COVID-19 Strategic Intelligence Group

3.00 pm on 1 June 2020 by Zoom Video Conference

Present:

Professor Ian Young	Chief Scientific Officer, DOH
Dr Michael McBride	Chief Medical Officer, DOH
Dr Lourda Geoghegan	DCMO, DOH
Professor Hugo Van Woerdon	Director of Public Health, PHA
Professor Frank Kee	Centre for Public Health, QUB
Professor Diarmuid O'Donovan	Centre for Public Health, QUB
Dr Declan Bradley	Consultant Public Health Medicine, PHA
Professor Stuart Elborn	Faculty Pro-Vice-Chancellor, School of Medicine, Dentistry and Biomedical Sciences. QUB
Dr. Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Dr. Eugene Mooney	Senior Statistician, DOH
Professor Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Dr. Stephen Bergin	Assistant Director Public Health – Population Screening, PHA
Tricia Lavery	DOH (Secretariat)

Apologies

Dr Jenny Mack	Public Health Registrar ST4, DoH

Welcome

1. Prof Young welcomed participants to the meeting and confirmed that all were content with the note of the last meeting.

   1.1. There were two actions from the previous meeting:

      1.1.1. In Para 7.1 there is an issue to be raised at the next meeting with ROI colleagues, which will be actioned when this meeting takes place.

      1.1.2. Paper relating to the duration of isolation and serial viral culture results has been circulated.

Status Update

2. Prof Young presented slides on current status to update the group.

   2.1. In general there has been a gradual fall in terms of number of cases etc. over the weekend in keeping with R being below 1. Data relating to mobility trends in the community was shared. This shows a progressive increase in mobility, growing more steeply with time.

   2.2. Data on different categories of travel, with zero being the baseline, shows that in terms of parks and beaches the figures have risen above baseline levels, so there are more of these journeys than there were pre-lockdown. This can be related to the impact of the warm weather and the willingness of individuals to travel to beaches, parks etc for recreational purposes.

   2.3. The modelling group continues to work on a new predictive model, trying to use a combination of early indicators to predict what will happen to R. Nearing the end of the initial 10 day period, the data shows that the trend in R was predicted very closely, although the margin of error starts to increase approaching the end of the 10 day period. Given that it can take up to 3 weeks to see the impact of behavioural changes on the value of R, consideration may be given to expanding the period of the predictive model to a 3 week period. Some indicators being used are the N111 calls, GP calls and number of positive cases and the group are looking at additional early indicators to include as the model develops.

   2.4. The modelling group are also now working on a different type of dynamic model, aligned to the one discussed by Independent SAGE, and will continue to run multiple models in parallel in the future.

Reasonable Worst Case Planning Scenario (Paper 2)

3. Prof Young presented the paper, which was prepared at the behest of the

Cabinet Office by SPI-M, with the intention of using its outputs for planning purposes in England.

3.1. It proposes that R is allowed to rise to 1.7 for a period of 4 weeks before re-introducing severe restrictions and bringing R back to about 0.7, until cases return to the baseline level.

3.2. In general this is not considered to be a reasonable worst case planning scenario for Northern Ireland. Allowing R to rise to 1.7 does not align with the current Executive plan and the gradual easing of restrictions. We would hope to identify any smaller rise in R significantly before that. Colleagues in Wales and Scotland hold similar reservations about the suitability of this scenario as a reasonable worst case for planning purposes.

3.3. The modelling group plan to carry out modelling looking at R values ranging from 1.1 up to 1.5 but no higher, and to subsequently show the potential impact of such values in terms of likely hospital admissions, ICU occupancy etc. Policy considerations following this could then lead to the selection of one R value from the range for use of a reasonable worst case scenario for planning.

3.4. The purpose of this paper and associated data is to enable NHS England to plan for futures, and it may not yet have been discussed with the devolved administrations. There was concern amongst the group at the high value of R used for this scenario and there are also concerns at the rapidity at which the restrictions are being relaxed in England and that this paper indicates a willingness to accept a greater risk than we would be content with in NI.

3.5. Previous modelling in NI showed that an R value of 1, if not responded to, would take our capacity to manage the epidemic to its limit, with potential numbers of patients in ICU to between 200-250 at peak. However at that stage it was not being considered as a reasonable worst case scenario. A previous paper considered by the UK CMO's had looked at keeping R below 1 or running R at or below 1.2. The collective view at that time was, to minimise the impact in terms of hospital admissions, ICU occupancy and deaths, that R needed to be maintained below 1.

3.6. Prof. Young agreed to feed the comments of the group back and will bring a further paper to this group which looks at scenarios for a range of lower values of R and potential impacts of these to enable consideration of what would be a reasonable worst case scenario for NI for planning purposes.

Preventing Outbreaks in Forgotten Institutional Settings (Paper 3)

4. Prof Young presented the paper which was a PowerPoint presentation to SAGE discussing a number of institutional settings, and invited comments from the group.

4.1. Hospitals and Care Homes have been considered in detail, and there has also been some considerable work done in prisons. Cruise ships are not a problem here in NI at the moment, but we may need to consider homeless hostels and long stay mental health settings.

4.2. Policy colleagues have been working on the long-stay mental health settings and as we begin to relax shielding, considerations need to be given to the significant number of individuals with learning disabilities who are otherwise fit and healthy but have been shielded to protect them. Many of these individuals have not had home visits or family visits since mid-March and there is now an urgent need to have conversations with those relatives and family members and, where practically possible, with the individuals themselves to allow either safe home visits or family visits to the facilities whilst at the same time minimising the risk of outbreaks in those facilities.

4.3. Work has been ongoing by PHA with the homeless sector in relation to homeless hostels etc. and it is not considered to be a pressure point at the moment. Public Health England are in the process of drafting an SOP for homeless settings and hostels which will provide further guidance on those settings.

4.4. There are approximately 15,000 domiciliary care workers across NI providing care to up to 25,000 service users. As the same care worker will visit multiple service users' homes daily they may need to be considered as a group also, however this may be covered further in Paper 4 in the meeting pack today.

4.5. In terms of Halls of Residence, within NI these mainly comprise the two universities, both of which still currently have a number of students residing in a variety of geographical locations. There are remarkably few incidences of positive cases amongst this grouping, but this may become an additional touchpoint in September as students return. Consideration also needs to be given to the Holylands area as it could be regarded one very large house of multiple occupancy (HMO) with students tending to move freely between the houses there. An HMO does not lend itself well to the limitations that would be required to protect both the students and others they are in contact with.

4.6. As these are potential areas for new outbreaks in coming weeks and months, consideration may need to be given to contact tracing within those facilities and also to what preparatory work can be done at this early stage. There may be merit in considering some swab testing or serology testing amongst this student population, given that their age would correlate with having only limited mild symptoms. There have already been some discussions this week around having some walk-in centres for contact tracing testing and a location in the Holylands area would be ideal, whether in a QUB building or some other building in close proximity. Other institutions to consider in NI are meat processing factories and mushroom pickers who tend to be housed in HMOs.

Communicating Behaviours to Reduce Transmission between Social Networks (Paper 4)

5. Prof Young presented the paper, published by SAGE which looks at communicating behaviours to reduce transmissions between social networks.

   5.1. The paper addresses the risks associated with individuals who have relatively large numbers of contacts by virtue of their occupation e.g. teachers, hairdressers, people working in retail etc. each of which grouping contains large numbers.

   5.2. Observations over the weekend highlighted concerns with HSC staff seen to be not socially distancing when outside clinical areas and it highlights again the complexity of messaging in this area. Evidence gathered from England suggest that a high proportion of transmission in hospitals stems in part from staff not maintaining social distancing when they are not directly attending to patients. There are a suite of areas that will become important as various groups like schools, hairdressers come back to work, such as staff rooms, tea-rooms, toilets etc.

   5.3. The paper has a useful focus on identifying sub-groups of individuals who, by virtue of their occupation, end up with substantial networks and who are therefore potential conduits for infection.

   5.4. The principles outlined in the paper are very helpful. As we start thinking about more people returning to the workplace, there is a need for simple messaging that indicates the packages and tools available, provides good examples to follow and increases awareness around the situation.

   5.5. A guidance document for the various sectors around the regulations is being prepared for publication in early June. It may be useful to look at some further specific tailored documentation for each of the sectors eg universities, schools, businesses, tourism etc to inform what arrangements they need to put in place. It is also likely that England will develop a series of toolkits on the back of this paper and these could potentially be adapted for use in NI. The references included at the end of the paper may also provide a good starting point to create a toolkit template for use alongside a co-production approach with the various sectors to help them work through the steps and to get the basics in place.

ACTION: DoH to consider how they can engage with other departments around some of this messaging.

JBC Alert Change Criteria (Paper 5)

6. Prof Young presented the paper which came to SAGE asking for the views on SAGE on the Joint Biosecurity Centre (JBC) and how it was intended to work.

    6.1. There remains a significant lack of clarity in terms of how Scotland, Wales and Northern Ireland will interact with the JBC. It is proposed that the JBC will have 5 levels of alert, with level 1 indicating no incidence of COVID-19 anywhere and effectively this will not be reached until a vaccine is in use. This leaves 4 levels to work with.

    6.2. Ministers in England have commented that they the UK is currently transitioning from level 4 to level 3 and thus are introducing further relaxations, however JBC have maintained the alert level at level 4. It is the 4 UK CMOs that advise the alert level and they agreed for their own countries that the alert level should remain at 4.

    6.3. None of the descriptors used relate specifically to any of the devolved administrations and so we continue to reserve judgement in terms of the nature of our interaction with JBC and no final decision has yet been made. Because the way JBC will operate has not yet been fully worked through, and in particular how it will interact with the devolved administrations, no recommendations have been put to ministers here as yet and discussions are thought to be still ongoing with Cabinet Office.

    6.4. Prof. Young proposed that we return to this topic once there is more clarity

Duration of Isolation (Paper 6)

7. Prof Young presented the paper which describes the thinking around the period required for self-isolation.

    7.1. The paper shows the UK in comparison with certain other guidelines and countries and suggests that as the number of cases falls in the community there may be a shift from a self-isolation period of 7 days to one of 10 days.

    7.2. As there were no comments or questions the paper was noted.

AOB

8. In response to a question from the group on the latest position of Test, Trace, Isolate, Support, Prof Young advised that this will be on the agenda for the meeting on 4 June, and there will be discussion on the associated paper that will be presented to the meeting. The Executive strategy states that we need to have a robust, well-established and effective test and trace programme, and indeed we

are ahead of the rest of the UK in launching our programme and anecdotally we are currently doing better in terms of the percentage of cases being contacted within 48 hours.

8.1. Prof. Young commented that there has been further media coverage on this today which is focussing on the need for symptomatic individuals to get themselves tested. Currently the number of cases being detected is lower than expected and part of the issue is thought to be that only a small proportion of people with symptoms are currently arranging to be tested. It is hoped that as a result of this new media coverage more people will get tested. Whilst this may result in an increase in the number of cases this does not equate to an increase in the activity of the epidemic, it is just an indication that the ability to pick up cases is improving.

Date of next meeting

9. Next meeting will be on Thursday 4 June at 3pm and will be via Zoom video conference.