Trust Board, 20th May 2020 – members of the public questions, comments and responses

Responses to the questions received from members of the public for Trust Board, received in advance of the meeting.

QUESTIONS FROM THE PUBLIC	TRUST RESPONSE
1. From: Dr Karen Liebreich MBE	
i. **"How can the Trust staff have any confidence in the Trust board and how it will support them during the current COVID pandemic and the pressures on them, when the current Trust chair Paula Vennells was responsible for the catastrophic hounding of post office staff during her previous role as head of the Post Office? Her behaviour during the many years when post office staff were hounded over computer errors and the resulting scandal covered up do not inspire any confidence that she is a fit person to be chair."**	As previously discussed at public Board meetings, Ms Vennells was appointed by NHS Improvement who conducted a fit and proper persons regulation test at the time. The Trust has since reviewed the application of this test based on information available currently and remains satisfied. Ms Vennells continues to be committed and engaged in supporting the executive team to develop and deliver the organisation's strategy in line with its values. Ms Vennells had been fully engaged in the Trust's response to the pandemic and had held daily calls with the chief executive, as well as overseeing other board level governance, including weekly virtual meetings held with non-executive directors.
2. From: Elaina Arkeooll	
"First I would like to thank everyone for the selfless hard work they have undertaken to give healthcare to patients who have been in need of treatment during this pandemic. I cannot begin to imagine the intensity of the working environment and the risks that staff have taken on behalf of us Londoners, especially those of us In H&F for who Charing Cross, Hammersmith and St Mary's are our local healthcare hubs for secondary care. May I offer my condolences for those who have sadly lost their lives to the Pandemic, both staff and patients.	
i. **<u>Online appointments</u> are, I understand being offered to cardiology and other patients to maintain contact and assurance to patients who are non-urgent. Are there any other 'remote technology' solutions that might/are now being rolled out as aids to diagnosis that might have been in the pipeline but not ready to trial?**	Yes, online appointments and consultations have been carried out in all specialities across the Trust. In cardiology we do have some ECG technologies that can be used at home or even wearable, and these have played a part in the remote care process. We are just extending the use of technologies in the hope of being able to continue remote only consultations but with more information made available. The Trust has also been using other vital signs technologies [Current Health] for monitoring patients at home and in care homes, and we continue to explore what remote pathways we can best develop, using technologies where appropriate.

ii. <u>Testing for COVID-19 & antibody testing</u> are seen as the solution to the pandemic but, given the Common Cold Unit ran from 1949-1989 without lasting solutions to the issue of corona virus, it appears that living with the COVID-19 is a real possibility. There has been validated research that does show nasal cleaning with Sterimar MN does help to prevent Acute Rhino Sinusitis (<u>The effectiveness of long-term course of Sterimar Mn nasal spray for treatment of the recurrence rates of acute allergic rhinitis in patients with chronic allergic rhinitis</u>. Might it be timely to encourage use as a prophylactic across a wider range of patients, especially those at risk? Would the Trust consider it should be available on prescription for those who might benefit? Or do you research will need to be undertaken to prove benefit? The pharmacy at the Royal National Throat Nose and Ear Hospital do prescribe it? Might this therapy be good practice for all frontline NHS staff?"	We have asked our chief pharmacist, Ann Mounsey, and Mr Hesham Saleh, one of our specialist ENT consultants, for their views: Saline solutions can be beneficial for people with allergies and sinus or nasal disorders. There are indeed a number of proprietary based products on the market including Sterimar and NeilMed Nasal Rinse as well as many recipes for 'home made' salt and water solutions. Rinsing your nasal passages helps wash away any excess mucous or irritants inside your nose assisting the recovery of the natural mucociliary cleaning. Whilst not yet stocked by the pharmacy in this Trust, our ENT consultants do recommend saline nasal irrigation for some of our patients. There is, however, as yet, no evidence that regularly rinsing the nose with saline (or any other product including the addition of baby shampoo!) protects you from Covid-19 or reduces the severity of the illness. What we need are the results of randomised, well designed, large scale, controlled clinical trials which evaluate the role and mechanism of nasopharygeal irrigation and its place in prophylaxis or in reducing symptoms once infected with Covid-19. Once this information is available to us, we will be in a better position to consider its use, for staff or for patients. The World Health Organisation (WHO) produced a graphic in relation to 'myth busting' showing they too, currently, do not support this approach. Finally, we must also always remember that the viral load of any coronavirus can be heaviest in the sinuses/nasal cavity and saliva and therefore what any individual may choose to do with regard to nasal irrigation we must be alert that any devices used have surfaces that could harbour active Covid-19 droplets for some time, increasing the spread of the virus.
3. From: Jim Grealy, of Hammersmith and Fulham Save Our NHS	
"I appreciate the extraordinary work of the Trust in dealing with the Covid-19 pandemic and wish to thank all staff who have clearly worked well beyond what might be expected in order to keep the public safe at this time. In particular, I offer condolences to families, colleagues and friends of those Trust staff who have died as a result of the pandemic.	

i. <u>Deferred treatment</u> I recognise that tackling Covid has rightly been the central focus of Imperial work in recent months. I have a question on deferred referrals of patients:	
▪ **When does the Trust expect to be in a position to publish, for the public, a draft strategy aimed at tackling the deferred treatment backlog?**	All hospitals in London have been asked to make big changes to how we provide our services to help keep patients as safe as possible. We are actively working on plans to restart our wider services, whilst recognising that we need to adapt them to a very different world where we need extreme vigilance to minimise the risk of infection and to be ready to step up again if there are further waves of infection. We won't resume any planned surgery until we are sure we have safe and effective pathways in place to do so, which is likely to be sometime in June at the earliest. Tackling the deferred treatment backlog will be very important and our strategy will be to book patients according to the latest assessment of risk and clinical priority, and not necessarily in the order of length of wait. In the meantime, time-critical surgery will continue as it has done since the start of the pandemic, mostly taking place in protected hospitals, run by specialist NHS trusts or in the independent sector.
▪ **Does the Trust recognise any mental health wellbeing implications for patients who now face long deferrals of treatment for serious physical health conditions?**	As part of our clinical harm review we have established a framework that takes into account potential physical and mental health harm from the deferral of treatment. Clinical harm reviews have been carried out in a systematic way for the inpatient waiting list (mostly surgical procedures) and throughout the whole of the cancer diagnostic and treatment pathway. In addition we have logged and monitored calls to our cancer navigators, clinical nurse specialists (CNS) and consultant discussions. In some cases mental and physical potential harm have required patients to be offered a higher priority / more urgent treatment option. Some patients however have declined due to their concerns over Covid or after discussion about the risk of Covid infections. We have not logged severe mental health harm in the patients we have reviewed, however we acknowledge that there is currently an increased level of distress over delays in treatment, changes in treatment or fear of Covid infection.

▪ **Is there any ongoing assessment of deterioration in the health conditions of patients whose treatment is being deferred over this period?**	All patients who have had any treatment deferred due to Covid-19, or for any other reason, will have their pathway reviewed for potential clinical harm. Prior to the Covid-19 pandemic outbreak this review focused on the long waiting referral-to-treatment (RTT) patients, in particular those waiting over 52 weeks and in 2019 this was expanded to those over 44 weeks. A monthly report is produced and reviewed by the team leading our RTT management. During Covid-19 this work has continued and expanded as the numbers waiting for routine treatments (lower priority procedures) for over 52 weeks has risen. In addition a new clinical priority and harm matrix is being used to support clinicians as they review their patients in various settings (outpatients, or rescheduling or oncology etc). This approach provides a defined, logical framework to both acknowledge a planned deferral of treatment and to assess the individual patient's potential clinical harm risk. The output would be a revised priority for the patient's treatment (and time to treatment). We know that all planned surgical patients and those awaiting endoscopy, cardiology, oncology, haematology have all undergone a priority assessment and the patients in the second priority group (planned for treatment within a month) have all been treated or scheduled in independent sector hospitals (where possible) or internally in our Trust hospitals if required. We anticipate that the most significant potential clinical harm, which is yet unquantified, will be in the oncology patient population with the alteration and deferral of chemotherapy and radiotherapy treatments, all under the guidance of NHS England.
▪ **What kind of assessment is being made of the adequacy of phone or video consultations as against face to face consultations on patients who may have multiple or complex conditions?**	To date, the Covid-19 pandemic has necessitated not having patients come to hospital if at all possible, and therefore most outpatient consultations have been by telephone or video. Now that we are entering a phase in which virtual outpatient appointments are not necessarily essential but continue to offer significant benefits, including for safety, we will need to evaluate them further in terms of safety, outcomes and patient experience. We will work with patients to establish a set of appropriate metrics and determine the best approach longer term.
▪ **How does the Trust plan to communicate details of deferred treatment pathways for possibly a very large number of patients? And how will the Trust publicise its strategy to deal with backlog and ongoing referral?"**	It is even more important in these worrying times that we ensure the best possible experience for our patients as well as for their carers, families and friends. As we make changes to how we provide our services, we're drawing on what we've learnt from the past two months of our Covid-19 response and are working through how we engage, involve and inform

	patients in the new context. We think we can make much better use of online platforms, especially our Care Information Exchange, for some groups of patients. We are already engaging with the Trust's Strategic Lay Forum about our plans for 'recovery and reset' and will continue to share these plans more widely as they develop.
4. From: Merril Hammer, Secretary, Hammersmith and Fulham Save Our NHS	
"Can I echo the sentiments expressed above by Jim which are undoubtedly shared widely by the general public. The successful efforts of all workers within the NHS have been hugely appreciated – as is very evident not just in the public clapping on Thursday evenings but in the rainbow windows all around Hammersmith and Fulham. I would add to Jim's remarks further congratulations at the significant steps taken to incorporate the previously outsourced hospitality workers under circumstances which no one would have wished on the Trust. Now to my question!	
i. **<u>Care of staff.</u> Over this period, staff have faced worked long hours, often putting their own health at risk, sometimes having had to separate from family, had to work in unaccustomed areas and face the anxiety that the pandemic might get out of hand. As pressures reduce, staff across the board will face exhaustion and possible burnout together with having to tackle huge backlogs of deferred treatment cases. What strategy is the board developing to support the health, physical and mental, of all staff in this difficult situation? Will staff shortages, possibly exacerbated by effects of the c-virus, make it difficult to cope with what will be an ongoing pressure on hospital care?"**	The Trust initiated a comprehensive health and well-being programme covering emotional and psychological well-being in collaboration with Central and North West London Mental Health Trust. The programme also included physical and financial well-being with support for parking, accommodation and food. In collaboration with our staff networks we have been looking at spiritual well-being as well as how the virus has differentially impacted on staff with protected characteristics under the Equalities Act, particularly staff from Black, Asian and Minority Ethnic (BAME) communities. In terms of shortages, the Trust massively reduced vacancy rates this year moving from a peak of almost 16%, down to 10%, so we were much better placed to handle the absence and ongoing pressures created by the Covid-19 virus. We also initiated a redeployment and recruitment programme to support essential clinical services.
ii. **There has been considerable concern about the number of cases of Covid-19 diagnosed in residents of care homes and the shocking number of deaths in care homes. Can the Board reassure the public that, at this time, Imperial hospitals are not discharging any patients to care homes without first testing these patients and then ensuring that the results of the tests are negative for Covid-19 before discharge? Does such a testing/results process also apply to other patients discharged from Imperial's hospitals?**	All inpatients are tested for Covid-19 and the outcome of this test will shape the advice and support provided for discharge once they are medically fit. We have clear and agreed processes for discharging any patient who has tested positive for Covid-19 to any setting – they are set out in a series of tailored leaflets including information and support for any continuing self isolation required.
5. From Adrian Whyatt, Hammersmith and Fulham Save our NHS	

i. "Can you please re-assure the public that informed consent is obtained for all treatments including trials and vaccinations, including for any infectious diseases and any other infectious agents, such as Covid-19-SARS-2, and of any additives including storage envelopes for treatments such as mercury and aluminium, especially in the light of public concerns raised by highly reputable scientists such as Professor of Translational Medicine Dr. Dolores Cahill of University College Dublin School of Medicine (publicly available in a recent long interview for the Irish press on YouTube)?"	Informed consent is required for all clinical studies, including trials of new medications. Imperial College Healthcare applies all the international regulations on the conduct of clinical trials and participates in regular internal audits and external audits by the MHRA to ensure compliance. There are a small number of licensed medications which contain tiny amounts of either mercury or aluminium. These pharmaceutical products have been subjected to extensive safety review before receiving market authorisation and safety surveillance since they came on the market. Our Trust is no different to any other healthcare provider in the use of these products.
6. From: Victoria Lay	
Infection prevention and control and Social distancing in the workplace	
▪ **Can you tell me when you implemented social distancing at the trust in non-patient facing roles.**	We promoted social distancing measures at the beginning of the Covid-19 outbreak. We supported a large number of staff to work from home early in our response and have moved many of our non-clinical management activities to Microsoft teams. We ae now working through the HSE guidance on safe working as the lockdown is eased and some of our non-essential services are stood back up.
▪ **When was the first time that The Trust was told about the emergence of a novel Coronavirus Originating in Wuhan?**	We first became aware of the novel SARS-CoV-2 coronavirus in China towards the end of December 2019. The initial communications from PHE about the novel coronavirus were launched in January 2020.
▪ **Did you receive a letter from PHE around the 10th of January about the emergence of a novel Coronavirus in Wuhan and the Infection prevention and control measures recommended including 2 metre social distancing and wearing of facemasks ?**	The first version of PHE's Infection Prevention and Control guidelines were published on their website on 10 January 2020. These initial guidelines focussed on the management of individual patients with confirmed or suspected COVID-19, and recommended a fluid-resistant surgical mask when in close contact (within 1 metre) of a patient with COVID-19 symptoms, and at all times when in a cohort area. FFP3 masks were recommended for aerosol generating procedures and when working in units when aerosol generating procedures are common (such as in intensive care units). These guidelines have subsequently been updated several times.
▪ **Did you have any excess pneumonia cases in Dec/Jan/Feb and is there any research going on looking at previous blood samples taken in these months to detect whether any show antibodies to COVID-19.**	There was an increase in cases of pneumonia seen in December 2019, compared to the previous two years. The number of cases seen in January 2020 was the same as that seen in in January 2019, and less than January

	2018. The number of cases of pneumonia seen in February 2020 was same as last year and slightly less than 2018. Researching whether any of these cases may have possibly had COVID-19 is being explored.
7. From: Abdifatah Dhuhulow	
i. **SAVING MONEY STRATEGIES AND IMPROVING SERVICES FOR THE DISABLED AND OTHER PATIENTS**	
"Through using the purchasing power of the Trust and NHS in general, I shared with the Trust valuable strategies that would save money for the Trust while improving the services that are offered to the disabled and other patients. Although I have not received any feedback yet, I would like to know what the Trust has done with my input".	Thank you for your suggestions. We were exploring some of these ideas but this work has had to be put on hold as we prioritised the Covid-19 response.
ii. **REDEVELOPMENT** When governments or businesses want to introduce new policies or products/services, they gather data about the public opinions or carry on market research to test the viability of their policies and their new products/services respectively.	
Since the Trust's staff, Doctors and the communities are those who will use the new hospital, can the development Committee tell us if they have sought the opinions of the people who will use the new hospital to justify the cost/valuable assets exchanged and to test whether it will meet users' needs.	Our Trust's estate redevelopment programme proposes a complete redevelopment of St Mary's Hospital as well as significant developments and major refurbishments for our Charing Cross and Hammersmith/Queen Charlotte's & Chelsea sites – with services currently located at Western Eye Hospital being incorporated into the most appropriate of these developments. As quickly as possible, we want to begin the comprehensive redevelopment of St Mary's Hospital, which is our largest site in the most urgent need of repair and renovation. We have set out our aim to become the most 'user-focused' organisation in the NHS. Specifically for St Mary's, we have stated our ambition to "make the most of the once-in-a-generation opportunity, created by Paddington area regeneration combined with Government investment in NHS infrastructure, to produce a hospital for the future at St Mary's. One that has impact locally, nationally and internationally, setting new benchmarks for innovation, user experience and community benefit." We see our primary users as patients, their carers, family and friends; our staff and volunteers; and our local community, workers and visitors to the area.

	To date a limited number of key staff and lay partners have been involved in planning for the St Mary's redevelopment and in work for implementation of our wider organisational strategy and redevelopment proposals. We are now working to develop a much broader engagement and involvement approach to include all of our users and potential users, partners and stakeholders. We want to involve them at all stages of our programme, developing two-way, on-going relationships that allow us to build mutual understanding, to be genuinely responsive and to take people with us on a journey to achieve a shared vision.
Secondly, if the answer is yes, what was the method used to communicate and capture the valuable inputs from the users of the new hospital.	Following on from the previous response, to help us kick start our broader involvement strategy, we are in the process of commissioning an initial piece of staff, patient and stakeholder research to gain insight on what our key audiences think and feel in order to shape what the St Mary's Hospital of the future should offer, how it should be accessed and used, how individuals should experience our services and what's most important about look and feel. We want as many of our key audiences as possible to have the chance to be involved in this research in some way so that we can put outstanding patient, carer and staff experiences at the heart of the new St. Mary's design. We expect this research to draw on our existing relationships and user insight, especially where individuals or groups would expect to be closely involved in the development from the start. We also want it to be undertaken in a way that will enable us to begin to build relationships with individuals and organisations who get involved and with whom we have had little previous contact outside of specific care interactions. As such, we will be looking at further ideas on how we can use the outcomes of this research to shape further research, involvement and co-production with our key audiences.