Public Health England

Protecting and improving the nation's health

Minutes

Title of meeting	Pandemic Influenza Co-ordination Group (PICOG)
Date	26 July 2019
Time	14:00
Venue	1B10/Skype
Attendees	Mary Ramsay (MR, Chair), Gavin Dabrera (GD), Richard Pebody (RP), Eamonn O'Moore (EOM), Deborah Turbitt (DT), Maria Zambon (MZ), NR, Gareth Thomas (GT), George Leahy (GL)
Apologies	Charles Beck (Field Service)

1) Approval of minutes, review of actions and matter arising

The minutes of the previous meeting were accepted as accurate with minor corrections.

Review of actions from the last meeting

Action	Status
Action 6.1: GD to update the document about doing an update for the PHE Pandemic Flu Plan, adding additional clarity about what Is expected from PICOG.	Complete and sent out.
Action 6.2: for PICOG members to make comments/sense check this (NHSE proposal for how swabbing and virological investigations could be commissioned in the early days of a pandemic), before it goes to the PIPP board. Comments by end of February. Once comments received, go to NHS E, and then to PIPP if they will not take responsibility for funding.	No comments were received but will keep as an action as we are waiting for approval on the NHS-E side. See item 3 for more information.
Action 6.3: MZ to hold offline discussions about assurance of laboratory testing.	See lab update
Action 6.4 NR to identify who is the most appropriate representative from marketing.	Complete: Name Redacted leads on flu in marketing
Action 6.5: MZ to chase up with NR what happened at the meeting, and is there anything else this group needs to be aware of.	See lab update

2) PHE Pandemic Flu Plan Update (Gavin Dabrera)

GD has prepared a paper on Outline Specific Functions; as this is a draft, the divisions listed in the document are in no particular order. GD thanked those who have already contributed; GD still waiting for a few more sections of PHE to contribute. Noted that the challenge is that some PHE structures have changed significantly since the last PHE pandemic flu plan was published so we have to reorganise the document in that respect (e.g. NIS was formed since the last plan was published). Once the content is agreed in draft form within PICOG, the aim is to include a head count of available staff in PHE to have some assurance that we have sufficient capacity to deliver the functions outlined. Once we have more detail on functions, each division will therefore be asked to estimate the head counts required and available to inform whether resource would need to be moved about at the time of a pandemic. This head count will not be published but is important for appropriate internal planning.

There are still some outstanding revisions required to the Communications section and to reallocate some of the immunisation work into Data and Analytical Sciences (DAS). We also need contributions from Finance, Marketing, and the People Directorate. As no one from Finance or the People Directorate attend these meetings, we need to identify individuals from these areas to attend these meetings and contribute to the document.

Action 7.1: NR to speak to Name Redacted to see where they are up to regarding their contribution to the Communications section of the Outline of Specific Functions document for the PHE Pandemic Flu Plan Update.

Action 7.2: Secretariat to email Name Redacted in Marketing for a contribution to the Outline of Specific Functions document for the PHE Pandemic Flu Plan Update

Action 7.3: GD to identify individuals from Finance, Marketing, and the People directorate to attend these meetings and contribute to the PHE Pandemic Flu Update

EOM raised the issue of HR processes in the event of a pandemic response, it will be important for staff from other directorates to support an incident. GL mentioned there has been a similar issue with staff working on EU exit and we could approach HR for some clarification NR is leading the EU exit HR processes but NR is the overall lead). Apparently, there is a new policy around incident management that explains what terms and conditions can be applied and applies to all staff (except those on medical and dental contracts as the Local Medical Committee (LMC) has not agreed it).

Meeting agreed that we will probably need HR on this group, when we go through the final plan, to confirm that we can identify and redeploy staff onto a pandemic incident.

Action 7.4: MR to write to NR to say that we need HR to engage with the pandemic plan and need someone on it to contribute to the plan.

Post meeting note: Current policy on PHEnet is under the Guidance for employees involved in operations at level 4 policy last updated in October 2014. However, it is currently under review with **NR** *leading from HR, once changes have been made it will then require final approval. LMC have sent their corrections to the policy and are keen for resolution.*

The finance section was discussed, and agreed that it needed to separate internal PHE finance (mainly HR) from programme related finances, managed by PHE Vaccine and Countermeasures Response (VCR).

GT explained that the flu programme resources managed in VCR would cover all operational costs relating to stockpiles; storage and distribution; the National Pandemic Flu Service (NPFS), including IT infrastructure and costs of managing the treatment algorithm; and the logistics of getting stock out to the sites for distribution. The HPA flu resource centres in the last pandemic were set up because National Pandemic Flu Service (NPFS) was not active but the current NPFS contract is now in place for that function. It is a national system to administer treatment and will come out of the DHSC ring fenced programme funds that will have to be bid for at the time of the pandemic. GT has no reason to believe that the process of funding will be any different to last time where HMT (the Treasury) will authorise the spend.

There was general agreement that perhaps a contribution from the Finance department would be a second stage of the writing process or once the almost final plan is ready for them to look at once we have all the contributions from the different sections and groups.

Target for the next round of submissions for the pandemic plan is around September due to the summer holidays. There will be specific email outs with individual requests to specific sections as some have provided information and others have not.

With EU exit going on, there has been no word from DHSC on the DHSC pandemic strategy, PHE have provided all contributions already.

3) PHE/NHS England plans for swabbing during a pandemic *(Richard Pebody)*

This was discussed at the last meeting (04/02/2019) and refers to the need to undertake some swabbing and virological investigations in the early days of a pandemic. This protocol/ proposal was developed with NHS England around the sampling of the first cases and having in place a mechanism to do that ideally through NHS-E and the sort of costing up of what will be needed to do it.

After the last meeting, RP went back to NHS-E for their final sign off and discuss whether they were going to take responsibility of the funding. The contact point in NHS-E has been on long term leave and is just picking this up now and going through their internal discussion processes. It was not felt that it this would be ready for discussion at the upcoming PIPP board meeting in October. The paper sets out what needs to be done and the proposal is that it will be done by

NHS-E but this has not been approved yet. Noted that NHS-E may not have had time to agree it by the time of the next PIPP board meeting. Agreed to leave the following as an outstanding action until we receive the paper back from NHS-E.

> ***Action 6.2:*** *for PICOG members to make comments/sense check this, before it goes to the PIPP board. Comments by end of February. Once comments received, RP proposal to go to NHSE, and then to PIPP if they will not take responsibility for funding. Final comments to be sent to RP by the end of October 2019.*

It is unknown what NHS-E's position is on the issue of who pays would be. General diagnostics and care would normally be NHS but this would be FF100 sampling for epidemiological purposes. It would not be people receiving their usual clinical care and would require people going into homes to do the swabbing. NHS-E could argue that if it was for epidemiological purposes and not care and treatment, it would fall to PHE.

The main issue is ensuring the swabbing gets done and therefore it may require a proper team and a proper contract to fund this. This could then be commissioned by NHS-E like the teams they have for outbreak control which would not be dissimilar to the NPFS but as a much smaller resource. There was general agreement that practically it would be better to be commissioned by NHS-E and sampling provided by NHS staff, although funding could potentially be part of programme monies – this would require GT's team to develop a business case and supporting documents. It will be useful to see what NHS-E comes up with and that this would be our fall-back position if they do not find a solution. Going forwards, plan is to wait until we have a response from NHS-E and then progress via PIPP board.

4) Updates on work from each area

a) *Pandemic flu office:*
GD: The main focus is the pandemic flu plan. There is a PIPP board for the 8th October and therefore need to prepare the PHE contributions for this and include input on any pandemic preparedness activity that PHE divisions are working on.

Action 7.5: Secretariat to send round the template for the PIPP update and deadline for submissions will be Tuesday 10th September 2019.

Two points for information only:
The current pandemic clinical guidelines document requires an update including antibiotic treatment. This guidance was previously led by British Thoracic Society (BTS) who were funded by DH to write the document with input from HPA. This need was raised at New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) who identified that the documents were out of date; NERVTAG wrote to the DHSC who then wrote to colleagues in PHE. However, as this does not fall under PHE remit, DHSC has agreed that NHS-E will take responsibility for updating the document. NHS-E has said that the

guidance will not be ready for this winter. This document will be relevant and important for the clinical advice in the event of an outbreak as well as for the pandemic stockpile. PHE look at antibiotic resistance annually and expect that we will get a bespoke request from NHS-E for this piece of work. NR is fully aware of the situation.

The second point is the Pandemic flu infection prevention and control guidance, DHSC wrote to Health Protection Scotland (HPS) to update the guidance and this work is in progress. It has been raised at NERVTAG to make sure it goes to all the UK public health agencies for comment as well as to NERVTAG. To be clear it will not be a PHE authored document.

b) *Flu surveillance:*
RP reported currently revising and updating all the different surveillance systems operational during the different phases of a pandemic. Once protocols have been agreed, they will be put onto Q-pulse; also, looking at what resources will be needed to run those systems both on the epi and lab side which is still work in progress.

There is ongoing work on FF100 IT developments to strengthen the IT system. There was the MERS-CoV incident last year which provided some useful learning. We are testing the system within the flu team in August before field testing with wider stakeholders in the Autumn.

During a pandemic, we have set up a data platform developed on the ImmForm website for sharing data and we intend to test this platform during seasonal flu. The sharing of data during a pandemic is particularly important for modelling and we intend on testing some of the models on seasonal flu this coming winter.

In terms of modelling, flu surveillance team working with the modellers to update their operational protocols so we've got clear modelling plans during the different stages of a pandemic in what models we run. Will also use the opportunity of seasonal flu to test those models on seasonal flu as part of these forecasting exercises.

c) *Laboratories:*
MZ: In the last meeting, it was mentioned that Medicines and Healthcare products Regulatory Agency (MHRA) have asked that PHE organise the CE marking for materials instead of distributing material to the regional lab. The lab has been creating this pathway for emergency response for the provision of CE marked material that is needed by labs for diagnostic use, with H7N9 as the exemplar (which is quite near completion). At the point where H7N9 will be available in the National Institute for Biological Standards and Control (NIBSC) catalogue will represent the creation of a pathway for emergency response for unusual things which should not just work for flu but other material should this be required. They put it in the catalogue and charge a nominal fee for the cost of postage and

packaging, and regional labs purchase it from NIBSC. Not sure yet how money can be claimed back by PHE.

We are also updating and revising the molecular diagnostics for H9N2 as the recent H9N2 case indicated a little bit of movement which suggested that we in turn need to update to the national protocols.

> ***Update on Action 6.3:*** *MZ to hold offline discussions about assurance of laboratory testing*

MZ explains that the detection assurance capability issue needs to be addressed as resources to prepare bespoke materials for distribution to assure the detection capability was taken out the laboratory as part of financial planning, presumably expecting that the work would be taken up by NEQAS (External Quality Assessment Services). MZ noted there is a resource gap and does not know how this can be managed in future as Respiratory Virus Unit (RVU) does not have the time or resource to create bespoke quality assurance panels. It seems that UK NEQAS (External Quality Assessment Services) is not in a position to do this work and therefore no one is doing this work.

Action 7.6: MZ to draft a brief document regarding what function is needed/missing i.e. bespoke assurance work/ gap in detection assurance capability and the likely resource that it is likely to require. Then to send this to Neil Woodford and Andrew Mumford.

> ***Update on Action 6.5:*** *MZ to chase up with John Watson what happened at the meeting, and is there anything else this group needs to be aware of.*

MZ explained that the Nagoya protocol came up in the World Health Assembly this year and is actively being discussed within WHO. The issue for us in the UK is making sure that we understand who authorises the use of materials. For example, if we end up with a pandemic where we have identified a virus which might be useful as a starting point for vaccine manufacturers, that comes under Nagoya protocol. Vaccine manufacturers will now not accept vaccine strains from companies unless there is explicit sign off because of the Nagoya protocol benefit sharing issue. The only thing that we need to be clear about is exactly who should sign that off on behalf of the UK.

John Watson has written to Sharon Peacock to say that she needs to be engaged with this discussion. This is an NIS issue and not wider but the question that needs to be posed it what is the pathway for the UK to release materials to vaccine manufacturers? However, the signatory to Nagoya sits with DEFRA and not DH so clarification needs to be sort. The cross-government liaison tends to be with DH between departments, it was suggested the following DH colleagues would be key; JVT, the DCMO; Kevin Dodds and Cheryl Cavanagh who leads on pandemic preparedness.

Action 7.7: MZ to draft a brief letter for Sharon Peacock around getting clarification on who signs off material that comes under the Nagoya protocol and what the pathway to getting sign off should be; and suggest that she may want to send this request to the following DH colleagues: JVT; Kevin Dodds; Cheryl Cavanagh

d) *Countermeasures:*
GT-The main movement for stockpiles last year and this year is regarding the procurement of and replenishment of antivirals and antibiotics which was slightly accelerated due to the original EU exit dates in March, April and now the 31st October, we probably believe the last date more so than the others. This is going well.

The other stock item of interest strategically is the procurement of the pandemic specific vaccine (PSV) which we have contract for its early production until May 2022 and there is still work going on there about the economics of whether it is a good thing to do or not as there was some doubt on that based on some of the recent discussions.

On the storage and distribution, we changed our contract last year. It was originally with DHL for storage and distribution. A new facility that is being built in Haydock which has just come online and so stock in the North was in temporary store but appropriately regulated. This was a temporary measure and this has now been moved into Haydock.

ICT update: GT is writing the Strategic Outline Case(SOC) for the NPFS from 2021, there are 7 technical components which will be subject to a separate Outline Business Case (OBC). This is all in development and should be finished in the next couple of weeks.

Review of the NPFS clinical guidance algorithms meeting was last Wednesday and was very productive and actions to follow up with. There was a very active discussion around one area regarding governance. The governance issue is whether there is a clear way of updating the guidance and the algorithms with the right experts in the room; areas where there are genuine disputes between clinicians and scientists can be resolved; and where we can attain a formal sign off - is this Pandemic Influenza Clinical Advisory Group (PICAG) or somewhere else?

GD explained that PICAG was mentioned at the time because it was around whether certain questions would still be relevant at the time of a pandemic and PICAG would be constituted at the time of a pandemic to make critical decisions. In peace time, it is unclear where we would get that sign off as it would require people with enough technical knowledge but also senior enough strategically to sign it off. One of topics from that meeting was about the inclusion of screening questions for some of the airborne High consequence infectious diseases (HCIDs) during a pandemic to differentiate between different HCIDs. These are clinical questions that need some strategic input about whether it was operationally feasibility and clinically sensible to include and implement.

Discussion regarding governance of the clinical content of the NPFS clinical algorithm that would be part of the specification but would be subject to change by PICAG at the time of a genuine pandemic, particularly decision maker during peace-time. Could be a PHE group or an expert group- NERVTAG but it was agreed that this was not properly configured to deal with other issues like malaria so it would need to be a broader group but not clear who that broader group would be. Agreed that there isn't an obvious place and it would have to be pan-UK group therefore other than an ad-hoc group to meet purely for this purpose there does not seem to be any other options. GT suggested that seeing as PICAG would be the ones to decide in the event of a pandemic, would it be possible provided that PICAG be constituted to look at it. There is quite a lot of work that would need to go into the NPFS algorithm and therefore some time to find out what group would be in the best position to sign it off.

Action 7.8: GD and MR to discuss offline what options there are and then to put them in an email/ to the group what their recommendation would be which could be PICAG or something else.

e) *Field Services:*
Not online.

f) *PHE Centres: Centres & Regions*
DT updated to say that the PHE Centres over the last 6 months have all done pandemic flu table top exercises with about 80% of our Local Authorities and received good feedback.

g) *Health Protection directorate (inclu. CRCE)*
Nothing to update.

h) *Emergency Response Department*
Not online.

i) *Health Improvement: Within Health & Justice*

There is nothing to update from wider Health Improvement apart from what in is the pandemic plan.

EOM provided an update for the Health and Justice (H&J). H&J planned to hold meetings to firm up their section of the Pandemic Plan but these were called off very last minute by NHS-E for various reasons. Given the time of year they are at now, they are preparing for seasonal flu and would probably push any plans to do any table top exercises to the end of the financial year or earlier in the new financial year.

There is a draft plan for a pandemic flu response for secure and detained settings and where the exercises will be delivered.

GD wanted to double check something with EOM from a previous meeting regarding review of 2007/08 modelling work done on pandemic flu in the prison estate and whether there was any capacity in the Ministry of Justice (MOJ) to look at this. EOM explained that analytical capacity in the MOJ for this task is not available now but they had done some work last summer for mortality predictions but they are overtaken by other emergent priorities. This remains an open action due to the lack of analytical capacity in the MOJ for this. The table top exercises may help to unleash some of that capacity for this work and reprioritise it.

GD raised another issue from a previous meeting regarding access to PPE in health and justice settings- and asked whether EOM had any further contact with NR NR EOM believes this position was clarified with colleagues who work with seasonal flu who confirmed that prison healthcare staff are given PPE by the providers commissioned by NHS-E.

j) Communications

NR left early but will liaise with Name Redacted for an update for the plan.

k) Marketing

Not online.

5) AOB

Point of Care Testing (POCT)

POCT was discussed at NERVTAG recently but MZ was unsure of the outcome and thinks that it should be something to be considered in pandemic planning. The planned update meeting hosted by FS on 16th October to bring out the latest experiences of the application of POCT for seasonal flu may have learning for a pandemic. MZ explained that the POCT meeting in October is to get early adopter experiences of POCT community use such as; in care homes and GP practices; and any other useful intelligence coming from secondary care settings as people start to implement some of these devices.

MR said that she had raised with NR whether some kind of procurement or APA for POCT could be considered for targeting treatment in a pandemic.

GD explained that it was discussed at NERVTAG in detail with NR presenting on current near patient testing technologies. NERVTAG decided that POCT did not have a clear role in the main pandemic flu response and have dismissed it for now.

MR asked if there was a watching brief on POCT for NERVTAG or whether it was gone. GD thought it might not be on future agenda. RP mentioned that it was about the predictive value and maybe they were thinking about different times of the pandemic and they did refer to some modelling; and looked at some of the most common devices and the capacity for the number of tests of those devices compared to expansion of clinical laboratory capacity. RP explained that NR s team did some economic modelling on POCT which suggested that it was not cost effective. MR agreed it probably was not economical with the current near patient testing as it is probably quite expensive but as MZ suggests, in five years' time it could be completely different picture.

One point that GD mentioned in NERVTAG and the NPFS clinical guidance algorithms meeting was that these technologies will be in routine use at the time of the next pandemic and therefore, may need to be considered in terms of the health professional portal and the NPFS algorithm. MR said that POCTs are currently used in seasonal flu and it was expected that once staff get used to using it for seasonal flu that it would be likely that there would be expectation of use of POCTs during a pandemic. RP questioned deployment of POCTs, including where best to deploy them (eg. for issuing antivirals when they have a mild illness or at the hospital door for infection control) and at what stage of the pandemic.

GT asked for clarification from a potential operational approach as the NPFS would not invited the patient to a healthcare setting, they would be assessed over the phone. A patient would nominate a person (their flu friend) to pick up the anti-virals on their behalf as part of the collection process. Although POCT is a physical test, MR suggested that the person could pick up the POCT at the same time as the antivirals and the test could be done at home. It would clearly require some thought to POCT into NPFS; but it may be easier to envisage it for those that go into care, where POCTs may influence the management of those cases.

MR and MZ agreed that in the future it was likely that the cost and use of POCT would be cheaper and more accurate than it is now; and therefore, should be revisited as part of pandemic planning.

MZ highlighted that there are two issues; one being the performance of any such device and a separate piece of work on the provision of diagnostics within the NHS.

MR suggests that if NERVTAG have dismissed it for now, there are two options; one is that we ask them to look at it again or that PHE undertake an internal piece of work to think through the potential implications.

MZ believes that NERVTAG may not have the exact expertise that realise the full implications and might need more steering on the use of POCTs. For example, during the first wave of the last pandemic, there was a very low proportion positive, whereas in the second wave, there is more disease around but laboratories can't cope and so there is a possibility of needing POCT for extra capacity.

EOM explains that one area that could really benefit from POCT is the justice setting and is a real clinical and operational imperative to get rapid diagnosis and diagnostic confirmation. POCT are increasingly used in prison medicine. There is an incident going on right now in one of our immigration removal centres where there is an outbreak of seasonal flu which has taken three days to confirm because there are issues with laboratory testing and swabs.

MR suggested that PHE could produce a high-level scoping document of all the different possible uses of POCT in a pandemic. It was agreed that it would suit a Specialist Registrar (SpR) project. MZ suggested that we could use the event in October and perhaps identify someone through that in FS.

Action 7.9: MZ to contact Paul Cleary and Andrew Fox who are leading the FS hosted POCT event in Manchester on 16th October, to suggest use learning from the event to perhaps identify someone to do a SpR project to put together a high-level scoping document on POCT in the event of a pandemic.

GT flagged that once internal discussions have been had, it would be good for someone to run it through with their team if it will impact the NPFS service.

Actions Table

No.	Action
6.2	For PICOG members to make comments/sense check this (NHSE proposal for how swabbing and virological investigations could be commissioned in the early days of a pandemic), before it goes to the PIPP board. Comments by end of February. Once comments received, go to NHS E, and then to PIPP if they will not take responsibility for funding. ***27/06/2019 Agreed to leave the following as an outstanding action until we receive the paper back from NHS-E. Final comments to be sent to RP by the end of October 2019.***
7.1	**Action 7.** NR to speak to NR to see where they are up to regarding their contribution to the Communications section of the Outline of Specific Functions document for the PHE Pandemic Flu Plan Update.
7.2	**Action 7.2:** Secretariat to email NR in Marketing for a contribution to the Outline of Specific Functions document for the PHE Pandemic Flu Plan Update
7.3	**Action 7.3:** GD to identify individuals from Finance, Marketing, and the People directorate to attend these meetings and contribute to the PHE Pandemic Flu Update
7.4	**Action 7.4:** MR to write to NR to say that we need HR to engage with the pandemic plan and need someone on it to contribute to the plan.
7.5	**Action 7.5:** Secretariat to send round the template for the PIPP update and deadline for submissions will be Tuesday 10th September 2019.
7.6	**Action 7.6:** MZ to draft a brief document regarding what function is needed/missing i.e. bespoke assurance work/ gap in detection assurance capability and the likely resource that it is likely to require. Then to send this to Neil Woodford and Andrew Mumford.
7.7	**Action 7.7:** MZ to draft a brief letter for NR round getting clarification on who signs off material that comes under the Nagoya protocol and what the pathway to getting sign off should be; and suggest that she may want to send this request to the following DH colleagues: JVT; Kevin Dodds; Cheryl Cavanagh
7.8	**Action 7.8:** GD and MR to discuss offline what options there are and then to put them in an email/ to the group what their recommendation would be which could be PICAG or something else.
7.9	**Action 7.9:** MZ to contact Paul Cleary and Andrew Fox who are leading the FS hosted POCT event in Manchester on 16th October, to suggest use learning from the event to perhaps identify someone to do a SpR project to put together a high-level scoping document on POCT in the event of a pandemic.