SARS-CoV-2 network webex
13 March 2020

Agenda

1. Declaring the pandemic (WHO/Europe)
2. Risk assessment (ECDC)
3. Mortality surveillance
4. Global and European surveillance strategy
5. Reporting to TESSy/HQ
6. Experiences with sentinel surveillance and situation updates
7. Laboratory supply shortages, update and survey results
8. Feedback and discussion, AOB


World Health Organization (WHO) Retweeted
Tedros Adhanom Ghebreyesus @DrTedros · 21h
Today I briefed @WHO's Member States on #COVID19 and our decision to describe it as a pandemic. We have made this assessment for two main reasons:
-the speed & scale of transmission
-the lack of political commitment in some countries to control it, despite our frequent warnings.
194
1.2K
2.4K
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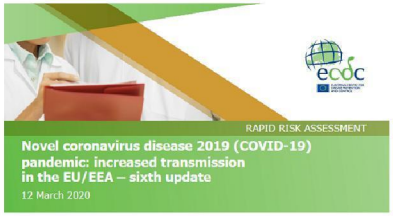
ECDC Rapid Risk Assessment on COVID-19, sixth update

The risk of severe disease associated with COVID-19 infection in the EU/EEA and the UK is considered

- **Moderate** for the general population
- **High** for older adults and individuals with chronic underlying conditions

The risk of healthcare system capacity being exceeded in the EU/EEA and the UK in the coming weeks is considered **high**.

The risk of transmission of COVID-19 in health and social institutions with large vulnerable populations is considered **high**.



RAPID RISK ASSESSMENT

Novel coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA – sixth update

12 March 2020

Summary

On 31 December 2019, a cluster of pneumonia cases of unknown aetiology was reported in Wuhan, Hubei Province, China. On 9 January 2020, China CDC reported a novel coronavirus as the causative agent of this outbreak, which is phylogenetically in the SARS-CoV clade. The disease associated with the virus is referred to as novel coronavirus disease 2019 (COVID-19).

As of 11 March 2020, 118 326 cases of COVID-19 were reported worldwide by more than 100 countries. Since late February, the majority of cases reported are from outside China, with an increasing majority of these reported from EU/EEA countries and the UK.

The Director General of the World Health Organisation declared COVID-19 a global pandemic on 11 March 2020.

All EU/EEA countries and the UK are affected, reporting a total of 17 413 cases as of 11 March. Seven hundred and eleven cases reported by EU/EEA countries and the UK have died. Italy represents 39% of the cases (n=6 149) and 88% of the fatalities (n=631). The current pace of the increase in cases in the EU/EEA and the UK mirrors trends seen in China in January-early February and trends seen in Italy in mid-February.

In the current situation where COVID-19 is rapidly spreading worldwide and the number of cases in Europe is rising with increasing pace in several affected areas, there is a need for immediate targeted action. The speed with which COVID-19 can cause nationally incapacitating epidemics once transmission within the community is established, indicates that in a few weeks or even days, it is likely that similar situations to those seen in China and Italy may be seen in other EU/EEA countries or the UK.

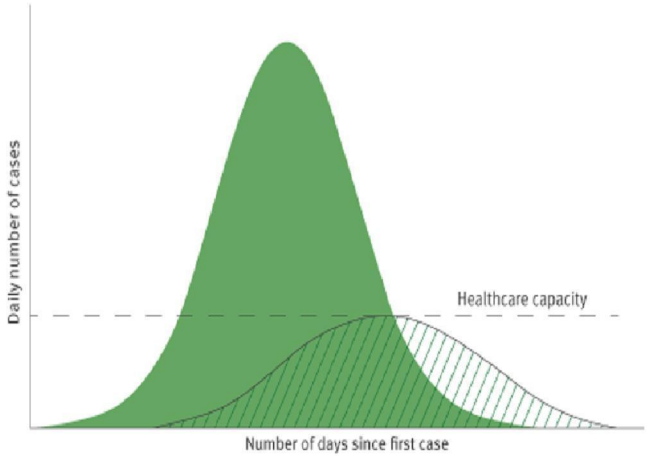
There are no vaccines available and there is little evidence on the effectiveness of potential therapeutic agents. In addition, there is presumable no pre-existing immunity in the population against the new coronavirus and everyone in the population is assumed to be susceptible. Clinical presentations of COVID-19 range from no symptoms (asymptomatic) to severe pneumonia; severe disease can lead to death. While the majority of cases (80%) are milder respiratory infections and pneumonias, severe illness and death is more common among the elderly with other chronic underlining conditions, with these risk groups accounting for the majority of severe disease and fatalities to date.

The risk of severe disease associated with COVID-19 infection for people in the EU/EEA and UK is currently considered moderate for the general population and high for older adults and individuals with chronic underlying conditions, based on the probability of community transmission and the impact of the disease.

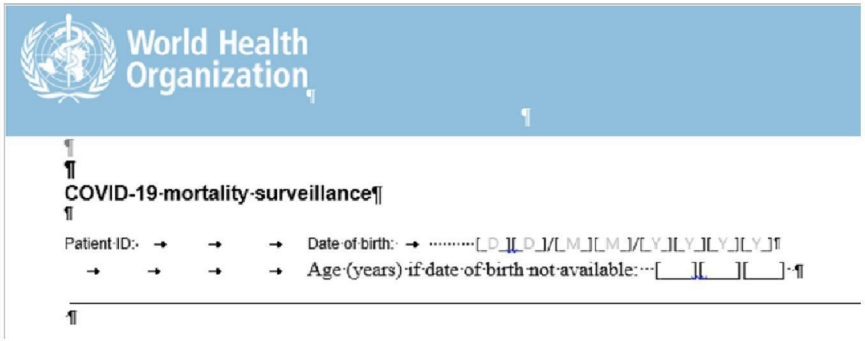
Suggested citation: European Centre for Disease Prevention and Control. Novel coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA – sixth update – 12 March 2020. Stockholm: ECDC; 2020.

Measures to mitigate the impact of the pandemic

- Social distancing measures
- Protect hospitals and long-term care facilities
- Risk communication
- Rational approaches in case of constraints/shortages
- Robust surveillance



WHO Euro mortality



World Health Organization

COVID-19 mortality surveillance

Patient ID: → → → Date of birth: → ·····[_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

→ → → → Age (years) if date of birth not available: ···[___][___][___]

Global and European surveillance strategy

- Test hospitalised SARI cases
- Use sentinel ILI/ARI syndromic surveillance
- Test specimens from sentinel surveillance

- Keep reporting case-based data as long as possible at least minimum dataset
- Start reporting aggr. COVID-19 data from sentinel and SARI

TESSy reporting

As of 13:45 on 13 March:
6 199 cases; 8 deaths

No data from Italy since start of outbreak in Northern Italy

Epidemic intelligence:
28 358 cases; 1 191 deaths

Excluding Italy: 13 245; 175 deaths

Metadata update (6 March)

Case-based:

- Updated according to WHO case report form
- Simplified
- Possible to report limited dataset

Aggregated reporting:

- According to WHO aggregate reporting template
- In addition, variables on testing in sentinel sites + SARI/ICU surveillance

Plan for reporting of data

- Case-based data (NCOV recordtype v1 or 2)
  - Full variable set if feasible
  - Mandatory variables
  - Reminder end of the week
- Aggregated data (NCOVAGGR)
  - If reporting case-based data, report only testing, sentinel, SARI/ICU data
  - If *not* reporting case-based data, report all variables
  - Deadline: Wednesday 12:00 noon

Instructions will be sent by email

Reporting overview

Member State	Case report form	Aggregated data		Sentinel surveillance
		Daily (cases and deaths only)	Weekly*	
EU/EEA	TESSy	ECDC reports to WHO HQ daily, based on official country reports	TESSy	TESSy

* includes reporting of qualitiative indicator of level of transmission (no cases; sporadic cases; clusters of cases; community transmission)

Experiences with sentinel surveillance and situation updates

Feedback Member States

Laboratory shortages

Sampling material

- use one swab per patient for sampling

➢ sample oropharynx (throat) and nasopharynx with one swab

PPE

- BSL2 requirement for sample preparation
  - No FFP2 and FFP3 required for laboratory personnel
  - Working in the laminar hood
- Shortages reported for goggles, gowns, surgical masks, respirators, aprons

Laboratory shortages

- Plastic consumables
- RNA extraction
- RT-PCR
  - primers, probes, positive controls >>WHO distribution
  - enzymes
- Machine time
  - Institutional arrangements
- Personnel
  - Students, trainees, retirees, shift work

RT-PCR testing

1) If you have local transmission and sufficient resources
- expand and test the sentinel ARI/ILI specimens for COVID-19 and all SARI/hospitalised patients
- continue performing confirmatory test in the local laboratories
- pool specimens of a single patient
- continue expanding laboratory capacity
- continue to validate commercial tests
- continue to test for influenza and other respiratory viruses

2) If you have widespread transmission
- focus testing the hospitalised cases but continue testing ARI/ILI as long as possible
- confirm the inconclusive
- continue to test for influenza and other respiratory viruses

Commercial assays

Many commercial molecular assays on the market

- How do the countries use them?
- Have you done validation?

- Anybody to volunteer to join efforts on an validation inventory?
- Please email [redacted] @ecdc.europa.eu

Sequencing

- WGS sequencing preferred to monitor all primer and probe sites
- INSaFLU set up for WGS analysis https://insaflu.insa.pt
- Upload sequences to GISAID
- Visualisation tools available at Nextstrain: https://nextstrain.org/ncov

- ECDC has a contractor available to support WGS sequencing

➢ Please email [redacted] @ecdc.europa.eu if you need support for WGS

Chat points I

[redacted], Germany:

Online questionaire for mortality surveillance: does this mean reporting to WHO AND via Tessy to ECDC again?

from EOC Manager to everyone:

ECDC shares all TESSy data to WHO incl mortality

from (10)(2e) to everyone:

In the Netherlands so far 4 swabs positive in primary care sentinel ILI surveillance in different areas

from (10)(2e) to everyone:

(10)(2e) 4 out of how many tested? understanding the extent of community transmission would tell when the ILI/ARY system is sensitive enough to be used as monitoring system

from (10)(2e) to everyone:

>400 ILI patients swabbed, so approximately 1% positive

from (10)(2e) to everyone:

and what guidelines about PPE are you sending to GP to continue the influenza surveillance?

from Norway to everyone:

The laboratories stop testing for influenza in order to save reagents. In Norway it is not recommended to seek medical care if not in need. We will loose ILI data and labdata both on influenza and Corona

Chat points II

from (10)(2e) (10)(2e) (Scotland) to everyone:

We are starting to hear from some GPs that some individuals with ILI are phoning the practices and then adviced to stay home, therefore not coming to practice and not swabbed.

from (10)(2e) to everyone:

@(10)(2e): are the phone consultations included in the sentinel syndromic data?

from (10)(2e) to everyone:

Same situation in Denmark from yesterday.

from (10)(2e) to everyone:

If patients are advised to call a number, then the local PH authority can organise to test a number of them to assess the proportion positive for COVID-19

from (10)(2e), GR to everyone:

Is it a commercial kit for serology?

from (10)(2e) to everyone:

(10)(2e) are you also thinking of analysing residual sera from the general population? having a few snapshots of the situation in the population can be essential for predicting the course of the epidemic

from (10)(2e) to everyone:

yes, this plan is already in place, ie. population based residual sera collected last fall and another population based this spring - (10)(2e) is our immunologist in charge of the lab methods development

Participants

(10)(2e)