

COVID-19 Strategic Intelligence Group

12.00 pm – 17 August 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 Naresh Chada	DCMO, DOH
Dr. Eugene Mooney	Senior Statistician, DOH
Dr. Liz Mitchell	Chair of Contact Tracing Service Steering Group, DoH
Professor Hugo Van Woerden	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 Frank Kee	Centre for Public Health, QUB
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 Cathy Gormley-Heenan	Pro-Vice-Chancellor (Research and Impact), Ulster University
Professor Fiona Alderdice	Nuffield Department of Population Health, University of Oxford
Tricia Lavery	DOH (Secretariat)

Apologies

Dr. Michael Quinn	Head of Clinical Information, HSCB
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Welcome

1. Prof Young welcomed all participants to the meeting.

1.1. Prof. Young confirmed that all were content with the note of the last meeting and

minutes were agreed as issued subject to correction of a typo in Papa 2.8.

Current state of the Epidemic and the types of measures that may be required.

2. Prof Young provided an update to the group on the current state of the epidemic.
 - 2.1. In terms of the 7 day rolling average of cases per day (to Friday 14 August), levels have risen from between 3-4 at the beginning of July and were between 17-18 at 10 August. This figure has now risen to 34, showing that it is now doubling every 7 days.
 - 2.2. Expressing this as the number of cases per 100K of the population over a 7 day period, the figure for NI as a whole (at Friday 14 August) was 12. This figure had again doubled from the previous week and it is expected to be significantly higher today.
 - 2.3. In terms of the number of tests carried out per 1000 of the population, there are some who argue that the increase in numbers of cases is due to more testing being carried out, however this figure over the 7 day period to 14 August showed around a 20% increase in testing against a doubling of the number of cases. This reflects changes in the percentage of positive tests which had been 0.3% at the beginning of July but which has been rising progressively and which currently sits at 1.63%. Whilst testing partly explains this increase, it is by no means a full explanation. Part of the reason for the rise in positive cases could be due to better targeting of testing through the Test, Trace, Protect programme, but this would not explain all of it. It is clear that, whatever the reasons, the numbers in general are going up.
 - 2.4. Looking at the numbers of positive tests per 100K of the population, split by Local Government District (LGD), for the 7 day period up to 16 August, there is evidence of low level disease activity in 5 LGDs (Fermanagh & Omagh, Derry City & Strabane, Mid-Ulster, Armagh City, Banbridge & Craigavon and Ards & North Down). There is then a further group of 4 LGDs (Lisburn & Castlereagh, Belfast, Newry, Mourne & Down and Causeway Coast & Glens) where levels are between 10-20 per 100K of the population and which would give some cause for concern. Finally there are 2 LGDs (Antrim & Newtownabbey and Mid & East Antrim) which are causing the most concern with figures of 33 and 53 per 100K of population respectively.
 - 2.5. Putting this into context, Mid & East Antrim currently has more cases per 100K of population than Leicester at present. The high-risk counties in RoI have been at around 100, and the highest region in the UK currently is Oldham at between 80-100, but Mid & East Antrim is now one of the hotspots in the UK and RoI as a whole, and this is also true for Antrim & Newtownabbey, but to a lesser extent. There is a 20-30 fold difference between these 2 LGDs and the lower risk LGDs in NI. Therefore there is clearly not an equal spread of the disease across NI.

- 2.6. In Mid & East Antrim there are 2 significant outbreaks associated with meat plants however it is unclear whether these are meat plant outbreaks that have passed into community, or are community outbreaks which have now affected the meat plants, and it would be important to make this distinction. In Antrim & Newtownabbey there is a significant cluster associated with a social event at the British Legion in Whiteabbey. It is currently unclear as to what proportion of the cases in these two LGDs are associated with these clusters and outbreaks and what proportion are due to community transmission.
- 2.7. In terms of the current estimate of R based on the number of hospital admissions, the numbers are still relatively low. This estimate of R rose above 2 last week but has since fallen and is approaching 1 again. The estimate of R based on the number of positive cases is running between 1.5 – 1.6 at present but this has not translated through to hospital admissions. Hospital admissions were at a level of around 2 per day in mid-July, and whilst it had risen last week to 11, it is now at between 7-8 and therefore there is no signal from this to cause concern. This is most likely due to NI being in a lag period before the rise in cases translates to hospital admissions but this could also be due to the cases being in younger people who are much less likely to develop severe illness and require hospitalisation.
- 2.8. A key question to consider is to what extent would we be warranted in considering local restrictions in parts of NI, given that the level of cases in some areas is now similar to that in other parts of the UK and RoI when local restrictions were brought in? A further question would then be what would such restrictions look like?
- 2.9. There was discussion around level of IT support for the Test, Trace, Protect programme. It was agreed that the level of support is not optimal at present and consideration should be given to identifying any further help that can be given to enable TTP to obtain the analysis they would like and which would be helpful to this group. It is considered crucially important that we can have early identification of clusters and the ability to disaggregate the cases that are associated with clusters from those which are not to allow interrogation of the epidemiology in the weeks and months ahead.
- 2.10. It was commented that BSO have raised a governance issue preventing sharing Health & Social Care (HSC) number with the Contact Tracing Service (CTS) which would make the database much more efficient. It was agreed that this would be investigated further as it would have been assumed that the CTS would have been part of the HSC system and therefore there would not be a barrier to sharing this information for a public health issue.

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.

- 2.11. It was clarified that it is currently not possible to determine the distribution of cases associated with clusters versus cases associated with community

incidental transmission, nor is there any detail of the age demographic of the cases in these 2 LGDs. Knowledge of these factors would be useful in giving consideration to the potential local interventions that could be introduced. It was stated that part of the challenge is that a cluster associated with a workplace can quickly bleed into community transmission through subsequent household transmission, and with individuals in that workplace attending other community settings and leading to further community transmission. Rol colleagues do seem to be able to provide such a breakdown but we are not in that place as yet, partly due to the issues with the IT infrastructure previously discussed. There is no current breakdown by age across the LGDs, but it is thought that this information is likely to be held on the TTP systems and would certainly be useful to have.

- 2.12. Whilst there is a train of thought that feels it would be acceptable to allow the number of cases in the younger population to continue to rise, this will most likely eventually translate through to the older members of the population and result in a rise in hospital admissions and possible deaths.
- 2.13. The TTP team have been made aware of the need to flex up the service at short notice and to ensure that recruitment proceeds at a sufficiently fast pace to ensure this is possible. The team have ask for additional HR resource from BSO to speed up the recruitment process and get staff in post quicker. There were also interviews last week for additional Clinical Leads and all four candidates were deemed appointable and will take up post shortly, and further clinical leads are being sought. It was noted that there are increasing resource issue across all of the Health Protection areas within PHA and recruitment processes are underway to resolve this.
- 2.14. There was concern raised around observations across the province which show people now appear less inclined to adhere to social distancing guidelines, although more people do seem to be wearing face-coverings. These concerns have been raised to the Executive and there need to be metrics established to measure and monitor the extent of the issue. Consideration is being given to establishing more regular Health press briefings in place of the current ad-hoc requests for media interviews. There is also a need for clear and consistent approach and close working with PHA in terms of media messaging.
- 2.15. It was commented that the added value of any local interventions would be not just for the local community involved in those interventions but for NI as a whole and it reinforces the message once again that that this is a serious situation and there are increasing observations of a lax approach to the epidemic. It would be prudent to look at any lessons learned from other local interventions in places such as Leicester that could be used as part of our decision making on the way forward with local interventions.
- 2.16. The 4 UK CMOs hosted a learning event last week looking a learning from cluster management across each of the 4 UK nations. The presentations were very valuable and in the case of the Leicester cluster, looked at the data behind the decision making. It is clear that the data is really important and part of the challenge for Leicester was that there was only data available for the Pillar 1

testing (the NHS PHE tests) and it was only when the Pillar 2 testing (the National Initiative testing) became available that the full picture emerged, which was a very different pattern from what the Pillar 1 testing alone was showing. The presentation of the data by geographies is also very important, as is the need to see clearly the rate of transmission by geography and by 100K of the population including the clusters and also excluding the clusters. RoI colleagues have confirmed this is an important area of focus for them also therefore there is now an urgent need for us in NI to be able to disaggregate the cluster-associated cases from the overall cases. Connection into the BAME population will also be really important, as will the ability to have epidemiologists on the ground engaging with people in affected communities and encouraging people to get tested. There was also important learning gained from the outbreak in a meat plant in Anglesey.

2.17. In terms of the impact on schools within areas subject to local interventions, it was clarified that there would be no intention to delay or modify plans for the reopening of schools, and local interventions would therefore need to include other measures to allow schools in those areas a bit more headroom to operate. These may include restrictions around household visits, indoor venues and possibly restaurant, pubs, cafes etc. and with some additional thought given to clubs, social venues and even churches.

2.18. In considering messaging for the BAME community, recent activity in Oxford looking at preferred mechanisms of communication identified that Instagram has emerged as being really important to achieve effective messaging within the BAME community and it is also known to be extremely popular with the younger generations. It was agreed to pass this information onto the DoH and PHA Comms teams. It may also be useful to identify the key local influencers across NI and to engage them to assist with improving levels of engagement and uptake of the App with both hard to reach groups and the younger generation.

2.19. In summary, the group agreed that there is a need to consider the possibility of local interventions based on the number of cases, trying to take account of the number of clusters both in terms of the direct benefit in an area but also in terms of sending out a signal to the broader NI population about the potential consequences of people not adhering to the social distancing and other measures that we would like them to.

Singing, Wind Instruments and Performance Activities (Paper 2)

3. Prof Young presented the paper which reflects the updated views of the EMG sub-group that reports to SAGE.

3.1. This concludes that singing is not really of any more risk than talking, and the risk of transmission of droplets relates more to loudness of the singing or talking or shouting rather than the activity itself. It is clear that there is considerable between-individual variability in terms of the extent of droplet spread, although

this is not easily understood at the moment.

- 3.2. This does however fit with the concept of super-spreaders, and having one such individual at a singing event or musical event, the risk of transmission would be considerably greater.
- 3.3. A social distance of 2m is adequate to minimise transmission risk, and it is reassuring to note the low risk associated with a range of instruments.
- 3.4. It was noted that the paper, when finalised, should be shared with the Entertainment Forum, the Churches Forum and also the Educational sector in terms of schools and universities.

ACTION: The paper, when finalised, is to be shared with the Entertainment Forum, the Churches Forum and also the Educational sector in terms of schools and universities.

- 3.5. It is interesting to note that very loud singing and speaking can generate around 20-30 times more aerosol than breathing, quiet singing and speaking, and also that there appears to be more risk to members of the choir and conductor than to the audience and mitigations (e.g. 2m distance) may be more appropriate for the performers than the audience. Consideration would therefore also need to be given to 2m distancing between different household groups in a church congregation where singing will occur.

ACTION: Mitigations of a 2m social distance to be considered between members of a choir and also its conductor and also between different household groups in a church congregation where singing will occur.

There being no further comments the paper was noted.

AOB

4. Dr. Geoghegan asked if members had any suggestions, in terms of the local restrictions, as to what areas it may be useful to target those to. In terms of geographical area, this is likely to focus on LGD or council area as most people will know which council area they live in. One element being considered is to advise people within the affected area to restrict the range within which they travel, other than for essential purposes, as well as possibly targeting specific activities or types of premises within that council area. This is similar to the approach taken in Aberdeen, Leicester and Kildare. It is agreed that opening schools and universities is a priority, although in the case of universities there may be need to be some restrictions in terms of non-teaching activities. In terms of timescales, any local intervention that may be applied would need to be in place for a minimum of 2 weeks given what is known about the natural history of the virus before the situation would be reviewed. However consideration will also need to be given to possible unintended consequences of people deciding to travel out of a restricted area a few miles down

the road to visit unrestricted premises. There is a meeting planned with PSNI later this week to discuss local interventions which will no doubt take this into account.

Date of next meeting

5. Next meeting will be on Monday 24 August at 12pm and will be via Zoom video conference.