

COVID-19 Strategic Intelligence Group

3.00 pm on 8 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
Dr Lourda Geoghegan	DCMO, DoH
Professor Frank Kee	Centre for Public Health, QUB
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
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Dr. Michael Quinn	Head of Clinical Information, HSCB
Professor Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University
Dr Jenny Mack	Public Health Registrar ST4, DoH
Dr. Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Tricia Lavery	Secretariat, DoH

Apologies

None noted.

Welcome

1. Prof Young welcomed all participants to the meeting.
 - 1.1. In line with a range of other meetings that are reducing in frequency, the Strategic Intelligence Group meetings will now take place once per week on a Monday at 3pm. As SAGE now meets weekly on Thursday, this allows time to consider which papers from the SAGE meeting are relevant to bring to the SIG meeting. As always, members are welcome to submit any further papers of interest for discussion at these meetings.
 - 1.2. Prof. Young confirmed that all were content with the note of the last meeting. Whilst these minutes are not currently published, they may be published in the future, depending on policy decisions.

Status Update

2. Prof Young provided a status update to the group, which included slides published by the Department of Health last night.
 - 2.1. The estimate of R from modelling remains at between 0.5 - 0.9. The modelling group will meet on Tuesday 16th June to determine this week's value for R.
 - 2.2. In terms of prevalence of current infection, the estimate of community cases is between 300 and 2000. The reason for the considerable range is partly due to uncertainty from modelling and partly due to scientific uncertainty around the proportion of cases that are believed to be asymptomatic. This proportion had been considered to be one third, and this was the figure used in models to date. However, the ONS survey results from England currently indicate the asymptomatic proportion to be around 80%. This is a much higher proportion than previously anticipated and therefore introduces more uncertainty into the estimated number of community cases.
 - 2.3. Serology results indicate that less than 5% of the population have been infected and recovered. This means around 95% of the population are still likely to be susceptible to infection and so in terms of developing population immunity we remain at the beginning of the epidemic.
 - 2.4. R still remains well below 1. Whilst R is slightly higher this week, the longer term prediction is that it will fall again later this week so there is no cause for concern at present.
 - 2.5. Data from the various English modelling groups for the 4 Nations gives a consensus value for R in NI to be 0.6 – 1. In general the R value across the 4 Nations is currently the same. The 7 day rolling average of total new positive tests (including care homes, hospitals and in the community) is 8. An

annotated view will be presented next week, mapping relaxations to this graph to see any impacts of these. The situation seems to have stabilised at the moment with the last few weeks showing a fairly constant low level of new cases which isn't falling, some of which could be due to increased testing, particularly of symptomatic individuals.

- 2.6. Total hospital admissions with community-acquired COVID shows a continuing slow decline, remaining in low single figures daily representing a low level persisting presence of COVID in the community.

Managing infection risk in high contact occupations (Paper 2)

3. Prof Young presented the paper, which is an updated version of a previous paper considered by this group.
 - 3.1. It considers emerging evidence that some occupations and situations pose particularly high risk of infection due to high levels of social connection. This higher risk is linked to increased mortality in some occupations and sectors of the population, including lower income and BAME communities.
 - 3.2. People in occupations involving numerous social contacts of longer duration and close proximity may also be at increased risk of both contracting and spreading COVID-19. Examples of potentially higher risk occupations may include: bus and taxi drivers, social care and healthcare workers and people working in some retail, catering, security, and manufacturing settings.
 - 3.3. One of the key behavioural-change messages is about getting the different groups to take responsibility and ownership, including customers and people using services. However it was perhaps surprising that no issues with cleaners was mentioned as this group would be exposed to residual aerosols and contact with virus-contaminated surfaces. The group agreed to note this group and look for any published research on increased risk.
 - 3.4. The PHE Incident Team meeting this morning discussed the potential for outbreaks in meat factories, and work is ongoing to investigate if this is due to the factories themselves or the fact that the workers tend to have greater social interaction with each other and live together in shared accommodation.
 - 3.5. The next steps in the paper mentions the development of toolkits, and it is understood that BES, PHE and DfE (NI) are engaged in the development of such toolkits for the various sectors. Whilst this is not primarily a health role, DoH have indicated willingness to comment on documents produced and to provide the principles that would help to guide others to develop these toolkits.

ACTION: It was agreed to share the paper with the Department for Economy (DfE) to inform their development of guidance as the economy opens up.

3.6. There being no further comments the paper was noted.

Using masks to mitigate risk of transmission of COVID 19 (Papers 3 & 4)

4. Prof Young presented the paper, which relates to face-coverings and their potential efficacy.
 - 4.1. Whilst the group have revisited this subject a number of times it is appropriate to do to consider any significant new evidence as it emerges.
 - 4.2. The Lancet meta-analysis paper discussed previously considered social distancing, face-coverings and eye protection and their relative importance. The statistical analysis contained in this came under significant criticism over the weekend. It was noted that WHO have now produced a greatly strengthened statement around face-coverings and are now encouraging them.
 - 4.3. England have now made face-coverings mandatory on public transport and within care settings, for staff, patients and visitors, with a small number of exceptions. We had previously agreed to strengthen our advice in NI to firmly recommend face-coverings, however anecdotal evidence would put the level of uptake in shops and supermarkets at less than 5%.
 - 4.4. Prof. Young will attend a cross-departmental meeting later in the week to discuss the face-coverings issue. Recent evidence points towards increased benefits of face-coverings and it would be beneficial to achieve a significant shift in the extent to which they are being used.
 - 4.5. It was agreed that it is unlikely there will ever be a study to definitively answer this question and it therefore becomes a body of evidence decision. Most of the modelling and experimental studies in relation to droplet spread and aerosolisation appear to have reasonably consistent conclusions and to suggest that there is some benefit in wearing face-coverings, especially in those indoor situations where physical distancing cannot be guaranteed. If future policy decisions drifted towards a reduction in physical distancing then the mitigations that wearing face-coverings would bring would be very significant and therefore trying to push this message at an early stage in advance of any change would pay dividends.
 - 4.6. WHO advice is not for 1m distancing but for 1 metre as a minimum. It was noted that there is a particular drive at present for a reduction in the distancing measures in pubs and restaurants etc., and these are environments in which face-coverings would be particularly problematic.
 - 4.7. It was considered by the group that there is not yet strong enough evidence to consider a move to mandatory wearing of face-coverings. However, if considerable efforts were made to encourage much greater uptake and

despite this uptake remained at very low levels there may then be a good case to move to a mandatory position.

- 4.8. It was noted that some of the strongest voices in favour of mandatory wearing of face-coverings at present are coming from organizations representing employees who are working in high risk environment, who view it as a potential protection for those in high-risk occupations if customers have to wear face-coverings.
- 4.9. Discussions in relation to use of face-coverings in healthcare settings have been ongoing.
- 4.10. In relation to waiting areas associated with clinical environments such as Emergency Departments (EDs) and GP Surgeries etc., it was agreed that members of the public could, would and should be asked to assist healthcare providers by wearing face-coverings when attending such facilities. It was also noted that with EDs in particular, risk assessments would need to be undertaken, particular in those EDs where it is impossible to maintain social distancing when the ED becomes very busy and when numbers in attendance cannot be controlled. The Chief Nursing Officer is in discussions with the Directors of Nursing across the Trusts and will provide support with this.
- 4.11. The third area discussed was in relation to visitors coming into healthcare environments and particularly care homes and/or other areas where there may be higher risk patients e.g. haematology, oncology, burns services. Again visitors should always be guided by the advice and requirements by the ward staff, Charge Nurse and Ward Sister and should also be strongly encouraged to wear face-coverings when visiting such areas.
- 4.12. There being no further comments the paper was noted.

Transmission Clusters and super-spreading events (Paper 5)

5. Prof Young presented the paper which looks at super-spreading events and the parameter K , a measure of dispersion.
 - 5.1. The paper contains tables looking at values for K and the proportion of cases which will occur in clusters and the potential implications of that.
 - 5.2. It is unclear at present to what extent the cases we are seeing in NI at the moment are occurring in clusters and to what extent they represented isolated community transmission events. It would be useful to get some more detail about the cases being identified at the moment, where are they occurring, are they in clusters etc. to give a better sense of the extent to which we have ongoing community transmission or whether most transmission is in identifiable clusters.

5.3. The Contact Tracing Steering Group will be producing a weekly update report on cases, clusters outbreaks and will give a report to this meeting next week.

5.4. There being no further comments the paper was noted.

CO-CIN case fatality in hospitalised patients with COVID (Paper 6)

6. Prof Young presented the paper which looked at mortality for males and females by age band for a sample of almost 45,000 patients with the presence of one or more comorbidity..

6.1. The data will be used by the modelling group to refine some of the estimates.

6.2. There being no further comments the paper was noted.

AOB

7. Prof. Young invited members to raise any other issues for discussion today.

7.1. In response to a question from the group on exit strategies, Prof. Young confirmed that there is a ramped-up piece of work being developed nationally to look at the broader impacts of the epidemic, including the impacts of the restrictions that were put in place. There is a commitment to following populations, including those who have and have not had COVID, in the longer term to try and get some sense of the broader impacts on them. There will be a particular focus in terms of mental health but also the impact of loss of schooling for a period etc. It may be slightly broader than the remit of this group, but as emerge they will be brought to this group for discussion.

7.2. There being no other business the meeting closed.

Date of next meeting

8. Next meeting will be on Monday 22 June at 3pm and will be via Zoom video conference.