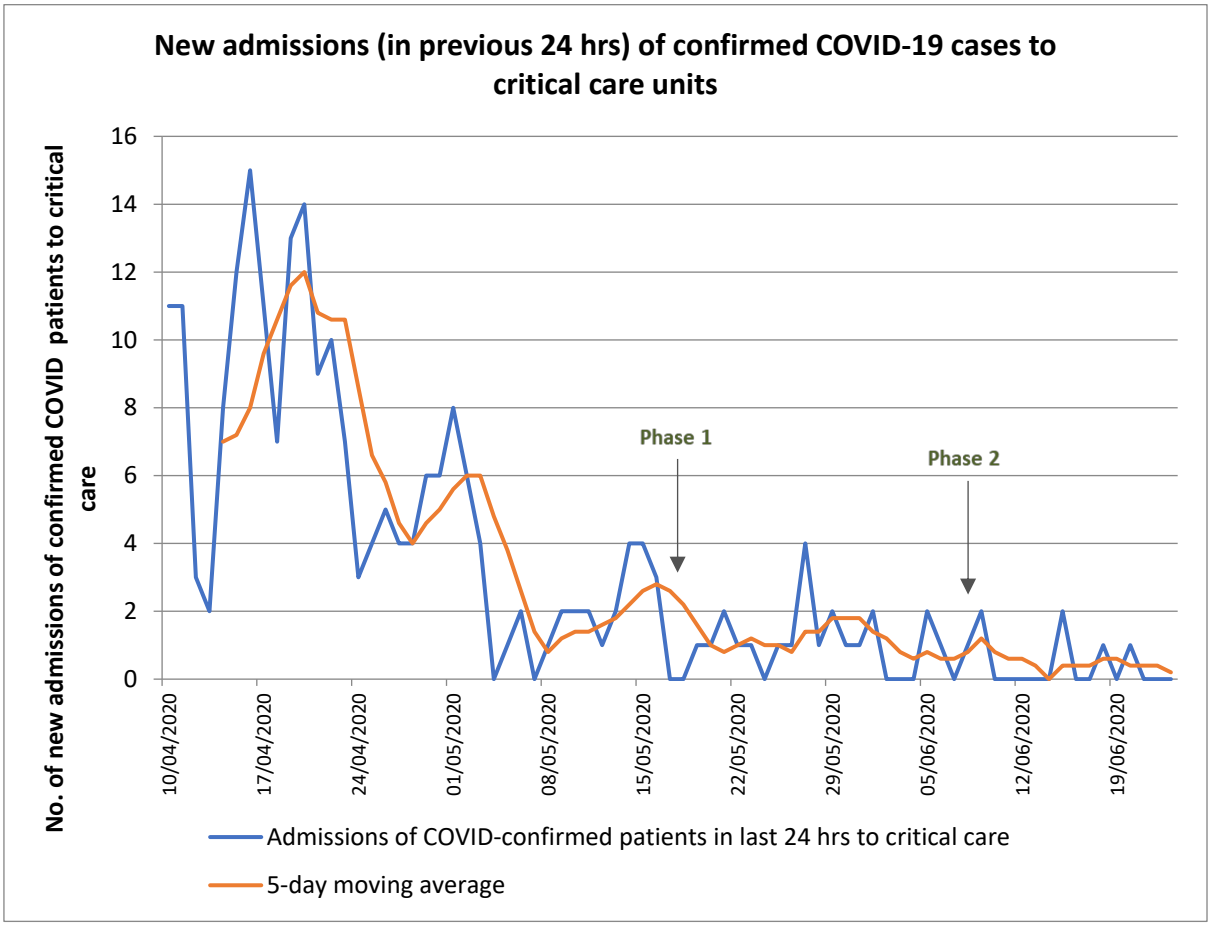
The charts set out in this section provide an overview of recent trends relating to key indicators on COVID-19 activity in critical care units.

The number of confirmed COVID-19 cases in critical care units was 11 on the 23nd of June (evening report). This represents a 68% decline since the beginning of Phase 2 (on 8th June) and compares with a peak of 160 on the 9th of April.



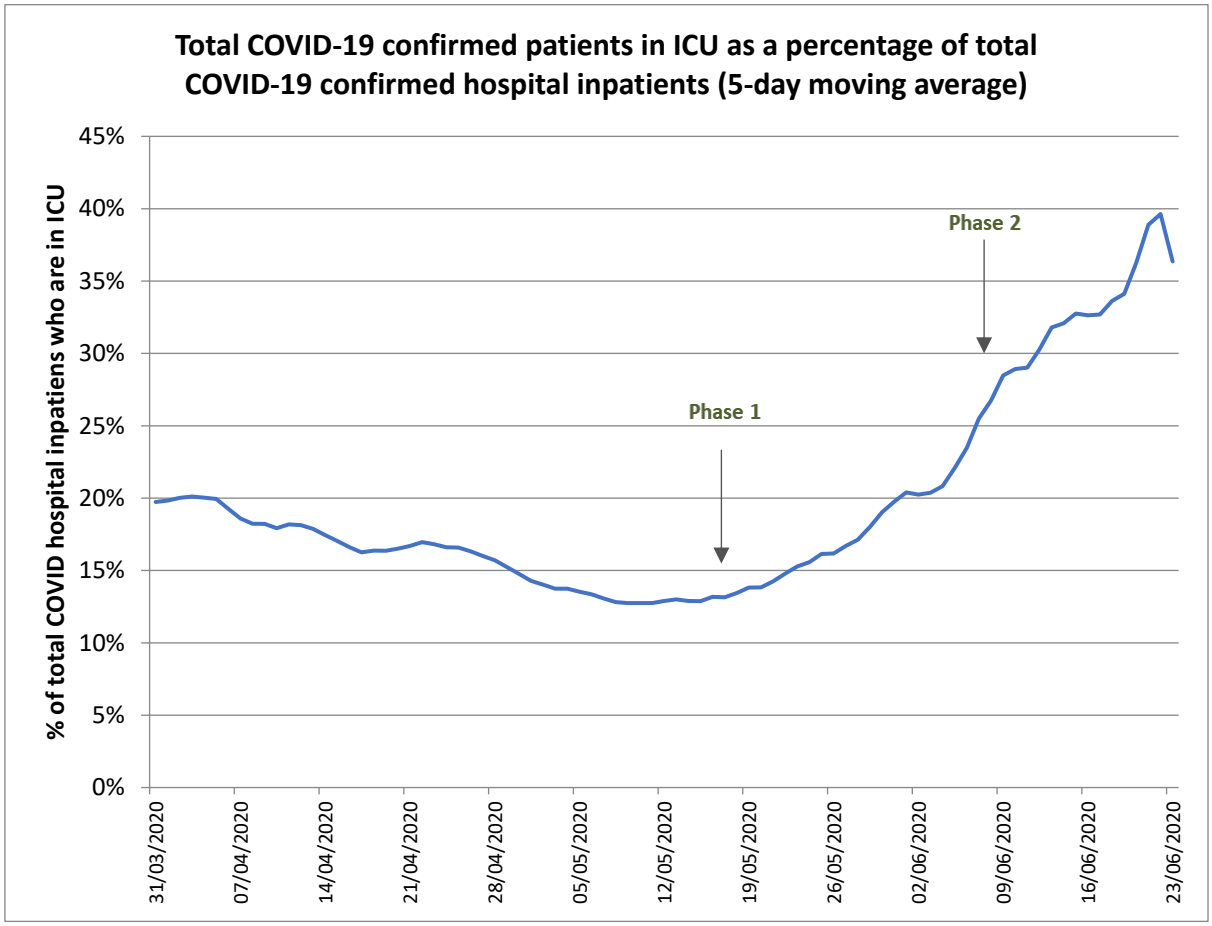
Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals

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. The 5-day moving average of new daily admissions to critical care units is 0.2 to 23rd June. This is 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 calculated is 14/04/20

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, was trending downwards from 20% on the 2nd of April to approximately 13% in mid-May. However, in recent weeks there has been an increase in the rate, which was 36.3% on 23rd June. Again, caution should be taken when interpreting this statistic as the number of confirmed COVID-19 cases in critical care was low during this time period and even a small change in the number could result in a large percentage change. The length of stay for those patients who require critical care is generally longer than for those who require general hospitalisation which may impact upon these figures.

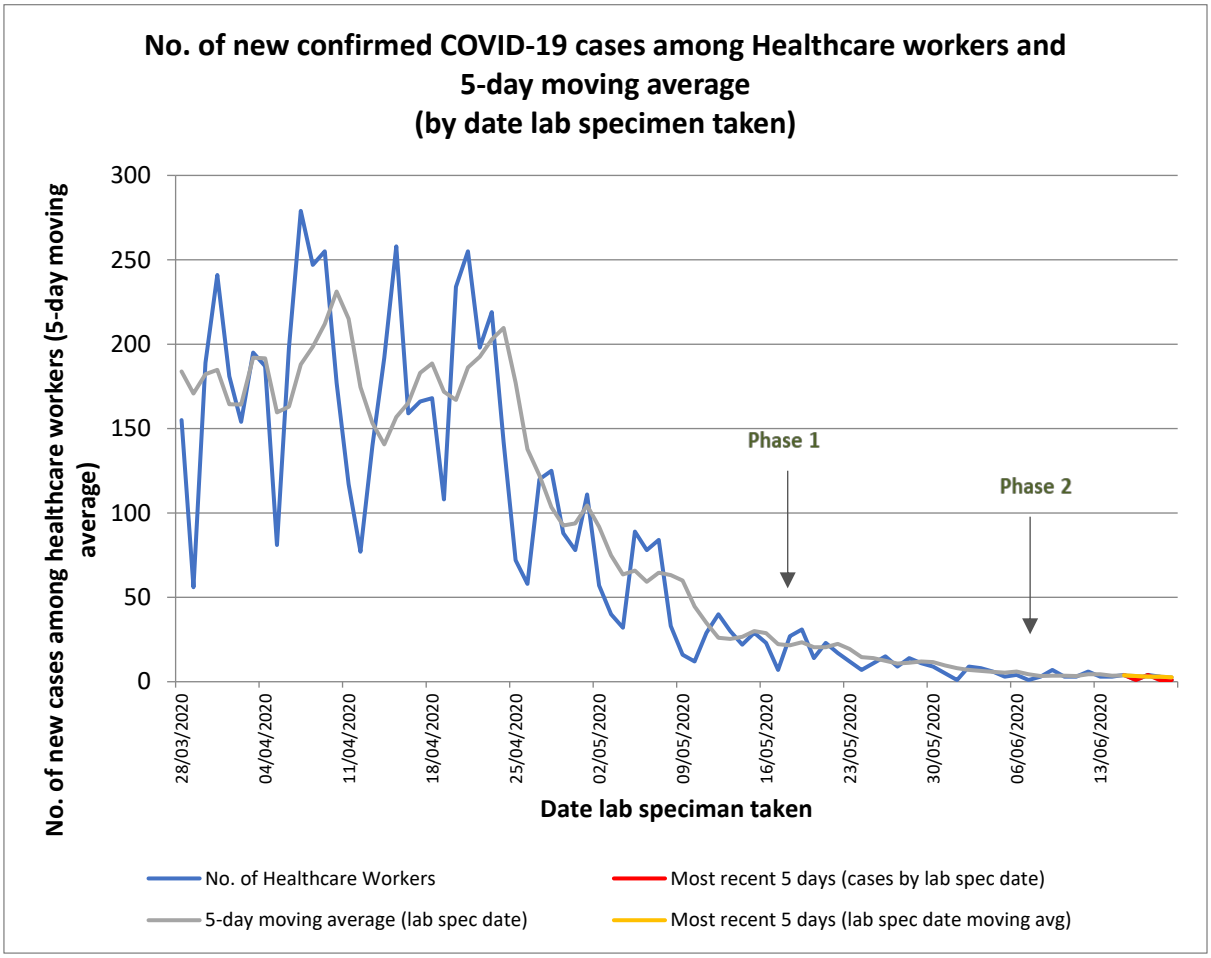


Source: National Office of Clinical Audit, ICU Business Information System, 28 acute public hospitals and 5 private hospitals; and HSE, SDU, extract from SBAR - 29 Hospitals

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 midnight 22nd of June, 32% (n=8,173) of all confirmed cases to date has been among healthcare workers. The number of confirmed cases among healthcare workers as measured by the 5-day moving average peaked at 230 on the 10th April. This has been declining since the end of April to now stand at 3. 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

Note: Time lags in data reporting mean that data for the most recent 5 days should be considered provisional and subject to change.

Outbreaks/Clusters of COVID-19 in Hospitals and Residential Care Facilities in Ireland

During week ending on the 20th of June, (week 25) there were 98 new COVID-19 outbreaks notified as compared to 102 during week 24 2020. Of the 98 outbreaks notified in week 25, 93 were delayed notifications of family outbreaks which occurred in March (n=47), April (n=38) and May (n=8). Further information on outbreaks is available in section D.

Influenza Like Illness Rate

The sentinel GP Influenza-like illness (ILI) consultation rate slightly increased during week 25 2020 (week ending 20th June) to 2.8 per 100,000 compared to an updated rate of 0.7 per 100,000 in week 24. The ILI rate remains stable and below baseline (18.07 per 100,000). The ILI rate has now been below baseline for seven continuous weeks. The ILI rate peaked during week 12 with a rate of 187.6 per 100,000. This was reflective of the current COVID-19 pandemic rather than influenza.

Modelling data

The effective reproduction number as at 23rd of June is estimated to be between 0.5 and 0.8. Given the low numbers of cases seen in past several days, we would expect reproduction number to be low. However, it should be noted that the small number of cases makes the reproduction number difficult

to estimate, and the more meaningful number to monitor in our country at this point in the pandemic is the number of new cases per day.

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 Irish Epidemiology Modelling Advisory Group (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 overleaf reflect the Acute Hospital capacity situation of the Health service in the context of the current COVID-19 Pandemic response. This excludes Critical Care Capacity.

Overview of current Acute Hospital Bed Capacity – Public Hospitals

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.

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. It is important to note that attendance at Emergency Departments is returning to near what would be expected at this time of year and the number of patients being admitted through EDs has also increased.

It is also important to note that the number of beds available in not distributed evenly and in some hospitals relatively few beds are available. However, there are surge beds available if required.

The surge capacity requires an additional 858 staff. These are currently subject to the Ireland On Call recruitment process. Note that absenteeism due to COVID-19 as at 17 June 2020 is 335 in Acute Services. This is largely reflected in the 280 closed beds in the table below.

Between 28th May and 19th June the number of beds vacant and available in public hospital has increased from 443 to 739. This remains below the 853 beds available on 14 May.

	14-May	24-May	28-May	19-Jun
Public Hospitals	**Beds**			
Total In-patient beds	11,597*	11,597*	11,597*	11,597
Minus beds closed for infection control	*-172*	*-127*	*-138*	*-126*
Minus beds closed	*-244*	*-175*	*-280*	*-152*
Subtotal available beds	11,181	11,295	11,179	11,319
Day Case Beds for Surge		*+1,633*	*+1,633*	*+1,633*
Additional Surge Acute Beds		*+485*	*+485*	
Total Surge Capacity	+2,118	+2,118	+2,118	+1,633
Total Overall Available Capacity	13,299	13,413	13,297	12,952
Of which = beds occupied	12,446	12,829	12,854	12,213
In-patient beds currently vacant and available (current capacity)	**853**	**584**	**443**	**739**

Source: Special Delivery Unit, HSE

* The figure for inpatient beds in public hospitals was incorrectly reported in previous reports (by an additional 310 beds). Data for inpatient beds, available beds/capacity and vacant beds for previous periods has been corrected in the table above.

Overview of current Acute Hospital Bed Capacity – Private Hospitals

Private Hospital Capacity

The additional capacity available in private hospitals is set out below. This capacity will cease to be available after 30 June, though it is expected that access to it would be available in a COVID-19 surge scenario. There was a decrease in the number of in-patient beds vacant, going from 949 on 14 May to 881 on 19 June.

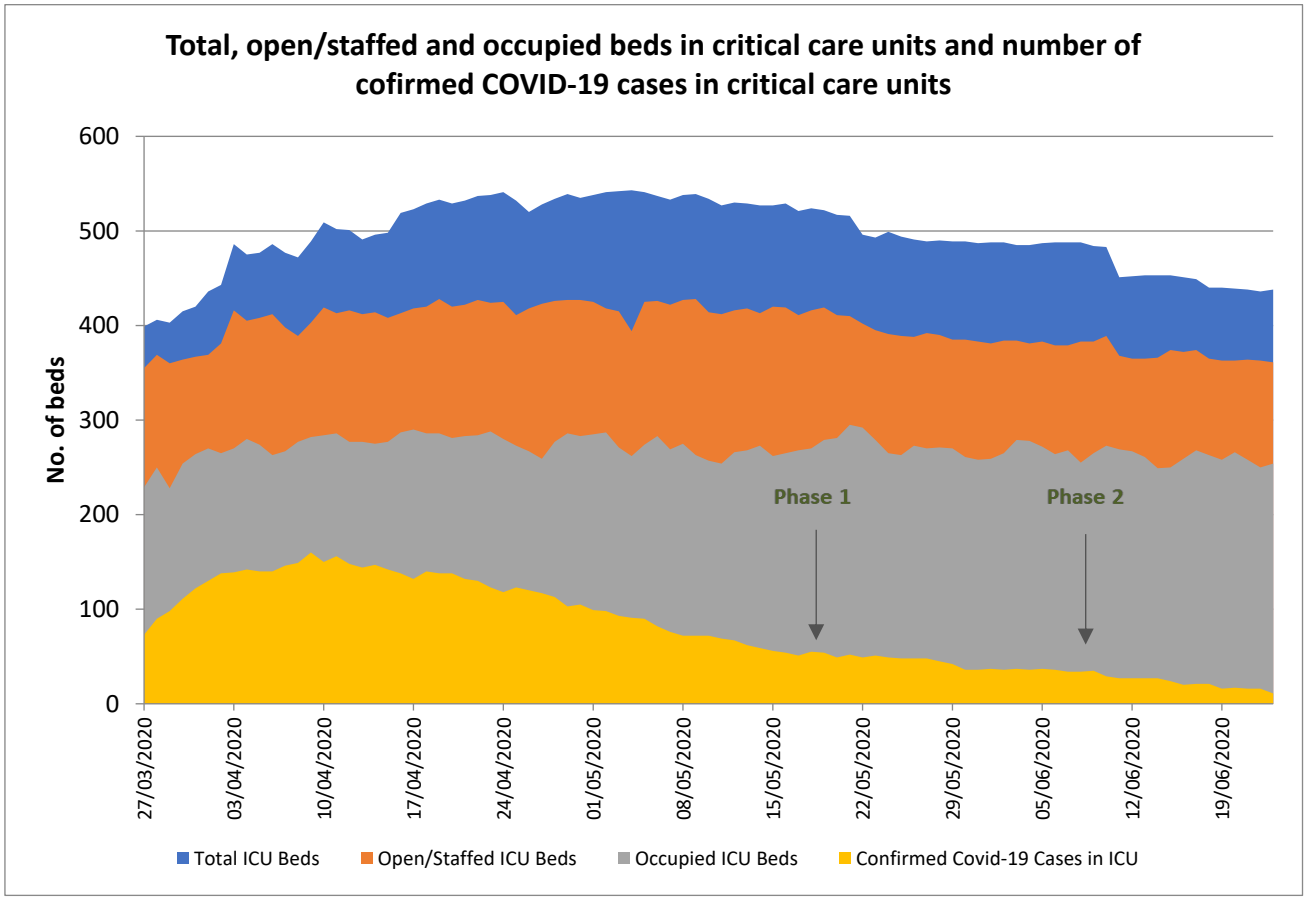
	14-May	24-May	28-May	19-Jun
Private Hospitals	**Beds**			
Total In-patient beds	1,696	1,696	1,696	1,696
In-patient beds that are vacant	**949**	**831**	**831**	**881**
Day patient beds	569	569	569	569

Source: Special Delivery Unit, HSE

Overview of current Critical Care Bed 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.

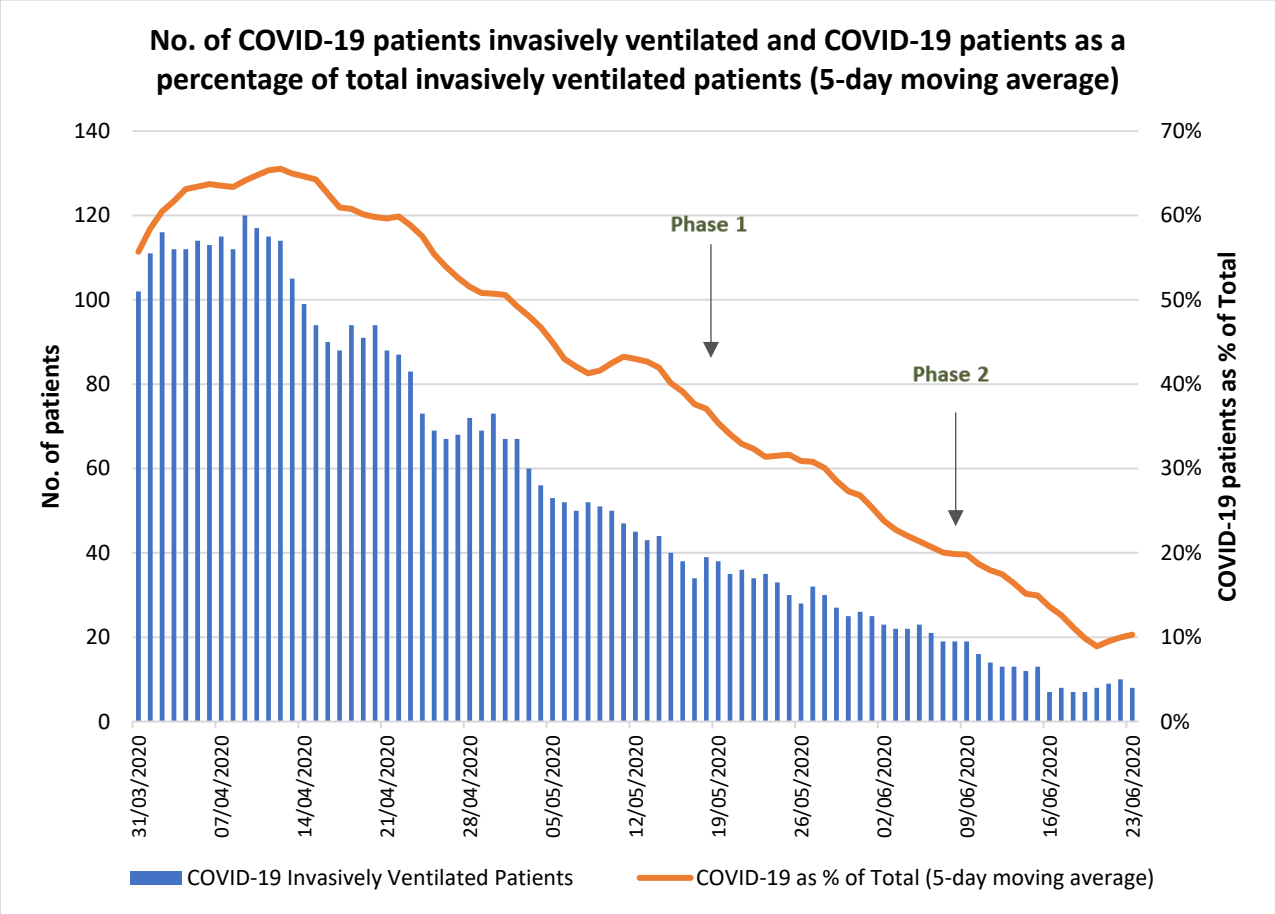
The decline in total ICU beds is influenced by the fact that, as the number of COVID patients has declined, some 'Off Unit' critical care bed capacity (beds not located in critical care units but identified as additional critical capacity to cope with COVID-19) are no longer being reported as critical care beds.



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

Note: The decline in Total ICU Beds is influenced by the fact that, as the number of COVID patients has declined, some 'Off Unit' critical care bed capacity (beds not located in critical care units but identified as additional critical care beds for COVID-19) are no longer being reported as critical care beds.

In addition to the number of critical care beds that are occupied by COVID-19 patients, the extent to which the total ventilation capacity of critical care units is being used to treat COVID-19 patients is another important consideration when assessing ICU capacity. With regard to the number of COVID-19 patients invasively ventilated, this has been steadily declining since a peak of 120 on the 9th of April reaching 8 on the 23rd of June. The share of total invasively ventilated patients accounted for by COVID-19 cases (as a 5-day moving average) has been steadily falling from 66% on the 12th of April to 10% on the 23rd of June.



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

Note: As data from the NOCA ICU-BIS system began on 27/03/2020, the earliest date that a 5-day moving average can be calculated is 31/03/20

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 worked intensively 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.

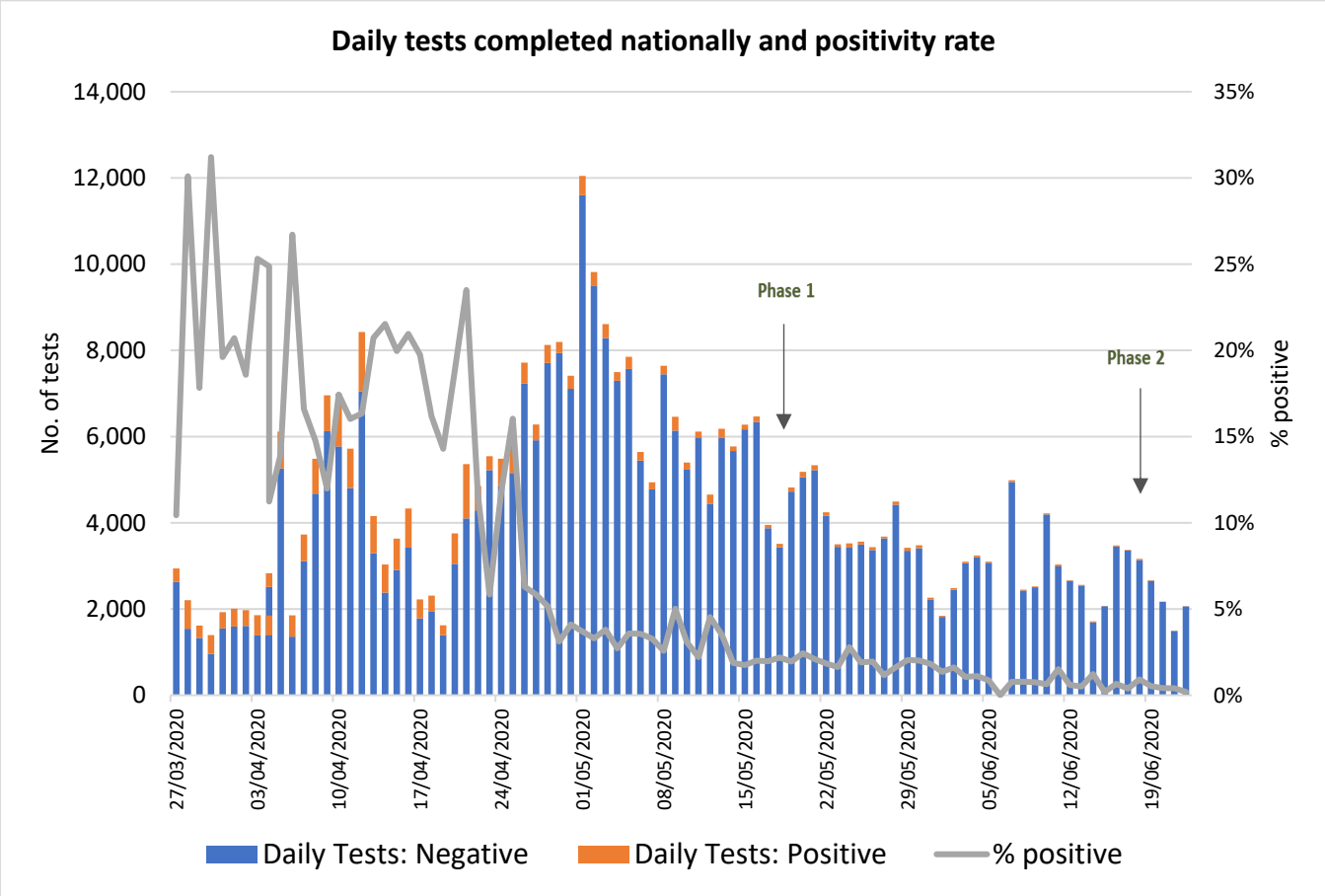
There is now capacity across the full testing and tracing pathway for the agreed target of 15,000 tests per day. Turnaround times have also improved significantly. The HSE had set a target end-to-end turnaround time from referral to completion of contact tracing of 3 days or less for 90% of cases and this target is now being met.

The HSE is continuing to work to improve turnaround times and consistency across the full testing and contract tracing pathway through further process improvements and automation where possible.

Testing & Contact Tracing Activity

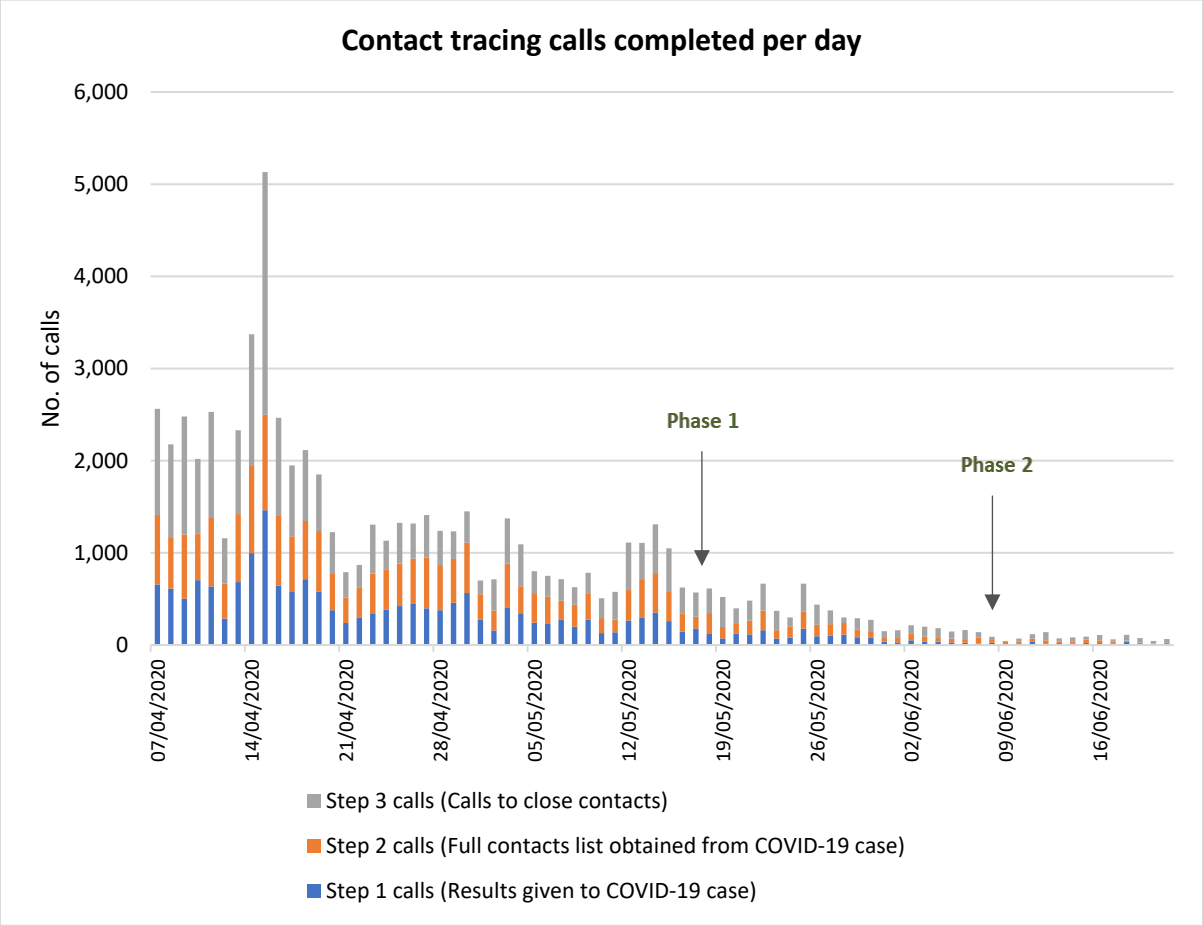
Testing activity levels and positivity rates are influenced by a range of factors: prevalence of the virus, testing strategy and case definition and testing capacity. Activity levels have fluctuated since testing commenced. There was a peak of over 8,000 tests processed a day in mid-April as a result of the utilisation of a German laboratory to process a build-up of samples, with a further peak at the start of May reaching 12,000 on one day reflecting the roll-out of a one-off mass testing programme across Long Term Residential Care facilities. In general, activity levels have gradually decreased during May and June. Over the last week (16 June – 22 June), 18,417 tests were completed, averaging over 2,600 tests per day.

There has also been considerable fluctuation in the positivity rate. For the month of April, the rate was generally between 15% - 30% reflecting a relatively narrow case definition at the time. NPHET made a number of changes to the case definition in late April and early May which resulted in effectively a lower threshold for testing referrals. Between the 1st - 22nd of June, the daily positivity rate has fallen from 1.4% to 0.2%. In total, for all tests completed to date, 7% have been positive.



Source: Daily testing reports from HPSC

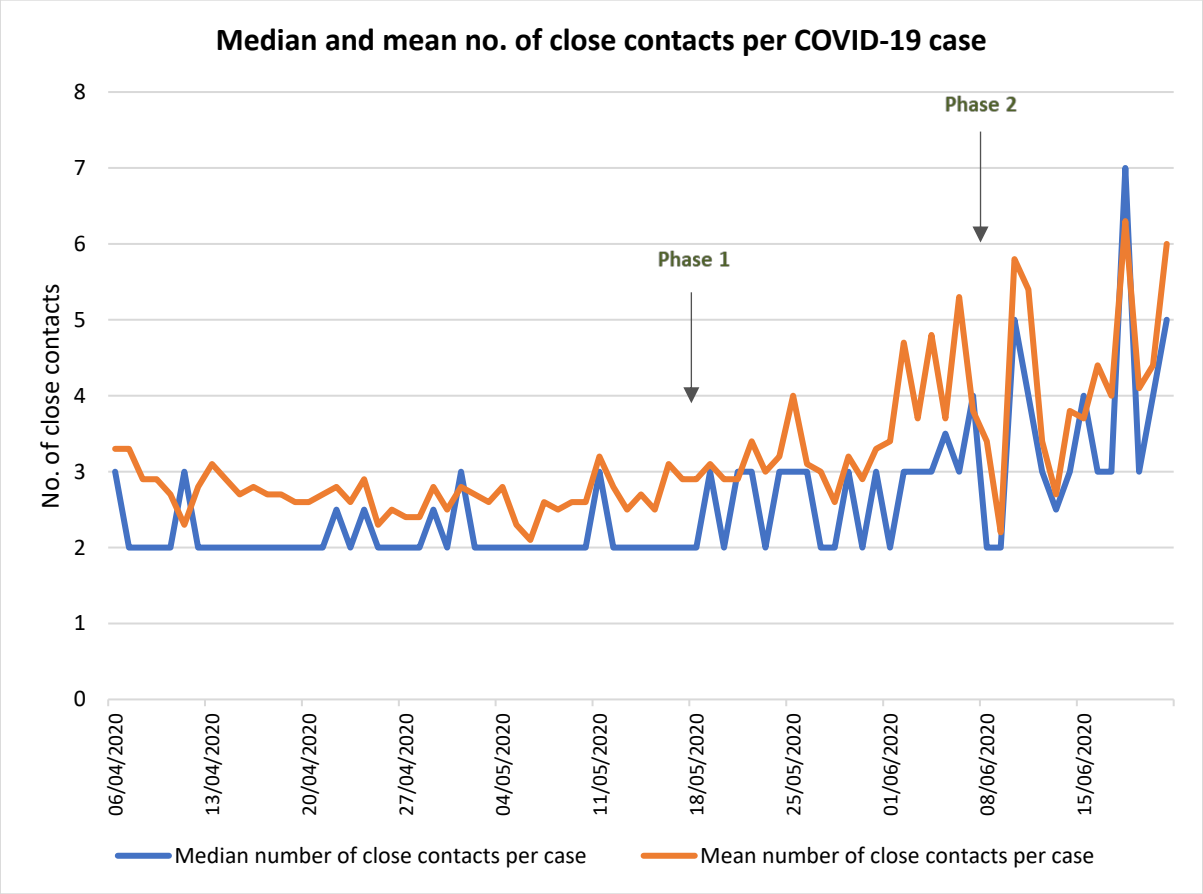
Contact tracing activity levels are influenced by the number of positive cases and the number of close contacts that each individual case has. The process involves three steps: an initial call to the person that was tested to confirm the result, a follow-up call to that person to gather information on their close contacts, and finally calls to all close contacts identified. As with testing activity levels, contact tracing activity has fluctuated since March. Over the week (15th June – 21st June), 557 calls were made across Calls 1, 2 and 3 by Contact Tracing Centres to communicate positive results and trace close contacts.



Source: HSE Daily COVID-19 Situational Report

Number of close contacts

The median number of close contacts remained stable between 2 and 3 close contacts per person throughout April and into mid-May. However, as can be seen below the median number of close contacts, while fluctuating, has exhibited an increasing trend since the beginning of Phase 1. This is to be expected as restrictions are eased and individuals become increasingly mobile.



Source: HSE Daily COVID-19 Situational Report

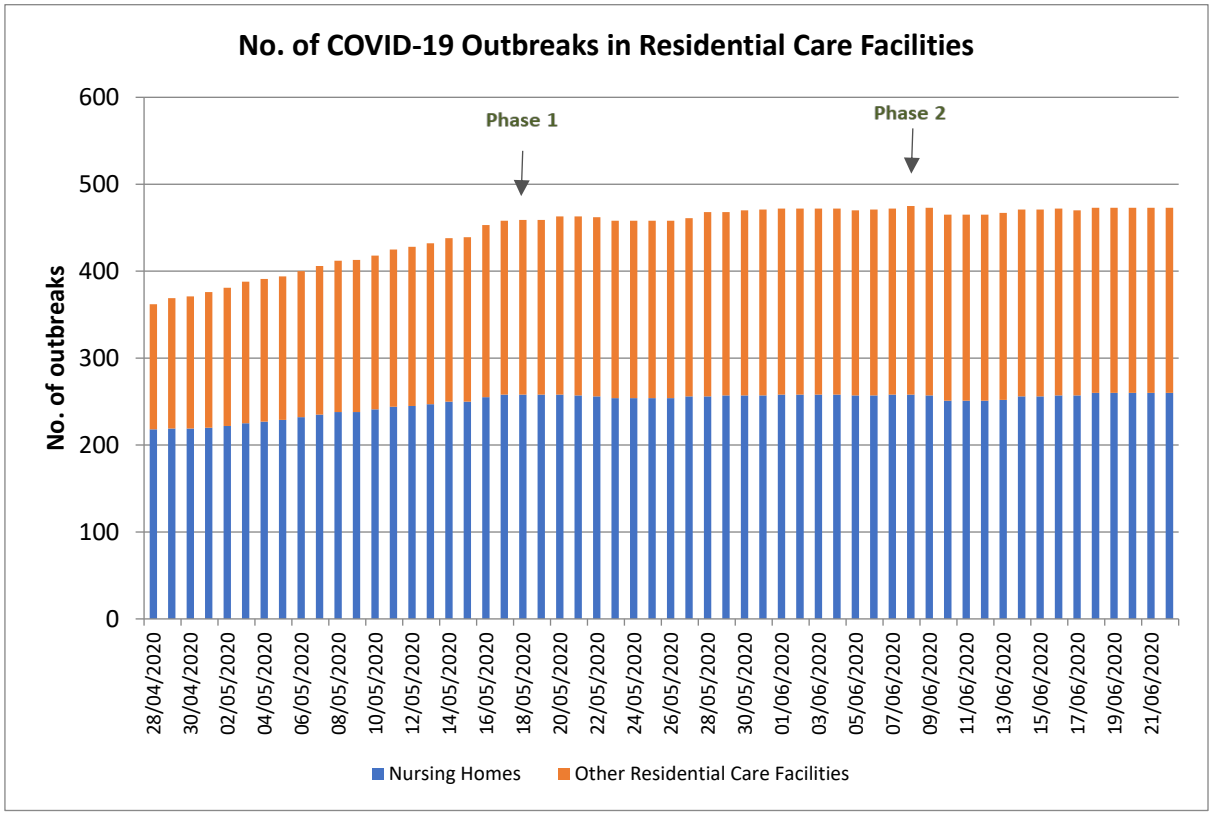
D) Ability to Shield and Care for at Risk Groups

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.

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.[2]

As of 22nd June there was a cumulative total of 473 outbreaks/clusters in residential care settings, 260 of these in nursing homes and the remainder in other residential care facilities. The rate of increase in clusters slowed considerably as May progressed. The total number of outbreaks in residential facilities has remained relatively stable overall in recent weeks.

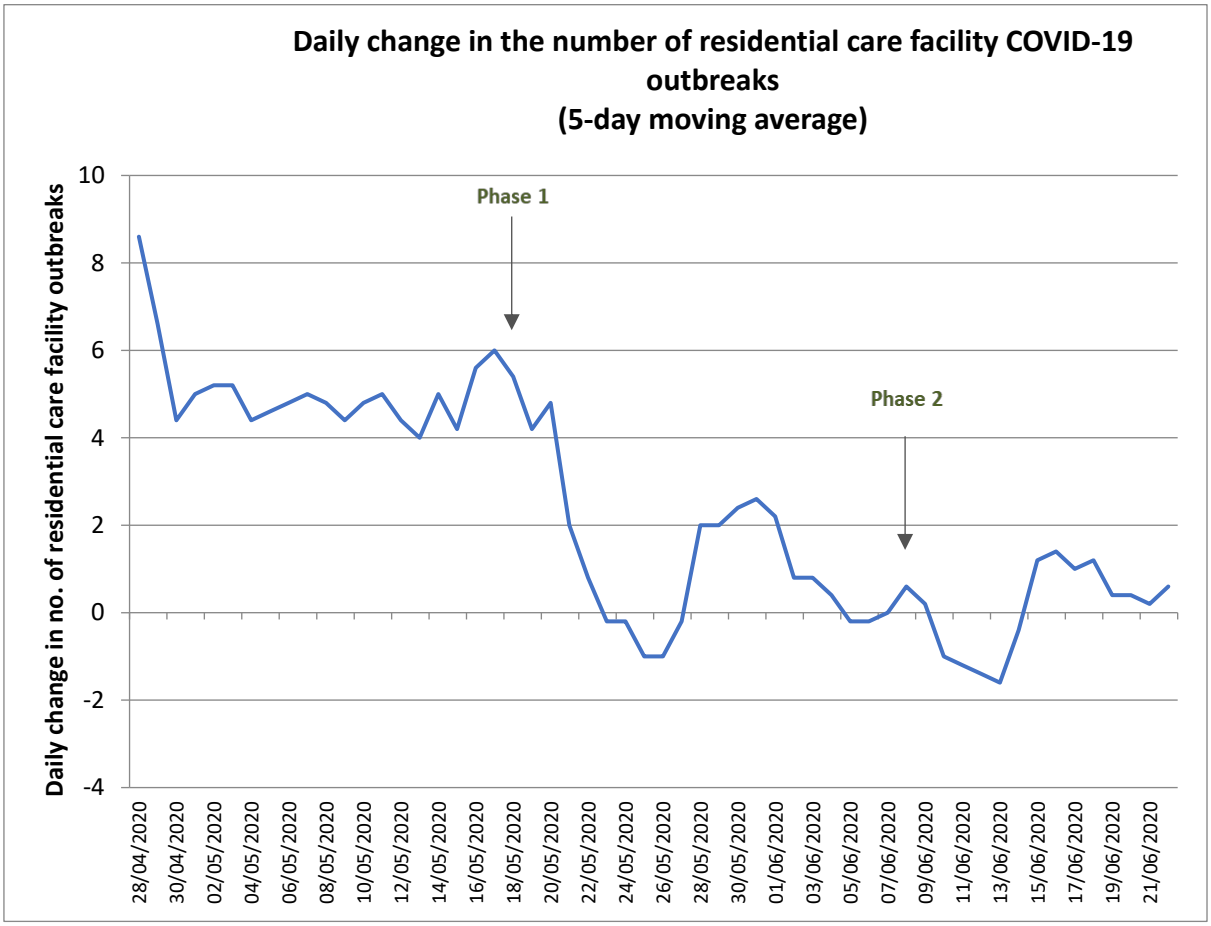


Source: HPSC Daily Outbreak Reports

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

[2] 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.

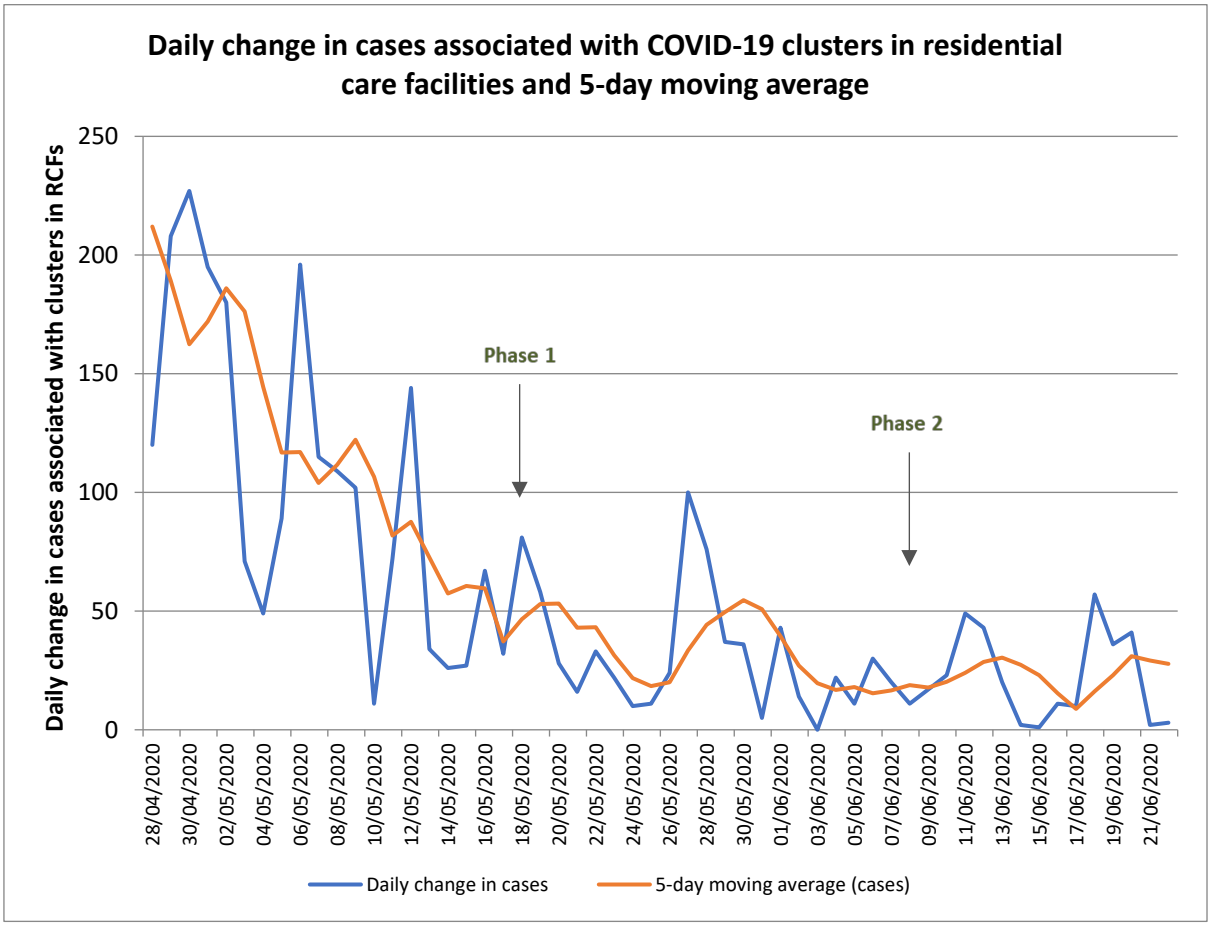
The decline in the total number of outbreaks/clusters from 8 June led to negative daily changes in the number of outbreaks/clusters, based on a 5-day moving average. While there was a return to positive daily increases from 15 June the 5-day moving average of new clusters/outbreaks reported in residential care facilities has remained below 2 since 15 June and is now 0.6.



Source: HPSC Daily Outbreak Reports.

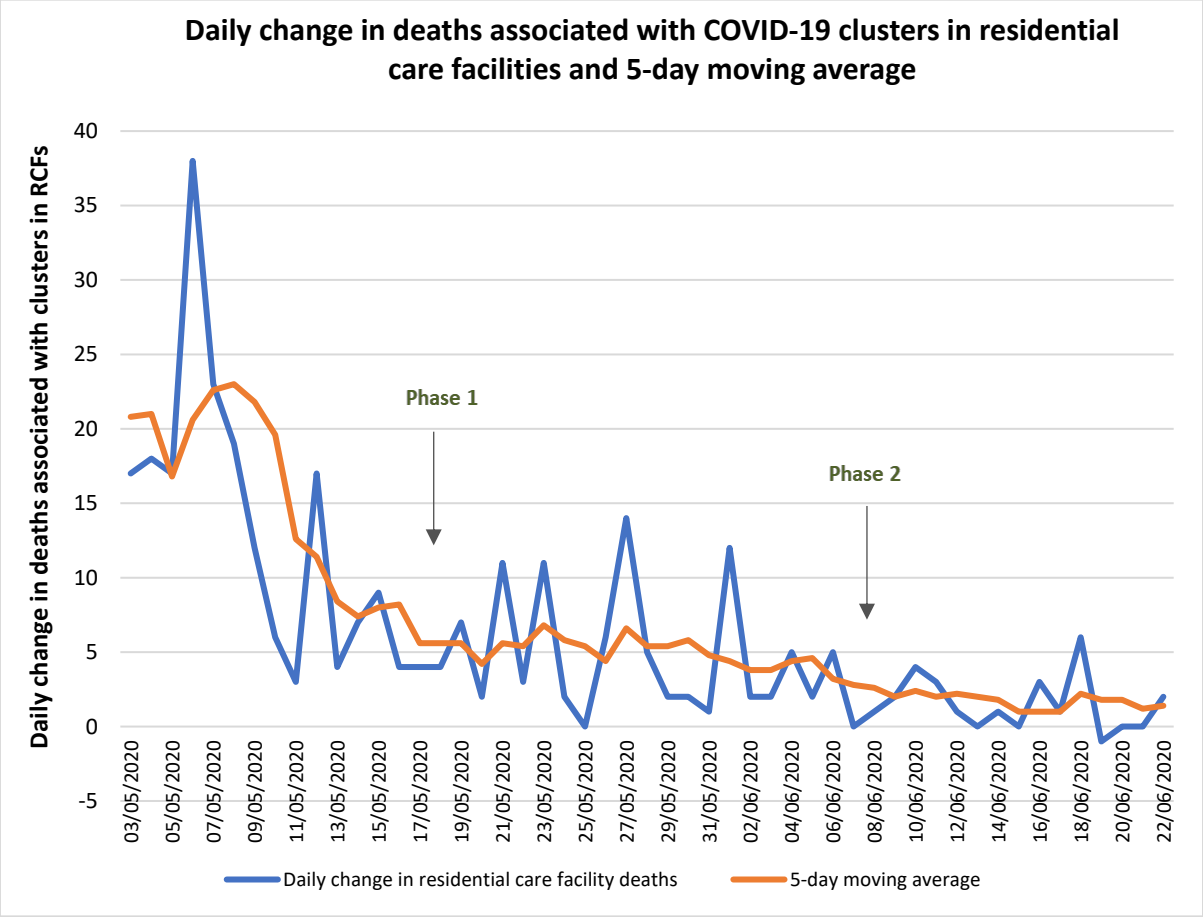
Note: The daily change is calculated as the difference between the total number of clusters/outbreaks reported one day and the number reported the previous day. The total number of outbreaks may decline due to the de-notification or re-classification of some clusters and 'closed' clusters being removed.

Considering the five-day moving average, there was a generally downward trend in the number of new cases associated with clusters/outbreaks in residential care facilities up to 26th May. A relatively large number of new cases reported on one day reversed this trend, but this was followed by another decrease and the trend in the five-day moving average has remained relatively stable in the month of June.



Source: HPSC Daily Outbreak Reports
Note: The daily change is calculated as the difference between the total number of cases associated with clusters/outbreaks reported one day and the number reported the previous day.

Since the start of May, the daily change in the number of deaths associated with outbreaks in residential care facilities peaked at 38 on 6th May. There has been a steady decline since that time. Excluding the most recent five days, to account for delays in notification, the 5-day moving average of daily deaths in residential care facilities up to 18th of June was 2.2.



Source: HPSC Daily Outbreak Reports

Note: The daily change is calculated as the difference between the total number of deaths associated with clusters/outbreaks reported one day and the number reported the previous day.

COVID-19 Outbreaks in Other Vulnerable Populations

As of week 25 2020 (week ending 20th June), outbreaks have been identified across the following settings. A breakdown of these outbreaks and the cases associated with them is provided in the table below.

	Number of outbreaks notified			Laboratory Confirmed Cases linked to outbreaks				
Vulnerable populations/settings	Week 25	Week 10-25	Number Open	Cases notified in week 25	Total Cases	Total hospitalised Cases	Total ICU Cases	Deaths[3]
Roma community	0	4	1	0	42	10	5	4
Irish Traveller community	0	7	3	0	63	3	2	0
Direct Provision Centres	0	16	4	0	180	12	0	0
Homeless^/those with addiction issues	0	6	1	0	18	6	2	2

^ this includes some facilities that provide long term supported accommodation

[3] All COVID-19 cases that died and were linked to outbreaks in these settings have been laboratory confirmed. No deaths in probable/possible cases linked to outbreaks in these settings have been notified.

There were no new workplace outbreaks notified during week 25. In total, 48 COVID-19 outbreaks in workplaces[4] have been notified up to midnight on 20th of June. Workplace outbreaks involved a variety of workplaces and facilities, including food wholesalers/distribution centres, pizza delivery premises, factories, primary care centres and garda stations.

A number of Government Departments have responsibility for services to vulnerable people and these services are provided through a range of settings. Cohorts of people either due to living arrangements or social inequalities are more vulnerable to transmission of COVID-19 for example, 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.

[4] Workplace outbreaks exclude the following workplaces hospitals, residential facilities, hotels, public houses and retail outlets. These are reported under those headings.

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 22, there were 172,400 excess deaths estimated in total, including 157,400 in the age group ≥65 years and 12,900 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. As of week 24 2020, pooled estimates of all-cause mortality for the countries in the EuroMOMO network had returned to normal levels, although few countries were still seeing some excess mortality.

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,
- 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 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 21 June 2020 (end of week 25), demonstrates a significant excess of deaths (all cause 'pneumonia and influenza' specifically) for weeks 13-18, inclusive. To date, no excess mortality has been recorded for the period covering weeks 19-24, inclusive, although the delay in registration of deaths prevents a more complete and timely analysis of this.

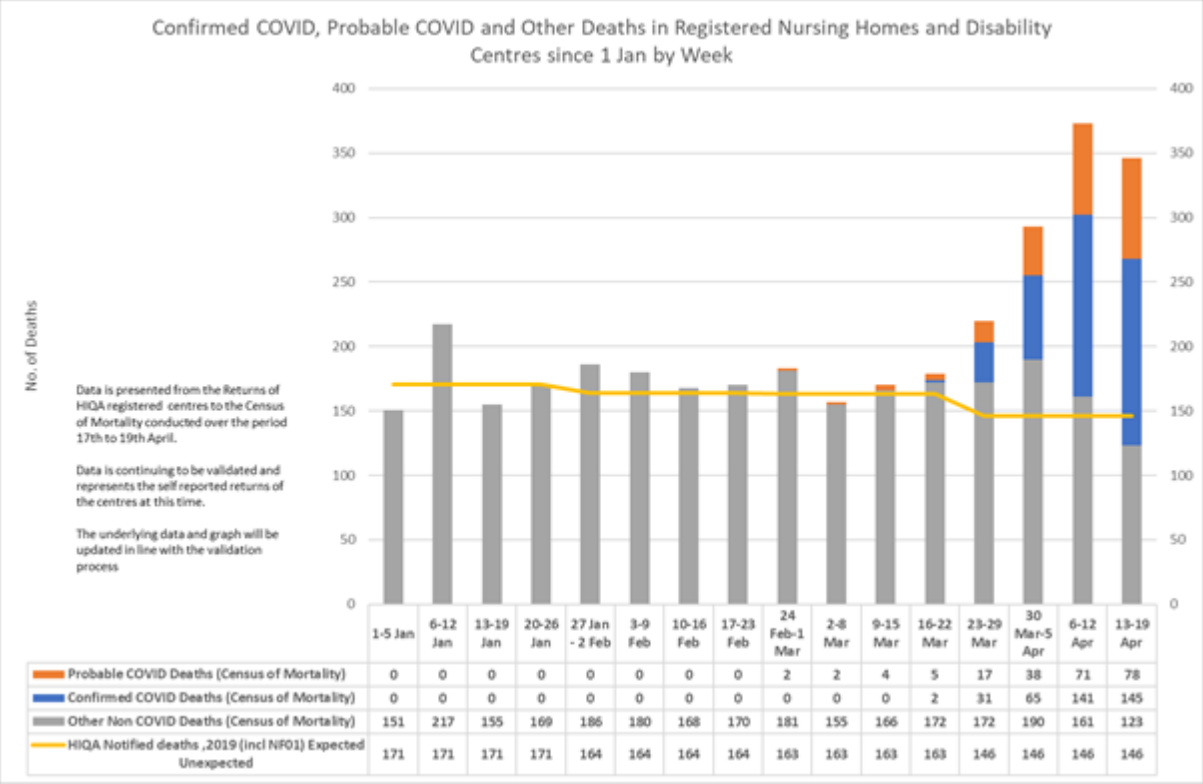
Mortality Census LTRC

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.

25th June 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).

You will recall that at last week's NPHET meeting, on the basis of the overall public health risk and the good progress that has been made in suppressing the overall incidence of COVID-19 infection the NPHET presented its advice to you in relation to realigning the Public Health Framework Approach to reducing restrictive measures into two final phases. This was in recognition of the combined efforts and collective action of people across Irish society over the months of March and April to change the trajectory of the COVID-19 epidemic in Ireland.

During May and continuing into June, continued progress has been made in suppressing the overall incidence of the COVID-19 disease in Ireland. Through high levels of adherence to the public health restrictive measures and the rapid adjustment to new personal and collective hygiene behaviours, people across the country have been protected from infection and lives have been saved. In the last week these downward trends in all key parameters have been sustained.

Current Epidemiological Situation

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

(i) the number of confirmed cases stands at 25,396 (with an average of 9 cases notified per day over the past 5 days);
(ii) 37 confirmed cases in hospital yesterday;
(iii) the number of confirmed COVID-19 patients requiring critical care yesterday was 9, with a further 10 patients suspected of having COVID-19 also in critical care;
(iv) 8,177 cases (32% of all cases) were associated with healthcare workers;
(v) 1,726 deaths due to COVID-19 recorded to date, with 6 new deaths notified yesterday.

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* This number is lower than previously reported, as some cases or outbreaks have been de-notified or reclassified as part of normal data validation processes.

With regard to clusters and outbreaks specifically, NPHET noted–

(vi) the total number of clusters in residential care facilities to date has been 470*,

(vii) the number of confirmed cases in residential care facilities stands at 7,121 of which 5,600 have been in nursing homes,

(viii) that as of Saturday 20th June, there have been–

- 4 COVID-19 outbreaks involving the Roma community involving 42 cases. One of these outbreaks remains open. No new cases were notified in the past week in this cohort,
- 7 COVID-19 outbreaks involving the Irish Traveller Community, involving 63* cases. 4 of these outbreaks remain open. No new cases were notified in the past week in this cohort,
- 6* COVID-19 outbreaks notified in residential facilities for the homeless involving 18* cases. 2 of these outbreaks remain open. No new cases were notified in the past week in this cohort,
- 16 outbreaks in Direct Provision Centres, involving 180 cases. 4 of these outbreaks remain open. No new cases were notified in the past week in this cohort,
- 48 clusters in workplaces including 23 in meat processing plants. 24 of these outbreaks remain open, including 13 in meat processing plants. Just 2 new cases were associated with meat processing plants in the week to Saturday 20th June and no new cases were notified in association with other workplaces, and
- 5 new outbreaks were notified in the previous week. 2 of these were in nursing home settings and 3 were in private households.

The NPHET also took note of the following:

- the effective reproductive number is now estimated to be between 0.5 and 0.8 (it should be noted however, that it is difficult to estimate the reproduction number given the current small number of cases);
- the positivity rate for all tests processed nationally in the past week is 0.5%;
- the latest reported influenza like illness rate (ILI rate) is 2.8 per 100,000 (i.e. below threshold).
- the increased number of new cases within the last 14 days related to travel.

Furthermore, the ECDC published an updated risk assessment for the EU/EEA and the UK on 11th June and the NPHET noted its assessment that–

- *the risk of COVID 19 in the general population of the EU/EEA and the UK is currently assessed as:* ***low*** *in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates; and* ***moderate*** *in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place,*

- *the risk of COVID 19 to the population with defined factors associated with severe disease outcome is currently assessed as:* ***moderate*** *in areas where community transmission has been reduced and/or maintained at low levels and where there is extensive testing showing very low detection rates; and* ***very high*** *in areas where there is substantial ongoing community transmission and where appropriate physical distancing measures are not in place,* and

* This number is lower than previously reported, as some cases or outbreaks have been de-notified or reclassified as part of normal data validation processes.

- *the risk of COVID-19 incidence rising to a level that may require the re-introduction of stricter control measures is currently assessed as* ***moderate*** *if measures are phased out gradually, when only sporadic or cluster transmission is reported, and when appropriate monitoring systems and capacities for extensive testing and contact tracing are in place; and* ***high*** *if measures are phased out when there is still ongoing community transmission, and no appropriate monitoring systems and capacities for extensive testing and contact tracing are in place.*

Advice regarding realigned Phase 3 Easing of Measures

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 most recent ECDC risk assessment, the NPHET today considered the public health measures currently in place. Arising from the discussion at today's meeting, the NPHET recommends that Government give consideration to the realigned Phase 3 easing measures in the NPHET's Advice to Government on 18th June, and as set out in the Appendix to this letter, with effect from the 29th June 2020.

In developing this public health advice to Government in relation to the reduction of the public health restrictive measures, the NPHET had regard to the following:

- the report to Government prepared by the Department of Health 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.

- ongoing evidence and information regarding the experiences of members of the public; adherence to the public health personal behaviours and social distancing measures in place through regular quantitative and qualitative public opinion research and focus groups; analysis of non-health information sources such as transportation, mobility, and congregation data;

- the NPHET's *Advice to Government in relation to realigning the Public Health Framework Approach to reducing restrictive measures into two final Phases* of the 18th June;

- the experiences internationally, including in some countries, which have seen some significant increases in cases of COVID-19 infection, following the easing of public health measures, including outbreaks in some settings and regions; and

- 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.

In providing this public health advice to Government the NPHET reiterated 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 measures and stricter measures may have to be reintroduced if a strong upsurge of infection were to occur at some point in the future. In this regard, the NPHET emphasised the ongoing importance of a continued focus by the health service and across Government on–

- ongoing monitoring and review of epidemiological trends and health system impact of COVID-19 such that any changes in the overall situation will be detected rapidly, in order that future advice to Government, and health service measures and responses can be implemented 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 the population and health system capacity,

- 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, higher risk populations, including healthcare workers,

- clear consistent sustained accessible risk communication strategy with the public and other key groups, to continually re-emphasise collective behaviours and solidarity in limiting the spread of infection for the foreseeable future and support the desired behavioural change through ongoing communication and education initiatives,

- ongoing public health responses, infection prevention and control, surveillance including the prevention and management of outbreaks in different settings including workplaces, residential and other settings,

- effective engagement with employers in light of 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,

- ongoing implementation, monitoring, review and re-calibration of measures including regionalised, localised or sector-specific responses, bearing in mind the specific associated public health risks, and

- maintaining the continued commitment across society from all arms of the State, organisations, employers, businesses and individuals to work together to collectively promote and adhere to the core public health principles.

Overseas Travel

As the NPHET has previously emphasised, it is important that Ireland carefully heeds the recent advice of the European Centre for Disease Prevention and Control that *"the pandemic is not over, and hypothetical forecasting indicates a rise in cases is likely in the coming weeks"*.

As you will be aware, on the 16th March, the NPHET recommended that all Irish residents be advised against all non-essential travel overseas at this time and that all persons, including Irish residents, entering the country from overseas should restrict movements for 14 days, if asymptomatic.

As noted in its letter of 8th May, the NPHET is concerned that, as the number of indigenous cases here declines and Ireland continues to ease measures, the relative importance of the risk of importation of cases from overseas increases. Given the significantly improved epidemiological profile of the disease in Ireland in the interim, travel-related introduction of the disease is now a significant and growing concern, this represents a major threat to public health and increases the risk of a potential second-wave of the disease in Ireland.

In this context, the NPHET today noted that 7% of cases notified over the past fortnight have been associated with travel. In addition, the NPHET noted the acceleration of the pandemic internationally, including that–

- 9.1 million cases and 474,000 deaths have been recorded globally to date,
- the largest day on day increase in cases globally was recorded within the past week,
- while 10,000 cases were recorded in the first month of the pandemic, 4 million cases were recorded within the last month,
- the epidemiological profile of the disease remains uncertain in many countries due to limited testing and/or reporting,
- in the past fortnight, 27 of 54 countries within the WHO European Region have reported a greater than 10% increase in cumulative 14-day incidence versus the previous fortnight, and
- in the past fortnight, within the EU27/UK, while Ireland has experienced a very substantial (c.65%) improvement in the number of cases reported, 11 countries have reported a greater than 10% increase in cumulative 14-day incidence versus the previous fortnight.

NPHET noted that consideration is being given by Government and at EU level to the establishment of reciprocal travel arrangements with countries that have a broadly similar or better epidemiological profile (which can be verified as such). In order to ensure the credibility of these arrangements, it will be necessary to put in place legal restrictions regarding travel from countries which do not qualify for such arrangements, as is the approach taken by other EU Member States. In this regard, the NPHET recalls with urgency its prior recommendations on the need for legal restrictions to be put in place in regard to overseas travel.

Critical Care Capacity

You may wish to note that the NPHET supported a proposal to expand critical care capacity in acute hospitals for the delivery of COVID-19 care needs as well as non-COVID care and in particular, the intention to seek the necessary approvals through the normal processes.

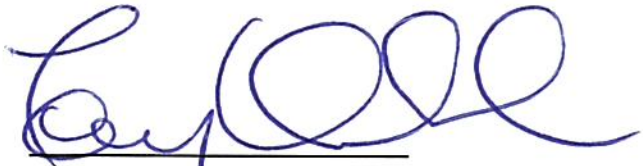
Finally, in the context of nearing the completion of the Phases of the *Revised Roadmap for Reopening Ireland*, the NPHET will now commence work on the development of further public health advice to provide for a more nuanced approach to the ongoing future management of the pandemic, which takes into account the evolving epidemiological situation both here and internationally, the understanding gleaned from Ireland's experience of this disease to date and emerging evidence with regard to factors impacting transmission and control of this disease.

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.

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

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 in relation to the realigned Phase 3 reduction of public health measures in advance of 29 June 2020

The NPHET, taking note of the continued progress during the month of June to suppress the overall incidence of the COVID-19 disease in Ireland and the current overall public health risk, advises that Government may wish to give consideration to implementing with effect from the 29th June 2020 the realigned Phase 3 easing measures contained in the NPHET's *Advice to Government* of 18th June and as set out below:

Section 1: Updated general advice from Phase 3 onwards & Public Health Checklist

Should Government decide to commence the realigned Phase 3 easing on 29th June, this will see the re-opening of a majority of the remaining businesses, services, amenities and sectors, as well as social, cultural and recreational activities, that had been closed in light of the public health restrictive measures.

Public health messages

Consequently, it is recommended that the following updated general public health messages continue to be communicated:

- wash your hands frequently with soap and water or use an alcohol-based hand rub even if your hands are not visibly dirty;
- practise 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 physical 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;
- remember that this disease spreads easily in crowded environments, therefore avoid crowded places as much as possible, leave if a location becomes overcrowded and physical distancing becomes difficult;
- everyone should be vigilant of the symptoms of the virus and should self-isolate and seek medical care as quickly as possible if they have even mild symptoms, including flu-like symptoms. When self-isolating, stay at home and do not go to work or school and the household contacts of a confirmed or suspected case, should follow public health advice and restrict their movements until advised otherwise.

Public Health Checklist

In Phase 3 many of the public health restrictions are being lifted and there will no longer be detailed rules in place. Therefore, everybody in society will now exercise their own judgement and take personal responsibility for decisions that they make about the risk of infection to themselves and to others in different situations.

The Public Health Checklist set out in the NPHET's advice of 18th June is intended to provide assistance to individuals and families, in making decisions about how to assess the risk of different activities and take actions to lower the risk of spreading infection. It is also provided as a means of supporting organisations, businesses, schools, community groups etc., who should assess the risk of different activities and identify ways to lower the risk for themselves, other workers, employees, colleagues, customers, students, and other participants that engage in the work or activities associated with the organisation.

Section 2: Community Health

In the realigned Phase 3 the following are recommended:

Face Coverings

- The wearing of face coverings continues to be recommended as an additional hygiene measure, when using busy public transport or when in indoor public areas including retail outlets, where appropriate, and where physical distancing cannot be maintained.

Cocooning

- Cocooning for those aged 70 years and over and the medically vulnerable continues to be recommended for their safety. However, it is important that people who are cocooning feel empowered to exercise their own judgement and autonomy regarding the extent to which they consider the cocooning guidance is appropriate to their individual circumstances.
- For people aged 70 years and over and the medically vulnerable who wish to visit others, receive visitors in their home, attending shops, and engage in other activities, it is recommended that they:
    - (and their visitors) maintain strict hand hygiene and respiratory etiquette,
    - continue to strictly adhere to the physical distancing guidance of 2m,
    - avoiding touching surfaces and cleaning surfaces touched by visitors,
    - ideally use face coverings when attending the shops or other busy public areas.
- Those cocooning who are planning to travel within and outside their region should acquaint themselves with the level of transmission of the virus in the relevant area, and consider how best to protect themselves.
- See HPSC's *Guidance on cocooning to protect people over 70 years and those extremely medically vulnerable from COVID-19* for useful practical guidance.

Travel within Ireland

- From the 29th June it is recommended that people may travel throughout the country, and travel to Ireland's offshore islands by non-residents may now resume. Those planning to travel should acquaint themselves with the level of transmission of the virus in the relevant area and consider how best to protect themselves. NPHET continues to advise that non-essential travel outside of Ireland is not recommended at this time.

Family and non-family activities and social visits

- No specific number is now given for a gathering in a private home other than that people should restrict the number so that adequate physical distancing and ventilation of the home can be maintained bearing in mind the size of the home.
- During Phase 3, in line with the Mass Gatherings restrictions below, indoor mass gatherings should be limited to groups of up to 50 people and outdoor mass gatherings limited to groups of up to 200 people.

Section 3: Mass Gatherings of People

In the context of the COVID-19 pandemic it is widely recognised that mass gatherings of people can amplify the transmission of the virus and have the potential to significantly impact on the health service and wider COVID-19 response.

Mass gatherings are events where there is a concentration of people at a specific location for a specific purpose over a set period of time and constitute a diverse range of gatherings such as sports, music/entertainment, religious events, family events (e.g weddings, funerals etc.) large conferences and exhibitions, as well as community, charity events and other types of events.

In line with the advice of the European Centre for Disease Prevention and Control and the current approach of many other EU countries, it is recommended that for the duration of Phase 3 indoor and outdoor mass gatherings be restricted to 50 and 200 respectively, bearing in mind the following:

- Mass gatherings should be organised in advance to enable adequate planning by organisers so that prevention and control measures can be implemented, and physical distancing can be maintained so as to reduce the risk of transmission and avoid strain on health services;
- The mass gathering numbers listed above are total numbers of people at mass gathering events including organisers, participants and attendees;
- Mass gatherings operating in line with the limits above should comply with the Public Health Checklist and physical distancing, having regard to the size of the venue;

- Adopting a cautious approach considering the high risk of infection spread at mass gatherings, it is recommended that marquees, tents, circuses etc. be considered indoor venues for the purposes of these mass gatherings restrictions.

Section 4: Easing of restrictive public health measures in Phase 3:

The following measures are recommended to Government for re-commencement in Phase 3 unless specified elsewhere in the NPHET document *Advice to Government in relation to realigning the Public Health Framework Approach to reducing restrictive measures into two final Phases* dated 18th June 2020.

Health and Social Care Measures:

- Recommencement of visiting at hospitals, and other residential settings on a planned and phased basis.
- Finalisation and implementation by the HSE and service providers of the Service Continuity Framework for the Resumption of Non-COVID-19 Care.

Community, Religious, Cultural, Social and Sport Measures:

In reopening, following venues, amenities and activities should operate in line with physical distancing, the Public Health Checklist and Mass Gathering restrictions applying in Phase 3, as set out above:

Re-open venues, amenities, organised events, ceremonies including–

- Religious buildings and places of worship,
- Museums, galleries, theatres, concert halls and other cultural outlets,
- Cinemas, music venues (excluding nightclubs and discotheques), leisure facilities, bingo halls, arcades, skating rinks, amusement parks etc.,
- All other recreational venues unless specified elsewhere in the NPHET document *Advice to Government in relation to realigning the Public Health Framework Approach to reducing restrictive measures into two final Phases* dated 18th June 2020.

Re-commence all sporting activities and venues including–

- Team leagues for adults and children, close contact sports, as well as organised sporting spectator events and fixtures,
- Indoor gyms, exercise, yoga, Pilates and dance studios, sports clubs, public swimming pools.

The following precautions are recommended where the practice, teaching and performance, of (i) Choirs and (ii) brass and wind music groups takes place:

- Maintenance of very strict physical distancing of a minimum of 2 metres from other people, ideally activities to be held outdoors, limit duration and include frequent breaks to facilitate regular ventilation of rooms and instrument cleaning (where applicable);
    - Singers and musicians should consider protective equipment and measures to minimise the potential for droplet or aerosol emission (e.g. instrument covers, screens, face coverings etc);
    - A risk assessment should be carried out to minimise the risk to the participants and their audience, including bearing in mind the age profile and risk factors of the participants/audience in question.

Education, Childcare and Children's Measures:

- Re-commence all other education, adult education and community-based activities, projects and facilities (e.g. adult education programmes, community groups, Men's Sheds etc.).
- Re-commence crèches, childminders and pre-schools for children of essential workers in phased manner with physical distancing and other requirements applying as per the HPSC Guidance.
- Re-commence all other indoor and outdoor amenities, including summer camps and youth clubs, for children and teenagers of all ages.

In reopening adult education and community-based activities, projects and facilities, as well as indoor and outdoor amenities, including summer camps and youth clubs, for children and teenagers of all ages, these should operate in line with physical distancing, the Public Health Checklist and Mass Gathering restrictions applying in Phase 3.

Retail, Personal Services & Commercial Activities:

- Re-open all remaining health and wellbeing-related services e.g. chiropractic, massage therapy, acupuncture, reflexology, homoeopathy etc.
- Re-open all remaining providers of contact personal services e.g. hairdressing salons, barbers, nail and brow salons, beauty salons, spas, make-up application services, tanning, tattooing and piercing services etc.
- Re-open all remaining retail (e.g. bookmakers), personal services, commercial activities and services.
- Re-commence restaurants and cafés providing on-premises food and beverages in line with HPSC guidance.
- Re-commence hotels, caravan parks, holiday parks, hostels for social and tourist activities. Hostels will need to risk assess the safety of communal room-sharing arrangements. Communal spaces of these venues and amenities to operate in line with physical distancing, the Public Health Checklist and the Mass Gatherings restrictions in Phase 3.

Economic Activity (Work):

- All workers and businesses that can work remotely from home should continue to do so to the maximum extent possible.
- Organisations should continue to deploy their own plans for prioritising onsite working arrangements by those workers that are required to work onsite utilising all options to limit the number of workers interacting with each other at any one time e.g. shift work, staggered hours, designated teams working always together, defined break times, etc.
- Employers should 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.
- Businesses and organisations 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, including having a COVID-19 Response Plan in place.
- Workers should not come to work, should self-isolate and should seek medical care if they have even mild 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.

Transport Measures:

Those providing transport services, whether commercially or in a private capacity, or where vehicle sharing is a normal feature of work or activity, should consider developing guidance for their sector / organisation.

- Re-commence driving schools, driving test centres, voluntary or other driving services etc.
- Re-commence all other private transport services, including tourist and entertainment activities (e.g. tour buses, event buses, private bus and vehicle hire etc.)
- All transport providers should increasingly encourage the use of face coverings on public transport as an additional measure to hand hygiene / respiratory etiquette.
- In light of the numbers of people, the importance of communal handrails, to reduce the risk for those using public transport, provide hand sanitizer for use by passengers.
- Public and private transport providers to continue to actively monitor passenger numbers and progressively decrease restrictions on numbers travelling on public transport.
- Continue to encourage the public to stagger travelling times on public transport in order to maintain physical distancing on public transport.

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,
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25th June 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 decision of the NPHET which is now required to be actioned by the HSE, in close collaboration with the Department:

- The NPHET notes and supports the proposal to expand critical care capacity in acute hospitals for the delivery of COVID-19 care needs as well as non-COVID care and notes the intention to seek the necessary approvals through the normal processes.

For information, the NCMT may wish to note that following consideration of the current epidemiolocal and national data the NPHET recommends that Government give consideration to the reduction and adjustment of the public health measures, in accordance with Phase 3 of the *Revised Roadmap for Reopening Ireland* published on the 18th of June.

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

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