By email to:

Dr Susan Hopkins
Chief Medical Adviser to UKHSA
17, Smith Square
Westminster
London SW1P 3HX

14th July 2022

Dear Dr Hopkins,

Re: Inconsistencies between public messaging on airborne transmission of Covid-19 and IPC guidance across the UK - Response to your letter 17th June 2022

Thank you for your letter in response to our letter of 11th April 2022 concerning your letter of 21st March 2022. Given the accountability of your role as Chief Medical Adviser at the UK Health Security Agency, we feel we have a duty to advise you that many of your statements are factually incorrect or subject to incorrect interpretation. This letter has been written with the intention of supporting you in your role as we appreciate that responses can be drafted by other staff and the need for transparency given the emotive subject of interpretation of evidence and its impact. Whilst we have

already given detailed rationale for our comments in our previous letters, we hope you will not mind us repeating some of that evidence?

Thank you for your apology for the lack of a response to our letter to UKHSA in July 2021, co-signed by the Royal College of Nursing.

We have highlighted below some key points below covered by you in your last response. We acknowledge that your response to us will have been written by another member of the UKHSA or NHS Infection Prevention and Control team. We include links in the attached Annex which we hope you find useful. We note that the guidance referred to in our original letter is no longer in use, therefore commentary within this letter is provided for context and transparency purposes only.

Removal of modes of transmission – Consultation September 2021

CAPA and its members contributed to this consultation despite not being offered the opportunity to do so and having engaged with other stakeholders in a meeting with DHSC in June 2021 and having written many letters to relevant government bodies and leaders throughout the pandemic.

Whilst we as an alliance of 19 organisations noted many errors in the draft Appendix 1 to the consultation document i.e. "Patient placement and FRSM/RPE for respiratory infections / infectious agents", our response, and that of other major stakeholders, focused on clarity of the transmission of SARS-CoV-2. This was not addressed and is conflated with wider feedback on inaccuracies in the appendix. As reported by our members working in diverse settings, the focus on aerosol generating procedures and language such as 'wholly' or 'partially' is confusing and does not support risk assessment as required under COSHH regulations. We remain committed to the need for the airborne route of SARS-CoV-2 to be clearly highlighted and appear first in any reference to transmission routes to enable risk assessment in the workplace wherever this is.

The NHS IPC team committed to stakeholders to publish the consultation responses and rationale for decisions based on feedback. This commitment has not been met by the NHS IPC Team.

WHO guidance and extended use of respiratory equipment

WHO guidance issued on 22nd December 2021 *'WHO recommendations on mask use by health workers, in light of the Omicron variant of concern' states: A respirator (FFP2, FFP3, NIOSH-approved N95, or equivalent or higher-level certified respirator) or a medical mask should be worn by health workers along with other personal protective equipment (PPE) – a gown, gloves and eye protection – before entering a room where there is a patient with suspected or confirmed COVID-19.'* This was published when the IPC Winter respiratory guidance was still in effect.

This does not align with your remark that no changes in WHO IPC guidance have occurred since October 2021.

This failure to mention the latest WHO guidance is perplexing, particularly as it enables AGPs to remain the prime indicator for RPE.

ECDC guidance

This guidance was issued February 2021 as you correctly state and remains unchanged. It clearly states on page 6 that 'Healthcare workers in contact with a possible or confirmed COVID-19 case should wear a well-fitted respirator and eye protection (i.e. visor or goggles) [40].'

However, the sentence to which you referred relates to "universal masking". We would draw your attention to the fact that ECDC guidance also states that, where health and care workers come into contact with patients / residents who have symptoms of COVID-19, they should wear an FFP2 respirator if available (or medical face mask if not) and that "FFP respirators are mainly used by healthcare workers to protect themselves". We should reiterate that surgical FRSMs are not classified as protective equipment for the wearer by HSE. Furthermore, the official standard for medical / surgical masks (BS EN 14683:2019) states unambiguously that "the standard is not applicable to masks intended exclusively for the personal protection of staff".

CDC guidance

The attached CDC IPC guidance, updated 2nd February 2022, is explicit (at page 6) that 'HCPs who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).' CDC goes further to include that even porters transporting patients should wear N95 or equivalent. Risk assessment is not the prerequisite for use of RPE which is predicated on the above guidance.

IPC manuals

In your last paragraph, you state that all of your comments and previous guidance no longer apply as IPC manuals from each country have now replaced all previous guidance. You have not commented on how these manuals concur with or deviate from previous guidance. However, we note that the English version now includes the words "wholly or partly":

"For a list of organisms spread wholly or partly by the airborne (aerosol) or droplet routes see Appendix 11". (Page 32). This can be applied to Coronaviruses as in the Table on page 48 where these viruses are said to be transmitted via Droplet/Airborne route subject to the headnote above the table which states:

"Current guidance is that an FFP3 respirator must be worn by staff when caring for patients with a suspected or confirmed infection spread by the airborne route, when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet or airborne route, and when deemed necessary after risk assessment". (Page 47)

The entry on coronaviruses in the above table also states:

"Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs please see note above."* (Appendix 11A, Table page 48).

We remain perplexed as to why "routine care" should attract only FRSMs despite the HCW being exposed to airborne transmission as in the CDC guidance on non-clinical support staff.

We are pleased to see the "Precautionary principle" mentioned when in doubt as in:
"If the hazard is unknown the clinical judgement and expertise of IPC staff is crucial and the precautionary principle should apply" (Point 2.4 page 31). This means that "*… the precautionary principle should apply and RPE such as FFP3, elastomeric, or powered respirators should be used, not surgical masks, irrespective of procedure.*".

However, as can be seen in appendix 11 to their NIPC Manual, Scotland is still resolutely denying airborne transmission. This results in something of a "Postcode Lottery" in respect of protecting the

safety of healthcare workers across the four nations of the UK. This is unsatisfactory and we call on you (with your UK-wide remit) to try and bring these different factions together. You will surely recognise that such disagreements and divergence in official guidance is unhelpful during this continuing pandemic which, once again, is becoming a major burden on all aspects of healthcare services throughout the UK.

These inconsistencies coming so far into a global pandemic are confusing and unhelpful to duty-holders in Health Trusts/Boards.

Glossary

You indicate that a feeling of what Airborne transmission "looks like" could be obtained from the glossary to IPC guidance. We beg to disagree. Since this mode of transmission is not linked to Covid-19 anywhere in that guidance, the glossary definition is irrelevant and unhelpful.

AGP paradigm

The AGP list has dominated UK IPC practice throughout the pandemic to date, but this is counter intuitive.

The current AGP list is poorly underpinned by science which clearly shows that just breathing, speaking or coughing are enough to permit aerosol transmission even in asymptomatic cases and to the same or greater levels than so-called AGPs. (Aerator study). The AGP dogma needs to be abandoned in favour of protection against aerosol transmission with appropriate RPE, irrespective of procedure.

Risk assessment

As already mentioned, any risk assessment must be predicated on a clear understanding of the cause and transmission route of biological hazards that pose risks to healthcare workers in all settings. The focus on the hierarchy of controls within current IPC guidance is misleading when considering close-contact care of infectious patients. Neither the HCW nor the risk assessor has any means of quantifying the amount of virus-laden aerosols being emitted from the patient and, since none of the COSHH 'hierarchy of controls' are effective at mitigating the risk at close-quarters, respiratory protective equipment RPE (e.g. FFP3) is the only viable control measure to protect the HCW and should be the default, mandatory requirement.

The failure to specify that airborne transmission is a very significant factor in the way the virus spreads, coupled with the continuing reference to 'wholly or partly airborne' leaves healthcare workers confused and at risk from ill-informed risk assessments which fail to provide for adequate respiratory protection. Under the COSHH Regulations, if a hazard is airborne to <u>any</u> extent (even "partly") then respiratory protection is required. The fact that other routes of transmission also apply (droplet/fomite) does not detract from this in any way. As noted above, CDC guidance does not include risk assessment as a pre-requisite for use of RPE.

Failure to address inconsistencies

We have sought to draw your attention to obvious ongoing inconsistencies within guidance in the UK and the home nations. These inconsistencies have not been eliminated in the latest IPC manuals which now form the basis of IPC responses to respiratory pathogens such as Sars-CoV-2. The resurgence of Omicron variants and the impact on provision of non Covid-19 care in the NHS is being

seriously affected by staff illness and nosocomial infections caused by Covid-19. Our comments are therefore as important as ever and need a more science-based response than is evident at present. Failure to address our constructive criticism will lead to further confusion and inadequate protection of HCWs from SARS-CoV-2and other airborne viruses.

Yours sincerely,

Dr Barry Jones BSc, MBBS, MD, FRCP
Chair of CAPA – Covid Airborne Protection Alliance

Attached:

1) CDC IPC Guidance for Healthcare Personnel (2 Feb 2022)

2) CDC Clinical Questions and Answers about COVID-19 (8 June 2022)

* Members of CAPA

- ARTP - Association for Respiratory Technology & Physiology
- BAPEN – British Association for Parenteral and Enteral Nutrition
- BIASP – British and Irish Association of Stroke Physicians
- BDA – British Dietetic Association
- BOHS - British Occupational Health Society
- BSG - British Society of Gastroenterology
- College of Paramedics
- CSP – Chartered Society of Physiotherapy
- FreshAir NHS
- GMB Union
- HCSA - Hospital Consultants and Specialists Association
- MSDUK Med Supply Drive UK
- NNNG - National Nurses Nutrition Group
- QNI - Queen's Nursing Institute
- RCSLT – Royal College of Speech and Language Therapists
- Unite the Union
- Doctors Association UK
- Trident H&S

ANNEX A

GUIDANCE FROM OTHER COUNTRIES/ ORGANISATIONS

ORGANISATION	KEY POINTS	LINKS/ ATTACHMENTS
WHO		
	Your letter states that there has been no change to WHO IPC guidance since October 2021. This is factually incorrect. "Interim guidance" was issued by WHO on 22nd December 2021 (see attached), which states that "…. A respirator should be worn before entering a room where there is a patient with suspected or confirmed COVID-19". Recommendation 2 goes on to include AGPs as an indication for RPE but this is no longer the only indication for RPE as stated in Recommendation 1. WHO in their Coronavirus Q&A (30 Apr 2021) unambiguously stated "A person can be infected when **aerosols** or droplets containing the virus are inhaled".	Copy of WHO "Interim" guidance 22nd December attached WHO Coronavirus Q&A (30 Apr 2021)
ECDC	March 2020 ECDC guidance was clear that, if available, FFP2/3 masks should be worn when undertaking activities which "may provoke coughing and/or sneezing and therefore lead to the production of aerosols" e.g. taking nasopharyngeal swabs In May 2020 ECDC advocated that health and social care staff should wear FFP2 respirators, if available, when providing care to patients and care home residents in areas with community transmission.	March 2020 ECDC guidance May 2020 ECDC guidance
CDC	We note that you have selected three out of the four CDC recommendations as to when respirators or higher level respirators should be used (AGPs, higher risk surgical procedures and poor ventilation). However, the fourth recommendation was omitted: "facilities … with substantial or high transmission may consider implementing universal use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission. Also the "Q&A document" under "Infection Control" which is headed "*Why does CDC continue to recommend respiratory protection (e.g. N95 or better) for care of patients with known or suspected COVID-19?*" includes as follows:	See attached CDC document "Interim IPC Recommendations for Healthcare Personnel" 2 Feb 2022 (highlighted at page 4)

	• Facemasks provide a barrier against droplet sprays… but they are not designed to protect wearers from inhaling small particles. • N95s, FFPs, PAPRs and elastomerics provide both barrier and respiratory protection • Respirators should be used as part of a respiratory protection program that provides staff with medical evaluations, training, and fit testing. • Although facemasks are routinely used for the care of patients with common viral respiratory infections, N95 or equivalent or higher level respirators are routinely recommended for emerging pathogens like SARS CoV-2, which have the potential for transmission via small particles, the ability to cause severe infections, and limited or no treatment options.	See attached CDC document: "Clinical Questions about COVID-19: Questions and Answers" (Highlighted at page 5)