MEMORANDUM E (20) 201 (C)

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

DATE: **20 August 2020**

TO: **EXECUTIVE COLLEAGUES**

FINAL EXECUTIVE PAPER: HEALTH PROTECTION (CORONAVIRUS, RESTRICTIONS) (No. 2) REGULATIONS (NORTHERN IRELAND) 2020: FIRST REVIEW OF THE NEED FOR THE RESTRICTIONS AND REQUIREMENTS

Introduction

1. This paper reports on the first review of the need for the restrictions and requirements in the Health Protection (Coronavirus, Restrictions) (No. 2) Regulations (Northern Ireland) 2020 ("the No. 2 Regulations"), and, in light of the review, recommends that the current restrictions are a necessary and proportionate response to the epidemic at this time.

2. The paper also revisits the option of imposing restrictions in response to local increases in incidence.

Background

3. The No. 2 Regulations, which were made on 23 July, clarified and simplified the existing provisions; retained those restrictions and requirements that we considered still to be necessary; clarified powers for the imposition of new restrictions should the need arise; and updated and simplified the restrictions on gatherings, together with residual restrictions on businesses and premises. The current restrictions are summarised in Annex A.

4. The No. 2 Regulations require the Department of Health to review the need for the restrictions and requirements in the Regulations at least every 28 days. The first review must be completed by 21 August.

Related legislation

5. Two other sets of regulations are intended specifically to protect the population from COVID-19: the International Travel Regulations and the regulations requiring people to wear face coverings in certain settings.

International Travel Regulations

6. The Health Protection (Coronavirus, Public Health Advice for Persons Travelling to Northern Ireland) Regulations (Northern Ireland) 2020 and the Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020 both came into operation on 8 June 2020. These set out the information that must be provided to travellers entering Northern Ireland and the need for travellers to complete a passenger locator form and self-isolate for 14 days (unless from an exempted country). Both are updated on an ongoing basis and were last formally reviewed on 10 August 2020.

Regulations on face coverings

7. The Health Protection (Coronavirus, Restrictions) (Amendment No. 11) Regulations (Northern Ireland) 2020, introduced a requirement to wear face coverings on public transport. This came into operation on 9 July. The Health Protection (Coronavirus, Wearing of Face Coverings) (Amendment) Regulations (Northern Ireland) 2020, which were made on 31 July and came into operation on 10 August, require members of the public to wear face coverings whilst inside a relevant place, i.e. in a shop or a shopping centre. It is too early to observe any change in transmission that could be attributed to these regulations.

Review of the need for the restrictions and requirements

Balancing necessity and harm

8. The second review of the restrictions regulations, completed on 7 May, identified two broad purposes of the restrictions and requirements:
    a. minimise the numbers of cases and deaths, and
    b. ensure as far as possible that the healthcare system has the capacity to care for COVID-19 patients and care for all patients, present and future.

9. That review also recognised that the restrictions and requirements were harming our health and well-being, economy and way of life, and therefore the importance of finding a balance between the continuing need to control the infection and the need to minimise and mitigate the adverse impacts of the restrictions and requirements.

10. The need for such a balance informed the guiding principles that we adopted as the basis for our decision-making:
    a. focus on primary purposes, i.e. controlling transmission and protecting healthcare capacity;
    b. necessity;
    c. proportionality, and

d. reliance on evidence.

11. The present review has been guided by these principles and by the continuing need to find the best possible balance between necessity and harm. Given that too narrow a focus on reducing transmission could have serious and long-term adverse consequences for people's health and well-being; their education, life-chances, economic activity and prosperity, and community life, we have sought to take a holistic approach to this review.

Progress of the epidemic

Modelling the COVID-19 epidemic; the Reproduction Number and other indicators

12. As of 18 August the key indicators of the epidemic are as follows.

Current estimate of R (hospital inpatients): 1.0 – 1.4 (definitely above 1)

Current estimate of R (new positive tests): 1.2 - 1.6 (definitely above 1)

Average number of new positive tests per day, last 7 days: 42.6 (increased from 27.7)

7-day incidence based on new positive tests: 15.7 / 100k population (up from 10.2)

14-day incidence based on new positive tests: 26.1 / 100k population (up from 15.5)

7-day average of total tests (pillar 1 and 2) which are positive – 1.12% (down from 1.18)

First COVID +ve hospital admission in last week: 9 (down from 11)

13. It is important to model the COVID-19 epidemic in Northern Ireland in order to plan the delivery of Health and Social Care services and to inform decision making with regard to social distancing and other restrictions which may be required. The Reproduction Number (R) has been central to modelling the course of the epidemic to date. R is the number of individuals who, on average, will be infected by a single person with the infection. R does not have a fixed value but varies with time, and is likely to be different every day.

14. When R is above 1, the transmission of the epidemic will increase, resulting in more cases, hospital admissions and deaths. The greater the value of R above 1, the more rapid the increase. When R is below 1, there will be a fall in the number

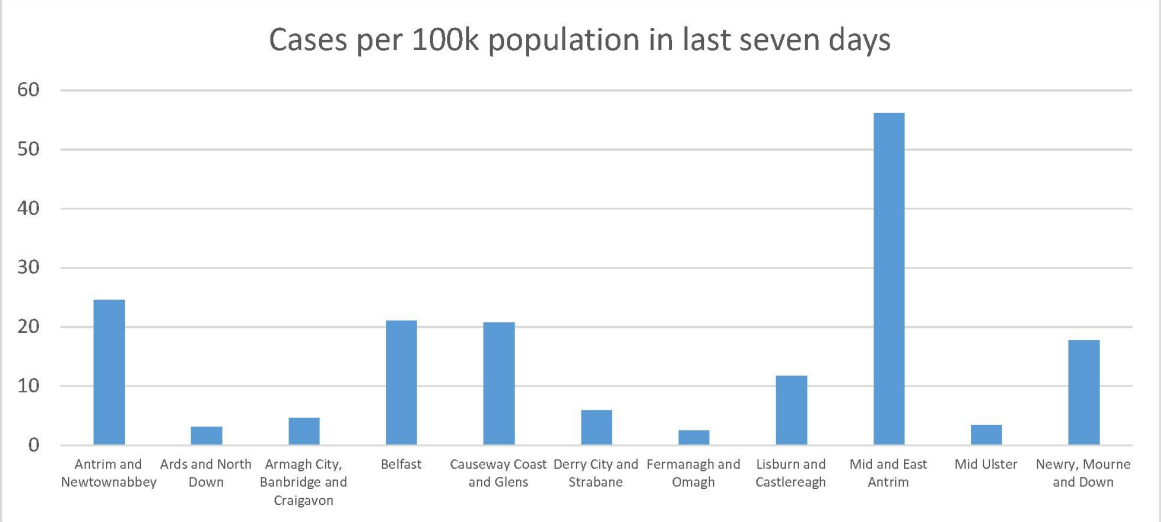
of cases, hospital admissions and deaths. The further R is below 1, the more rapid the fall will be. We have agreed that keeping R below 1 is a key objective as we move forwards in the epidemic.

15. However, when community transmission of the virus is very low, R will no longer be the most important number for the purpose of policy decisions. In particular, once the number of new cases is sufficiently low in the presence of a robust testing programme and test/trace/protect strategy, number of positive tests per day is likely to be a more important parameter in the context of planning.

16. At present R is likely to be around 1.3, and is definitely above 1. The above indicators generally show a further increase in transmission in the last week. The 7-day rolling average for new cases has increased, while test positivity has remained static. 14-day cases per 100k are now a little higher than UK and ROI. This is likely to be partly explainable by increased testing in the context of the Test / Trace / Protect service. However, there is also likely to be a more widespread increase in community transmission which is a matter of significant concern. Hospital admissions have remained stable and are still at a low level. However, the view from both the Modelling Group and the Strategic Intelligence Group is that they will inevitably rise if cases continue to do so.

Regional variation in cases

17. There is marked variation in COVID cases in Local Government Districts, with Fermanagh and Omagh the lowest and Mid and East Antrim the highest.



Determining the value of R

18. The most common approach to determining R during an epidemic is to use mathematical modelling, in particular a compartmental model using a SIR (susceptible-infectious-recovered) approach or a variation of it. Dozens of such models have been published and are in use throughout the world; there is no single standard model which everyone uses.

19. In addition to the impact of the mathematical model used, the calculated value of R is also influenced by the choice of input variable. R calculated for new COVID-19 cases will not be the same as R calculated for hospital admissions, or ICU occupancy, or deaths. There may be a significant lag (2-3 weeks) before a fall in R is apparent depending on the input variable(s) used.

20. Once the activity of the epidemic is at a low level (as at present) marked fluctuations in R may be observed over short periods of time as a result of localised outbreaks or clusters. Local measures to address the cluster or outbreak will represent the most appropriate response in those circumstances, rather than general measures which are more appropriate when there is widespread community transmission.

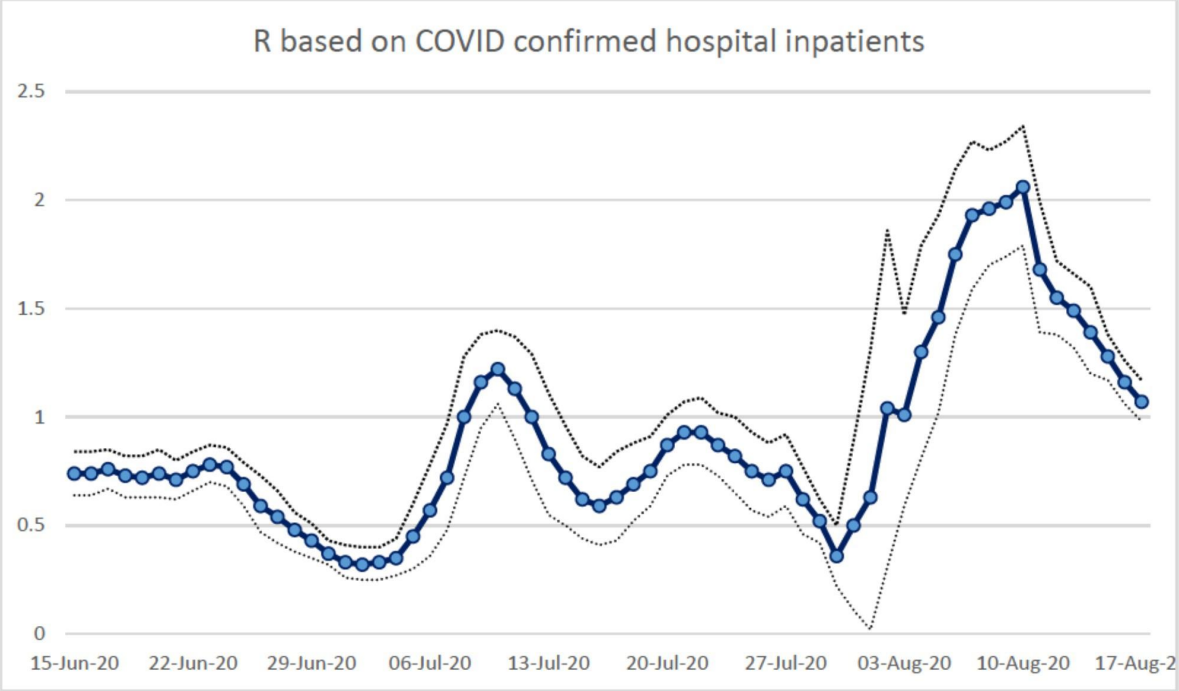
21. At present the situation is in rapid flux and it is difficult to assess the extent of community transmission vs. the impact of clusters. This will be kept under close review. However, the significant increase in all indicators in the last week is of considerable concern.

Determining R for NI

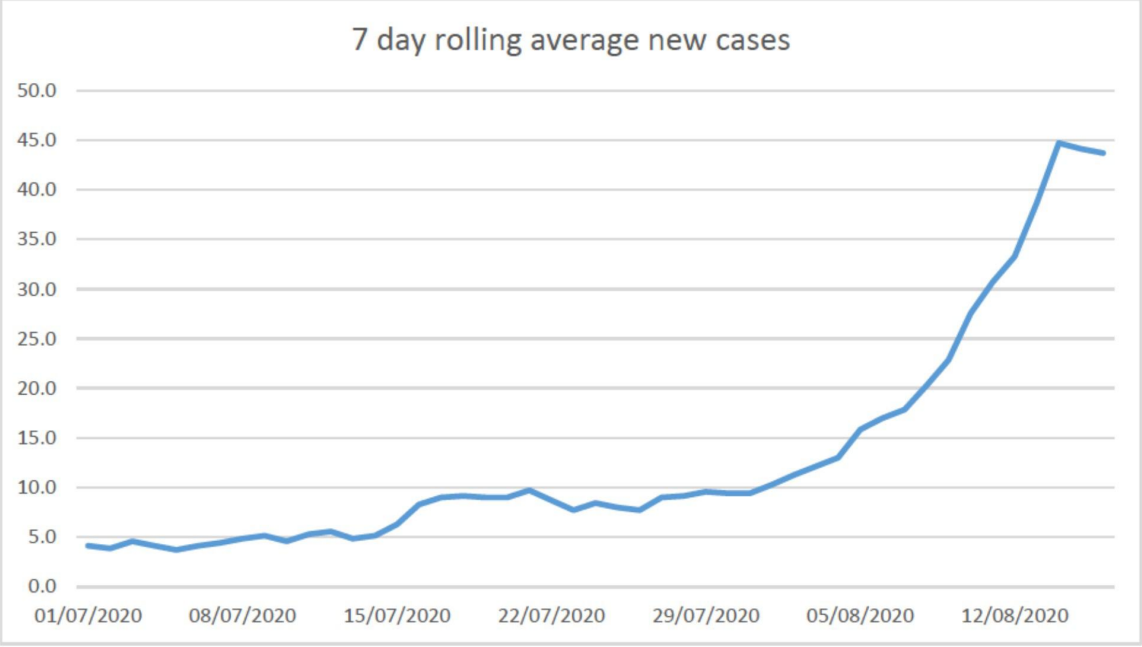
22. The modelling group determines R each day using a bespoke Northern Ireland SIR model. As its primary input the group uses hospital in-patients with community acquired COVID-19, but also uses a range of other inputs. We therefore have several different values for R each day, each of which has a midpoint value and a lower and upper boundary (95% confidence intervals). In addition a number of academic groups, both in the UK and ROI, model the COVID-19 epidemic and we have access to their estimates of R for Northern Ireland. R can also be determined based on a contact matrix survey, and this approach may be more reliable when levels of community transmission are very low.

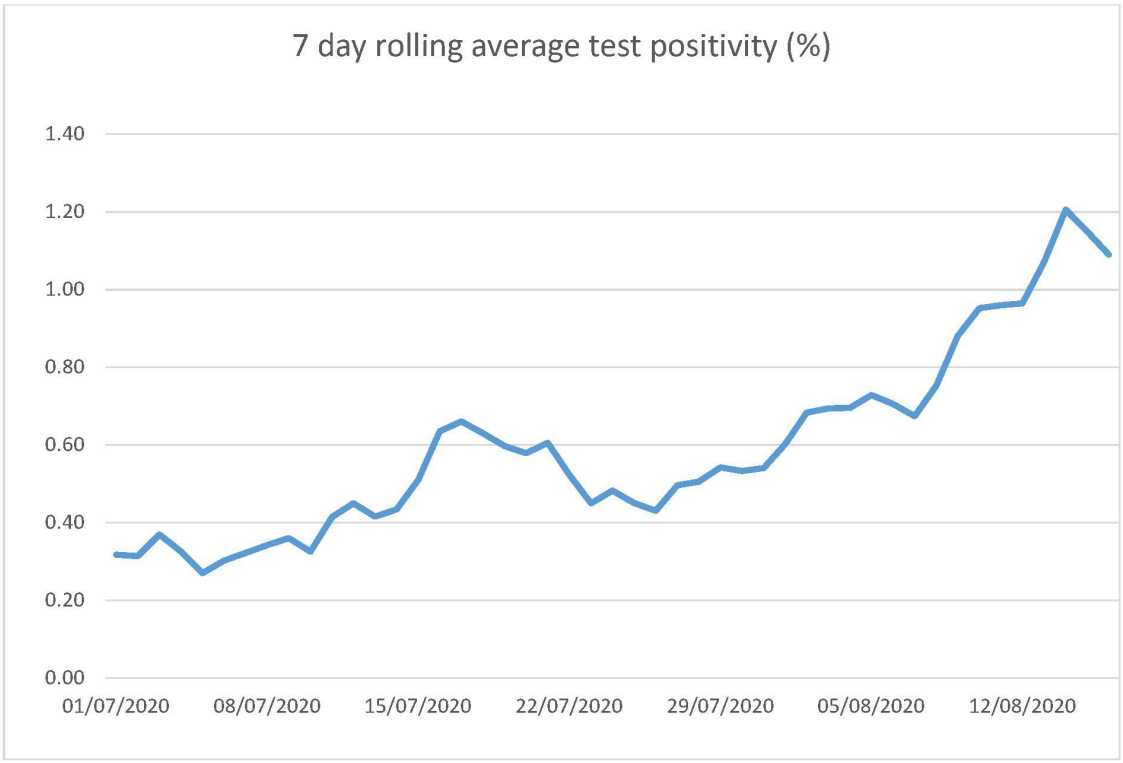
Trends for R for Northern Ireland

23. The graph below shows how R has changed over time during the course of the COVID-19 epidemic in Northern Ireland using hospital in-patients with community acquired COVID-19 as an example. The value of R differs somewhat when other inputs are used.

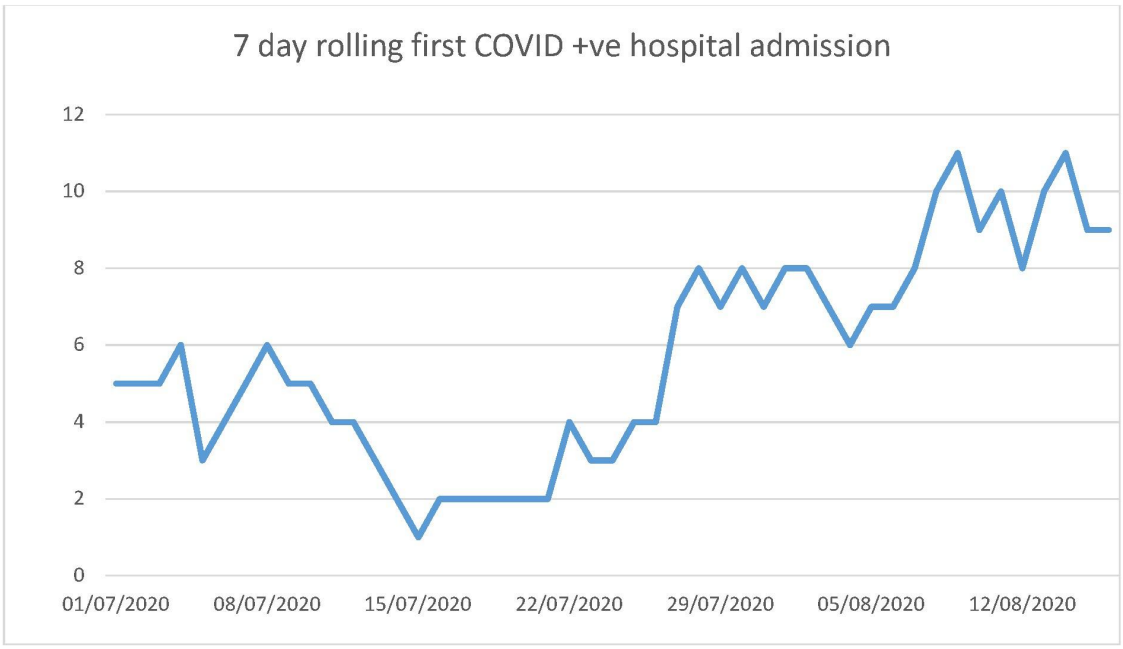


24. The graphs below shows that the number of new COVID 19 cases have increased over the last week. Cases and % test positivity are both trending significantly upwards. Data are taken from the DoH Dashboard report 18/8/20.





25. The following graph shows first hospital admission of COVID +ve patients over a rolling 7 day period. To give context, this peaked at 260 during wave 1.



Health and Social Care capacity and demand

26. The Department is continuing to plan for further possible waves of COVID-19 to ensure that there are comprehensive surge plans in place for critical care, hospital beds and care homes. Whilst the timing of any further wave remains unpredictable, and may coincide with colder weather and winter pressures, capacity planning is now informed by increasingly more robust data in comparison to the initial surge which occurred in mid-April. The modelling group established by the Chief Medical Officer has made it possible to track and monitor the trajectory of the pandemic much more effectively. Using the available data, it is intended that if the system reaches defined levels of capacity I will provide advice to Executive colleagues on the need to re-introduce measures to reduce R. Using this approach, our intention is to ensure that the system is equipped to deal with a significant increase in demand, but also to control this more effectively within defined parameters. In the meantime, COVID-19 patients are being cared for within current HSC capacity, whilst Trusts continue the important work of rebuilding other services under the Strategic Framework which I published in May.

Update on Test, Trace and Protect, the StopCOVID-NI app

27. The four key elements of Test, Trace and Protect are early identification and isolation of possible cases, clusters and outbreaks; rapid testing of possible cases; tracing of close contacts of cases; and early, effective and supported isolation of close contacts to prevent onward transmission of infection. In this regard I have previously highlighted the critical importance of a robust testing and contact tracing system to drive down virus transmission, reduce the risk or magnitude of a second wave and support the easement of restrictions.

28. Testing in line with emerging scientific evidence continues to be a vital tool in our response to the COVID-19 pandemic. Everyone including children under the age of five years of age (from 16 July) in Northern Ireland is eligible for a COVID-19 test if they are showing symptoms of infection. The details of how to get a test are available via the PHA website. The groups eligible for testing are kept under constant review and our testing programme continues to expand as required in line with emerging scientific and medical advice. There is currently sufficient testing capacity to ensure that everyone in Northern Ireland who needs a test can be tested.

29. The COVID-19 Testing Strategy for Northern Ireland was agreed on 7 April 2020 and aligns with the UK's strategic approach to scale-up of testing for COVID-19 (the Five Pillar Approach). An Expert Advisory Group on Testing (EAGT) oversees the coordination and implementation of the Testing Strategy.

30. This strategic plan is underpinned by an Interim Protocol for Testing, an operational tool kept under constant review, with priority groups for testing extended regularly in line with emerging scientific evidence and expansions being delivered in testing capacity.

Pillar 1: HSC/Consortium Laboratory System

31. All HSC Trusts have developed local arrangements for testing of hospitalised patients, HCWs and some key workers. Multiple testing platforms are being used to build resilience into the service and to utilise different supply chains.

Pillar 2: National Initiative

32. Through the National Testing Programme the following arrangements have been established to support the testing of HCWs, key workers and all symptomatic members of the public: four operational drive-through test sites in Northern Ireland; six Mobile Testing Units (The MTU can be rapidly deployed if there is a cluster or an outbreak); home test kits (postal option); and satellite testing via an online portal where tests are couriered to and from sites.

Testing Capacity

33. In addition to ongoing engagement with the Health and Care Sector, new partnerships with local universities and industry have been established. Work continues with a number of key stakeholders and delivery partners to significantly increase testing capacity across all laboratory services and networks. Current testing capacity which is flexible and informed by demand is: Pillar 1 (HSC/Consortium Laboratory system) is up to 2,200 tests per day; and Pillar 2 (National Testing Programme) is up to 6,500 tests per day when operating at full capacity.

Care Home Testing

34. An initial comprehensive programme offering COVID-19 testing to all residents and staff across all care homes, including care homes which, do not and have not had, a COVID-19 outbreak completed at the end of June 2020. On 3 August 2020, a regular programme of COVID-19 care home testing commenced. There are two components to this care home testing programme:

35. Testing in 'green' care homes with no suspected or confirmed COVID-19 outbreak will be undertaken through the National Testing Programme (Pillar 2). All staff will be tested every 14 days and residents every 287 days; and

36. Testing in care homes with a suspected or confirmed outbreak will be managed by the PHA and HSC Trusts through the HSC/Consortium Laboratory System (Pillar 1). The number of rounds of testing to be undertaken in potential outbreak situations will be determined by the outcome of the first round of testing.

37. The requirement to vary the frequency of the testing undertaken in care homes will be kept under active review and continue to be informed by emerging scientific evidence and other contributory factors, including local community transmission rates of the virus in Northern Ireland over the coming months.

38. Testing for surveillance purposes is critical to determine the level of COVID-19 in circulation in the wider community. There are a number of strands of surveillance testing currently underway, and more in development, the results of which inform decision-making as we progress through the pandemic response and in planning for a potential second surge.

39. Over recent months my Department has also continued to take forward urgent work to implement a Contact Tracing Service in Northern Ireland and I am pleased to report that a fully operational contact tracing service is now in place in County Hall, Ballymena. This is essentially a manual contact tracing centre where skilled clinical contact tracers call all positive cases and their contacts to advise and guide on next steps. The contact tracers are supported by Public Health consultants who provide medical advice and clinical leadership to the centre as well as dealing with complex cases and managing outbreaks or clusters of diseases. Other staff are also being recruited to support the analysis of the information and intelligence gathered in order to advise on the progression and management of the disease. Importantly, the workforce planning approach to the Contact Tracing Service is based on a flexible model to provide for an effective response to any increase/decrease in case numbers. Indeed this model has proven to be particularly effective in responding appropriately to a recent increase in numbers.

40. At present anyone who tests positive for COVID-19 in NI will be contacted by the contact tracing team to be given advice on the need to self-isolate to prevent any wider spread of the virus. They will also be asked who they have been in contact with so that we can follow up with those individuals to give them advice to help prevent the further spread of infection.

41. A Covid Care Advisory Service has also been established, through NI Direct, to provide information and support to members of the public who do not have access to the internet, on various aspects of checking symptoms, booking tests and providing signposting to sources of social and community support.

42. In addition a new smartphone app, StopCOVID NI, which will augment the Public Health Agency's Test, Trace and Protect programme, has now been introduced. The smartphone app helps to speed up the process to identify people at risk of catching the virus, and slow down its spread. Using the app along with existing public health measures will help the public to stay safe when they meet up, socialise, work or travel. To date there have been approximately 265,000

downloads of the app and officials are currently considering how this figure can be increased to ensure that the benefits of the app are fully realised.

43. There has been a wide ranging programme of engagement with stakeholders throughout the development of the contact tracing service which is on-going and you will also be aware of the recent public information campaign aimed at raising awareness of the symptoms of Coronavirus and encouraging individuals who are symptomatic to follow the appropriate steps including booking a test quickly; helping with contact tracing; and self-isolating when advised.

44. Weekly information on the contact tracing service is now available on the PHA website [https://www.publichealth.hscni.net/covid-19-coronavirus/testing-and-tracing-covid-19/contact-tracing-service-management-information].

Wider health, societal and economic impacts of the regulations

Economic impacts

45. My Department has continued to liaise with DfE on the economic impacts of COVID-19 and the regulations. In summary:

- DfE considers that the Northern Ireland economy was running around 25% below normal during lockdown.
- Recent UK GDP figures estimate that the UK economy saw monthly GDP growth of minus 6.9% in March 2020 and then minus 20.0% in April 2020 (i.e. contraction of around 25% in total). Monthly GDP then grew by 2.4% in May 2020, followed by growth of 8.7% in June 2020, with many sectors showing definite signs of improvement. Despite this, the level of overall output did not fully recover from the record falls seen across March and April 2020.
- Locally, there are signs of improvement in economic activity. Firms have begun to 'unfurlough' staff and a number of manufacturing plants and construction sites have resumed activity, while retailers have reopened their doors to customers.
- Latest figures (claims to 30 June 2020) indicate that 240,200 employees in Northern Ireland have availed of HMRC's Job Retention Scheme. 76,000 claims have been made in Northern Ireland under HMRC's Self-Employment Income Support Scheme, out of 96,000 eligible for the scheme.
- The Claimant Count now stands at over 60,000. Further job losses and the planned ending of the furlough scheme could mean that the Claimant Count could plausibly exceed 100,000 before the end of 2020 or shortly afterwards.
- While an economic recovery is underway in Northern Ireland, with many sectors and businesses being reopened, there are still significant risks if recovery of output and jobs is not swift and sustained. Recent estimates from

both the Ulster University Economic Policy Centre (UUEPC) and EY suggest that output could fall by over 10% during 2020 as a whole. Even though the local economy is 'in recovery', with many sectors improving, it may take years before economic activity overall is back to its pre-pandemic levels.

Wider Impacts on health

46. You will recall that my Department commissioned an initial analysis of the impact of the current regulations on wider health outcomes. This was supplemented with a number of pieces of work being taken forward at the UK level by DHSC and PHE, which all show the same trend and come to similar conclusions. In summary:
    - Overall population health is highly likely to be negatively affected by the wider impacts of the COVID-19 restrictions.
    - Population health – including life expectancy growth - and inequalities are expected to be significantly affected, with the greatest effects felt by the most disadvantaged.
    - Many key behavioural risk factors are likely to be worsening.
    - Public health resources had been re-prioritised to support on the direct impacts of COVID-19, which limited the system's capacity to address the wider impacts. However, work is now underway to restart a range of services though some may operate at reduced capacity.
    - Emerging evidence suggests that the disease burden from conditions such as mental health is already rising.

47. The real world data continues to demonstrate these trends, though it is likely to take time for the full effect to be known. Further update on the impacts will inform the next review, along with more detailed information on potential inequalities in relation to specific issues, such as the impact on maternal and infant health and obesity.

Demographic differentials in impacts of the pandemic

48. We should take into account demographic differentials in morbidity and mortality when considering whether the restrictions and requirements are a proportionate response to the epidemic.

49. The risk of severe disease and death correlates strongly with age. In NI people aged 80 and over account for 19.5% of those who have tested positive, but account for 67% of the 559 deaths to date. In contrast, people under 60 account for 63.5% of all positive tests but 4.5% of all deaths.

50. Since the peak of 19 deaths on 22 April the number of deaths has decreased significantly and has remained low. There have been 3 deaths from COVID-19 in NI since 12 July.

51. One factor in this has been a significant decrease in care home outbreaks. On 7 May in NI there were 75 confirmed outbreaks and 35 suspected outbreaks in care homes. As of 18 August there were 7 confirmed outbreaks and 6 suspected outbreaks in care homes. (The number of confirmed outbreaks rose by 3 between 17 August and 18 August.)

52. Internationally, the current rises in cases are predominantly in younger people of working age, who are less susceptible to severe illness and less at risk of dying from the disease.

53. There have been advances in the treatment of COVID-19, so patient outcomes are improving.

54. Given that one of the two main purposes of the coronavirus restrictions is to preserve the capacity of healthcare to treat COVID-19 cases as well as non-COVID-19 patients, we should take into account that the threat to the capacity of the healthcare system is less pressing than it was in April, and less pressing than would be if the age profiles for severe disease and deaths were more skewed towards older age groups.

55. Against this, we should be cognisant that people of working age tend to be more directly impacted by restrictions on economic activity, and possibly also by the restrictions on social and community activity.

Restrictions on gatherings: current issues and options for change

Addressing the immediate issues

56. In response to the current rise in transmission my Department has proposed that as a matter of urgency:

- the restrictions on indoor and outdoor gatherings should be tightened, such that the number of persons that can participate in an outdoor gathering, whether in a public space or a private garden, should be changed from 30 persons to 15 persons, and the requirement for an organiser to carry out a risk assessment and put suitable measures in place would then apply to any gathering of more than 15 persons, and

- the current limit on people meeting in a private dwelling should be reduced: instead of 10 individuals from up to 4 households, the limit should be 6 individuals from no more than 2 households.

These proposals are in the paper being tabled today by FM and dFM.

Enforcement issues

57. Regulation 5 in the No. 2 Regulations prohibits participation in indoor or outdoor gatherings consisting of more than 30 persons. Exceptions are made for gatherings organised or operated for cultural, entertainment, recreational, outdoor sports, social, community, educational, work, legal, religious or political purposes, where the organiser has carried out a risk assessment and has taken all reasonable measures to limit the transmission of coronavirus.

58. Two specific issues have emerged since the new regulations came into operation.

59. Regulation 5(4)(a) requires the organiser of a gathering of over 30 people to carry out a risk assessment which meets the requirements of the Management of Health and Safety at Work Regulations (Northern Ireland) 2000. The requirement to take all reasonable measures to limit transmission is in regulation 5(4)(b). There are significant challenges as regards the capacity to enforce these requirements, in particular the first.

60. The second issue, which can be resolved more readily, is that the prohibition is on participation in such gatherings rather than on organising them ("a person shall not participate in an indoor or outdoor gathering which consists of more than thirty persons.") so participants rather than organisers are liable to the penalties.

61. I will bring forward proposals in the near future for addressing these issues.

Other considerations

62. In addition to the current general increase in transmission in Northern Ireland, my Department is mindful of the risks associated with the imminent re-opening of schools and the forthcoming flu season, for which an extended flu immunisation programme is being planned. The resurgence of cases in Ireland, Spain, France, the Netherlands and other countries and regions remind us of the speed and potential scale of major new outbreaks.

Conclusions on the need for the current restrictions and requirements

63. While we must aim to achieve the optimum balance of necessary health protection measures and minimising the harms associated with these, we are now at a critical juncture in the course of the epidemic, with the potential for imminent renewed exponential growth in transmission. Having considered the factors set out above,

in particular the current rise in transmission in Northern Ireland, I have concluded that the current restrictions are a necessary and proportionate response to the threat at this time.

Responding to local increases in transmission of COVID-19

64. At our meeting of 23 July we agreed not to legislate for enforceable actions to respond to local rises in cases. The arguments against enforceable localised restrictions or requirements include potential demands on PSNI; proportionality of the response; doubts about the potential effectiveness of such measures; timeliness; challenges in setting appropriate geographical boundaries; and acceptability to local communities. We noted that legislation is not the only instrument of public health policy; that responding to cases and clusters of infectious diseases is one of the core functions of the Public Health Agency; that the PHA has comprehensive plans in place for responding to COVID-19 clusters, including the Test, Track and Protect programme and the deployment of Mobile Testing Centres; and that much of the progress in bringing down the rate of transmission could be attributed to responsible citizenship and a high level of voluntary compliance with public health advice.

65. My Department has kept this question under review, with the Public Health Agency and the Strategic Intelligence Group, particularly in light of current increased virus transmission in certain District Council areas, and has observed developments and responses in Aberdeen, Leicester, the Irish midlands and elsewhere.

66. The relaxation of COVID-19 restrictions is arguably a factor in increased transmission, however all the relaxations to date have applied across Northern Ireland, so clearly this would not explain variations between District Council areas or between other geographical units such as postcode areas.

67. It is important to recognise that some local outbreaks result in part from clusters of cases associated with particular workplaces rather than higher community transmission in one neighbourhood or a larger geographical area. The current high incidence in Mid and East Antrim DC area (paragraph 17 above) is a case in point. Such clusters can involve workers who commute across an extensive catchment area, with specific risks factors such as car-sharing in addition to the practical difficulties of social distancing in some workplaces. Such risks are addressed in the first instance through interventions by PHA health protection specialists working with other statutory partners and with the employers concerned.

68. PHA has analysed epidemiological data to disaggregate cluster-related cases from local community transmission and seek a clearer understanding of the extent and the possible causes of increased community transmission.

69. In the case of Mid and East Antrim DC, once cases associated with one particular workplace are accounted for, the number of cases per 100,000 population falls from around 55 to around 30. This is still high and a cause for concern. CMO, the Chief Scientific Adviser and colleagues in DoH have considered carefully whether at present there is a case for local restrictions. The immediate and urgent focus is on tackling the cluster. Cooperation by the employer has been poor. Following supportive interventions by PHA, the Agency has now written to the company threatening enforcement action if the company does not comply fully with the Agency, particularly as regards the testing of employees. Taking account of the actions by the PHA, and pending evidence of full cooperation by the company, the Department is now monitoring this situation closely. The impact of the measures being taken will take at least two weeks to become evident.

70. As regards the option of imposing local restrictions in Mid and East Antrim or in parts of the DC area, the Department's position at this point in time is that this is a finely balanced decision and we should allow enough time to see whether the measures being taken have the necessary effect on transmission in this area.

71. More generally, CMO has discussed the existing restrictions with ACC NR and the option of additional, local restrictions. ACC NR has advised that PSNI is ready to use targeted enforcement of the existing restrictions in localities where there is evidence of breaches of the rules, e.g. wet pubs operating illegally. He does not see a case at present for additional power of enforcement.

72. The Department continues to monitor the progress of the epidemic in Northern Ireland and may be in a position in the coming weeks to assess whether the mandatory wearing of face coverings since 10 August impacts on incidence and clusters of COVID-19. From his engagement with the retail sector ACC NR has advised that compliance with the requirement to wear face coverings is around 90%, with no enforcement required.

73. At this stage I recommend that we continue the agreed policy that we should respond to significant local rises in transmission by means other than legislation; that we continue to concentrate on prevention, and that the option of local enforceable restrictions should be kept open.

Recommendation / Decision sought

74. I recommend that the Executive agrees that:

i. the requirement in regulation 3 for a review of the need for the restrictions and requirements in the No. 2 Regulations has been duly met;

ii. the No. 2 Regulations continue to be an appropriate and necessary 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. overall the restrictions and requirements imposed by these Regulations continue to be proportionate to what the Regulations seek to achieve, which is a public health response to that infectious disease threat, and

iv. the imposition of restrictions in response to high rates of transmission in local areas should not be adopted at this time but this option should be kept open.

LPP/LAP

ROBIN SWANN MLA
MINISTER OF HEALTH

Annex A

Summary of restrictions in the No. 2 Regulations

The No. 2 Regulations:

- require the closure of certain businesses, services and premises listed in the Schedule, except for limited permitted uses, specifically:
    - bars, including bars in hotels;
    - public houses and
    - clubs registered under the Registration of Clubs (NI) Order 1996;

- require the closure of:
    - theatres;
    - nightclubs;
    - conference halls and conference facilities, including those in hotels;
    - concert halls and
    - soft play areas;

- impose restrictions on gatherings, both indoor and outdoor, of more than 30 people, unless for certain purposes and
    - if the organiser or operator of the gathering has undertaken a risk assessment and complies with relevant guidance,

and

- impose restrictions on gatherings in private dwellings, of more than 30 people outdoor or 10 people indoor, subject to exceptions.