Minutes of the NERVTAG COVID-19 Tenth Meeting: 20 March 2020

Date & Location:	11:00 – 12:30, 20 March 2020 Via telecon only
In attendance:	Peter Horby (Chair), Camille Tsang (Secretariat), Emma Petty (Temporary Secretariat) NERVTAG Members: Wendy Barclay (WB), Ben Killingley (BK), Calum Semple (CS), Jim McMenamin (JM), Ian Brown (IB), Robert Dingwall (RD), Wei Shen Lim (WL). Andrew Hayward (AH), Cariad Evans (CE) NHSEI: Chloe Sellwood (CS) PHE: Maria Zambon (MZ), Gavin Dabrera (GD), Meera Chand (MC) DHSC Observers: Jonathan Van-Tam (JVT), Bethan Loveless (BL), Sadia Dorsani (SD), Alison Deakin (AD) SAGE: Stephanie Croker
Apologies:	Neil Ferguson, David Connell, Ursula Wells

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NERVTAG TENTH MEETING

1 Welcome

1.1 The Chair welcomed members and thanked them for joining the meeting.

1.2 The Chair noted that there were three items for discussion at the meeting. Although the spokesperson for the last item was not present.

2 Brief Epi update

2.1 GD gave an update on numbers for England, with 3269 positive tests, a daily increase of 643 cases and a total of 144 deaths. He also provided an update on surveillance, with 10 positives from 561 tested by RCGP swabbing (1.8%) and 2.8% positives from HDU / ICU testing. It was noted that the RCGP data were from swabs received from mid-February to 15th March. Globally the impact assessment is set at high, with over 211000 cases worldwide on 19th March.

2.2 JM added that 3 out of 88 primary care tests in Scotland were positive.

2.3 The Chair suggested that members should be kept up to date on UK epi data on a weekly basis, with figures provided in advance of the weekly meeting. JVT noted that the CO-CIN database could also provide regular updates on hospital cases to the committee. It was agreed that PHE would provide a weekly surveillance summary for England, which would be collated with Scottish data and the CO-CIN update, to be circulated in advance of Friday's meeting. The documents would be classified as to their sensitive nature.

[Action: GD, JM & CS to co-ordinate weekly surveillance updates on UK numbers for distribution prior to Friday's meeting]

[Action: Secretariat to label summary documents 'official sensitive']

2.4 The Chair suggested to have a brief weekly meeting on Wednesdays with JVT to review the priority points for the weekly Friday meeting.

[Action: Chair & JVT to discuss on Wednesdays the agenda for the Friday meetings]

3 Review of data on the role of children in transmission

3.1 CS introduced the paper on the role of children in the transmission of SARS-CoV-2 in the COVD-19, which had been written by Karl Holden. There was little data on transmission by children of SARS-CoV-2. The review was broadened to encompass SARS-CoV-1 and MERS. There were no specific data on respiratory transmission. There was evidence of positive rectal swabs with negative respiratory samples, but this was considered to be of limited transmission risk. There were three case reports identifying a child as the source of SARS

transmission. Based on the available evidence it is not possible to say if children pose a greater or lesser risk of onward transmission than infected adults.

3.2 JVT noted that a similar paper by CMO's registrars had been submitted to Lancet Infectious Diseases, with essentially the same conclusions. This would be circulated to NERVTAG.

[Action: JVT to provide Lancet submission to the committee]

3.3 Members discussed the need for ongoing work on this issue and the requirement for serological assays. It was noted that a series of work has been planned by PHE. The use of the FF100 study was discussed and analysis of household transmission.

3.4 MZ discussed the details of one case with members which demonstrated proven vertical transmission during pregnancy. Once the timeline for the case had been laid out, a note would be sent to DHSC and CMO for consideration with guidance for pregnant women. Members questioned whether this would be considered an exceptional case due to the level of viral load. It was noted that there appeared to be no development issues with the child.

3.5 Members discussed the value of 'top and tail' style studies on children (swabbing of throat and anus). Currently samples are being taken in hospitals, but there are few children hospitalised. Sampling in a school or nursery environment would be useful to determine how much virus is present in children and on what surfaces within the school/nursery. It would not show the role of children in transmission; however, a household study may provide more information. With schools now being closed, it would be difficult to undertake such a study. Consideration could be given to schools open to the children of key workers. A potential pressure point for such a study would be the testing of samples. This would probably need to be undertaken in academic laboratories. The question of how to deal with positive samples, in terms of duty of care, should be considered separately. The Chair proposed that a recommendation be made for a 'top and tail' style study to be undertaken in a school/nursery environment if possible, with testing carried out in academic laboratories.

[Recommendation: Proposal for a study to be undertaken in children]

4 Review of evidence for asymptomatic or subclinical transmission

4.1 JVT noted that the previously circulated paper by MZ presented the evidence position well. There is plenty of information on asymptomatic people testing positive for SARS-CoV-2 but very little information regarding transmission. There is an ongoing process at PHE to track new information. There are sporadic reports, but the data are not convincing. The Chair requested that the paper be updated by WB & PHE Virology Cell.

[Action: PHE to update previous paper on asymptomatic transmission and pass to WB for additional input]

5 AOB and Next Meeting

5.1 The Chair noted that PHE had raised the following questions for NERVTAG to consider under AOB:

1. To inform discussion and planning of potential antibody testing in the community:
   a. How quickly does NERVTAG consider that IgG could be detectable after onset of symptoms?
   b. What might be the likely duration of IgG detection in COVID-19 cases following acute illness?
   c. Whether NERVTAG consider that a clinically recovered case can be re-infected? – based on any early intelligence from clinical / neutralising antibodies studies, for instance.
2. What is the NERVTAG position on whether coughing produces an infectious aerosol risk and, whether a coughing confirmed patient be treated the same as an APG in terms of PPE?

5.2 MZ provided an overview of serological strategies. It was noted that there was an explosion of information on serology, but that some of this was confused. There was good potential for innovation with the current outbreak.

5.3 Members discussed access to specimens and active studies undertaking biological sampling.

5.4 Members discussed answers for question 1. It was agreed that there is likely to be considerable variability between individuals in IgG dynamics and that more data are needed. The paper by WB circulated for the ninth meeting provided some information on question 1c; however more evidence was now available. The Chair requested that the paper be updated and circulated to members.

[Action: WB to update paper on the potential for reinfection]

5.5 Members discussed the issue of the COVID-19 aerosol risk from coughing. It was noted that the infectious dose from aerosols was not known for this virus. For SARS, AGP are recognised as a greater risk than coughing. Caution was suggested with the concept that aerosols from coughs may not be as infectious, based on SARS information. Recommendations from the committee should have a scientific basis, but also consider the priorities for the availability of PPE in the UK, particularly with FFP3 masks.

5.6 The Chair proposed that the responses to the questions were:

1a. More data are needed but the best-guess is 14-21 days based on what is known from other virial infections.

1b. More data are needed.

1c. The updated paper will provide more information.

2. There is no change to the current guidance, but a further meeting is needed to review this.

5.7 JVT noted a separate group was considering supplies of PPE, both for the NHS and for other groups, such as social care and prisons. It was agreed that a joint meeting would be useful in determining a strategy which considered the scientific evidence and how to prioritise the available stock. The Chair suggested that BK, WB, LR and AH should be involved with this meeting for NERVTAG. JVT would organise the meeting arrangements.

5.8 The Chair confirmed that the meetings would continue on a weekly basis. The minutes of these would be condensed to provide the key discussion points and the actions. The next meeting would take place on Friday 27th March.

5.9 The Chair closed the meeting at 12.38pm.