Transcript: Webinar – Winter planning and influenza| 13 September 2023

Watch the webinar

During this webinar our audience submitted their 8 questions to our expert panel:

- Maria Zambon, Chair of International Society for Influenza and other Respiratory Viruses (ISIRV) and Head of Influenza & Respiratory Viruses, UK Health Security Agency
- Chris Settle, Consultant Microbiologist, South Tyneside and Sunderland NHS Foundation Trust
- Chris Blyth, Paediatric Infectious Diseases Physician and Clinical Microbiologist, University of Western Australia

Chair: Jasmin Islam, Infectious Diseases and Microbiology Consultant, UK Health Security Agency

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20230913 Winter planning and influenza

Wed, Sep 13, 2023 5:38PM • 57:21

SUMMARY KEYWORDS

patients, infection, people, chris, vaccines, maria, influenza, question, flu, staff, year, viruses, vaccination, uk, masks, point, variant, manage, number, impact

SPEAKERS

Chris Blyth, Chris Settle, Jasmin Islam, Maria Zambon

Jasmin Islam 00:08
Thank you all for joining us for our IPC challenges and solutions webinar series. Today's webinar is about winning winter planning and influenza. I'll be chairing the session, I've had a few technical difficulties this morning but hopefully it will all run really smoothly. My name is Jasmin Islam, I'm a consultant in infectious diseases and microbiology and working at UK Health Security Agency and King's College Hospital London. Just to say, today's webinar is a joint webinar that's being run between the Healthcare Infection Society and the International Society of Influenza and other Respiratory Virus Diseases. So, first of all, before we start I'd just like to invite our panel members to introduce themselves so firstly, Maria Zambon and followed by Chris Settle and then Chris Blyth.

Maria Zambon 00:58
Good afternoon everyone. And I'm Maria Zambon, long standing influenza virologist, head of influenza and respiratory virology at UK HSA.

Jasmin Islam 01:11
Thanks, Maria. Chris Settle.

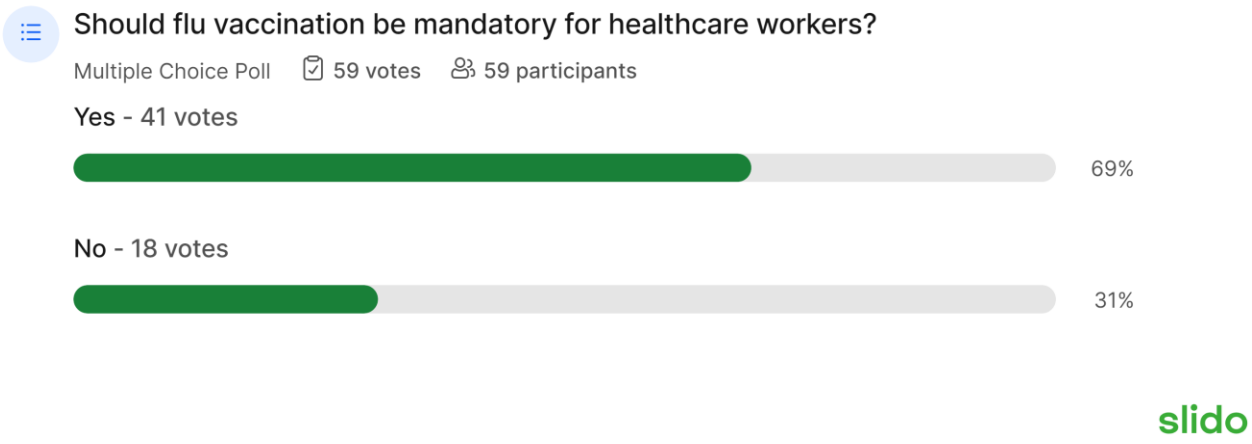
Chris Settle 01:15
Afternoon everyone. I'm Chris Settle. I'm a consultant microbiologist and infection control doctor in South Tyneside and Sunderland, up in the Northeast.

Jasmin Islam 01:27
Thanks, Chris. And then last but not least, Chris Blyth.

Chris Blyth 01:31
Yes. Hi, I'm Chris Blyth. I'm a professor of pediatric infectious diseases in Western Australia, and a clinical microbiologist.

Jasmin Islam 01:41

Great, thank you so much. So just before we get on to the main part of the webinar, we had asked the audience to submit questions to the panel, so we've selected our eight most popular questions for the panel to discuss in the first 40 minutes of the webinar. During the last 15 minutes, there'll be a more of a question and answer session. And you can submit those questions via slido. Fine. So I think we'll probably move on to our first audience poll question now. We'll just give it a few minutes for people to start accessing slido, but I'll just read the question out. So the question is, should flu vaccination be mandatory for health care workers? So I'll just give a few minutes for people to answer that. Okay, so I don't know if just we're all waiting for the last few people. There's quite a clear split there. Do any of the panelists want to give any thoughts initially on the polling results as they've come in?



Maria Zambon 02:47
Well, maybe Jas, let me start, then. I think it's a tricky question as to making things mandatory, because there are very often objections from people about forced vaccination. And typically, in UK HSA, we do kind of go down the line of trying to encourage and persuade people rather than mandate people. Personally, I'd prefer to see 100% of uptake achieved voluntarily rather than mandatory, on a mandatory basis. So that's very much a personal view. But it does also sort of reflect how we tend to operate based on advice in the UK.

Jasmin Islam 03:42
Thanks, Maria. And I think you know, that's probably true and reflects some of the things that we saw during the pandemic with COVID vaccinations and things that came up from there. Chris Settle, or Chris Byth, do you have any comments before we move on to the first question?

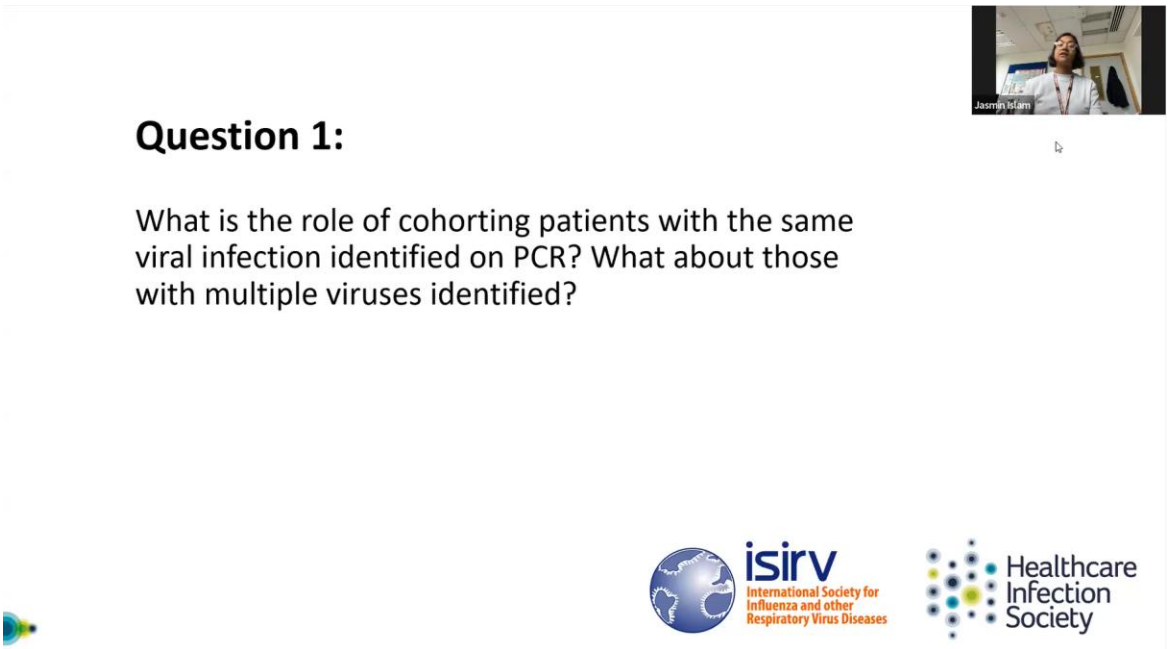
Chris Settle 03:59
Yeah, I mean, for me, the bottom line is that most individuals in the healthcare service you would imagine would want to be vaccinated. And so you'd like to go through the position of asking people to be vaccinated and hope that 100% will say yes, and then not 100% do say yes. And that creates a bit of tension, because then you're wondering, well, how can we improve the number of people who, who will comply with this request? And so this question about whether it should be mandatory comes in.

Unfortunately, when something is mandatory, some people who would get vaccinated decide not to because they've been told they have to, so you're still stymied slightly. And obviously, it's a very difficult one. And obviously, some countries have decided that this is the way to go. But you're right Maria, in the UK is not traditionally the way we do things. And I think the sort of- the attitude amongst the British population generally being told they have to do something is to resist it. So although I'd like it to be mandatory, I don't think it's necessarily practical for it to be mandatory.

Maria Zambon 05:11
Perhaps I should also just add a qualifier, there may be some clinical areas where flu vaccinations should be mandatory. So for example, working on a bone marrow transplant unit may be one of those, you know, so one could consider that there might be niche areas of requiring vaccination. Sorry, Chris, if I jumped in.

Chris Blyth 05:31
I was gonna give a bit of an Australian perspective. Similar to the UK, there's actually very few centers that have mandatory vaccination policies for flu. Although having mandatory policies for other key vaccinations such as measles, chicken pox, hepatitis B, there are a number of units that have very strict policies for high risk units or higher risk areas. And I suppose in my experience, actually fairly high uptake can be achieved, often with activities other than mandates. So most centers have not moved in there to date, but similar to my other panel members I would love to see 100% uptake, particularly in areas managing some of our most vulnerable patients.

Jasmin Islam 06:14
Great, thank you. Thanks, Chris. So yeah, I suppose you know, that's the kind of unified consistent response from the panel to start off with, we'll see if that remains for the rest of the webinar. Great if we move on to the first question now. The first question is, what is the role of cohorting patients with the same viral infection identified on PCR? And what about those with multiple viruses identified? And I think this question is going to be for Chris Settle to answer.

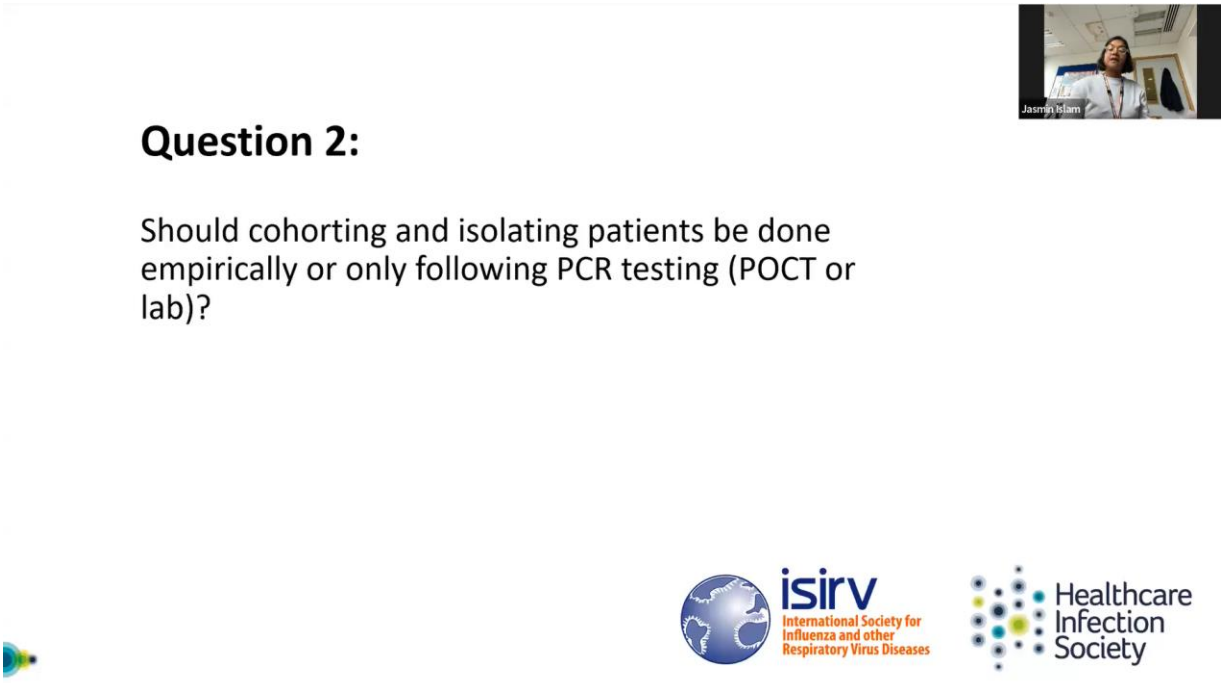


Chris Settle 06:48
Yeah, thank you Jas. It's an issue that's definitely been real for most people, I think in recent times. Because on the face of it, you would have a simple principle that anybody who's got a particular infection, a respiratory infection, which is transmissible would be isolated and managed in a side room or in an isolation facility. And that's the ideal situation. I think in reality, most healthcare settings, in the UK anyway, do not have the opportunity, they don't have the availability of the number of facilities in isolation facilities or side rooms that they would require. And in combination with extremely high bed occupancy rates, you soon meet a problem where you've got more patients that you'd like to put in these isolation rooms or side rooms, than you've actually got side rooms to do so. And therefore, the next principle of IPC would be, let's see if we can put the patients with the same infection together. That seems to make sense. There are some patients obviously, who you identify with more than one virus and certainly what we've done, in recent times, when there's been a large number of identified infections, that we haven't had side rooms sufficient to put them all in, we have adopted this principle. So we've allowed patients who have been identified as influenza A to be cohorted in the same place, we've allowed patients who've got influenza B, similarly, although they're usually much lower numbers. And then we've obviously had COVID patients who've been cohorted, and to some lesser extent, RSV, when we've had patients who've had two of those viruses or more, we have really taken the principle that those are priority patients to be in an isolation area because we can't share them with any of the other groups, because if we do, then there's a chance that they will unfortunately transmit the other infection to those other patients. And you'll end up with more patients who've got dual infections, and dual infections are considered to be more harmful than single infections. So we have had a much more- well, much lower threshold for putting patients with dual infection into side rooms as a priority and not cohorting them with anyone else.

Jasmin Islam 09:26
Great, thank you, Chris. Do either of the panel members have any other comments add to Chris's?

Chris Blyth 09:33
I might jump in Jas. I think this is actually an increasingly complex area. I think as we are moving in microbiology practices to increasing multiplexing and many panel approaches, we discover patients have viruses that we didn't even know about. I particularly see that in the pediatric setting; which one is causing the child to have the symptoms is almost impossible to detect. So not infrequently, where we're using broad range bioflex panels we're seeing children with two or three viruses. So it actually makes it really quite hard to manage. So I think it needs to be determined on the virus and the patient population. And that informs practice as much as how many viruses are there.

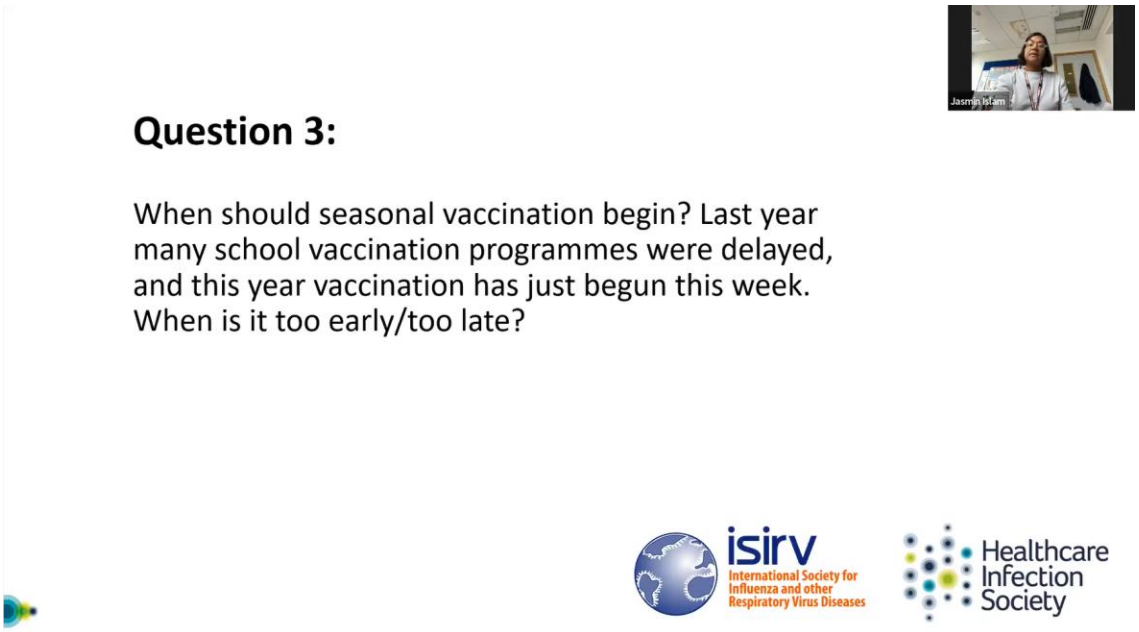
Jasmin Islam 10:17
Yeah, no, great Chris, that does make complete sense, particularly in those vulnerable populations, I think you've alluded to before, it becomes increasingly important. Brilliant. Okay, if we move on to question two, just in interest of time. So question two is should cohorting and isolating patients be done empirically? Or only following PCR testing? So point of care testing or lab. And this one is for Chris Settle again.



Chris Settle 10:47
Yeah, thanks, Jas. So it seems to stand to reason that it would be preferable to actually identify what's wrong with somebody before you decide on whether they can be cohorted or isolated. And I guess that's a sensible principle to adopt. And you'd think, well, that's simple. We don't need to really go any further than that. However, what we found is, in real life, it's not so simple, because there are a couple of potential confounding things. One is the number of patients that are appearing with these infections, which may exceed the ability to isolate them. And the other thing is where and how fast can the test result be obtained. So in reality, if you've got access to a point of care, PCR result within a few minutes,

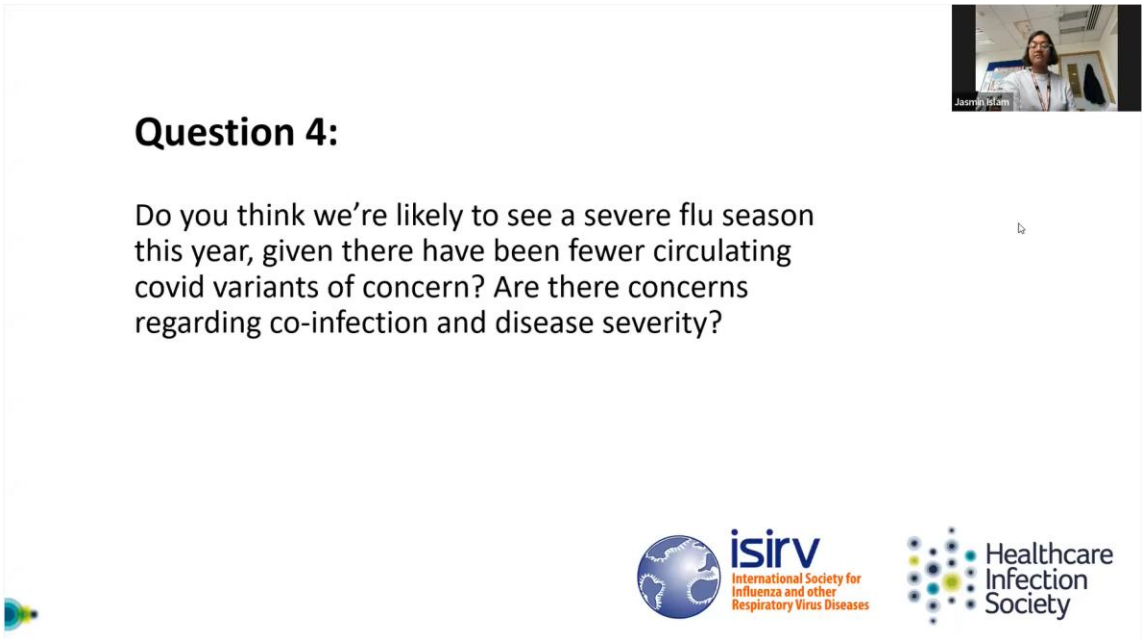
which we sometimes have had, it really has helped significantly, in terms of directing patients into the right sort of cohort, or deciding where they should go in the organization. I don't know that that's always going to be the case and not everywhere will have immediate access to those sorts of test results, at that timeframe. And if you're sending off site, your PCR test, it will inevitably take somewhere in the region of six to eight hours most likely, before you'll get an answer. And what will happen if you keep those patients isolated pending that result is that you run out of side room facilities fairly quickly. And then there's great pressure on the organization to move people around and place people in the wrong locations. So one thing which might assist that is that even if you don't have access to PCI immediately, to diagnose the particular viral infection, that's causing the patient to be admitted, you might consider whether you could screen them for COVID initially, using either you know, lateral flow, the MiraDx, or some other modality that's locally available, and at least try and identify one group of patients who you think have got a certain infection, the others remains to some extent unknown and might be isolated until a laboratory result comes back. But I think that's the challenge is whether or not we can manage to access and persuade our organizations to provide local point of care PCR testing for all of these viruses in our admission areas, on a long term basis. It happened during COVID, but during COVID it was slightly different, because a lot of this testing was being paid for by central funding. And when it's not being paid for by central funding, that the question gets asked as to whether or not it's going to be retained. And certainly, I think in our trust, there is the feeling that we might not retain all of the point of care testing that we had back in 2020-2021. And we might have to think of some more ingenious systems for managing patients who come with respiratory viral infections. And we certainly talked about, as I say, screening for COVID cohorting. Those may be trying to work with the other patients as long as we can. But if we have to end up cohorting other patients together without knowing what's wrong with them, then that may be forced upon us.

Jasmin Islam 14:27
Great, thank you, Chris. And I think we'll move straight on to question three if that's okay. So, when should seasonal vaccination begin (first part)?. Last year, lots of school vaccination programs were delayed and this year vaccination has just begun this week. It's come a bit a bit sooner, which you may have seen in the news. So when is it either too early or too late? And that question is for Maria.



Maria Zambon 14:55
Okay, thanks, Jas. Well, in a way, the answer here is dictated by pragmatics as much as sort of scientific rationale. Making flu vaccine is a complex process. It's year round, it's on a very tight schedule. And for Northern Hemisphere, decisions are made in February about what goes into the vaccine and vaccine is delivered into arms basically, from September onwards, ideally, from the end of September onwards in anticipation of increase in respiratory infection and a flu epidemic, some point between October and end of March. Now, complex things and many moving parts means that small delays in one part of the system can lead to large delays in others. So if, for example, during the time of let's say batch release for preparation of flu vaccine, there is a critical failure of a set of laboratory tests, that might delay that part of the overall process by a week or so which in turn may have bigger knock on effects later on for delivery of vaccines. So, what I'm winding up to say is that ideally, you want to have your vaccines in arms, or up the noses of children ahead of the peak of respiratory viral infection so that you induce the best levels of protective immunity. Sometimes that doesn't work in the way that you actually want to. And there are delays in the delivery of the vaccine, either through procurement and supply chain or some other issue which affects the kind of rollout program. And one of the things that we have seen in recent years, which is disappointing is that, for example, the childhood vaccination has been delivered after Christmas to vulnerable children, which is really not what you want. Flu is highly unpredictable, you would expect to see a peak at some point between October and March, assuming we don't have a pandemic. But you can't tell when it's going to come. Typically flu, h3 and h1 tend to be ahead of flu B, which is later in the year. And to maximize the immunity, you really want to get the vaccines in October time, assuming we don't have an early season. Hopefully that sort of explains. Too early, I don't think we're ever going to have that problem because you can't make vaccines quick enough to give it too early. Too late, that is dependent on, to an extent, of things beyond control. So if we get a nasty early season and vaccines haven't arrived. So, you know, say you were seeing something that was particularly unseasonal in early October, and vaccines haven't arrived, then by definition, you will be too late with your vaccine. So it's a very complex system with multiple moving parts.

Jasmin Islam 18:16
Great, thank you that very comprehensive answer Maria. And I think we'll move straight on to the next question. And obviously, it will be very interesting to hear from Chris Blyth, as well. We're lucky to have the sort of southern hemisphere perspective, but I think that will tie in here. So do you think we're likely to see a severe flu season this year, given there have been fewer and fewer circulating COVID variants of concern? Are there concerns regarding co-infection disease severity? So I think this question is for Maria, and then I'm sure Chris will jump in.



Maria Zambon 18:49
One of the things as a long standing influenza virologist you learn to do is not to make predictions. So, because you'll almost certainly be wrong. What I can say is the majority of circulating flu globally at this point in 2023, is h1n1 influenza A followed by influenza B. Typically that influenza h1n1 is associated with more infections in younger people and slightly mild, it doesn't have quite the disease severity profile of h3n2 so winding up that question there. If we see an h1n1 season - flu A, h1n1, would predict that it would be less severe than an h3n2 season and potentially impact a slightly different section of the population. So it'll be interesting to hear what Chris has to say about what's happened in Aus recently.

Chris Blyth 19:55
I'm happy to jump in so we had a significant flu season this season. So of course that for us is usually between May and August, and it was predominantly h1 and B season. A real shift. And it's a bit hard to tease apart changes in testing practices from epidemiology, but it's shift to younger individuals. And it really sort of raises the question about the immunity gap that may be there after a couple of years of low influenza seasons, around COVID. So we had a significant flu season, our largest since 2019, and our second largest on record, with large numbers of hospitalizations of children and adults, we're on the downhill run at the moment, heading into our warmer summer months. But I think the real challenge

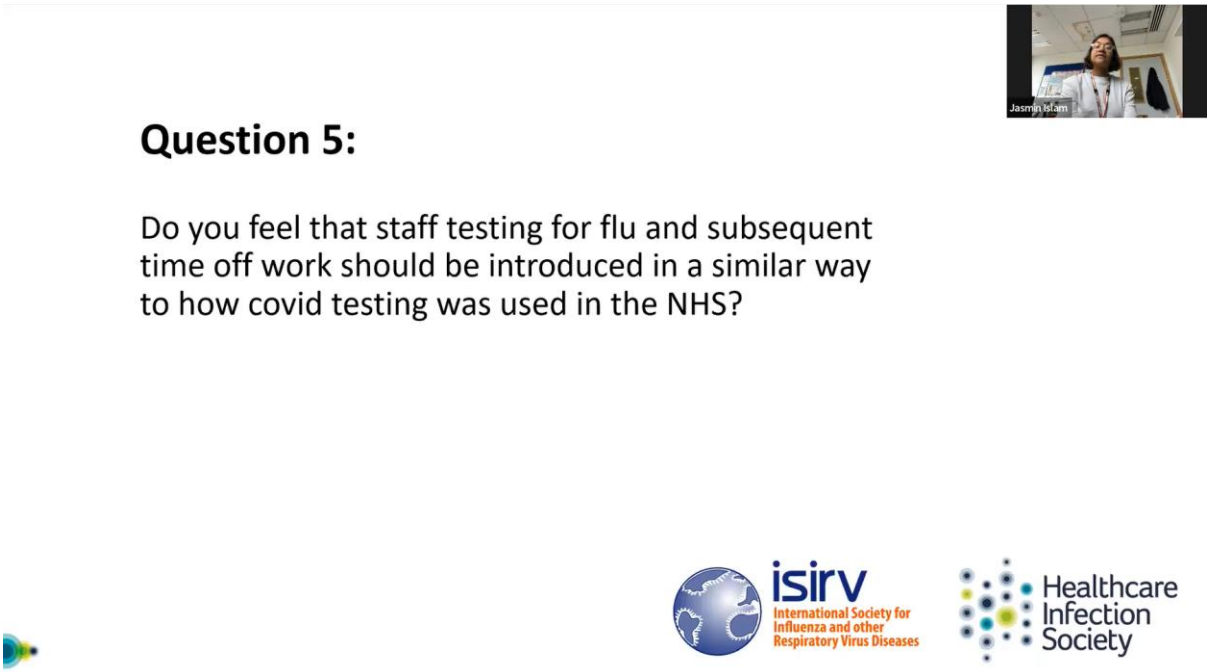
and I think as we've seen in COVID, flu is unpredictable, all of these respiratory viruses are unpredictable and more importantly, things are even more unpredictable at the moment. I'm not sure specifically we've quite got back to that predictable seasonality that we had pre COVID. Now, I suspect you're six months ahead of us in the UK, as far as that predictability, but whether this will be a stock standard season for you, or something new, I don't predict either.

Maria Zambon 21:15
Now, very wise, I think. Your last question, are there concerns regarding co-infection and disease severity? So I would say yes, there are some concerns about co-infection, particularly flu and SARS that can be very nasty in risk groups. And certainly the early work that was done indicated increased morbidity and mortality, of course this was pre vaccination to be fair for SARS. But, you know, it makes sense that if you do have co infection of two nasty viruses, you're likely to have a worse outcome. So co infection is a significant concern. But the amount of disease burden it contributes I'm not sure we've got a really good handle on just yet.

Jasmin Islam 22:04
Yeah, great. Thank you, Maria. And I don't know, Chris Settle, is there anything you want to add to this question, or will we move on to the next one?

Chris Settle 22:16
Nothing from me. Thanks.

Jasmin Islam 22:19
Perfect. So we'll move on to Question five. So do you feel that staff testing for flu and subsequent time off work should be introduced in a similar way to how COVID testing was used in the NHS? And that's a question for Chris Settle to start off with.



Chris Settle 22:37
Thanks, again. I think that's a very difficult question to answer because no one really knows what the answer to it is. My gut feeling is it might cause more problems than it solves, because of the staffing level issue that we've already experienced before. So even with the COVID management system, that did result in you know, quite a number of staff being off work for fairly lengthy periods, sometimes, when they've actually felt quite well. And I do wonder, therefore, whether or not it might be best to manage respiratory viral illness, in terms of how the staff, individuals will, will vary in how ill or otherwise they are from these infections. And so really having a policy of saying, well, we'll test you for something. And if you've got it, we'll send you off work for 10 days, or for seven days, or however many days, but that's quite inflexible, and it doesn't accommodate the variation that you'll naturally see between individuals. So my preference, I suppose, is to try and gauge how well people are, have they got fevers have they got symptoms, do they feel, you know, terrible, if they've got any of those things, then they don't need to be at work, obviously. But once they feel well, and haven't got a fever and haven't got symptoms, then whatever day that happens to be after their illness, and you might not even know what the illness is, perhaps they can actually work. But, you know, we can work in ways that might reduce the risk as well. We can try and make sure that our workplace is well ventilated, we can try and make sure that we don't sit for long periods of breaks in confined areas with loads of other people, we can possibly, you know, use PPE masks or other means to reduce the risk if we have an infection that we you know, disseminate droplets or aerosols at close range to the staff. So I think there are ways we can try and manage it without being as prescriptive as saying, we're going to start testing for influenza and COVID. And next year, we'll have RSV and the year after that we'll have something else, before long we'll be testing every member of staff for 15 different complaints before they come to work every day. And if they've got one of those, they don't need to turn up you know, it could be quite difficult.

Jasmin Islam 24:58
Anybody else wants to comment in there? Maria, Chris?

Maria Zambon 25:02
Yeah I'd like to, I think Chris's response is, very sort of pragmatic and I absolutely indorse it. You really want to manage symptomatic illness. I should also remind that during COVID many of the measures that were introduced were highly precautionary when there wasn't a good understanding of kinetics of virus replication or infectiousness of individuals. So at that time, particularly in the absence of sort of countermeasures, it was felt prudent to have quite rigid sort of approach to this, which was less dependent on people's discretion and less dependent on pressures of the workplace as we come out of that, and we have better understanding of kinetics of viral replication and infectiousness, I think it is much more sensible to manage on the symptomatic illness bases, which is really how we've always managed flu, I think.

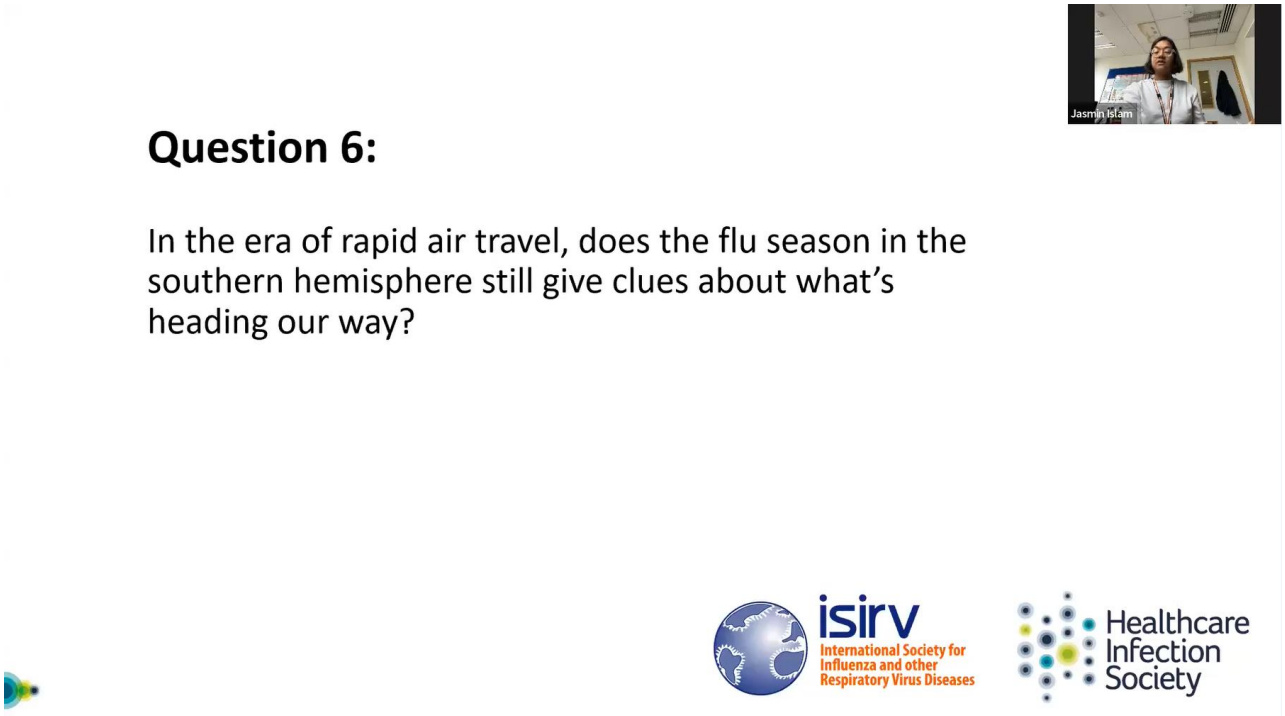
Chris Blyth 26:02
And Jas, we've done a very similar thing in Australia, even though we had success of keeping COVID out for a number of- for a significant period of time, it's just impractical now to, to manage this without just focusing on symptoms. So largely, for our symptomatic staff, our request is stay at home for a period of time, it varies between different areas, between five and seven days. And we're really trying to

focus on symptoms, just because of the practicality of staffing our units. And I'm sure staffing in the UK is as challenging as staffing is here, and particularly highly specialist nursing staff are really hard to find.

Jasmin Islam 26:43
Thanks, Chris. I think it's interesting, isn't it, conceptually. You wonder, though, for staff themselves, if there has been a real mind shift or a change in the way people perceive the importance of symptoms, because for COVID, it did become very closely associated with prescriptive time off work in a way that I think is not clear, as we said, not the same for influenza. And so I think it'll be interesting to see how healthcare staff sort of interpret their results or interpret their illness going forward now, because I suspect there might be a change in in the way people view their symptoms, generally. So I think that's kind of interesting, and something that needs to be looked at.

Chris Blyth 27:24
I think there's been a much greater appreciation Jas globally about the importance of staff staying home when they're symptomatic, I think we're all been guilty of that pre pandemic. I certainly have been, particularly some people in specialist areas or, you know, very specialized staff. So I think there's been a greater appreciation, clearly, that it's better for patients.

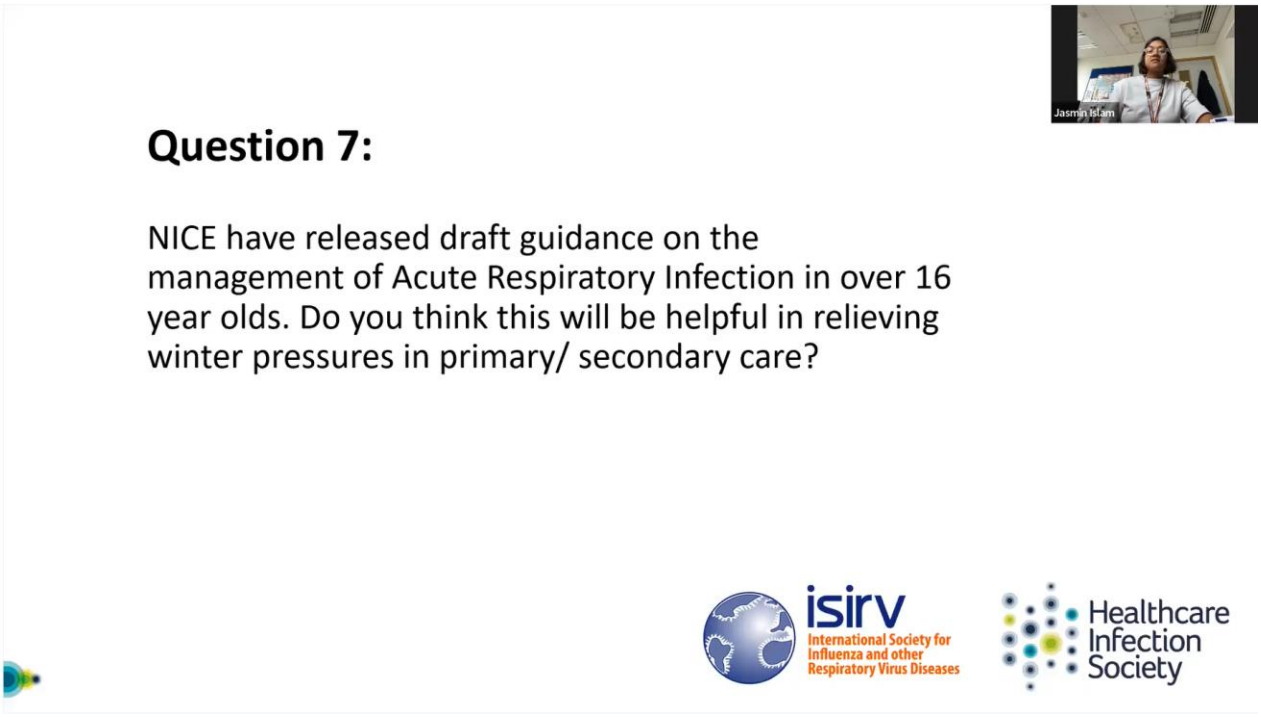
Jasmin Islam 27:46
Great. Okay. Thank you. On to the next question now, question seven. Oh, sorry. I think question six, getting ahead of myself. So in the era of rapid air travel, does the flu season in the southern hemisphere still give clues about what's heading our way? So no surprises here, I think this question is for Chris Blyth.



Chris Blyth 28:08
The influenza virology response is no, it doesn't. We do know influenza viruses in general flow from probably Asia through southern hemisphere into the northern hemisphere. But there's so many other factors at play here. So the stock standard answer is no, if we had a big season, it doesn't mean you're going to have a big season in the UK. Now, similar to Maria before, I wouldn't be surprised if you're going to have an h1 B season. But there's lots of other things at play there.

Maria Zambon 28:41
Yeah, so the bit I'd add to that is that we may have the same strains, but they may have a different impact. Meaning that, you know, the overall impact of what you have in a winter season is very much dependent on what viruses are circulating, but also population structures and population immunity. So, you know, it is perfectly possible for a strain circulating in Australia to cause bad impact, and the same strain be seen as a proportion of what we see here, northern hemisphere, and it not have quite such a bad impact, potentially vice versa, too, because it is all about population structures, and sort of immune susceptibility. So typically, we don't get too excited by what happens in southern hemisphere, because we're not quite sure what it means for us. We watch it carefully. But we don't anticipate that exactly what happens in southern hemisphere is what's going to happen with us.

Jasmin Islam 29:47
Thanks Maria. We'll move into question seven now. So NICE have released draft guidance on management of acute respiratory infections in over 16 year olds. So do you think this will be helpful in relieving winter pressures, either in primary or secondary care setting? And so if we go to Chris Blyth first, I suppose to give us a bit of a description of how you may use similar things like outpatient services in Australia and then and if that's been helpful in this setting, and then come back to the rest of the panel for any thoughts.



Chris Blyth 30:25
Yeah, happy to. Thanks for the question, Jas, you know, I think anything we can do to try and relieve the pressure on our inpatient areas, is- you know, the UK is very similar to Australia and clearly there's enormous pressure on hospitals, and winter is the time when they are greatest. I think the added pressure post COVID, and I'm sure it's the same with the UK, is actually access to primary care is more challenging now than it was pre so I think some of the highest risk patients are in a really vulnerable place about difficulty accessing primary care, but also we're trying to get them out of the hospital space. So we do need to be more inventive about how we use our care coordination, particularly some of our highest risk patients, our OpET services or outpatient services, particularly to provide clear guidance, rapidly assess if there's a need for antivirals, whether that be flu antivirals, or COVID antivirals, using those in those particularly high risk patients to try and relieve that pressure on our inpatient beds. And I think it's also important to highlight the need to think about in the same way, particularly in the aged care, or the residential care populations as well, clearly at high risk of one of those impacts, but also a high risk of having a major impact on our hospital system.

Jasmin Islam 31:48
Thank you, Chris. Maria, or Chris Settle, any comments?

Maria Zambon 31:52
Chris, maybe next? Did you have any comments, Chris on it?

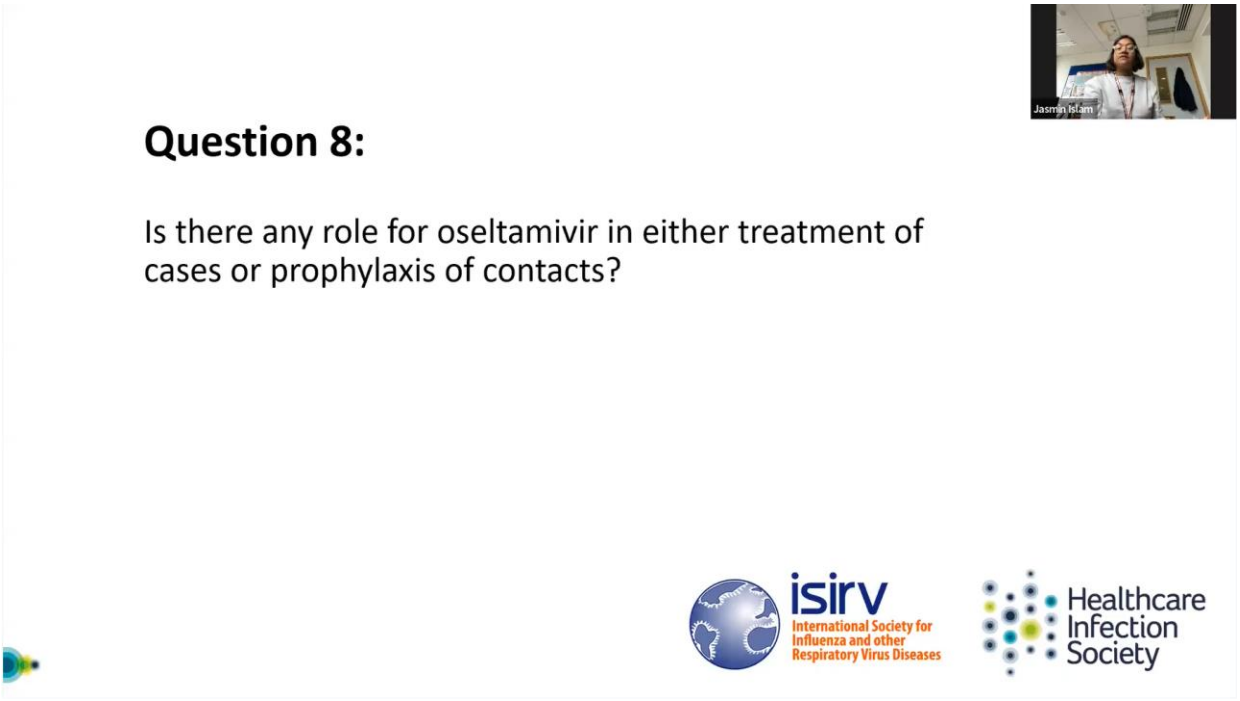
Chris Settle 31:58
Yeah, I think that similar to Chris Blyth, we're interested in doing anything possible. And acknowledging the fact that patients turning up to hospitals in the numbers they are is not really a sustainable way forward. And everywhere has been really struggling this year through summer to actually manage the patients who are presenting. So anything that might have an impact on that, and sensibly assess a patient as to whether they really need to be at the hospital doors or not, and reduce some of the ones who attend would be a good thing. And this guidance, it really focuses on, you know, what are the signs and symptoms the patient has got? Can we stratify them into low risk and medium risk and high risk? The only ones who need to go to hospital the high risk ones. The only ones who need antibiotics are probably the ones who are in the medium risk, or the high risk, and the ones at low risk probably don't need any. So that sounds like a good thing to do. It hasn't been fully tested. But at least the principles that seems to me to be very sensible.

Maria Zambon 33:02
I agree with both Chris's on what's been said, I think trying to manage the sort of winter pressures of seasonal respiratory infection has become more and more challenging every year. I do think the NICE guidance, as it is currently out to consultation doesn't nearly enough recognize the importance of viral infections in acute respiratory illnesses. And whether or not there ought to be more attention to use of point of care tests and things as part of it, I'm not sure that I completely agree with how it's written. Because it does seem to focus very much on the bacterial side of acute respiratory infections. But yeah, got nothing else to contribute here. I think it does need managing, it's an enormous workload.

Chris Settle 34:03
Yeah, one of the other pressures that they may be feeling, and one of the reasons why it seems to focus, as you say, on whether you need antibiotics or not, is the whole issue of antimicrobial resistance. And that is a big agenda. And so that's maybe pushed the idea of the virological causes a little bit to the side. But you know, you're right. If there is if there is a group of patients who, if you diagnose them with influenza, you could treat with something that would reduce their risk of coming to hospitals subsequently, actually you might be doing yourself a favor, but I don't really know if they've got enough assessment in that work that they've already done to be able to say,

Maria Zambon 34:42
Yeah, tricky.

Jasmin Islam 34:45
Yeah, I mean, I think we're just gonna have to see, aren't we? I guess, in a way, it's great to limit patients coming to secondary care, but primary care is already quite overwhelmed. And so I think it's going to be interesting to see whether these guidelines have any impact or how that changes the model of care that we're able to deliver in winter. So, yeah, let's wait and see. Okay, great. So we'll move on to the next question, please. So is there any role for oseltamivir in either treatment of cases or prophylaxis of contacts? And so this is a question, to start off with, for Maria. And then Chris Blyth to comment.



Maria Zambon 35:30
Well, I think my answer to this is yes, there obviously is. And there's situations where you may wish to both treat and prophylax. So vulnerable settings would be one very obvious place, such as nursing homes, but also risk patients. And, if you will, the kind of guidance that UK HSA put out about the use of antiviral prescribing tries to provide context for the different sorts of situations where you might

actually want to do either treatment or prophylaxis, always within the product guidelines, but sometimes also using clinical judgment where you think you may have a particularly vulnerable patient or don't have good vaccine cover. Yeah, so there is a place most definitely for that. And, you know, I'll be interested to hear what my colleagues have to say about that. You might have a different view in pediatrics, I guess?

Chris Blyth 36:40
Probably not that different from you, Maria, I totally support the need for antivirals. We under utilize influenza antivirals, particularly in those with influenza that's severe enough to be hospitalized. And I think we under utilize it in pediatrics for that reason. Not to mean that every person who has flu in the community needs to jump straight to an antiviral. I'm not proposing that, but we do under utilize it in some of our sick patients, and some of our high risk patients. I think it's also getting the messages out to our highest risk patients about those who are exposed to almost have a plan like we should be doing for COVID as well as for flu. 'If I was exposed, what would I do in this situation' is a useful conversation for people to have both from the primary care, but also hospitalized care perspective.

Jasmin Islam 37:34
Great, thank you. Chris Settle did you have anything to add?

Chris Settle 37:38
Yeah, we've certainly used oseltamivir in prophylaxis or for treatment of patients with influenza. And we haven't really got any immediate expectation that we're going to discontinue doing that. So I don't know if there's going to be some official word that says anything different. But certainly at the moment, we would continue with that strategy in hospitalized settings. And as you say, Maria in in some of the primary care settings where there are multiple vulnerable individuals, and they do have outbreaks of things like influenza in care homes, and they do see quite a lot of morbidity from that.

Jasmin Islam 38:18
Great. Thank you, Chris. Any last thoughts on this question before we move on to the more general Q&A? No? Okay. So I think we'll move on now to the question and answer session. So I think if we start off with question one: any ideas on how to increase vaccine uptake among staff as we are observing vaccine fatigue in community health care staff? So I think for these, it's just open to any of the panelists to jump in.

Maria Zambon 38:55
Okay, I'll make a start. I'm sure my colleagues have got things to say. I think this is pragmatic as much as persuasion. Healthcare staff are busy people, it's sometimes difficult for them to organize themselves to get vaccines, anything we can do, to make it easier, like trolleys going around hospital wards, or, you know, extended sessions, anything that can be done to make it easier for people to get vaccine, I think, is one way of increasing uptake. And that's my first stab at this question. Over to Chris's.

Chris Settle 39:35

Yeah, we've used that strategy in our organization in the past and don't think we managed to do it successfully last year, because staffing levels around the whole trust was so poor, that we couldn't really afford to have teams of individuals going round wards etc. but certainly the year before that it was adopted, and it made a difference. I think it changed. I think we had one of our best uptake years of just over 85 percent using the strategy you're talking about, which is doing everything possible to make the vaccine available to people who, some of whom wish to get the vaccine, but don't get the opportunity to get it if you know what I mean. Whereas in the subsequent year, when we haven't been able to do that, we're down back to the 65% level. So yes, I think it makes a big difference.

Chris Blyth 40:22
Just to add, there's clearly an increase in vaccine hesitancy, not just only in healthcare workers, but in the community, we're seeing that globally at the moment, it's well measured. So I do think we need to acknowledge that, highlight that actually, if we are trying to get high uptake, we need to pull out all stops, as far as out programs go and make sure that our healthcare workers have clear understanding of the importance not only for themselves, but clearly their patients as well.

Jasmin Islam 40:51
Thanks. I'll just add in one comment there with my UKHSA hat on. So I work on the SIREN study, which is a big study of healthcare workers across the UK. And obviously, some of the work we've been doing is working with healthcare workers and doing focus groups to look at their thoughts on vaccination so we can understand what the barriers are, what the challenges are. And so I think it's a responsibility for all of us to share some of those things that we learn and try and reach some of those other groups that maybe are often marginalized and have been throughout the pandemic. There's the things that I want to talk about: making vaccines more available, also just trying to break down some of the barriers to why people may not want to take vaccination. So there's an education element that we probably all need to think about as well at some point. Okay, great, if we go on to the next question. I'm having to look at it from my phone. So this is one, it's about the new variant. What is known about COVID-19 vaccination efficacy for the BA.2.86 variant? Maria, do you have any thoughts?

Maria Zambon 42:15
Yes, I can make some comments on that. We've just had a nursing home outbreak here with BA.2.86. It was a care home where a high proportion of residents had BA.2.86. With when the formal measurements of vaccine effectiveness were done, indicated very low vaccine effectiveness, around about 15% as measured against infection, but as measured against hospitalization, there is higher vaccine effectiveness. So point number one, it depends how you measure outcome, whether you're measuring against infection or whether you're measuring against more severe outcomes. Number two the 2.86 variant is antigenic or looks as though it's antigenically different to other circulating variants. But still about equidistant to XBB and BA.5, I think from the cartography that I've seen, so measuring the actual impact of immune escape of this variant is a bit difficult at the present time. The nursing home outbreak that we had was a kind of a wake up call because we had a very high attack rate of something like 88%, I think in this nursing home. So it says that the thing is transmissible at least in a closed setting. But the fact that it isn't as widespread as you might expect yet does give some pause as to what is the actual impact of this variant and has it got a fitness advantage over other variants? I don't think we know yet.

Jasmin Islam 44:11
Thanks, Maria. Chris, Chris, any comments?

Chris Settle 44:17
Yeah, there was a webinar yesterday which covered something about the new variant and, as Maria mentions, demonstrated that it has got a lot of different mutations. But they were thinking perhaps that it was less fit and maybe not as transmissible. Obviously, in a nursing home setting it's not quite the same. But their comment was that if it did have any further development and became extremely transmissible, that it would be quite a tricky strain to handle because it's not really protected against particularly effectively from an infection point of view as you say, with the vaccines that we've currently got, but you know, vaccines can be changed can't they. So if you get new variants then like you do with influenza, I dare say you start to make vaccines with the newer strains that then perhaps will have more efficacy.

Jasmin Islam 45:22
Any last thoughts on this? Or we'll move on to the next question.

Maria Zambon 45:29
So I'd say it's early days, I don't think we've got a proper risk assessment yet on this virus, I think it'll be a week or two before we've got full UK data, which allows us to really refine our risk assessment on this variant, and get a kind of more complete picture. It's always the same at the beginning, because you've got high degree of uncertainty of the data that you've got, and what's actually going to happen.

Jasmin Islam 45:58
Thanks, Maria. Okay, let's move on to the next question. We've got a lot of questions. So what is the likelihood of antigen testing for flu similar to what we have for COVID?

Maria Zambon 46:23
I think that's going to be me, isn't it? Antigen testing like lateral flow devices have existed for influenza for many, many years. The earliest LFTs were brought onto the market and around about 2000 to coincide with the launch of neuraminidase inhibitor drugs, they've always had performance characteristics of high specificity, but low sensitivity, meaning that a positive predictive value is good, but the negative predictive value is not so good. And doctors find it difficult to use those devices to rule out infection. So my comment in comparing those with the COVID lateral flow devices is that overall, the performance characteristics in terms of antigen detection are probably quite similar. But the characteristics of viral replication and virus shedding are different in COVID than flu because typically, in flu, you have a much shorter period of viral replication. And again, typically, flu is multiple infections over a lifetime. So you have some host immunity. So they're less useful in flu, I would say at this point in time, but they can be very useful for outbreaks. And how we might use them on admitting people to hospitals for the lateral flow devices, I think is something that needs to be looked at.

Jasmin Islam 48:02
Thanks Maria, and Chris Blyth, Chris Settle any comments?

Chris Blyth 48:07
I'm happy to. I think the other thing that has changed is the availability of lateral flow assays. Many things sold in pharmacies in Australia, even supermarkets, actually provide- and the public are moving toward these devices ahead of necessarily advice. So it does change the way you approach things. Similar to Maria, though, I do have some challenges with particularly the sensitivity. And so the clinical utility, still, I don't think is quite there.

Chris Settle 48:42
Yeah, I mean, the same as any of these tests there is the basic sensitivity, specificity analysis, but on top of that, you've got the pre-test probability. So as soon as you start moving into populations with an unlikely diagnosis, with a test that's not very sensitive, you know, you're really going to be up against it.

Jasmin Islam 49:02
Great. Thank you. Thanks, Chris, Chris, Maria. So we've probably got time for one last question. So we'll just do one more. And so should you universal masking be implemented this winter? And if so, who do we think this is protecting? Is it protecting staff? Or is it protecting patients, or both?

Chris Blyth 49:30
So I'm gonna lay this out and let you know what we did this winter, we had relatively low COVID activity heading into winter, so most centers moved away from universal masking. But certainly many of the centers I've been associated in the thick of winter, went back to universal masking, particularly in some of our high areas. And actually staff were much more willing to do universal masking than they've ever been. And I've been keen to have that conversation with health services and healthcare workers going forward, again, working in the pediatric hospitals, we've tolerated staff getting sick regularly through winter, just because they don't use PPE as regularly as they should do, particularly in some of those high risk spaces. So we've found it very effective. Now, there is a desire to step away from that, you know, after a number of weeks and months. And so we get away from that practice, but I'd be having that same conversation next winter, again, particularly for our emergency departments and some of our high risk areas. And I think it's a very useful tool for staff and for patients. I'm just talking about surgical masks, we were not going down respirator routes in that space.

Maria Zambon 50:47
Let me just add another perspective, which is quite keen on the idea of masking coming at it from a different perspective, which is the knowledge which I don't think is as widespread as it could be about the significance and extent of nosocomial transmission of respiratory infection, nosocomial viral infections, in hospital settings. So anything that you can do to actually minimize that for vulnerable patients because those who acquire nosocomial respiratory infection, whether it be SARS, or influenza, or even RSV, are typically much worse off. So anything that we can do to try and minimize that spread, I think it's an important thing. Whether that's universal masking, I'm not completely sure. But there is a role potentially, for more mask wearing, I would say.

Chris Settle 51:42

Yeah we've certainly used masks in higher prevalence settings. So when you've got outbreaks and things like that, then they've obviously been reintroduced. And similarly in some of the high risk patient population wards, then there's been a much lower threshold for reintroducing masks. And also, staff preference is something which we are quite happy to, you know, allow. If staff wish to wear masks, then staff can wear masks, it's not as if we're going to say you're not allowed to wear a mask. And so sometimes those preferences do move, practice in certain areas of the organization. But I think the answer to the question 'is it protecting staff or patients?' is 'protecting both'. Because, yes, you've got vulnerable patients that staff might actually cause infection on, but similarly, you're working closely with your colleagues. And if you haven't got a mask and you do have an infection, then you will no doubt spread it more easily.

Jasmin Islam 52:42
Great. And I think just one last comment on this. I guess it would be interesting to hear what the panel's thoughts are on whether or not you feel, given the evidence basis for that is quite a contentious question, so probably not the one to ask at three minutes to 14:00, but the evidence base for wearing masks, any thoughts on whether that needs to be strengthened, or if we were to try to have to persuade staff to wear masks again, any thoughts on how that might be done? Or if it's even needed?

Maria Zambon 53:13
Well, let me start and then see what others think. I do think there are a number of quite serious reviews of the impact of non pharmaceutical interventions, including mask wearing, that have got really detailed data behind them being undertaken at this point in time to look at, well what was done in the pandemic, what worked, what didn't work, what might we do next time round. Arising from that will be some messages about mask wearing and PPE generally. And I think what we need to do is distill those down and work out what can we take from that that we could use in everyday practice, but distill down is really important, because these are areas that have got complex arguments, and complex data. And we need to find ways of simplifying the messages. So that's my kind of perspective on it.

Jasmin Islam 54:05
Thanks, Maria. Chris, any last thoughts?

Chris Settle 54:08
I think it would be very helpful to have more certainty about exactly what benefit there was. Because it's certainly very easy to assume that there must be a benefit and therefore with fairly low threshold, adopt these things. And yes, there are sustainability issues and other factors to take into account. So if it did turn out that actually certain things are beneficial and other things aren't so beneficial. It would be better that we knew that and could inform people with more certainty about what the benefits were with wearing a surgical mask or not. Because I think otherwise there's more tendency amongst staff in general to want to use these types of PPE, then perhaps there is a feeling amongst IPC professionals that it's essential. And as I say, when that is the situation, then the best solution is to allow people to, to use such PPE because otherwise, it creates a very difficult dynamic between IPC teams and staff in the workplace. And you damage the relationship quite badly if you come across as denying people, you know, something that they feel is important, even if it turns out that it's not important. And I don't, I'm not saying that they're not important, I think masks have got a significant benefit in situations where

someone has got an infection, and they are not going to be disseminating the same amount of droplet particles, if they're wearing a mask compared to if they aren't. Small aerosols, you know, they are probably going to escape. But again, maybe not directly into someone's face, if you're wearing a mask. So there still could be benefits even there.

Chris Blyth 55:53
Jas, just one comment about the evidence base, I think it's actually really important for some of our high risk patients, that familiarity of wearing masks in the community now is so much greater than it used to be. So actually, you know, we should be sort of for some of our highest risk patients, you know, if there was good evidence base, they could easily use masks in high risk areas. And it would be good to have a stronger evidence base to be able to give them advice for and to give out, particularly as they're transiting through high risk environments, including hospitals.

Jasmin Islam 56:25
Great, thank you, Chris. Okay, so I think that brings us up to time. So I just like to first of all, thank everyone, for attending this webinar and extend a huge thank you to all of our panelists today for all their insights and useful comments. Thanks very much for watching, thanks to HIS and to ISIRV for hosting this webinar. It'd be really great to get people's feedback so if you could scan this QR code and provide some feedback for the webinar, that'd be brilliant. And the recording and transcript will be available after the event. You can also access previous webinars on the HIS website and certificates of attendance will be available as well for this.