

## COVID-19 Strategic Intelligence Group

3.00 pm on 22 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 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
Gerry Waldron	Head of Health Protection, PHA
Tricia Lavery	Secretariat, DoH

### Apologies

Apologies were received from the following:

Dr. Gillian Armstrong	Senior Medical Officer, DoH
Dr. Michael Quinn	Head of Clinical Information, HSCB

## 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 as issued

## Status Update

2. Prof Young provided a status update to the group.
  - 2.1. The latest position as of Thursday 18 June was :
    - .The estimate of R from modelling is between 0.6 - 0.9.
    - Growth rate is -0.03 - -0.06
    - Average number of new positive tests per day for the last 7 days is 8
    - Current community incidence estimate (new cases per day) is between 40 - 135
    - Current community prevalence estimate (total infectious individuals) is between 280 - 945.
  - 2.2. It will be difficult to see a further fall in terms of any of these numbers as there is currently such a low level of community-acquired hospital admission.
  - 2.3. The estimate of R, based on COVID-confirmed hospital inpatients, is sitting firmly below 1 although the confidence interval is widening due to falling numbers of hospital inpatients. This number currently sits around 40 and will fall further and as it does the confidence limits will widen and R will become of limited value. The confidence interval for R may soon overlap with 1 but as numbers are so low this is of little significance; there will be a need for a communication exercise for the general public to explain this clearly. England are now considering stopping publishing R values as it is becoming unhelpful at this stage of the epidemic, and NI may have to give consideration to this also.
  - 2.4. Data from the SAGE sub-groups for the 4 UK nations estimate the NI value of R as 0.6 – 0.9 also. England and Scotland are fairly similar, but Wales has a higher value which is attributable to two rather large recent outbreaks in meat-processing factories.
  - 2.5. England have started to publish data on growth rates this week, but with such low numbers this may have limited use and the public may find it more complicated than helpful. There was a general consensus amongst the group that there would be little value in publishing growth rate data for NI. It was agreed to keep this under review for now.

2.6. The 7 day rolling average of new cases was approaching 5 towards the end of last week. The 7 day rolling average of total hospital admissions was approaching 2 per day and for community-acquired hospital admissions was approaching 1.

### **SPI-M-O: Consensus Statement on COVID-19 (Paper 2)**

3. Prof Young presented the paper, which partly references the growth rate in the UK as being between -2% to -4% per day.
  - 3.1. Paragraph 5 of the paper discuss SPI-M concerns around the discharge of infectious patients from hospital, both into the community and into high-risk environments such as care homes. It is the collective view of SPI-M-O that the infection/infectious status of all individuals should be known at discharge, and consideration given to quarantine outside the home for potentially infectious persons.
  - 3.2. This was discussed previously at the Hospital Onset Working Group, a sub-group of SAGE. It was raised as part of a discussion around how nosocomial activity seems to be driving outbreak activity across some regions in England, and around reports that most people being admitted to hospital in some regions were acquiring their infection either from a previous stay in hospital or via healthcare workers who were working in a hospital environment.
  - 3.3. Given that NI currently has limited evidence of nosocomial infection, it may be less relevant here but it may be useful to bear in mind should this situation change.
  - 3.4. It is important to note that NI are currently testing all people before entering the care home sector, and the policy position is that these individuals are tested 48 hours prior to transfer to ensure infection status is known and able to be managed accordingly on arrival at a care home. In addition any patient transferring from hospital to a care home is isolated on arrival for 14 days.
  - 3.5. It was reported that SPI-M are considering that the healthcare system may now be the engine driving the epidemic now, and that there is a cycle of infection occurring between staff and patients in hospitals and care homes that is leeching back out into the community. They have therefore identified that the movement of people between these settings is a point at which to interrupt this transmission.
  - 3.6. Given that the Testing programme has capacity at present, there may be merit in commissioning a point prevalence survey at a single hospital site to establish the current position with regard to nosocomial transmission as this is likely to become a problem as services restart and as we move into the autumn/winter period. **It was agreed to raise the possibility of commissioning a point prevalence study with Dr. Farrell from the**

**Testing cell** It was also considered that a point-prevalence study in sites within each of the Trusts would be useful.

**ACTION: Prof. Young and Dr Elborn agreed to discuss undertaking a point-prevalence study with Dr. Farrell and to draft a plan to take this forward.**

3.7. Discussion last week around use of face-coverings in health care settings concluded that:

- for non-clinical areas a much stronger emphasis was required on social distancing, hand hygiene, respiratory hygiene and environmental cleaning.
- for waiting areas around clinical services, such as in Emergency Departments or GP surgeries, social distancing, hand hygiene, respiratory hygiene and environmental cleaning should also be implemented. However when social distancing cannot be maintained, even though this may not be on a continual basis, a risk assessment should be undertaken and staff and members of the public to subsequently be advised to wear face masks / face-coverings. Members of the public planning to attend such clinical services should also be asked to assist the Health Service by wearing face-coverings.

3.8. It was further reported that the messaging from the Executive will change this week from *“members of the public should consider wearing face-coverings where social distancing is not possible”* to *“it is strongly recommended that members of the public should wear face-coverings where social distancing is not possible.”*

3.9. Work is ongoing to progress the QUB proposal for testing in schools. This was discussed and agreed by the Expert Advisory Group last week and was strongly supported. A protocol for this has been drawn up but engagement with Education Authority and the Department of Education (DE) is proving problematic at present. CMO is content to escalate this with DE through official lines if necessary. It was also suggested some cross-border studies with schools would be useful.

## **Serial Testing (Papers 3, 4 & 5)**

4. Prof Young presented the papers, all of which touch on the issue of serial testing.

4.1. In essence this is scientifically trying to look at the question of how you can be confident that an individual is COVID negative in relation to the number of negative tests that are required and also the timing of such tests.

4.2. It is potentially important for individuals who are entering the country and subject to the 14 day quarantine period and also to those identified as

contacts of a positive case and advised to self-isolate. Whilst numbers remain relatively small at present, these could become greater with further relaxation of restrictions.

- 4.3. Each test carries the risk of being a false negative. Colleagues in ROI are currently piloting a process which involves a swab test of identified close contacts at Day 0 and Day 7. The argument in the papers favours carrying out 2 or 3 tests in fairly quick succession and requires each of the tests to be negative to declare the individual as infection-free. As a compromise, SPI-M reached the view that 2 negative tests around day 6 and 7 would be sufficient to clear someone as infection-free. This was also the considered view of SAGE.
- 4.4. It was agreed that NI may not yet be ready to implement any such initiative and therefore this is presented today as information only. As we approach the flu season or if community transmission begin to increase this approach may become more important as people are potentially asked to isolate on multiple occasions. However consideration is being given to introducing some follow-up with contacts in self-isolation to encourage them to stay in self-isolation for the full duration, possibly using automated texting similar to the ROI model.
- 4.5. There being no further comments the papers were noted.

## **Wider Environmental Transmission (Paper 6)**

5. Prof Young presented this paper which looks at outdoor air, water, outdoor surfaces and food.
  - 5.1. The paper highlights that within 2m the risk of outdoor aerosol or droplet transmission in close face to face contact is likely to be similar to indoor settings. This will be important as pressure increases to allow large outdoor events involving crowds closely together (spectator sports, concerts etc.) as this suggests a view that there would be significant risk associated with such events despite being in an outdoor setting.
  - 5.2. The paper also looks at waste water analysis, and colleagues in other regions of the UK are exploring the monitoring of waste water as a method of detecting virus activity in the community and is something to consider discussing with other departments.
  - 5.3. The information around public toilets was also useful as they are areas of risk but availability of these facilities will become necessary as more public spaces begin to open up and therefore they will need to be appropriately and hygienically managed. This issue has already been discussed with relevant ministers in relation to public transport, shopping malls, and it will also become an issue in schools, universities, shared workplaces etc. The mitigations are relatively complex and there are associated concerns with the

use of hand driers which carry considerable risks and mitigations such as cleaning, ventilation, wearing of face –coverings would help, and the drying issue may be more difficult to mitigate than the actual toilets.

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

### **COVID and Play (Paper 7)**

6. Prof Young presented the paper which is not just driven by science but also by a policy perspective.

6.1. There is nothing novel in the paper from a scientific perspective but is possibly one to share with the Department of Education, if it has not already been shared.

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

### **Surveillance in Hospital Staff in England (Paper 8)**

7. Prof Young presented the paper which discusses a snapshot PCR surveillance in England.

7.1. The findings in the paper suggested that when the prevalence was low, routine and repeated screening would be unlikely to have a significant value, and that the majority of participants that tested positive were unlikely to be infectious as no culturable virus was present.

7.2. The paper is of note as it is anticipated that NI will be pushed in coming weeks around testing strategies and the frequency of testing for HSC staff in both hospitals and care homes. The Nosocomial sub-group of SAGE is considering this at present.

7.3. Data received last week from the recent seroprevalence study in the Belfast Trust was indicating a 6% positive serology measure amongst clinical staff and around 3-4% for laboratory staff.

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

### **AOB**

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

8.1. NERVTAG have commissioned work to develop a model of risk that will inform the future advice to people that had previously been shielding and

which will also inform prioritisation decisions around potential vaccinations. This is intended to be a 4 Nations model but there is some delay gaining agreement from NI primary care. As this work was commissioned by the 4 UK CMOs and NERVTAG are pursuing at their request, Dr. McBride offered to escalate this issue if required.

8.2. There being no further business the meeting ended.

### **Date of next meeting**

9. Next meeting will be on Monday 29 June at 3pm and will be via Zoom video conference.