Meeting **IPC Cell Discussion**

Date & Time **22 December 2020 – 10:00-11:30**

In attendance: Lisa Ritchie, NHSEI (Chair)/ NR NR AACE/Laura Imrie, ARHAI Scotland/Eleri Davies, PH Wales/ NR NR Catherine Heffernan, PHE/ NR PH Wales/ NR NR Jackie McIntyre, NHSEI/Colin Brown, PHE/Debra Adams/ NR NHSEI/Mark Wilcox, NR NR PHE/Renu Bindra, PHE/Misha Moore, PHE

Meeting notes

LR talked through the ARHAI, Scotland, rapid review of literature, Rapid review of the literature SARS-CoV-2 variant VUI-202012/01: Implications for infection control within health and care settings, December 2020 See Appendix A.

MW - When variants are discovered they are called 'variants under investigation - VUI'. Once investigated they are called 'variants of concern - VOC'.

RB - Everything LR has summarised is what has been discussed by PHE so far.

LR - There seems to be a higher rate in the variant strain in under 60s.

MW - Data is based on 250 patients approximately, so numbers are small, but the majority are under 60 years. However, this could be due to who have presented for testing, there may be implications of transmissibility in children, but this is conjecture.

NR There are staff that are not happy working with COVID positive patients, as they are worried about this new strain so clear messaging is needed.

MW talked through the paper, SPI-M approved summary document: Estimating the importance of different routes of SARS-CoV-2 transmission in hospital settings, December 2020. See Appendix B.

The predominant transmission, according to modelling is patient to patient, between patient and healthcare workers is less frequent. New data is supplemented by the Wave 2 data. The learning has not changed. The new SPI-M consensus statement adds that if you are a nosocomial case, you are more likely to transmit infection. Community cases are more likely to be identified earlier. This reinforces the need to concentrate on patient to patient transmission. Patients wearing face masks should be mandatory unless there are clinical reasons for them not to do so. We should urge organisations to measure compliance with IPC measures and implement more rapid testing/shorter turnaround times, ideally at the front door (Emerg. Depts.) so patients can be placed appropriately. Patient movement should be limited.

NR - We need to make face mask/covering guidance clear for patients in other settings external to hospitals.

NR - We need to provide face masks for patients during their stay as there have been reports of patients only having one mask for their entire inpatient stay. We must work with winter pressure teams, as there can be conflicting advice re patient flow.

MW - Raised the patient flow issue at a meeting with the emergency care pathway team. Steve Powis was keen to emphasise minimal (safe) patient movement.

MM - We do not have legislation on mandatory face mask wearing for patients so it may cause issues with some patient groups for example, unseen disabilities so guidance should be clear on this.

NR We should consider the question of cohorting inpatient contacts and the risk of positive patients transmitting infection.

MW - This emphasises the need for rapid testing.

CB - The patient groups most likely to transmit infection are those very unwell patients unable to wear masks.

NR - There is a strong recommendation for inpatient face mask wearing in Scotland - it has been recommended that it should be documented in patient notes if patients cannot wear a mask.

NR - There is an issue of shared patient areas for example toilets cleaning of these areas must be increased and we need to be mindful of those patients with dementia wearing masks for example.

NR - There is a challenge with managing quarantine bays. We need to be clear when masks should be worn, as there has been an assumption that patients would not have to wear masks whilst in bed.

NR - For elderly patients, many are unable to comply with mask wearing most of the time. The ability to achieve a 2-metre distance between patients is difficult we should be mandating toilet cleaning after every patient use. It is not ideal to cohort patients with respiratory infections but with 90% capacity and some hospitals this is not achievable.

NR - We should consider whether current guidance drives the movement of patients in hospital.

MM - The title for the guidance may not be the best and we may need to consider changing it.

NR There are already local governance measures in place to drive the changes forward.

NR - Most patients brought in by ambulance could be wearing masks. There is a concern that extra measures could cause further delays to ambulances outside hospitals.

NR - Patient should wear masks. There is also the importance of role modelling by staff some staff are not wearing masks in the correct way, for example.

LI - We are currently looking at whether the new variant has caused hospital clusters to understand the transmission. We would be wary of recommending FFP 3 masks out with current recommendations at the moment and should look for the evidence first.

CB – It is difficult given the lack of evidence, but should we consider going back to a Table 4 style approach of PPE for everyone until the evidence is generated.

LR – If patient and staff face mask wearing and other IPC measures e.g. decontamination of environment/equipment are not being reliably implemented as they should be, it does not seem appropriate, in the absence of evidence regarding any change in mode of transmission, that a change to PPE should be recommended at this time.

NR - There is minimal evidence of patient to staff transmission, apart from what is known about high risk aerosol generating procedures. Therefore, we should not need to further recommend FFP3 masks at this time.

NR - Staff may not have a lot of time to educate patients on mask wearing. We should consider whether this could be done centrally.

NR - If we increase the use of FFP3 masks we need to consider stock availability, as this could put additional pressure on Trusts.

NR - If we make a decision regarding FFP3 masks, we need to be clear on why and we should review if evidence changes.

CB - Our understanding of aerosol transmission has changed. A precautionary approach to move to FFP3 masks whilst we are awaiting evidence should be advised.

NR - We need to consider the evidence we have available to us now. How do we manage staff expectations across hospitals and all other care settings if a FFP3 precautionary approach is taken ?

CB - Some hospitals are already moving to FFP 3 masks. We need a clear review date in a week and a rapid review of staff testing positive to confirm whether it is caused by a lapse in the use of PPE.

NR - There have been changes in patient attack rate on wards and the speed of transmission. There have also been changes in the attack rate among staff in red wards where COVID has increased. We need to take a different approach.

LR - It is important to gather the intelligence that all current IPC recommendations are being fully implemented.

NR We have seen generally good compliance with PPE so evidence should not be put on poor use of PPE.

MM - Issues of increased transmission could also be to do with poor estate/ventilation.

LI - We need to decide what indicators we are going to measure against and what intelligence we will use.

ED - There will be pressure from organisations and bodies for more precautionary measures. The confidence of staff in high intensity units is being lost. If there is a high-risk pathway, we should take precautionary measures.

NR - We need a clear rationale for the use of FFP 3 masks in different areas. There are other ways we can support staff.

NR - Patients in high risk areas (AGP hot spots) are more likely to have symptoms, therefore FFP3 masks could be worn in these pathways.

CB - we will need to get any changes signed off.

LI - we need to consider issues with fit testing and staff being excluded from work when failing a fit test.

LR – We appear to have consensus:

- that face masks for patients should be strongly recommended, and patients should be provided with a new mask every day or more often if required
- on the importance of rapid testing and limiting patient movement with hospitals
- on patient education on mask wearing
- on reviewing data on staff positivity and ongoing review of emerging evidence/science and data to inform IPC guidance

On the question of whether we need to change recommendations on the level of PPE/RPE - there does not appear to be available evidence that the PPE/RPE level currently recommended in the IPC guidance should change at this time.