

COVID-19 Strategic Intelligence Group

2.00 pm 14 May 2020 Zoom Video Conference

Present:

Professor Ian Young	Chief Scientific Officer, DOH
Dr Michael McBride	Chief Medical Officer, DOH
Dr Lourda Geoghegan	DCMO, DOH
Dr Naresh Chada	DCMO, DOH
Dr Gillian Armstrong	SMO, DOH
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Professor Frank Kee	Centre for Public Health, QUB
Professor Diarmuid O'Donovan	Centre for Public Health, QUB
Dr Stephen Bergin	Asst Director of Public Health PHA
Dr Gerry Waldron	Asst. Director of Public Health (Health Protection) PHA
Dr Declan Bradley	Consultant Public Health Medicine, PHA
Professor Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University
Professor Stuart Elborn	Faculty Pro-Vice-Chancellor, School of Medicine, Dentistry and Biomedical Sciences. QUB
Dr Michael Quinn	Belfast Health and Social Care Trust
Eugene Mooney	Senior Statistician, DOH
Wendy Robinson	DOH (minute-taker)

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 updated the group on key developments. An anticipated decline was in evidence in the R value in NI. There were also early indications that the initial increase in infections in care homes was slowing. The Executive had issued a five-stage plan for recovery earlier in the week and any decisions on relaxing of restrictions were awaited. The R value would continue to be closely monitored and a contact survey was to be conducted every two weeks for a period of eight weeks to help assess the impact on the rate of transmission. **Prof Young undertook to provide a paper for next week's SIG meeting on how warning signals might be detected following the easing of restrictions** – the Welsh government were known to be looking at this with a view to implementing what they described as a 'circuit-breaker' approach.

3. It was noted that NI had signalled interest in participating in a new Joint Biosecurity Centre which was being established by the UK Government. It would support the work of the public health authorities by undertaking primarily a surveillance and response function, analysing infection outbreaks and advising the government on how they should be addressed.
4. There was some discussion about the determination of the R value in different jurisdictions. There were known to be variations in modelling approaches which meant that comparisons of R were not always valid. It was noted that some 20% of the London population were now believed to have antibodies, particularly among the younger population. In NI the equivalent figure was thought to be less than 5%.

EMG Paper on the survival of SARS-CoV-2 in the Environment

5. The Group considered a paper on the survival of the virus in the environment. While it was noted that the data in the paper had come from outside the UK, the findings were considered to be helpful in terms of supporting the idea that outdoor activities were relatively low risk.

Care Homes Analysis paper

6. The Group considered a paper examining how best to address outbreaks of the virus in care homes, noting that the data was from England and Scotland. The paper addressed a number of questions, the responses to three of which were discussed as the findings were considered to be potentially of relevance to NI.
7. On the issue of transmission mechanisms between and within care homes it was agreed that the paper did not provide any new information. While Scotland was taking a different approach from the other UK jurisdictions in requiring two negative tests when releasing a patient from hospital into a care home, there was no data to suggest that the overall care home situation in Scotland was better than elsewhere. Indeed, there was a sense that NI was performing relatively well in this area, probably due in part to its integrated health and care system and the small number and size of care homes.
8. On the issue of swabbing and testing, while there was an aspiration to ramp up testing in the NI care home sector it was noted that universal testing was not expected to be possible given the numbers of residents/staff involved and the demand for testing in other sectors. NI was already testing more people per 100,000 than any other part of the UK and had expanded care home testing ahead of the other jurisdictions. The National Testing Programme would be providing some support to the HSC in this area, including four mobile testing units/ the citizens' portal, but in the immediate term there would not be sufficient capacity to carry out care home testing on a weekly basis as suggested in the paper. The top priorities for testing at this stage were any home experiencing two or more cases in a 14 day period, requiring everyone in the home to be tested;

and any home where one person was symptomatic, in which case they alone were tested. Some Trust areas were experiencing lower outbreaks in care homes than others, the reasons for which were not yet fully understood. The PHA had been asked to carry out anticipatory testing in homes that had not experienced an outbreak, primarily on staff, with the aim of keeping them infection-free. There followed some discussion of the *Safe at Home* model where care home staff would 'live-in'. This was currently being finalised and was expected to be issued to the care home sector as a model they might like to follow.

9. On the impact of approaches to risk the paper considered three approaches which were discussed by the Group:
 - 9.1. Non-rotation of care workers – the Group noted that the RQIA inspection team had been re-purposed early in the pandemic to become a support team across the care home/domiciliary care sector. Single points of contact had been implemented in each Trust, and the support provided by Trusts had included supplying staff to care homes and tracking/limiting staff movement between care facilities.
 - 9.2. Cohorting of residents – while most care home residents occupied single rooms, it was noted that it was often difficult to cohort in care home settings.
 - 9.3. Handwashing/surface cleaning – there were challenges in this area and the RQIA inspection team, which included infection control expertise, would be providing valuable support to care homes, as would Trust staff.
10. There was some discussion about social distancing guidance for staff in care settings. **Dr Geoghegan agreed to consider whether this needed to be reinforced**
11. **Prof Young agreed to provide the evidence behind the Care Homes Analysis paper to Dr Geoghegan.**

The Independent SAGE Report

12. While Independent SAGE were not part of the formal response to the pandemic Prof Young had considered it important to table the paper they had produced for any views/points of interest. There were no plans to engage with Independent SAGE/respond to the paper.
13. Generally, it was felt that it would have been helpful if the paper had confined itself to the science, and not strayed into matters of government policy. Some of the issues it highlighted were considered to be already part of the NI response. For example the paper suggested that NI and ROI should be closely aligned in their responses to the pandemic, and the regular ongoing contact between the two jurisdictions was noted. The paper also pointed to the importance of

community engagement/public messaging and this was known to be fully recognised by the NI Executive. Some issues discussed in the paper were flagged as warranting further consideration by the SIG, notably alternative modelling approaches and isolation periods.

14. Given the size of the Independent SAGE paper it was agreed that **it would be helpful to table it again for further discussion** at the next meeting. In the meantime **Prof Young agreed to circulate a paper on isolation periods for information.**

15. Another issue for consideration next week would be 'bubbling'. **Prof Young would table a paper on this from SAGE.**

DONM

Monday 18 May at 2pm. Zoom contact details to be shared in due course.