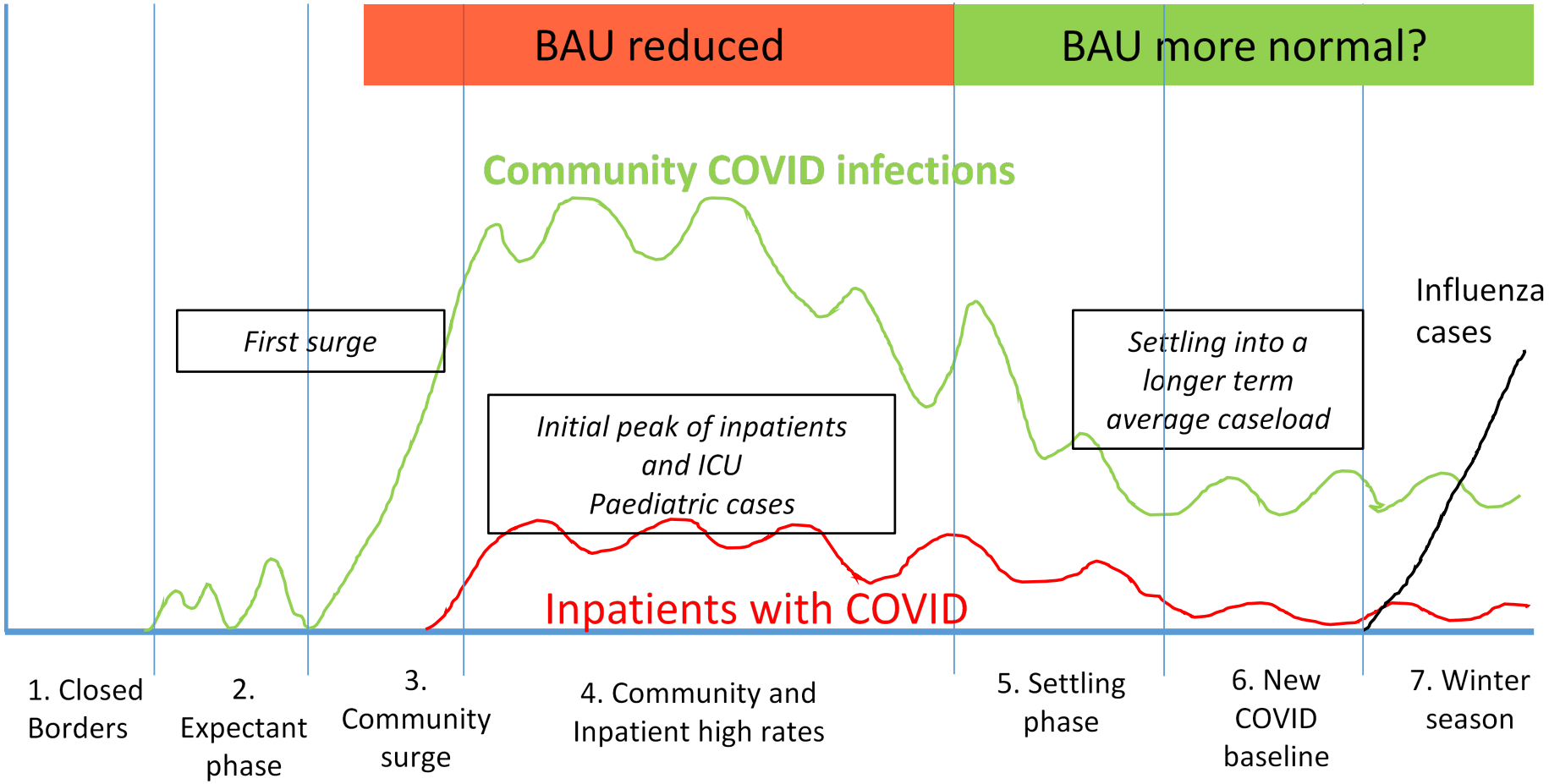
Pinnacle
Midlands Health Network

Covid In The Community

Clinical Zoom 27th October 2021

How this will develop



First Phases

1. Closed Borders
   Current (22/10/2021) situation. Border with Auckland and parts of the Waikato Closed.
2. Expectant Phase
   Waikato is currently experiencing this phase. Cases are effectively traced and contained but with flare ups.
3. Community surge
   Contact tracing is overwhelmed. Our effort might reduce the steepness of the rise. Auckland is currently in this phase.

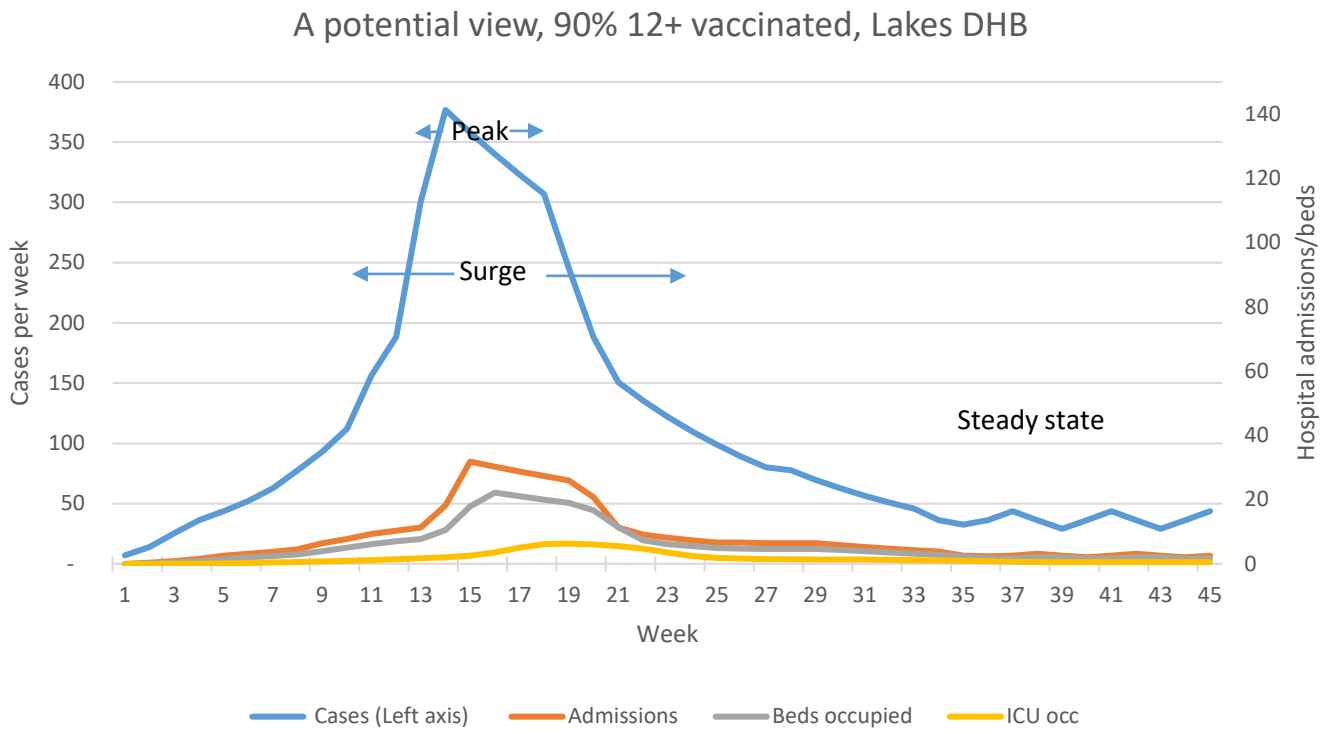
- 90% adult vaccination rate by Dec 2021.
- Children ages 12-15 are vaccinated.
- 0-11 year olds not vaccinated.
- Borders are opened 1 Jan 2022.
- Restrictions remain on travel to some countries, but otherwise quarantine-free travel is occurring.
- Assume Delta variant is main issue, medium R0 = 4.5 per REF.
- Assume variation in coverage by community around the average vaccination coverages.
- Vaccine efficacy (Pfizer) against Delta = 88%, against severe disease 94%.
- Assume severity proportions as per REF.
- Vaccine reduction in transmission - 85%.
- No further community lockdowns, but case isolation and contact tracing e.g. as measles is managed now, drops R0 44% .
- Health care workers at 93% coverage - assume other groups slightly lower.
- M + P have 2.5 and 3x the rate of hospitalisation as European/Other.
- Planned Care will be managed based on current occupancy and a decision matrix
- Some communities in the Midland region are particularly vulnerable and will need additional resources and support.

Size of the problem

	Over 2022 year							Average per week in 2022		
DHB	Cases	Hospitali-sations	Deaths	% cases M	% cases P	% deaths M	% deaths P	Cases	Hospitali-sations	Deaths
BOP DHB	36,800	2,100	220	31%	2%	50%	0%	710	41	4
Lakes DHB	16,900	1,000	100	42%	3%	50%	0%	330	20	2
Tairawhiti DHB	7,800	560	60	60%	3%	87%	0%	150	11	1
Taranaki DHB	17,600	880	90	24%	1%	50%	0%	340	17	2
Waikato DHB	62,000	3,200	320	27%	4%	33%	0%	1,200	60	6
Total Regional	141,200	7,800	790	31%	3%	40%	0%	2,700	150	15

Potential forecast – planning scenario - Lakes DHB

Could start sometime in the next 2 months



	Steady state	Surge (3-4 mths)	Peak (4-6 wks)
Daily cases	5	27	54
Daily admissions	0.4	2	6
Daily ED attends	1	4	12
Daily ED attends w covid	0.1	0	1
Daily child cases	1	10	30
Primary care monitored /day	11	49	98
Primary care consults / day	3	17	51
Avg occupied beds	2	11	19
Max occupied	7	22	22
Average ICU	1	3	5
Max ICU	2	6	6
Infectious per 1000 pop	1	3	6

Steady State = Tight Controls
Surge = Looser controls used to size
Peak = attendance fluctuation of approx 3x surge

Estimated deaths over year: 27 total and 13 Māori (50%)
Hospitalisations weight in a similar way – inequitable impact.

Scope of current planning

- Identification of cases and initial assessment of best place for care
- Social and welfare risk stratification
- Wrap-around services – who what where when and how
- Clinical Risk stratification
- Clinical assessment inc. equipment and funding
- Treatment options
- Escalation process
- Palliative care
- Shared record keeping and notes access

How will care flow ?

COVID-19 Primary Care Clinical Model

(The model refers to sections in green. Other sections are being developed in parallel and sit outside this scope)

Identification *of People with COVID-19*

Clinical Care *Of people with COVID-19*

Test setting ***Notification*** ***Assessment*** ***Risk Stratification*** ***Review Plan*** ***Escalation / De-Escalation*** ***Discharge and Clearance*** ***Follow-up check***

Primary and community

Hospital

Public Health *TBC*

- Notification of positive test
- Register, inform, assign, investigate case, create location, link case
- Provision of isolation and infection control guidelines
- Contact tracing questionnaire
- Assess suitability of isolation at home / in community settings
- Notify registered general practice / PHO, or assign primary care clinical provider if not enrolled

Provider / Function TBC

- Arrange welfare, accommodation and transport
- Social and welfare needs assessment
- Social and welfare care coordination with Community SIQ coordinator

Primary Care / General Practice

Initial Virtual Consultation

- Clinical assessment risk factors and severity of symptoms identified
- Risk stratification and clinical assessment to determine care level
- Assess whether non COVID-19 health care is being addressed, and social supports are being activated
- Liaise with public health, Community SIQ as needed.
- Notify community pharmacist if known

Low

Medium

High

Symptoms

Model of Care Level 1: Regular virtual/telehealth health check monitoring, referral for other health and social supports

Workforce: Hybrid model integrating with individual/whānau regular or alternative general practice provider with urgent care support, telehealth services, service navigator and kaiāwhina support

Model of Care Level 2: Regular more frequent virtual/telehealth health check monitoring and consultation as required, supported by multi disciplinary clinical team with shared care approach. (In person care may be required for non-covid urgent care needs).

Workforce: Whānau centric MDT includes general practice, telehealth services clinical team, urgent care, secondary care specialists and nurses, pharmacists, physiotherapists and paramedics (to be regionally determined), service navigator and kaiāwhina support

Model of Care: Acute care in hospital setting, or palliative care

Workforce: Secondary care teams, service navigator and kaiāwhina support

Emergency ambulance transfer

Clinical Service Release

General Practice / Primary Care / Telehealth Services

Public Health Release

COVID-19 HealthPathways

Telehealth services for COVID-19 enquiries and after-hours clinical advice

Data capture and integrated IT systems

Welfare and social support, accommodation and transport

Shared governance and oversight to support continuous improvement

Risk Stratification Assessment for Clinical Care of COVID-19 in the Community

A detailed assessment tool sits underneath this framework and will be available through the COVID-19 Community HealthPathways

Infant < 1 month old, child aged < 2yr that was born premature (< 37/40), or child any age with co-morbidities?

NO

Asses the risk of the most vulnerable adult in the 'bubble'

YES

COVID-19 Vaccination course completed more than 2 weeks ago?

YES

NO

Immunocompromised?

YES

NO

Māori or Pacific Island (PI) ethnicity ?

NO

YES

≥65 years

YES

MEDIUM TO HIGH RISK

* High Risk if one or more medical risk or dynamic / complex circumstance

NO

≥ 44 (Māori)
≥ 40yr (PI)

YES

NO

Medical risks: Pregnant (or within 6 weeks of pregnancy), BMI >30, Active malignancy
Co-morbidities ie (HT, DM, IHD, CKD,COPD, Asthma, CVA, Epilepsy)
Smoker (tobacco or cannabis)
CPAP

YES

Dynamic or complex circumstances (considerations): social isolation, geographically isolated (rural), lack of transport, housing insecurity, housing crowded or damp and cold, needs carer support, absence of suitable caregiver, disability support required, mental health supports required, addiction support required, drug support required, health literacy support required

NO

LOW RISK

MEDIUM TO HIGH RISK

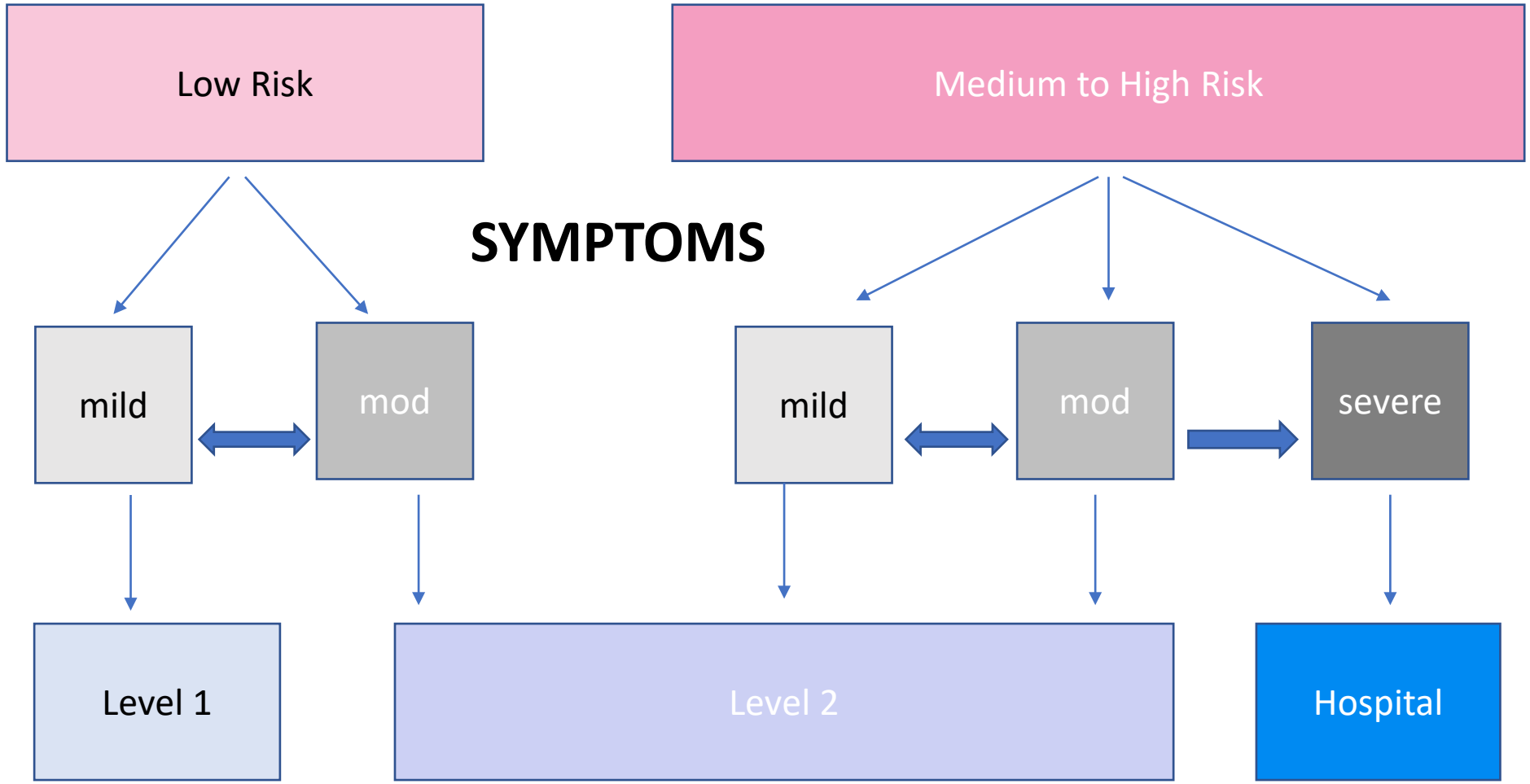
* High Risk if one or more medical risk or dynamic / complex circumstance

This draft risk stratification tool been developed taking into account the following resources. RPA version: rpavirtual Delta Risk Stratification Tool_Version_3.1_06102021.pdf and Ontario Hamilton Family Medicine Assessment , Monitoring and Management of COVID https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/

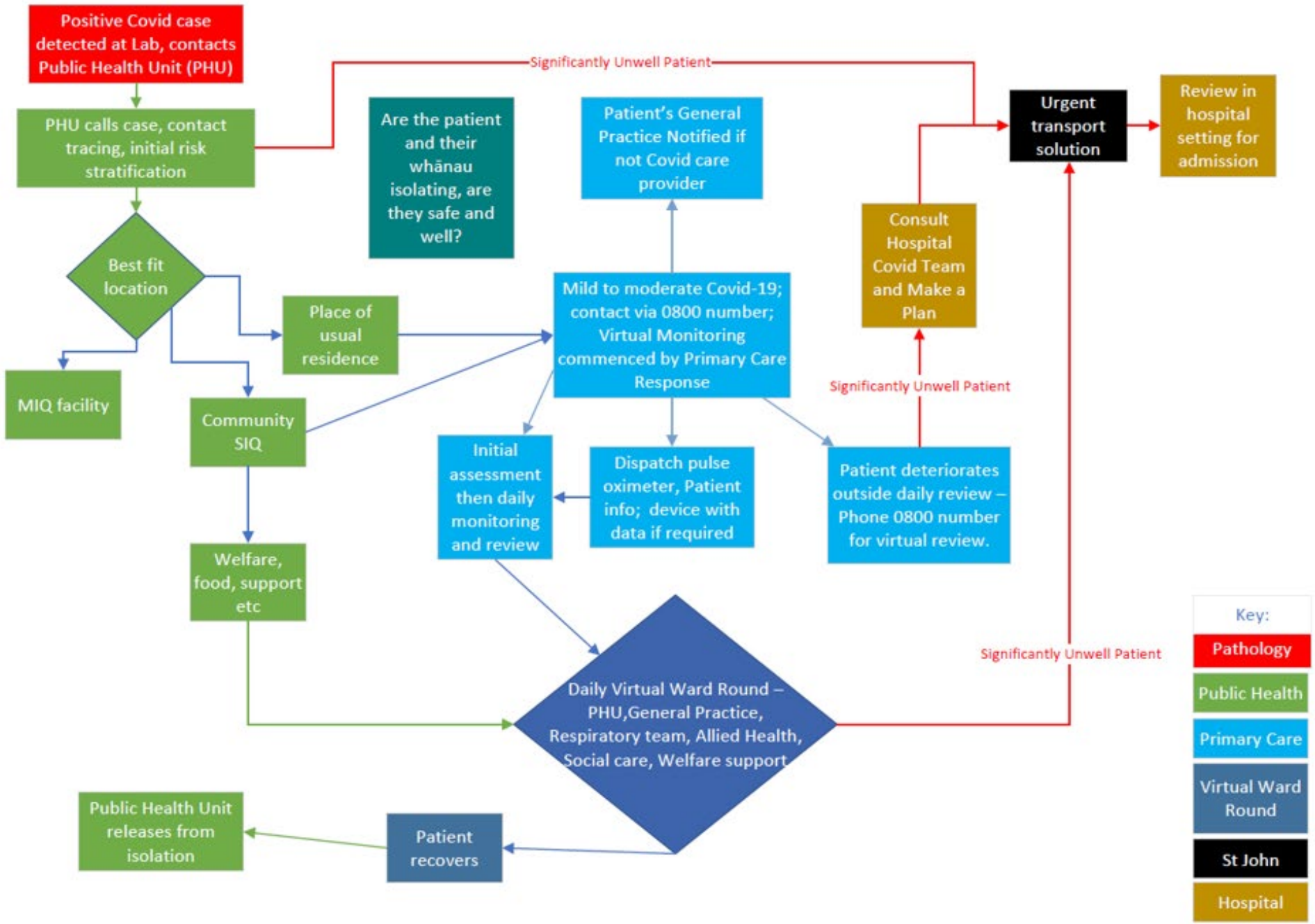
Model of Care

The model of care level is determined by the risk of the most vulnerable/at-risk person within a 'bubble' and the intensity of symptoms

A detailed assessment tool sits underneath this framework and will be available through the COVID-19 Community HealthPathways



Covid Care in Community initial response Southern Health System draft 21 September



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Risk Level

High Risk	Average Risk	Low Risk
Patients with any of the safety net flags		Otherwise healthy adults
Patients with symptom deterioration	Pregnant women	No comorbidities
Any age with medical comorbidities		No safety net flags
Maori or Pacific		
Age > 60	40-60 years old with no medical comorbidities	Age 1-39 years old
MONITOR Once or Twice Daily for 14 days	MONITOR Every daily for 10 days - ask to self-monitor for additional 4 days	MONITOR Consider self-monitoring only; check-ins determined by individual patient. (Consider at 5-6 and 10 -12 days)

In patients who require admission to hospital, the average time from symptoms starting to breathing difficulties is 5 days. If there is to be a rapid immune system collapse and deterioration, it usually happens around day 10-12.

COVID-19 Red Flag Symptoms

RESPIRATORY
- Severe shortness of breath at rest
- Difficulty in breathing
- Increasing significant fatigue (reported in some patients as a marker for hypoxemia without dyspnoea)
- Blue lips or face
- Haemoptysis

OTHER
- Cold, clammy, or pale and mottled skin
- Reduced level of consciousness or new confusion
- Little / no urine output
- Pain or pressure in the chest

Syncope

Consider consulting with specialist services if:

- HR >110, SPO2 consistently ≤ 92%, RR >24
- Severe shortness of breath at rest (e.g. Breathlessness RR >30 despite normal O2 sats)
- Difficulty in breathing (work of breathing)
- Reducing O2 saturation (see guidance under Examination/Assessing Vital Signs on this page)
- Pain or pressure in chest
- DVT symptoms / signs
- Decreased oral intake or urine output (dehydrated, needing IV fluids)
- Cold, clammy or pale mottled skin
- New onset of confusion, becoming difficult to rouse, syncope
- Blue lips or face
- Coughing up blood
- Other symptoms indicating severe illness, or significant or rapid deterioration including markedly increased fatigue if O2 Sats are not available.

NB if the patient has other conditions that mean admission to hospital is unlikely to be in their best interests consider referral to palliative care.

Respiratory Assessment[1] :

1. Ask the patient to describe the problem with their breathing in their own words and assess the ease and comfort of their speech. Ask open ended questions and listen to whether the patient can complete their sentences:

   - "How is your breathing today?"

2. Ask Three Questions:

   - "Are you so breathless that you are unable to speak more than a few words?"
   - "Are you breathing harder or faster than usual when doing nothing at all?"
   - "Are you so ill that you've stopped doing all of your usual daily activities?"

3. Focus on change. A clear story of deterioration is more important than whether the patient currently feels short of breath. Ask questions such as

   - "Is your breathing faster, slower, or the same as normal?"
   - "What could you do yesterday that you can't do today?"
   - "What makes you breathless now that didn't make you breathless yesterday?"

4. Interpret the breathlessness in the context of the wider history and physical signs. For example, a new, audible wheeze and a verbal report of blueness of the lips in a breathless patient are concerning.

   - There is no evidence that attempts to measure a patient's respiratory rate over the phone would give an accurate reading, and experts do not use such tests. It is possible, however, to measure the respiratory rate via a good video connection. More generally, video may allow a more detailed assessment and prevent the need for an in-person visit.

If they have a pulse oximeter - previously healthy lungs or previously documented normal O2 sat – a new consistent reading of < 92% is a red flag.
If underlying lung disease with documented low normal O2 sat at baseline – a new reading of < 90% is a red flag. If patient on home oxygen normally and their O2 requirements increase with COVID illness – this is a red flag, If they are having oxygen at home – aim for SpO2 92-96%, If risk of CO2 retention, aim saturation 88-92%

[1] (From Trish Greenlagh et al BMJ (https://www.bmj.com/content/368/bmj.m1182)

What Happens to Staff who are exposed ?

Note:
All exposure category decisions are based on a local risk assessment.
This matrix should be seen as guidance only.

The highest risk duration or proximity parameter met should be used (e.g., face-to-face trumps <30min in the room and > 1.5m)

Case = confirmed positive case in a patient, staff member or other person in the health care environment.

Not a contact = transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact.

PPE = Personal protective equipment

Low Risk Exposure

- Shared indoor space: In general, < 30 minutes cumulative and >1.5m

OR

- Exposure outdoors <1.5m for >30 minutes & no AGP/AGB

Moderate Risk Exposure

- Any face-to-face contact/care within 1.5 metres and less than cumulative 15 minutes

OR

- In general, shared indoor space greater than cumulative 30 mins in 24 hrs >1.5m

OR

- Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment

High Risk Exposure

- Prolonged face-to-face contact within 1.5 metres and greater than cumulative 15 minutes,

OR

- Aerosol generating behaviours (AGBs from the case e.g., coughing, singing, shouting, exercise),

OR

- Aerosol generating procedures (AGPs) during procedure or settle time,

OR

- Contact with multiple COVID-19 cases/suspected cases/probable cases,

OR

- Direct exposure to the mouth/nose/eyes with infectious body fluids (e.g., coughed, sneezed, vomited on) from the case, or handling of infectious bodily fluids,

OR

- Lab worker handling COVID-19 specimens

	Vaccination status of the healthcare worker					
	Partial or none	**Full****	**Partial or none**	**Full****	**Partial or none**	**Full****
No effective PPE worn by staff member or case (no PPE or PPE with major breaches such as mask below nose)	Moderate risk / High risk Based on risk assessment	Low risk / Moderate risk Based on risk assessment	High risk	Moderate risk	Highest Risk	
Medical mask only worn by staff member • Case no PPE	Moderate risk	Low risk	Moderate risk	Low risk	High risk	High risk
Medical mask worn by staff member AND • Case wearing mask	Low risk	Low risk	Low risk	Low risk	High risk	Moderate risk
Staff member in P2/N95 but no eye protection with no breaches	Low risk	Low risk	Low risk	Low risk	Moderate risk	Low risk
Staff member in P2/N95 and eye protection with no breaches	No risk – general surveillance testing should continue					

Note: Eye protection may be recommended for IPC purposes to reduce transmission risk in the workplace, but not wearing eye protection does not constitute sufficient exposure risk to warrant inclusion in exposure event criteria EXCEPT when aerosol generating procedures are being undertaken. However, employees should follow all IPC guidance provided by their employers at all times and this may include the routine use of eye protection.

Use of gown/apron and gloves should be risk assessed based on individual incident, exposure to body substance and chances of environmental contamination.
*Always subject to local documented risk assessment, including assessments of occupational exposures and of the closed space.
**Full = is 14 days following 2nd dose.

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Risk category	Vaccination status of the healthcare worker	
	Partial or none	**Full****
LOW TO MODERATE RISK	• No stand down required • Monitor symptoms for 14 days • Test if symptomatic, no matter how mild • Comply with IPC protocols when at work • Continue regular surveillance testing • Offer support to be vaccinated as soon as possible	• No stand down required • Daily symptom / fitness for work screen as per local protocols • Monitor symptoms for 14 days • Test and self isolate if symptomatic, no matter how mild • Comply with IPC protocols when at work • Continue regular surveillance testing
MODERATE RISK	• If exposure on current shift, leave workplace at the end of the shift, comply with IPC protocols, test on days 2 & 5 post exposure • If exposure occurred prior to current shift and/or outside of workplace, leave immediately, test immediately & day 5 post exposure • Stay at home until negative day 5 test is available • Monitor for symptoms, test again if become symptomatic within 14 days post exposure • Continue regular surveillance testing • Offer support to be vaccinated as soon as possible	• No stand down required • Daily symptom / fitness for work screen as per local protocols • Must wear N95/P2 mask and comply with IPC protocols • When mask must be removed (e.g., for eating and drinking), ensure physical distancing is maintained • Post exposure testing as directed (e.g., PCR test no earlier than days 2 & 5 post exposure; or daily RAT if approved) • Return to institutional general masking policy & physical distancing after negative day 5 test result is available • Test if symptomatic, no matter how mild • Comply with IPC protocols when at work • Continue regular surveillance testing
HIGH RISK	• If exposure has occurred on current shift, leave workplace at the end of the shift, comply with IPC protocols • If exposure occurred prior to current shift and/or outside of the workplace, leave immediately • Isolate for 10 days, test on days 2/3, 6 and 9 post exposure. • Monitor for symptoms for the remaining 4 days until day 14 but can return to work • Monitor for symptoms, test again and self-isolate if becomes symptomatic within 14 days post exposure • Continue regular surveillance testing • Offer support to be vaccinated as soon as possible	• No stand down required • Daily symptom / fitness for work screen as per local protocols • Must wear N95/P2 mask and comply with IPC protocols • Post exposure daily testing required until day 10, instead of quarantine • Test again if symptoms develop, no matter how mild • When mask must be removed (e.g., for eating and drinking), ensure physical distancing is maintained • Eat alone in a well-ventilated space, if possible • Comply with IPC protocols when at work
HIGHEST RISK (AGBs/AGPs)	• If exposure on current shift, leave workplace at the end of the shift, comply with IPC protocols • If exposure occurred prior to current shift and/or outside the workplace, leave immediately • Isolate for 10 days, test on days 2/3, 6 and 9 post exposure. • Monitor for symptoms for the remaining 4 days until day 14 but can return to work • Monitor for symptoms, test again and self-isolate if becomes symptomatic within 14 days post exposure • Continue regular surveillance testing • Offer support to be vaccinated as soon as possible	• If exposure on current shift, leave workplace at the end of the shift, comply with IPC protocols • If exposure occurred prior to current shift, leave immediately, test immediately • Isolate for 10 days, test on days 2/3, 6 and 9 post exposure. Can return to work after 10 days if all tests negative • Monitor for symptoms, test again if become symptomatic

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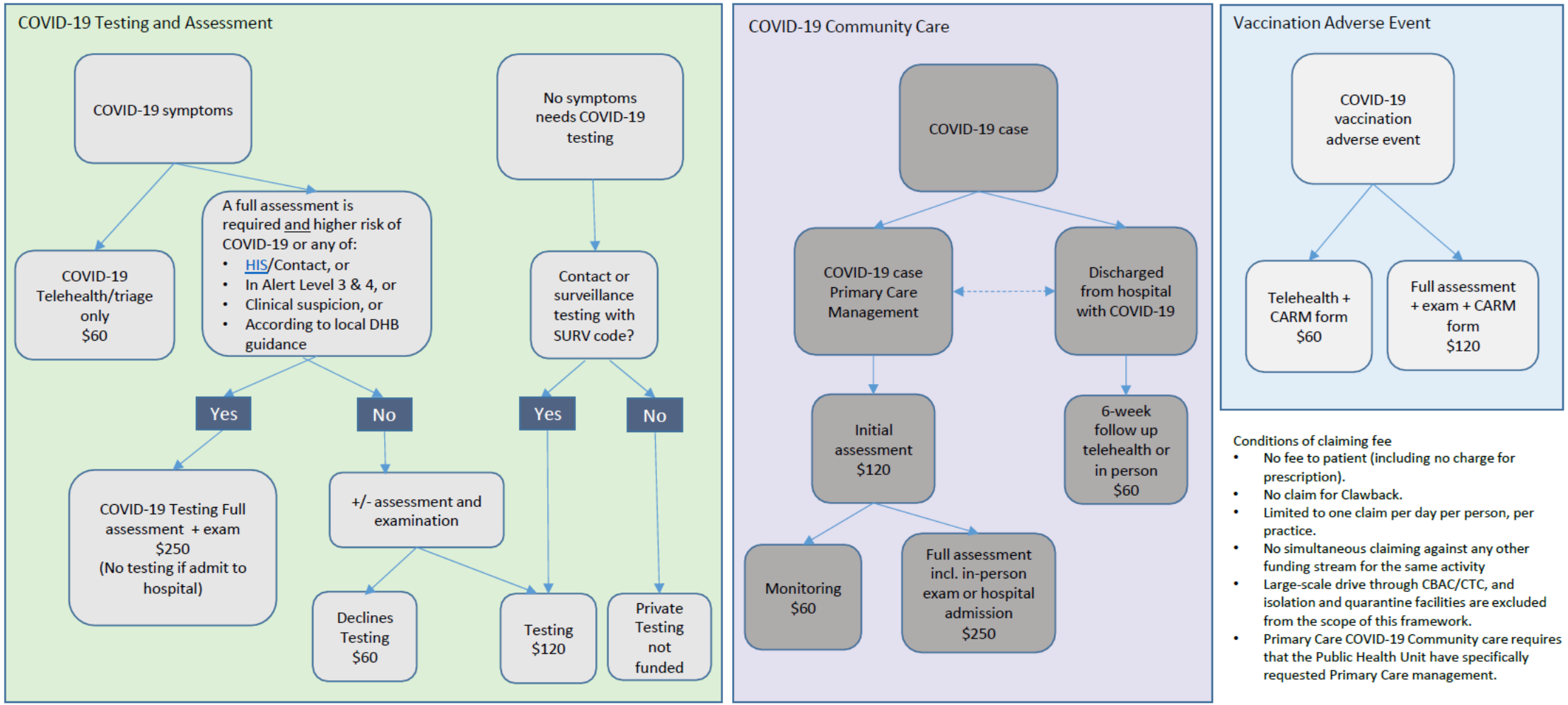
Funding ?

Appendix 1: Primary Care Based COVID-19 Activity Framework

	COVID-19 Assessment and Testing (National)			COVID-19 Case Primary Care Management (Auckland Only)	COVID-19 Vaccine Adverse Event (National)
Indication	COVID-19 activity	Either: • COVID-19 symptoms +/- a limited examination, or • Asymptomatic contact or surveillance testing	A full assessment is required and patient is at higher risk of COVID-19 i.e: • HIS/Contact, or • In Alert Level 3 & 4, or • Clinical suspicion, or • According to local DHB guidance		
Consult type	Triage/telehealth consultation.	Needs be seen in-person for symptoms of COVID-19 and swabbing.		Telehealth unless in-person assessment is clinically indicated.	Telehealth or in-person assessment if this is clinically indicated.
Provider of clinical care	Assessment by nurse, nurse practitioner or general practitioner.	Seen in person by nurse, nurse practitioner or general practitioner.	Seen in person by general practitioner or nurse practitioner.	Initial assessment and 6-week follow-up: general practitioner or nurse practitioner, Monitoring: general practitioner, nurse practitioner or nurse. In-person full assessment or hospital admission: by general practitioner or nurse practitioner.	Assessment by nurse, nurse practitioner or general practitioner. Full patient assessment by general practitioner or nurse practitioner.
Examination	Documented risk assessment and consultation.	Documented limited examination and observations with swab (if applicable).	Documented full patient assessment, including a history, consideration of pre-existing medical conditions, clinically appropriate examination and management plan and a swab. A swab is not required if the patient is admitted to hospital.	Initial assessment: Full patient assessment, including a history, consideration of pre-existing medical conditions and management plan. Monitoring: Documented review of symptoms and care plan and escalation of care if required. Full assessment that requires some in-person assessment, or a consult resulting in hospital admission.	Either: Documented limited history and examination +/- observations and completion of CARM form. Or: Documented full patient assessment, including a history, consideration of pre-existing medical conditions, clinically appropriate examination and management plan and completion of CARM form. Or: If COVID-19 symptoms to manage as possible COVID in COVID-19 Assessment and Testing and complete CARM form.
Follow up care		Provide written Testing Advice if tested, test result provided to person and follow up if a recollect is required.		If admitted to hospital provide a 6-week post COVID-19 follow-up consult	-
Fee Claim	$60	$120 COVID-19 symptoms and but no swab $60	$250	Initial consult $120 Monitoring $60 In-person full assessment or hospital admission $250 6-week follow-up $60	Virtual or in person limited assessment $60 In-person full assessment $120 If COVID-19 symptoms to claim as per COVID-19 Assessment and Testing.
Condition of claiming fee	No fee to patient (including no charge for prescription) and no claim for Clawback. Limited to one claim per day per person, per practice. No simultaneous claiming against any other funding stream. Large-scale drive through CBAC/CTC models are excluded from the scope of this Framework. The DHB will commission these separately. Higher Index of Suspicion (HIS) For Primary Care COVID-19 case management - requires that the Public Health Unit have specifically requested Primary Care management. For COVID-19 vaccine adverse events, claims must be for events within 2 weeks of vaccination.				

Funding in Auckland

Appendix 2: Primary Care Based COVID-19 Activity Algorithm



Conditions of claiming fee

- No fee to patient (including no charge for prescription).
- No claim for Clawback.
- Limited to one claim per day per person, per practice.
- No simultaneous claiming against any other funding stream for the same activity
- Large-scale drive through CBAC/CTC, and isolation and quarantine facilities are excluded from the scope of this framework.
- Primary Care COVID-19 Community care requires that the Public Health Unit have specifically requested Primary Care management.

Shared IT system

MINISTRY OF HEALTH
MANATŪ HAUORA

Border Clinical Management System

Training Guide

Response to COVID-19

Last updated: Oct 2021

How to log in to BCMS

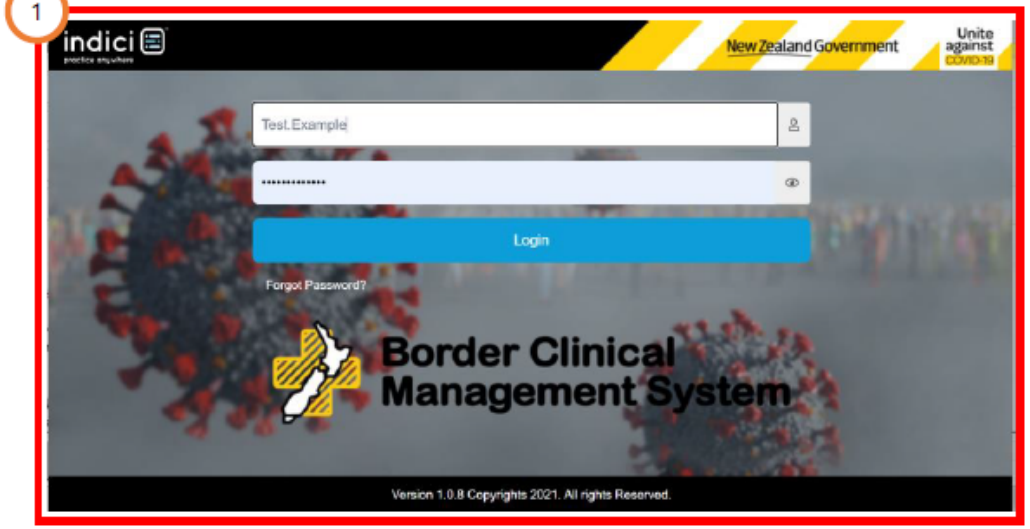
1. Log in using your username and password at https://covid.indici.nz.

2. Use the dropdown boxes to select your practice and location if required – they should be set to the correct options unless you change sites. Click Continue to log in.

Tip:

If you have forgotten your password, click on Forgot Password to reset it.

1



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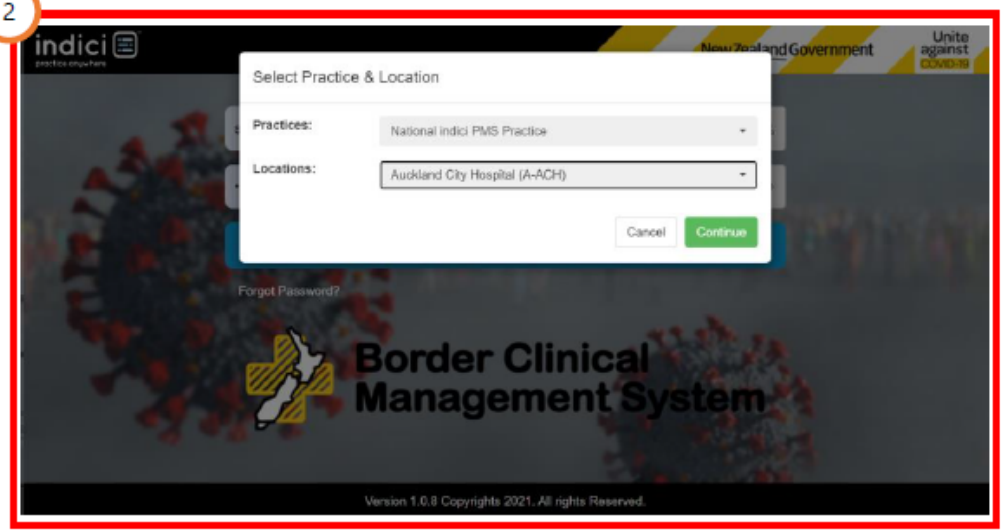
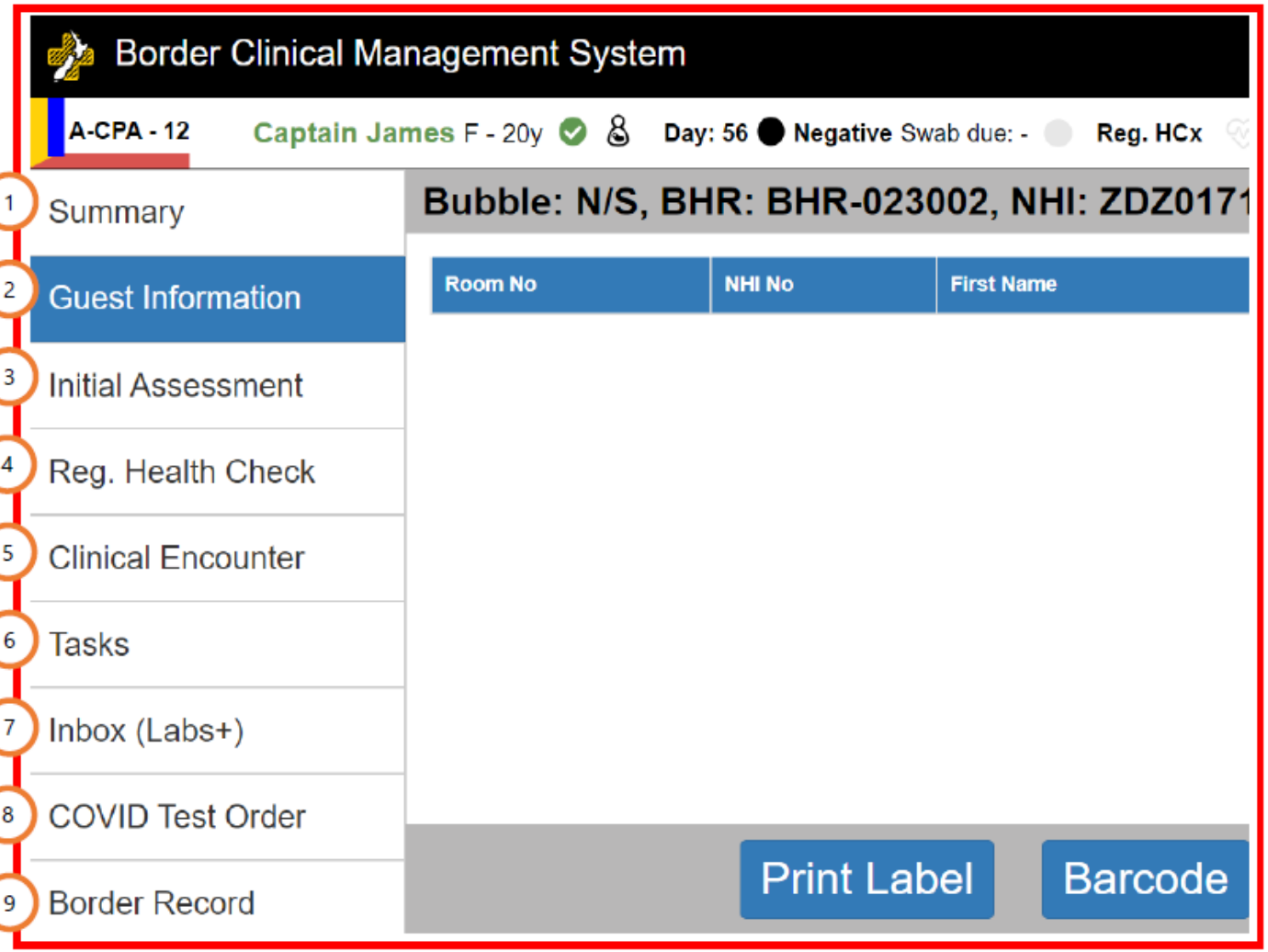


Guest Detail Page

1. **Summary**: Includes a summary of a guests stay, vitals and notes. Also links to the Note Timeline.
2. **Guest Information**: Contact, GP and bubble information
3. **Initial Assessment**: Used to record important information about medical history, welfare and wellbeing
4. **Reg Health Check**: Used to record the daily checks
5. **Clinical Encounter**: Used for various clinical requests, flag management and tests
6. **Tasks**: For viewing and requesting tasks
7. **Inbox (LABS+)**: For viewing lab results
8. **COVID Test Order**: To request a COVID test outside the scheduled swab schedule
9. **Border Record**: A display of the latest information from the Border Health Record, and the Access Log.



Guest Summary

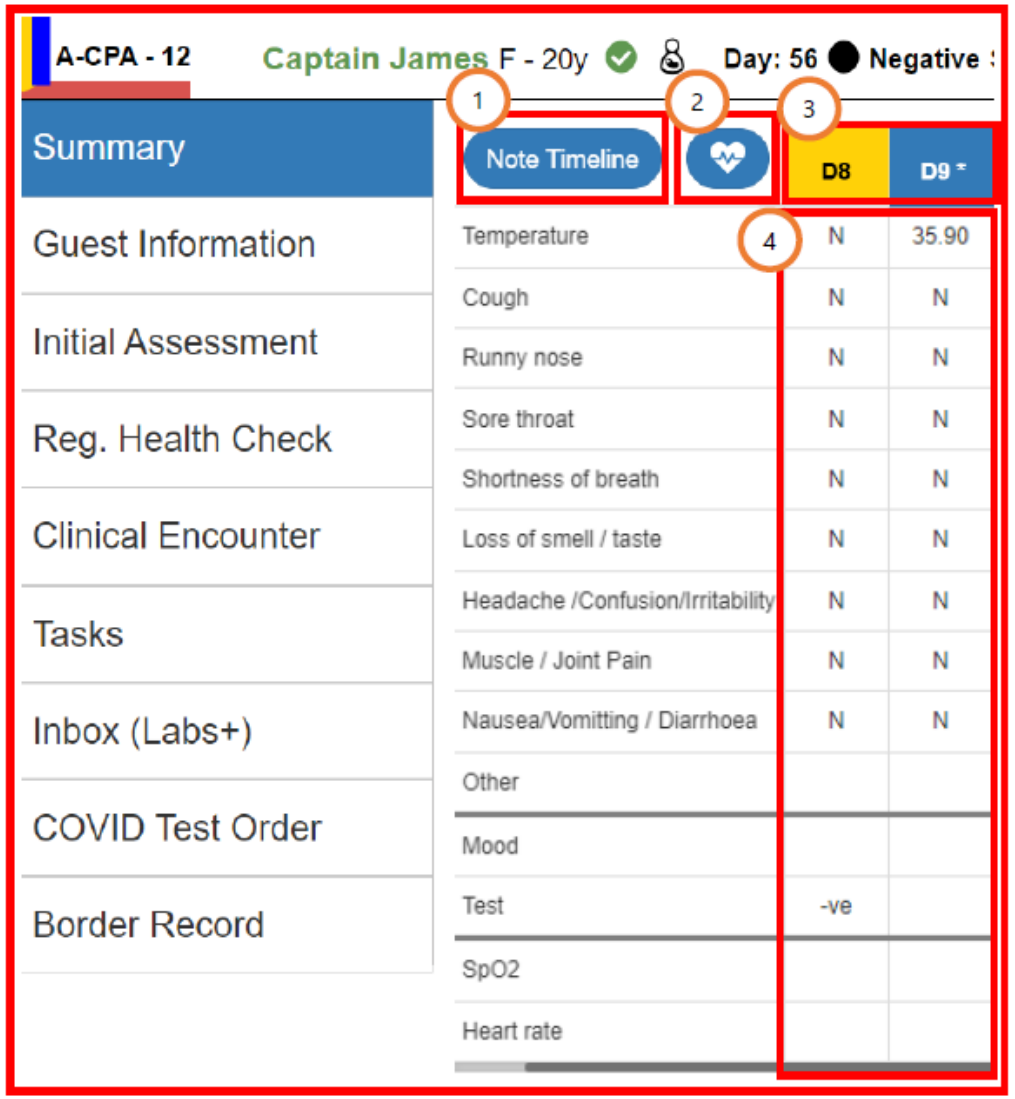
Includes a summary of a guests stay, vitals and notes

1. **Note Timeline:** Used to view notes and change records
2. **Update Vitals:** Click on this to overwrite today's measurements
3. **Daily Vital Details Graph:** Clicking on a day number with a star will bring up a vitals graph for measurements taken throughout the day – yellow in this place means the guest was in isolation on those days.
4. **Daily Summary:** Displays results from daily health checks and any vitals taken. Red highlighted boxes here mean they are a concern.

Tip:

Click on the day to see the list of health checks done that day.

Click on the white column to view the plot graph of vitals.



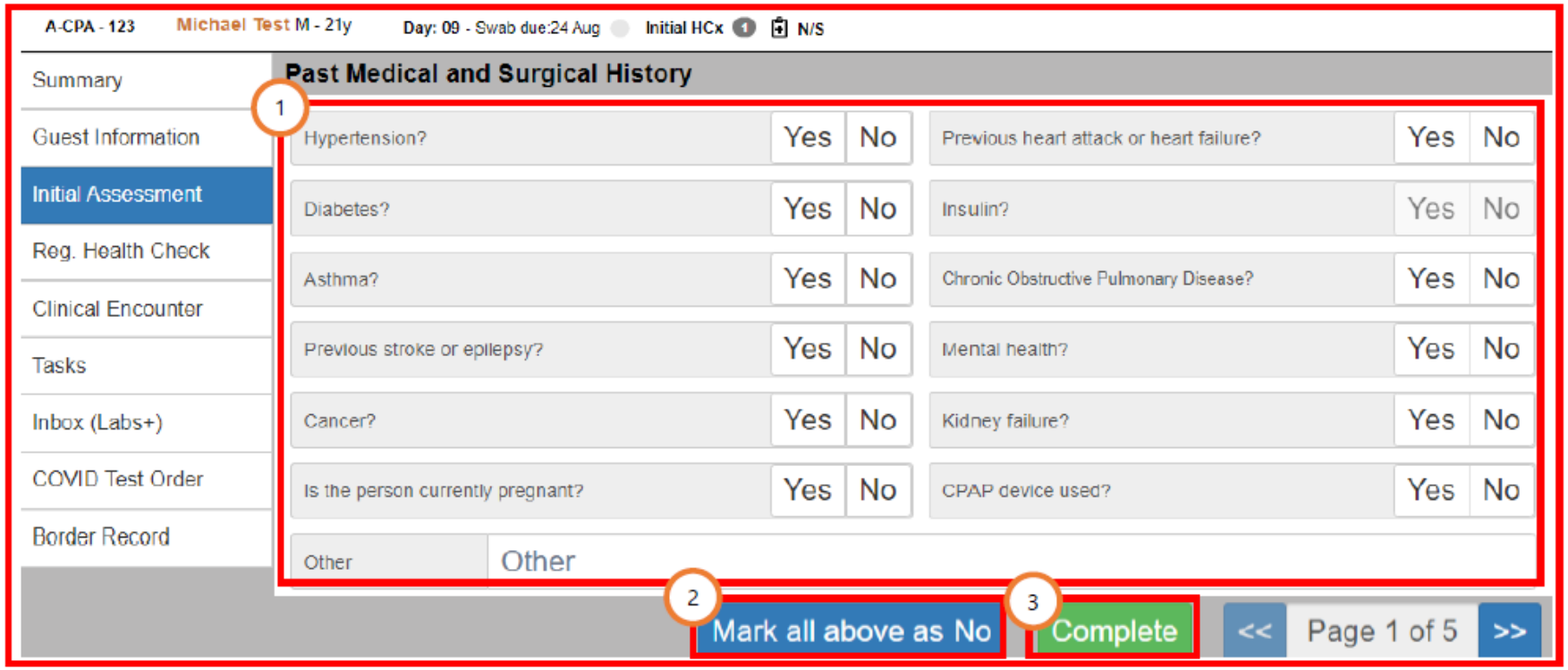
Initial Assessment

Complete this as part of an Initial Health Assessment – this can be updated as required – Step 2

1. Once on the Initial Assessment page, complete as much of the information on all pages as applicable, the same as you did on the Guest Information page. Use the navigation arrows in the bottom right to move between pages.

2. On some pages you can select Mark all above as No to save time.

3. Click on Complete.



Tip:

Click on **Complete** before reviewing flags or data may be lost

Smoking & NRT

Note: On Page 2 of Initial Assessment

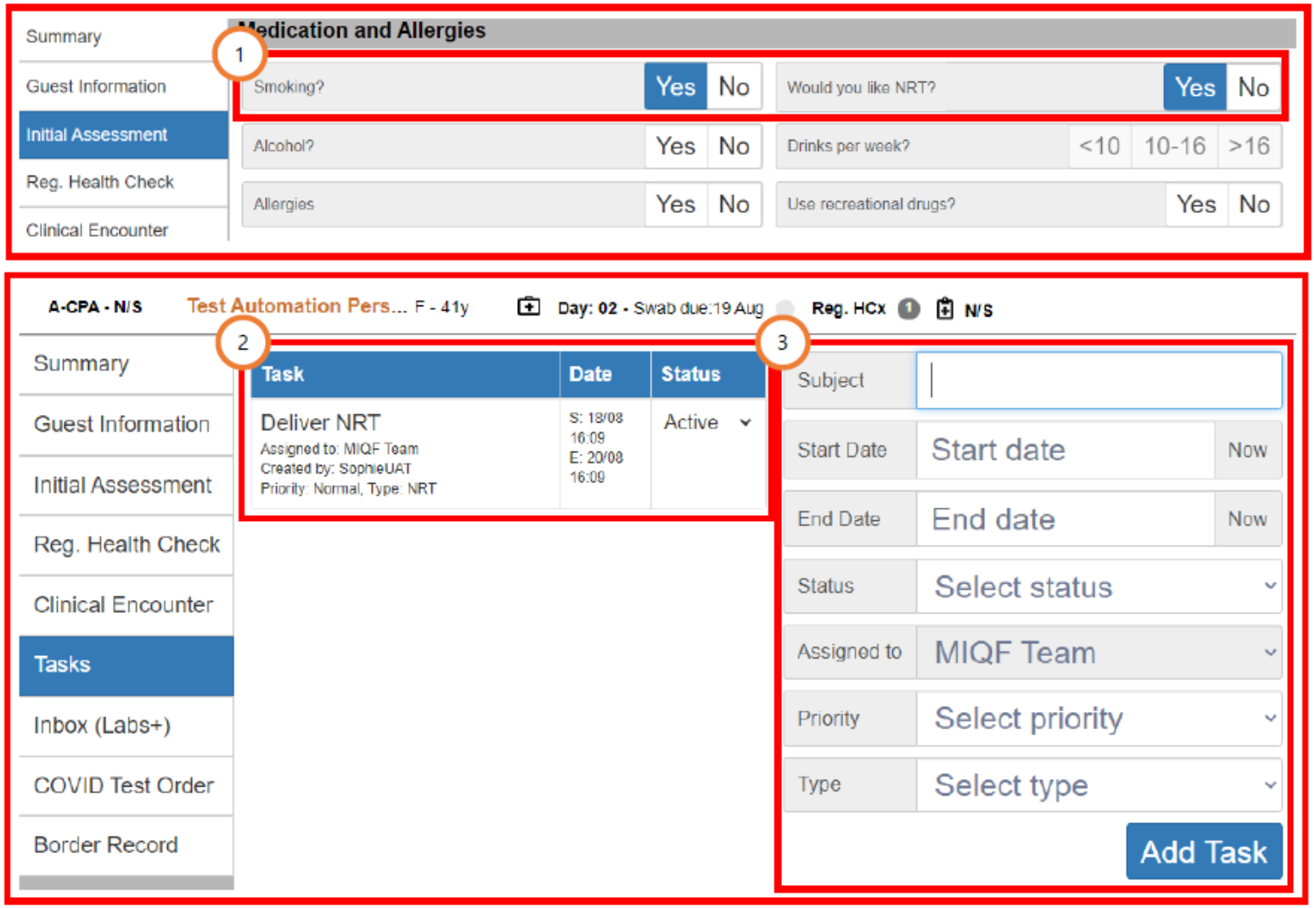
1. If a person smokes, you can simply mark if they would like NRT.

2. Selecting **Yes** will add a task to **Deliver NRT**. When delivered, mark the task as complete, which will also write to the **Note Timeline** that this has been done.

3. You can also add a manual NRT task if needed (e.g. if a returnee requests NRT after the Initial Assessment is already completed).

2

23/08/2021 11:14:42 (Task Note)
Comments: Deliver NRT
Completed By: Nursemanager NURSE



Reg. Health Check

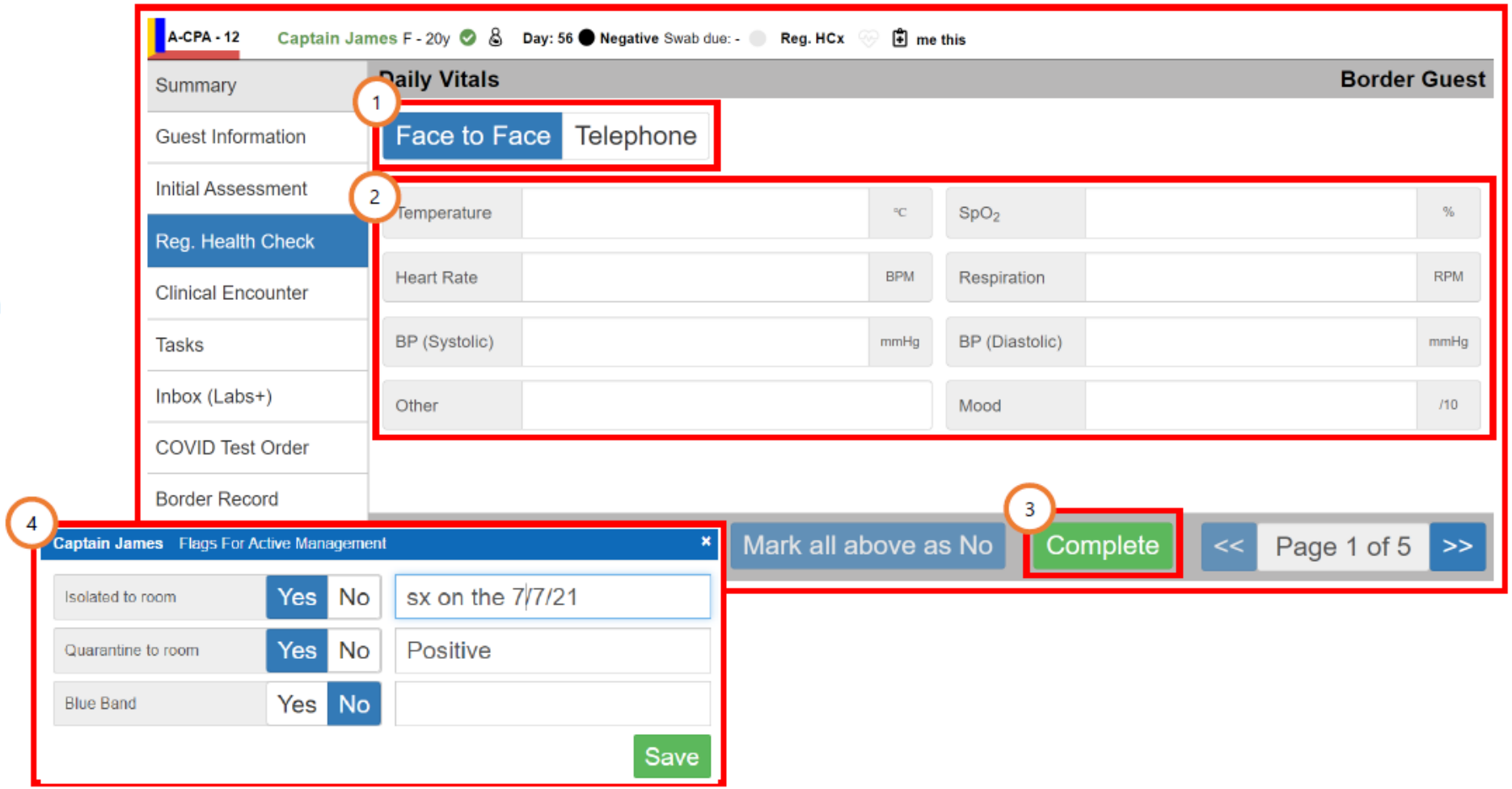
Use this page to complete a Daily Health Check

1. Once on the Reg. Health Check page, Select **Telephone** or **Face to Face** depending on which is relevant.

2. Complete as much of the information on all pages as applicable, using the navigation arrows in the bottom right to move between pages.

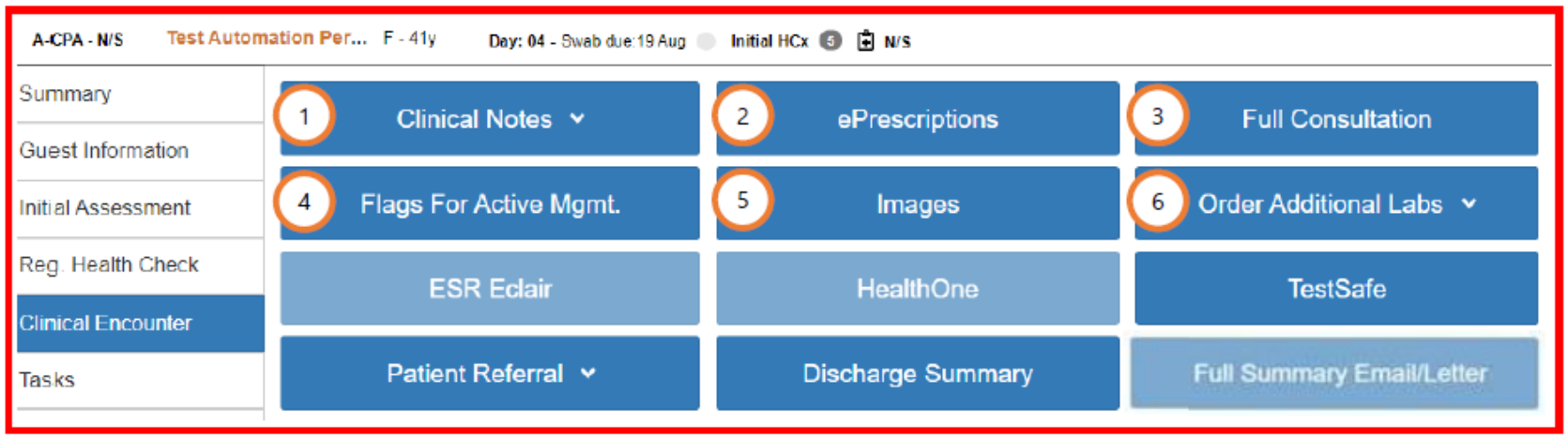
3. Click on Complete

4. A pop up will come up asking you to confirm the returnees isolation, quarantine and blue band status.



Clinical Encounter – Page 1

1. **Clinical Notes**: Various Clinical Note templates
2. **ePrescriptions**: Opens Indici e-prescribing.
3. **Full Consultation:** Opens Indici PMS.
4. **Flags for Active Mgmt.**: Toggle isolation, quarantine, translation requirements on/off – more info here
5. **Images**: Pictures relating to a guests care (wounds etc) can be uploaded here either directly from the device or from another one using a QR code.
6. **Order Additional Labs:** Allows the ordering labs other than Covid tests, such as blood tests.



Pinnacle
Midlands Health Network

Regional Update

Upcoming opportunities

- https://www.goodfellowunit.org/node/970087

Covid in the home – what primary care needs to know

- **WEBINAR: Thursday 28 October 2021, 7.30 - 8.45 pm**