I-MOVE-COVID-19 project

WP2 primary care meeting: Tuesday 08 September 2020

References

Author: (10)(2e), (10)(2e), (10)(2e)
Date: 08 September 2020 (14:00 hrs CEST)
Purpose: Minutes of the regular meeting

Attendees

	PARTICIPANTS
The Netherlands, Nivel	(10)(2e), (10)(2e) (10)(2e)
Epiconcept	(10)(2e), (10)(2e), (10)(2e)
ECDC	(10)(2e),
France, Sentinelles	(10)(2e)
Ireland	(10)(2e), (10)(2e), (10)(2e)
The Netherlands, RIVM	(10)(2e)
Portugal, INSA	(10)(2e), (10)(2e) (10)(2e)
Spain, ISCIII Epi	(10)(2e)
Spain, ISPL Navarra	(10)(2e)
Sweden, PHA	(10)(2e)
UK, PHS	(10)(2e)10 (10)(2e), (10)(2e) (10)(2e) (10)(2e) (10)(2e) (10)(2e), (10)(2e)
UK, PHE	(10)(2e)
UK, RCGP	(10)(2e), (10)(2e)

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Summary of teleconference: I-MOVE-COVID-19 project

1. Agenda

- Welcome, administrative issues
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- D2.5 surveillance report
- Briefly: update on paper 'lessons learned'
- Next steps
- AOB

2. Main points

2.1. Welcome and general (administrative) issues

- Welcome and thanks to all study sites, colleagues from ECDC; apologies to all for the challenging burden of ethical documents required by the European Commission (EC)
- Data sharing with ECDC: for most sites we have the agreement; (10)(2e) is working with ECDC legal department
    - (10)(2e): We had some questions from colleagues about data sharing with regard to TESSy; regarding the data access policy once reported to TESSy. If ECDC receives a request by a third party, they need to share the data but it's unlikely they will get many requests as it's not something they collect regularly or advertise. If this is a problem there are some solutions. One is that data are not reported to ECDC within TESSy but are reported elsewhere and only collected by ECDC to run some analyses – this is done with other data around hospitals. We have to check the feasibility of this with Epiconcept and will discuss further.
    - (10)(2e): We all have willingness to share data but it's the sharing of the data

elsewhere afterwards that poses concerns; we will see with ECDC later how to do this and inform you.

- Update of the data management plan: (10)(2e) is finalising this; this is a deliverable to be submitted next week
- The protocol for vaccine effectiveness (VE) study was also due to be submitted on the 15th of September, but we have requested to the EC to postpone this as it's not yet feasible; EC will accept draft protocol early Feb and final early May so we will start to prepare it as soon as possible and if it is ready before, we will submit it then.
- (10)(2e): Re VE - we also don't know about who is administering the vaccine and who are the risk groups. So tricky to do protocol at this stage.

2.2. Brief summary partners' state of affairs

- France
  - (10)(2e): We see an increase in number of SARS-CoV2; we sample suspected COVID-19 cases and ILI cases; we don't see such high activity in ARI but we do in suspected COVID-19.
    We will restart virological surveillance – and define soon the protocol for the next season.
- Ireland
  - (10)(2e): Overall in Ireland the COVID-19 cases are starting to increase again with an age disribution of 70% in the <45. The schools have opened about a week ago; about three or four schools have closed but not many. Increases in Dublin and in Limerick are being observed at the moment. Currently we have 59 sentinel GPs covering the country; monitoring clinical ILIs weekly, there were about 33 last week. Focused on areas with high levels of COVID-19 so reflected regular surveillance data. We are also monitoring the labs. We are hoping to establish soon the clinical and virological workstrea, using referral forms for COVID-19 that sentinel GPs pick up - aiming to test all suspected COVID-19 patients and additionally testing a subset of 3 patients per week, which gives a total of 180 a week (above the WHO minimum of 150); we are not doing rhinovirus testing. We will get back to you on data sharing and integrating I-MOVE variables. We haven't seen much flu - not sure they are being tested for.
  - (10)(2e): we will have from sentinel GP network two data streams: one on all patients meeting COVID-19 case definition and a subset which is all patients from those (i.e. the first three patients that present to GPs each week). This subset will be swabbed for influenza and RSV as well (the rest will be only tested for SARS-CoV-2). We will be also collecting data on influenza vaccine and hopefully in future the COVID-19 vaccine. We are also trying to establish that when patients go to the community hubs for swabs, these all go to the national reference lab, so we only have to collect data from one lab. This should be easier.
    This has been hugely complex as so many different partners and stakeholders are involved – it includes lots of IT work. It should be ready for October.

- The Netherlands
  - (10)(2e): The number of samples in the sentinel surveillance system has dropped drastically after the way that GPs have changed the way they see their patients. There are not many patients coming to the GP with respiratory symptoms. There is a triage that is recommended by the Dutch Association of GPs. The number of samples is low. We haven't seen SARS-CoV-2 positive patients for several months. We test for flu, rhinovirus, enterovirus and RSV. The number of rhinovirus patients have increased. We don't know for the other surveillance/testing system in the Netherlands for COVID-19 whether the majority of viruses seen are SARS-CoV-2, they are not tested for other respiratory viruses in a systematic way. The percentage positive for SARS-CoV-2 is between 5-10% maximum positive in different areas in the Netherlands.
    The GP system is functioning, but we do not receive many specimens. Usually the number of

specimens from the start of October will increase. This is what we expect.
    - (10)(2e) ((10)(2e) : This is the same in Scotland, very low positivity of SARS-CoV-2 in community: two positives among 1000 samples. But we are seeing increase in NHS24 calls with respiratory symptoms and seeing an overall increase of rhinovirus detections.

- Portugal
    - (10)(2e) : We have finalised the protocol and will send it tomorrow/this week. We are seeing an increase in COVID-19 patients in last three weeks mainly in two regions; and we are still having same issues in setting up the sentinel system. The national strategy for surveillance does not include COVID-19; we are trying to manage this with the Ministry of Health to have this included in the influenza surveillance system but no updates since last time.
- Spain, national:
    - (10)(2e) : We don't have any further update from Spain at the moment.
- Sweden
    (10)(2e) : The number of cases is decreasing and has been flat for a couple of weeks. This is for sentinel surveillance also; it is our fourth week of no positives, but we also have not received many samples. We hope it stays like this. We are preparing for next season and for influenza and hope we can continue with sentinel as before.
- UK-PHS
    - (10)(2e) ((10)(2e) : We have adapted the community primary care surveillance system, where we receive over 1000 samples/week. Our work now is trying to adapt over the next 3 weeks to what is going to happen in the winter. We are in contact with government labs and primary care to see if patients with ARI should go through same centres as before; surveillance has been implemented; we are hoping to see if labs can test for influenza and for COVID-19; given all the good work (10)(2e) and the team are doing we have buy-in from everyone who sees the benefits from the data. It has been successful in terms of informing lockdowns and local lockdowns.
    - (10)(2e) : We are also looking to the government ot fund surveillance and we will bid for participation to May 2021. And we are also getting closer to launching a digital surveillance form for clinicians to complete, this will ease the burden of data entry. A parallel development is with the clinical assessment app, we are hoping to extract data from this for those with moderate symptoms.
    - (10)(2e) ((10)(2e) : We are also hoping that the data could be sent next week to the I-MOVE-COVID-19 central hub; we are finalising IT and ethics issues this week. We may be able to send data to (10)(2e) through the Scottish NHS secure system. We have >9000 samples.
- UK-RCGP

(10)(2e) shared his screen showing the RCGP/Oxford COVID-19 observatory. This showed the rate per 10,000 and number of patients, and pillar 2 testing. The overall impression could be that we may be heading for another wave? Interesting in age is that younger ages showing an increase. Older ages were mostly affected in earlier waves. Higher rates in the north of the country vs. the south. We had a lot of national testing going on. We have a complicated protocol through to the end of the season - it is in the final stage of being written and should be available next week. We are moving to more self-sampling and we are collecting around 1000 serology samples/week. It's a hectic time. I'm sure our data flow is held up in governance. But there is a final draft of an Oxford/PHE data sharing agreement. This project is second in the queue after national data to be signed off by the government.
Our denominator is 0.7 million going up to 17 million potentially.

2.3. Summary of data collection

- General points:
  - Presentation about data received and RF study
  - Data from three countries (SE, FR, NL) for surveillance and for RF study
    - Preliminary results show no association between influenza vaccine and COVID-19 after adjusting for age
  - Weekly aggregated surveillance data: not yet implemented

Discussion on the weekly aggregate data

(10)(2e): We have to decide about stratification of the aggregate weekly data. If every site does a CSV upload, we can use the 10-year age-groups. If the data are being entered weekly by every GP and they have to complete eight age-groups x two sex groups x pos and neg; this is a high burden. Question: is there any site thinking about using the web form (one data entry per week)? If nobody will use the web form then we don't need to discuss it.

Sweden, (10)(2e): we can collect the data from the lab system, and upload weekly. This would be on samples from the first five patients entering the GP, rather than a comprehensive surveillance.

(10)(2e): The sample of patients is no problem.

Ireland, (10)(2e): Are you asking for the data by GP? Unclear of the dataset you want. Not feasible for GPs to enter data.

(10)(2e): No – we do not need these data by GP, but we would like to stratify by region. But if this is not feasible/relevant then we can upload just one dataset.

Ireland, (10)(2e): In Ireland it's not feasible for GPs to enter data, so we prefer one national upload per week. It may be difficult to provide a regional breakdown.

(10)(2e): we thought it useful initially to stratify by region, as perhaps in one there is more COVID-19 in one region vs. another.

France, (10)(2e): the number of patients reported will depend on the practitioners. We collect individual data. We do not have representative geographical distribution of GPs. We can submit by region but it is not incidence. We are the same as Lisa; we try to be representative for regions but there are some regions under-represented. We can submit weekly data and can do it by region but interpreting it is difficult.

(10)(2e): I assume in England and Scotland it will depend on clearance.

Scotland, (10)(2e) ((10)(2e): no this is aggregated data - we only need clearance if data are pseudonymised. Our preference is a CSV file we can upload. We can provide data by regions/health boards, but like others it may not be representative. How will this work in the winter we have to report to TESSy the aggregate positives - used to be in flu reporting? Can we harmonise with TESSy?

(10)(2e): these data do not go into TESSy at the moment - and they differ in the fact that they are stratified by age and sex (and potentially region), so add value.

ECDC, (10)(2e): difficult to upload these data in TESSy. Having the right contact point is difficult for ECDC. We can investigate. It will take time. We have to define metadata, etc. It will be easier to go through Epiconcept for this.

RCGP/Oxford, (10)(2e): In general, we prefer CSV to web forms. Our agreement covers all data items already discussed.

(10)(2e): We will come back to you with another proposal skipping the manual data entry to the form only unless it's added by study site coordination level and will ask ECDC about other possibilities of integrating these data into TESSy

Navarra Spain, (10)(2e) (commented through e-mail): We are ready to send cases and controls. We can send an aggregate file with sex, age group, week for the whole epidemic period.

2.4. Surveillance report

(10)(2e): We sent the first draft so we won't go into details during this TC about the results. An important issue is that at this moment it only represents pooled data. Countries publishing country-specific on their websites so we are not duplicating. Also, it may become problematic as some cells have very small numbers so not enough data to stratify. On the other hand, we learned that there are a lot of differences between countries - please comment by email and let us know if you have any suggestions. We also decided to limit results to countries that reported data - if only one country reports this variable, then we have single-country results.

Please comment before Friday.

2.5. Briefly: update on paper 'lessons learned'

- Scotland, (10)(2e): Thanks to everyone who has sent inputs to the piece of work that we started on lessons learnt; initially we thought we would do semi-structured interviews. But when we looked at what we received, the information looked neater in tabular form.
- We are looking at the surveillance in different periods: Before COVID-19, Mar-May and where countries are now. There are different patterns in the information received from the countries. Very interesting. There are three countries pending. We will start to pull everything into a paper soon. Thanks to all.

ECDC

No comments from (10)(2e).

2.6. Next steps

- Many deliverables are due next week and we will keep you posted about aggregated surveillance and risk factor data.

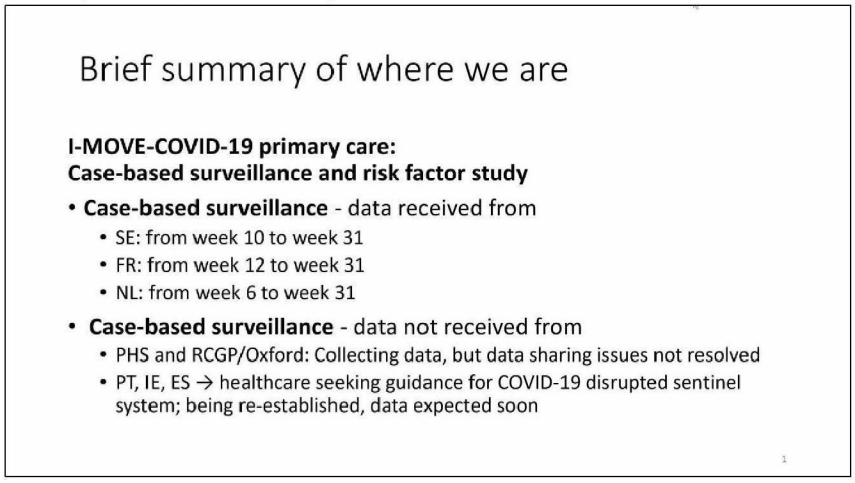
2.7. AOB

- We really need the ethics deliverables for the European Commission as soon as possible. Meeting was closed at 15:03 CET

3. Action points

	Action	Responsible (deadline)
1	Refine protocol for aggregated surveillance	WP2 lead ((10)(2e)) (end of September)
2	Comment on surveillance report	Partners (Friday 11th September)
3	Ethics deliverables	Partners (asap)

Annex 1: presentation from the meeting



Brief summary of where we are

I-MOVE-COVID-19 primary care:
Case-based surveillance and risk factor study

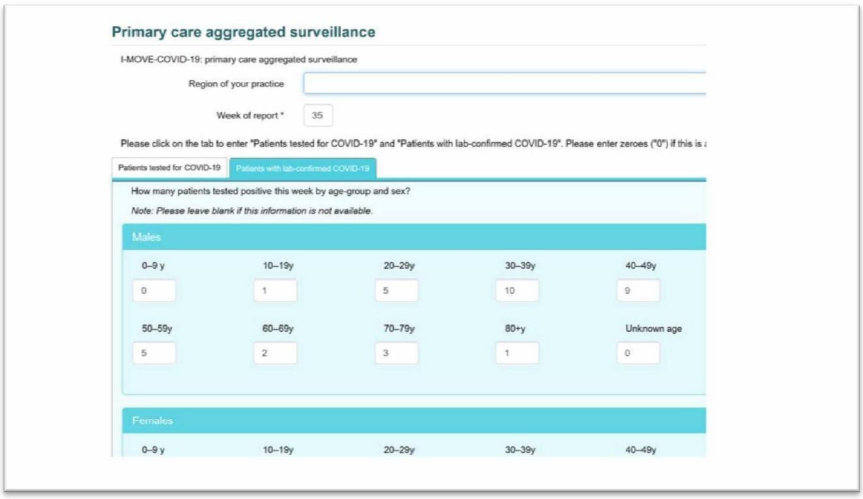
- **Risk factor study** - data received from
  - SE: from week 10 to week 31
  - FR: from week 12 to week 31
  - NL: cases only week 6 to week 31, controls to follow

→ I-MOVE (influenza) meeting

- Preliminary results to show no association between influenza vaccine and COVID-19 after adjusting for age (29th of September)
  - Results not disseminated and shared prior to meeting with study sites providing data

Weekly aggregated surveillance data

- Reminder:
  - Number of tests and number of COVID-19 cases
    - By week
    - By age group and sex (region if possible)
    - To complement ECDC sentinel surveillance data (total numbers only)
  - Web form exists
    - GP or national institute enters data
  - Direct data transfer via csv possible
  - ECDC age groups used (10 year age groups)
    - Heavy data entry burden
- Not yet implemented – to be discussed



Weekly aggregated surveillance data

- Is there a need for manual data entry (web form)?
- If yes:
  - data entry by study site coordinator = 1 entry per week
  - or data entry by each GP = many entries per week
  - limitation of number of strata (age groups, sex, region?)
- If no manual data entry is needed:
  - 10-year age bands, incl. unknown age
  - sex, incl. unknow sex
  - Regio
- Only pooled results? Then region is NOT needed.

First surveillance report (D2.5)

- Deadline: 15 September
- Structure: summary of findings - results (mainly graphs) - some background

DISCUSSION

- Only results on pooled data - no country info in 'open data'
- Variables reported by just one study site => include or not?
- Results are presented by months
- To be included: more information on definitions of variables