5 Update on PPE

5.1 A high-level discussion took place; an update on PPE will be published but not considered to be a major change.

5.1.1 There was an update on aerosol generating procedures (AGPs), which was mainly clarification: two of the important ones were on 'any open suctioning'. Endoscopy includes involves some suctioning and similarly some ENT procedures; these would be added to the list of AGPs.

5.1.2 Chest compression and defibrillation per se, are not AGP. Recognising that first responders can do chest compressions and defibrillation but leave the scene when the resuscitation team carry out airway procedures.

5.2 PHE asked DHSC to check if there are responses in hand to the letter from the British Society of Gastroenterologists about endoscopy and the conflict between the recommendations on CPR and the recommendations of the Resuscitation Council.

Action 5: DHSC to check if these queries related to endoscopy and CPR have been addressed

5.3 Questions: Robert Dingwall – raised the question from MEAG regarding the implication of full beards for PPE. Representatives of Sikh faith were concerned about the fact that their beliefs required them to maintain full beards. Request for guidance from NERVTAG. It was noted that there is already guidance about beards – powered air hoods. It is in IPC guidance - there is an appendix about beards.

6 Non-invasive ventilation subgroup

6.1 Ken Baillie agreed to chair the group to answer a query from the CMO – is there any utility in a trial of different non-invasive ventilation strategies to prevent patients having to have mechanical ventilation?

6.2 The group was asked 4 questions -
a) Is there a patient group who may do as well on high flow oxygen or NIVE or invasive mechanical ventilation? The subgroup unanimously agreed that randomisation to NIV vs IMV was not a realistic option.

b) Is a triage decision based on these options based on rational considerations? That requires trial evidence, so focussed on the question of what supportive care options are available for a deteriorating patient that may reduce the need for invasive ventilation. There is a significant unmet need for trial data; although there is an extensive literature from deteriorating patients with pneumonia and ARDS, COVID-19 is different and there is likely to be opportunity to provide evidence that could have large scale benefit.