

COVID-19 Strategic Intelligence Group

10 January 2022 at 13:00 – Zoom Video Conference

Present:

Professor Ian Young (Chair)	Chief Scientific Advisor, DoH
Dr Lourda Geoghegan	DCMO, DoH
Dr Naresh Chada	DCMO, DoH
Dr Joanne McClean	Associate DCMO, DoH
Professor Stuart Elborn	Faculty Pro-Vice Chancellor, School of Medicine, Dentistry and Biomedical Sciences, QUB
Professor Diarmuid O'Donovan	Professor of Global Health, Centre for Public Health, QUB
Professor Duncan Morrow	Director of Civic Engagement & Student Affairs, Ulster University
Dr Bríd Farrell	Acting Director for Public Health, PHA
Dr Nicola Armstrong	Programme Manager, PHA
Dr Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Dr Gillian Armstrong	Consultant in Health Protection, PHA
Dr Eugene Mooney	Director of Information and Analysis, DoH
Dr Sophie Davidson	ADEPT
Jonathan Norwood	Secretariat, DoH

Apologies:

Professor Sir Michael McBride	Chief Medical Officer, DoH
Dr Declan Bradley	Deputy Chief Scientific Advisor, DoH
Professor Frank McKee	Centre for Public Health, QUB
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford

Welcome, Introductions and Apologies

1. Prof Young welcomed all participants back to the meeting.
 - Apologies were as noted above.
 - Minutes from the previous meeting (**Paper 1**) were agreed.

Update on Disease Status

2. The group discussed messaging for the next stage of the epidemic. Prof Young provided an update on the current position of the epidemic:
 - A positive LFT no longer requires confirmatory PCR.
 - There was a rapid increase in case numbers up to the middle of last week. Test strategy changed and the advice altered to positive LFTs no longer requiring a confirmatory PCR. Individuals are encouraged to report results. Case numbers have thus fallen rapidly. Is this due to an alteration in testing behaviour or a reduction in virus transmission or a combination of both?
 - Dr Farrell summarised the current testing position. PCR demand has decreased drastically by almost 70%. The high daily numbers still being reported might be attributed to a clearing of a backlog of samples. Consequently, there has been a dramatic increase in LFT results being reported.
 - Test positivity reached 30% but has also decreased and this will continue with the revised guidance. It is likely that there are also many positive LFTs unreported, which means that positivity is not a reliable indicator going forward either.
 - The most critical indicator is the number of people in hospital. Case numbers are not a reliable or useful indicator currently due the significant drop in testing with the revised guidance.
 - Is there an estimate of how many people in Northern Ireland have had COVID-19? ONS data suggested that as many as 1 in 10 people had COVID-19 in Northern Ireland over the Christmas period. This is very high but still equates to 9 in 10 people remaining uninfected.
 - There were over 367,000 positives in 2021 of which approximately 130,500 were from the 1st December; over a third of cases occurred in the last month of 2021.
 - Due to the recent alteration in testing strategy, it is difficult to ascertain the exact peak of this wave.
 - There has been a slow rise in hospital admission observed.
 - Community acquired inpatient numbers are decreasing.

- 22% of inpatients have hospital acquired COVID-19 and is increasing due to the transmissibility, which will increase hospital pressures.
- Emergency admissions who are positive were also discussed and the proportion presenting with COVID-19 or found to have incidental COVID-19.
- There are 436 inpatients and these numbers are also rising slowly. Discharge rates are also rising, which is keeping the numbers stable at present.
- Length of stay of Omicron inpatients is significantly shorter than for delta by an average of approximately 3-4 days. Dr Geoghegan queried if we have any local data to compare to this data from England. She reflected on the pressures that all admissions are having on the system whether they have been admitted for elective surgery and then found to be positive or otherwise.
- Respiratory support outside of critical care is at a stable rate and has been for some time throughout this wave.
- ICU numbers are stable at 31 of which 25 have the Delta variant. Critical care pressures were discussed in detail.

ACTION: Dr Armstrong to investigate the variant that all ICU patients are infected with and confirm these numbers with Prof Young.

- In summary, hospital pressures will be the most reliable indicator going forward and advice will be given on this basis primarily. The 7 day average will be key given the daily variance of admissions.
- We are at or very near the peak of this wave.
- It is unlikely that there will be a significant rise in critical care pressures. Pressures will be more general hospital pressures and staff absences will contribute to this significantly.
- The group agreed with Prof Young's summary.
- Conversion rate of cases to hospitalisation and multipliers were discussed.
- There are not many restrictions in place. Nightclubs are closed, table service in bars continue and there are limits on household mixing. At what point do we begin to recommend relaxing restrictions? One suggestion is when we are very confident that hospital admissions are continuously decreasing. Case numbers will decrease rapidly now with the change in guidance, which will undoubtedly increase the pressure to remove restrictions.
- The consensus is that continuous decreasing of hospital admissions would be a pragmatic point to consider relaxations. Timely discharge will also be necessary and should be monitored given the likelihood of future outbreaks in care homes.
- What is the end point of our approach to COVID-19? The group discussed the

strategy for the next 6 months and beyond in terms of testing, restrictions, TTP, face coverings, blended working and surveillance.

- TTP will ultimately be stood down and all restrictions will be removed. There may be some long term alteration to behaviours such as working from home as it brings much benefit to the environment and quality of life. Face coverings at certain times of the year and certain settings will be helpful in reducing many types of respiratory infections and are a relatively low cost intervention. We are still some way from that but these discussions are important to gauge the trajectory or to raise aspects that should be maintained in the medium and longer term.

SPI-M-O: Consensus Statement (Paper 2)

EMG: Potential Application of air cleaning devices and personal decontamination to manage transmission of COVID-19 (Paper 3)

Professor Young provided a brief overview of the papers:

- Paper 3 details the use of HEPA filters in schools.
- There is considerable public and political interest given the return of schools. SAGE has considered this and the advice has been passed to the DE and EA.
- The best ventilation is fresh air ventilation; this can be challenging in some classrooms. Where this cannot be achieved and CO₂ monitors indicate poor ventilation, then HEPA filters correctly installed and maintained, might offer some protection and a reduction in infection risk.
- DoH nor PHA are not in a position to quantify the number of classrooms with inadequate supply of fresh air. DE should work with relevant colleagues to assess the risk in each classroom.
- QUB have bought a number of HEPA filters and installed them in a few rooms that cannot be adequately ventilated by fresh air. They provide a level of confidence to lecturers and students but there is no measurable outcome. Routine maintenance is rigorous as filters must be changed and checked. They use a lot of energy and bills at QUB are soaring with heating on and windows open. Consequently, this is detrimental to CO₂ footprint.
- Dr Geoghegan reflected on the Pseudomonas outbreak and learning from the similar idea of applying filters to taps should be considered. A holistic risk assessment is required before mass purchasing and installing of these filters. This would be a considerable investment for an unproven idea. Further thought is required before any recommendations are made and DoH will engage with DE when they begin their risk assessments.
- Class sizes and airflow in buildings might be better places to spend investment and should be further considerations for DE. DoH does not have the aerobiological

expertise to lead on this. DE will lead with input from DoH when appropriate.

AOB

3. Professor Young asked the group to raise any further items for discussion and there being no further business, the meeting closed.

Date of Next Meeting

4. The next meeting is to be confirmed and will be via Zoom.