Update on PPE and AGPs for BAPEN members, August 2021

Much has happened over the last month and it is time to update you on our activities. So-called "freedom day" came and went on July 19th and with it the Emergency Covid legislation enacted last year was set aside. Many of us failed to realise the implications of this for our campaign to obtain changes in PHE/IPC guidance on PPE for all close contact Covid care, but it means that more normal responses to harmful circumstances at work can occur again. HSE can resume its responsibilities under the law as the national regulator of safety at work, and this includes exposure to Covid-19. HSE had a disclaimer in its guidance during the Covid response which meant that employers did not have to report infections or deaths from infection potentially acquired at work in the NHS or care sector, provided that the worker was compliant with PHE guidance on use of PPE including FRSM (which we know to have been inadequate). This disclaimer has been removed and the HSE website now includes a statement to this effect, ie Covid infections acquired at work must be reported. It follows that employers are now again legally responsible for ensuring the safety of their employees when exposed to Covid-19 under COSHH regulations, and since airborne/aerosol transmission is now accepted by WHO, CDC, SAGE and PHE ("Hands, Face, Space, Fresh Air") the IPC based guidance from PHE is now defunct in our opinion.

The changes mean that employers must provide adequate levels of protection which means FFP3 or equivalent assuming supplies are available- something the government has assured us of. This was not so during the earlier phases of the pandemic when the initial guidance to use FFP3 for airborne protection was downgraded to FRSM at the same time as the disease was downgraded from a High Consequence Infectious Disease (HCID) in mid March, 2020. Despite opportunities to pro-actively revert to better protection when the "Kent" variant and later the "delta" variant took over, no such move occurred despite our best efforts through the AGP Alliance and its many partners. As part of these efforts we met with DHSC and PHE on June 4th 2021 but we could not elicit a response to our question concerning risk of aerosol transmission within 2m of a patient with covid infection. On June 1st, PHE did alter its guidance slightly to include local risk assessment with the possibility of using FFP3 but retained their statement that "*FRSM MUST be worn when providing direct patient care within 2 metres of a suspected/confirmed Covid-19 patient*" and FFP3 should be used only for AGPs. We have argued throughout that PHE guidance is not fit for purpose and strongly support the view that it is now trumped by COSHH regulations dealing with known hazards including the airborne nature of Covid-19.

As you all know, NGT insertion is classed by WHO and PHE as a Non-AGP on spurious grounds which we have challenged up to the highest levels including the Prime Minister, First Ministers, Secretary of State for Health, CMOs, CNOs and the Chair of the Commons Select Committee on Health throughout the pandemic. The latest evidence review performed by the Independent High Risk AGP Panel found no new evidence on NGT insertion and none at all for dysphagia assessments so concluded that neither procedure could be classified as an AGP, which is an entirely erroneous and one-sided scientific conclusion. As we now know that the acts of breathing, talking, shouting, singing, sneezing but above all, coughing produce far greater aerosol concentrations that alleged AGPs we are hopeful that the AGP list will become obsolete. Cough is king in the world of AGPs!

We also know that aerosol transmission can occur in the absence of close contact without touching infected surfaces or being in range of droplets and that asymptomatic patients can transmit by all 3 routes. Simple physics dictates that aerosol concentration is greatest the nearer to the origin of an

aerosol plume and so it follows that all who come in to contact with suspected or confirmed Covid patients must take a precautionary approach and wear FFP3 masks. These can be re-usable fitted masks which are environmentally and economically preferable to disposable ones, are more comfortable and can be made to fit even the most difficult of faces.

If despite this update you are still having problems persuading your IPC leads or managers to permit safer PPE when in close contact with Covid-19 patients or performing a NGT insertion, don't despair as change is coming in the form of a risk assessment tool developed by Alliance members, the RCN, BMA and BOHS* in conjunction with HSE. Thre BMA has issued its own guidance which is worth reading.

https://www.bma.org.uk/media/4376/bma-covid-19-reducing-infection-risk-to-staff-in-healthcare-settings-august-2021.pdf

Your managers and IPC leads are now responsible for providing adequate protection against the known airborne hazard of Covid-19 and must legally explain how workers have become infected whilst wearing only FRSM as PPE as this is NOT PPE as legally defined in HSE regulations which clearly state that FRSM do not protect against aerosols.

To give you further information on this you can find detailed explanations and examples of risk assessments on the website of an expert Health & Safety adviser we have been working with. https://www.tridenthse.co.uk/covid.html

For those of you who have contracted Covid at work, the public enquiry looms and BAPEN and the AGP Alliance with its partners will be giving evidence on your behalf to demonstrate the lack of response to our expert views as stakeholders. With 1500 healthcare workers having died, an estimated 100,000 suffering from long covid and nosocomial infections involved in up to 40% of all deaths, there will be many questions to answer.

Prepared by Dr Barry Jones

Chair, BAPEN IAC and Chair, AGP Alliance

*BOHS: British Occupational Hygiene Society