

Message

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Sent: 23/12/2020 10:47:04 AM
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CC: [redacted] NR @nhs.scot; Abigail Mullings [Abigail.Mullings@nhs.scot]
Subject: RE: URGENT: UK IPC guidance consensus by 12md 23rd Dec 2020

Flag: Follow up

Many thanks Lisa for pulling this together

Can you confirm by return (midday tomorrow) whether you wish to recommend the use of FFP3 respirators in the high-risk pathway?

1. The evidence base has not changed regarding the route of transmission therefore on what basis would the UK IPC guidance be changed for these specific settings?

At the meeting held on 22/12/20 we agreed “Based on the rapid review it was agreed that there is currently insufficient evidence to change the IPC/ PPE precautions in response to the emergence of this variant strain. The UK IPC cell, PHE have agreed to continue to monitor and review the emerging evidence and data and if this situation changes amend the guidance accordingly. This rapid evidence review has not identified a change in the mode of transmission between this variant strain and previous circulating strains of SARS- CoV-2 and therefore it was agreed that there should be no changes to the PPE recommendations as currently set out in the guidance until more evidence/data is available.”

The evidence available prior to the new variant strain being reported has not changed. The CDC’s scientific brief dated 5th October (<https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html>), the following is stated; ‘circumstances under which airborne transmission of SARS-CoV-2 appears to have occurred include:

- Enclosed spaces within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space;
- Prolonged exposure to respiratory particles, often generated with expiratory exertion (e.g., shouting, singing, exercising) that increased the concentration of suspended respiratory droplets in the air space;
- Inadequate ventilation or air handling that allowed a build-up of suspended small respiratory droplets and particles.

There is no clear evidence of airborne transmission. The references provided at the end of the scientific brief largely consist of outbreak reports from restaurants, sports settings and a choir practice. There are unfortunately no air

sampling studies to provide a more detailed analysis of these settings/scenarios. These reports have been described in the media as 'super-spreading events' where people are likely in close enough proximity and engaged in activities that would allow direct and indirect contact transmission from droplet production. This is in line with a summary by [SAGE](#) 'This close-range transmission may be due to a combination of droplets and aerosols, as well as contaminated surfaces, and it is not yet possible to determine which mechanisms are dominating this transmission... There is no evidence of long-range airborne transmission.' The World Health Organization in their [9th July scientific brief](#), also acknowledge that in poorly ventilated spaces, transmission through an airborne route cannot be ruled out, however state that 'the detailed investigations of these clusters suggest that droplet and fomite transmission could also explain human-to-human transmission.' Poor adherence to mask use, physical distancing and hand hygiene would also increase the risk of droplet/contact transmission in these scenarios.

There is a larger evidence base for the assessment of airborne transmission that also includes prospective sampling studies undertaken in healthcare settings; this evidence base, which the CDC do not make reference to, is summarised in the [ARHAI Scotland IPC rapid review](#). Where it is stated that studies have reported both positive and negative results from air sampling studies in healthcare settings. This evidence base is in line with the [SAGE](#) position, which states that 'the evidence that aerosol transmission is significant compared to other routes is not sufficiently strong to recommend that respirators are used in locations other than high risk clinical areas where aerosol generating procedures take place.' The ARHAI Scotland rapid review is updated on a monthly basis with evidence appraised weekly; international guidance is also appraised.

2. High risk pathways are not the only pathway where COVID patients present – what would be the evidence/justification for HCW working in medium pathways not having access to the same level of PPE when there is intelligence from all 4 UK countries that COVID clusters occur in these pathways?

Are we suggesting that patients admitted with COVID are a higher risk of onward transmission than hospital onset cases? My understanding of the data was that hospital onset cases were more likely to infect a greater number of people when compared to community onset hospitalised patients. While the reasons for this may not be fully understood this does not support the approach of selecting the high risk pathway where the majority of cases will be known/suspected on admission from community for a different level of PPE compared to areas where onward transmission events are frequently recorded. In the absence of supporting evidence a clear understanding of the justification is required in order to communicate the risks that exist to staff in these areas that are not present in the other acute pathways or indeed other care settings i.e. out of hours, community settings.

In essence we would be changing the high risk event from a AGP to an COVID patient area however cases can be identified on any pathway and therefore if PPE is considered a necessary control to prevent HCW being exposed should this not be the same level across health and social care where there is a documented risk of this event occurring?

3. Given the SPI-M summary, discussed at the meeting, highlighted staff to staff transmission should the focus for reducing the risk of HCW exposure be on changing PPE guidance in a single pathway?

What evidence is there from Trusts/Boards that staff within these areas have higher risk of infection from a patient source? – do any of the nations have workforce data that supports a higher infection rate within these settings? If so this would be very helpful to understand.

We had a lengthy discussion at the meeting about clusters/outbreaks (out with high risk areas) and the importance of the hierarchy of controls and improvements that could be made to reduce transmission including, most areas reporting challenges in implementing some aspects of the current published IPC remobilisation guidance. Is introducing FFP3 in high risk areas diverting the messaging required to address the compliance with the hierarchy of controls?

The introduction of FFP3 within high risk areas will have no impact in reducing patient to patient transmission, as these occur out with the high risk pathway or staff to staff transmission if the behaviours out with the clinical area remain the same and all IPC controls are not fully implemented across the working environment and beyond.