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.

RD - 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.

DC - 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.

JM - 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.