

## Transcript: Webinar - COVID-19 challenges and solutions

How COVID has changed my field | 16 June 2021

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

### Panel members:

- **Greg Fell**, Director of Public Health, Sheffield Council
- **Jim Gray**, Editor-in-Chief, Journal of Hospital Infection
- **Diamantis Plachouras**, Principal Expert Antimicrobial Resistance and Healthcare-Associated Infections, ECDC

**Chair: James Price**, Director of Infection Prevention and Control, Imperial College Healthcare NHS Trust

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**James Price 0:09**

Good evening everyone. Thank for joining today's webinar on How COVID has changed my field which is hosted by the Healthcare Infection Society. My name is James Price, and as well as being a DIPC at Imperial, I chair the Professional Development Committee at HIS. We have a fantastic panel of experts here today to provide their personal thoughts on how COVID has changed their field of work. So I'm gonna start by asking them to introduce themselves. So let's start with Greg. Hi Greg.

**Greg Fell 0:40**

I am Greg Fell I'm Director of Public Health in Sheffield

**James Price 0:45**

Great, you are very welcome. Let's move to Jim. Hi Jim.

**Jim Gray 0:48**

Good evening everybody, I'm Jim. I'm a jobbing consultant microbiologist at Birmingham Women's and Children's Hospital, and I'm also the editor of the Journal of Hospital Infection.

**James Price 0:58**

Jim you are very welcome. And last but by no means least, we have Dr Diamantis Plachouras.

**Diamantis Plachouras 1:08**

Yes, hello everyone. So I am a Diamantis Plachouras from the European Centre for Disease Prevention and Control. I work with and microbial resistance and healthcare associated infections, and I'm very happy to be here in this webinar with you. Thank you.

**James Price 1:27**

Thank you. You are very welcome, thanks to each of you for volunteering your time to give your personal views on this topic. So, before this webinar we asked you to submit your questions to our panel. We've selected the most popular questions to discuss for the first 40 minutes or so. And during the last 15 minutes we're going to answer your live questions which you can submit during the webinar via Slido. So for those of you who haven't used Slido before, this is an app which you can download and you open it up and you enter the code #HIS. And this will point you to the right place to submit any questions you want answering, within reason. And you'll see on there as well that there'll be other questions that have been asked. Do feel free to 'like' them so we know which are popular that we can ask them at the end. There's also the ability to use your laptop I through the Slido website. So without further ado, let's move to our first panelists.

To answer the first set of questions so I'm gonna reach out to Greg first of all. Hi Greg. So there's two questions that people are particularly keen to ask you the first one is

Over to you, Greg.

## Question 1:

How has COVID-19 impacted on other public health objectives?



**Greg Fell 2:46**

Are there any other public health objectives? Is the really short answer to the thorny question.

So, the short answer is, we've dropped a load of stuff because we've had to focus on the most significant global public health emergency that I hope we will ever see in our lifetimes. Famous Last Words and touching some wood. You can't not respond to a very transmissible respiratory virus with more than 1% case fatality rate. That's a big deal. So, we've dropped other stuff.

The longer answer to the question. Firstly, what's in the black box that's public health? Just so that folks know, so, so I've got about a 25 staff that cover five/six broad functions. Firstly, health promotion, which is everything from cigarettes, alcohol, obesity, lack of sweat, aka physical inactivity and right the way backwards through to poverty housing policy, economic and employment policy, and all things in between. Secondly, health intelligence applied by demography and applied epidemiology, help all your people, what do they fall ill with? etc etc. Third is around NHS and social care advising NHS and social care on commissioning and provision health, health and social care quality clinical and cost effectiveness, etc. Fourth is the public health grant which is what most people know is public health so health is things on nursing sexual health, tobacco. Tobacco treatment services alcohol treatment services - things that fall into that space. Fifth is public health leadership - whatever the hell that actually means. And lastly is health protection.

There's been a really really big health protection issue that's been going on for about 18 months now you might have noticed it's called SARS-CoV2. So, but there's other stuff in that black box which also includes a whole bunch of other IPC type of stuff also includes vaccination also includes screening also includes response to chemical incidents etc. So all of that is the stuff that's in the standard day job Directors of Public Health.

For almost most of that, my 25 staff have dropped, most of it to focus on COVID for the last 18 months or so now. There will be payback for that, because it's perfectly apparent there lots and lots of other things are going, going awry going off course, losing the thread losing coherence. There will definitely be a payback for that. We're trying to get an exit strategy out of COVID-19, but it's proving quite difficult because we're about to enter the fourth wave if you live in the north of the country. The third wave if you live in the south of the country. So the exit strategy for people with the words public and health in their job title, won't be for another nine months. If there are any public health specialist on the call, I'm very sorry to have to break that bad news, which I doubt will be good news to any of you. So, other stuff. Maintaining core services, so some of the stuff was funded by the bag of cash, sexual health, health visiting, district nursing, tobacco control drug and alcohol services, maintaining some of that has been really rather difficult over the course of the pandemic, as particularly clinically trained people are pulled off their day job to do acute response to COVID. Quite understandably, absolutely and rightly, but maintaining some of the core stuff has been really difficult.

Also, massive demand, so we're in the business of social and economic impacts of COVID - financial cliff edge is a massive deal. There's huge swathes of the population now facing very very difficult financial circumstances as a result of the recession that we will be in, layoffs economic macro economic stuff. Furlough will come to an end eventually, and that will lead to significant financial hardship and eviction bans for people in insecure housing. All of that will have a massive impact on demand for services funded by Public Health either directly - Citizens Advice Bureau for instance - or indirectly in terms of the knock-on consequences and demands.

Well, last thing that it's not really a how's this change my practice but the pandemic is really really brought into sharp focus the question of who is accountable for health? The NHS is accountable for health care. No doubts. More things than health care contributes to the health of the population, poverty, poor housing, air quality, could go on for a long time. Who's accountable for health? No one's really able to answer that question we all study the carpet at that point for an interesting pattern.

So not a new question, my practice hasn't changed as a result of it, but it has gone into really really sharp focus. So short answer is, we've dropped a lot of stuff. Long answer, is complicated. I've given you some insight.

#### **James Price 7:48**

Greg, thank you. Food for Thought. As you're suggesting to try to get back to a normal, what is the what is normal or what is the new normal game going to be? It's fascinating. I'm sure that's raised a lot of questions in our audience so please do put your questions in through Slido. And we'll aim to come back to those later on. What I'm going to do is stick with you now come on to the second question, if that's okay because we don't like to give people any rest time during this. The next question that people are really interested to understand is

## Question 2:

What new insights has the pandemic revealed in health and social care inequalities?



00:01



We'd really like to get your thoughts on this.

### Greg Fell 8:34

So it's a good job I was prepared, and he gave me some insight. So I had five minutes to prep. So not really any new insights to people with went public and health in their job title, certainly. But what the pandemic did - what we'll have - because it's not going away - what it did do is shine a very very harsh light on the inequalities in health outcomes, and access to services, that were already there. Really, unfortunately, [Mike Marmot's "10 years 10 on report"](#) was published in February. February, early March last year, just as it was all beginning to kick off, but if anyone ever wants the answer to the question of how to solve health inequalities, my stock answer is read Michael Marmot's report and implement the 242 recommendations, the end. It is not quite as easy as that, as we all know, my mother produced his 10 years old report. In February, early March last year, and it really wasn't terribly complimentary about the last 10 years and basically said life expectancy - which has historically been improving - has stalled and a gap is now starting to widen. So COVID has just basically shone a light on that. Some, some specifics: COVID has really really highlighted the interface between infectious disease and the social determinants of health, which you can't always know is there. TB has always been an issue of poor-quality housing, overcrowded housing communities, well, COVID has demonstrated that again. As if we needed to be demonstrating again, particularly around isolation, one of the better bete noires of the whole pandemic is that there's a large group of people who are on insecure, contracts, cash in hand, low pay, living overcrowded housing. That can't afford the financial consequences of 10 days isolation. It's fine for me to just be in my spare bedroom for another 10 days. So all of that stuff is way upstream of the recommendation that you need to isolate. That's had a massive difference on ongoing transmission rate. So, the interface between the social determinants of health, however you want to frame that and infection has been writ large again. But through the whole pathway from exposure to infection to harm, and then to long term social and economic impact that comes from nearly a year and a half of lockdown is all unequally distributed, and has really shone a sharp line on the haves versus the haven'ts. We will be dealing with the social

and economic consequences of this regeneration that will not be equally spread. The haves will probably do okay, the have nots might not.

A very specific example, unemployment in the sectors that are most affected by the pandemic, hospitality, in particular, will have a very, very tough time over the next few years, that will most affect young people who work in hospitality - that will have a scarring and lifelong social and economic impact that will translate into a health impact by further down the line. So, now, that's the kind of the learning, arguably not new, but all of the stuff that was in play before COVID is really, really, really in play now.

**James Price** 11:58

Thanks Greg, presumably this has been a learning process for all of us. And as we go through, we continue to learn that, without wanting to be the bearer of bad news I'm sure we're all aware there are other folks out there that are probably going to be contributing and how that's going to contribute, or those are going to contribute as we go through the next wave and winter. Fascinating.

So, we have quite an interactive session here so do everybody put their questions on Slido you'll see some questions have already gone up so like the ones you like and we will aim to answer those. So Greg, thank you. I'll give you a break now and we'll move on and talk to Jim if that's okay.

Jim, thank you again for joining us. So, two key questions that have come up to ask, in your capacity as editor of JHI and the first question that's come up is around COVID related articles, or open access and how to get your thoughts on how this has been managed across the journals and what impact it is likely to have in the future. Thanks Jim.

### Question 3:

All COVID related articles are open access:  
how has this been managed across journals,  
what has been the impact and what is the  
future?



**Jim Gray** 13:13

It's a great question, and I think really all of the this came from the publishers very early on. In retrospect they deserves, enormous amount of credit for recognizing that COVID was going to turn out, like it was. Because if you look back into the pages of JHI and at the beginning of 2020, we were

publishing articles from people like Didier Petit at WHO in Geneva, sort of saying well we don't know how this is gonna work out, it might actually be alright, or it might turn into a pandemic. But already the publishers had nailed their colours to the mast and said we think it's gonna be a big thing we want things to be open access. And I think all journals were contacted by their publishers to see whether they were willing to take part in this Open Access Initiative and of course we we did like like most other journals. And I think we didn't really know where it would take us, because my early concern was that so does that leave based on our local experience, where we're life or just turn to thinking about COVID and nothing else. I did wonder whether we were going to see a drawing up of any papers on anything other than COVID. And basically, journals would just turn into COVID publishing machines. And in fact, it, it just never, at least not so far it has never turned out like that, because we've continued to get pretty much the same number of papers on subjects other than COVID that we'd always been getting. And what we've had on top of that is probably another twice as many papers on COVID And really that's only begun to settle down in the last few weeks, so from about last March through to about March or April of this year, we've been getting 10 or more submissions a day. Compared with the normal three or four that we'd expect to get. And I think, in a way that's been quite a relief for me, because there are two things that I think people connected with journals (be it the editors, or the people in societies who count beans from the journals) are concerned about. One is impact factor, and the other is finance. And if you have a journal that follows the same sort of subscription model that JHI does, and if we had ended up in a situation where 90% of our papers were open access anyway, then that would have had a significant risk for not only the existing revenue for the sidey, but also the revenue going forward because I think people would then be challenging, whether there was, there was a need for such a subscription journal again. So, so I think it's been quite a relief that actually what's happened during the pandemic is that the journal has got fatter, and it's got fatter because we've continued to publish what we normally publish. Plus, a good chunk of COVID related papers as well. And then the other thing which none of us really have got much idea on yet, is what the impact of COVID is going to be on impact factor in the next two or three years ahead. Because the way that impact factor is calculated is on the number of citations that are received in two years following publication. So a paper that's published in 2020, it's only the citations in 2021 and 2022 that count towards impact factor. And for papers published in 2021, it will be 2022 and 2023, and so on. So, if you were to become a journal that was very very dedicated towards publishing on COVID and not a lot else. I think the risk is that as we come towards the end of the pandemic and people stop or slow down, publishing on COVID, they're going to be less likely to be citing the articles that you have published over the preceding two years. So I think there are some unknowns around that in the future.

But I think it's been really reassuring from an JHI point of view that open access hasn't taken over from the sort of standard model so far and we've still managed to maintain a good throughput of papers across a wide range of of subjects other COVID. Quite hard people find time to write them, I have sometimes wondered about. But that's what, that's where we are. Thinking to the future. There is a lot of debate about that at the moment. And I think it even starts before open access, and it starts with the massive expansion of pre print publication that COVID has brought along with us. So, so many of the submissions that are coming into journals now have been sitting in preprint access for for many months, and as an editor, it's kind of sneakily quite useful because if you see that it's been sitting in preprint for nine months before it's submitted to you, you know, it's been somewhere before has come to JHI. And that sometimes helps you think well, actually, other people looked at this and not really thought it was worthwhile. So, let me look at it in a bit more detail and see where we're going with it. But I suspect that the industry preprint is gonna expand, but I think already some of the bigger pre print server sites are are actually having starting to screen things before they accept them because

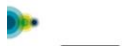
of the quality of some of the articles that are on them. And I don't know, there was a lot of and has been a lot of pressure or last two, three years on, on making all journals open access. Difficult to know whether COVID will be a game changer in that or not. I think we just need to wait and see.

**James Price 20:10**

Thanks Jim, it's great to hear that people are continuing, non COVID research and I can only imagine it's all done instead of sleep, it'd be interesting to see I kind of sleep deprivation study to compensate for research. So, thank you. I think this leads nicely onto the next question that our audience were keen to understand. How is COVID research progressed through the pandemic and, and how has this impacted non COVID research?

### Question 4:

How has COVID research progressed through the pandemic and how has this impacted non-COVID research?



I know you've looked at some of that they've interested to hear a bit more about the progress thanks.

**Jim Gray 20:43**

Yeah, thanks. I mean it is it is an interesting area, and I think when we look back on COVID and you look at the enormous amount of work, that's been published. My personal view is it falls into two groups. Remembering that a year and a half ago nobody had heard of COVID and nobody knew what was coming. There are obviously some really big, rapidly put together trials that have been central to to defining the treatment of COVID. And obviously those papers are going to go into the really high impact journals. Other than that, nobody's really had much time to plan their research around COVID.

And that I think has a number of things that we can think about. Very early on, we sat down as an editorial team in the journal, and thought, well "what are we going to do that can help our readers in this?", and we had some information about the perception of the journal amongst readers. And we knew from that work, that one of the areas that we were perceived as being particularly strong on was disinfection. And so, so one of the areas that we really tried hard to publish on early on, what was evidence for the use of disinfectants against SARS-CoV2, and I think it was in March or April in 2020



we [published a paper by Gunter Kampf](#) in Germany - who many of you will know, is a very strong supporter of the society, and the journal - is a real expert on disinfection. And I think there a couple things that I would say about that. One is it probably gave us an insight into what I think almost every other editor of journals was experiencing at the time, which was, you had this urgency to try to get things into press as quickly as possible. And I think others we're rushing to get things published as well. And there was an enormous amount of scrutiny of the paper. And we didn't have any serious criticisms of it by our journal standards. I think there were a couple of people who, who wrote letters to the journal, and we actually took a precaution of having an independent editor review the paper to make sure that we didn't need to retract it. And I'm pleased to say that all we did was we published an author's clarification from Gunter going through just on a couple of points where it was felt that he kind of may not have fully explored the existing literature around the effective disinfectants on coronaviruses. The paper has been very heavily cited and very heavily covered on social media. So I think that was the right area for us to focus on as a journal.

And the other thing that we tried to do was to try to publish things quickly often in letter format because people obviously didn't have enough data, or hadn't had the time to convert the data into a paper, and I'm not sure how useful readers found that. But certainly, as an editorial team I think we found it quite useful in when we were sort of writing our own policies for the hospital and you could sort of think, we've heard from Italy. One I can particularly remember was was a recommendation that serious trauma cases should be screened early for COVID. Because by the time they came hospital, they had been seen, often by multiple members of the public and multiple health care professionals before they even reached hospital. And certainly we we incorporated that into our local policy.

And then I think if you if you kind of follow what happened in JHI, it's sort of almost, we get clusters of papers depending on what was, was popular at the time so for last summer we've got an enormous number of papers on the reprocessing of PPE. Then, once antibody testing became widely available, lots of papers were submitted - we didn't published too many on seroprevalence studies. And then I think that sort of moved into vaccination. And I think the point we've got to now is that I kind of feel that a lot of the anecdotal stuff that we were prepared to publish a year ago there is not an awful lot new to be said about experience with, with COVID. I think what we're particularly interested in now is people's experience of what they were not able to do during COVID, and what the impact of that has been, and also what they might learn from COVID that might choose to practice going forward in terms of other infection control.

So for me, I think the key thing for a journal like JHI is I think we've been quite lucky in that we've been able to publish COVID on top of the other stuff. And that means that when we reach a point when there is nothing interesting to say anymore, we can kind of switch that off quite quickly and get back to business as usual, with just a little bit about the sort of lasting impact of COVID and the way that we practice, but it's worked out for us, a lot better than I thought a year ago, it might, in, we've been able to carry on doing what we always did.

#### **James Price 27:38**

Thanks Jim. Great to hear, and also be interesting to see whether the readership - the audience - has changed as well. We know that people have an interest in infection prevention and control particularly who maybe didn't have one before the COVID pandemic and so whether that's changed as well but it's, it's fascinating to hear how things are evolving. Thank you, Jim.

I'll give you a rest for now, and we'll move on to talk to Diamantis and before, before we do that I'm just going to remind everybody that we've got a few minutes left to submit your questions, and to like those questions that have already been submitted. Our team are working hard to prepare those. So while they do that, let's move on to the Diamantis.

Hi, welcome and again we've had a plethora of questions come in for your thoughts on the first one that really struck out was a very small question to answer and so would be great to hear your thoughts.

## Question 5:

How has the COVID pandemic impacted HCAI and AMR across Europe?



### Diamantis Plachouras 28:40

Yes, thank you. Yes, indeed I mean after several years in which people who are working with antimicrobial resistance where, you know, used to AMR being, you know, one of the highest public health priorities and actually also many years of extensive efforts to keep healthcare associated Infections under control. The pandemic came and actually has monopolized infection control both in terms of actions and resources, who have heard about it also before. So it's certainly of great interest to see what is the effect of the pandemic, on, on these two issues that are very, very much late, of course. Now in terms of healthcare associated infections, I think, one obvious point is healthcare associated COVID-19. So, hospitals and long-term care facilities such as nursing homes have been, of course, more frequently affected by outbreaks. We think infections are spreading among basins and staff. I mean the impact on nursing homes is very well known and very clearly demonstrated but I think a lot of for acute care hospitals, it has been a bit of an overlooked problem. Data so actually that almost one in six hospitalized cases with COVID had healthcare associated with COVID, most likely. And this, in general, I mean, the whole picture may be a small but I think still a sizable proportion of the total number of COVID cases. And we should not forget that it can be linked to mean a disproportionately high burden, due to the fact that hospitalized patients are vulnerable with very often multiple comorbidities and are prone to really unfavourable outcomes.

Now, another point I think that was very, very interesting. During this pandemic in terms of healthcare associated COVID of course. And in addition to the large number of healthcare workers that had had COVID - was that in the beginning we were expected that it would be mostly a problem of severely ill cases transmitting the disease - where one would be exposed to what is known as aerosol generating procedures. But in the other thing is, it appeared more that healthcare associated COVID is probably mostly also or at least similar degree linked to two cases that are undiagnosed, that come to the emergency department with probably mild symptoms or early the disease. And then there, people are probably not using, or at least in the early stages, we're not using personal protective equipment or the whole system - the whole administrative process was not yet prepared to address these, these patients. But even now, in the second year of the pandemic, and even now we have a substantial proportion of vaccinated healthcare workers that were still seeing outbreaks in healthcare settings. And this I think shows how big a challenge that it is for prevention, even in settings with trained staff, and who are familiar with infection control.

But of course it's not only healthcare associated with COVID. We should not forget, other healthcare associated infections and antimicrobial resistance which again they are very much related. At least for healthcare settings.

Now, in ECDC here the European Center for Disease Control collects data regularly on antimicrobial resistance. Every year as a surveillance network. However, we cannot say yet from regular surveillance data from 2020 what is the effect on antimicrobial resistance because we are seeing the process of collecting these data, and the results will not be available before later this year. However, from the literature, we can identify two opposing forces in both. I think that the two main factors that that affect and antimicrobial resistance, and also apparently healthcare associated Infections one is antimicrobial use, and the other is infection control practices. So on the one hand, our antimicrobial use in the community seems to have increased during the pandemic, probably among other reasons because of lower number of visits to primary care, and probably also lower incidence of other respiratory tract infection. COVID was really monopolizing that too. There has also been in in healthcare at least really increased focus on infection control, and, in principle, these to lead to fewer healthcare associated infections, but it remains to be seen because antibiotic use for patients with COVID-19 has a very high and very often empiric out of concern for bacterial infections, which has not been proven to be the case, actually, and also secondary infections. Now in terms of infection control there are reports of practices, such as not changing gloves or gowns from one patient to the next, or using double gloves and these practices have not traditionally been considered preferred infection control options, and may be related to increased transmission of both multidrug resistant bacteria and other pathogens.

I think even more importantly, a high workload is an important factor leading to poor infection control practices. The substantive workload on healthcare workers, due to COVID-19 can certainly have had a negative impact on both healthcare associated infections, and the spread of antimicrobial resistance. Last but not least I think at national level, the implementation of action plans against the antimicrobial resistance, may have been slowed down or even discontinued due to their reprioritization of resources. So I mean, altogether, we cannot foresee exactly how these opposing forces will play out so we're looking forward to seeing if any observable effect on AMR will be detected from the upcoming surveillance data. However, we need to keep in mind of course, that any potential impact on AMR may not be immediately obvious. It may take a few years to see how things will evolve, and whether, in the end there will be any long term effects from the pandemic on AMR and healthcare associated infections.

**James Price** 35:48

Thank you and as you say, it's going to be interesting as we go forward as people become more maybe more comfortable with the PPE that's being worn and maybe become more comfortable with using more narrow spectrum agents in terms of treating superimposed infections and not suggesting that all multidrug resistant and what the trends are going to be related to that and it's going to be fascinating. Let's stick with you Diamantis for your final question, if that's okay and this is a number of people have been really interested to understand this, what do you feel the legacies of the pandemic, are going to be regarding surveillance regarding these kind of health care associated infections, thanks.

### Question 6:

What will be the legacies of the pandemic for surveillance and HCAI?



#### Diamantis Plachouras 36:29

Yes thank you. I think, with one word I would say, acceleration, for a for surveillance, at least. This would be the the key word. First of all it was impressive how rapidly surveillance for COVID-19 was set up, but also the wealth of information available to policymakers, but also the public at a global level, on a daily basis. I think this showed clearly the capacity and the value of surveillance. Therefore, to collect, analyze, interpret and then service data at all levels, I think are commendable and there is definitely going to be a legacy from this. In addition, we would like to go a bit more, more specifically, I think the pandemic accelerated immensely the implementation of molecular methods and surveillance. I mean, we see very clearly now especially with with the variants. There is everywhere we see, development and building up of capacity, and of generating and analyzing and sharing information – it is impressive how much control we have over this now; how closely, we're monitoring the evolution of the viruses in a way. And with the data being available on platforms, globally, I think this is one of the greatest successes that we have been monitoring and eventually controlling the outbreak. So certainly with the capacity building that is taking place during the pandemic, we will be seeing more and more use of molecular sources and methods in surveillance for other diseases as well I mean it's certainly going to happen. But of course I think right now, during the pandemic, everything, all resources are focused on, on COVID, so we need to ensure in the future the availability of infrastructure and human resources for data acquisition, data analysis, interpretation and sharing to sustain these things and promote also further development of other innovations in surveillance. I would highlight automation, for example in multiple levels, which is

really needed. And I think will help us, you know, collect more fruit from, from all of these. In terms of healthcare associated infections, the legacy of the pandemic. That's also very, very interesting, I think, on the one hand I think the pandemic illustrated the importance and impact of healthcare associated viral respiratory infections, through you know transmission between patients and healthcare workers but also among healthcare workers. And among patients. So, I mean, transmission between healthcare workers in the break rooms is now well documented and we also know very well how this may affect, you know the patients for the vulnerable people in this equation, and we should not forget that respiratory tract infections are the most common health care associated infections, and in a substantial proportion of cases the cause is a virus or is not identified. So it is very likely I think that what we see during the pandemic, it's just a modified version of what was happening before and what might happen after the pandemic with other respiratory viruses, and COVID of course because I don't think that COVID is going to disappear very, very soon. So I think we can use this opportunity to revisit our approaches with regards to prevention and control measures for, you know, healthcare associated respiratory tract infections. Now, you know, we introduced universal masking in healthcare settings, and if you ask me whether it will be a legacy, I mean whether it will stay whether it will survive, is whether this measure will survive COVID, I cannot say with certainty, you know, but there is still room I think for improvement for other measures such as I would highlight I think, you know, emphasizing the importance of influenza vaccination for example among health care workers, or you know, staying at home when even, you know, mildly sick, and also other areas that will be key to translate the lessons for pandemic further infection control practice in the coming years are, I think, you know ventilation in hospitals, I mean we, it is something that we had there, it was there, but I don't think it was in our everyday, you know, practice I think we need to look closer at that also crowding in the wards - crowded wards. And this is also something we need to look into, you know, probably we need more single bedrooms, if possible. And finally, another point is policies for visitors. This will be probably one of the key lessons from the pandemic and all these things can lead to fewer respiratory tract infections that are healthcare associated and eventually may lead to, to better, better, hospital care. Finally, I mean I cannot but, you know mentioned the pandemic laid bare the vulnerability of long term and then elderly care residents to respiratory tract viral infections, and this was already known, I mean, in a way from from influenza, but the way that the magnitude of the problem during the pandemic, brought this issue forward I think this will hopefully lead to, you know, long term, in the long term to the better infection control in these settings so that in the future we will have also less, less impact in this group of, of people.

**James Price 42:56**

Thank you and I think I agree acceleration is exactly the right term, it certainly accelerated our use of, Teams and Zoom and how to use virtual platforms as well. Thank you that's great. So what I'm going to do is move us on now, accelerate forward. I've got one question to ask each of our panellists, which I think is it came this question came in on a variety of different a variety of different ways but I think it's going to be really interesting just to get some key thoughts on what do each of you think has been the most surprising aspect of the pandemic for you. So why don't we start with Greg moved to Jim and then to Diamantis. So Greg, what's been the most surprising aspect for you.

## Question 7:

In hindsight, what has been the most surprising aspect of the pandemic for you?



### Greg Fell 43:42

Two things. One, the politicization and polarization of science. It's been perfectly apparent from the (oh the suns in my eyes) it's been perfectly apparent in lots of different spaces, face masks aerosols, of who we do and do not vaccinate when, we could go on forever. So for anyone thinks that science exists in a vacuum is sorely mistaken. Science exists in society, you've kind of got to use the science to mould people's beliefs but ultimately beliefs are important. So, really interesting watching the science play out sometimes when the science is really clear. Sometimes when the science just isn't clear and is emerging and we've learned a lot, science wise, and how that gets polarized and politicized has been really, really, really interesting. And second one more quickly, is communication. For me this has been a story about communication about everything with everybody for me being really, really, really careful what I say because locally the Directors of Public Health have been on point for their places for this one. Everything you say will 1. be treated like words written on tablets of stone and 2. twisted. So, most famously I said something along the lines when asked the question at science and technology select committee something along the lines of. So 'are you worried about pubs reopening' - this was some time ago. And I said 'No not really at the top of my risk radar at the moment, some transmission will occur in pubs, but really the business end of this is in households' with the Daily Mail headline the following day was 'Sheffield's chief nanny bags, Britain's boozers to reopen immediately' which isn't what I said and missed all the context but the lesson was be really careful, really careful what you say. So there's been a lot of interesting stories on those lines.

### James Price 45:39

Really important lesson for us all, Greg, thank you for sharing. Jim, what about you, what have been the most surprising aspects.

### Jim Gray 45:48

I think the obvious answer is, is vaccination. The world's gone from having no vaccine to having a vaccine that seems to be highly effective against the respiratory virus, and has been delivered to millions and millions of people all within a year and a half is just absolutely astonishing. But I think on the sort of more prosaic level, I think, for me as a jobbing infection control practitioner, it was the cooperation that we got from clinical colleagues who we battled with for years to say you've got to be bare below the elbows, you got to take your watch off, you got to wash your hands, and suddenly they all became so much more compliant. And for me that that's, that's something that we've got to learn from, and see how we can harness that for the future.

**James Price 46:42**

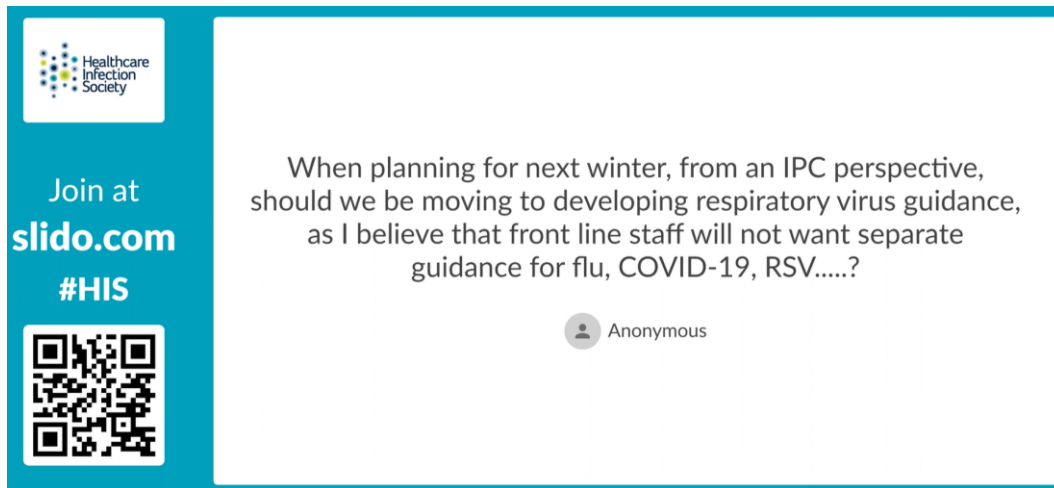
It's certainly been an interesting process lots of people engage with IPC it's fantastic how we harness that and embrace it and take that forward it's got to be a key, key outcome of all of this thanks, Jim. Diamantis, how about you, any surprise any surprising aspects for you.

**Diamantis Plachouras 47:01**

Well, yes, I mean on top of the big surprise of the pandemic as such. I didn't expect to, sort of, you know, to experience this in my lifetime, but anyway, I think one of the positive surprises was, it was really impressive how fast you know, new evidence was produced and then subsequently rapidly shared not only through. I mean, of course, even through regular publications, but also you know with pre-prints and even virtual meetings you know there was all this sharing of information, with, with people that really helped a lot. And also, I think in terms of evidence, there were large, randomized clinical trials for treatments and of course as already mentioned the rapid development of vaccines. This has been these have been unquestionable triumphs of the scientific efforts, and this is certainly going to be a very positive legacy for the future. However, I think I was also a bit negatively surprised, I think, on the other hand, seeing relative shortage of similarly high-quality stance on infection prevention and control measures. Of course, this definitely has to do partly at least with, you know the challenges of designing and performing some such studies in the real world. But I would have expected you know that the pandemic would have provided an opportunity to answer some questions for good you know with all these opportunities for, you know, studying transmission and control measures. And I mean, we also suddenly, I mean, not suddenly but we had seen these. But going back and revisiting all the available evidence and reading reviews, older and more recent ones, it strikes one that you know the low quality of evidence with several traditional infection control measures for respiratory tract infections are based on such as you know use of face masks or physical distance or, you know, environmental measures, disinfection and so on and so forth. So I think that the, although there has been an explosion of studies, the majority of them are were really small underpowered ones with highly diverse methodologies and the results that are difficult to interpret and then to you know to come to really sound conclusion so I think, a lesson from that would be that we, we need large coordinated methodologically sound studies on infection control measures. If possible, run by large networks that will have the capacity to carry them out in time, even in crisis situations, instead of you know each little place, and centre, you know, doing their own little study where it's difficult really to get to grips with what, what is the meaning of the results. So I think this can be a lesson for the future. Although you know a surprise, right now.

**James Price** 50:10

Thank you and let's hope people can continue the momentum, the speed, the enthusiasm to take this forward to address those kind of questions. So thank you all, I think that moves us now into the live questions and I know from Jo Walker who's been coordinating all of this behind the scenes, there's been a plethora of questions coming through. So why don't we start with the first question which is coming on to our screen now which is a nice short question I see.



The screenshot shows a Slido presentation slide. On the left side, there is a teal vertical bar containing the Healthcare Infection Society logo, the text "Join at **slido.com** #HIS", and a QR code. The main white area of the slide contains the following text: "When planning for next winter, from an IPC perspective, should we be moving to developing respiratory virus guidance, as I believe that front line staff will not want separate guidance for flu, COVID-19, RSV.....?". Below the text is a small grey circle with a person icon and the word "Anonymous".

So the question is When planning for next winter from an IPC perspective, should we be moving to developing respiratory virus guidance, as I believe that frontline staff will not want separate guidance for Flu, COVID, RSV etc. Who's interested in taking this on. So let's go to great Greg.

**Greg Fell** 51:07

Yeah, what a great idea, I never really thought about it, to be honest, it seems so obvious. Yeah there are gonna be some specifics and some nuances, but from sort of a generalist perspective, sort of, people kind of on take on on wards in A&E for GPS etc. Yeah, respiratory viruses are respiratory viruses, particularly the prevention of – yeah seems a no brainer so Yes.

**James Price** 51:37

Yes. Thanks, Greg. Any objections any feeling that we need to keep those separated out.

**Diamantis Plachouras** 51:42

If I may - no objections at all definitely but I think that can you remind me what is flu?

**James Price** 51:51



Influenza. We may see it again.

**Diamantis Plachouras 51:58**

[Laugh] It has disappeared, we may see it again of course but I think what has worked for COVID will obviously work for other for other respiratory tract infections, with a likely exception for I don't know, common cold viruses or Rhinoviruses. But yes I think it makes sense to have some kind of guidance that is, that addresses all respiratory tract viral infections, and I think for the time being at least for the next winter, COVID-19 will probably be still with us and that we will still have to stick with similar measures in healthcare settings at least.

**James Price 52:47**

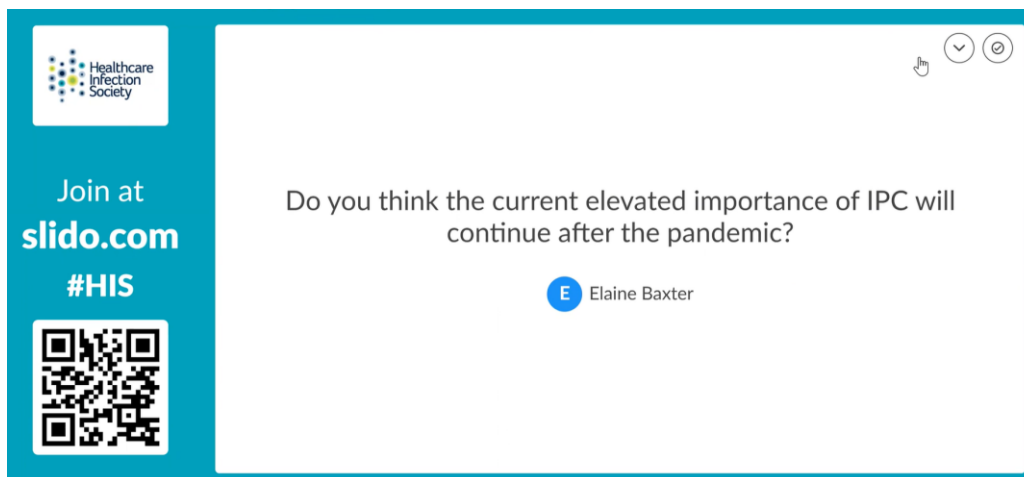
And I think we all wait with bated breath to see how we manage multiple respiratory pathogens within healthcare settings and within primary care settings. Jim.

**Jim Gray 52:55**

Yeah, I mean, coming from a children's hospital I would just say that we're, we're very firmly there already. Since the 17 May, it was like somebody had switched a tap on. We've gone from seeing less than five and many weeks no respiratory viruses at all in our inpatients other than SARS-CoV-2 to two weeks ago I think we peaked at 30 in-patients with mainly Para-flu-3 and Rhinovirus, and it tailed off a little bit last week, but we've had to adapt already we've had to change our Emergency Department systems now, because basically, when we were trying to separate out COVID from others, it just got such a mess. It was leading to sort of waiting time breaches, etc, etc. So we've moved now to all respiratory infections are treated in one pathway, and then anything not respiratory goes in another pathway. So, so I think in children's hospitals, we've already hit that that problem.

**James Price 54:08**

I feel like a whole webinar coming up on something around these is going to be valuable, but perhaps for the future. why don't we move on to the next question we've got about six minutes left so we'll see how many we can get through the next question, thanks to Elaine is - Do you think the current elevated importance of IPC will continue after the pandemic – oh interesting, be great to hear what people's thoughts are on that. Anyone think it will die away?



The screenshot shows a Slido poll interface. On the left, there is a blue sidebar with the Healthcare Infection Society logo, the text "Join at slido.com", the hashtag "#HIS", and a QR code. The main white area contains the poll question: "Do you think the current elevated importance of IPC will continue after the pandemic?". Below the question is a blue circle with the letter "E" and the name "Elaine Baxter". In the top right corner of the white area, there are three small icons: a hand cursor, a downward arrow, and a circular refresh icon.

**Greg Fell** 54:44

Go on I'll start. I think it will wane – I speak from the perspective of the DPH - clearly public health in the spotlight at the moment, we're treated like rock stars unfairly and not rightly so, that will fade everyone will forget about it. Sadly, I think IPC will be in the same space. So it's up to us to capitalize on the opportunity to keep it in the right space and I think one of the revelations for me is community IPC outside of hospital, and even primary care settings and really getting IPC into social care sectors, that we've never ever seen before and actually just about getting now into workplaces as well which is a really really interesting development. It's up to us to capitalize on that however because it won't happen by magic.

**James Price** 55:30

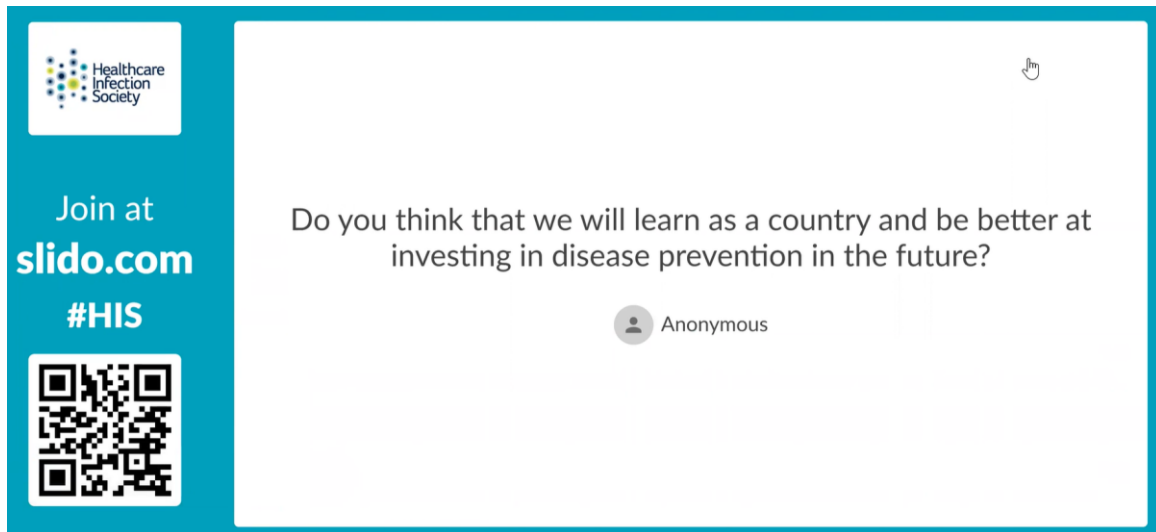
I agree I think it's, I think we've got a unique opportunity here to help support the interest and enthusiasm that people have around this and the you know the questioning around it and how we can work with people to address the learning experience that we're all, we're all going through. Yeah, interesting. I don't know if Diamantis or Jim have any thoughts on that.

**Jim Gray** 55:54

Yeah, I mean, I think we've probably got a couple of years, while it's still fresh in people's minds and particularly, you know, thinking about people other than frontline clinicians, and it's about opportunities for things we've learned to design better systems. I mean we're going to take your challenge in our hospital because we are building, we're, we're planning a new hospital, and it's a real challenge to think what does the hospital need to look like in five years' time, because it probably ought to look quite different to how one looks at the moment.


**James Price** 56:35

Really, really good point. I think we've got we've got time for one last question, which is coming on our screens now I am gonna talk, slowly whilst it pops up - there we go.




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Do you think that we will learn as a country and be better at investing in disease prevention in the future?

 Anonymous

Thanks to anonymous - Do you think that we will learn as a country, or do you think we will learn as a country and be better at investing in disease prevention in the future. So these kind of lessons learnt, what do people think about that?

**Greg Fell 57:05**

So I'll start. Of course I'd like to say yes but sadly I think the answer is no. On disease prevention more broadly. Sir Derek Wanless, remember him, reviewed the investment in prevention, about two decades ago for the Treasury. Governments of all colours have ignored the findings of Sir Derek, who's sadly now departed, for about two and a half decades now. I think that will continue. I wish that weren't the case but I think it is the case so sadly no,

**James Price 57:38**

That's a fair point, how we can incorporate whether there'll be more of a focus on emergency preparedness, or whether we're there or not is going to be interesting to see.

Well, I think we're coming towards the end, we're about to hit six o'clock. So I think this is time to wrap up. I'd like to say a big thank you to our panellists to Greg to Jim to Diamantis, it was really great to hear your thoughts, your personal thoughts about this, not representing anybody that's, thank you. I'd also like to thank the Healthcare Infection Society for hosting this and to GAMA Healthcare for their support, we wouldn't be able to put on these webinars without them. And to the audience for participating. Thank you for your questions - they've been really insightful. Certificates of attendance will be sent out after the event. The recording and transcript of this webinar is going to be available on the Healthcare Infection Society website shortly as well as those of the other webinars and a whole host of COVID and non-COVID related resources so check out the website. Our next webinar is going to be on the 21st of July. And that's going to aim to answer the question of can we test our way back

to normal. And this is going to be our last webinar before our summer break. So, finally thank you and have a great evening. Goodbye.