



14 April 2022

Duncan Burton  
Deputy Chief Nursing Officer  
NHS England

Sent by email: [Duncan.Burton@nhs.net](mailto:Duncan.Burton@nhs.net)

Dear Duncan,

The COVID-19 pandemic continues to place a significant burden on health and care services affecting both the workforce (through direct and indirect sickness) and those we care for. Recent media reports regarding the removal of testing from admissions to hospitals and potential plans to remove cohorting of patients with known or unknown COVID-19 status is a cause of significant concern to the alliance we represent.

Despite the current government rhetoric to 'live with covid' we consider COVID-19 to be a core patient safety issue that must be managed and monitored. Whilst we recognise the urgent need to manage the elective backlog and treat emergency patients presenting in hospitals we believe this

has to be balanced with transparent processes and governance that allows staff to deliver care as safely as possible. Our deep concern is based on the following:

- SARS-CoV-2 remains a hazard group 3 biological hazard as classified by the Advisory Committee on Dangerous Pathogens. This means exposure to the virus through work activities (i.e. when carrying out procedures in close contact with COVID positive patients) must be controlled and managed under COSHH Regulations in line with health and Safety Law.
- The ability to suitably risk assess the type of Respiratory Protective Equipment (RPE) required by healthcare workers (where risk remains following implementation of other control measures) requires clarity on the risk present. The absence of transmission route of COVID-19 in the current infection prevention guidance, and/ or a lack of knowledge on the COVID status of patients prevents a suitable and sufficient risk assessment from being undertaken. On the other hand, UK Cabinet Office guidance is clear that the airborne route is significant.
- When assessing the risks from biological agents, such as SARS-CoV-2, the HSE Approved Code of Practice (L5) to the COSHH Regulations, clearly states there should be consideration how and where biological agents are present and how they are transmitted (para 64).
- In an airborne state, biological agents such as SARS-CoV-2, are classed as particles and can be removed by filter-type RPE. When selecting RPE, it should be the highest efficiency filter possible, with a protection factor of at least 20 (FFP3) [HSE HSG53 Appendix 6](#)
- Risks to both healthcare workers and patients from acquiring COVID-19 within health and care premises, depleting the workforce even further and opening the NHS to a large number of litigation cases.
- A lack of timely transparent and publicly available data on healthcare acquired COVID-19 definitions and numbers in NHS Trusts for both staff and patients.

We are writing to you in Ruth May's absence seeking assurance that patient safety will not be compromised and to seek clarity on the points raised above.

We have also written to Dr Susan Hopkins, Chief Medical Adviser to UKHSA and a copy of this letter and enclosures are attached.

Yours sincerely,



Dr Barry Jones MD FRCP  
Chair of CAPA (Covid Airborne Protection Alliance)

\*CAPA

- ARTP - Association for Respiratory Technology & Physiology
- BAPEN – British Association for Parenteral and Enteral Nutrition
- BIASP – British and Irish Association of Stroke Physicians
- BDA – British Dietetic Association
- BOHS - British Occupational Health Society
- BSG - British Society of Gastroenterology
- College of Paramedics
- CSP – Chartered Society of Physiotherapy
- FreshAir NHS

- GMB Union
- HCSA - Hospital Consultants and Specialists Association
- MSDUK Med Supply Drive UK
- NNNG - National Nurses Nutrition Group
- QNI - Queen's Nursing Institute
- RCSLT – Royal College of Speech and Language Therapists
- Unite the Union
- Doctors Association UK
- Trident H&S