Minutes

Technical Advisory Group for 2019-nCOV Teleconference (Final)

Date:	27 February 2020
Time:	9:00 am- 10:300 am
Location:	National Health Coordination Centre (NHCC), 133 Molesworth St Wellington
Chair:	Dr Caroline McElnay
Attendees:	Dr Sally Roberts Professor Michael Baker Dr Nigel Raymond Dr Virginia Hope Dr Shanika Perera Dr Bryan Betty Dr Anja Werno Dr Erasmus Smit Ministry of Health staff: Dr Caroline McElnay Dr Tom Kiedrzynski Dr Juliet Rumball Smith Dr Richard Jaine Dr Niki Stefanogiannis Andi Shirtcliffe Claudia Rees (minutes)
Apologies:	Dr Harriette Carr, Dr David Murdoch, Professor Stephen Chambers

Documents tabled:

- Minutes of the last meeting (13 February 2020) – approved with no changes.

Item	Notes
0	**Preliminaries** • No corrections from the previous two minutes; both confirmed as finalised minutes.
1	**Situation Update** The main concern of the last week has been the increasing number of cases outside of mainland China. There has been increasing concern regarding the hotspots of Republic of Korea, Iran (mainly due to the lack of clarity on the number of cases), and Italy. WHO overnight indicated that they may not declare a pandemic because of the implications that this had for H1N1. What we are seeing could be defined as a pandemic. Increasingly, this makes it more difficult to 'keep it out.' The Ministry are progressing planning for a COVID-19 response plan. The Ministry of Health is working on planning for the next phase, moving from 'keep it out' and 'stamp it out.' The Ministry is working on health sector preparedness for future models. Australia has published a COVID 19 pandemic plan (https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_1.pdf). The international community is planning for a pandemic. There is concern about the Middle East and other countries that have civil disruption due to the ability for the infection to rapidly spread. Movement of people and number of cases may be difficult to monitor and control. It was outlined that the ability of each country and health system to respond is different.
2	**Case definition** Email feedback had been received from members following email request on Sunday evening. This has been reviewed and a draft new case definition prepared. Decisions regarding the clinical criteria: - It was **agreed** that the clinical criteria will stay the same as it was. "Sore throat" is to be added back to the case definition (this was incorrectly removed). Discussion about the epidemiological criteria: - There was discussion about the use of 'transit through' and the implications the terminology could raise. There was the view that transit situations can vary widely, and the risk of exposure to the virus depends on the transit context. - There was concern about how GPs and Primary Care would operationalise including 'transit through.' - It was outlined that people 'transiting through' were unlikely to have sustained contact with people with the virus and in small spaces. - It was clarified that the case definition tool is to guide clinicians to make decisions on testing. Decisions regarding the epidemiological criteria: - It was **agreed** that the epidemiological criteria should be before the clinical criteria in the formatting - There was **consensus** on the concept of a Category 1 and Category 2, with self isolation advice for asymptomatic travellers from Category 1 only.

	- There was **agreement** to remove regions and maintain countries only. Therefore, the wording of categories are:
	  o Category 1: Mainland China
	  o Category 2: Hong Kong, Iran, Italy, Japan, Republic of Korea, Singapore, Thailand.
	- **Agreement** that countries of concern will need to be continuously updated.
	- **Agreement** that the epidemiological criteria would 'exclude airport transit through' countries of concern.
	
	Discussion about the categorisation of countries:
	- It was discussed that there would need to be urgent work done on how countries shift between being a category 1 and category 2 area of concern, particularly as some countries start to have a higher rate of disease, and others contain the virus.
	- There were discussions about balancing making the categorisations too simple and making them too complex due to the implications the definition will have on the health system.
	- It was clarified that at this stage, public health needs to know when any test is being taken and that clinicians need to manage patients who are being tested as a suspect. It was acknowledged that at a later stage, this may change.
	- There was discussion about adding other countries to the list of 'areas of concern' and how to decide whether a country should be on it or not. It was agreed that there should be clear data and justification for when countries are added, and that this criterion needed further urgent consideration by the epidemiological sub-group.
	
	Action: Epidemiology sub-group to help decide how to move countries from category 1 to 2 and vice-versa.
	
	Action: Epidemiology sub-group to look at data for countries who have lots of traffic to New Zealand and countries who pose a high risk to New Zealand. Epidemiological group to look at metrics for what would generate those countries being moved into each category.

3	**IPC advice for Primary care (paper was distributed to TAG)** **Action:** Niki to send the paper to Bryan for more comments. Discussion about the paper: - There was a discussion about the need to clarify why there are different PPE requirements for in a hospital setting compared to general practice i.e. N95 masks versus surgical masks. It was noted N95 masks need to be fitted properly, and if not did not provide any better protection than a surgical mask. - It was highlighted that there is anxiety from practitioners about not having PPE or adequate PPE, particularly in primary care. This may be due to primary care practitioners comparing their PPE requirements to secondary care, and from practitioners comparing their PPE requirements to photos they see from overseas. - It was raised that we need to be practical about PPE going forward. - There needs to be clarity in the paper about the higher risk for practitioners in a hospital setting, and the generally lower risk for general practice - It was raised that primary care needs to have clarification about GP presentation vs hospital presentation of patients to ensure that there is appropriate management of patients within both primary and secondary settings. - It was agreed that anyone who requires aerosol generating procedures needs to go to hospital.

	- It was advised that DHB and PHO CEOs have been sent a letter outlining the expectations for ensuring adequate PPE, and that DHBs should be assisting PHOs with this. - It was advised that a primary care subgroup is being set up with first meeting next Monday. - It was **agreed** that we need to clarify messaging to show that our PPE advice is consistent with Australia, WHO and elsewhere. **Agreed changes to the paper for action**: - remove runny nose as a symptom - add in lines about the progression of the infection - change any reference to 'management of suspected cases' to 'management of suspected or confirmed cases.' **Action**: Ministry of Health to consider PPE requirements and advice for community radiology when pneumonia is suspected.
4	**Update on any supply chain issues for PPE and essential medicines for chronic conditions** The following updates were provided: - a letter has been sent out to DHB and PHO CEOs asking them to work together to ensure PPE supplies in primary care are adequate. PHOs have also been asked to respond to a survey. - DHBs will need to access their PPE supplies if PHOs need them. The national supply will top up DHBs. - There is work to advise what 'sufficient PPE' is, noting that some practices have more vulnerable groups i.e. elderly and Māori / Pacific. - Tū ora compass is doing work to model this. - It is understood that there is one local manufacturer of masks. - New Zealand currently has 9 million surgical masks and 9 million N95. This 18 million in total for New Zealand is reported to be similar to the total for Australia. It is not known if this figure includes expired masks. - It was noted that there is an out of date stock issue. The Ministry's current advice is to not use expi ed PPE, but not to throw it away unless they have new stock. Medicines update: - PHARMAC and Ministry are meeting to consider long term options for provision of essential medicines.
5	**Updates from the subgroups**
5a	**Lab (Anja, Virginia)** It was advised that if a case is symptom free for 48 hours, they can be declared as non-infectious. Most people feel comfortable with this. However, more discussion is required about the practical application of this. **Action:** Lab subgroup to discuss 48-hour symptom free in more depth and assess this for suitability. Lab subgroup to bring this back to TAG. Update on contamination issue: - An investigation has occurred and it appears that contamination likely to have occurred at the place the probe was purchased from. - It was noted that Supplier IDT has had contamination issues in the past too.

	- It was agreed that its important that labs are aware of the potential for contamination. - Dunedin is close to testing but still not up and running - It was confirmed that ESR date completely captures all the labs, including 'under investigation'. - There is a capacity at the moment to support an increase in testing. **Action:** Anja to find out whether probes are Sigma probes. **Action:** Labs to be notified of the potential for contamination.
5b	**Public health (Harriette and Shanika)** Recommendations 1. Management of high-risk casual contacts – need additional information 2. Use of thermometers – daily monitoring of close contacts not recommended. Sent to Harriet and Tom **Action**: Planning around the use of public health training and / or Homecare medical. Coming up with a plan to present to the public health subgroup.
5c	**Epidemiology (Michael and Richard)** Still waiting on model from Michael for further information. **Action:** Michael to advise when we can share the modelling.

6.	**Other business**
	- An initial teleconference with lead pharmacy practice advisors is being set up for next week. This will talk to:
	  o the PPE primary care guidance and explore whether it is appropriate in a pharmacy context
	  o any other feedback from pharmacy
	  o whether there is a need for an on-going engagement or whether ad-hoc is all that's needed.

7.	**Summary of recommendations**
	
	Case definition:
	- It was **agreed** that the clinical criteria will stay the same as it was. "Sore throat" is to be added back to the case definition (this was incorrectly removed).
	- There was **consensus** on the concept of a Category 1 and Category 2 for the epidemiological criteria, with self-isolation advice for asymptomatic travellers from Category 1 only.
	- There was **agreement** to remove regions and maintain countries only. Therefore, the wording of categories are:
	  o Category 1: Mainland China
	  o Category 2: Hong Kong, Iran, Italy, Japan, Republic of Korea, Singapore, Thailand.
	- **Agreement** that countries of concern will need to be continuously updated.
	- **Agreement** that the epidemiological criteria would 'exclude airport transit through' countries of concern.

	Date and time of next meeting: Thursday, 5 March 2020, 9 - 10:30am