COVID-19 Strategic Intelligence Group

3.00 pm on 16 July 2020 by Zoom Video Conference

Present:

Professor Ian Young (Chair)	Chief Scientific Officer, DoH
Dr Michael McBride	Chief Medical Officer, DoH
Dr Naresh Chada	DCMO, DoH
Dr Lourda Geoghegan	DCMO, DoH
Professor Stuart Elborn	Faculty Pro-Vice-Chancellor, School of Medicine, Dentistry and Biomedical Sciences. QUB
Professor Frank Kee	Centre for Public Health, QUB
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Dr Jenny Mack	Public Health Registrar ST4, DoH
Dr. Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Dr Declan Bradley	Consultant Public Health Medicine, PHA
Dr. Michael Quinn	Head of Clinical Information, HSCB
Professor Diarmuid O'Donovan	Centre for Public Health, QUB
Tricia Lavery	Secretariat, DoH

Apologies

Apologies were received from the following:

Dr. Eugene Mooney	Senior Statistician, DOH
Professor Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University
Gerry Waldron	Head of Health Protection, PHA
Professor Hugo Van Woerdon	Director of Public Health, PHA

Welcome, introductions and apologies

1. Prof Young welcomed all participants to the meeting.

   1.1. Apologies were received as noted.

Minutes of Previous Meeting and Actions (Paper 1)

2. Prof. Young confirmed that all were content with the note of the last meeting as issued.

Status Update

3. Prof Young provided a status update to the group.

   3.1. R is currently 0.5 and 1. The average number of positive tests over the past 7 days, determined on Tuesday, was 4. Current community incidence estimate of new cases per day is running at less than 20, with a community prevalence of 25-150.

   3.2. The situation is essentially stable however the current view of the Modelling Group is that R is an unsafe indicator in terms of informing public policy. Transmission is so low that R will be heavily influenced by small localised outbreaks, which may not reflect wider community transmission.

   3.3. R was reported as 0.5 to 1 last week, and is the same this week, but in between it rose to above 1.2 over the weekend before settling back down again. This indicates the volatility of R. We continue to use hospital inpatients as the main determinant of R, which are now down to low double figures. When R was determined this week based on cases, the value was 1 and this reflects the fact that the rolling average number of cases has been steady for the past 3 weeks and running at a low level. However it would only take a small, modest outbreak somewhere in NI to push the number of cases up quite significantly and indeed there has been a rise in the number of cases reported on the DoH dashboard yesterday.

   3.4. RoI colleagues yesterday reported that R is now between 1.4 - 1.8, and approaching 2. This was determined based on number of cases and has led to a decision to delay some relaxations that had been proposed. They continue to deal with a number of substantial outbreaks including one associated with a celebration in a domestic environment, leading to a large number of cases which have now been linked to a number of secondary cases.

   3.5. Consideration therefore needs to be given as to how we can separate these

type of superspreader events from the wider community transmission, as it is inevitable that we will have such outbreaks and events.

3.6. In summary, this group concludes that R is no longer a safe indicator to be used for policy development or decision. A much more holistic view of the data around the epidemic and in terms of cases, where are the cases and to what extent are they part of clusters, rather than reacting just to R.

3.7. CMO commented that some of the increased number of cases today relate to similar circumstances to those observed in other jurisdictions. Those in younger age brackets will continue to find ways to socialise indoors where there are not opportunities to facilitate interactions in pubs and other venues and appear to feel that they are immune but our messaging needs to emphasise the risk of transmission to those who may be vulnerable or susceptible.

3.8. A paper will follow in due course on learnings from the Leicester outbreak, but some initial data suggests that all of the increase in cases has been in the 20-65 year old group, with virtually no increase in younger or older individuals and hence has not translated through to much evidence of increased deaths. The outbreak is not associated with any single setting or source but is due to widespread community transmission.

Airborne Transmission (Paper 2)

4. Prof Young presented the paper which relates to the role of airborne transmission and which is tabled primarily for information.

4.1. The paper underpinned the WHO change in advice or thinking around routes of transmission and provides indicators to some of the evidence considered.

4.2. It does not changing the thinking or advice of this group particularly but is useful to note.

4.3. In terms of ventilations considerations, the situation around fans and even air-conditioning is quite complex and can depend on the space and the nature of the air-conditioning unit etc. and the best source of adequate ventilation is opening windows.

4.4. It is also important to maintain an emphasis on droplet infection whilst recognising the potential importance of aerosols.

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

Modes of Transmission (Paper 3)

5. Prof Young presented the paper which is a linked paper from WHO which discusses transmission routes.

6. The paper is primarily for information and does present anything that would lead this group to make a change in advice.

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

COVID secure measurement (Paper 4)

7. Prof Young presented the paper which looks at the concept of COVID Security.

   7.1. The concept of COVID Security has become an important one and is a phrase used quite often in England, with several ministers quoting that people will be safe to return to an environment that is “COVID Secure”.

   7.2. However the main message of the paper is that it is extremely difficult to define what is meant by COVID Secure or to place a number or value on it that would be useful. Whilst it is certainly possible to take actions that will make an environment COVID secure or certainly less COVID risky, it would be very difficult to state that somewhere is or is not COVID secure and SAGE is not supportive at present of labelling spaces as COVID Secure (as is done in terms of food safety for example).

   7.3. RoI are in the early stages of development of an accreditation scheme for the hospitality sector, where venues would sign up to a range of measures and to unannounced inspections to be designated “COVID Secure”.

   7.4. The paper could be used also to prompt thinking around mitigations that can be used to maximise COVID security in a particular setting and reduce risk of transmission, which would vary from venue to venue and feeds into discussion around use of face-coverings.

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

Preparing for a Challenging Winter 2020-21 (Paper 5)

8. Prof Young presented the paper which is presented by the Academy of Medical Science and is now in the public domain.

   8.1. SAGE have advised that the RWC Scenario modelled in the paper is not a SAGE endorsed model but is only used as an example.

   8.2. The paper contains a considerable amount of information but possible

contains nothing of surprise but serves as a strong and useful introduction to anybody thinking about what might be needed as we move forward with the epidemic.

8.3. There was a note of disappointment however that the paper did not place enough emphasis on nursing and residential care homes or nosocomial spread, which are two very important areas for consideration for future outbreaks.

8.4. CMO advised that plans for future regular care home testing are progressing well and a submission to Minister is being prepared. It would be hoped to offer testing to all care home staff and residents every 28 days, but given the current low level of community transmission to consider increasing frequency of testing for staff to every 2 weeks.

8.5. In terms of preparation for the winter, there may be a need for an over-arching co-ordinating mechanism in terms of winter planning. There are several discrete areas of planning under the new departmental Programme Board and there is probably a need to pull these all together into a co-ordinated plan for autumn/winter 2020/21, recognising that it will be particularly challenging.

8.6. Prof. Young agreed to bring forward papers next week which look at the effect of testing of healthcare staff at different frequencies for consideration.

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

Educational Settings (Papers 6 - 10)

9. Prof Young presented the paper which look at the schools, colleges and university sector.

9.1. In terms of schools, the previous discussions at this group remain valid in that children, particularly younger children, get very little in the way of symptoms, are probably less susceptible and are probably less likely to transmit the virus and these papers appear to show evidence to strengthen this opinion.

9.2. However there is evidence of countries where schools have opened fully with very little evidence of a problem and evidence of other countries where school have opened relatively fully and it appears to have caused major problems. The current situation in Israel is a good example of having major associated problems, but it is unclear as to what has caused the differences worldwide, so there needs to be a degree of caution in considering the likely impact of reopening of schools in NI fully. Wales have shared plans of opening schools fully and England are more or less in the process of doing the same. The Department of Education in NI are considering their plans for reopening I n August and intend to revise their guidance in coming weeks

based on changes in England and will share with CMO etc in due course.

9.3. QUB and UU are developing a study in schools to run a surveillance programme over the academic year, using sputum testing as opposed to swab testing, across around 60 schools including pre-primary, post-primary and special schools. There are GDPR and operational issues to resolve and there will be a resource deficit to overcome to enable this to be up and running by the start of September. The study aims to answer the question of what is the epidemiology and behaviour of infection in NI schools over an academic year and will also provide an opportunity for some well-being activity and surveys with both children and teachers.

9.4. In terms of Further and Higher Education settings, both universities have been reflecting carefully on the best pathway for the safe return of students to both the educational setting and to associated domestic and other settings.

9.5. The papers are very useful in terms of highlighting issues, most of which have already been considered. Each situation is unique and needs specific thought. QUB Halls of Residence have students from QUB, UU and Belfast Met in residence whilst the private landlords in the Holylands have HMOs with students from numerous institutions. There is a quite a mixing of students, particularly in Belfast, and also in Derry and Coleraine.

9.6. There will be around 1500 students arriving from overseas in September, and the current strategy for these is to quarantine them on arrival for 2 weeks, and anyone arriving with symptoms will be sent for test and onward interaction with the Contact Tracing Service.

9.7. A sub-group has been formed in QUB to develop an outbreak plan but there has not been much discussion on segmenting of the student population as it seem to be quite a complex process in a higher education settings and it may therefore be more effective to focus on universal precautions with mitigations. All students and staff will be provided with face-coverings for use where social distancing cannot be sustained, and all staff and students will be required to undertake a training programme before arriving on campus to advise on the behavioural expectations they will be required to adhere to.

9.8. There are particular concerns around ensuring that the student population living in HMOs are fully aware that everyone in the house would be required to self -isolate if one occupant in that HMO has symptoms until that individual receives a negative test result. It is hoped to run a pilot study in August to try to locate a Mobile Testing Unit in the Holylands which has a high volume of students living in HMOs. A further issue will be the high volume of students who return home over the weekends which is another potential transmission route, and one that may be unique to Northern Ireland.

9.9. There is also a concern around student social settings where large numbers of students tend to congregate, for example local bars and clubs. The universities have good connections with this sector and will investigate

management of this.

AOB

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

10.1. In relation to face-coverings Prof. Young stated that, thanks to the advice of this group and the evidence it has considered, both himself and CMO have been increasingly persuaded of the need to take further action in this area. As reported in the media there is a plan to bring forward a paper which recommends mandating the use of face-coverings in retail environments and more widely in other indoor settings, to include Higher Educational settings (e.g. lecture theatres). Any decision on this is clearly a decision for the Executive but the advice of this group has been very helpful in terms of influencing and y decision and the ongoing support of this group in relation to wearing face-coverings is welcomed.

10.2. In relation to the issue of imported cases from other countries. Since 1 June there have only been 4 travel related cases in NI (up to 10 July) and this continues to be monitored closely by the Contact Tracing Service, with all new cases being asked, as part of the call script, if they have been outside NI in the 14 days prior to onset of symptoms or receiving a positive test result whilst asymptomatic. Colleagues in Ro1 have reported that a substantial number of their cases being linked to travel. This includes both directly imported cases (infection acquired outside RoI) and secondary cases (infection acquired from individuals that have contracted COVID outside RoI). They have identified a substantial problem which is causing great concern but have not identified the source as being from any specific country, and it is therefore a widespread general issue.

10.3. The plans for NI are to keep the situation under review. In theory inbound travel from any country which has a higher prevalence higher than that of NI represents a relative risk. Currently this would include a large number of counties currently on the JBC Amber list, and at present inbound travellers from amber countries are not required to quarantine. This also includes some areas within the Common Travel Area. It has been agreed that inbound travellers from Red list countries are required to quarantine for 14 days on arrival into NI.

10.4. There has been ongoing work around the secondary use of data and the unlocking of data sets, at least within the Health sector. A briefing document has been issued to the Health Committee and MLAs which outlines what a future data strategy might look like.

10.5. There being no further business the meeting ended.

Date of next meeting

11. Next meeting will be on Monday 20 July at 12pm and will be via Zoom video conference.