Minutes

Technical Advisory Group for COVID-19 Teleconference (final)

Date:	5 March 2020
Time:	9:00 am - 10:30 am
Location:	National Health Coordination Centre (NHCC), 133 Molesworth St Wellington
Chair:	Dr Caroline McElnay
Attendees:	Dr Anja Werno Dr Bryan Betty Dr David Murdoch Dr Erasmus Smit Prof. Michael Baker Dr Sally Roberts Dr Shanika Perera Prof. Stephen Chambers Dr Virginia Hope Ministry of Health staff: Dr Caroline McElnay Dr Tom Kiedrzynski Dr Juliet Rumball-Smith Dr Richard Jaine Dr Niki Stefanogiannis Andi Shirtcliffe Dr Geoffrey Roche Dr Harriette Carr Asad Abdullahi
Apologies:	Dr Nigel Raymond

Documents tabled:

- Minutes of the last meeting (27 February 2020) – approved with no changes.
- TAG Proposed Agenda Thursday 5 March 2020.
- Richard Jaine. COVID-19 Risk Assessment 03 March 2020.
- Preliminary modelling paper. Dr Lucy Telfar Barnard, Prof Nick Wilson, Dr Amanda Kvalsvig, Prof Michael Baker. *Modelled Estimates for the Spread and Health Impact of Covid-19 in New Zealand: Revised Preliminary Report for the NZ Ministry of Health*. 27 February 2020. (Draft).

Item	Notes
0	**Preliminaries** • The Minutes of the last meeting were accepted.
1	**Situation Update** *a) Notification of third case.* A third case was notified last night. All three cases were notified in Auckland. Two originated in Iran. Case number 2 had travel history in Lombardy, northern Italy. Results from the second case's husband would be available later today. *b) Self-Isolation guidelines.* Uncertainty was reported anecdotally regarding self-isolation. It was noted that easy, intelligible guidance was being distributed to DHBs and was published on the Ministry website. It was noted that the retrospective application of travel and quarantine advice (i.e. self-isolation for those who had been in northern Italy) was creating issues. *c) Testing loads* There was discussion on the variance in testing demand, community versus hospital settings. Auckland reported a 50/50 split between community versus hospital, Christchurch reported that there were few, if any, hospital inquiries. *d) Border restrictions* Since the last TAG meeting of Friday, 13 March 2020, the situation has moved very quickly and the Government decided to add Iran to Category 1, which has led to a split in Category 1 into Category 1a (Category 1a countries have travel restrictions and foreign nationals travelling from or transiting through Category 1a countries will be prevented entering New Zealand), and Category 1b (category 1b will include countries with no border restrictions but people who have been in category 1b countries are requested to register with Healthline and self-isolate for 14 days starting from the date of departure from a Category 1b country or territory). The Ministry of Health needs TAG to advise on criteria for which countries should be in Category 1 and 2 and how a country moves between these categories. There was a question if New Zealand now using the term 'pandemic' in the context the COVID-19.

	It was explained that NZ is waiting for WHO to use the term 'pandemic' but we are certainly planning for the possibility for a pandemic as this situation is highly dynamic and has a potential for the situation becoming a pandemic. An enquiry was made if we are developing a specific COVID-19 emergency planning on the experience from Australia and China. It was confirmed that the COVID-19 emergency planning document is being developed by NHCC. The draft response plan is informed by Australian and the UK response plans as well as the WHO-China Joint Mission on COVID-19 Report. The Ministry will appreciate TAG's comments and feedback on the draft response plan before it is being finalised. We will circulate the draft response plan for consultation shortly. **Action 1: Asad to send the WHO-China Joint Mission on COVID-19 Report - actioned.** **Action 2: Asad to send out the COVID-19 Emergency Response Plan draft - when ready**
2	**Revisiting Case Definition** An urgent TAG meeting was held on 4 March 2020 to review the epidemiological criteria of the case definition. The meeting was attended by 5 TAG members. It was agreed on to; • Retain both criteria (epidemiological and clinical) of the current case definition. • Daily monitoring and review the list of high-risk countries at a set time • Communicate the updated list of high-risk countries to all stakeholders including the primary health care and public health units • Daily update the Ministry of Health website • Ensure testing for COVDI-19 is included for all SARI admissions • Ensure testing of respiratory samples from ICU admissions includes COVID-19 • Initiate a community-based sentinel surveillance system and testing for COVID - 19 included. **Action 3: Asad to send out the minutes of the meeting. Actioned.** The following comments were made about this meeting: • Sensitivity and due considerations should be exercised in relation to testing of respiratory samples from ICU admissions includes COVID-19. There was discussion on whom samples should be taken from and it was agreed that COVID-19 testing should only be undertaken on those with a respiratory infection in ICU (not for those admitted for other reasons – eg post-operative patients). **Action 4: Caroline to follow up concerns regarding the implementation of the new criteria with the ICU subgroup (Andrew Simpson) and report back to the group.** Further discussion on the case definition: • To review and update the list of high-risk countries we need to develop some – options or criteria to use for identifying what countries to add to the high-risk list countries and when as this is a rapidly changing situation. Factors to consider are: • Epidemiological criteria

	• Phase of response plan (we are still in containment phase) • Local transmission (as defined in WHO sitreps) does not equate to community transmission. • Information dissemination issues if too many countries are being added continuously to the list of high-risk countries. • The purpose of the case definition (identifying who to test and diagnose rather than border advisory) • Workforce implications – increase in primary care presentations, lab testing, border resources etc • It was noted that primary care needs to be supported more on decision around case definition – the current advice is 'call medical officer of health'. The primary care may not have capacity to do this – potentially setting up a phone number for primary care to ring for advice may be useful • As the situation is rapidly changing globally, it is challenging to keep the case definition up to date. • Other considerations include • Do we need to think how to manage people at home, e.g. Healthline can facilitate triaging and manage people with mild symptoms at home. • If you have people with mild symptoms staying home – you are moving away from testing to verify COVID-19 infections. We want to test these people to pick up infections and stop community transmission. • Setting up a campaign that 'if you have mild or moderate symptoms you stay at home and call Healthline'.
3	**Updates from the subgroups**
3a	**Lab (Anja, Virginia)** • Three labs have the capacity to do COVID-19 testing ESR, LabPlus and Canterbury. • In NZ and overseas, there are some issues with assays producing negative with single gene targets where multiple gene targets are positive. There is a need to be up to speed with what gene targets are reported and whether methods are sufficiently sensitive. There is a need to look at alternative assays for backup. • Canterbury Lab is looking at how to ramp up capacity and what other assays are coming online for testing; what options are there for rapid point of case testing – options for rapid flu and rapid COVID-19 testing.
3b	**IPC (Niki and Sally)** • A number of documents have been produced and uploaded onto website. • Primary care guidance has been uploaded.
3c	**Public health (Harriette and Shanika)** • There was discussion when clearance of patients can occur and debate on when this would occur. More work needs to be done in this area • Contact tracing on plane discussed and the risk of people sitting in the outer part of the second row in front or behind the case. The TAG discussed that the risk was lower for those more than 1 metre away and this should be considered in the contact tracing advice for those on aircrafts.

3d	**Epidemiology (Michael and Richard)** • Epidemiology case definition issues discussed above • Michael discussed his modelling paper and it was clarified that more work needed to be done in relation to modelling different phases of the response. • Michael has updated the modelling paper and will send out to group today.

3e	**Primary Health Care (Juliet and Andi)**
	
	• Primary Health care subgroup, met on Monday and discussed the following:
	  • advice on immunocompromised staff ie diabetes.
	  • Capacity of primary care
	  • financial impact on practices
	
	• A formal request was made for a document outlining the rationale of PPE recommendations in primary care.
	
	Action 5: IPC subgroup to produce specific advice on the use of face masks in primary care – Actioned and document on Ministry website

5.	**Other** • It was noted that a shared site where all TAG could sit would be useful. **Action – has been actioned with NHCC operations** • Face to face meeting of TAG would be good **Asad will look at dates and times for this in 3 weeks.**
6.	**Summary of recommendations**
7.	**Date and time of next meeting: Friday 13 March, 9am**

Minutes

Technical Advisory Group for COVID-19 Teleconference (Final)

Date:	12 March 2020
Time:	9:00 am - 10:40 am
Location:	Room GC2, 133 Molesworth St Wellington
Chair:	Dr Niki Stefanogiannis
Attendees:	Dr Anja Werno Dr Bryan Betty Dr David Murdoch Dr Erasmus Smit Prof. Michael Baker Dr Sally Roberts Dr Shanika Perera Prof. Stephen Chambers Dr Virginia Hope Ministry of Health staff: Shari Mason (Guest) James Greenwell (Guest) Dr Juliet Rumball-Smith Dr Ian Town Dr Richard Jaine Dr Niki Stefanogiannis Dr Geoffrey Roche Dr Harriette Carr Asad Abdullahi
Apologies:	Dr Caroline McElnay, Dr Tomasz Kiedrzynski and Andi Shirtcliffe.

Documents tabled:

- Minutes of the last meeting (5 March 2012)
- TAG proposed agenda 12 March 2020
- Proposed_COVID19_dashboard_indicators.xlsx

Item	Notes
0	**Preliminaries** • The Minutes of the last meeting were accepted.
1	**Situation Update** • The Director General of the WHO has just declared COVID19 a pandemic (Wednesday 11 March). Planning in New Zealand is proceeding as planned; the Action Plan will be revisited. • Currently there are 5 confirmed cases and 2 probable. There are no changes in the count since Saturday. Case 1 was discharged yesterday 11 March 2020. The other cases are being managed at home. Of the two probable cases, one was the father of the confirmed case who had been to Iran; the other had been aboard the cruise ship Grand Princess in California. • The National Crisis Management Centre is being stood up and will manage the whole-of-government response. The National Health Coordination Centre (NHCC) will manage the health response. ***Discussion*** It was suggested that NAAT serology testing should be considered on the probable case who had been onboard the Grand Princess. The other probable case was the household member of two confirmed cases (who had no travel history), who had returned from Iran and had mild symptoms for 48 days but had a negative test.
2	**Dashboard** Shari Mason and James Greenwell (Health and Disability Intelligence, Analytical Projects) presented work on an all-of-government dashboard system currently being developed to relay key information on the COVID 19 response. The Ministry was approached by the Department of the Prime Minister and Cabinet (DPMC) to contribute to the dashboard, which will present health, welfare and economic data. The dashboard is being built by MSD. There will be two 'products'; a publicly accessible online dashboard, and a separate A3 sheet for the Ministers. Content will be updated daily or weekly, depending on the specific content. A phased approach will be taken to publishing information, beginning with high-level statistics (e.g. total number of confirmed cases). Other suggested indicators are laid out in the Excel sheet tabled at the meeting. Information from DHBs will be collated, and the State Services Commission has requested that other indicators be added. Demographic breakdowns will be provided but confidentiality will need to be considered. The developers are working with Health Legal and the data governance groups on details.

They will also be liaising with DHBs to determine what data is available and with MSD on the final look of the dashboard. Indicators will also be discussed with the NHCC to ensure that they are correct for their needs. Advice from clinical leads was needed on where the data would come from. Also requiring agreement are standard definitions used in reporting. Ashley would be asked for final signoff.

Discussion

The distinction between the public and Minister's dashboards was discussed. The Minister's dashboard is to provide a broad overview of the health system, in particular system capacity and management of 'business as usual' (BAU).

TAG provided the following feedback:

- The production of a dashboard was good idea
- The purpose of the dashboard – for both public and the Minister should be considered as well as the audience
- It was important to include primary care and laboratory indicators
- Interpretation of indicators was important to inform policy decisions
- separation of indicators into themes would be useful e.g. burden of disease, service pressures

Other indicators could also be included:

- the workload on frontline GPs, and how they were managing with demand. There was concern that secondary care could be overloaded, and the data was needed to inform overall management of the response.
- epidemiological data; ILI surveillance; FluTracker
- elective surgeries in DHBs, and cancellations;
- COVID 19 hospital admissions, broken down into COVID 19 admissions to ICUs, hospitals, and occupancy.
- Laboratory data, capacity, reagents used, number of tests performed, what the results are. This was particularly important given the need to understand the impact on lab work anticipated that other strategic decisions will make.
- data that will identify clustering of cases and linked to high deprivation and low socioeconomic areas.
- Data on number of close contacts and number of self-isolations.
- Supply chain data on availability of PPE and swabs
- Relevant pharmaceuticals
- other indicators could be included such as rates of isolation and quarantine; the median time from symptom onset to isolation of contacts; proportion of contacts identified; number of people quarantined; median time from exposure to quarantine.

It was noted that the one-pager A3 sheet for the Minister would include a glossary that provided context for interpretation. Individual cells of the public dashboard could also be provided with a plain English definition and interpretation that was updated weekly.

Decisions

TAG **endorsed** the approach of the proposal.

Actions

Shari and James will continue to develop the dashboard taking into account TAG advice as above.

3 **Case definition - epidemiological criteria (Richard)**

Update following the last 48 hours:

48 hours ago the Epidemiology Subgroup discussed the categorisation of other countries; it was decided to put Europe into Category 2, Italy into category 1B, and not put the USA in a risk category. In the last 24 hours there has been an increase in cases in the USA, around 200 cases a day.

Feedback from NHCC (Border Operations) is that the frequent of small changes are not feasible as this is confusing for traveller/tourists coming into the country and this should be considered in any updates of the epidemiological criteria.

Discussion
TAG considered the current epidemiology of COVID-19 and noted the increasing numbers across Europe as well as in the United States. Specifying cities or regions within a country was considered too confusing. TAG also noted any widening of the epidemiological criteria would have an impact on both primary care and laboratory capacity – due to increased presentations and testing. As a result, systems needed to be in place to support any broadening of the criteria. Taking into account these considerations the TAG **recommended** staggering the changes in the epidemiological criteria.

The following classifications are recommended to be in place on Monday, 16 March 2020.

Classification	**areas**
Category 1A	Mainland China, Iran
Category 1B	Republic of Korea Italy
Category 2	Europe[1] (excluding Italy) and the UK but excluding Italy. All of the United States of America.

- On Wednesday or a later date Category 2 should be expanded to include all international travellers
- On 17 March, the Epidemiology subgroup will consider whether the mainland China and the Republic of Korea should be re-categorised into Category 1b or Category 2.
- The advice would be prospective, not retrospective.

In addition,

- There was support for a more straightforward approach, i.e. applying the same principle to all international travel and adding all of USA is better for clear communication and understanding in the sector.

[1] The European Schengen visa countries

	• It was suggested to have an ongoing watch on some other European countries (e.g. Germany, France, Spain, Switzerland) for potential consideration into Category 1b if appropriate. • There was discussion regarding placing Seattle into Category 1b. This was not recommended, due to being too granular, and would have implementation / communication issues, as well as complicating future decisions by requiring the need to consider epidemiology and make decisions at city levels. • Flow- on effects of any changes to the travel history classification would include the load on Healthline (given the number of people registering their self- isolation). • It was noted that ARPHS has already scaled down some activities due to the load on their workforce; they are not gate-keeping for lab testing and are not providing negative results to those who have been tested. Alternatives were being considered to support GPs. • Burden on Pacific community needed to be considered, were a restriction to be placed on all countries.
4	**Case definition - clinical criteria (Harriette)** The TAG was asked to comment on whether the case definition should be revised from "fever and respiratory illness" To "fever or respiratory illness" The TAG noted that in broadening the case definition, there needs to be a consideration between balancing the need to avoid missing cases; and the need to avoid overloading the testing system. In particular, it was noted that lab testing capacity and availability of PPE were issues and that rationing would be required. The TAG **recommended** revising itbut acknowledged that regional services need to be prepared. It needed to be introduced in tandem with streamlining testing processes TAG **recommended** separating out criteria 3 from the other two criteria as criteria 3 was primarily for surveillance purposes. **Action:** Harriette to edit the case definition; separating out testing for surveillance purposes into a separate table
5.	**Other issues discussed** 1. There is a move to testing of COVID not needing approval by Medical Officer of Health as this would reduce time delays for primary care waiting for approval before testing However that this would result in an increased workload for primary care and/or laboratories, in terms of reporting back results. Because this approach is likely to be implemented quickly it was agreed that a working group was needed, comprising representatives from the laboratory, public health and primary care subgroups to:

	• Identify the issues and solutions associated with the anticipated increase in workload, and the decision that a Medical Officer of Health will no longer be necessary to approve of a COVID-19 lab test. • An algorithm for processing a positive result • An algorithm for processing a negative result The group will meet tomorrow, 13 March 2020 and will report back to the TAG on the outcome. It was noted that, whilst some PHUs may prefer to take their own approach, others would be expecting guidance. It was also noted that, given the increasing load on the system, a more nationally guided and consistent approach was required that did not warrant regional variation. In addition, the critical importance of rapid testing and rapid turnaround, and the emphasis on diagnosis and containment, was noted, given the experience in the Republic of Korea and Singapore. This suggested that the response be led centrally by the Ministry rather than by individual DHBs and laboratories. 2. The TAG gave feedback to the draft COVID 19 strategy document out of session. Some members of the TAG would like more engagement with the work around the broader strategy. There will be more opportunity for the TAG to input into the strategic plan at the face to face meeting. 3. The TAG requested that documents are provided with sufficient time to review. 4. Ian Town reported that university Vice Chancellors have been asked to report back on their state of readiness if China's borders were to open. 5. Bryan raised concerns by local GP that an upcoming event at Whangamata (Beach Hop music festival, 25th-29th March 2020) was going ahead. This will be followed up out of session by Niki
6	**Public Health (Harriette)** The Public Health subgroup has recommended that the close contact criteria be changed; they recommend that close contact is now defined as being within 2 meters for more than 15 minutes.
7	**Review of current recommendations on clearance** The document on clearance was discussed. More consideration is needed – probably by clinical subgroup of the TAG.
8	**Mass Events:** Niki asked for feedback on paper sent out on social isolation that had been produced by AHPPC.
9	Face to face meeting – Friday 20 March, 1 to 5pm 2. TAG members requested to send suggested agenda items to Asad 3. Niki confirmed that travel arrangements would be made by the Ministry.
10	**Summary of Action Points**

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<tr><td></td><td>
<table>
<tr><th>Agenda item</th><th>Actions</th></tr>
<tr><td>Dashboard</td><td>TAG endorsed the approach of the proposal.

Shari and James will continue to develop the dashboard taking into account TAG advice as above.</td></tr>
<tr><td>Case definition – epidemiological criteria</td><td>• The following changes are recommended:

<table>
<tr><th>Classification</th><th>areas</th></tr>
<tr><td>Category 1A</td><td>Mainland China, Iran</td></tr>
<tr><td>Category 1B</td><td>Republic of Korea Italy</td></tr>
<tr><td>Category 2</td><td>Europe (excluding Italy) and the UK. United States of America.</td></tr>
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<tr><td></td><td>• Category 2 expansion to all international travellers
• The Epidemiology subgroup will consider whether mainland China and the Republic of Korea should be re- categorised.</td></tr>
<tr><td>Case definition - clinical criteria</td><td>• Broaden clinical criteria in line with changes to access to testing.
• Clarify surveillance in hospital setting</td></tr>
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<tr><td>11</td><td>Next meeting: Friday 20 March 1 - 5pm
Face to face, 133 Molesworth St.</td></tr>
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Minutes

Technical Advisory Group for COVID-19 Teleconference

Date:	20 March 2020
Time:	1.00pm – 5.00pm
Location:	Room 1S.5, 133 Molesworth St Wellington
Chair:	Dr Ian Town
Members:	Dr Sally Roberts Prof Michael Baker Prof Stephen Chambers Dr Anja Werno Dr Erasmus Smit Dr Nigel Raymond Dr Virginia Hope Dr Shanika Perera Dr David Murdoch Dr Bryan Betty Ministry of Health Attendees: Dr Caroline McElnay Dr Harriette Carr Dr Tomasz Kiedrzynski Dr Juliet Rumball-Smith Dr Richard Jaine Dr Niki Stefanogiannis Andi Shirtcliffe Asad Abdullahi Shona Meyrick Andrew Forsyth Bronwyn Rendle Doug Lush
Guests:	Prof Nick Wilson, Dr Hernando Acosta, Louise Chamberlain, Steve Brazier (ESR),
Apologies:	Dr Geoffrey Roche

Item	Notes
1	**Governance** Dr Ian Town welcomed all Members, Attendees and Guests to the meeting in his capacity as Technical Advisory Group for COVID-19 Chair. Minutes of the last meeting (12 March 2020) were accepted.
2	**Surveillance** Dr Hernando Acosta, Principal Advisor, Communicable Diseases Team, Ministry of Health presented an update on New Zealand's ILI surveillance programmes to inform COVID-19 surveillance and response. • A rapid assessment of New Zealand's current ILI surveillance systems has determined that, with minor modifications, the earlier-than-normal start (i.e. as soon as possible and before the flu season) of the following programmes could provide valuable information for prioritising COVID-19 surveillance and help detect community transmission and that monitoring and analysing the following (syndromic) data sources over this coming period would be a cost-effective approach to evaluate their value as complementary information for prioritising COVID-19 surveillance and investigations across the country.

ILI surveillance for COVID-19			
Providers	**Programme**	**Surveillance/Service**	**Comments**
CGB Health Research Ltd	Healthstat	GP sentinel-based surveillance	No virological surveillance Expand from 90 to 380
ESR	Event-based surveillance	Event-based (EpiSurv module)	Set up and running cost for three months, assuming a total of 1000 tests (50 tests/DHB) and a weekly summary report
	Virological surveillance (COVID-19)	Laboratory testing (SARS-COV-2)	
	Dashboard integrating: • Healthstat • Healthline • COVID-19 data	Report/Intel advice	
MOH- NSW	• FluTracking	Communnity-based/ participatory	>34000
Syndromic data sources			
Ministry of Education	School absenteeism (students and staff) data	No value if school close. In line with WHO/UNICEF advice to response to COVID-19	
Green Cross Health	Cold/Flu OTC sales data		
The Warehouse Group	Cold/Flu OTC sales and Staff absenteeism data		
IRD	Modelling and analysis of syndromic data		
Eagle technology	Data analysis and dashboard for syndromic data		

Implementation Plan

- Surveillance proposal was approved by the Ministry on 16 March and implementation rollout began the same day. All surveillance programmes and an integrated online reporting dashboard are expected to be up and running by the first week of April.

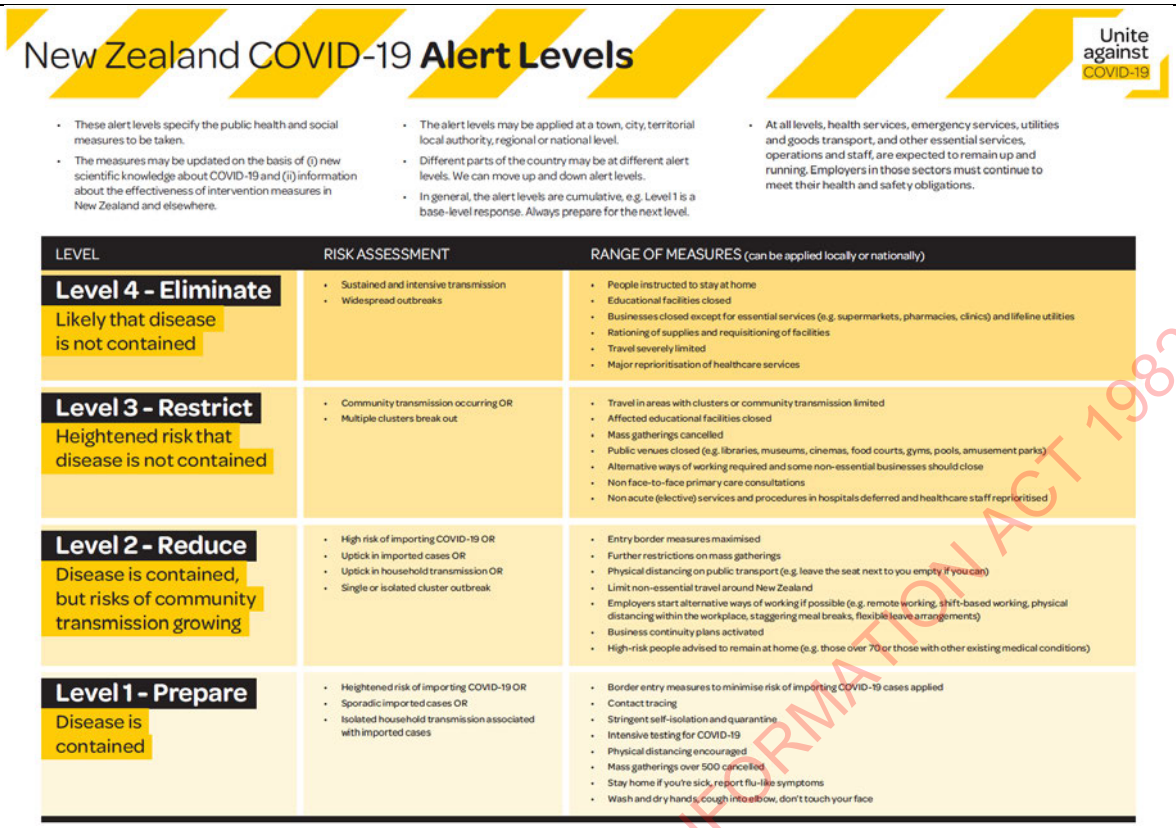
	Mar		Mar-Apr	Apr			Apr-May	May			
	16-22	23-29	30-5	6-12	13-19	20-26	27-3	4-10	11-17	18-24	25-31
SURVEILLANCE PROGRAMME											
• **FluTracking** (started 02 March)											
• **Healthline (ILI)**											
• **Healthstat – 90 practices** (all year round)											
– 380 practices											
• **Event-based surveillance**											
ANALYSIS AND REPORTING (ESR)											
• **email/PDF**											
• **online/Dashboard**											

	• FluTracking began 2 March and will run the whole flu season. Becoming popular as a community-based programme (used in Australia and Europe). Complementary to this, data can assist with determining if the usual increase of ILI across are related to ILI or to something else. • Clarification required on whether Healthline data is only ILI surveillance. Healthline programme runs throughout the year and provides daily reports during the flu season. • Healthstat expected to expand to 380 practices by first week of April. Invitation letters are being distributed today. • Event-based surveillance is ready. • Laboratory testing currently conducted is mainly diagnostic not surveillance. • Hospital cases include blood tests and other samples. • Healthline and Healthstat data ready to be sent to MoH today. • School absenteeism and OTC pharmacy data feed has been established. Laboratory Testing (SARS-COV-2): • Testing will still be mainly for diagnostic not surveillance purposes. • ILI surveillance will be used to prioritise further surveillance testing. • The virological sentinel surveillance's flu swabs (270 tests per week from 90 GP practices) will not be tested for SARS-COV-2, as it is not sensitive enough for cluster control. • Testing for surveillance, and diagnosis, will eventually be determined. • ICU SARI cases are currently being tested across the country (for surveillance purposes as part of the current case definition). • Testing for non-ICU SARI will be highly dependent on available resources and lab capacity. • Testing for COVID-19 will be determined by the availability of resources at any particular time eg: there is currently a worldwide shortage of swabs First report as at Friday 20 March was presented.  ILI_Surv_COVID-19_ TAG_200320.pptx Discussion: • Questions have been adjusted for people answering the survey, following Australian feedback, so now if patients answer yes for both fever or cough, they are now prompted with additional questions. • Potential equity issues are of concern as certain populations may not be able to engage with an online questionnaire. Careful consideration is being given to where sampling occurs to assist with these populations engaging with the surveillance if they are not in touch with their GP. Healthstat is currently well represented at a national level. • Green Cross Health are larger pharmacies and may not pick up vulnerable populations.
3	**Testing Criteria, Testing Logistics, PPE Capacity and Supply** Testing Criteria • Questions are still being raised about the criteria for testing. • Current advice on MOH website is still coupling symptoms and travelling. Considering trajectory of community transmission and supply issues, TAG was asked to consider

	whether the current advice should be balanced between symptoms and travelling and provide guidance on appropriate advice. Discussion • We may now be seeing cases of community transmission – currently 2 developing cases with no history of travel. • Almost at testing capacity, will have to test those with highest risk. • Consider case definition against volumes – there is a current increase in testing as people are returning home with new travel restrictions but this group will drop off. • A lot of data is not being entered into Episurve due to resourcing. • TAG considered that anyone with clinical symptoms should be tested. • Testing criteria already covers people presenting with symptoms that have not travelled – the clinical judgement criterion. • Precautionary advice required, considering best way to deploy staff and PPE. Testing Logistics • MOH is currently working with all suppliers and centralising discussion on supply chains and considering testing logistics and centralised procurement. • Three main streams are being considered – diplomatic, procurement, university capacity. • There has been a positive response from universities on an arrangement to apply their scientific resources. • A high risk around quality is recognised for unvalidated suppliers offering new rapid testing kits. • All available testing kit sources are being investigated. • A backup plan may be required to send testing offshore. TAG recommendations: • No change to current test case definition. • Use PPE as currently worded for patients with significant respiratory symptoms. Work to rationalise messaging on PPE. **Action:** PPE Issues to be addressed by Caroline McElnay in discussion with Juliet Rumball-Smith
4	**Providing guidance to healthcare workers with respiratory systems** TAG was asked to consider the following scenario and to provide guidance and confirm the advice given on the ability to work, and testing: Scenario: Healthcare workers with symptoms (i.e. respiratory, influenza-like etc) who are not suspected cases or close contacts with suspected cases, Questions put to TAG: 1. Do we test healthcare workers if they have mild symptoms but are not a close or casual contact of a confirmed case, and do not have a travel history? ○ TAG response to Q1: ▪ YES, we do test 2. Do we request healthcare workers to stand down from work if they have mild respiratory symptoms but do not meet the case definition for a suspected case?

	○ TAG response to Q2: ▪ YES, we do request stand down from work ▪ Based on assumptions that there has been limited contact; can return to work if negative and asymptomatic for 24 hours **Providing guidance to healthcare workers who have an underlying condition or who are pregnant** Question put to TAG: 3. What is the recommendation to health care workers with comorbidities regarding involvement in care of COVID-19 suspected or confirmed cases? Discussion: ○ Consider 3 high risk groups – those with conditions such as diabetes, those over 65, those who are pregnant. ○ Current evidence does not support pregnancy as being an especially high risk situation. ○ Help line is currently being set up for community health workers and GPs for general COVID-19 enquiries. If not a straight forward case, specialist clinical advice will be sought. TAG Recommendations: ○ These workers should be deployed to work 'virtually' or in an area with non-patient contact. ○ Provide guidance and principles to organisations on reducing face to face exposure to ensure workers are kept safe. ○ Ensure workers are well informed on the risk and enabled to voice concerns. ○ Provide clarity and clinical guidance on patients who are being taken off immunosuppressants. **Action:** IPC subgroup
5	**Modelling** Professor Nick Wilson, University of Otago, presented his modelling reports: 1. 13 March 2020 report- models the potential health impact of the COVID-19 pandemic spreading in NZ and the extent to which this impact could be mitigated with control measures; 2. 16 March 2020 report – models the potential age-specific health outcomes from the uncontrolled spread of COVID-19. • Modelling is being conducted using NZ demographic data and relevant parameters from international literature, with a wide range of scenarios being explored. . • Planning to produce a new report using most up to date information, on scenarios to reduce hospitalisation and fatality rates. • Key message – if reproduction number (R0) can be reduced to near 1.0, the epidemic peak could be pushed into 2021 when a vaccine is available. High isolation rates will be required to push peak into 2021 • Seasonal factors are also being modelled. • Currently modelling a 6-month control period

	• Effectiveness of quarantine is dependent on social practices. • A revised modelling paper bringing the 2 earlier reports together will be available 21 March. **Additional Papers Tabled** • Paper on links between cases of confirmed and probable COVID-19 cases was tabled. Current data suggests NZ is on the cusp of community outbreak. This data is currently being used in discussion with Ministers. • Work on current progression rates is underway. This will be compared to other countries rates and used to map NZ control measures. **Decisions** • 13 March and 16 March modelling reports are currently undergoing signoff. The 21 March report will then be uploaded onto the MoH website on 23 March. The Chair acknowledged the modelling has been and will continue to be critical to decision making.
7	**New Zealand COVID-19 Alert Levels and COVID-19 Strategic Response Plan** Shona Meyrick presented New Zealand COVID-19 Alert Levels and the Draft COVID-19 Strategic Response Plan for TAG information and feedback. **NZ COVID-19 Alert Levels** • These alert levels are part of a framework for setting the scene for national construct and signalling to other agencies what they need to be doing. The Chair advised we have now eased into Level 2 – Disease is contained, but risks of community transmission are growing. • NZ's COVID-19 strategy focuses on keeping it out, stamping it out and slowing it down. • The 4 alert levels specify the public health measures to be taken and the impacts on daily life. • The alert levels may be applied at the town/city, TLA, regional or national levels. Different parts of the country may be at different alert levels • In general, the alert levels are cumulative.



TAG feedback on Alert Levels:

- Current diagram reads as if measures are sequential. Should they be shown in parallel?

COVID-19 Strategic Response Plan

- The Response Plan establishes a framework for operational planning. It is aimed at the health sector but includes some components relevant to other agencies and sectors. The Plan will be finalised on the 23 March and published by end of March. It will be a 'living document' which will continue to be updated.
- Detailed operational plans will not be published as 'living documents'. There will be up to 10 operational plans.

TAG feedback on the overall Plan:

- Phasing terminology needs to be aligned with alert levels and other documentation
- Include an up-front statement giving an ethical and community lens is needed along with a purpose statement.

Section 1 - Key Aspects of the Plan

- Currently reflects the broader pandemic phases, but this will narrow to the current phase of the COVID-19 pandemic.

Section 2 – Strategic Response Action Plan

- Response Plan identifies 8-10 areas of planning activities. They are not intended to be siloed; there are activities that impact across all areas.

Public Health

- Confirmed high level action of 'increased contact tracing capacity to 50 cases per day' is 50 cases nationally, not per public health area.

Action: Dr Shanika Perera will check this relates to cases in the community and provide feedback.

- A contact tracing platform based at the Ministry has been launched this week.
- A separate Psychosocial Plan is being developed.
- A workstream is currently investigating options for providing accommodation during self-isolation eg, campervans and hotels. Current expectation is for individuals to pay for this themselves.

Hospitals

- All District Health Boards (DHBs) are required to have Action Plans for Communicable diseases – this work is well underway.
- DHBs have been advised to activate their Business Continuity Plans.
- "Hospital at home" arrangements are not widely understood. There is evidence that mild pneumonia can be safely managed at home, although this could be an issue in high deprivation areas and is dependent on nurse availability. There is a possibility this could be rolled out in certain areas eg: Kapiti Coast which has existing infrastructure that could be used.

  Action: Dr Bryan Betty will enquire amongst colleagues if there are areas with current infrastructure that could support this.
- ICU capacity is being worked on eg: ventilator sourcing.
- There are conversations underway with private hospitals eg: routine care of non-COVID-19 patients. Acknowledged there is a constraint with many staff currently working across both public and private hospitals.

TAG feedback:

- Replace 'field hospital' terminology with 'non-health settings'. DHBs may need to think about additional planning for this.
- Include Personal Protective Equipment (PPE) lessons learnt eg: a group of GPs in the Wairarapa have developed a process to sterilise and re-use masks but we are not sure if this is safe and effective

Care in the Community

- Health Pathways system will be extended nationally and will be complementary to with regional pathways as an enabling technology to support decisioning.

TAG feedback:

- The role of primary care is not properly described. Plan does give a sense of the differential spread of high needs.
- BAU should be included eg: underling care in the community.
- Include the at-risk populations such as migrant and refugee communities

Infection prevention and control (IPC)

- Operational plans are focused on standards and best practice.
- All communications channels are being planned and activated in parallel.

TAG feedback:

- Clarity which health care workers require masks.
- Guidance on domestic cleaning has been requested and published.

- There is a lot of IPC information on the CDC website which should be incorporated for PIMS messaging. This is an opportunity to streamline messaging around the greatest transmission place being the home. Discussion links with PIM flow from IPC group.
- IPC and Public Health areas need to be linked.
  Action: PIM needs to lead the focus on home messaging.
- Require public facing messaging for extra precautions for patients leaving hospital to avoid them infecting others.
  Action: IPC subgroup consider.

Health and disability supply chain

- Pharmac and Medicines NZ are being urged to align their objectives as part of managing medicines supply chain issues.

TAG feedback:

- **Action:** Andi Shirtcliffe will assist with wording for Order in Council.
- Consider the role for local manufacture for products such as masks and hand sanitisers for use in the home.

At risk population

- Discussions progressing with Maori Leaders. There is urgency to discuss and deliver marae based intervention and support.
- Chronic disease has been considered in this area of the plan.
- Active and focused conversations are underway with local councils which cover higher risk population areas.

TAG feedback:

- Plan needs to include how to consider providing directed support for high needs patients to manage equity provisions. All at risk individuals including disability clients should have a plan now. This process needs to begin now to increase realisation of benefits.
- Pacific island nations are at risk for several reasons. ESR has offered testing services for samples sent in from the Pacific.
- Change 'at risk' to priority populations.

Workforce

- Legislation/regulatory work in progress to make other resources available.

TAG feedback

- Require specific instructions for occupational health services.
- Can requirement for health staff not being able to work for 14 days be relaxed? ?
  Action: Dr Sally Roberts will connect on the 14 days with Health and Safety Group in Northern Region.
- Assistance required with gaining traction with NZ Medication Council on recruitment eg: SMOs.
  Action: Chair will discuss registration and training with NZ Medical Council (lead is Dr Andrew Simpson CMO).

TAG invited to share any further feedback on the Strategic Response Plan with Shona Meyrick as soon as possible for incorporation into the document on Monday: Shona.Meyrick@health.govt.nz

8	**Any Other Business**
	• The Chair requested the meeting consider mechanisms for providing more frequent advice between TAG formal meetings. Suggest establishing 'on duty subgroup representative' who could provide fast-turnaround information to Policy and escalate to the wider subgroup at a later point.
	  ○ Meeting agreed:
	  Action: Louise Chamberlain will work with Subgroup Chairs to develop clear processes and identify senior key individuals for this role.
	• A Clinical Subgroup will be established across key disciplines. Membership should include a Clinical Pharmacologist.

9 New Action Items raised during meeting:

Agenda item	Actions
PPE Capacity and Supply	PPE Issues to be addressed by Caroline McElnay in discussion with Juliet Rumball-Smith
Providing guidance to healthcare workers who have an underlying condition or who are pregnant	IPC subgroup to provide guidance and principles for health care workers with comorbidities regarding involvement in care of COVID-19 suspected or confirmed cases.
Strategic Response Plan **Hospitals**	Dr Bryan Betty will enquire amongst colleagues if there are areas with current infrastructure that could support 'hospital at home' arrangements.
Strategic Response Plan **Infection prevention and control (IPC)**	PIM to lead the focus on home messaging.
Strategic Response Plan **Infection prevention and control (IPC)**	IPC subgroup consider public facing messaging for extra precautions for patients leaving hospital to avoid them infecting others.
Strategic Response Plan **Health and disability supply chain**	Andi Shirtcliffe will assist with wording for Order in Council.
Strategic Response Plan **Workforce**	Dr Sally Roberts will connect with Health and Safety Group in Northern Region on the 14 day requirement for health staff not being able to work.
Strategic Response Plan **Workforce**	Chair will discuss registration and training with NZ Medical Council (lead is Dr Andrew Simpson CMO).
Strategic Response Plan **Public Health**	Dr Shanika Perera will check contact tracing capacity relates to cases in the community and provide feedback.
Providing mechanism for more frequent advice	Louise Chamberlain will work with Subgroup Chairs to develop clear processes and identify senior key individuals for an 'on duty subgroup representative' who could provide fast-turnaround information to Policy and escalate to the wider subgroup at a later point.

10	Next meeting: Tuesday 24 March Teleconference

Minutes: Technical Advisory Group COVID-19

Date:	Tuesday 24 March 2020
Time:	3.00pm – 4.30pm
Location:	NHCC meeting room – basement 133 Molesworth St Teleconference: see calendar invitation for details
Chair:	Dr Ian Town
Attendees:	Dr Sally Roberts, Prof Michael Baker, Prof Stephen Chambers Dr Anja Werno, Dr Erasmus Smit, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Dr David Murdoch, Dr Bryan Betty **Ministry of Health staff**– Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Andi Shirtcliffe, Asad Abdullahi, Shona Meyrick, Fiona Gillam (Secretariat)
Guests	Louise Chamberlain (PwC)
Apologies:	N/A

Item	Governance
1	Dr Ian Town welcomed all Members, Attendees and Guests to the meeting in his capacity as Technical Advisory Group for COVID-19 Chair. Minutes of the last meeting (20 March 2020) were accepted.
2	**Subgroup verbal updates** **Epidemiology** • Considering criteria for progressive step-down from Alert Level 4. A considerable amount of information is required to determine step-down criteria and will test utility of information available through considering two scenarios – testing limitations or not. • Discussed how to streamline information on surveillance and extending ESR dashboard surveillance. **Laboratory** • Have national linkages on increasing capacity and improving supply chain. Also considering private suppliers. This is being led by the MOH procurement team. **Primary Health Care** • Have requested issues with telehealth resourcing and virtual consultation (phone lines falling over) to be raised at national level. • Data and Digital and Logistics are linking in with telehealth and feeding into legislation on state of emergency.

	Infection Prevention and Control • DHB IPC guide – now focusing on aged residential care and hospice guidance and supporting guidance on transport eg: air ambulance. **Public Health** • Have been discussing physical distancing conditions. Next meeting will focus on case definition, travel history implications, EPI criteria and its impact on testing regimes. Considering how to prioritise testing if criteria is broadened. Do not want case definition defined by testing ability. **Clinical** • Discussions underway on set up of a specialist clinical subgroup. Requirement to have access to specialists at short notice - 10-12 specialities focusing on key areas, and potentially providing advice by email.
3	**Definition of Recovered** Dr Harriette Carr presented a Review of possible NZ criteria for release from isolation. Australia recently updated their definition. There has been a consensus from Laboratory network using 2 negative tests as a criterion is not supported. TAG Feedback: • Wish to see science behind decision making. • It is known that younger patients, although younger and seemingly health, have the highest viral load. • PCR could be positive for weeks • Singapore Chief Medical Officer has implemented to policy of requiring 2 negative tests prior to release from self-isolation. • Consider discharge planning – persistence of post viral cough can be issue for release from isolation in absence of pre-existing illnesses. • Consider monitoring of cases post release. • Consider the official release process and it implications for families • Discussions underway with Operations on appointing Episerve Officer in every Public Health unit and agreeing process eg: updated by certain time daily to incorporate into reporting **Action:** Provide any further feedback to Fiona Gillam urgently. TAG Recommendation: • TAG recommended we adopt the Australian criteria (minus the double testing requirement)
4	**COVID-19 Health and Disability Response Plan** The Chair thanked TAG for their previous feedback and contributions to the plan. Any further feedback needs to be received by Shona Meyrick by COB 24 March prior to being published. The plan will include operational plans which will be continually updated as required. Plan likely to be updated within 2-4 weeks – ie, will be living a document TAG Feedback: **Primary Care**

	• Clarity required on levels 3 and 4 requirements in the health system (different alert levels apply) • Current wording of no face to face consultations in primary care has caused significant issues. Propose rewording to 'minimise face to face'. • Most DHBs will have prepared their plans as pandemic. DHB Team is currently working to resolve confusion on how levels operate. Communications Plan is in draft, currently receiving sector feedback. • NHCC Intelligence is working on strategic view and planning on measuring effectiveness at level 4 and movement between levels 3 and 4. Societal approach does not mean the same for health sector. **Action:** EPI subgroup to consider criteria of cases going up or down, numbers of community transmission and total cases on the alert levels **Health and Disability** • Do not have capacity in Auckland for all residential care support. Can carer roles be more flexible?
5	**Formation of Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group** Dr Bryan Betty presented briefing paper - Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group to Technical Advisory Group and Senior Science Advisors • TAG noted the formation of the Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group on 13 March, made up of key leaders in Māori health, including Primary Care Specialists, Public Health experts, Public Health Physicians, Māori physicians, Māori Nurses and iwi leaders. The group has established a communication platform, has strong active links with a large number of Māori organisations and has an active media presence. • Primary Care subgroup has endorsed the recommendation to appoint a member of Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group to the Technical Advisory Group. **TAG Recommendation:** • A member of Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group should be appointed to the Technical Advisory Group. **Action:** Dr Ian Town will action this appointment through the Maori Directorate. Juliet to consider if NHCC requires Maori support. **TAG discussion:** • Discussions underway for Pacific Island representative to join TAG.
6	**Operation of subgroups** Louise Chamberlain presented proposal on operation of subgroups for centralising and managing urgent requests: • There is expected to be an increase in information requests. • Nominate an 'on duty' subgroup member to drive quick turnaround of technical and scientific advice on urgent information requests • A TAG inbox is being created as a single point of contact for information requests • Proof of concept will be released over new few days.

7	**New Action Items raised during meeting:** **Agenda Item** / **Actions** Item 3 – Definition of Recovered: All of TAG to provide any further feedback to Fiona Gillam urgently. Item 4 - COVID-19 Health and Disability Response Plan - Alert Levels: EPI subgroup to consider criteria of cases going up or down, numbers of community transmission and total cases on the alert levels moving between levels 3 and 4 Item 5 - Formation of Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group - Maori representation on TAG: Dr Ian Town to action appointment of member of Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group through the Maori Directorate. Dr Juliet Juliet Rumball-Smith to consider if NHCC requires Maori support
8	Meeting closed at 4.15pm Next meeting Friday 27th March Time 10.00am – 11.00am

Minutes: Technical Advisory Group COVID-19

Date:	Friday 27 March 2020
Time:	10.00am – 11.00am
Location:	Video conference; Room 3N.3 133 Molesworth St
Chair:	Dr Ian Town
Attendees:	Prof Stephen Chambers, Dr Erasmus Smit, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Dr David Murdoch, Dr Colin Tukuitonga, Louise Chamberlain **Ministry of Health staff** - Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Andi Shirtcliffe, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	No apologies were received prior to the meeting, however technical difficulties with telephony prevented full attendance. All meetings will now be conducted via Zoom.

Item	Governance
1	Dr Ian Town welcomed all Members and Attendees to the meeting in his capacity as Technical Advisory Group for COVID-19 Chair. Minutes of the last meeting (24 March 2020) were accepted.
2	**Subgroup verbal updates** **Epidemiology** • Discussions in progress to increase membership to include a wider group of specialists with practical and academic knowledge, to assist with management of high workload. Richard Jain will update members by email. **Laboratory** • Evidence has found a lot of new tests have not being validated. Ministry Procurement Team is working through a formal process of assessment. • Universities are stepping up efforts in university laboratories to conduct testing, but this could be 3-4 weeks away. **Primary Health Care** PPE • Healthcare logistics and comms are working on getting clarity on current supply chain • Need to provide guidance to essential industry groups – healthcare workers are the priority. • Teleconferences being held today with DHBs and Health Staff Unions.

	Public Health • Advice for health professionals on criteria for release from isolation for probable and confirmed cases has been updated to be released to clinical community.   updated-advice-for-health-professiona COVID-19 release from isolation criteri • Decoupling case definition and test criteria **Action:** Dr Harriette Carr will provide proposal for discussion today on decoupling case definition and test criteria with an eye to supply issues. Clarity on 1 / 2 mt social distancing rule • There appears to be a need to provide additional clarity to the public and to health care workers on social distancing rules although current advice is readily available on website (at least 1mt, preferably 2mt for general physical distancing and 2mt for contact tracing of close contacts). Any change to current advice needs to be led by Clinical but come back through Public Health **Action:** Dr Harriette Carr to progress with Clinical Desk **Clinical** • Discussions underway on set up of a specialist clinical subgroup. Requirement to have access to specialists at short notice - 10-12 specialities focusing on key areas, and potentially providing advice by email.
3	**Point of Care Testing** Louise Chamberlain presented a request for advice: TAG was requested to provide advice to the Laboratory Testing workstream on whether point of care testing is to be a component of their Testing Strategy, considering: • If point of care testing is to be implemented as part of the testing strategy; • If so, what are parameters to implement to - where would point of care testing be placed? – (all CBACs; only large ones; hospitals etc) Noted by Advice Requestor: From a practical perspective, the benefits are that this will increase our national test capacity and take some load off central labs. TAG Feedback: • Would be an advantage from a strategic and logistics point of view • POC test ned to be valid and have good sensitivity and specificity TAG Recommendation: • Do not deploy point of care testing until we are confident that the exercise will be effective and not harmful. • POC testing will be evaluated continuously by ESR and Michael Bunce

4	**Update on operation of TAG and subgroups** • An updated proposal on the process to provide advice on a short turnaround basis will be presented to next meeting, following feedback about capacity. • Dr Matire Harwood from Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group and Dr Collin Tukuitonga from Pacific COVID-19 Response Team have been appointed as members of the Technical Advisory Group. • New requirement of a 4-hour turnaround to provide TAG actions and decisions to Director General of Health after each meeting. • Meeting agreed TAG is to meet twice weekly, on Tuesdays and Fridays, preferably late morning.
5	**Any other business** • Work has started on intelligence inputs and strategy. • An information management resource is being set up, to create a single repository for academic and research collateral. • A daily questionnaire will be going to DHBs next week, seeking information about patients and facilities. • Following the meeting - an update about the proposed stand up of primary care clinician phone line. This will undergo trials mid next week – provider will be National Telephone Service. **Action:** Dr Ian Town to progress communications on availability
6	**New Action Items raised during meeting:**

Agenda Item	Actions
Item 2 – Public Health - Decoupling case definition and test criteria	Dr Harriette Carr will provide proposal for discussion on decoupling case definition and test criteria with an eye to supply issues. To be considered further at next TAG meeting 31 March.
Item 2 – Public Health - Clarity on 1/2mt social distancing rule	Dr Harriette Carr to progress with Clinical Desk
Any other business - Stand up of clinician-to-clinician line	NTS standing up mid next week. Dr Ian Town will monitor and report back.

7	Meeting closed at 11.00am Next meeting Tuesday 31 March 10.00am – 11.00am

Minutes: Technical Advisory Group COVID-19

Date:	Tuesday 31 March 2020
Time:	10.00am – 11.00am
Location:	Zoom; Room 3S.5 133 Molesworth St
Chair:	Dr Ian Town
Attendees:	Dr Sally Roberts, Prof Michael Baker, Prof Stephen Chambers, Dr Anja Werno, Dr Erasmus Smit, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Dr David Murdoch, Dr Bryan Betty, Dr Colin Tukuitonga, Dr Matire Harwood **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	N/A

Item	Governance
1.0	Dr Ian Town welcomed all Members and Attendees, particularly new Members Dr Matire Harwood from Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group and Dr Collin Tukuitonga from Pacific COVID-19 Response Team. Minutes of the last meeting (27 March 2020) were accepted, noting an amendment has been made to refence case definition and test criteria to be considered at today's meeting.
2.0	**Update on open actions** Actions 03, 04, 08, 10 were closed. Actions 02, 06, 09 remain open.
3.0	**Case Definition and Test Criteria** The Chair advised the Director General of Health requires a recommendation today on Case Definition and Test Criteria for COVID-19. • DG would like the criteria decoupled from travel and traveller Dr Harriette Carr presented options:  Memo Re options for case definition a TAG Discussion: • Current strategy is elimination. • Test criteria must be simple, quantified, reflect elimination strategy and be easy to interpret. Supplementary guidance will be required for people who do not meet case definition.

	• Data is required to understand success of elimination strategy and to inform future escalation or de-escalation decisions. • Option 2a (Remove epidemiological criteria from Suspect Case definition and refine clinical criteria) is simplest option - some criteria are based on most common symptoms and would be most useful for people running CBACs in areas difficult to self-isolate without a positive test result. • Decouple case definition from travel. • Many people are being tested that do not fit current test definition and criteria. • Managing suspect cases without testing for long period of time may be an issue outside of lockdown period. • Respiratory illness hospital admissions should be treated as COVID-19 until proven otherwise. • Lab capacity will be increasing over next 2-3 weeks. • Clear comms is required, not only to health sector but also to public. **TAG Decision:** • Agreed we are pursuing an elimination strategy. • Approved in principle that a version of Option 2a be adopted. **Action:** Dr Harriette Carr to draft and provide version of Option 2a for submission to the Director General.
4.0	**Clinical Subgroup** Louise Chamberlain provided an update on the establishment of the Clinical Subgroup: • Developing a core group of experts for advice and rapid response to clinical questions. • Working with representatives from Health Pathways and Hospital Pathways, on improving information delivery. • National Telephone Service is piloting an advice line for Health Professionals (not just GPs). • Invite feedback on Clinical Subgroup Terms of Reference **Action:** Louise Chamberlain distribute TOR to TAG for feedback
5.0	**Supply of Essential Medicines** Andi Shirtcliffe provided an update on the supply of essential medicines: • Putting together advice on stocks levels across sector. • No projected out of stock situation; any issues to date have been related to communications between wholesalers and suppliers, and some stockpiling. • PHARMAC and Medsafe are in regular contact with suppliers. • MFAT working with air freight operators to circumvent potential supply issue in 4-6 weeks. • Need information on current and likely future use of antivirals, likely range of antibiotics, which oral medicines are being used to treat moderate COVID-19. **Acton:** Dr Nigel Raymond investigate and report back
6.0	**Evidence Base and Thematic Analysis** Dr Ian Town provided information on clinical trials: • Library and information management staff developing reporting which will be forwarded to TAG regularly.

7.0	**Laboratory Testing** Dr Ian Town provided information on laboratory testing: • Circulated paper has been prepared by Michael Bunce, Chief Science Advisor at EPA, and has been provided to Ministry and other agencies, including MOH supply chain team. • Research on potentially useful test kits is being tracked with support from ESR. • Information or feedback on any test kits welcomed. TAG feedback: • Need to connect with clinical community and laboratory specialists • A Diagnostic Laboratory Expert needs to be involved in future assessments (E Smit) • Likely NZ will be slow producing data to validate tests as we have low case numbers • Concerned some organisations have the right to bring test kits into NZ. • University laboratories should not be developing their own assays. • Limited test capacity in Pacific Island communities. WHO is involved in supporting testing capacity uplift. • Rise in IgG not being detectable until 2nd week at earliest and this means that serology testing is not very useful for acute diagnosis.
8.0	**Subgroup verbal updates** **Epidemiology** • Subgroup has been strengthened and will consider forward planning strategy which will then be used by officials for scenario planning. **Primary Health Care** • Ongoing discussions on PPE supply and deployment. • Advice for health care workers – no difference with patients presenting with respiratory conditions in hospitals or private practice. • Not enough flu vaccine in vulnerable communities – the MOH is working with PHARMAC on this. • Adjusting practice to treat respiratory symptoms then sending to CBACs (an example in South Auckland) **Infection Prevention and Control** • Revised self-isolation criteria and advice published 30 March. • Important that advice is specific - release from isolation must be a conversation between the patient and their practitioner. **Other:** • Supporting work on overcrowded housing and options to relieve; information flows and GPs providing support for Pacific Island communities.
9.0	**Any other business** • No other business discussed
10.00	**Agenda items for next meeting** • No future agenda items raised

11.00 **New Action Items raised during meeting**

#	Agenda Item	Actions	Owner
11	Item 3 - Case Definition and Test Criteria	Draft and provide version of Option 2a for submission to the Director General	Dr Harriette Carr
12	Item 4 - Clinical Subgroup	Distribute Clinical TOR to TAG for feedback	Louise Chamberlain
13	Item 5 - Supply of Essential Medicines	Investigate and report back on current and likely future use of antivirals, likely range of antibiotics, which oral medicines are being used to treat moderate COVID-19	Dr Nigel Raymond

12.00 **TAG Decisions**

- Agreed we are pursuing an elimination strategy.
- Case Definition and Test Criteria - Approved in principle that a version of Option 2a be adopted.

13.00 Meeting closed at 11.00am

Next meeting Friday 3 April 10.30am – 11.30am

Action #	Agenda item	Actions	Action Owner	Updates	Status
02	Providing guidance to healthcare workers who have an underlying condition or who are pregnant	IPC subgroup to provide guidance and principles for health care workers with comorbidities regarding involvement in care of COVID-19 suspected or confirmed cases.	Dr Sally Roberts	31/03 –Progressing pregnancy related with Royal College. Disability comorbidities has not progressed. Links to be added to website when resolved. 20/03 – Action raised	Open
03	National Health and Disability Plan	Several actions raised (3a – 3g – see full action register for details) and now completed	Dr Ian Town	31/03 – Plan is to be released today by MOH. Action closed 20/03 – Actions raised	Closed
04	Providing mechanism for more frequent advice	Work with Subgroup Chairs to develop clear processes and identify senior key individuals for an 'on duty subgroup representative' who could provide fast-turnaround information to Policy and escalate to the wider subgroup at a later point.	Louise Chamberlain	31/03 – Will continue to be progressed. Action closed 20/03 – Action raised	Closed
06	Item 4 - COVID-19 Health and Disability Response Plan Alert Levels	EPI subgroup to consider criteria of cases going up or down, numbers of community transmission and total cases on the alert levels moving between levels 3 and 4	Dr Richard Jaine	31/03 – In progress. To be further discussed at EPI subgroup meeting 1 April. 24/03 – Action raised	Open
08	Item 2 – Public Health Decoupling case definition and test criteria	Dr Harriette Carr will provide proposal for discussion on decoupling case definition and test criteria with an eye to supply issues.	Dr Harriette Carr	31/03 – Presented for decision at meeting • Agreed we are pursuing an elimination strategy. • Approved - a version of Option 2a will be drafted and provided to the Director General 31/03. Action closed 27/03 – Action raised	Closed
09	Item 2 – Public Health Clarity on 1/2mt social distancing rule	Progress with Clinical Desk	Dr Harriette Carr	31/03 – Action remains open for Public Health to progress with Clinical Desk. Communication must be considered. 27/03 – Action raised	Open

10	Any other business Stand up of clinician-to-clinician line	NTS standing up mid next week. Dr Ian Town will monitor and report back.	Dr Ian Town	31/03 – Clinician-to-Clinician line staffed by senior nurses and 2nd tier GPs being tested 01/04, with plans to launch 01/04. Action closed 27/03 – Action raised	Closed

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 3 April 2020
Time:	10.30am – 11.30am
Location:	Zoom; Room 3S.1 133 Molesworth St
Chair:	Dr Ian Town
Attendees:	Dr Sally Roberts, Prof Michael Baker, Prof Stephen Chambers, Dr Anja Werno, Dr Erasmus Smit, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Dr David Murdoch, Dr Bryan Betty, Dr Colin Tukuitonga, Dr Matire Harwood **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Niki Stefanogiannis, Andi Shirtcliffe Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	Dr Richard Jaine

Item	Governance
1.0	Dr Ian Town welcomed all Members and Attendees, in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (31 March 2020) were accepted.
2.0	**Update on open actions** Actions 9, 11, 12 were closed. Actions 2, 6, 13 remain open.
3.0	**Clinical Criteria of Case Definition** The Chair advised that feedback received on the Case Definition and Test Criteria (updated on 2 April) indicates further fine-tuning is required. TAG was requested to advise and provide decision on changes required. • Range of feedback received – too broad; too onerous; too narrow – potentially missing cases; particularly how to operationalise in hospital setting – isolation issue • Have received update on current presentation of cases and update from Intel on presentation of combination of symptoms • Requesting close contact analysis data from ESR • Multiple procurement systems in place to increase testing capacity TAG Feedback: • Must be simple and clear message • Sensitive clinical criteria important • Public messaging must align and provide clarity as issues have arisen with current public messaging and is impacting front line staff

	• Difficult to capture all clinical judgement in a clinical definition. Clinical judgment critical eg: if there is another clear source of fever • Issue with drawing on other country's experience as they have not been operating under an Elimination Strategy • Anosmia is an important symptom to consider • Unlikely to get data for those who test negative – Public Health have not been recording patient details **TAG Decision:** **Clinical Criteria of Case Definition** • Make criteria as sensitive as possible • Fever is no longer a requirement. Replace case definition with 'a range of common respiratory symptoms' • There is still an overarching clinical judgement criterion **Action:** Clinical Criteria of Case Definition to be redrafted by early afternoon today and will be posted on Ministry of Health website 3 April.
4.0	**Clearance Criteria** Dr Harriette Carr advised the Director General of Health has requested TAG clarify the difference between the Australian and New Zealand Clearance Criteria. Current criteria: • 48 hours symptom free TAG feedback: • Queries being received from health professionals and the community that we are not aligned with other countries • Not enough data exists to base decision on. Must balance any change with sensible practicalities. **TAG Decision:** • No evidence to support a change to the 48 hour criteria
5.0	**Influenza Vaccine Availability** Dr Niki Stefanogiannis provided an update from the Immunisation Team: • 1,000,000 vaccines arrived 2 days ago, 200,000 are in transit. • The max order of 60 doses applies, but providers do have the ability to request more. • Reviewing orders daily and coordinating to ensure supplying where most needed. • Practices eligible for funding are receiving. • Coordinators working to move local stockpiles around. • More stock arriving through to mid-May. • Pharmac have ordered 1.6mill doses. TAG feedback: • Supply chain issues have not been resolved. • Must be able to order more than 60 vaccines per practice at a time.

- Available vaccines should be prioritised for the over 65 years old, especially in Maori and Pacific communities.
  Action: Provide this feedback to Immunisation Team

6.0 Sector Communications

Not discussed due to time constraints

Action: Louise Chamberlain to distribute update

7.0 Subgroup verbal updates

Laboratory

- NZMN serological testing update published today.
- Aged residential care facilities - trying to test rather than isolate
- University laboratories are working on establishing the PCR test

Clinical

- Developing guidance principles for subgroup and building relationships with other active groups and individuals
- Update on Hydroxychloroquine Request for Advice (RFA)
  - Restriction at present to non COVID-19 use. Usual criteria and levels of evidence still very important to refer to. Not yet adequate information to use for prescribing to COVID-=19 patients outside a trial
  - Clinical HRC RFP includes proposals for various clinical trials which will be announced by the HRC on April 9th

8.0 Any other business

- No other business discussed

9.0 Agenda items for next meeting

- No future agenda items raised

10.0 New Action Items raised during meeting

#	Agenda Item	Actions	Owner
14	Clinical Criteria of Case Definition	Redraft early afternoon today to be posted on Ministry of Health website 3 April.	Dr Harriette Carr
15	Influenza Vaccine Availability	Provide TAG's feedback to Immunisation Team	Dr Niki Stefanogiannis
16	Sector communications	Distribute update	Louise Chamberlain

11.0 Summary of TAG Decisions

Clinical Criteria of Case Definition

- Make criteria as sensitive as possible
- Fever is no longer a requirement. Replace case definition with 'a range of common respiratory symptoms'

	• There is an overarching clinical judgement criterion **Clearance Criteria:** • No evidence to support a change to the 48 hour criteria
13.0	Meeting closed at 11.30am Next meeting Tuesday 7 April 10.30am – 11.30am

Action #	Agenda item	Actions	Action Owner	Updates	Status
02	Providing guidance to healthcare workers who have an underlying condition or who are pregnant	IPC subgroup to provide guidance and principles for health care workers with comorbidities regarding involvement in care of COVID-19 suspected or confirmed cases.	Dr Sally Roberts	03/04 – In process of retracting incorrect FAQs to reset practical obstetric guidance. Clinical advice phone line being piloted next week. Clinical desk providing current MOH advice and advising to seek clinical guidance. Guidance being sent to DHBs today 31/03 – Progressing pregnancy related with Royal College. Disability comorbidities has not progressed. Links to be added to website when resolved. 20/03 – Action raised	Open
06	Item 4 - COVID-19 Health and Disability Response Plan Alert Levels	EPI subgroup to consider criteria of cases going up or down, numbers of community transmission and total cases on the alert levels moving between levels 3 and 4	Dr Richard Jaine	03/04 – Expanded Surveillance Plan is being developed with input from Office of the Director of Public Health and ESR. Testing data will be centralised going forward and linked to case mgmt. systems. 31/03 – In progress. To be further discussed at EPI subgroup meeting 1 April. 24/03 – Action raised	Open
13	Treatment protocols for COVID-19 patients	Investigate and report back on current and likely future use of antivirals, likely range of antibiotics, which oral medicines are being used to treat moderate COVID-19	Dr Nigel Raymond	03/04 – In progress. Have been assigned a PHARMAC Liaison Representative for TAG. Provide further update next week. 31/03 - Action raised	Open

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 17 April 2020
Time:	10.30am – 11.30am
Location:	Teleconference
Chair:	Dr Ian Town
Attendees:	Dr Sally Roberts, Prof Michael Baker, Prof Stephen Chambers, Dr Anja Werno, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Matire Harwood, Dr Patricia Priest, Dr Colin Tukuitonga, Dr Erasmus Smit **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	N/A

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members and Attendees in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (9 April 2020) were accepted.
2.0	**Update on open actions** Action 19 remains open with a revised emphasis on a possible rapid review testing strategy and performance
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health including the development advice on moving out of Level 4 lockdown along with the monitoring and surveillance tools for the next phase of the pandemic response. Data analysis continues, with the Ministry acknowledging the need for improved processes and infrastructure in this area. Further work on a strategic approach will commence on April 20th. TAG noted that Epidemiology Subgroup has not been providing independent reviews of data (as has been publicly stated).
4.0	**Peak Surge Capacity required to support contact tracing** TAG considered Dr Ayesha Verrall's report and subsequent request for advice on peak surge capacity required to support contact tracing, received from the National Contact Tracing Service. TAG noted this request for advice has been considered by the Public Health Subgroup. TAG feedback:

	• Agree with the principal of surge capacity, but this needs to be considered against measures to ensure quality of contact tracing • Contact tracing is not a linear process. Complex cases are an additional consideration, as are operational implications • Ensure feasible indicators and parameters based on circumstances are used. • The number of 1000 is reflecting rapid spread/surge in certain circumstances. Modelling group should be engaged, as they move to more of a network modelling framework which takes into accounts people movements. • The figure of 1000 was not evidence based • An increase of cases in high density poverty areas should be considered in contact tracing scenario planning. **Action:** Laboratory, Epidemiology and Public Health Subgroups to consider process and elements further, as input into scenario and surveillance planning work. TAG recommendation: • Yes, surge capacity is required in all regions to respond to outbreaks • Further work is required to understand the process, elements and strategic overview and should be considered more as 'the capacity to respond' rather than a 'number' **Action:** Communicate recommendation
5.0	**Serology Testing** TAG noted Serology testing for COVID-19 paper by Dr Erasmus Smit, Clinical Virologist ESR and activities underway in the area TAG feedback: • Point of care and rapid serology testing is not yet at a state to deploy in NZ now, but would be useful in the future to monitor prevalence of antibodies in the community. • Main issue currently is specificity and accuracy of any such with the current low prevalence levels. • Even if specificity isn't as high as we would like, analysis can consider the known specificity with good statistics to identify levels of prevalence. • Epidemiologists should be leading the discussion with a systematic and targeted approach, not just convalescent samples from people suspected of having COVID but tested negative from PCR **Action:** Provide feedback to be incorporated into Surveillance Plan
6.0	**Data** **Asymptotic Contact Data** • Current guidance is to only test symptomatic patients. More comprehensive testing is required on asymptomatic contacts in and around clusters • Chair advised data is being gathered in Queenstown and Waikato on clusters in response to Prime Minister's request and will form part of Surveillance Plan **Aged Care Facility Data** • Chair advised that more detailed information is being gathered on aged care facility outbreaks **Healthcare Workers** • Data on how healthcare workers were infected would be useful to guide healthcare worker safety and conditions

7.0	**TAG Terms of Reference and Documentation** TAG noted work is progressing on TAG and Subgroup ways of working framework, including refining the Terms of Reference, the definition and completion of 'advice' and fees framework. The Chair noted a recent announcement by the Director General of Health on a change to leadership structure at the Ministry. Keriana Brooking has been appointed as Deputy Chief Executive responsible for the COVID-19 response
8.0	**Pacific COVID-19 Response Team** TAG noted the Draft Operational Plan - Pacific COVID-19 Response has been provided and is aligned to national plans. TAG is invited to provide any feedback on the plan to the Pacific COVID-19 Response Team,  Pacific action plan v1.6.docx contact s 9(2)(a) • Availability of accurate Pacific data continues to be an issue • Mobile testing for Maori and Pacific communities is being scaled up in Auckland
9.0	**Te Rōpū Whakakaupapa Urutā/ Māori Pandemic Coordination Group** • Greater numbers of Maori and Pacific people are presenting to their GPs in designated clinics • Availability of accurate Maori data continues to be an issue. Testing should be monitored by ethnicity. Wider issues of contact tracing and quarantining exist for those already living in crowded homes. • Ensure Maori involvement in data sovereignty **Action:** Seek guidance on data sovereignty from Professor Tahu Kukutai, University of Waikato
10.0	**Technical Advisory Groups operating in other regions** The Chair noted a teleconference is to be held next week with the Chairs of Technical Advisory Groups operating in other regions, to offer support and ensure alignment.
11.0	**Aged Residential Care – Testing Requirement** TAG noted the Ministry does not support the requirement for a negative test followed by a 14-day quarantine period before new residents are admitted to an aged residential care facility. • An independent view has now been sought on whether TAG supports the Ministry's view. • Public Health Subgroup are progressing, considering that of all rest home cases to date, only 1 case has been brought in by a resident, with all other cases being brought in by healthcare workers. **Action:** Laboratory Subgroup will consider this urgently and provide advice back to the Public Health Subgroup.
12.0	**Subgroup verbal updates** **Epidemiology** • Have been advocating strongly for equity to be as key consideration for data to be collected. Not yet seeing that coming through in data. **Public Health**

- Have commented on draft cluster investigation reports and agree the need for National Coordinator role
- Considering options for intensive case and contact management to support elimination strategy
  Action: Summarise options and next steps and provide to Clinical and Primary Care Subgroups for their consideration

Primary Care

- Test result data coding differences between PHOs is creating issues for tracking patients
- Have moved to surveillance with coding to capture asymptomatic cases
- Laboratory access has become difficult in some areas, eg: patients presenting with temperature being denied testing
- GPs who have had contact with possible COVID-19 cases are not being granted access to rest homes

Laboratory

- Continuing to manage ongoing supply chain issues
- Have seen a shift to lower CT values on positive results as people present slightly later, particularly in aged residential care facilities. Being addressed locally
- Will provide an update at next TAG meeting on advice on Point of Care instruments

Clinical

- Finalising Clozapine advice
- Finalising swabbing for sore throat advice
- Occupational health - considering ways of utilising tools for vulnerable health workers

13.0 Any other business

- TAG requested a public statement on the development of new contact tracing
  Action: Follow-up on public statement being provided

14.0 Agenda items for next meeting

- Surveillance Plan
- Data and data analysis

15.0 New Action Items raised during meeting

#	Agenda Item	Actions	Owner
21	Peak Surge Capacity required to support contact tracing	Laboratory, Epidemiology and Public Health Subgroups to consider process and elements further, as input into scenario and surveillance planning	Dr Anya Werno Dr Patricia Priest Dr Shanika Perera
22	Peak Surge Capacity recommendation	Communicate TAG's recommendation	Louise Chamberlain
23	Serology Testing	Provide TAG feedback for incorporation into Surveillance Plan	Dr Caroline McElnay/ Dr Richard Jaine
24	Data sovereignty	Seek guidance on data sovereignty from Professor Tahu Kukutai, University of Waikato	Dr Ian Town

	25	Aged Residential Care – Testing Requirement	Laboratory Subgroup consider urgently and provide advice back to the Public Health Subgroup.	Dr Anya Werno
	26	Intensive case and contact management to support elimination strategy	Summarise options and next steps and provide to Clinical and Primary Care Subgroups for their consideration	Dr Harriette Carr
	27	Public statement on the development of new contact tracing tools	Follow-up on public statement being provided	Dr Ian Town
16.0	**Summary of TAG Recommendations** **Peak Surge Capacity required to support contact tracing** • Yes, surge capacity is required in all regions to respond to outbreaks • Further work is required to understand the process, elements and strategic overview and should be considered more as 'the capacity to respond' rather than a 'number'			
17.0	Meeting closed at 11.30am Next meeting Tuesday 21 April 10.30am – 11.30am			

Action #	Agenda item	Actions	Action Owner	Updates	Status
19	Coordinating laboratory activities and logistics	Laboratory subgroup to provide a recommendation about establishing a central Laboratory coordination role	Prof David Murdoch	17/04 – Prepare and circulate Terms of Reference and suggestions for parties to be involved 09/04 – In progress 07/04 – Action raised	Open

Minutes: Technical Advisory Group for COVID-19

Date:	Tuesday 21 April 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Ian Town
Attendees:	Dr Sally Roberts, Prof Michael Baker, Prof Stephen Chambers, Dr Anja Werno, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Matire Harwood, Dr Patricia Priest, Dr Erasmus Smit **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	Dr Colin Tukuitonga

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members and Attendees in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (17 April 2020) were accepted. • TAG noted the Epidemiology Subgroup has not provided any specific figures related to the 1000 new cases per day target (item 4 - Peak Surge Capacity required to support contact tracing) as has been publicly stated).
2.0	**Update on open actions** Actions 19 and 24 remain open. Actions 21, 22, 23, 25, 26 were closed.
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health particularly the preparation and delivery of advice to the Government on movement down from Alert Level 4. The Ministry will continue to provide ongoing monitoring and advice on any movement from Alert Level 3 to Alert Level 2 in the coming week. The Chair thanked TAG and Subgroups for all work related to this.
4.0	**Surveillance Plan** TAG discussed Surveillance Plan v3.0, which has been updated with some of the feedback from the Epidemiology Subgroup, with some of their feedback requiring further consideration. A critical part of the Plan is surveillance testing, and this area needs further detailed work. The Plan will continue to be developed rapidly to support the provision of information and advice to inform the next phase of the response.

	TAG feedback: • Clarification required on the level of input sought and roles and responsibilities eg: Epidemiology and Laboratory Subgroups, ESR, other experts **Action:** Clarify roles, tasks and timing and advise Community Testing: - The Ministry of Health is developing this aspect of the Surveillance Plan which will include serological testing in the future - Testing must be systematic/population based to enable meaningful conclusions - ESR have offered to develop a serum bank - NZ is in a different situation than the rest of the world and consideration needs to be given to NZ having a different need for serological testing, as we are assuming only a small proportion of the population is infected.
5.0	**Data and Data Analysis** The Chair noted that he was convening data and analytics workshops. Current methodology is linear and manual and contributing to delays. Options being considered for better tools for public health staff in the field. • Epidemiology and Public Health intelligence needs to be linked • Results of workshops will be shared at the next TAG meeting
6.0	**Healthcare Workers with COVID-19** TAG discussed analysis on healthcare workers with COVID-19. The Intelligence Team is conducting further analysis. TAG feedback: • Critical to understand, particularly with the emergence of clusters in healthcare facilities • Important to know how healthcare workers have become infected, but patients also need to know they are in a safe environment • Clinical Subgroup would like to be more involved and work with Public Health and analytics • Needs a combination of occupational health, public health and infection prevention and control • How has exposure occurred? Eg: household vs workplace; absence of PPE / PPE breach • Need to provide clear guidance to healthcare workers and their employers
7.0	**Rapid review of laboratory testing** TAG discussed the recommendation for a rapid review of laboratory testing. TAG feedback: • Ensure linkage of current parallel activities, complex relationships and the possible future state would all be helpful • Include laboratory capacity and pathways in rural and regional areas • Consider operational side of service workload and issue of re-agent supply TAG recommendation: • Support given for a rapid review of laboratory testing **Action:** Finalise review proposal and submit for consideration and approval Further TAG feedback:

	• Consider a rapid review of Epidemiology and Surveillance. How are decisions being made and who is having input?
8.0	**Subgroup verbal updates** **Epidemiology** • Received Surveillance Report V2.0 and have provided some initial feedback. Will also expect to discuss further in the coming days. • Have been meeting more frequently as necessary for incoming requests **Primary Care** • Providing both positive and negative cases test results back to GPs is considered very important. Current gap in this provision is resulting in a split focus with CBACs and regular Clinical care. • Access to data continues to be an issue • Primary Care subgroup particularly interested in methodology for evaluating Point of Care Testing now and in future. The Chair advised that Section 37 Notice - Point of Care Testing will be issued on 22nd April preventing the importation of POC test kits that have not been assessed for validity. **Laboratory** • Working on defining best utilisation for GenExpert, a rapid molecular test **IPC** • Have received additional requests for random testing of asymptomatic people, which infers PPE standards and prevention control is not good enough. **Clinical** • Sore throat swabbing in children (Group A strep & Rheumatic Fever) - Recommendations for primary care management: aiming to finalize RFA by next TAG meeting - Considering whether to recommend CBACs should do throat swabbing in high risk groups – for TAG member comments • Vulnerable healthcare workers (with comorbidities) – linking Occupational Medicine specialist resource with HealthPathways • Clozapine advice finalised: being implemented by MedSafe; sector communication pending
9.0	**Intensive case and contact management to support elimination strategy** Discussion resulting from action 26: TAG feedback: • How are probable cases managed in terms of isolation and then quarantine requirements eg: would contacts be isolated for probable cases? • Epidemiological and clinical factors to be considered • Consider Maori and Pacific isolation and quarantine restrictions in overcrowded homes • Maori health service providers should be involved in contact tracing
10.0	**Any other business** • No other business discussed

11.0 **Agenda items for next meeting**

- Data and data analysis – results of workshops on monitoring response
- Healthcare Workers with COVID-19 – results of further analysis

12.0 **New Action Items raised during meeting**

#	Agenda Item	Actions	Owner
28	Surveillance Plan	Clarify roles and responsibilities, tasks and timing requirements for input into Surveillance Plan eg: Epidemiology and Laboratory Subgroups, ESR, other experts	Dr Ian Town / Dr Caroline McElnay
29	Rapid review of laboratory testing	Finalise review proposal and submit for consideration and approval	Dr Ian Town / Prof David Murdoch

13.0 **Summary of TAG Recommendations**

- Support given for a rapid review of laboratory testing

14.0 Meeting closed at 11.30am
Next meeting Friday 24 April 10.30am – 11.30am

Action #	Agenda item	Actions	Action Owner	Updates	Status
19	Coordinating laboratory activities and logistics	Laboratory subgroup to provide a recommendation about ~~establishing a central Laboratory coordination role~~ a rapid review of laboratory testing	Prod David Murdoch	21/04 – Action has evolved to become a recommendation on a rapid review of laboratory testing (item 7.0) 17/04 – Prepare and circulate Terms of Reference and suggestions for parties to be involved 09/04 – In progress 07/04 – Action raised	Open
21	Peak Surge Capacity required to support contact tracing	Laboratory, Epidemiology and Public Health Subgroups to consider process and elements further, as input into scenario and surveillance planning	Dr Anya Werno Dr Patricia Priest Dr Shanika Perera	21/04 – Incorrectly captured as an action. Closed 17/04 – Action raised	Closed
22	Peak Surge Capacity recommendation	Communicate TAG's recommendation	Louise Chamberlain	21/04 – Recommendation has been communicated to Director General of Health 17/04 – Action raised	Closed
23	Serology Testing	Provide TAG feedback for incorporation into Surveillance Plan	Dr Caroline McElnay/ Dr Richard Jaine	21/04 – Feedback has been provided for incorporation into Plan. Surveillance Plan provided for discussion (item 4.0) Action closed 17/04 – Action raised	Closed
24	Data sovereignty	Seek guidance on data sovereignty from Professor Tahu Kukutai, University of Waikato	Dr Ian Town	21/04 – Yet to progress 17/04 – Action raised	Open
25	Aged Residential Care – Testing Requirement	Laboratory Subgroup consider urgently and provide advice back to the Public Health Subgroup.	Dr Anya Werno	21/04 – Advice has been redrafted with caveats and will be provided to Public Health subgroup today. Action closed Wider issue of management of cases within the aged care environment under discussion. Disability sector and youth justice included. Action closed 17/04 – Action raised	Closed
26	Intensive case and contact management to support elimination strategy	Summarise options and next steps and provide to Clinical and Primary Care Subgroups for their consideration	Dr Harriette Carr	21/04 – Options and next steps provided. Development of national contact tracing service ongoing. Noted – case management	Closed

				guidance source documents need to be updated. Action closed 17/04 – Action raised	
27	Public statement on the development of new testing tools and contact tracing	Follow-up on public statement being provided	Dr Ian Town	21/04 – Ap technology still in development. Announcement to be made 1st May. Action closed 17/04 – Action raised	Closed

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 1 May 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Ian Town
Members:	Dr Sally Roberts, Prof Michael Baker, Dr Anja Werno, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Patricia Priest, Dr Erasmus Smit, Prof Stephen Chambers **Ministry of Health staff** - Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	N/A
Apologies:	Dr Collin Tukuitonga, Dr Caroline McElnay, Dr Matire Harwood

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members and Attendees in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (24 April 2020) were accepted.
2.0	**Update on open actions** Actions 28, 30, 32, 33 remain open. Actions 24 and 31 were closed.
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health, which includes: • Preparation of Cabinet advice on further movement down to Alert Level 2. Considering against the original seven criteria; downwards overall trend in new cases, low numbers with no obvious source, community transmission, new clusters, assurance of active surveillance, case finding and gold standard contact tracing and adequate health system capacity • Particular focus on minimum period of 28 days for downward trend and if this interval is long enough • Regular discussions are occurring with overseas colleagues, considering international experience, especially in Australia • 4 May Cabinet paper introduces the approach to a gradual step down through alert levels. Cabinet decision due 11 May • Healthline for Primary Health Clinicians has been contracted to a national telehealth service and launched 30 April • Web enabled addition to contact tracing system soft launch 1 May

	• Integrated data query platform has been produced by Data and Analytics team
4.0	**Terms of Reference** The Chair noted the final draft Terms of Reference (TOR), thanked those who have given feedback and provided opportunity for final feedback before TOR are approved. • TAG agreed no further changes are required to the TOR • TOR and Fees Framework will now go through approval process with Keriana Brooking (DDG) • Appointment letters will be distributed • Concerns remain over capacity in some subgroups. An increase in membership may be required • COVID-19 response portfolio is being realigned across the Ministry. • Two Senior Advisor positions have been created to support TAG Subgroups
5.0	**Testing Strategy** TAG noted the discussion document (taken as read) which will be developed into a Testing Strategy under the umbrella of the Surveillance Plan and will consider DHB approach and plans, targeting asymptomatic patients in higher risk settings. Statistical advice has been provided about sampling frames. TAG feedback: • Any directive to test contacts to ascertain source of infection needs to be considered against laboratory capacity ○ Will be reassessed and scaled back if required • Sensitivity and prevalence along with positive predictive values will need to be considered • Communicating purpose of testing to the public is important • Advice to DHBs on targeted asymptomatic testing will include protocols for quality checks • Suspect case definition may be changed for Alert Level 2, as prevalence becomes lower
6.0	**Request for brief update on COVID-19 vaccine framework** The Chair noted the development of a Cabinet Paper on Vaccination Strategy. • Requests for advice and input to the paper have been received from Ministers Woods and Clark • Considerations for any Vaccination Strategy include: development of a safe vaccine, vaccine supply, immunisation program, international relationships, trade and supply chain • Ministerial announcement on the Strategy and process expected on May 11
7.0	**Rapid Review of Laboratory Testing** The Chair noted the request for a rapid review of laboratory testing has been declined by the Director-General and will not proceed, s 9(2)(g)(i) [redacted]
8.0	**Subgroup verbal updates** **Epidemiology** • Input to surveillance testing and statistics • Require assurance advice provided is being considered • Request subgroup is advised of wider Ministry epidemiologist to support the intelligence group

	Primary Care • Data being shared between PHOs and DHBs • Swab notification – clarification received that these are being sent to practice inbox • Testing strategy and planning for CBAC operations through winter • Confidentiality issue with some employers asking for test results for level 3 work certificates • National directive from NZMA and GPNZ will advise to continue operating red and green zones throughout winter **Public Health** • Probable Case definition is being written up and progressing to sign-out stage; thanks given for NZMN position and confirmation ○ Updated advice in how PHUs classify probable cases will reduce the number of classified probable cases • Providing advice on national guidance for the management of ARC clusters, including clearance and recovery planning of an ARC facility that has had cluster, 28-day period to clear cluster and implement step down approach, visitor policy, clinical requirements **Laboratory** • Focussed discussions held by NZMN on serological studies and serum banking. Laboratories require clear processes • Supply Chain Portfolio being linked to laboratories under new aligned structure is a positive development • Supply chain continues to be fragile **Infection Prevention and Control** • Healthcare worker data required to enable focused advice and decision making • Tuesday 5 May is world hand hygiene day **Clinical** • Sore throat management in children – advice has been finalised and circulated • IPC Subgroup will link in with Clinical Subgroup on requests for advice on sore throat management and rheumatic fever and a press release on the high risk of sore throats • Clear public health messaging required giving reassurances it is safe to visit health practices, as normal health services resume
10.0	**Any other business** • No other business discussed
11.0	**Agenda items for next meeting** • No specific agenda items discussed
13.0	**New Action Items raised during meeting** • No new action items raised
14.0	**Summary of TAG Recommendations** • No further changes are required to the final draft Terms of Reference
15.0	Meeting closed at 11.30am Next meeting Tuesday 5 May 10.30am – 11.30am

Action #	Agenda item	Actions	Action Owner	Updates	Status
24	Data sovereignty	Seek guidance on data sovereignty from Professor Tahu Kukutai, University of Waikato	Dr Ian Town	01/05 – Discussions have been held with Professor Kukutai, Digital and Data Specialists and Insights Manager of Maori Health Directorate. Action closed. 24/04 –Meeting to be held 24/04. Report back at next meeting 21/04 – Yet to progress 17/04 – Action raised	Closed
28	Surveillance Plan	Clarify roles and responsibilities, tasks and timing requirements for input into Surveillance Plan eg: Epidemiology and Laboratory Subgroups, ESR, other experts	Dr Ian Town / Dr Caroline McElnay	01/05 – Testing Strategy discussion document will be developed and incorporated into Surveillance Plan v4.0. 24/04 – Refer item 4.0 for discussion. 21/04 – Action raised	Open
30	Public facing testing communications	Seek involvement of Siouxsie Wiles on public facing testing communications	Dr Ian Town / Dr Harriette Carr	01/05 – To be progressed further as Testing Strategy is developed. 24/04 – Action raised	Open
31	CBAC role in Primary Care	Provide detail to Chair, of concerns of CBAC role in primary care and managing long term chronic conditions, for escalation within Ministry	Dr Bryan Betty	01/05 – Has been escalated to Primary and Secondary Care Strategy Management. Action closed. 24/04 – Action raised	Closed
32	Samples for later analysis	Provide item for inclusion in Surveillance Plan - Collecting samples of people with COVID-19 for later analysis	Dr Ian Town	01/05 – To be progressed. 24/04 – Action raised	Open
33	Risk of using nebulisers	Discuss whether current advice needs to be changed	Dr Ian Town / Dr Juliet Rumball-Smith	01/05 – Literature review required prior to being considered by IPC Subgroup. • Advice must align with evidence and be context based • Requires consideration at a National level • Any change requires careful planning of implementation 24/04 – Action raised	Open

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 8 May 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Ian Town
Members:	Dr Sally Roberts, Prof Michael Baker, Dr Anja Werno, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Patricia Priest, Dr Erasmus Smit, Prof Stephen Chambers, Dr Collin Tukuitonga, Dr Matire Harwood **Ministry of Health staff** - Dr Harriette Carr, Dr Caroline McElnay, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	Dr Natasha White
Apologies:	-

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members and Attendees in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (1 May 2020) were accepted.
2.0	**Update on open actions** Actions 30, 32, 33 remain open. Action 28 closed.
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health, which includes finalising staged approach options, advice and guidance on alert level step down criteria across health sector, schools, public transport and workplaces to inform the Cabinet decision 11 May.
4.0	**Surveillance Plan** The Chair acknowledged the amount of work that has occurred to produce Surveillance Plan v4, particularly by the Public Health Directorate, Surveillance Team, Tom Love and Sarah Jeffries. TAG Members are invited to provide any feedback on the plan by early next week. The Plan will be brought back to next TAG meeting for endorsement. • The Plan is a living document and will continue to be reviewed as new surveillance opportunities occur • There is a commitment within the Ministry to provide accurate data to enable tracking the pandemic progression and produce data sets for research • V4 will be used within the Ministry as a working draft, prior to endorsement • V4 can be distributed to Subgroups

	Action: Review Surveillance Plan v4 and provide feedback
5.0	**System Strategy Level 2 and beyond** TAG noted the framework for public health approach required over the coming weeks and months as the country moves down through alert levels is being developed, considering Elimination Strategy pillars and epidemiology criteria. Framework will inform all new directorate work across the COVID-19 response and support the success of the Elimination Strategy over the coming months until a vaccine is available. Draft framework currently with Director General of Health for review and will be circulated to TAG. • Considering what moving through alerts will mean for existing protocols, guidelines and systems. • Framework being considered against the four pillars of the Elimination Strategy 1. Border controls – how and when these can be relaxed when it is safe to do so; trans-Tasman bubble opportunities 2. Robust case definition and surveillance - Ability to identify and act quickly - What testing needs to be in place to inform surveillance - Case definition influences test strategy 3. Effective contact testing and isolation - Case management and isolation management going forward eg: managed isolation facilities - Close contact testing and management - Assurances of isolation or quarantine compliance - Equity issues 4. Community support - Require continued community compliance with physical distancing, hygiene, appropriate PPE use, staying at home when sick TAG Feedback: • Voluntary isolation and quarantine should be considered – facilities may be required on a case by case basis • Border controls ○ Success of Elimination Strategy will become increasingly difficult as border controls are relaxed • Vaccine ○ Success of Elimination Strategy is based on assumption of vaccine development within 24 months ○ NZ's participation in vaccine research in Australasia and the Pacific is to be part of an all of Government Cabinet discussion on 18 May • Physical distancing ○ Basic precautions are at the heart of public health response and must continue ○ Adherence is breaking down at Level 3 ○ Biggest risk is people in mass gatherings who are not already part of an existing group. Modelling commissioned by Epidemiology Subgroup suggests the number of cases not detected is similar to the number of confirmed cases (eg 5-10 cases not reported). Recommending not jumping straight to allowing large gatherings but make decisions based on a balance between statistical risk and surveillance. ○ Requirements need to be evidence based, particularly if low prevalence continues • Communications

	○ Initiatives need to be part of strategy and woven into all of government communications ○ To date communications have been reactive, particularly in front line health sector. Must have strong leadership, be clear and related back to Elimination Strategy
6.0	**Wearing of masks in public** The Ministry is developing a more formal policy on the wearing of masks in public. TAG noted the Review of Science and Policy around Face Masks and COVID-19 provided for discussion. • Considering range of international policies • Need to reflect on core IPC principles in a range of settings - community, health, non-health • Current WHO advice is there is no evidence of benefit for use of masks by healthy people in community • Continue to receive feedback on current literature review on website. • Chair will respond directly to feedback and ensure documents are kept up to date IPC feedback: • Two purposes of wearing masks in healthcare settings is source control and prevention of inhalation during provision of care in internal spaces – used within a range of hierarchical infection prevention controls • Healthcare masks are of an accepted quality standard • Release of masks for general public that meet healthcare masks standards will result in a supply issue • Issue if general public wear non standard masks that do not meet filter efficiencies • A number of countries are using masks in public settings, particularly with mass public transport and dense housing, which NZ does not have • Of limited benefit in social interaction settings • General public not understanding the hierarchy of controls is of major concern • Aligned with Netherland's view - mass mask wearing in public won't have significant impact TAG feedback: • Practice caution in invoking policy in the absence of evidence • More risks in mass public masking that outweigh any benefits • The success of mass public masking internationally needs to be considered against those country's infection rates – benefits are not necessarily evident • Any policy must be accompanied by clear messaging on effective use and infection control • The option of recommending the use of masks on public transport was noted Summary: • There is not currently a good evidence base for mass public masking • Policy continues to be developed, with IPC Subgroup input
7.0	**Changes to case definition** TAG noted changes to case definition and testing prioritisation are being considered. Three options being considered: 1. Retain current suspect case definition for as long as we can or for a certain number of weeks; phase any change; becomes part of surveillance in terms of picking up possible cases

	2. Revise and narrow suspect case definition and test all those that meet suspect case definition eg: base on most common symptoms 3. Introduce epidemiology criteria eg: close contact of a case; recently travelled; age cutoff a. Considered using data to date, although this may not be relevant, considering a large number of early cases were imported cases, and this data won't necessarily reflect where cases will be going forward TAG feedback: • Analysis of impacts is required – there will be unintended consequences of changing definition • Any change to definition must be timely, planned strategically and communicated widely across health sector • Confirming case definition is now urgent for primary care, particularly as we head into winter • Can case definition and testing strategy be decoupled? • Link Subgroup Chairs and ESR to consider changes • Any changes need to form part of overall Testing and Surveillance Strategies **Action:** Write up options paper for consideration by Subgroup Chairs and ESR
8.0	**Frequency of meetings** TAG noted TAG meetings will now occur once weekly - Friday 10.30. The Chair thanked and acknowledged Subgroups for all additional meetings and the high level of commitment that has occurred to date.
9.0	**Maori perspectives** • Will be involved in changes to case definition decisions • Updated guidance on the swabbing of children with a sore throat has been distributed
10.0	**Subgroup verbal updates** **Primary Care** • Throat swabbing as above • Need to communicate testing strategy clearly **Public Health** • Current subgroup meeting minutes being finalised • No further updates in addition to case definition and testing prioritisation as were discussed earlier in the meeting **Laboratory** • Laboratories now have received kits for rapid molecular diagnosis using the GeneXpert. Low numbers of kits will be available to laboratories every week **Infection Prevention and Control** • Healthcare worker testing to be discussed offline with Laboratory Subgroup Chair **Clinical** • Working with PHARMAC on Propofyl supply

<table>
<tr><td>11.0</td><td>Any other business
No other business discussed</td></tr>
<tr><td>12.0</td><td>Agenda items for next meeting
Acceptance of Surveillance Plan v4
Changes to case definition</td></tr>
<tr><td>13.0</td><td>New Action Items raised during meeting
<table>
<tr><th>#</th><th>Agenda Item</th><th>Actions</th><th>Owner</th></tr>
<tr><td>34</td><td>Surveillance Plan v4</td><td>Review Surveillance Plan v4 and provide feedback</td><td>All</td></tr>
<tr><td>35</td><td>Changes to case definition</td><td>Write up options paper for consideration by Subgroup Chairs and ESR</td><td>Dr Harriette Carr</td></tr>
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<tr><td>14.0</td><td>Summary of TAG Recommendations
N/A</td></tr>
<tr><td>15.0</td><td>Meeting closed at 11.30am
Next meeting Friday 15 May 10.30am – 11.30am</td></tr>
</table>

Action #	Agenda item	Actions	Action Owner	Updates	Status
30	Public facing testing communications	Seek involvement of Siouxsie Wiles on public facing testing communications	Dr Ian Town / Dr Harriette Carr	08/05 - To be progressed further as Testing Strategy is developed. 01/05 – To be progressed further as Testing Strategy is developed. 24/04 – Action raised	Open
32	Samples for later analysis	Provide item for inclusion in Surveillance Plan - Collecting samples of people with COVID-19 for later analysis	Dr Ian Town / Prof David Murdoch / Dr Erasmus Smit	08/05 - Discuss further: • Requires systematic approach: • Needs to be clear clinical or research purpose • Ethical considerations 01/05 – To be progressed 24/04 – Action raised	Open
33	Risk of using nebulisers	Discuss whether current advice needs to be changed	Dr Ian Town / Dr Juliet Rumball-Smith	08/05 – Literature review has been commissioned. Difficulty with finding specific policies with scientific basis, no evidence tail. Consider findings of review (due 08/05). 01/05 – Literature review required prior to being considered by IPC Subgroup. • Advice must align with evidence and be context based • Requires consideration at a National level • Any change requires careful planning of implementation 24/04 – Action raised	Open

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 15 May 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Andrew Simpson
Members:	Dr Sally Roberts, Prof Michael Baker, Dr Anja Werno, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Patricia Priest, Dr Erasmus Smit, Prof Stephen Chambers, Dr Matire Harwood **Ministry of Health staff** - Dr Harriette Carr, Dr Caroline McElnay, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	Dr Natasha White
Apologies:	Dr Ian Town, Dr Caroline McElnay, Dr Collin Tukuitonga

1.0	**Welcome and Previous Minutes** Dr Andrew Simpson welcomed all Members and Attendees in his capacity as Chair (in Dr Ian Town's absence). Minutes of the last meeting (11 May 2020) were accepted.
2.0	**Update on open actions** Actions 30, 32, 33 remain open. Action 35 closed.
4.0	**Surveillance Plan** TAG noted Surveillance Plan v4.0 • Previous TAG feedback has been incorporated • Testing Strategy – currently working through next phase of testing approach; scaling back on asymptomatic testing and scaling up systematic testing • DHB testing rates are available • Future versions will be brought back to TAG TAG feedback: • As this is a living document, in future, it would be helpful if changes between versions could be highlighted • Section 4 – Public Health Strategy, Case and Contact Management – should explicitly state surveillance testing through ARC testing • Testing Strategy impacts Laboratory capacity

5.0	**Healthcare workers with COVID-19** TAG noted the COVID-19 cases in health workers report, taken as read and were invited to comment on the report and any further analysis requirements • Report data has been pulled from EpiSurv data • Currently purely quantitative data. Over time there are opportunities to provide improved qualitative data eg: source additional data through public health as they have had links with patients TAG feedback: • Provide further breakdown of 'Allied health workers' as this covers a wide range of professions. • Confirmation on whether the 4 Community Doctors are GPs. Want to provide feedback to the sector • Improve on how healthcare worker title and role and healthcare setting data is captured • Important to link incident reviews back to public health messaging, particulary as Waitakere report has highlighted IPC issues (IPC Subgroup currently progressing) • Further analysis required on source of infection eg: 53% locally acquired cases, epidemiologically linked – transmitted via other healthcare workers or a community cluster? • Helpful to know both directions of transmission for household contacts and potential risks from healthcare workers eg: separate households • Infections from patients – helpful to know if this was due to failure of ppe / no ppe – as could possibly address through policy • A lot of information is not collected in any one surveillance system. Is there an opportunity to conduct as a case series/comparison as a group rather than public health units? • How does NZ healthcare workers infected by a patient data compare to international data? Intel Team will continue to seek data from other sources and provide further analysis and detail
6.0	**Revision of suspect case definition and testing criteria for COVID-19** TAG discussed suspect case definition and testing criteria options. Subgroups requested to consider options and feedback to Public Health Subgroup • ESR input has been sought. Additional data is being provided • Consider any other data needed or other organisations to be involved to support a decision • To be brought back to next TAG meeting to agree position TAG Feedback: • Discuss children impact with paediatric • Borders - consider EPI criteria for return travellers; possible leakage from people who are associated with people in quarantine; consider extra border teting • Clarify relationship/intent between laboratory testing definition and case definition; would change in different phases of pandemic – at moment they are linked, should they be disassociated? If delink changing in lab testing criteria would be a variation of option • Consider case definitions of other countries in similar position eg Taiwan, Singaport • A lot of sector feedback on difficulty in making testing work eg: disestablishing CBACs, school services starting up. Testing will be moving away from community and back to primary care. More refined clinical criteria required– can mix and match approaches.

	• Need clinical oversight particularly as moving into winter eg: sector capacity and workload **Action:** Add comms to website – case definition under review **Action:** All Subgroups to consider options and feed back to Public Health Subgroup
7.0	**Aged Residential Care IPC Outpatients** Related to current policy of a 14-day quarantine requirement for residents who have attended outpatients and leaving premises for a short period of time • IPC Subgroup developing advice on whether 14-day quarantine is required • Communications to ARC sector be considered following development of advice
8.0	**Release from isolation** TAG discussed a request for advice on release from isolation for people who have had persistent ongoing respiratory symptoms and PCR positivity after recovery. Clinical Subgroup developing advice. Isolation policy could be updated with AU guidelines but will only apply to a handful of people • Evidence base for infectivity is required • Have given advice DHBs should decide locally but a person should not be sent back into a high risk work area until more recovered. • DHBs are asking for national advice (there are a few people who have been in isolation for almost 2 months) • An interim position is required, to be used as case by case assessment, as well as a longer term plan • IPC Subgroup developing paper for NZRM on recommendations for healthcare workers returning to work – will advise looking at evidence for infectivity. Will bring back to TAG for feedback • Interim messages and longer term plan can be shared with Regional DHB TAGs at meeting next week TAG feedback: • Evidence has shown a low rate of observed cases in those who are exposed late. Ability to culture virus relates to viral load and PCR test cutoff is a rough estimate of viral load. Difficult to say people are completely non infectious. • For many diseases, people are RNA positive for weeks after recovery but there is no evidence they can still infect. • There is circumstantial evidence in NZ that prolonged shedding only picked up that had symptoms that reappeared. No cases came out of re-isolated people • AU keep using PCR, not necessarily what they recommending as guidelines, but if PCR in guidelines, it will be used • Virus cannot be cultured after 7-8 days • Most labs won't attempt to culture with low PCR. Cannot culture with viral load less than 100,000. • After a week secrete IGA and own antibiodies kick in and so very unlikely people are infectious.
9.0	**Membership – conflicts of interest** • Not discussed due to time constraints (information will be emailed)
10.0	**Maori perspectives** • Involvement in review of case definition

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- Concerns with public health act and marae access
- Allowable Tangihanga numbers have been increased

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Subgroup verbal updates

Epi

- Looking at plan for surveillance testing

Primary Care

- Public masking

Public Health

- Case definition
- Tightened issue testing and management of close contacts of probable and confirmed cases on DHB feedback

Laboratory

- Continue to work on evidence for de-isolation

Infection Prevention and Control

- Reviewing all information on website
- Seeking guidance on mask use
- ARC
- Have added support to subgroup

Clinical

- Monitoring medicine supply – Profofol. PHARMAC have asked for guidance from sector if gets low

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Any other business

- No other business discussed

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<tr><td>13.0</td><td>

Agenda items for next meeting

- Suspect case definition and testing criteria for COVID-19

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New Action Items raised during meeting

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<tr><th>#</th><th>Agenda Item</th><th>Actions</th><th>Owner</th></tr>
<tr><td>36</td><td>Revision of suspect case definition and testing criteria for COVID-19</td><td>Add comms to website – case definition under review</td><td>Dr Harriette Carr</td></tr>
<tr><td>37</td><td>Revision of suspect case definition and testing criteria for COVID-19</td><td>All Subgroups to consider options and feed back to Public Health Subgroup</td><td>Subgroup Chairs</td></tr>
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Summary of TAG Recommendations

- N/A

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<tr><td>16.0</td><td>Meeting closed at 11.30am
Next meeting Friday 22 May 10.30am – 11.30am</td></tr>
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Action #	Agenda item	Actions	Action Owner	Updates	Status
30	Public facing testing communications	Seek involvement of Siouxsie Wiles on public facing testing communications	Dr Ian Town / Dr Harriette Carr	15/05 – No further update 08/05 - To be progressed further as Testing Strategy is developed. 01/05 – To be progressed further as Testing Strategy is developed. 24/04 – Action raised	Open
32	Samples for later analysis	Provide item for inclusion in Surveillance Plan - Collecting samples of people with COVID-19 for later analysis	Dr Ian Town / Prof David Murdoch / Dr Erasmus Smit	15/05 – No further update 08/05 - Discuss further: • Requires systematic approach: • Needs to be clear clinical or research purpose • Ethical considerations 01/05 – To be progressed 24/04 – Action raised	Open
33	Risk of using nebulisers	Discuss whether current advice needs to be changed	Dr Ian Town / Dr Juliet Rumball-Smith	15/05 –Literature review remains in progress. IPC Subgroup have provided additional studies for consideration. 08/05 – Literature review has been commissioned. Difficulty with finding specific policies with scientific basis, no evidence tail. Consider findings of review (due 08/05). 01/05 – Literature review required prior to being considered by IPC Subgroup. • Advice must align with evidence and be context based • Requires consideration at a National level • Any change requires careful planning of implementation 24/04 – Action raised	Open

35	Changes to case definition	Write up options paper for consideration by Subgroup Chairs and ESR	Dr Harriette Carr	15/05 – Options paper provided to ESR and Public Health subgroup. Provided for discussion (see item 5.0). Action closed 08/05 – Action raised	Closed

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 22 May 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Ian Town
Members:	Dr Sally Roberts, Prof Michael Baker, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Dr Patricia Priest, Dr Erasmus Smit, Prof Stephen Chambers, Dr Matire Harwood, Dr Collin Tukuitonga **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Caroline McElnay, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Richard Jaine, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	Jill Sherwood (ESR), Dr Natasha White, Sarah Mitchell, Chris Hedlund
Apologies:	Dr Anja Werno

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (15 May 2020) were accepted.
2.0	**Update on open actions** Actions 30, 33 remain open. Action 32, 36 closed.
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health, which included: • Continuing to provide advice to Cabinet on stepping down through alert levels • Advice to continue in Level 2 for at least 4 weeks, considering potential impacts of increased activity in Level 2 • An integrated research file of de-identified data is being developed, to be made available for universities and other research organisations. • Vaccine Strategy will be announced by joint Ministers next week on May 25th
4.0	**Suspect case definition and testing criteria for COVID-19** TAG discussed options for changes to the suspect case definition and testing criteria for COVID-19. Subgroups have considered the options and Chairs provided feedback. Homecare Medical feedback has also been sought. Homecare Medical: • Recommended continue with status quo for 28 days

- Broad clinical criteria paired with epidemiology criteria
- Operationalising advice and public communications
- Consider equity

Clinical Subgroup:

- Border:
    - Returned travellers and their contacts are the greatest risk, so detecting all of these is the best protection for the community. So should maintain the current sensitive SCD and consider epi criteria which would detect any 'leakage' from travellers as well as airport or isolation/quarantine workers, house-hold contacts if home isolation, quarantine exceptions.
- Children:
    - Feedback from paediatric ID specialists (Auckland, Chch) would support children only being included in the SCD if there is an exposure (travel-related, cluster) or being acutely admitted to hospital with an ARI. Discretion but not requirement to test in other circumstances
- Adults with no exposure:
    - A difficult challenge. On the one hand, aiming to detect most cases early to prevent transmission and a large cluster; testing for a needle in a hay-stack for a community benefit. On the other hand, testing mild or non-specific illness when there is almost no community transmission is causing practical challenges and unintended patient harm. Labelling someone a suspect case has led to requirements to swab and isolate, which is now often directed care away from patients' actual needs. This is partly due to inclusion of people with symptoms unlikely to be Covid/ARI and partly healthcare staff feeling obliged to institute testing and then isolation. For acute hospital admissions, testing only those with a clear picture of an ARI, and not those with atypical pictures unless after thoughtful review. Most members of the clinical subgroup favoured a narrower clinical SCD in some form.

Epidemiology Subgroup:

- Support remaining with status quo for 2 to 4 weeks
- Have a number of epidemiological criteria mainly around groups at risk because of contact with a new case; groups that might be considered at risk given the case's characteristics (e.g. if the case is a member of a particular occupational group, then others in that group might be appropriately tested)
- Should be a low threshold for testing healthcare workers and ARC residents and workers
- Apply equity considerations as part of decision to test

Infection Prevention and Control Subgroup:

- Maintain the current case definition for a further 2-4 weeks (4 weeks, or 2 incubation periods), since the step from Alert Level 3 to Alert Level 2 would allow for monitoring of the impact of increased mobility including return to school and to work environments
- The diagnostic laboratory sector has capacity to undertake the current volume of testing
    - Consideration should be given to testing for influenza in parallel
- If it was delinked to the requirement to wear PPE (appropriate for both contact and droplet precautions) in the hospital setting, then this would reduce unnecessary use of PPE whilst providing care for patients meeting the case definition but who have a very low risk of having COVID-19 infection
- Prioritisation of testing, as suggested by Option three, may complicate the screening process and reduce testing across all groups in the community. It may also make the

	management of patients with suspected but not test positive COVID-19 infection difficult if people chose not to comply with public health expectations • Do not agree with excluding children under the age of 15 from testing as suggested by Option two. There is evidence from the Auckland region that children have been under-sampled • There are also reports from overseas of a very small number of children presenting with an atypical immune response (atypical Kawasaki's disease) syndromes. Testing in children is required to support early recognition of this syndrome. Primary Care Subgroup: • Winter illness and ILI potentially increasing need to review the case definition, especially in context of winter demand in community care, role of CBAC's, workload, and patient flow • Sense of urgency from the sector to have a clear change on definition • Communication important • Under 15 year old need specific consideration • Suggest clinical definition plus epidemiological criteria plus prioritization • Need clinical judgement applied and oversight as to who gets tested Laboratory Subgroup: • Focus on what we're trying to achieve, remain with current case definition but need to move to epidemiology criteria • Decouple PPE / isolation from testing to minimise barriers to testing • Look at modelling, including possibility of mild flu winter, to help with decision-making. • RhF issues to be addressed Public Health Subgroup: • Universal support for continuing Option 1 (i.e. status quo in the short term) • When suspect case definition is changed, proposal to remove suspect case definition. This is based on the current suspect case definition has no surveillance purpose (there is no reporting of suspect cases). Instead, clinical algorithm and pathway could be used to communicate changes in testing, management, PPE use and notification process. In addition, this proposal will still align with the surveillance plan and testing strategy in order to ensure all testing is considered as part of surveillance. • One approach is to have two tiers of clinical criteria that result in testing: (i) broad clinical criteria with epi/other criteria and (ii) narrow clinical criteria with no epi/other criteria. An alternative approach to retain the broad clinical criteria with epi/other criteria and have sentinel surveillance that covers other groups that are not tested. **Action:** Public Health Subgroup prepare recommendation for next meeting
5.0	**Use of masks in public** Guidance on the use of masks in public about to be published on the Ministry website was presented: • Evidence is inconclusive for a requirement of widespread public use of masks in NZ at this time • Risks include equity, unsafe use, decreased adherence to other infection control measures • Prioritise masks for healthcare and border management

	• Website will reflect rationale for current position and what would need to occur for this guidance to change • Guidance on how people with COVID-19 needing to access primary care, without access to public transport can access, and guidance on the correct use of masks. TAG feedback: • There is more evidence for masks as a barrier for source control than there is for the effectiveness of mass masking. • Messaging should reflect that PPE is different from mass masking amongst the general public • Masks are part of a multi-barrier approach, we should be using all the cheap and simple barriers we can. Masking on public transport should be used as a part of source controls • Care required with messaging that there is low or no risk – impact now in primary care eg: people are beginning to refuse testing **Action:** Dr White and Chief Nurse to review the website material and submit to Dr Ashley Bloomfield for his review and approval
6.0	**Review of literature around SARS-COV-2, COVID-19, and nebuliser use** TAG noted the Review of literature around SARS-COV-2, COVID-19, and nebuliser use which has been updated with IPC feedback. IPC Subgroup continuing to ensure scientific evidence is used as a basis for any decision to change advice. No immediate change proposed.
7.0	**COVID-19 response hub structure** TAG noted the structure of the new COVID-19 Response HUB which was established 18 May TAG feedback: • Seeking clarity on how Maori and Equity teams and workstreams link in and out of TAG **Action:** Seek changes to org structure diagrams to include Maori and Equity pathways
8.0	**Science and Technical Advisory Update** • TAG feedback into Terms of Reference has been appreciated • Feedback on Treaty and equity obligations is being discussed with Equity Team and will be incorporated into the TOR and ways of working • Developing processes to provide additional Subgroup support
9.0	**Maori perspectives** • Equity issue with cervical cancer self-swabbing • Issue with medicine supply as whanau are released from quarantine following international travel • CHF admission rates in Auckland over lockdown compared with same period last year were 66% lower for Maori. Now facing large amount of very ill people seeking health care • **Action:** Supply information on these issues for triaging to correct Ministry areas to address
10.0	**Any other business** • Summary of events during NZ COVID-19 pandemic to be shared
11.0	**Agenda items for next meeting** • Recommendation on changes to suspect case definition and testing criteria for COVID-19

12.0 New Action Items raised during meeting

#	Agenda Item	Actions	Owner
37	Suspect case definition and testing criteria for COVID-19	Prepare paper on recommendation for next meeting	Dr Shanika Perera / Dr Harriette Carr
38	COVID-19 HUB structure	Seek changes to org structure diagrams to include Maori and Equity pathways	Louise Chamberlain
39	Uruta issues	Supply information on issues raised for triaging to correct Ministry areas to address	Dr Matire Harwood
40	Wearing masks in public	Dr White and Chief Nurse to review the website material and submit to Dr Ashley Bloomfield for his review and approval	Dr Natasha White

13.0 Summary of TAG Recommendations

- N/A

14.0 Meeting closed at 11.30am
Next meeting Friday 29 May 10.30am – 11.30am

Action #	Agenda item	Actions	Action Owner	Updates	Status
30	Public facing testing communications	Seek involvement of Siouxsie Wiles on public facing testing communications	Dr Ian Town / Dr Harriette Carr	22/05 – Siouxsie is available as required 15/05 – No further update – carry forward 08/05 - To be progressed further as Testing Strategy is developed. 01/05 – To be progressed further as Testing Strategy is developed. 24/04 – Action raised	Open
32	Samples for later analysis	Provide item for inclusion in Surveillance Plan - Collecting samples of people with COVID-19 for later analysis	Dr Ian Town / Prof David Murdoch / Dr Erasmus Smit	22/05 – Blood serum bank is being established. No further action required 15/05 – No further update – carry forward 08/05 - Discuss further: • Requires systematic approach: • Needs to be clear clinical or research purpose • Ethical considerations 01/05 – To be progressed 24/04 – Action raised	Closed
33	Risk of using nebulisers	Discuss whether current advice needs to be changed	Dr Ian Town / Dr Juliet Rumball-Smith	22/05 – IPC Subgroup feedback incorporated into review (item 6.0) 15/05 –Literature review remains in progress. IPC Subgroup have provided additional studies for consideration. 08/05 – Literature review has been commissioned. Difficulty with finding specific policies with scientific basis, no evidence tail. Consider findings of review (due 08/05). 01/05 – Literature review required prior to being considered by IPC Subgroup. • Advice must align with evidence and be context based • Requires consideration at a National level	Open

				• Any change requires careful planning of implementation 24/04 – Action raised	
36	Revision of suspect case definition and testing criteria for COVID-19	Add comms to website – case definition under review	Dr Harriette Carr	22/05 – Comms added. Action closed 15/05 – Action raised	Closed

Minutes: Technical Advisory Group for COVID-19

Date:	Friday 29 May 2020
Time:	10.30am – 11.30am
Location:	Zoom Meeting
Chair:	Dr Ian Town
Members:	Dr Sally Roberts, Prof Michael Baker, Dr Nigel Raymond, Dr Virginia Hope, Dr Shanika Perera, Prof David Murdoch, Dr Bryan Betty, Prof Stephen Chambers, Dr Matire Harwood, Dr Collin Tukuitonga, Dr Anja Werno **Ministry of Health staff** - Dr Caroline McElnay, Dr Harriette Carr, Dr Tomasz Kiedrzynski, Dr Juliet Rumball-Smith, Dr Niki Stefanogiannis, Andi Shirtcliffe, Asad Abdullahi, Margaret Broodkoorn, Louise Chamberlain, Fiona Gillam (Secretariat)
Guests	Prof Nigel French (Delegate for EPI Chair)
Apologies:	Dr Patricia Priest, Dr Erasmus Smit, Dr Richard Jaine

1.0	**Welcome and Previous Minutes** Dr Ian Town welcomed all Members, Attendees and Guests in his capacity as Chair of the Technical Advisory Group for COVID-19. Minutes of the last meeting (22 May 2020) were accepted.
2.0	**Update on open actions** Actions 37, 38 remain open. Action 30, 33, 39, 40 closed.
3.0	**Ministry of Health update on COVID-19 response** The Chair gave an update on current issues being worked on in Ministry of Health, which includes: • With the continuation of another day with no further new cases, NZ is moving towards the 28 days confidence level. There is an opportunity to reframe NZ risk profile if the situation of no new cases continues. 8 June Cabinet meeting will be the next planned review. • Research data set for will be available from next week and will provide an opportunity for researchers to use the data for their own research. In the future the availability of this data set is likely to be extended, particularly in light of NZ's current pandemic experience
4.0	**Suspect case definition and testing criteria for COVID-19** Feedback from TAG and Subgroups on options to change suspect case definition and testing criteria for COVID-19 has been appreciated. TAG was presented with a proposed change to the approach, for which approval is currently being sought.

The proposed approach is a combination of the three options.

- Retain status quo up to and including Wednesday 10 June (28 days or 2 incubations periods since start of Alert Level 2).
- On Thursday 11 June, introduce the following:
  - COVID-19 symptoms remain the same: Any acute respiratory infection with at least one of the following symptoms: cough, sore throat, shortness of breath, coryza e.g. runny nose, sneezing, post-nasal drip.' anosmia – loss of sense of smell. with or without fever.
  - Remove suspect case definition / no longer refer to anyone with symptoms consistent with COVID-19 as a suspect case.
  - Align higher exposure risk or 'under investigation' category to those being tested where there is a higher degree of likelihood of COVID-19 – i.e. symptoms of COVID-19 **and** relevant epidemiological criteria. Further consideration should be given to what this category is called for primary/clinical care and public use as 'under investigation' is more for public health or EpiSurv use only.
- Proposed epidemiological criteria:
  - close contacts of probable or confirmed cases
  - people meeting the clinical criteria who have travelled overseas in the last 14 days, or have had contact, in the last 14 days, with someone else who has recently travelled overseas (includes border, quarantine and isolation facility staff, air crew, travellers and their households)
- Probable and Confirmed case definitions – remain the same.

TAG discussion:

- Focusing on identifying those who are a case, or at high likelihood of being a case
- Uncoupling PPE and self-isolation requirements for general public with acute respiratory symptoms, but maintaining for high risks groups
- This proposed change is separate to Testing Strategy and Surveillance Plan
- Testing Strategy is a framework which does not contain operational plans. All testing is part of surveillance and feeds into the Testing Strategy. Communication to the sector is part of how Strategy is operationalised
- Public Health Subgroup are developing a clinical algorithm to support testing, PPE, notification requirements. This will be useful to assist with central guidance as changes to case definition are implemented
- If proposed change is approved, there is a need for clear communications for the public and within all primary care and clinical settings
  - Clinical Subgroup suggest messaging could change from COVID-19 isolation to more general isolation for acute respiratory infections, or good IPC approaches for acute respiratory infection and testing more as surveillance activity is more than 'clinical likelihood'

Action: Subgroups are requested to consider the following and provide feedback to Public Health Subgroup:

- IPC – what are the implications of proposed changes for IPC? eg: presenting to primary care with respiratory illness and advice for higher risk group – within a health care setting
- PC – how would advice be operationalised in a primary care setting?
- Clinical – how would advice be operationalised in a hospital setting?

	○ PH – are casual contacts of a confirmed case with symptoms considered high risk or not?
5.0	**IPC controls in community health and medical practices** There is a need for clear national guidance on IPC controls in community health and medical practices, particularly over winter. IPC Subgroup have been developing national IPC guidelines and will share this with PC Subgroup as an input to community health practice guidance **Action:** Provide published national IPC guidelines to PC Subgroup Chair
6.0	**Healthcare Workers return to work guidance** TAG was presented with proposed returning to work guidance for infected healthcare workers or who are close contacts with an infected person. This guidance is being developed by the IPC Subgroup. Consistent national guidance is required. TAG feedback: • Time taken to recovery is longer than earlier thought. National guidance required so workforce is not stood down for long period unnecessarily • The Australian PHLN (Public Health Laboratory Network) is leading a project to establish a quantitative viral load assay for SARS-CoV-2 which will assist in making the Ct values reported by all the different assays used comparable. In future, this may lead to defining a Ct value cut-off (for each assay) that aligns with non-infectivity • Additionally, subgenomic messenger RNA assays may also guide the assessment of patient infectivity – this is currently research and development • Also impacts on occupational health practice **Actions:** • Subgroups consider and provide feedback to IPC Subgroup • Clinical Subgroup seek feedback from NZ ASID and Occupational Health Network
7.0	**Maori perspectives** • Appreciation for quick resolution by Ministry staff of Urutā issues raised at previous meeting
8.0	**Pacific perspectives** • Exploring NZ and Pacific bubble ahead of Trans-Tasman bubble • Considering Pacific responsibilities related to Vaccine Strategy (1st meeting of vaccine taskforce scheduled for next week)
9.0	**Subgroup verbal updates** Epidemiology • Providing advice and response on Testing Strategy • Discussing assessment model based on approach to specificity and sensitivity • Considering network modelling to look for potential hotspots at different phases of the response; currently considering border Primary Care • Infection control and community medical centres • Changes to case definition

Public Health

- Case definition changes and clinical algorithms
- Close contact criteria

Laboratory

- Public Health England (PHE) has published validation data for the Abbott and Roche serology assays. Both perform quite well.
- In terms of assay set up, a chemiluminescent assay appears to be more sensitive than other immunoassays using different detection systems

Infection Prevention and Control

- National IPC guidelines
- Aeroplanes and masking advice
- Have received UK public health review of aerosol generating procedures and will use as input into guidance
    - Ministry has been receiving feedback from rural hospital community
      Action: Share rural hospital feedback/issues with IPC Subgroup

Clinical

- Infected Healthcare workers
    - Considering how information/data can be pulled together from various sources to provide useful analysis
    - IPC Subgroup has been working to source useful information on cases; is receiving DHB reviews which are showing up IPC issues
    - This needs to be a piece of work driven by the Ministry
      Action: Discuss requirements and Clinical Subgroup involvement for this piece of work

Additional:

- TAG noted the Ministry is aware of issues with airline crews and that there has been issues with mixed quarantine management. Ministry will publish updated guidance for Airline Crew in the next few days.

10.0 Any other business

- To date there has been only one case of a community Pharmacist contracting COVID-19. This is a good news story, considering that IPC is not usually a core part of community pharmacy business

11.0 Agenda items for next meeting

- N/A

12.0 New Action Items raised during meeting

#	Agenda Item	Actions	Owner
41	Proposed change to suspect case definition and testing criteria	Consider the following and provide feedback to Public Health Subgroup: ○ IPC – what are the implication of proposed changes for IPC? eg: presenting to primary care with respiratory illness and advice for	Subgroup Chairs

			higher risk group – within a health care setting ○ PC – how would advice be operationalised in a primary care setting? ○ Clinical – how would advice be operationalised in a hospital setting? ○ PH – are casual contacts of a confirmed case with symptoms considered high risk or not?	
	42	National IPC guidelines	Provide published national IPC guidelines to PC Subgroup Chair	Dr Sally Roberts
	43	Healthcare Workers return to work guidance	Consider guidance and provide feedback to IPC Subgroup	Subgroup Chairs
	44	Healthcare Workers return to work guidance	Seek feedback from NZ ASID and Occupational Health Network	Dr Nigel Raymond / Prof Stephen Chambers
	45	Aerosol generating procedures	Share rural hospital feedback/issues with IPC Subgroup	Dr Juliet Rumball-Smith
	46	Ministry lead work on HCW infection data and analysis	Discuss requirements and Clinical Subgroup involvement for this piece of work	Dr Caroline McElnay / Dr Nigel Raymond
13.0	**Summary of TAG Recommendations** • N/A			
14.0	Meeting closed at 11.30am Next meeting Friday 5 June 10.30am – 11.30am			

Action #	Agenda item	Actions	Action Owner	Updates	Status
30	Public facing testing communications	Seek involvement of Siouxsie Wiles on public facing testing communications	Dr Ian Town / Dr Harriette Carr	29/05 – Discussions held with Siouxsie, available as required. Action closed 22/05 – Siouxsie is available as required 15/05 – No further update – carry forward 08/05 - To be progressed further as Testing Strategy is developed. 01/05 – To be progressed further as Testing Strategy is developed. 24/04 – Action raised	Closed
33	Risk of using nebulisers	Discuss whether current advice needs to be changed	Dr Ian Town / Dr Juliet Rumball-Smith	29/05 - IPC Subgroup continuing to ensure scientific evidence is used as a basis for any decision to change advice. No immediate change proposed. Action closed 22/05 – IPC Subgroup feedback incorporated into review (item 6.0) 15/05 –Literature review remains in progress. IPC Subgroup have provided additional studies for consideration. 08/05 – Literature review has been commissioned. Difficulty with finding specific policies with scientific basis, no evidence tail. Consider findings of review (due 08/05). 01/05 – Literature review required prior to being considered by IPC Subgroup. • Advice must align with evidence and be context based • Requires consideration at a National level • Any change requires careful planning of implementation 24/04 – Action raised	Closed

37	Suspect case definition and testing criteria for COVID-19	Ministry develop advice on changes to suspect case definition and testing criteria, with consideration of Subgroup feedback	Dr Caroline McElnay	29/05 – Verbal update to be provided (item 4.0) 22/05 – Action raised	Open
38	COVID-19 HUB structure	Seek changes to org structure diagrams to include Maori and Equity pathways	Louise Chamberlain	29/05 – In progress. Welcome questions 22/05 – Action raised	Open
39	Urutā issues	Supply information on issues raised for triaging to correct Ministry areas to address	Dr Matire Harwood	29/05 – Information supplied and acted upon by Juliet Rumball-Smith. Action closed 22/05 – Action raised	Closed
40	Wearing masks in public	Dr White and Chief Nurse to review the website material and submit to Dr Ashley Bloomfield for his review and approval	Dr Natasha White	29/05 – Website material reviewed, approved and due to be published on website today Action closed 22/05 – Action raised	Closed