Transcript: Webinar - COVID-19 challenges and solutions 7. Winter planning | 24 September 2020

Watch the webinar

During this webinar our audience submitted their COVID-19 IPC questions to our expert panel.

Confirmed panel members:

- Carole Fry, IPC Lead, Public Health England
- Mark Gilchrist, Consultant Pharmacist Infectious Diseases, Imperial College Healthcare NHS Trust
- Stephen Kidd, Clinical Scientist in Medical Microbiology, Molecular Diagnostics/POCT lead in Microbiology & Honorary Scientific Advisor at Vitamica Ltd, Hampshire Hospitals NHS Foundation Trust
- Luke Moore, Consultant Infectious Diseases and Clinical Microbiology, Chelsea and Westminster NHS Foundation Trust

Chair: Jincy Jerry, Assistant Director of Nursing in Infection Prevention & Control at Mater Misericordiae University Hospital, Dublin, Ireland. Member of HIS Professional Development Committee.

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Jincy Jerry 0:02

Good evening, everyone.

Thank you all for joining our COVID-19 challenges and solutions audience-led webinar series, hosted by Healthcare Infection Society. My name is Dr. Jincy Jerry Assistant Director of Nursing in Infection Prevention & Control at Mater Misericordiae University Hospital, Dublin, Ireland, and I am a member of the HIS professional development committee. Today's webinar will focus on winter planning. We have already started to see winter related infections, due to the changes in season. We are all preparing for the worst-case scenario this year. We have a fantastic panel of experts here to share their thoughts on a broad range of topics, related to winter planning. So I'm going to ask our panel members to introduce themselves. Stephen we might start with you.

Stephen Kidd 0:52

Sure. Hello, thank you for the invite to be on this panel. I'm Stephen Kidd, clinical scientist in medical microbiology and infectious diseases and molecular diagnostics and point of care for hospitals, and I've been working on number of COVID special projects for the Cabinet Office the past few months, so pleased to be here. Thank you.

Jincy Jerry 1:15

Thanks Stephen, and moving on we have Carole Fry

Jincy Jerry 1:30

Carole could you please unmute

Carole Fry 1:39

Can you hear me now? Thank you. I'm an IPC nurse, I've been working on COVID-19 since Christmas with Luke, on the 10th of January, and I'm the IPC lead for the PHE COVID-19 response.

Jincy Jerry 1:58

Thanks Carole over to Luke.

Luke Moore 3:26

So my name is Luke Moore, I'm a consultant in infectious diseases, microbiology and virology, practicing between Chelsea hospital, and the Imperial trust. And I've been particularly working on rapid diagnostics, so rapid PCR but also serological diagnostics for COVID. Thank you for inviting me.

Jincy Jerry 02:25

Thank you, Luke, and over to Mark.

Mark Gilchrist 02:27

Hi folks. Thanks very much for the invitation. My name is Mark Gilchrist and I'm a consultant pharmacist in infectious diseases. And really it's been around the challenges of stewardship and the challenges of managing our antimicrobials in a anti-viral world.

Jincy Jerry 02:44

Thanks. Thank you all, and thanks for everybody for all entering your time before this webinar we asked you to submit the questions to put the panel, we have selected eight of the most popular questions for the panel to discuss during the first 40 minutes of the webinar. During the last 15 minutes of the webinar, we will answer, live questions which you can submit via slido throughout the event, you will be able to use slido to express your opinion by voting on live polls to participate in polls and questions please open the slido app, and enter the code hashtag #HIS or scan the QR code. So the webinar is going to be recorded and will be available afterwards for anyone that couldn't make it today. So please, please feel free to watch it again on the HIS website. So, we will start with, question number one.

So the first question is what is the role of point of care testing to guide patients placement, are there any point of care testing tests that will pick up both influenza A and B, and SARS-CoV-2, which have a rapid turnaround time.

Stephen would you like to take this question.

Question 1:

What is the role of point of care testing (POCT) to guide patient placement? Are there any POCT tests that pick up both influenza (A&B) and SARS-CoV-2, which have rapid turnaround time?

Stephen Kidd 4:04

Absolutely. I think the role of point of care testing in the winter is generally very important, and it's often been used in RSV and influenza testing, historically, obviously, now we've got the challenge of of SARS-CoV-2 to into that mix as well. And symptoms being indistinguishable on presentation in the ED department for example. So, having that ability to rapidly assess patients that come to the front

door, adults and children is going to be critical this winter, and having that ability to place patients who are COVID positive into specially COVID hot wards if you will, and keep them away from other patients that can be vulnerable, or COVID negative is going to be important. So, there are a number of point of care tests which are beginning to get to the point where they could be released. But this probably before I go any further is probably one thing that's an important point to distinguish between. There's a lot of tests which are marketed as point of care when they're actually probably more near patient testing, which is quite a difference, and there's a lot of logistics to use near patient testing to proper point of care. So, in this field proper point of care is a non-scientifically trained individual who can operate an instrument which has limited interpretation, and is easy to use at the front door with good connectivity to a limit system. Now, there are a lot of things which gets sold or have been promised that are like this but clearly are not and I'm sure colleagues around the country are nodding their heads thinking. Absolutely. So I think it's very important to distinguish in near patient testing and point of care. And I believe, hopefully there'll be some coming off the production line, I mean, there is, for example a separate gene expert, that is, is something which a lot of labs are very familiar with, and have moved them into the point of care, places in ED and AMU's. However, there's also issues with supply chain. So, there is always going to be a want, and an ask for any new technology. So I think there are some coming, and I. There's probably too many to the list at the moment but I think it's important everyone asks a question, and finds a technology that answers that until they have the infrastructure to implement it safely. Because obviously you've got the safety implications of working with SARS outside of the laboratory in an environment like ED which can be quite problematic.

Jincy Jerry 6:47

Thank you Stephen, would any other panellists like to add something. So go ahead, Luke.

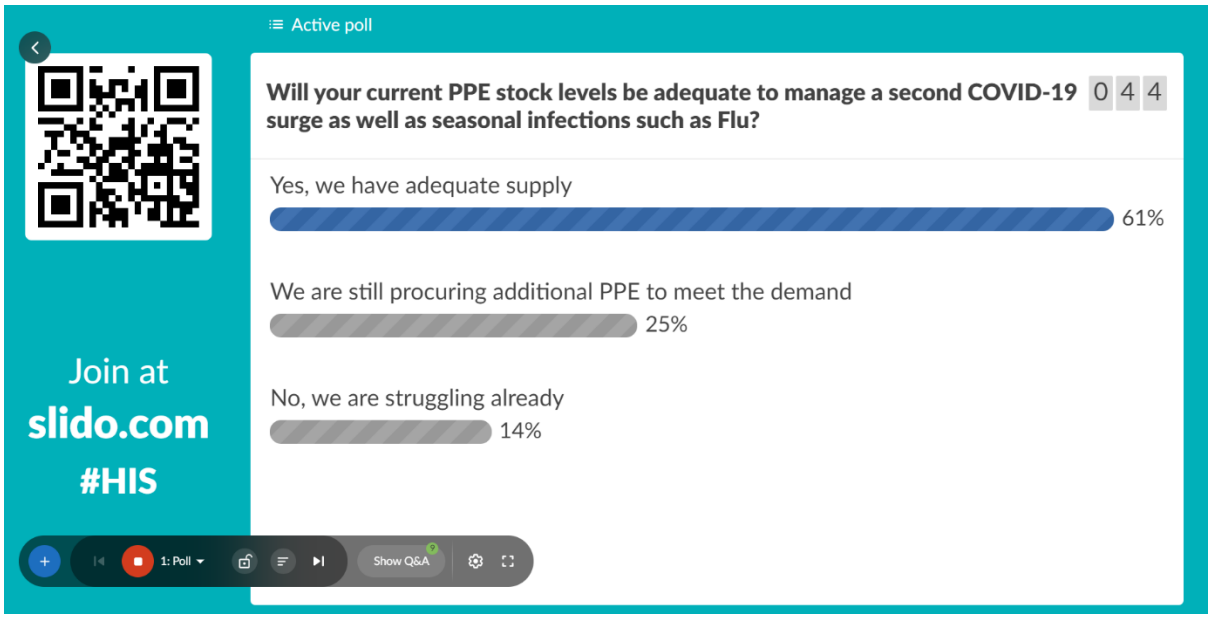
Luke Moore 6:52

Thank you. So, um, so just really to build on what Stephen mentioned. So, as Stephen said there are innumerable, but those who which have been most recently, and about to be kind of torn apart and sewn back together in some kind of interpretable way by us all as consumers are the KIER stats service being looked at by Tristan Clark coming out Southampton, and one of the good things about Tristan Clark's paper when it comes out, will be that they didn't just look at validation, which is something that we had as microbiologists will like, but they looked at the impact on patient pathways, which I think is part of the key question here asked by our astute audience member, they looked at then time to time to placement in definitive side rooms, and that was a really interesting piece of work, and there's Ravi Gupta from the SAMBA II in Cambridge, but again, as Steven said that some of these devices, possibly that one are not well versed with point of care. Then there's the DNA nudge platform which I've been involved with in West London which many of you have been been on the blower to me about, about how that fits. And that perhaps more is a as a point of care thing being able to be run, we happen to be using MLAs. It doesn't need to be an MLA who runs that piece of kit but I think what we what we as a group on this call need to do, and perhaps it is a role of some of the learned societies, is to press not just for simple validation and verification assays here, but as a Healthcare Infection Society to push forward to what is the impact of these near patient tests in terms of minimizing onward transmission in all of our healthcare organizations, and if we can put that earlier

as a question. Academically, to the people running these running these trials, then, then I think we'll always all be in a better place in a few months time.

Jincy Jerry 8:50

Thank you Luke. Okay, we have a poll now for the audience to take part. And so the first poll question is, will your current PPE stock levels be adequate to manage a second COVID-19 surge, as well as seasonal infections such as flu? Okay. A few seconds.



It's interesting to see a variety of response from across the country. But over the half of the country think that we have adequate supply. So, brilliant, and I think that leads us nicely into the second question. Are there recommendations for the use of Personal Respirator Southampton (PeRSo) or powered air purifying respirator in hospitals and dentistry, as a more comfortable and cost effective

alternative to FFP3 face mask and visors? Carole, would you like to take on this question?

Question 2:

Are there recommendations for the use of Personal Respirator Southampton (PeRSo) or powered air-purifying respirator (PAPR) in hospitals and dentistry as a more comfortable and cost effective alternative to FFP3 face masks and visors?

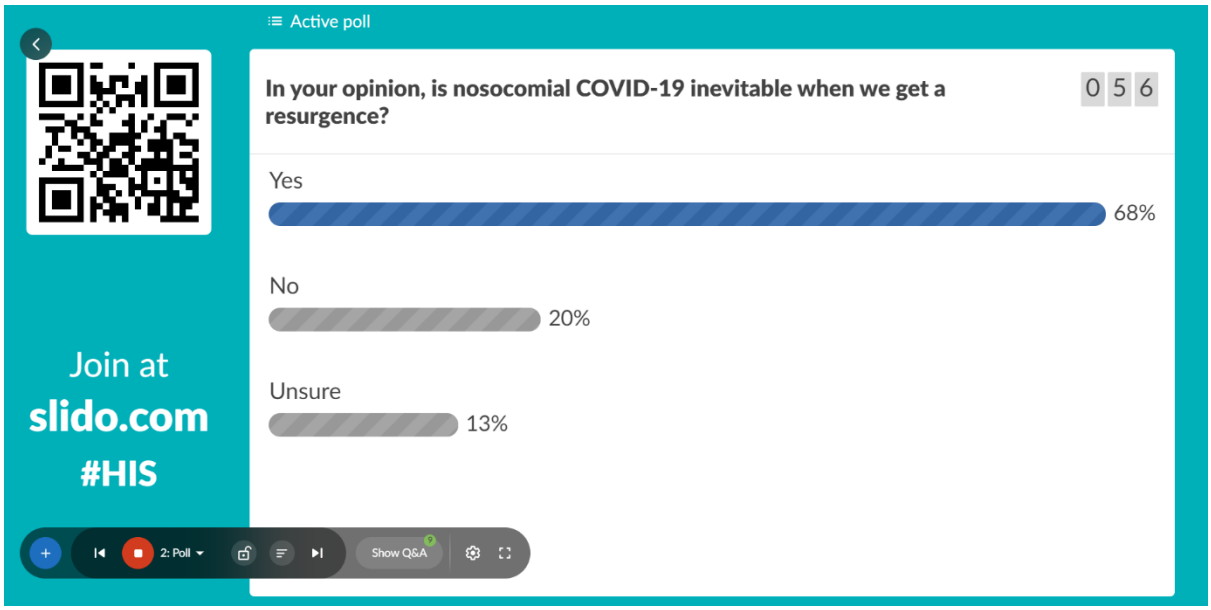
Carole Fry 10:30

Can you hear me? Very sorry about that user error, I'm afraid. And I think this is actually more of a question for Health and Safety Executive but I'll give it a shot. So, the Health and Safety Executive says that if respiratory protection is required, you need to use the highest level of protection. So this is an FFP3 respirator. Interestingly, the Healthcare Infection Society has a guideline on facial and respiratory protection, it is a little bit old now it goes back to 2013, the HSE were part of that working group, and they actually provided the legal position because there'd been a lot of people saying, they should get back up to FFP2, FFP3 but of course when we had shortages in the last wave of the pandemic we did have to have FFP2's in use as well. So that's the HSE line. Now clearly they don't work for everybody for a variety of reasons. Perhaps because their facial shape. Perhaps they have facial hair, but I think at the end of the day the decision to use a high level, of respiratory protection in terms of power respirator has to be a local one with a local risk assessment. They are not without their problems; you have to have an the properly maintained, cleaned, stored you have to think about the management of the battery packs. And again, people have to be trained to use them. So I think there is not an ideal respirator. I think it's also a bit of personal preference what people want to use. I think the disposal FFP3 respirators do have advantages, in the fact they are single use and disposable because some of the powered respirators have corrugated tubing down the back which is really really difficult to clean. As for the Southampton respirator as far as I'm able to ascertain that's a prototype that they're in discussion with manufacturers. It looks very promising, but it's very clear on their website that say it's still in development at the moment. So I think it's really down to the local choices about which respirator you use. But I can see that powered respirators will be more attractive to some people because when you've had multiple different FFP3 respirators delivered to your trust and you've had to had to fit test people multiple times that in itself is very time consuming and not what we want to be doing pandemic, so as I say local decisions, I think.

Jincy Jerry 13:01

Thanks that I'd like to open that up for other panel members. Then we go to the next poll question.

So, in your opinion, is nosocomial COVID-19 inevitable when we get a resurgence?



Again, majority believes COVID nosocomial COVID-19 is inevitable. That leads to our third question, increasingly healthcare workers are forced to self-isolate due to respiratory symptoms or symptomatic children who are awaiting COVID-19 testing. Should the children of healthcare workers be prioritized for COVID-19 testing?

Question 3:

Increasingly healthcare workers are forced to self-isolate due to respiratory symptoms or symptomatic children who are awaiting COVID-19 testing. Should the children of healthcare workers be prioritised for COVID-19 testing?

Stephen would you like to take on this question?

Stephen Kidd 14:29

Absolutely. I think those of us working in hospitals would agree that this is a very important testing pipeline. It's something that we explored quite early on in the, in the first wave at Hampshire hospitals because we identified this as potentially being a real issue. And we were lucky enough to be able to have the capacity to offer testing to family members of patients, of sorry of staff. And we saw quite an impact. So, I believe, when things started to when we broke the back of when the wave have started to diminish. And we had a bit of time to reflect and look at the data, I think, as far as I know, occupational health were saying that our average time to come back to work was, was quite lower than the national average. So I think if that is appropriate, can be done and I think some of it should be pushed I appreciate not all trusts have the ability to do that, but if possible. I think it's something very valuable because otherwise we could eventually run out of stuff in certain trusts.

Jincy Jerry 15:38

Ok would any other panellists like to comment?

Luke Moore 15:43

So I very much agree with Stephen. I think there's just two additional things to consider. One is the National testing program should be the mainstay. And, in my mind, pillar two testing should step up to that we, as I imagine many of the people on this call work in acute care settings with acute care laboratories, contributing to the pillar one testing strategy, which is obviously supposedly reserved for acutely unwell secondary care patients. Now in order to keep our work force at work, we, we do dip into that pillar one to support staff testing but also relatives of staff, and that's fine but I just want to emphasize that the pillar two my mind should be standing up to do that. The second point is that, providing testing for family members of health of health care workers is not just an element of providing mechanism to facilitate the test in the laboratory but it's also the pre-test, how'd you get to these children in this question, how to get the children to a testing facility who administers the swab. And then how is that result relayed and how is that result then entered into an electronic healthcare record that can be actioned from a governance perspective. So just doing the test, even if we lean in to pillar one to do the test. You've got to have some kind of infrastructure some kind of governance, infrastructure for that testing of family members that networks then into into test and trace. So, do I think we should be doing it. Yes, I do. But we should be doing it properly.

Jincy Jerry 17:26

Thanks Luke very relevant and should we go to the next question then. We know that the antibiotic use went up significantly in the last COVID surge. Did you learn anything you can apply to stop every “viral” patient being treated with antibiotics this winter. Mark, would you mind?

Question 4:

We know that antibiotic use went up significantly in the last COVID surge. Did we learn anything we can apply to stop every "viral" patient being treated with antibiotics this winter?

Mark Gilchrist 17:54

Yeah, sure. Thanks. So, I mean in my, in my head, this goes back to what a, an agile stewardship program should be able to do so, you've kind of got four I guess main buckets of this you've got the clinical aspect so that's around, you know, what do we treat how we treat, when, and that sometimes involves understanding what your community partners are doing that you will be bringing in these patients from community and secondary care, but also knowing that this is a constantly changing disease. So what worked, a couple of months ago might not work now. And so, one has to be agile. Hold your first principles but actually make sure you've got engagement of your frontline clinicians and your ICU clinicians and make sure that you are on the same information flow as they are. And the second bit of that is around surveillance and understanding how your antibiotics are changing and what anyone thinks about they think of all that's just loads of data trolling and loads of time I don't have. But actually, there's some very small, you know, sophisticated systems that you can utilize within your pharmacy departments or wider infection departments just to look at a number of key antibiotics are they going up, are they going down, and bear in mind that most hospitals have had to do this as part of CQUIN programs for a number of years so the data is the data should be there. And you can see what's going up and what's going down and, because sometimes you don't have electronic prescribing or the luxury of that, to see any hotspots. Thirdly, its about diagnostic testing and and bringing that into the field of prescribing so diagnostic stewardship has been coined. How does that fit in. How do people request it, but also how does the laboratory put the test back to the user. Because that's sometimes the forgotten bit you know the laboratory will sometimes send the test and say we did it but actually the user goes I can't find it on the computer screen so understanding that flow is important, and then I guess the fourth bucket is the engagement learning agile quality improvement work. It has to be constant. And what works, what we found anyways what works in ED doesn't always work in ICU, doesn't work in your acute medicine wards. And so you have to get on the ground and understand what happens what information they need, and also be aware that staff changes quite often in these scenarios, and the night shift will be on for a number of weeks they might not get that email, or that briefing or that webinar that you did at 4pm. So being able to adapt the information you have in a wider sector approach is really important. And also know what you friends are doing down the road. Because if you don't, you'll run into the unintended consequences of that

which is either shortages of drugs, shortage of diagnostic, over use of these things. And people become very confused. If you change your guidance, every other week.

Jincy Jerry 21:08

Thank you Mark, is there anything anybody else would like to add?

Luke Moore 21:11

I just wonder how many of us have anybody on the call and I guess I'm looking mainly at Stephen and Mark here. We got procalcitonin and just towards the tail end of wave one. And so we were still playing with it getting a feel and I guess part of the question from the audience this question might be might be derived around that. And I wonder if either Stephen or Mark, what they feel about procalcitonin as a stopping mechanism.

Mark Gilchrist 21:42

So I think it's a, it's a really useful tool, Luke, I think it's um, I think the problem we had in COVID is we didn't really know what the results meant we didn't know what what happened but in general yes it's good. But, you know, like our organization we were probably a bit late to the table when we started playing with it. And for us, anyway it was about the communication gap, what do you produce the result. But what does it. What does it mean and what does it mean to our ICU colleagues and ED colleagues and acute admission so I think, I think we're probably a bit naive to it at the moment we just need to learn a bit more, and would welcome other centres advice of how you've made managed to make it easy. I think

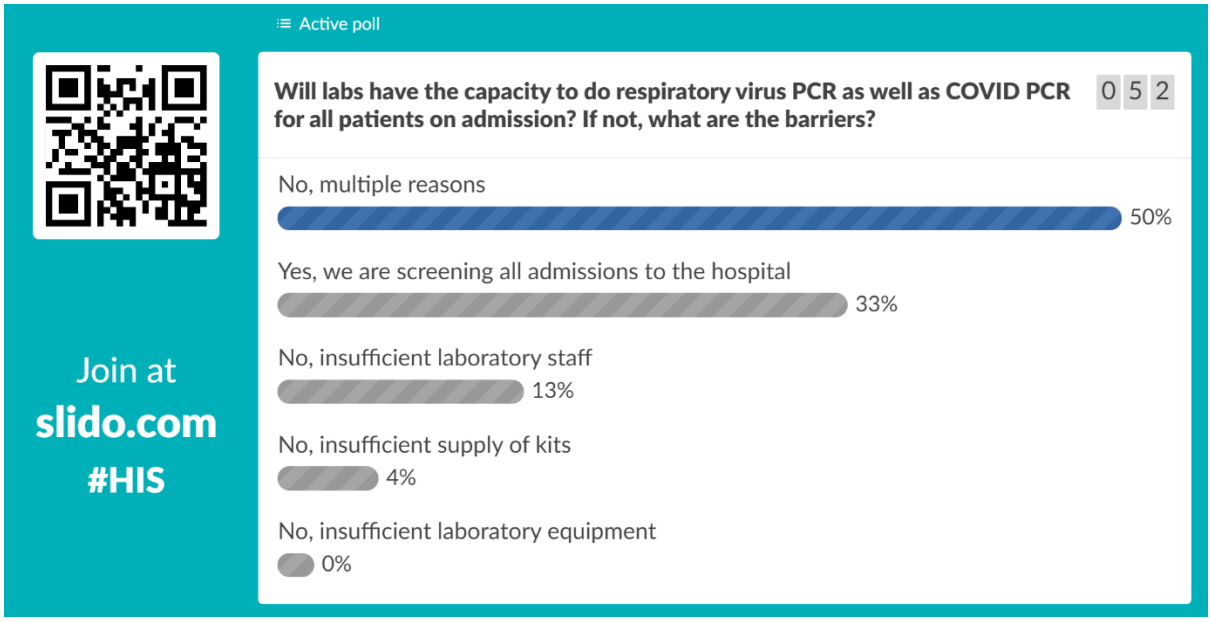
Stephen Kidd 22:24

It's something we've had at Hampshire hospitals for a number of years it was brought in by Sayed who has been a champion of procalcitonin for some time, and I think probably three or four years now we've had it so I know that we've had a number of clinical fellows, doing a deep dive on the PCT data. In most COVID positive patients and starting to get a flavour for how we can use it and I believe they are having some really good meetings at the minute to write a report on that and publish it so I think it's an interesting data coming out there so watch this space.

Jincy Jerry 22:57

Thanks everyone. And that brings us to the next poll. Will labs have the capacity to do respiratory virus PCR, as well as COVID PCR for all patients on admission? If not, what are the barriers?

Going to be an interesting to see what people have found on this.



So, approximately 50% answer is no, but for multiple reasons. Okay that take us to the next question. Can we use antibody status in conjunction with PCR to manage patient pathways? Mark. Would you like to take on this question?

Question 5:

Can we use antibody status, in conjunction with PCR, to manage patient pathways?

Luke Moore 24:21

So whilst mark is thinking about it, if you don't mind Jincy I'll wade in, the very short answer is no. The slightly longer answer is No, definitely not. And the facetious answer is we just we just don't know what the validity or what the immunogenicity of these antibodies are. So as many of you will be aware by far the majority of serological assays on the market, measure anti NP antibodies, which we know at least from animal models, do not confer immunity on the exposure of cells of SARS-CoV-2.

A small minority of the assays on the market, fortress as an example or the Imperial College dabber system, measure anti RBD anti spike antibodies and, at least in an animal model. There is some

evidence that if you are anti RBD antibody positive, then you, then you will get either an attenuated or no disease, when you are exposed to SARS-CoV-2 a second time, quite how that translates to humans, we don't know. And then, that's part one, part two is, how long do these antibodies last for, and certainly in the longitudinal serological assays, the smaller studies so I'm not talking about Siren which is obviously not reported yet, or React 2 which has only done its prevalence not its longitudinal work those two big studies are going to answer these questions, but the little studies that are coming through now and finding that both anti NP antibodies and anti RBD antibodies are waning by day 60 day 90 something like that. But what's that mean does that mean you've just lost your plasma cells and your now down to memory B cells? how is that going to react back up again when you're exposed a second time? we don't know the answer to any of those questions. And in separate to B cells there's obviously T cells, and how are they reacting to first exposure and then how will they defend us or not at second exposure, But the trouble of course as you all know, is that, you know, antibody assays are 5 quid or 10 quid that kind of range and T call assays are log or two log higher than that. So working that out it's going to be a long road. So can you use, going back to the question can you use antibodies in your flow, either your flow of patients, or your flow of staff return to work. No.

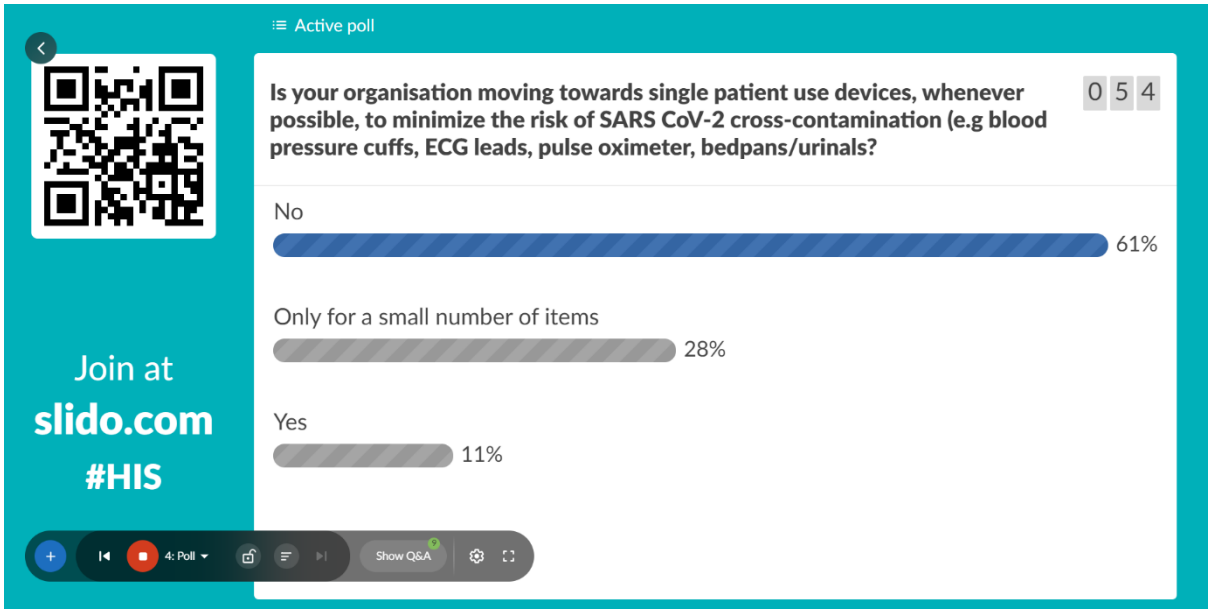
Which comes back to my very short answer from a few minutes a go.

Jincy Jerry 26:55

Thank you, Luke, really insightful, anybody else like to add on?

Okay, so then move on to the next question.

So our poll questions is, is your organisation moving towards single patient use devices, whenever possible, to minimise the risk of SARS CoV-2 cross-contamination (e.g. blood pressure cuffs, ECG leds, pulse oximeter, bedpans/urinals?



Majority says no.

Okay, so then go to the next question then. Anecdotally, there's an increase in transmission of multidrug resistant organisms and during the initial COVID wave. How do we prevent it going forwards and Mark, would you like to take on this question?

Question 6:

Anecdotally, there was an increase in transmission of MDRO during the initial COVID wave. How do we prevent it going forwards?

Mark Gilchrist 28:10

Yeah, thanks I'm sorry I lost my microphone and sound for a minute. And I think this goes back to what I was saying earlier around surveillance and understanding how you're managing your antibiotics. Back at base initially, but also the rapid diagnostic tests that you have available to de-escalate. I don't think anyone would forgive you to, you know, in the first 24-48 hours that you might have to go wider empirically, particularly if you're going into ICU and, and you've got different pathologies going on, but the real key here is the de-escalation there they're not not having patient on more antibiotics than we would want them to have for long periods of time. And I think you can get really caught in the trap of or they've had three days they're getting better. Let's just go for five. Let's just go for the odd numbers that everyone has in their psyche of antibiotic prescribing and, and, and not use what's around you, technology and diagnostics, and I appreciate that not, everyone has that. But, but there are some, some NICE guidance, and there are some principles that you can apply. And for us anyway it was going back to the drawing board or just reviewing our stewardship I guess aspirations goals and delivery outcomes, and to see whether or not we were doing what we said we were doing in practice. And some of the things we weren't doing as well as we thought we had to change them to.

Jincy Jerry 29:40

Thank you, Mark. Any other panellists would like to add? Yes Stephen.

Stephen Kidd 29:45

I would imagine, I'm probably thinking that as COVID hit us all really hard especially in the laboratory we started to drop a number of our routine pieces of work, and the pressure was put on the rest of the lab for what was deemed to be the most important piece of work, testing which potentially I'm not saying is the case could have picked out these multiple [inaudible] faster, probably might not be

important too quickly, had the lab be working normally under normal conditions so potentially patients were on suboptimal antibiotics for longer, than they would normally have had causing potentially a spread so I think it's probably a laboratory element as well with the pressures

Jincy Jerry 30:28

Thank you, Stephen. And that will lead us to the next question. What are the main similarities and differences between influenza and COVID-19 in terms of IPC precautions, cohorting, and management and isolation rooms are not available? I'm going to ask, Carole, to take the lead on this place.

Question 7:

What are the main similarities and differences between Influenza and COVID-19 in terms of IPC precautions, cohorting and management when isolation rooms are not available?

Carole Fry 31:00

Thank you. So, at its most basic level the IPC precautions for COVID-19 and flu, are exactly the same. I suspect in the main people adhere to the cautions better to COVID-19 because they're worried about catching it. And I think in the main when it comes to seasonal influenza people are not as vigilant about using those precautions. So it's obviously a high level of precaution if you are going to do an aerosol generating procedure we could spend the next half hour talking about aerosol generating procedures, which has become quite a decisive issues as all of you in clinical practice will know, just as an aside, the CMO has actually convened an independent AGP panel, and they are going to start to look at the evidence. They've commissioned a literature review. And one of the things they're going to look at is, I don't think any of us believe that all AGP's are equal in terms of the amount of virus that you disperse into the environment to see that there is some kind of gradation so we can have a more nuanced approach going forward. But it's a very blunt instrument, either you read the full kit for an AGP or you don't. And I think going forward, perhaps will we have more science more data to help us going forward, because it's been hard for everybody. So it's just about getting people to do it well. The other big differences that we have a vaccine for influenza. We don't currently have a vaccine for COVID-19, whether you can get your health care workers to get vaccinated of course is a different issue. I know Chelsea and Westminster when I was last there they did really well and got 85% of staff vaccinated which I thought was excellent. But other hospitals haven't fared as well. And that comes after a large piece of work to get yourself vaccinated. I do think it's going to be very interesting this winter to see

whether staff are more willing to come forward for an influenza vaccine, or whether he will still get the die-hard's who will not ever have it over their dead body it be interesting to see, and will those people be at the front of the queue when it comes to the COVID vaccines I think human behavior is interesting to observe during this, and I think that COVID has really shone a spotlight on IPC practice as Ebola did. Because when the only weapon in your armoury about how you control transmission of an organism, suddenly, everybody's really interested and my children and people say to me, now you're having a moment, people really want to wash their hands which is true. So, you know, every cloud has a silver lining. So I think it's just, just reminding people I think you have to monitor and audit continuously be available to answer questions, and just reassure people about about the PPE as I think certainly from where I'm sitting and I'm not on the frontline anymore. It's been too much emphasis on PPE, all everybody wants to talk to me about this PPE. And I think we've really got to educate staff in the hierarchy of controls. And actually when you're looking at your control mechanisms PPE is your last control mechanism. And you've got to look at engineering controls, work practice controls administrative controls. And there just zooming in to the PPE so I think we've got a bit of a PR job to do here to say yes, PPE is important in clinical environment clearly it is. But we know that some of the behaviours that healthcare workers, maybe they're fine when they're in clinical environment but when they get to staffroom. Sometimes they forget about it and we have well documented outbreaks related to staff and staff rooms, training seminars. And I think this is a message, we'll just have to keep reinforcing that the trouble is, if it's the same message are people hearing it? So are there innovative ways that we can engage them to get them to think about it. So it's just going to be more of the same, and doing it really really well but I think people do want to protect themselves from COVID so I think that does affect their behaviour. Thank you. Any comments from my colleagues.

Jincy Jerry 35:00

Thanks Carole, in the interest of time, we'll go to the next question.

How should hospitals manage simultaneous surges, and potential outbreaks in norovirus, influenza and COVID-19, when single rooms are in short supply and patients require isolation? Going to ask Carole again to take on this quesiton.

Question 8:

How should hospitals manage simultaneous surges and potential outbreaks in norovirus, influenza and COVID-19 when single rooms are in short supply and patients require isolation?

Carole Fry 35:31

I think it's going to be really hard this Winter. I think it is no no getting away from that. You know, I might be naive and hoping that maybe we'll see less norovirus transmission in hospital and people doing their IPC precautions well, maybe that's the vain hope but let's talk about it in the spring, I think, I think the only thing you can do is at the local level, you have to risk asses, and that sounds like a really fudgey answer, but it's not you know your hospital you know your patient population you know your hospital state you know your staff. You know what works for you, and I think it's communicating well with colleagues. I think if you can try and test different scenarios, maybe do some tabletop exercises, look at different scenarios on how you might configure things, what you come up with, first of all may not work so you need to evaluate is your plan working do you need to change, do you need to tweak it, listen to your staff that are working in these areas, they may see things that you don't, If you're just going to units just once or twice a day. So I think it is planning as best you can, but we have a lot of unknown unknowns I think to use the Donald Rumsfeld quote we have some known unknowns, but I don't, I don't think any of us really know what this is going to throw at us this Winter. I think we can say come up with some plausible scenarios. I think that, how easy it would be to retain green pathways in the middle of January, I don't know whether we're going to be able to maintain our sort of green zones I think that's going to be quite challenging. So I think it's going to be hard and plan as best as you can, communicate and listen, and talk to your colleagues, there is no magic bullet here unfortunately I wish there was.

Jincy Jerry 37:22

Thanks Carole, so I'll just open it up briefly to other panel members if anyone has any comments.

Luke Moore 37:32

Um, so I think I very much agree with everything Carole said but I think part of the answer to question 8 actually harps all the way back to question one we're talking about rapid diagnostics. And I think

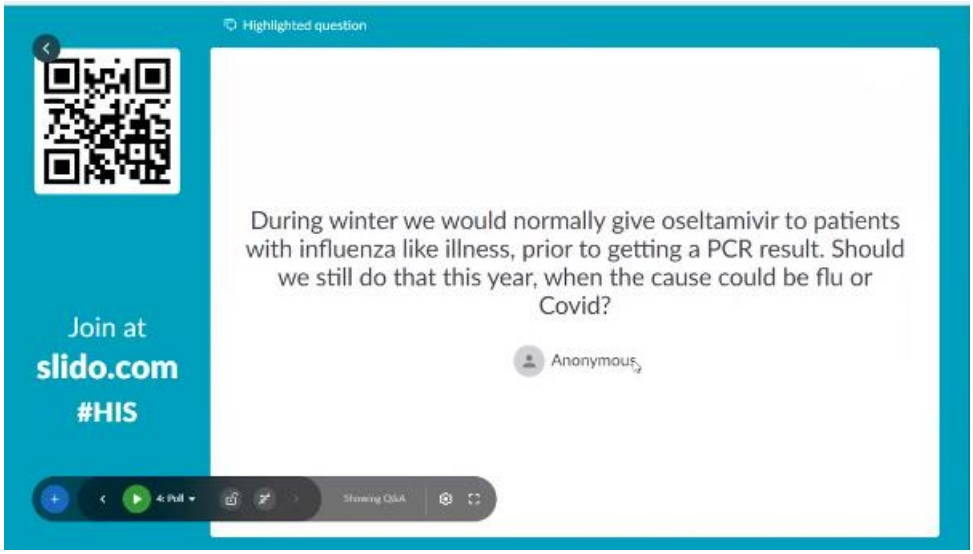
that'll help twofold. Because we'll be able to place positive patients appropriately, but we also have to be very cognisant, where we have tested patients with a low pre-test probability. Who then have a negative test, We can't, we can't keep them in side rooms. Granted, if they if they if they lurk and they feel like a COVID and you have a negative test give them in a side room but we've got to have some kind of de-escalation plan that is that is robust and pragmatic, because if we don't, we're going to very rapidly stock up our side rooms for all of these other winter borne viral infections. And so just, we're got to do that we're going to do that in the context of labs, having a COVID capacity crunch, and now we're wanting to add in flu I'm wanting to add in norovirus and C. diff testing and we just need to keep the diagnostic flow.

Carole Fry 38:40

Just to add to that we do need to remind ourselves that a significant number of patients are likely to be asymptomatic positive COVID. So that really reinforces that actually, if then you've, you've just got to show that they've got COVID, in a way, and just really assume that they are positive, until you are able to prove otherwise, because I think it's very dangerous and we don't know how effectively asymptomatic positives transmit to others. And that includes staff, as well as patients, and your colleagues. So, lots of things to think about. So it's really going back to basics and doing the IPC proportion really really well, and just educate people I know sometimes have PPE monitors or IPC monitors that go around and support staff. You don't want to get your finger out, because these people are under a huge amounts of pressure, how you can support them to get it right because they want to get it by they really do want to get it right. So be to supportive to them, to make sure they're doing the right thing.

Jincy Jerry 39:44

And I'm going to suggest that we move on to our live questions because we have like some really fascinating questions coming through. So, during winter we would normally give olseltamivir to patients with influenza like illness, prior to getting a PCR result. Should we still do that this year when the cause could be flu or COVID?



Who would like to take this question?

Luke Moore 40:28

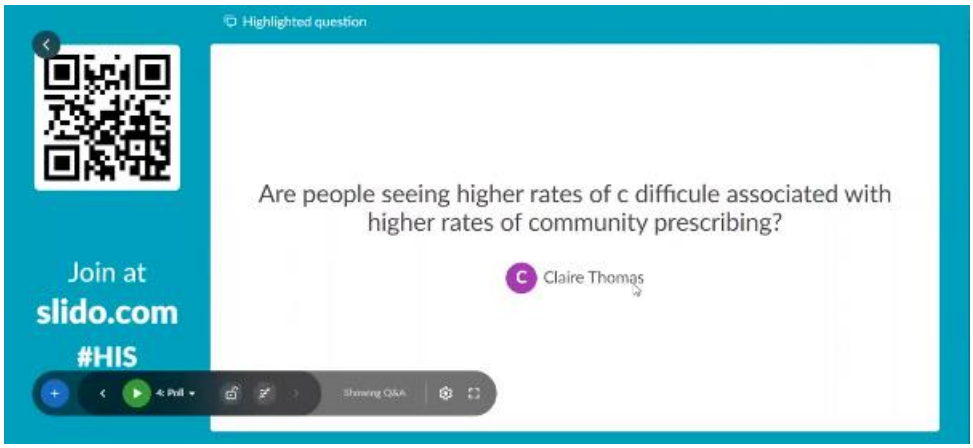
So I think something is different about this year from previous years. In that the pre-test probability of someone presenting with fever and new onset cough, is, is less likely to be flu, and certainly if you look at the epidemiological data coming out in the southern hemisphere, bearing in mind we usually take our northern hemisphere flu season. We take a guide from the southern hemisphere, then, then COVID outweighs flu. The second point is that we're going to be trying, as we've been saying for the last 40 minutes if it works, we're going to be trying to rapidly diagnose flu versus COVID we're talking about hours, if we can roll out Cepheidor Kierstat, Nudge or SAMBA or whatever we can roll out, if that works. So why why prescribe beforehand, I think, a slightly allied question is for those centers who are engaging with recovery or who are prescribing Remdesivir in line with extended Access Program. If you happen to be flu and COVID, if you're exceptionally lucky, should you have also Oseltamivir and Remdesivir and to that I will bow to people wiser than me, like, Mark.

Mark Gilchrist 41:36

It's a good question isn't it. We were discussing it today. What do you do in that, in that circumstance and I think the, the answer is we don't know. I think we were reflecting today around the evidence base for Oseltamivir here anyway. And we, and despite it going through multiple reviews in Cochrane and everything else we still reach for it. Don't wait for empirical therapy of patients coming through the door. So based on that and then the evidence of Remdesivir that's coming through. Will all of our patients get Remdesivir as well. I think this is going to be very behavioural driven. And I think, teams are going to find it really difficult to stop things. I think it's a great question. I don't have an answer for you and i think i think whoever solves it will be a better person than I but I have a real worry that you're going to, we will start, particularly overnight start someone on Tamiflu. They get a negative result, fine, but they're still querying about COVID, because the results being delayed or started on remdesivir, are they safe together, not sure. So I think it's an open question at the minute.

Jincy Jerry 42:51

Thank you Mark and Luke. Any other comments. As we go to the next question.



Are people seeing higher rates of C. difficile associated with the high rates of community prescribing? A straightforward question. Would any panellists, like to take on?

Luke Moore 43:24

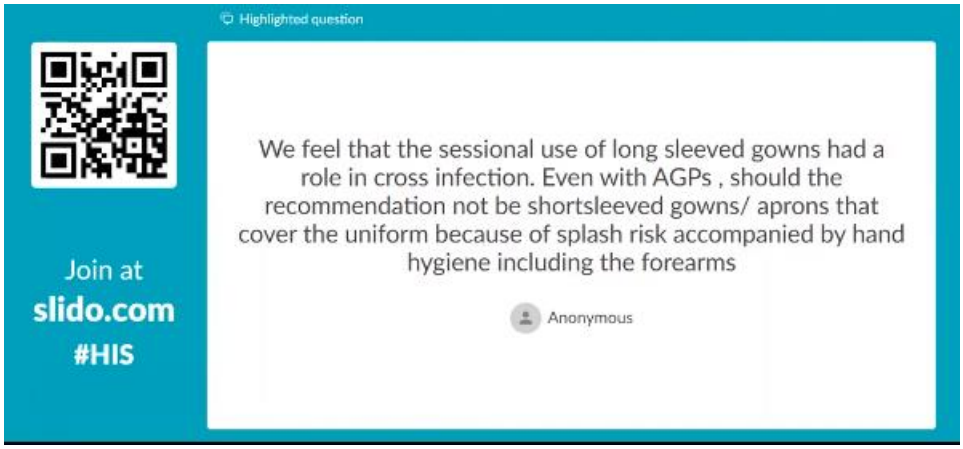
I will try and stop answering questions soon I promise. So from our west London experience from what we can ascertain the answer's no. But I think what is needed is one of the learned societies who has, who has access to national data, to put forward an answer to this I think it's valuable very valid question from Clare. I just say no locally but open question Mark.

Mike Gilchrist 43:54

I think locally we don't know when these things go in truncated time series don't they. I'm really interested in what's going to happen over the next couple of months, and I know we're going into winter, so we we've seen a difference in the prescribing some prescribing has gone down, and the general trend and in some areas going down but there have been increases in our augmenting use our Cipro use, particularly in primary care, and I really, we haven't seen that locally in our patch coming through. But I am watching it with bated breath, particularly as we go into winter season will we see this, this bubble, this squeezing of the bubble coming a bit later on. I think it's maybe a bit too early to have seen it at the moment.

Jincy Jerry 44:41

And we can move to the next question.



We feel that the sessional use of long sleeved gowns had a role in cross infection. Even with AGPS, should the recommendation not be short sleeve gowns/aprons that cover the uniform, because of splash risk, just, accompanied by hand hygiene, including the forearms. Please feel free whoever would like to take this question, yes Carole.

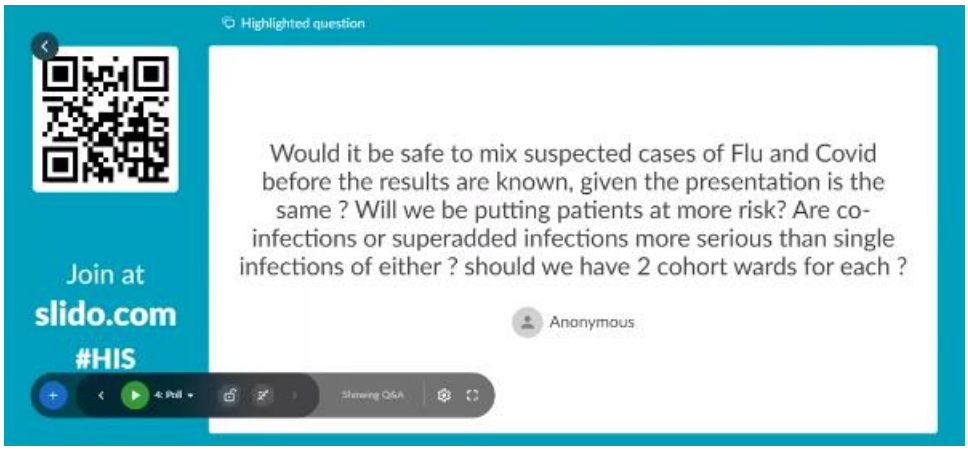
Carole Fry 45:22

So, I think you'll all be aware that sessional use of gowns was introduced because we didn't have enough PPE and was very different to what we would do outside of a pandemic. And I think that brought its own risks with it. And obviously have learned from that experience. And I know that it's probably associated with transmissions in multi resistant organisms so the law of unintended

consequences, while trying to keep yourself safe, it may have caused patients harm which clearly wasn't the intention. I gather that is now enough PPE that sessional use no longer has to be recommended. At the moment, I'll put a provider in there. This isn't a cop out but the NHS England wrote, led on the most recent IPC guidance and they continue to recommend long sleeve gowns for AGP's but I know there are colleagues out there who don't think that is the right approach. And at the of the day, the guidance is guidance, and I think if you think you have a better system that works for you, in your trust, then you do that. And I think as long as you have done an appropriate risk assessment, so you have thought through both the possible risks and harms to both the patients, and the staff. I think you do what works for you. So it's a it's, it's not written in tablets of stone, its not a legal document. And so I think it's to the Trust to determine if they think there's a better way for their intensive care unit to use that. And even if CQC if they go into trusts, I mean their, test is always about adherence to guidance. If you can show what you're doing is as good as or better than, and you have thought it through. That is fine. If you haven't thought through and haven't done a risk assessment well that won't be fine. So I don't think there's a right answer here. And I know that, but at least not using long sleeve gowns sessional I think has reduced at least for now.

Jincy Jerry 47:22

Thanks Carole and can we go into the next question please.



Would it be safe to mix suspected cases of Flu and COVID before the results are known, given the presentation is the same? Will we be putting patients at more risk? Are co-infections or superadded infections more serious than single infections of either? Should we have 2 cohort words for each?

Any panellists would like to take this question? Luke, yeah.

Luke Moore 48:13

So, I think, personally that it's unconscionable to mix unknown patients. But I say that, working in a building with a significant number of side rooms. For those organizations with fewer side rooms or whose flow of patients exceeds the rapid turnover of side room capacity to segregate patients who are awaiting results, which will become a particular problem, if the aforementioned rapid diagnostics do not occur, or are fallible, more fallible than we suspect. Then, then you got to have to, there's no way around that. I think what's perhaps even more unconscionable than mixing unknown patients, is where you have known flu and known COVID and you put them together, now I have no data that

superadded infections are worse, but it would seem biologically plausible, and particularly given as Mark was mentioning earlier, we do not know whether we can co-prescribe are two of our mainstay agents however much you believe they may be effective agent or not, I think, I think, why would you do that. Now, it's, it's very easy for me to say and very hard for lots of patient flow pathways to do that. At this planning stage in mid-September, and it's going to be even harder to segregate these patients in, in November, but I think we have to try right?

Stephen Kidd 49:46

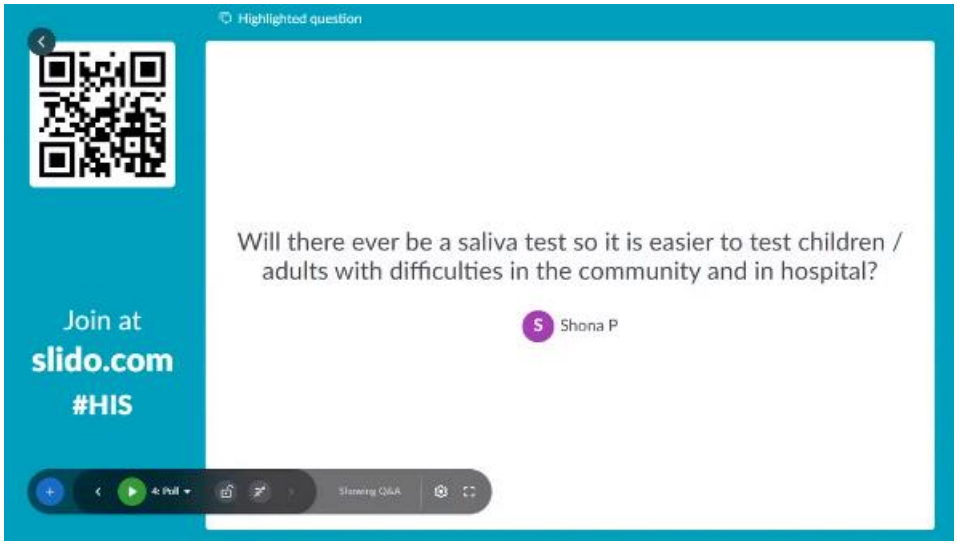
Yeah I fully agree. I think this is where the rapid diagnostics does come in and in lieu of any point of care resources could be a shortage of agents, and when they do full fully come online that a number of hospitals are setting up near patient hot labs near the front door to be able to do this obviously Tristan in Southampton has done that we are planning to on both our sites. So we can answer that question as quickly as possible so you will see patients who are symptomatic cohorted initially, obviously, pre diagnostic and then as soon as they got their diagnostic they'll be whipped out as quickly as possible so I think basically, people often refer to these as amber wards. Now, I think if you can get your diagnostics, almost as they're ready to be admitted so you know with, obviously with a great will in the world people need to journey get admitted within 20 minutes so within an hour, an hour and a half and most of the decent points of cares which will have a proper impact so you're looking at now 15 to 45 minutes this way, or we see, most of them will be aiming for is you they will have a result before they're officially admitted, so they can actually go to an appropriate Ward, out of the holding areas in ED, and elsewhere so diagnostics diagnostic diagnostics so test test test, as they say, so thank you.

Mark Gilchrist 51:12

Sorry, Jincy, I was gonna say, I guess the concern for me is that is that if that diagnostic pathway doesn't actually work and and you are bringing patients together. I guess what we haven't talked about the unintended consequences of these patients who will be put on antibiotics because they've got a chest infection when they come through the front door, that will happen at 2am, and how quickly they are, they are reviewed, because the unintended consequences of that is that you get potential c diff other, other things and then that goes on a ward and then you're in a real state. So I think it does come down to having it might not be perfect and I think that's the thing that we've found that the guidance you issue is subject to review. But, setting up some principles and best practice principles, particularly around the prescribing game, and talking to your senior clinicians is really important, because sometimes they are forgotten. When you're talking about flow diagnostics, other testing these simple things are just worthwhile bringing back into people's mind.

Jincy Jerry 52:21

Thank you everyone. And I think we have time for one more question.



Will there ever, ever be a saliva test so, it is easier to test children, adults with the difficulties in the community and in hospital? A question on testing, Luke oh sorry, Stephen.

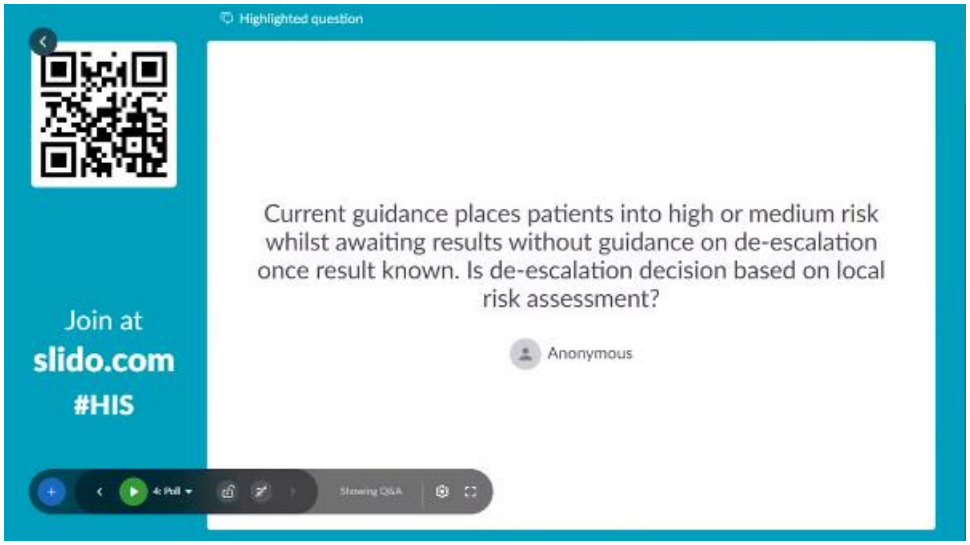
Stephen Kidd 52:50

Yes, there will be. I think we're just coming to the end of a big pilot, between a University of Southampton and University Birmingham and ourselves from out of [inaudible], a team looking at saliva testing looking at the best way of protein map testing, because people don't like repeat testing they don't like testing with swabs it's particularly unpleasant, especially if you're looking to maybe a symptomatically test asymptomatic staff or screening programs that there definitely will be some testing strategies using saliva, I think it's the only way that we can sustainably keep testing for the winter. Two reasons like I said it's not in place that swabs are pleasant, having swabs and also we could run out of swaps again, which is obviously something that could happen. I mean supply chain is often stretched and will be further compromised I'm sure this winter.

Jincy Jerry 53:56

Any other comments? We may as well go to one more question.

Current guidance places patients into high or medium risk whilst awaiting results without guidance on de-escalation once result known. Is de-escalation decision based on local risk assessment?

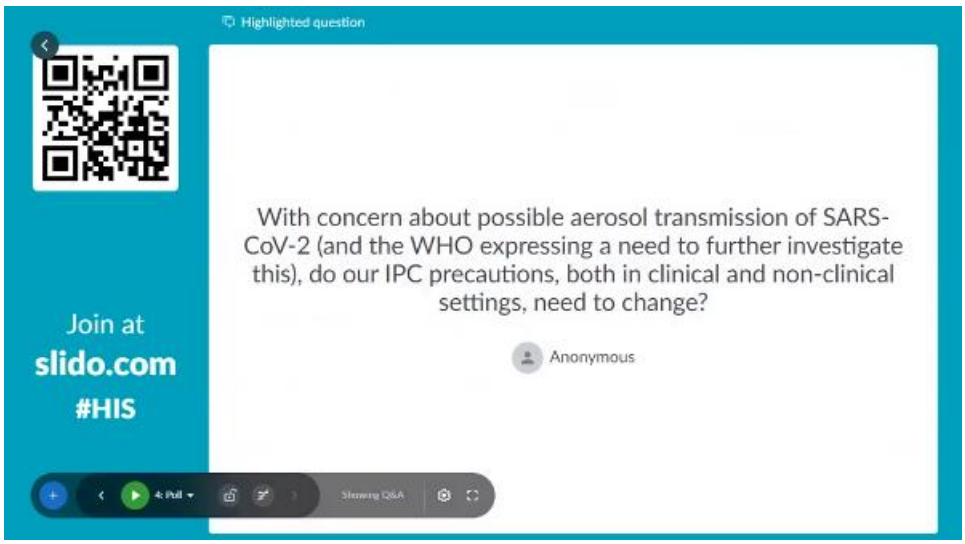


Carole Fry 54:35

So, this has been become very apparent since the new IPC guidance was issued that this needs to be addressed at NHS England can as we speak, are trying to provide information to help that process because I think, going from red to green is relatively straightforward, but if you want to go from amber to green, it's not as clear as it could be, to that is very much work in progress I don't have the absolute answer now, but it has been addressed and hopefully that will be out fairly soon.

Jincy Jerry 55:07

Thank you, anyone else would like to add? We have four more, minutes, shall we go ahead with one more question? It concerns about possible aerosol transmission of SARS-CoV-2 and the WHO expressing a need to further investigate this, do our IPC precautions, both in clinical, or non-clinical setting, need to change.



Carole Fry 55:44

I'm not sure I understand the question I can't see the question that's problematical, let me just try and see it. So obviously the aerosol generating procedures, and I know when there was a lot of noise in the media about aerosol transmission, WHO did a rapid review of the evidence. And I think they felt there wasn't enough evidence to suggest that outside of aerosol generating procedures, it was a lot of aerosol transmission. Just because you can recover a virus some way away from the person doesn't necessarily mean it's going to infect other people, and my own personal belief is I think we'd be think very different patterns of transmission if aerosol transmission was a significant factor I think we'll be seeing something quite different, because most of those they are post contacts with somebody that had COVID. And so I think it would be something much more diffuse pattern of infection. But as ever with all these things the evidence is kept under review. And you do as when the evidence changes, we will adapt the guidance accordingly. And that's why WHO talks about ventilation, so you know about getting airflow so getting your airflow changing. But I think with everything with COVID we need more research we need more research and evidence that we don't have the definitive answer. You know we're in our ninth month of COVID so let's remind ourselves that while there is a lot of literature out there. I'm not sure that it always provide the evidence but let's not go and start to debate that now.

Jincy Jerry 57:24

Okay. And so this leaves me to say a big thank you to all our panel members, Stephen Kidd, Luke Moore, Carole Fry and Mark Gilchrist. And also, a big thank you to Healthcare Infection Society for hosting this event, and to everyone in the audience for listening. Again, don't forget to tune in to our next webinar, the details will be coming up shortly. And I appreciate everyone, and happy evening. Thank you.