

COVID-19 Strategic Intelligence Group

3.00 pm on 4 June 2020 by Zoom Video Conference

Present:

Professor Ian Young	Chief Scientific Officer, DOH
Dr Michael McBride	Chief Medical Officer, DOH
Dr Naresh Chada	DCMO, DOH
Professor Hugo Van Woerden	Director of Public Health, PHA
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
Dr. Damien Bennett	Consultant in Public Health Medicine, PHA
Tricia Lavery	DOH (Secretariat)

Apologies

Dr Jenny Mack	Public Health Registrar ST4, DoH
Professor Frank Kee	Centre for Public Health, QUB
Dr Lourda Geoghegan	DCMO, DOH

Welcome

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

Status Update

2. Prof Young presented slides on the current status of the epidemic to update the group.
 - 2.1. The value of R for this week is in the range 0.7 to 0.9. This value is based on NI modelling and was presented to the Executive this morning and thus they have announced that they are proceeding with the relaxations agreed to commence on Monday 8 June.
 - 2.2. Analysis of the various UK-based modelling groups' estimation of R for NI for the past week is much more consistent than previously with our own modelling and shows median values of 0.7-0.9. Comparison of the other UK nations, using the UK modelling data, shows the NI estimate of R to be very similar to Wales, with Scotland lower and England higher than the NI estimate. We would further estimate that NI has probably half the number of cases per head of population compared to the rest of the UK.
 - 2.3. Looking at the NI predictive model, which has now been extended to give a 3 week view, it is not predicting any rise in R above the 0.9 level. Tracking against actual values of R will continue and we will review again at the next meeting.
 - 2.4. In response to a question from the group, Prof, Young advised that the effect of behaviours over the past weekend will not be reflected in the R value for approximately 2 weeks.
 - 2.5. The number of new positive cases per day has been quite low for the past few days and as numbers become low, then R becomes less important because R may begin to rise above 1 despite there being very low levels of infection in the population. This highlights the point that R on its own is relatively uninformative at very low levels of activity.
 - 2.6. A new modelling set from the UK groups predominantly based on back-calculations from hospitals admissions etc. and looking at tests and assumptions around the percentage of COVID cases who end up in hospital, estimates that in NI we currently have in the range of 500 - 1000 cases per day. However our modelling puts this estimate in the range of 200-300 cases per day, and we are currently only detecting single figures or low-double figures per day. It would be expected if there were 300 cases per day, 100 would be asymptomatic, the remaining 200 being symptomatic.

- 2.7. There is therefore a pressing need to push the message that everybody who is symptomatic must get a test to ensure we are getting a true sense of the number of cases actually occurring daily. Recent figures from primary care settings suggest that up to 500 per day are being advised to self-isolate.
- 2.8. The letter issued last week to GPs around the Contact Tracing Service advised that all individuals who are symptomatic are recommended to present for a test or are directed towards the 119 number and the various options for booking a test. There is more than sufficient capacity within the testing programme to facilitate any tests required. Work is ongoing to co-ordinate DoH /PHA communications to ensure the public message is clear around the need for testing and how to book a test. It is very important that the public are aware that all individuals with symptoms should book a test, even before they are advised by their GP to self-isolate. In addition, people should be aware that they can also get multiple tests if they develop symptoms more than once.
- 2.9. In consideration of a potential Reasonable Worst Case (RWC) scenario for planning purposes, the RWC scenario adopted by England is for R to be allowed to increase to 1.7. However, our modelling group feel this is not realistic for Northern Ireland.
- 2.10. Modelling was completed locally for NI taking a starting point of 8 June i.e. from the introductions of the most recently announces relaxations. This indicated that if R is allowed to rise to 1.7 we could expect to see around 70 patients in ICU after 4 weeks, which is similar to what was observed in wave 1. If the full restrictions were then re-imposed, the figures would fall back again over a number of weeks. The UK modelling using the RWC scenario gives an ICU occupancy estimate for NI of 500, which is far removed from our local modelling estimate.
- 2.11. Further local modelling was carried out values of R of 1.2, 1.3 and 1.5. This showed that if R rises to 1.2, we would reach a level of 100 COVID patients in ICU by December, if R rises to 1.3, the same level would be reached by September, and allowing R to rise to 1.5, we would reach an ICU occupancy of 100 by August. There is confidence that we can definitely detect R rising 1.2 and above, so there is now the need for a policy decision around what the RWC scenario should be adopted for planning purposes for NI. A RWC scenario based on an R value of 1.2 is considered to be the best option for planning purposes and would be consistent with previous discussions amongst the 4 UK CMO's and with previous advice to Minister.

Physical distancing, face masks, and eye protection (Paper 2)

3. Prof Young presented the paper, which was published in The Lancet and looks at physical distancing, face masks, and eye protection.

Social Distancing

- 3.1. In terms of social distancing the analysis shows that 2 meters is at least twice as good as 1 metre in terms of risk of transmission of infection, but it also shows that a 1m is still effective to some degree. SAGE maintain the view that they are not inclined to recommend a distance of less than 2m based on the evidence, and this paper tends to support, from a transmission perspective, the same 2m option rather than a 1m distance. Observations amongst the general population would suggest that the percentage of the population continuing to adhere to the 2m guidance has become relatively low.
- 3.2. A paper is expected to come to SAGE next week looking at the impact of mask wearing in relation to distancing. This will assess mask-wearing as a potential mitigation for situations where 2m cannot be observed and this will be re-visited following discussion of the paper at SAGE.

Face Masks

- 3.3. The paper references different types of masks ranging from the N95-type masks to cotton face-coverings. If there were no issues around supplies of N-95 masks there would be a case for encouraging wider use of such high-level masks, but that is not possible at this moment in time.
- 3.4. The paper suggests that whilst the N-95 mask is very useful to protect the wearer, other types of face-coverings are more useful to protect the wearer. The paper does not provide a clear basis on which to change our current messaging which is to encourage the wearing of face coverings in enclosed settings. However, the view of the group was that messaging should be strengthened to “recommend to wear” as opposed to “recommend *to consider to wear*”.
- 3.5. The message and the focus for the general public is around wearing face coverings rather than face masks to ensure additional pressures are not places on PPE supplies.
- 3.6. It was commented that advice on face-coverings is mainly intended for members of the public, whilst any advice on face-shields is more suited to workplace and also possibly educational settings.

In summary, the issue of face-coverings has been discussed and considered by the group and feel it would be reasonable to reinforce and strengthen existing messaging to say “people are recommended to wear face-coverings in enclosed settings” with emphasis on it being something to do to protect the people around you.

Non-pharmaceutical interventions modelling (Paper 3)

4. Due to time pressures, this paper will be carried forward to a subsequent meeting

Contact Tracing (Papers 4a & 4b, presented by Dr. Mitchell & Dr. Bennett)

5. Prof Young invited Dr. Mitchell and Dr. Bennett to present the paper on contact tracing in NI.
 - 5.1. Dr. Mitchell presented the paper (Paper 4a), the first part of which includes details on the concept and mechanics of the Contact Tracing Service. The main body of the paper looks at the metrics used to measure the effectiveness of the Service, what can be collected currently and what it is hoped can be collected in future for both public health reasons and to ensure that we are delivering an effective contact tracing service to help reduce the value of R.
 - 5.2. Appendix 1 of the paper describes what can be achieved currently in terms of metrics around number of cases and number of contacts. There is an issue around time stamping at present as there is a lack of data on the time-stamping it takes for test results to reach PHA which will need to be factored in, but the bulk of calls to contacts are made within the 24-48 hours window from test results are received.
 - 5.3. There is a short second paper presented today (Paper 4b) from Philip Vale, PHA which looks at the plans to capture some of that time-stamping information in the near future.
 - 5.4. Dr. Bennett presented the Appendix 2 section of Paper 4a which is a brief description of the contact tracing database and associated metrics.
 - 5.5. Issues around extraction of the data from the MS Dynamics platform should be resolved with the move to the Epi-info system which should go live this weekend.
 - 5.6. The key 6 metrics are considered to be:
 - number of cases per day;
 - number of cases successfully contacted per day;
 - Percentage cases contacted within 24 hours of test results;
 - number of contacts per case;
 - number of contacts successfully contacted per case; and
 - Percentage of contacts reached within 48 hrs of test and advised to isolate.
 - 5.7. The paper mentions some caveats around these metrics such as the lab results coming in 3 batches at differing time points and the need to look at options for better recording and/or reporting around this.

- 5.8. Prof. Young commended all involved on the huge amount of work achieved to date. The number of contacts per case appears low at present compared with other countries, which have ranged from 3 to 30. This could be explained by the fact that, to date, the majority of positive cases have been HSC staff many of whom have chosen to live in isolation and away from their household whilst working in COVID settings and so their household contacts would be expected to be low, and their occupational contacts would be traced through internal HSC routes.
- 5.9. It was noted that we contact-trace 100% of cases within 24 hours and congratulations were due to all involved for that.
- 5.10. There was some discussion around the process of making contact with cases and contacts as the telephone number used for outbound calls displays as a withheld number. Whilst cases and contacts are advised to expect a call from the Contact Tracing service within a few minutes which will display as a withheld number, there is still an urgent need to take further steps to provide public assurance as to the validity of the calls to ensure people know to answer the call, rather than ignore it. The focus group work carried out by Big Motive, which will be discussed at the Steering Group on Friday 5th June, may give some insight into whether this is an issue, and the team will continue to consider further actions around this issue.
- 5.11. In terms of tracing unknown contacts, there is a proximity App in development in the UK (NHS-X) which should be available mid-June and will give such information. There is also a similar App in development in ROI which is different to the UK one, and investigations are ongoing to look at a local de-centralised App for NI to interact with that. Considerations are also been given to the inter-operability of the NI App with both the UK and ROI Apps. There is a lot of public focus and concern from a human rights perspective and also from the ICO and Equality commissioners etc. around the proximity App connected to data storage.
- 5.12. There are no current issues around the capacity of the service and the ability to flex it upwards as demand requires using either the bank of Tier 2 staff housed in Ballymena or using the NI Direct option to undertake the more straight-forward call-handling of low risk contacts. Development of a NI equivalent of the UK CTAS platform is underway which should be operational by the end of June and which will enable positive cases to enter their own contacts independently of the other options.
- 5.13. Prof. Young advised that there were a few papers discussed at SAGE today which looked at the concept of “super-spreaders” and the suggestion of possible 80% of new cases will be attributable to 10-15% of individuals and how these could be identified. These papers will be brought to the next SIG meeting for discussion.

AOB

6. As there was no other business, the meeting ended.

Date of next meeting

7. Next meeting will be on Monday 8 June at 2pm and will be via Zoom video conference.