COVID-19 Strategic Intelligence Group

12.00 pm – 7 September 2020 - Zoom Video Conference

Present:

Professor Ian Young (Chair)	Chief Scientific Advisor, DOH
Dr Michael McBride	Chief Medical Officer, DOH
Dr Lourda Geoghegan	DCMO, DOH
Dr. Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Professor Hugo Van Woerdon	Director of Public Health, PHA
Dr Declan Bradley	Consultant Public Health Medicine, PHA
Professor Diarmuid O'Donovan	Centre for Public Health, QUB
Professor Stuart Elborn	Faculty Pro-Vice-Chancellor, School of Medicine, Dentistry and Biomedical Sciences. QUB
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Dr. Michael Quinn	Head of Clinical Information, HSCB
Tricia Lavery	DOH (Secretariat)

Apologies

Dr Naresh Chada	DCMO, DOH
Dr. Eugene Mooney	Senior Statistician, DOH
Dr Gerry Waldron	Asst. Director of Public Health (Health Protection) PHA
Professor Frank Kee	Centre for Public Health, QUB
Professor Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University

Welcome

1. Prof Young welcomed all participants to the meeting. There are no papers for today's

meeting, as the only item for discussion is the current status of the epidemic giving the ongoing increases in cases and the need to discuss what guidance and advice should be given to Minister and the Executive.

1.1. Prof. Young confirmed that all were content with the note of the last meeting Actions from the previous meeting were reviewed:

1.2. The following action points were reviewed

ACTION: Further investigation be undertaken to establish if there is a governance issue preventing the sharing of HSC numbers with the CTS and if there is, to see how this can be resolved.

Action Closed: Prof. O'Donovan confirmed the issue has been resolved.

ACTION: Prof. Young to share the latest research paper on estimating levels of prevalence in the population with the members of the group.

Action Closed: Paper shared with meeting papers today.

ACTION: Prof. Young to forward the 2 papers on large events and gatherings to Karen Pearson, TEO and ask her to subsequently share them with the appropriate sectors.

Action Closed: Papers forwarded.

ACTION: Professor Young to be forward the Paper on FE and HE settings reopening to the FE sector leads via Karen Pearson. TEO.

Action Closed: Paper forwarded.

Status Update

1. Prof Young provided an update to the group on the current state of the epidemic.

1.1. There has been a significant increase in cases over the weekend across the UK which is causing national concern and is the subject of significant current discussion. The NI number of cases shows an increase which plateaued towards the end of the week around the high 60s before rising further again over the weekend This figure has risen shown a substantial rise from early July.

1.2. In contrast the number of hospital admissions has declined significantly over the last week and the level today is similar to that seen in early July. There is therefore a considerable mismatch between hospital admissions and cases that are being

detected.

1.3. In terms of the number of COVID inpatients, the 7 day rolling average has increased steadily from early July but then plateaued and has now come down over the past few days. This is in line with the number of hospital admissions, and is currently falling despite the rise in cases.

1.4. As the main source of calculation of R is the number of hospital inpatients, and in line with that figure, R has fallen to below 1 in the last few days having been persistently above 1 for most of August. The value of R for cases is determined separately and that figure is just above 1, running at between 1.1 and 1.2. Normally a single figure of R is published weekly which covers both inpatients and cases, and this week is likely to be estimated at between 0.8 and 1.4.

1.5. Considering this current position of a substantial rise in cases with no signal in hospital admissions or deaths, there is a need to determine the reasons behind this.

1.6. Currently the cases are predominantly younger with approximately 90% of cases in the under 60s, whilst at the same level of cases in Wave 1, 50% of cases were in the under 60s. It is likely that the epidemic is not any different but the current testing regime is very different because in wave 1 only the very unwell were tested whereas now anyone with symptoms is offered a test, and there is also some screening being carried out. We are therefore most likely seeing a different mix of cases now, and as the under 60s are unlikely to end up in hospital, the number of hospital admissions is low.

1.7. Along with this, looking at the evidence in behavioural terms, from the contact matrix survey, there was a marked increase in contacts among younger people but little evidence of an increase in contacts among older people, and the older people would appear to be still quite cautious about mixing with other contacts whilst younger people do not.

1.8. The most likely follow-on from all this is that we are currently in a lag period and if the epidemic continues to increase we will see spread into the older population and we will then see a rise in hospital admissions etc. However some other hypotheses also need to be considered, such as:

- It is possible that resistance to the virus is greater than we expect and that consequently, even in older people, we are now less likely to see severe disease. This could perhaps be due to T-cell related factors in terms of immune function which cannot be easily measured and which could be linked to previous exposure to related viruses. If this was true, it would assume that there was a lot of exposure to COVID in wave 1, more than was originally thought, and that there is a significant group of the population who don’t really get ill as they have resistance to the virus.

- It is possible that there are different decisions now being made around hospital admissions with anecdotal evidence showing an increase in the use of “hospital-at-home” type approaches for people who are becoming

severely ill. However it would be expected to see an increase in deaths if this was correct and this is not the case. There is no doubt that there are better treatments available but the most that could be expected with these would be a one-third reduction in mortality and would not really explain the reduction in hospital admissions so this is perhaps not a useful explanation for the current situation.

- Finally, there is a school of thought which argues that current test results are misleading and it is already known that a proportion of people who have previously had COVID will continue to have a positive PCR test for quite a long time without having infectious virus. Whilst it is widely accepted that this is a small scale phenomenon which only applies to those who had quite a severe form of the disease, others would argue that it is much more widespread and that a lot of positive tests currently being detected might be misleading.

1.9. It is important for this group to be aware of the range of potential explanations for the current situation in terms of determining the necessary steps to take in tackling the epidemic. The virus is not spreading equally across NI, and looking at the latest figures for the cases per 100K over a 7 day period by Local Government District (LGD), the variation is clear. There had been a big increase in Mid & East Antrim, associated with the meat plant outbreak, which has now fallen back. For some time the big concern has been Belfast, and over the weekend Belfast rose to 54 and today is sitting over 60 per 100K over 7 days.

1.10. Due to concerns about this and a lack of any easy explanation it was decided to ask for a further breakdown by postcode. Thanks for this data are due to Paul McWilliams from SIB. This data shows the top 8 postcodes in terms of the same metric which are (in decreasing order): BT29, BT43, BT17, BT12, BT9, BT28, BT11 and BT5. BT29 is outside Belfast and covers the Crumlin and Lough Neagh area extending from Belfast and it is known that there is a large cluster associated with a social gathering in a pub in Crumlin which has a large number of associated cases. BT43 is the Ballymena area, BT28 is Lisburn, and the remaining 5 postcodes on the list are within Belfast, mainly in the west and south. These numbers are at levels that are at least as high as areas in the UK where local restrictions have be implemented, and in some cases the levels here are actually higher than that. These numbers are of significant concern and in some cases the numbers are very bad.

1.11. This group now needs to consider what to do, bearing in mind that we are in the strange situation of no hospital admissions. There are several options to consider:

- **Option 1**: Continue to observe and take no action, waiting on a signal from hospital admissions before putting in place further restrictions.

- **Option 2**: To consider targeted restrictions, looking most probably at postcodes, but given the lack of any signal of where these cases are coming from it would be difficult to know what to focus on. The approach in

Glasgow, where they have stopped all household visits of any kind, other than where households are in bubbles etc. could be used as a basis for this option.

- **Option 3**: Give specific advice to Care Homes around visiting in these postcode areas, and to those previously shielding and the elderly within these areas, flagging up that cases are particularly high in that area and therefor they should be particularly careful.

- **Option 4**: To introduce more general other restrictions for NI or some local restrictions which would also consider pubs and restaurants and other places where people meet together.

1.12. This is a clearly a very difficult stage in the epidemic and the advice of this group is sought on the best option to recommend to Minister as the way forward. The picture in NI is broadly similar to that in the rest of the UK and the anxiety here around the increasing numbers is shared across the UK. The situation in RoI is similar, with Dublin being a particular area of concern and again cases here are not associated with any major outbreaks, but considered to be a household or community spread. They have however reported an increase in cases in the over 75's.

1.13. Seroprevalence is estimated around 5-6% which would suggest that there is a large proportion of the community that has not yet been exposed and would support the thought that this is a lag period and therefore there are still a large proportion of vulnerable people potentially who have not yet been exposed to the virus.

1.14. There was a general discussion on the current situation and the options proposed. The group were clear that there is clearly a need for some action now rather than later, and there would be great concern about the risk to Care Homes given that there is an early indication of rising numbers of cases in these settings. There is more concern around the interactions that occur around school settings rather than within the schools themselves. Other than the BT29 postcode the remaining cases would be indicative of community transmission given there are low numbers from clusters. Interventions by postcodes is the obvious option given that people know the postcode they live in and it has previously been made public that a level of 80 cases per 100K of population would be the threshold for local interventions. This would therefore include BT29, BT43, BT17, BT12, BT9 and BT28 using today's numbers however it is anticipated that BT11 will cross this threshold later today.

1.15. There was a concern that there is not a universal pictured of levels of accessing testing across the province and it was agreed to ask the modelling group to see if they can extract any data around testing volumes across NI. It was noted that in some communities or social groups there may be some reluctance to be tested given the consequences of receiving a positive result which may put people of having a test result which may require their household to isolate.

1.16. In recent weeks there has been a reduction in the number of people who are able to meet either inside or outside and yet we have still seen a rise in cases, suggesting that more needs to be done. SAGE have always been concerned also that the reopening of schools would lead to an increase in interactions outside of schools. It is clear that there is a need to reduce the interactions people have at present, and the approach in Glasgow is a good option. Whilst this will have social impacts for people and households, it will have a lesser economic impact that having to close bars and restaurants etc. again. There may need to consider actions on hospital visiting, given that BT12 includes the RVH.

In Summary it was agreed to recommend to the Executive, who will make all decisions, the option of introducing general population measures or focussing on higher risk areas, stating that there is a need for very clear messaging to the population on an NI-wide level. If the Executive do not want a population-wide approach then they should be aksed to consider application of measures in the highest risk areas, defined by the threshold of 80 cases per 100K of population. However it would need to be pointed out that, similar to the overseas travel situation, the areas which are high risk may change rapidly and they may find themselves needing to give different advice out 2 or 3 times per week as levels of infection increase in different areas. It would be prudent also not to take an area out of restriction until levels have fallen by at least 50% (i.e to at least under 40 per 100K of population). The restrictions planned would be no household visits indoors with a small number of exceptions to cater for extended families, bubbling for single individuals etc. This may also include having no meetings in gardens etc. and it may also consider applying restrictions to numbers at tables in restaurants etc. to ensure no mixing of households in these settings. Consideration needs to also be given to restricting visitors to Care Homes and to advise the elderly and those previously shielding to be extra vigilant at this time.

Date of next meeting

2. The next meeting will be on Monday 14 September at 12pm and will be via Zoom video conference.