



11 April 2022

By email CMAPrivateOffice@UKHSA.gov.uk

Dr Susan Hopkins, Chief Medical Adviser to UKHSA

Dear Dr Hopkins,

Re: Inconsistencies between public messaging on airborne transmission of Covid-19 and IPC guidance across the UK. Response to your letter of 21st March 2022.

Thank you for your letter of 21 March, replying to our letter to the CMO, Prof Sir Chris Whitty of 11th February 2022. We note the attribution of responsibility to the bodies named in your letter but we still do not understand where ultimate accountability for current guidance sits.

There is also no transparency as to whom the IPC cell experts are, nor of their deliberations since neither have been made public. Organisations and individuals who are impacted by their guidance have an absolute right to know of the governance surrounding their appointment, appraisal of their performance and assurance of their competence to produce guidance upon which the life and death of so many healthcare workers depend during a pandemic.

You have offered thanks to all healthcare workers (HCWs) for their contributions to keeping staff and patients safe during the pandemic. Regrettably, we find this gratitude hard to accept in that government agencies have failed to take note of stakeholder advice and requests on the subject of HCW or patient safety throughout the pandemic. We have a long list of such interactions where highly regarded professional bodies and eminently well qualified scientific and medical practitioners have made approaches to the government and its advisory bodies such as PHE but with little or no subsequent engagement or acknowledgement of the detailed points we have raised. Indeed, they have largely been ignored or dismissed with trite platitudes along the lines of:

“We are concerned with staff safety as our highest priority, we work continuously to provide PPE to the front line and that our guidance has been constantly reviewed and formulated by experts”.

We also wrote as the AGP Alliance (precursor of CAPA) with the RCN to Dr Harries at UKHSA 8th July 2021 about the failure to engage with stakeholders and offering our support, but we did not even receive the courtesy of an acknowledgement, let alone a substantive reply to our concerns.

Although you mention that Section 6.5.7 has the agreement of the 4 CMOs, we find this hard to believe as Prof Sir Chris Whitty is on record as espousing ventilation for the airborne route as in our letter to him.

The penultimate paragraph in your letter on future plans for the healthcare workforce does not make sense. We would be interested to understand what these plans are in light of our ongoing concerns which we have re-iterated and amplified in our response below.

Clarifying the Transmission Route for SARS-CoV-2

We recognise that we have been on a journey in understanding and responding to the transmission routes for SARS-CoV-2. However, whilst members of the Alliance have kept up to date with the evidence of transmission routes and the subsequent implications for RPE, the IPC cell and others who inform the IPC guidance have clearly not done so. We should point out that acceptance of the airborne route does not exclude droplet or fomite transmission. All 3 routes are important, and all require mitigation.

For example, in 2020 some members of our Alliance initially focussed on the procedures which we thought should be included in the AGP list. Specifically, the insertion of nasogastric tubes (NGT) and the assessment of dysphagia. Both were repeatedly dismissed as not being AGPs despite the fact that they are associated with profuse coughing in the immediate vicinity of the HCW performing the procedure. As for NGT insertion as an AGP, every Royal College of Physicians and Surgeons in Great Britain and Ireland, together with 4 international bodies and many other British professional bodies supported NGT insertion as an AGP but this was completely ignored by the IPC cell, IHR AGP Panel, PHE, Secretary of State for Health and many more. We have known for some time that coughing is associated with greater aerosol generation than many designated AGPs. The AGP list has been rigidly adhered to by both the IPC cell and the Independent High Risk AGP Panel despite our detailed scientific refutation of the evidence on which these decisions were made originally by WHO, HPS and PHE. We now know that the scientific basis on which the AGP list depends is unacceptably poor or non-existent as described in previous correspondence to the CEO of PHE 16th April 2020. Our contention that respiratory protection should be available for all close contact care of infectious patients (not just AGPs) has been ignored. **The AGP list is now obsolete.**

The intransigence of the IPC cell and ARHAI to properly consider the airborne route has mystified the members of our Alliance and our colleagues in the RCN and BMA. We must remind you that there are many experts represented by the professional bodies within our Alliance and beyond who

strongly disagree with the principles upon which the IPC guidance is predicated ('droplet transmission' and 'FRSMs for protection'). In other words, only your experts are to be believed but those representing the doctors, nurses, dietitians, speech & language therapists, physiotherapists, paramedics and other HCWs who have to work to the guidance are ignored. This is unacceptable and means **that HCWs can have no confidence in the 4-nations IPC guidance, as stated in our letter with the RCN to the CMO England 12th March 2021.**

You have claimed to be "***following WHO IPC guidance***". We beg to differ. WHO has clearly indicated that "*a respirator should be worn by healthcare workers... before entering a room where there is a patient with suspected or known COVID-19*" - WHO 22/12/2021. This guidance was issued independently of the WHO Covid-19 IPC Guidelines Development Group which has rigidly adhered to the droplet transmission theory. Surely, this reflects a desire by WHO to overrule its IPC group which is merely an advisory body to WHO? WHO also states 23rd December 2021 that:

- *"Current evidence suggests that the virus spreads mainly between people who are in close contact with each other, for example at a conversational distance. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough, sneeze, speak, sing or breathe. Another person can then contract the virus when infectious particles that pass through the air are inhaled at short range (this is often called short-range aerosol or short-range airborne transmission) or if infectious particles come into direct contact with the eyes, nose, or mouth (droplet transmission).*
- *The virus can also spread in poorly ventilated and/or crowded indoor settings, where people tend to spend longer periods of time. This is because aerosols can remain suspended in the air or travel farther than conversational distance (this is often called long-range aerosol or long-range airborne transmission).*

[Coronavirus disease \(COVID-19\): How is it transmitted? \(who.int\)](https://www.who.int/news-room/fact-sheets/detail/coronavirus-2019-ncov)

We should point out that at no time during the pandemic has any credible evidence been forthcoming from WHO or PHE/IPC Cell to confirm that the droplet/fomite paradigm is correct, let alone the 'predominant' mode of transmission. In contrast, all the emerging evidence has been in support of the airborne route both for remote transmission and close quarter contact. We provided ample supporting examples of distinguished authorities agreeing with airborne transmission in our letter to the CMO 11th February 2022. Many other countries including the USA and the EU have long advised that Covid-19 is airborne and appropriate mitigation with filtering respirators is required when in close contact with suspected or confirmed covid patients

Clarification and removal of inconsistencies in guidance

In our letter to the CMO (11/2/2022) entitled "Inconsistencies between public messaging on airborne transmission of Covid-19 and IPC guidance across the UK," we asked for an explanation of these inconsistencies. He forwarded our letter to you on the basis that UK-HSA is the body responsible for these matters. However, no such explanation is forthcoming in your response. Indeed, you do not even mention UK Cabinet Office guidance which clearly states that SARS-CoV-2 is transmitted significantly by the airborne route. You have therefore not answered our question regarding the inconsistencies, now so patently obvious to all except UKHSA. You have not responded to the detail provided in our letter but have instead described your "minor" amendment to section 6.5.6. **Nor does the latest IPC guidance state the specific "modes of transmission" of Covid-19 as you have claimed.**

The latest iteration of IPC guidance does acknowledge that there has been input from unidentified stakeholders and that the “changes” to the guidance reflect this. Whilst it is encouraging that stakeholder engagement has been acknowledged, the response does not deliver the desired improvement in the guidelines.

Furthermore, **you have stated that the guidance remains the same as in the January 2022 iteration - but it is not.** The November iteration included the term “wholly transmissible by the airborne route” as an indication for Respiratory Protective Equipment (RPE) such as Filtering Face Piece (FFP3) respirators or equivalent. This clearly sought to exclude COVID-19 from the need for RPE since it is also transmissible by other routes.

The next iteration, in January 2022, stated that RPE was required for diseases “*transmissible by the airborne route*” (the word “wholly”, now being omitted). When taken alongside UK Government guidance published at the same time that the airborne route is significant in the transmission of COVID-19, the only interpretation possible is that RPE is required whilst caring for COVID patients. At the same time, doctors in primary care were given free access to FFP3 respirator masks. This sent clear signals across the healthcare sector that, at last, HCWs were going to be properly protected with RPE for the first time since the start of the pandemic.

Yet within just a few days, members of the IPC Cell were telling duty-holders such as the Association of Ambulance Chief Executives (AACE) that their guidance had been “misinterpreted” and they didn’t really intend for there to be any change in RPE requirements. As you will see from the attached ‘Position Statement’, the AACE were told that revised guidance would be published clarifying this within a week clarifying the position. Yet it took a whole month for the authors to come up with the term “predominantly transmissible” as a means of ‘clarifying’ the position. Far from it, with no indication within the guidance as to whether COVID-19 is “predominantly airborne” the guidance provided no clarification whatsoever and has only led to further confusion.

We do not understand the inclusion of the concept that only infections which are ‘predominantly airborne transmissible’ warrant the use of RPE rather than a simple Fluid Resistant Surgical Masks (FRSM) which are not RPE. For this to be the case the IPC authors would need to provide proven scientific evidence that the ‘droplet’ route of transmission which they currently espouse is a greater, more dominant cause of disease spread than that of ‘airborne’ and ‘fomite’ routes. We do not believe that any such reliable, peer-reviewed evidence exists and at no point has any been forthcoming from UKHSA or its predecessor. Furthermore, this notion flies in the face of advice from the Health and Safety Executive’s Chief Scientific Officer, Professor Andrew Curran, an eminent and well-respected scientist who has confirmed that the “airborne route is the most critical”. We respectfully suggest that you take note of this and act upon his scientific opinion.

The indisputable fact remains that UK legislation requires that workers be protected from airborne hazards (including pathogenic viruses) which they may encounter at work by the use of approved RPE. Sars-CoV-2 is still a Category 3 Hazard. **The HSE have never approved FRSMs as RPE and FRSMs are not certified for use as personal protective devices.**

Apart from any legal considerations, how would the phrase “predominantly airborne” be interpreted by HCWs, Trust executives and managers reading this guidance? How are they to know whether an individual patient is generating predominantly aerosol or droplets?

The term “**predominantly airborne**” has no validity whatsoever within the context of UK health and safety legislation. Whatever classification is assigned to a hazardous substance by the HSE (toxic, pathogenic, carcinogenic, sensitiser etc), if it is encountered as a part of an employee’s work

activities and it is capable of becoming airborne and inhalable, then the full weight of the Control of Substances Hazardous to Health (COSHH) Regulations applies. There are no exceptions to this. If a substance can also gain entry to the body via other routes (such as by ingestion, skin absorption or splashing direct onto eyes or mucosa) this in no way excuses the employer from deploying respiratory protection for the airborne component. Similarly, under the COSHH Regulations, there is no distinction between aerosols and droplets/mists, vapours or dusts. If it is hazardous and it is inhalable then COSHH rules apply regardless of the mode of transmission. COSHH rules do not permit FRSMs to be used for respiratory protection.

If one applies the test of “how would a HCW interpret the latest IPC guidance in the absence of other guidance?”- for example that from the UK Cabinet Office, how would that HCW conclude that RPE is required for Covid-19? The guidance does state that RPE is required for mitigation of airborne risk but only if predominantly airborne, in poorly ventilated areas, or for AGPs! **IPC guidance from November to the latest iteration gives NO indication of how Sars-CoV-2 is transmitted**, nor any of the other winter viruses. Since SARS coronaviruses were known to be transmitted by the airborne route**, as well as by droplets and fomites long before the pandemic, and since no virus has ever been known to change its route of transmission, why is there no clear indication of the airborne nature of SARS-CoV-2 in the guidance? Without this, it is impossible to interpret the guidance or to perform risk assessments since “unacceptable risk” depends on the exposure route being considered. It is therefore impossible for a ‘front line’ HCW providing close-quarter care to an infectious patient, or their employer to determine ‘by risk assessment’ whether they are at risk from airborne or droplet particles nor whether the droplet size is greater or less than 100 microns or greater or less than 5 microns which your scientists are unable to agree upon. SAGE, EMG and the Respiratory Evidence Panel all agree that the correct threshold between ‘aerosol’ and ‘droplet’ is 100 microns.

Since the scientific evidence around aerosol transmission has long pointed to the airborne route as a significant mode of transmission, we have been asking for recognition of this in the IPC guidance, but we find that only the UK Cabinet Office guidance on public avoidance of Covid-19 promotes this route- hence public health video campaigns by the government. If airborne transmission applies to the general public, why does it not do so to the close contact required to provide care to patients within 1-2m where aerosol density is greatest? Indeed, the evidence provided by the Expert Respiratory Evidence Panel* in October 2021 concluded that airborne transmission was possible with Covid-19 but that ventilation is effective only at distances greater than 2m. We have repeatedly pointed out that there are no feasible factors within the hierarchy of controls that are effective within 2m of an infected patient. Only effective RPE (and not FRSM) can provide such mitigation.

HSE has shown conclusively that FRSMs do not protect against airborne viruses, but IPC guidance continues to support their use except for AGPs or when risk assessments show “unacceptable risk”. What does this mean? Why does UKHSA guidance still adhere to the use of a method of protection which provides little or no protection according to HSE? To reiterate, **FRSMs are not RPE**.

The precautionary principle has been completely ignored even most recently by the inclusion of the word “predominantly” in the latest guidance. **The continuing wave of hospital admissions and transfer of sick Covid infected patients by ambulances necessitates an urgent revision of the guidance to make it absolutely clear that Covid-19 is transmitted via the airborne route as well as by droplets and fomites, and therefore that properly certified RPE is required for personal protection, rather than FRSMs**. Our view is that an “unacceptable risk of transmission” exists whenever providing contact care of suspected/confirmed cases and that RPE should be the default requirement, rather than being confined to a discredited list of prescribed AGPs or subject to the

vagaries of an indeterminable risk assessment. The word 'indeterminable' is used, simply because frontline HCWs have no means of quantifying, visualising, or otherwise detecting airborne virus when close to a patient. That is why RPE should be the default unless risk assessment shows otherwise (e.g. through repeated negative PCR tests) and irrespective of procedure.

The failure to respond to the many efforts by stakeholders such as those represented in this letter is sadly in keeping with the findings of the Lessons Learned report October 2021 and the culture of lack of responsiveness identified in the Shrewsbury maternity report, March 2022. This has led to a dereliction of the duty of care which NHS leaders should have for their workforce and represents a betrayal of UK healthcare workers throughout the pandemic. Is there nobody in UKHSA/DHSC/HSE who is willing to stand up for the NHS workers whom the whole nation was so happy to clap for earlier in the pandemic?

*This panel contained a wide spectrum of experts but none representing those HCWs who have to deliver care- for example the British Thoracic Society, British & Irish Association of Stroke Physicians, The Intensive Care Society, British Society of Gastroenterology, ENT-UK, RCSLT, QNI, CSP, College of Paramedics or BAPEN.

**as described by Prof Jonathan Van Tam and Dr Lisa Ritchie in their paper of 2013: Coia et al JHI 85(2013)170-182

Signed:



Dr Barry Jones MD FRCP, Chair of CAPA -Covid Airborne Protection Alliance

Attached: AACE letter 19/1/2022

Letter to UKHSA from AGPA & RCN August 2021

*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