Minutes of the NERVTAG Wuhan Novel Coronavirus Sixth Meeting: 07 February 2020

Date & Location:	14:30 – 15.30, 07 February 2020 Via telecon only
In attendance:	Peter Horby (Chair), Camille Tsang (Secretariat). NERVTAG Members: Peter Openshaw (PO), Calum Semple (CSm), Neil Ferguson (NF), Wei Shen Lim (WSL), James Rubin (JR), John Edmunds (JE) PHE Observers: Gavin Dabrera (GD), Meera Chand (MC), Mary Ramsay (MR), Jamie Lopez (JL) DHSC Observers: Jonathan Van-Tam (JVT), Jennie Harries (JH), Claire Blackmore (CB), Luke Collet-Fenson (LCF) SAGE: Olivia Tolania (OT) NHS-E: Chloe Sellwood (CSw) HPS: Lisa Ritchie (LR) Co-opted: David Connell (DC), Mark Pritchard (MP)
Apologies:	Kevin Rooney (KR), Cheryl Cavanagh (CC), Martyn Underdown (MU), Ben Killingley (BK)

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NERVTAG WUHAN NOVEL CORONAVIRUS SIXTH MEETING: **SUMMARY**

NERVTAG RECOMMENDED THE FOLLOWING:

Updated UK case definitions for case detection (not for travel advice)

1.1 NERVTAG endorses the changes to the case definition where *fever alone* (with a relevant travel history) has been included and the geographical distribution has been widened. There was consensus in the committee that a stricter definition of 'fever' would not help make the case definition more specific.

1.2 Members also suggested that the case definition should be more inclusive of children as discussed previously and should include the WHO term "difficult breathing in children".

1.3 NERVTAG highlighted that this is an evolving case definition that is consistent with the strategic aim of sensitivity at this point in the epidemic.

PPE for first responders

1.4 NERVTAG do not disagree with the science principles of the document apart from the point about physical contact. The document suggested that those within close proximity to a symptomatic case and no physical contact would not need PPE. NERVTAG disagrees with this as close contact is considered to be those within 2m and would therefore require PPE.

1.5 NERVTAG recommends clarification of the wording and clarity that the document refers to contact with symptomatic persons only.

FULL MINUTES

2 Introductions

2.1 The Chair welcomed everyone to the meeting and apologies were received from those listed above. A sub-group was called as the topics were mostly clinical and epidemiology based and the meeting was requested on the same day.

3 Updated UK case definitions for case detection (not for travel advice)

3.1 DHSC provided some background in that a UK case was confirmed yesterday with recent travel to a country that was not China but was in South East Asia.

3.2 This led to a change in the geographic criteria of the case definition for nCoV testing. The list was expanded to additional countries based on the number of cases and travel volume.

3.3 PHE explained that there have been discussions internally and externally with clinicians and the case definition was causing a lot of clinical variation. Therefore, a line to say that '*fever alone should also require testing'* was included to ensure that we have sensitivity to detect initial cases in the detection and containment phase.

3.4 PHE discussed the case definition with the airborne HCID network and the consensus from those discussions was that the case definition created new challenges overnight but they all agree that fever was an important component of the case definition and were supportive of the change. The airborne HCID network also wanted to make sure PHE highlighted through any communications that clinicians should also look for alternative diagnoses in these sick travellers.

3.5 SH commented that the main element that was causing problems reported from the airborne HCID network was a cough in otherwise well people who had travelled. PH noted that cough was not in the original ask to the committee and it was agreed with PHE that the inclusion of cough could come to the committee at a later date if required.

3.6 PHE would therefore like to ask the committee its view of the following clinical criteria of the case definition of '*fever alone* or *respiratory symptoms with fever or cough or with shortness of breath'* which was changed last night.

3.7 DHSC outlined that the strategic objective is sensitivity of detection so that we can identify, isolate and prevent early establishment of community transmission in the UK without overwhelming the health system.

3.8 Members discussed that immunocompromised patients were more likely to present with fever alone and members would support the inclusion of *fever alone* and the inclusion of the additional countries.

3.9 Members wanted to caveat this change with the fact that there is very limited clinical data to inform this decision and the majority of the information is based on hospitalised patients.

3.10 Members discussed whether a more prescribed definition of fever would be of any benefit. Members commented that measured fever can be difficult if people are taking antipyretics and therefore being overly prescriptive with a measured temperature may miss cases.

3.11 CS made the comment that a strict definition of fever was used during the 2009 pandemic and that caused a lot of problems. Fever now tends to be defined as 'having a fever or feeling feverish'.

3.12 SH commented that NHS 111 is taking a lot of calls and as part of that triage, they will ask questions about whether a person is sweating and other related questions and they will unlikely have a numerical temperature value.

3.13 There was consensus in the committee that a stricter definition of fever would not help make the case definition more specific.

3.14 JE noted and other members agreed that this case definition is for public health purposes and is a case definition for this point in the epidemic. As such, the case definition can and will change as the situation changes.

3.15 Members raised that the case definition should also have the amendment at the end of shortness of breath to be more inclusive of children as discussed previously. The amendment should include the WHO terminology “difficult breathing in children”

4 PPE for first responders

4.1 PHE outlined the PPE paper for first responders which has been agreed across government departments and aims to be a pragmatic approach for those who may be first responders in the community.

4.2 The novel coronavirus is currently considered to be an airborne HCID which dictates certain levels of PPE recommendations within a healthcare setting. However as first responders are often not in a healthcare setting, there was a need to clarify what PPE would be operationally possible and safe.

4.3 PHE explained that healthcare staff who are out in the community would not be able to use FFP3 as they are not trained to use FFP3. Water repellent masks are similar to the FRSM and can be rolled out operationally.

4.4 LR noted that a first responder can be a member of the public as well. It was confirmed that this guidance document was aimed at professional first responders.

4.5 Members suggested that the paragraph regarding the current information to date should be removed (as it will change frequently) and a link to the most up to date information could be included instead.

4.6 CS commented that the paragraph on how nCoV-2019 is spread is wrong in that it places the emphasis on inhalation as the major risk which it is not the case for typical respiratory viruses; the major spread is by fomites and contaminated surfaces. It needs to be more balanced in recognising surface contact to be a risk.

4.7 BK commented that you cannot inhale respiratory droplets but the spirit of the document suggests that they are referring to respiratory secretions and aerosolisation of respiratory secretions rather than inhaling respiratory droplets. The language needs to be clearer and take out the word *proven* as none of the routes of transmission have been proven.

4.8 Members commented that it was not clear in the document how a first responder would know or identify a person who was suspected of carrying the virus. As a first responder, they would not know that the person had relevant travel history. There is a danger of discrimination based on appearance.

4.9 Members agreed that the document should focus on contact with symptomatic people only.

4.10 Members agreed that wherever possible, first responders should isolate the person.

4.11 Members highlighted that hand hygiene should be emphasised and that alcohol gel is not a direct equivalent but recommended if soap and water is not available.

4.12 Members commented that parts of the document provided conflicting advice on the use of googles and this needs to be corrected. The correct advice is to use google with the facemasks if available.

4.13 Members commented that the document provides advice on PPE to first responders but then directs employees to follow the recommendations of the employer.

4.14 Members commented on the section on police where it was suggested that those with no physical contact would not need PPE. NERVTAG disagrees with this as close contact is considered to be those within 2m and would therefore not require physical contact.

Action: Members to send comments on the document to the secretariat within the hour and for the secretariat to collate and send back to PHE.