MEMORANDUM E (20) 90 (C)

FROM: **ROBIN SWANN MLA**
MINISTER FOR HEALTH

DATE: **7 May 2020**

TO: **EXECUTIVE COLLEAGUES**

FINAL EXECUTIVE PAPER - PLANNING FOR RECOVERY: SECOND REVIEW OF HEALTH PROTECTION (CORONAVIRUS, RESTRICTIONS) (NORTHERN IRELAND) REGULATIONS 2020

Introduction

1. The above Regulations were made and brought into operation on 28 March 2020. Regulation 2(2) requires that:

   "*The Department of Health must review the need for restrictions and requirements imposed by these Regulations at least once every 21 days, with the first review being carried out by 18th April 2020.*"

2. The first review of the restrictions considered: the progression of the outbreak of COVID-19 caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Northern Ireland to date, and the modelling of its future progression; the effectiveness of the Regulations in ensuring social distancing; and the professional advice of the Chief Medical Officer (CMO) and Chief Scientific Adviser (CSA). The Executive agreed without amendment the conclusions and recommendations from the first review on 15 April, i.e. that the restrictions then in place should be maintained.

3. My Department, with input from colleagues in other Departments, has completed a second review of the restrictions, drawing on the advice of the CMO and the CSA. I now wish to bring the conclusions and recommendations from that review to the Executive for decision.

4. The Regulations are intended to protect the health of the population by limiting the spread of COVID-19 infection in order to minimise the numbers of cases and deaths, and to ensure as far as possible that the health care system has the capacity to care for COVID-19 patients and care for all patients, present and future. The Regulations require the closure of certain businesses; impose restrictions on the conduct of business; impose restrictions on the movement of individuals, and prohibit gatherings of more than two people where the people concerned are not members of the same household.

5. The need for the Health and Social Care (HSC) system to be able to cope with a surge in hospital admissions and provide enough intensive care is well understood. It is important also to protect the capacity of the service as a whole and for non-coronavirus patients and for the future. A reduction in capacity and the redeployment of large numbers of staff within the service, with the dispersal of some established clinical teams, could have serious knock-on effects on the care provided to the wider population.

6. This paper sets out the principles and approach that will be applied to this second and to subsequent reviews of the Health Protection (Coronavirus restrictions) (Northern Ireland) Regulations 2020 and in particular it presents:

    a. Guiding principles to be applied when considering whether a specific restriction or requirement should be retained, withdrawn or modified;
    b. A decision making framework, allowing relative risks and benefits from easing restrictions to be assessed;
    c. A structured process by which Departments can propose future relaxations and amendments to the restriction regulations.

Aim, scope, approach, timing and devolved powers

Aim

7. The Executive paper from the First Minister and the deputy First Minister that was considered on 27 April set out in matrix form three **pillars**, i.e. health, society, and the economy, and three **phases** of progress, i.e. response, recovery and renewal. It is clear from the evidence around coronavirus cases and deaths that Northern Ireland, in common with the rest of the UK and with the Republic of Ireland, is still in the response phase. However, these phases are overlapping rather than discrete and sequential. Whilst we continue to respond to the pandemic we must at the same time start to prepare for recovery, recognising the significant impact the restrictions themselves are having on health, society and economy. At this time, therefore, the review of the restrictions needs to consider how to plot the safest possible path from the response phase to the recovery phase.

Scope

8. For the first review of the restrictions it was necessary to focus almost exclusively on their primary purposes, i.e. the protection of the health of the population from infectious disease, and the management of present and future capacity of the health care system, and the conclusion of the assessment was to continue with the restrictions. The review acknowledged the serious, all-pervasive adverse impacts of the restrictions on daily life, on the economy and on people's mental well-being, and potentially also their physical well-being. Increasingly these reviews must take into account both the benefits *and* the harms (actual or potential), in order to help the Executive to make informed decisions.

Approach

9. Regulation 2(3) requires that:

   "*As soon as the Department of Health considers that* ***any*** *restrictions or requirements set out in these Regulations are no longer* ***necessary*** *to prevent, protect against, control or provide a public health response to the incidence or spread of infection in Northern Ireland with the coronavirus, the Department of Health must publish a direction terminating* ***that restriction or requirement****.*" [Emphasis added.]

   The wording of regulation 2(3) unambiguously implies that the set of restrictions and requirements in the Regulations is not an indivisible whole but an edifice that has to be dismantled piece by piece as each restriction or requirement comes to be deemed unnecessary for the purposes that are stated in this regulation. Were this not the case, i.e. that the restrictions could only be terminated when it is eventually safe to remove them all simultaneously, the harms done to public health and well-being, to health services, to civil society, to the economy and to livelihoods would be aggravated by an order of magnitude and in many cases the lifting of the restrictions would come too late to enable recovery. This principle has already been acted on, when the Executive agreed on 24 April to amend the Regulations to open cemeteries in order to allow people to visit graves with appropriate safeguards on social distancing. With this in mind, this second review and subsequent reviews will seek as expeditiously as possible to examine each restriction on its own merits in terms of the balance between necessity and harm.

Timing

10. As regards timing and the frequency of the statutory reviews, while the Department of Health is required to review the restrictions and requirements **at least** every 21

days, Regulation 2(3) requires the Department to terminate any restriction or requirement **as soon as** it is no longer considered necessary. The clear implication is that the Department should not wait until 21 days have elapsed after the completion of one review before bringing a recommendation or recommendations to the Executive. Again, the amendment in respect of cemeteries is a case in point. This principle of action could become especially pertinent if urgent action is required in order to reduce further harms to health, society and the economy caused by the restrictions. Economists and other commentators have warned repeatedly that the damage done to businesses and to the economy by two months of lockdown is likely to be far greater than twice the damage done by one month of lockdown.

Devolved powers

11. Furthermore, the duty to terminate a restriction or a requirement as soon as it is considered unnecessary suggests that, notwithstanding the advantages of the four UK countries acting in unison and NI working in tandem with the Republic of Ireland, where the balance of necessity and harm of a specific provision indicates that it should be withdrawn or relaxed, the case for the Executive exercising its devolved prerogative may be stronger than the argument for keeping in step with the rest of the UK.

12. **I propose, therefore, that the Executive formally adopt an approach which is incremental and responsive to the evidence, which is based on timely re-appraisal of the restrictions and requirements, and which is tailored and specific to Northern Ireland.**

Guiding principles

13. Bearing in mind the primary purposes of the Regulations – minimise the numbers of cases and deaths, and ensure as far as possible that the health care system has the capacity to care for COVID-19 patients and care for all patients, present and future – I propose that the Executive adopt the following principles to be applied when considering whether a specific restriction or requirement should be retained, withdrawn or modified.

- ***Focus on primary purposes***
    - Controlling transmission. Progress on the path of recovery depends primarily on controlling the rate of transmission. The key metric for this purpose is the reproduction number R_0. (See paragraphs 21 - 25) A restriction or requirement should only be relaxed when there is a reasonable prospect of maintaining R_0 at or below 1.

  - o *Protecting healthcare capacity*. The healthcare system should have sufficient capacity to treat COVID-19 patients while phasing in the reintroduction of usual health and care services. The system should not be allowed to be overwhelmed by a second or subsequent wave of the pandemic. Taking actions to reduce R_0, ideally maintaining R_0 at or below 1, is key to protecting the healthcare system.

- ***Necessity***. In accordance with the terms of the Regulations, a specific restriction or requirement should be retained only as long as it is considered necessary to prevent, protect against, control, or provide a public health response to the incidence or spread of COVID-19.

- ***Proportionality***. The detrimental impacts on health, society and the economy that can reasonably be attributed to the restriction or requirement should be tolerated only as long as the risks associated with withdrawal or modification are assessed to be more severe.

- ***Reliance on evidence***. Proposals for change or for the retention of a restriction or requirement should be informed by the best available evidence and analysis.

14. These align closely with the WHO guidance, published 24 April 2020, which recommends that any step to ease restrictions must meet 6 criteria;

    - Transmission is controlled;
    - Health system capacities are in place to detect, test, isolate and treat every case and contact;
    - Outbreak risks are minimized in special settings like health facilities and nursing homes;
    - Preventive measures are in place in workplaces, schools and other places where it's essential for people to go;
    - Importation risks can be managed;
    - Communities are fully educated, engaged and empowered to adjust to the "new norm".

15. In addition to drawing on the WHO guidelines, our guiding principle of proportionality ensures that we consider at every stage whether the benefits of the restrictions in controlling transmission and protecting health service capacity continue to outweigh and justify the very significant damage the restrictions are inflicting on our society, economy and wider health outcomes.

16. **I propose that the Executive adopts these guiding principles, which are consistent with the approaches adopted in other jurisdictions and are in line with global best practice.**

General framework for decision-making

17. The ongoing reviews of the Regulations will consider the following aspects, as presented in the Executive paper 'Executive Approach to Coronavirus Decision Making' from HOCS on 6 May 2020:

    i) evidence and analysis relating to the pandemic, including the latest medical and scientific advice, the estimated level of transmission and the impact of relaxations on the future trajectory of the pandemic;
    ii) capacity of the health and social care services to deal with COVID-19 cases as well as the need to resume normal services;
    iii) assessment of the wider health, societal and economic impacts of the regulations, including identifying the areas where greatest benefit and lowest risk would result from relaxation.

The following sections consider each of these aspects of the review.

Evidence and analysis relating to the pandemic

Flattening the curve

18. As of 6 May, in Northern Ireland, 28,357 individuals have been tested for SARS-COV2 Virus; there have been 3,934 laboratory-confirmed cases of COVID-19 (an increase of 53 on the previous 24 hours); and 418 deaths associated with COVID-19 have been reported. Overall case numbers are continuing to rise but at a slower rate than before. The cumulative trend for hospital admissions, deaths and confirmed positive inpatients is shown in Annex A, illustrating a flattening epidemic curve. It should be noted that confirmed cases are a sub-set of total cases. It is not possible at this stage to know how many people have been infected but it is safe to assume the true number of cases is significantly higher than the number of confirmed cases.

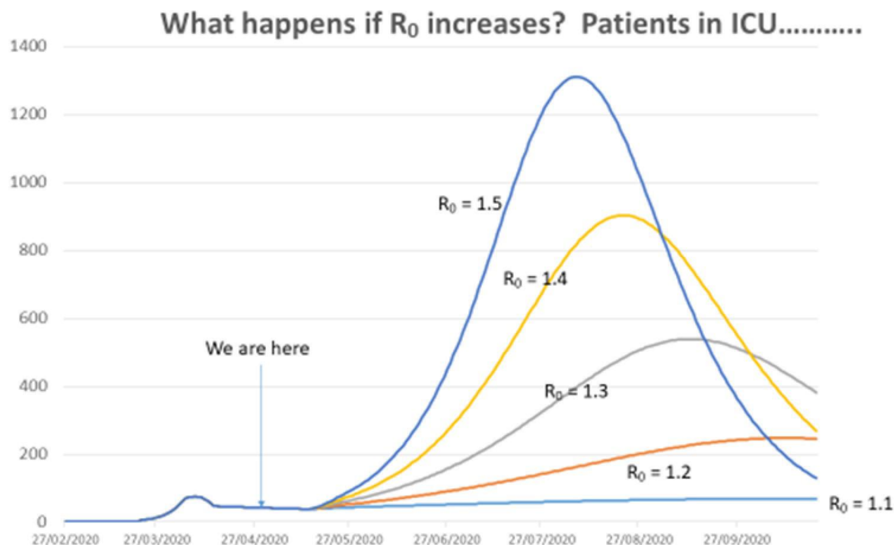
19. At the time of the first review of the restrictions, modelling had indicated that the peak of the first wave of the pandemic in Northern Ireland would be between 6 and 20 April 2020. It is now clear that the peak for hospital admissions and ICU occupancy occurred during the first part of this period, and that there has subsequently been a gradual decline in both, reflecting a reduction in transmission of the virus here and progression of the epidemic.

20. It is currently unclear how long those who have recovered from COVID-19 will retain immunity. Furthermore, at present best estimates suggest that less than 5% of our population are likely to have had the infection and recovered, which is not a sufficiently high level of population immunity to confer protection from further spread of the virus.

The significance of R_0

21. The parameter R_0 is a measure of virus transmission. Following the implementation of social distancing and other restrictions contained in the Regulations, R_0 for community transmission has fallen to less than 1, meaning that every new case of COVID-19 results in less than one additional new case. The most recent estimates indicate that R_0 is currently around 0.8 or less. This has resulted in a levelling off in hospital admissions, ICU occupancy and deaths and, provided that restrictions remain in place and public adherence remains at current levels, we would expect each of these to fall slowly and steadily in the coming weeks, reaching low levels by mid-summer.

22. In order to prevent an increase in the COVID-19 epidemic, it will be necessary to maintain R_0 at or below 1. Any relaxation in social distancing or other restrictions will be associated with an increase in R_0, with a risk that R_0 will exceed 1 and the number of cases will start to increase again. There is no relaxation that could be made to current restrictions without risk, however the degree of risk will vary from low to high depending on the measures which are relaxed. The figure below illustrates what is expected to happen if R0 is greater than 1.



23. In advance of availability of an effective vaccine, it is also possible to decrease R_0 by application of other measures. Principal among these is an efficient, extensive and robust testing and contact tracing strategy, with isolation of anyone who tests positive, and it is my view that the implementation of an effective system of testing and contact tracing is now the key to allowing us to ease restrictions in a staged manner without risking a sharp rise in transmission.

24. Following any changes, it will take at least 2-3 weeks for the new value of R_0 to become apparent with confidence, although it may be possible to estimate the effect of changes more rapidly through modelling which utilises a contact matrix

approach based on results of a periodic survey to assess numbers and patterns of contacts in a sample of the population.

25. Maintaining R_0 at less than one will minimise the direct harms resulting from the COVID-19 epidemic.

Seasonality in virus transmission

26. An issue which may be significant for decision-making later this year, and therefore should be considered at this stage, is seasonality in respiratory virus transmission. In particular the Executive should note:

    - the potential for seasonal variation in transmission of COVID-19, given the known seasonal variation in other respiratory viruses;
    - the possibility that increased transmission and concomitant circulation of other respiratory pathogens in autumn/winter (such as seasonal flu) may make test / isolate and track more difficult to maintain;
    - the implications of these for maintaining R_0 at or below 1 over a prolonged timeframe; and
    - the consequent significant likelihood of an increase in COVID-19 transmission and cases later this year, which may be even more impactful than the first wave.

27. It is not yet known whether there will be seasonal variation in transmission of COVID-19. However, we do know that transmission of other respiratory virus infections is low during the summer months and there is an upsurge in respiratory infections during autumn and winter. If COVID-19 follows this same pattern, the lower transmission risk over the summer months may enable relaxation of COVID-19 restrictions and a significant risk of an upsurge in virus transmission next autumn/winter may require the Executive to consider the reintroduction of some restrictions. A flare-up in the autumn or winter could then also give rise to perceptions that restrictions have been relaxed prematurely.

28. I can give a commitment that my Department will ensure a significant drive on seasonal flu vaccination and uptake this winter to reduce any potential impact seasonal flu may have on COVID-19 transmission and illness.

Responding to an upturn in R_0

29. If R_0 rises above one, two main options are likely to be available. Firstly, to accept that there will be a significant increase in patients, hospital admissions, ICU occupancy and deaths, while striving to ensure capacity of the Health and Social care system is adequate to deal with this. This approach has been taken by some countries (for example, Sweden). Secondly, consideration could be given to re-imposing restrictions which have been relaxed. This would need to be

done for at least 4-6 weeks to be effective, and a re-imposition following some lifting would be expected to be difficult and may not have public support.

30. **The advice of the CMO and CSA is that significant relaxation of the statutory restrictions and requirements should only be implemented when it is believed that measures are in place which give a reasonable prospect of ensuring that R_0 can be maintained below 1. If R_0 is observed to subsequently rise above 1 and there is a danger that services may be overwhelmed, then consideration will have to be given to re-imposing the current restrictions. In the absence of a vaccine, we will have to plan for a potential second wave of COVID-19 cases later in the year, and possibly further waves, once restrictions are eased or lifted.**

Capacity of Health and Social Care (HSC) system

31. Medical surge capacity refers to the ability to evaluate and care for a significantly increased volume of patients – one that challenges or exceeds normal operating capacity. Initial modelling carried out for Northern Ireland before social distancing had been introduced showed a potential demand for 150-500 critical care beds for COVID-19 patients across Northern Ireland.

32. On this basis, the HSC carried out significant work to expand critical care capacity to the maximum by freeing up general and acute beds. In an extreme surge situation, these plans would have provided the system with the capability of providing critical care to up to 286 patients. Not including ICU bed capacity, Trusts have also made significant numbers of acute medical beds available across their hospitals for COVID-19 patients. The Department has put in place arrangements for daily monitoring and reporting of changes to the position across critical care beds.

33. In order to achieve the level of readiness necessary to expand capacity to this level, HSC Trusts have had to take a number of actions. These have included:

    a. postponing non-urgent elective care and population screening programmes;
    b. rapid discharge of medically fit patients, and
    c. providing critical care training for key staff.

34. One of the most important factors in the treatment of COVID-19 patients is the availability of oxygen. The Department has overseen urgent work to ensure that all sites have sufficient capacity to provide oxygen to large numbers of patients on a sustainable basis. While there was initially much focus on provision of mechanical ventilation, it is also clear that the use of non-invasive ventilation puts additional significant strain on oxygen capacity.

35. The total number of mechanical ventilators across Trusts is currently 214, with further orders in progress to take account of revised demand modelling, as well as additional loan-stock equipment being received from NHS England.

36. My Department is continuing to work closely with BSO and HSC Trusts as well as national colleagues to ensure a continuous supply of PPE. PPE has been made available to Trusts from centrally held stockpiles albeit this must be carefully managed both at Trust and regional level. HSC Trusts are following the latest guidance regarding PPE and will continue to apply current guidance if and when it is updated.

37. My Department has also overseen the management of supplies of critical care medicines that are vital for the care of patients in intensive care, including neuromuscular blocking agents, sedatives, vasopressors, antipyretics and opioids, as well as renal replacement therapies. All have been in exceptionally high demand globally, with the risk of severe shortages. A new regional monitoring system was developed in NI and the latest report shows that there are currently sufficient stocks of critical care medicines and renal replacement therapy in NI to meet patient need.

38. Critical care demand peaked at 57 patients in early April. While this still represents a significant pressure on the system, it would appear that social distancing measures have reduced the impact of the surge locally.

39. As the pressure on critical care has lessened, the demands on our nursing and residential care homes have significantly increased. For some weeks now the frontline of our battle against COVID-19 has been in our care homes. My Department has taken steps to protect residents and staff, as well as providing significant funding to ensure that the premises can continue to operate at this difficult time. In the weeks ahead our care homes will continue to require support in their efforts of looking after some of the most vulnerable in our society at this difficult time.

40. While the position will continue to be closely monitored, the numbers of COVID-19 patients requiring hospitalisation are stabilising. At this point it is therefore essential that immediate action is taken to prioritise non-COVID-related services and functions that have been impacted by preparations for surge. However, it must be recognised that the impact of COVID-19 on the HSC is likely to continue across primary, secondary and community care services and it is unlikely that full services will be able to resume for some time. We are currently undertaking an assessment of these impacts to inform our planning for the resumption of services in parallel to maintaining surge capacity for the treatment of COVID patients, preparing for any potential second and subsequent waves.

41. **I am confident that the HSC has managed the first wave of this pandemic within capacity limits and the necessary planning is underway to ensure we**

have sufficient capacity to meet the demands of any future second and subsequent waves whilst ensuring a graduated return of normal services.

Wider health, societal and economic impacts of the regulations

42. The lives and livelihoods of many people have been severely affected in the past weeks, not only by the impact of the Coronavirus pandemic itself but by the measures we have needed to put in place to control the infection. As time goes on I recognise that the harm caused by the restriction measures grows and we therefore need to carefully balance the continued need to control this infection against the very real impacts the restrictions are having on our health and well-being, economy and way of life.

43. Detrimental impacts on society resulting from the restrictions imposed by the Regulations have been widely felt, with activities we take for granted prohibited for an extended time. Economic indicators show a profound down-turn which will place unprecedented pressure on individuals, businesses and the public finances for many years to come. The position is summarised in Minister Dodds' paper to the Executive of 4 May 2020.

44. The impacts on health are also profound, from the stepping down of screening programmes and elective care procedures through to the long-term impacts on health from interrupted education, job loss and financial stress. There has been a sharp downturn in people presenting to GPs and emergency departments, including a significant decline in the number referred for cancer investigations and treatment. We are also seeing a sharp rise in all-cause mortality, not all of which can be attributed to COVID infection and disease. We also know that there is a very real relationship between the level of deprivation in our communities and health outcomes.

45. To assist us in weighing up the benefits and harms of the restriction measures, my Department commissioned an initial analysis of the impact of the current regulations on wider health outcomes. This analysis recognises the influence of social, economic and environmental impacts on population health and health inequalities. The analysis therefore looked at the impacts of the Regulations through: the economic downturn; reduced access to public sector services and supports; interrupted access to social/family networks, and reduced access to other goods and services.

46. While there are positive and negative impacts of the regulations on wider public health, overall the analysis sets out that the net effect of the measures (excluding COVID-19 related deaths) is negative, with the potential for life expectancy to further stall and perhaps even flatten. In terms of the social determinants of health, there are negative impacts on poverty, employment, economic security, and potentially educational attainment, with the impact on housing and social capital unclear at this stage.

47. There are likely to be positive impacts on air quality and water quality which will counterbalance some of these impacts.

48. There would also be a range of impacts across behaviours, such a smoking, alcohol consumption, physical activity, and road safety, and while these differ for each behaviour the net effect of these impacts is likely to be negative. The biggest negative impacts on disease outcomes are likely to be in respect of mental wellbeing, and the development and management of long-term conditions. The analysis particularly highlighted that the regulations are likely to increase health inequalities in terms of both behaviours and disease outcomes. Of particular concern is the fact that the analysis points to the potential for widening inequalities in child health and outcomes in early years.

49. My Department is also linked in with wider UK analysis which is currently working to quantify these impacts, and over time we will have better tools to allow us to weigh up the risks and benefits associated with lifting the restrictions.

50. My Department is also linking to work led by PHE which is examining the apparent disproportionate impact of COVID-19 on the BAME population as well as marginalised groups such as the Roma community.

51. It should be noted that the picture is complex and the analysis looks at potential outcomes – these are not predictions. The longer the regulations remain in place, and the deeper and longer the economic downturn, the more negative the impact on health outcomes will become, and the balance will shift.

52. Large scale quantitative analysis of these collective impacts has not yet been completed to inform decision-making. However a degree of qualitative assessment and judgement may be applied, as suggested later in this paper.

53. **Should the restrictions continue as currently framed, or even if they are modified, each of us in the Executive could look at further mitigations to reduce the scale of the wider health, social and economic impacts.**

Key actions to move from response to recovery

54. Moving from the response phase to the recovery phase requires us to roll back the restrictions placed on society by the regulations. The use of the word "necessary" in regulation 2(3) prompts a general question: in the absence of a vaccine or proven effective treatment for COVID-19, and bearing in mind the danger of a second and further waves of the pandemic, how and when can Northern Ireland safely transition from a set of statutory restrictions and requirements to a mainly voluntary approach which relies on the great majority of citizens acting responsibly?

55. Sweden has adopted a purely voluntary approach and has so far kept cases relatively low, but has fared less well in terms of deaths (though still sits well below the UK rate per 100,000), while New Zealand is recording low, single-figure cases,

having imposed some of the strictest statutory measures in the world. However it is difficult to draw strong conclusions from this, as each country has its own unique set of demographic, social and geographical factors, differing testing rates and ways of recording and attributing deaths to COVID, and differing approaches to health care. Factors such as the extent to which the infection has entered the elderly care sector will also be significant.

56. I have outlined above how a guiding principle in decision making should be to continue to reduce transmission of the virus, measured by maintaining R_0 less than 1. There are three main elements to the strategy for reducing transmission and thereby allowing, over time, for restrictions to be lifted incrementally: testing and contact tracing; shielding vulnerable individuals and groups, and public messaging around maintaining social distancing and high levels of respiratory and hand hygiene. The most important of these is testing and contact tracing.

Testing and contact tracing

57. As outlined above, a key to lifting the restriction measures is to be able to maintain R_0 less than 1 through testing to identify infection, isolating infected cases and tracing those who have been in contact with the infected people. Close monitoring of R_0, to quickly enable any resurgence of infection to be detected, will also be critical to the resumption of activity in society and the economy.

58. My Department has therefore prioritised urgent work to develop and implement a Northern Ireland Contact Tracing Service. There is a strong international consensus that this work is a critical measure for bringing down the value of R_0 and thereby preventing or minimising further waves whilst allowing restrictions to be lifted. This work is a combination of traditional public health practice (testing potential cases, identifying their contacts and providing them with information on the symptoms to be aware of, and what to do if symptoms develop and if they need to self-isolate), and utilising digital support as appropriate to support the process.

59. Contact tracing was used in the early stages of the pandemic when numbers of cases and suspected cases in Northern Ireland were small and contact-tracing was feasible within existing capacity. Contact-tracing is labour-intensive.

60. The development of the Northern Ireland Contact Tracing Service is being taken forward rapidly. Preparatory work on reinstating contact tracing was completed in April 2020. On 27th April 2020 a pilot phase of contact-tracing began: a new cohort of contact tracers commenced training, and the system is now being further developed and tested. The team is currently being scaled up and will include specialist Public Health professionals, HSC and District Council staff, volunteers and call handlers. The contact tracing service is due to be operational by 11th May and there are grounds for confidence that the contact tracing work will help to lower the R_0 value, i.e. significantly reduce the risk or magnitude of a second wave.

61. Our current estimates are that by June, provided we have continued to see a decline in daily hospital admissions of COVID patients and ICU occupancy case numbers, we will have reasonably high confidence that we can identify and isolate new cases rapidly enough to significantly curtail transmission and maintain R_0 less than 1. This will create the conditions for more significant relaxation of restrictions.

Managing the process of review

62. The gradual withdrawal of the restrictions and requirements will involve the consideration of many details, a fast-growing body of evidence, and possible scenarios, with associated assessment of risks and a great deal of communication between and within departments and with ALBs and other stakeholders. This work should be done at pace in order to minimise avoidable detrimental impacts. In order to ensure that this process of change over the coming weeks and months is strategic rather than ad hoc, is conducted efficiently, is kept moving and is manageable, and to facilitate effective cooperation across organisations, I propose that NI Departments agree a decision-making framework and structured process.

63. Proposed changes to restrictions and requirements should be grouped whenever doing so would be more efficient and make the review process less onerous for Ministers, their Departments and other stakeholders.

Qualitative risk-benefit framework

64. Taking into consideration 1/the importance of maintaining R_0 below 1 to prevent a second wave of infection, 2/the implementation timeframe for the Northern Ireland Contact Tracing Service, 3/ the detrimental impacts of the restrictions outlined above, in line with the guiding principles of necessity and proportionality I am proposing a qualitative risk-benefit assessment framework to allow the Executive to consider where we might ease some restrictions in an incremental way. This framework would allow us to consider where easements to restrictions would provide the greatest benefit to society and economy with the lowest risk to health.

65. A proposed framework is presented in Annex B and would allow for the stratification of proposals for change by degrees of risk and potential benefits.

66. Departments are now considering a range of proposals for specific changes to the restrictions and requirements and these are being collated by TEO. Before being brought to the Executive for consideration each proposal will in future need to be assessed for risks and potential benefits in respect of the three pillars – health, society, and the economy.

67. To prioritise proposals for change, the risks and potential benefits of each proposed change can be summarised in terms of degree, reflecting the relative seriousness

of the risk and the relative value of the benefit. This will help to identify strong early candidates for reform, and at the other end of the scale, those changes that should be approached with the greatest caution. The table at Annex B has been prepared for illustrative purposes; the ratings are not based on a rigorous assessment of the proposals. In a fully worked version, the ratings for each proposal would reflect the analysis that has been done in the background.

68. This will be an emergent strategy which will unfold as a risk-stratification approach, with lower risk activities being permitted before those which are associated with greater risk. For example, relaxation of restrictions to allow more outdoor activities (leisure or work related) in circumstances in which social distancing can be maintained would be among early measures which could be taken. Throughout the strategy it is anticipated that social distancing will need to be maintained until a vaccine is available or some other effective treatment for the SARS-CoV-2 virus, and consideration given to continuing to shield the elderly and vulnerable.

Structured process

69. To assist with the recurrent review of the regulations, a step-by-step process for officials should be adopted for use across NI Departments. A draft is attached at Annex C. These directions are more specific and are closer to operational detail than the guiding principles proposed above.

Measures to complement legislative changes

70. As well as proposals for amending the Regulations my Department has received representations from other Departments that do not need legislative change but which suggest that there is scope for clearer messaging from Executive Departments to different sectors of the economy, such as the construction industry, manufacturing, public services, as well as to the general public. It is to be expected that many people are erring on the side of caution and not engaging in activities that are in fact permissible, safe and beneficial. This is understandable, given the extremely strange and very worrying times in which we are living.

71. **The Executive could now consider developing messaging aimed at giving people the knowledge and the confidence to enable them to live their lives as freely as possible within the existing legislative constraints and in line with public health advice, including a safe return to work. My Department will take this forward in cooperation with other Departments.**

Conclusion

72. My Department has completed the second review of the restrictions and requirements imposed by the Health Protection (Coronavirus restrictions) (Northern Ireland) Regulations 2020, as stipulated under Regulation 2(2). I have concluded that these regulations continue to be necessary and proportionate to address their primary purpose, which is controlling virus transmission and protecting health service capacity in the face of the COVID-19 threat.

73. To plot the safest possible path from the response phase into the recovery phase it is clear that the continuation of rigorous social distancing – whether by mainly statutory means or to some degree by voluntary means – will continue to save lives and protect our health service from being overwhelmed. The shared view of the CMO and CSA is that it is not yet time for a rapid or comprehensive relaxation of measures provided for in the regulations.

74. However, the restrictions imposed by the Regulations themselves cause harm to health, society and the economy. This is why it is vital that we adopt a dynamic review process that is able to respond to the developing evidence. As soon as the emerging evidence indicates that the harmful impacts of a restriction measures are likely to outweigh the benefits they must be reviewed and amended.

75. It must be recognised and accepted that in a rapidly developing situation the Executive will often be making decisions in the absence of complete information and an element of judgement will be necessary.

76. The introduction of a widespread testing and contact tracing system in NI will create the conditions for significant relaxation of restriction measures, combined with careful monitoring of R_0 to detect any upswing in transmission rates. Drawing on the experiences of other countries in easing of lockdown restrictions will also become increasingly possible.

77. In the interim it might be possible to ease some restrictions based on application of the qualitative risk-benefit assessment framework presented in this paper. Over time it will be possible to apply a greater degree of quantification to this decision-making process, to weigh the detrimental impacts of the restriction measures against the ongoing benefits in terms of infection control and health service capacity management. We will also be able to draw on assessments being undertaken on a UK-wide basis, in the RoI and in other countries.

78. My recommendation therefore is that the Executive agrees to the frameworks and processes I have outlined in this document and that I return to the Executive next week with an analysis of the specific requests made by Departments for change.

Recommendation / Decision sought

79. I recommend that the Executive agrees that:

i. the requirement in Regulation 2(2) for a second review of the Regulations has been met;

ii. the Regulations continue to be an appropriate response to the serious and imminent threat to public health which is posed by the incidence and spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Northern Ireland;

iii. the restrictions and requirements imposed by these Regulations continue to be proportionate to what they (the Regulations) seek to achieve, which is a public health response to that infectious disease threat;

iv. subsequent reviews should be conducted according to the terms set out above, in particular by timely re-appraisal of specific restrictions and requirements; and the incremental approach described in paragraphs 9 - 12 should be adopted;

v. the guiding principles set out in paragraph 13 should be adopted;

vi. the arrangements for managing the process of review, including the qualitative risk-benefit framework and the structured process, should be adopted, and

vii. the Executive should consider developing messaging aimed at giving people the knowledge and the confidence to enable them to live their lives as freely as possible within the existing legislative constraints and in line with public health advice, including a safe return to work.

I am copying this paper to the Attorney General and Departmental Solicitor, and to First Legislative Counsel.

ROBIN SWANN MLA

MINISTER OF HEALTH

Annex A

Chart showing admissions by week of first admission to hospital with community acquired infection

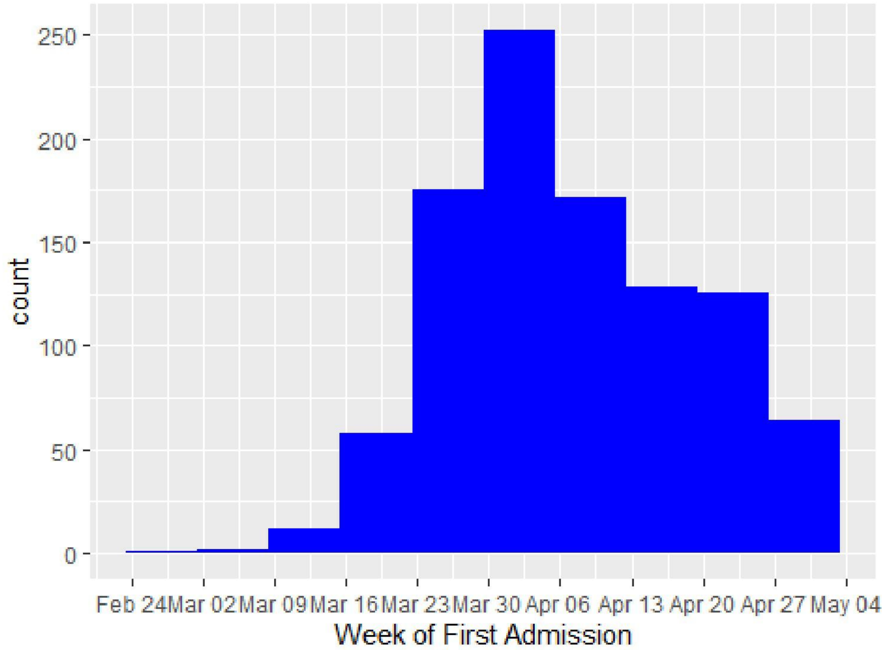
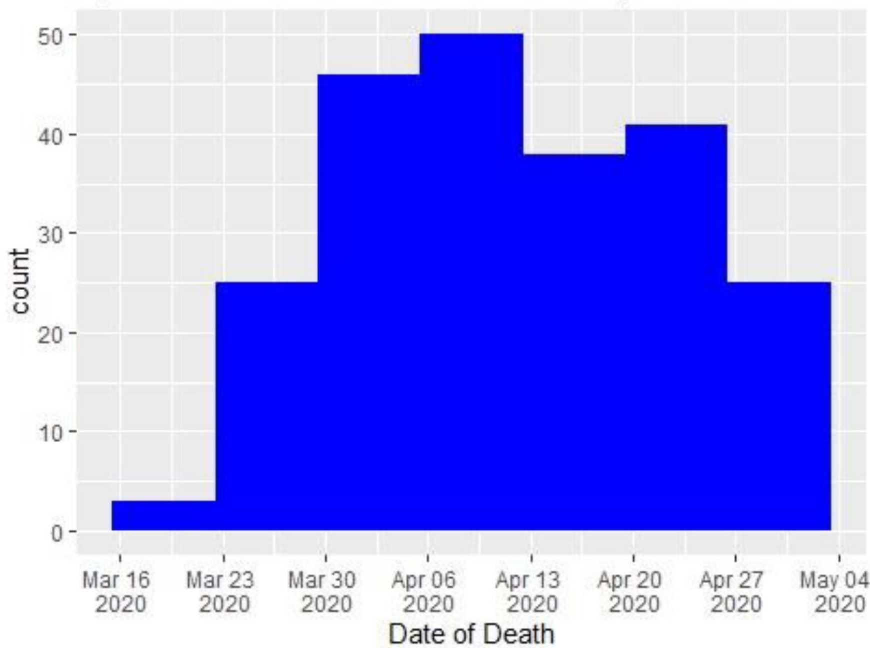
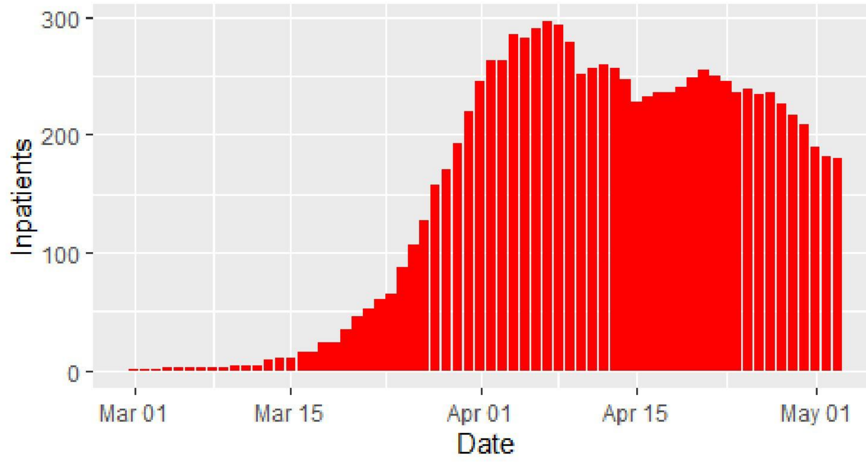


Chart showing deaths by week of death for hospitalised patients



Definite COVID-19 positive inpatients by date



Annex B

FOR ILLUSTRATIVE PURPOSES ONLY, 6 MAY 2020

Risk and benefit assessment matrix

Withdrawal or relaxation of COVID-19 restrictions and requirements: qualitative assessment of relative impact of easing social distancing measures

Overall rating of risk or potential benefit: key

- -3: highest risk
- -2: significant risk
- -1: moderate risk
- 0: negligible risk or benefit, or neutral
- +1: moderate benefit
- +2: significant benefit
- +3: greatest benefit

Assumptions:

1. All relaxations assume that adequate social distancing can be maintained, and would be accompanied by strong advisory to maintain 2-metre social distancing measures and hand hygiene.

2. In the case of young people attending school and sporting activities and returning to the workplace, this will be subject to them minimising contact with elderly or vulnerable people.

3. Assessments assume ongoing self-isolation by people with symptoms, supported by test, track, trace system

* Assumes adequate testing and contact tracing system in place

Note: the ratings on each row are not scores that can be summed. They would indicate the outcomes of largely qualitative assessments.

Possible change to restrictions / requirements	Impact on transmission *leading to serious disease*	Health impacts medium to long term	Society	Economy
	RISK	**POTENTIAL BENEFIT**		
Closure of premises – Reg 3(1) – withdrawal of this restriction on the following categories				
Restaurants	-3	+1	+2	+3

Cafes	-3	+1	+2	+3
Bars	-3	0	+2	+3
Public houses	-3	0	+2	+3
Closure of businesses – Reg 3(4) – withdrawal of this restriction on the following categories				
Cinemas	-2	+1	+3	+3
Theatres	-2	+1	+3	+3
Nightclubs	-3	+1	+3	+3
Bingo halls	-2	+1	+2	+2
Concert halls	-2	+1	+2	+2
Museums and galleries	-1	+1	+2	+2
Casinos				
Betting shops	-1	0	+2	+3
Spas	-1	+1	+1	+1
Nail, beauty, hair salons and barbers	-2	+1	+1	+3
Massage parlours	-2	0	0	+1
Tattoo and piercing parlours	-2	0	0	+1
Skating rinks	-1	+2	+2	+1
Indoor fitness studios, gyms, swimming pools, bowling alleys, amusement arcades or soft play areas or other indoor leisure centres or facilities	-2	+1	+2	+1
Funfairs, outdoors	-1	+1	+1	+1
Funfairs, indoors	-2	+1	+1	+1
Playgrounds, sports courts and outdoor gyms	-1	+2	+2	+1
Outdoor markets (stalls selling food are excepted)	-1	+1	+2	+2
Car showrooms	0	0	0	+3
Auction houses	-1	+1	+1	+1
Further restrictions & closures – Reg 4 – withdrawal of any of the following restrictions				
Restrictions on business not listed in Schedule 2 Part 3 to trade				

online, telephone or by mail order				
Need to fit ideas / details of possible easements into this table. Risk assessment would depend on nature of business.				
Closure of holiday accommodation	0	+1	+2	+3
Closure of places of worship	-1	+1	+3	+1
Closure of community centres	-1	+2	+3	+1
Closure of crematorium / burial ground	-1	+1	+2	+1
Restrictions on movement – Reg 5 – additional reasons for leaving home that would become reasonable excuses. Note: This is unlike the provisions above in that instead of a finite list of existing restrictions that could be withdrawn or relaxed, the potential set of reasonable excuses is open-ended.				
General restriction on leaving home	-2	+2	+3	+3
Grounds of reasonable excuse – any specific proposals for adding new grounds for leaving home should be generated by Departments. A Department generating such a proposal should lead in assessing the risks and the potential benefits.				
Restrictions on gatherings – Reg 6				

* Assumes adequate testing and contact tracing system in place

Annex C

Structured process for reviewing and amending specific restrictions and requirements of The Health Protection (Coronavirus, Restrictions) Regulations (NI) 2020

1 Approach and guiding principles for removing or amending specific restrictions will be as agreed by the Executive. The guiding principles are **[tbc]**: (1) focus on primary purposes, i.e. controlling transmission and protecting healthcare capacity; (2) necessity; (3) proportionality and (4) reliance on evidence.

2 All restrictions and requirements in the Regulations will be treated as cross-cutting and therefore requiring Executive referral.

3 As the Regulations are the responsibility of DoH, any amending regulations should be prepared by DoH.

4 Any NI Department can initiate a review of specific restrictions or requirements and make proposals for legislative change.

5 A Department developing a proposal for change should engage at an early stage with all other Departments with a direct policy interest in the restriction(s) or requirement(s) being reviewed. Each Department should respond to other Departments' proposals as promptly as possible.

6 For this purpose each Department should have a designated a point of contact.

7 Given the stipulation in the Regulations that a restriction or requirement should be in place no longer than is considered necessary, reform should progress as quickly as is prudent in light of the public health modelling and advice.

8 In the interest of consistency of approach and to facilitate strategic and orderly management of ongoing review of the restrictions and requirements, Departments should use an agreed common template to set out the case for change and to ensure that this work is informed by the guiding principles. The template is intended to be flexible as regards presentation of different types of evidence. Draft template is at Annex 1.

9 Proposed changes to restrictions and requirements should be grouped whenever doing so would be more efficient and make the review process less onerous for Ministers, their Departments and other stakeholders.

Process for reviewing and amending a restriction or requirement

10 The step-by-step process is as follows.

(1) Dept x identifies a specific restriction or requirement to be reviewed and put to Executive for decision and seeks ministerial approval to proceed.

(2) Subject to ministerial approval, Dept x advises TEO with a direct policy interest which restriction(s) or requirement(s) they are reviewing.

(3) Dept x considers evidence of detrimental impacts, with other Departments as appropriate, and risks associated with withdrawal or amendment.

(4) Dept x completes Part 1 of the template.

(5) Dept x sends template to DoH for assessment.

(6) DoH completes part 2.

If DoH supports the proposed change

(7) DoH prepares amending SR. (This work could be started at an earlier stage if DoH believes that the proposal is likely to be accepted.)

(8) DoH sends template and draft SR to DSO for advice.

(9) On receipt of DSO advice, DoH prepares an Executive paper, or adds details of the proposed changes to an Executive paper that is already in preparation.

(10)DoH Minister submits Executive paper.

(11)If the proposed changes are agreed by the Executive DoH makes the amending SR.

If DoH does not support the proposed change

(7) DoH advises Minister of position and discusses options with Dept x.

Annex C Appendix 1

TEMPLATE

REVIEW OF SPECIFIC COVID-19 RESTRICTIONS AND REQUIREMENTS

Part 1, to be completed by initiating Department	
Department initiating review	
Description of restriction or requirement	
Legislation reference	
Proposed change	
NI Departments with the most direct policy interest	
Advice received from these Departments	
Summary of evidence – quantitative or qualitative – that has been considered	
Summary of detrimental impacts of restriction or requirement, including references to evidence considered, and therefore benefits of removing or modifying the provision	
- Health	
- Society	
- Economy	
Summary of assessment of risks associated with removal or proposed modification	
- Health	
- Society	
- Economy	
Steps to mitigate any risks identified	
Commentary	
Current position on this restriction	
- England	
- Scotland	
- Wales	
- RoI, if applicable	
Conclusion	
Date:	
Part 2, to be completed by DoH	
DoH assessment including expected effect on R0 of removal or proposed change	
Date:	
Part 3, to be completed by DoH	
Summary of DSO advice	

Recommendation by DoH to Executive (Repeal / Modify / Retain)		
Date:		
Part 4, to be completed by Executive Secretariat		
Executive decision		Date: