Meeting Date	**25 August 2020**	**Agenda Item**	**4.6**
Report Title	**Considerations in mandating face coverings for visitors to hospital sites in SBUHB**		
Report Author	Dr Keith Reid, Executive Director of Public Health		
Report Sponsor	Dr Keith Reid		
Presented by	Dr Keith Reid		
Freedom of Information	Open		
Purpose of the Report	This paper sets out the background evidence for consideration in relation to a policy on the mandatory wearing of face coverings by visitors to hospital sites within SBUHB. It has been produced at the request of the Board to allow consideration of the issues around this policy. It raises a series of questions to be considered before such a policy could be developed for ratification.		
Key Issues	Face coverings are mandatory for hospital visitors (and staff in all areas) in England following an instruction to NHS Trusts from the Secretary of State for Health. No such policy exists in Wales. The evidence supporting such a policy is weak. Face coverings are seen as an adjunct to and not a substitute for other measures to control the spread of COVID-19. Nonetheless such a policy is defensible. The rationale for a departure from Welsh Government policy requires careful consideration.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☐	☐
Recommendations	Members are asked to: • **CONSIDER** 1. Whether there is a clear benefit in implementing a local policy on face coverings for hospital visitors 2. Whether to proceed in developing a local policy on face coverings for hospital visitors 3. The implications for staff use of masks or face coverings of such a policy		

Considerations in mandating face coverings for visitors to hospital sites in SBUHB

1. INTRODUCTION

Following discussion at the July 2020 meeting of the Health Board a request was made to provide a paper to the Quality and Safety Committee to allow consideration of the issues associated with introducing a policy for wearing of face coverings by those on Health Board sites. One other Health Board in Wales had encouraged the wearing of face masks for visitors to Health Board premises during an outbreak.

2. BACKGROUND

"Face masks" is the term usually reserved for face masks produced and certified for use in medical or industrial settings where there is a consistency around their performance and function.

"Face coverings" is the term used for masks whether formally or informally produced that are not produced to an agreed standard but which nonetheless offer a degree of interruption to the dissemination of respiratory secretions into the environment. The level of protection afforded by face coverings is difficult to establish precisely because they may not be made to a standard and materials (and so filtration and retention of secretions) and fit might be variable.

There are two types of protection: firstly, protection of the wearer from virus in the environment spread by others (this is the protection offered by high performance medical masks); and secondly, protection of others from the wearer's secretions (this is the principal protection offered by face coverings – source control).

Current Policy position

Current guidance (Table 4) on the use of Personal Protective Equipment (PPE) is for all staff delivering direct patient care to wear a Fluid Resistant Surgical Mask (FRSM Type 11R) as a minimum level of protection against airborne transmission and for patients to wear a generic surgical mask to reduce the risk of them transmitting the infection to others (so called "source control" measure), where possible.

A policy requiring visitors to hospitals to wear face coverings had been introduced in the NHS in England (from 15th June 2020) but not universally in Wales.

The policy decision in England was announced by the Secretary of State for Health and Social Care on 5th June for implementation by 15th June. It included the requirement to make healthcare environments 'COVID secure' by *"using social distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate"*. It also mandated the wearing of masks by all hospital staff at all times in non-COVID secure areas (in addition to PPE for clinical procedures) and the wearing of face coverings for source control by visitors and outpatients to hospital settings. The rationale for this decision was given as being based on advice from Scientific Advisory Group for Emergencies (SAGE).

Emergence of the English Policy Position

The Novel and Emerging Respiratory Virus Technical Advisory Group (NERVTAG) produced an advisory paper on the evidence for face mask use in the community which was considered on 13th April 2020. [https://www.gov.uk/government/publications/nervtag-face-mask-use-in-the-

community-13-april-2020] This review concluded that there was a rationale that the wearing of masks by infected individuals may reduce transmission by reducing the expulsion of infected particles into the environment. It also concluded that there was evidence suggestive of a protective effect of mask wearing by uninfected individuals entering into areas of high –risk (known infection risk due to the presence of infected individuals) for short duration.

A key influence appears to be a paper from the Data Evaluation and Learning for Viral Epidemics (DELVE) group in the Royal Society. This report set out a summary of the evidence and policy implications for the wearing of face masks by the general public. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/893227/S0206_DELVE_report_on_Face_Masks_for_the_General_Public.pdf] Their conclusion was that *"If used widely and correctly, face masks, including cloth masks, can reduce viral transmission."* The rationale for this assertion was that face mask / face covering wear would reduce the shedding of droplets into the environment from *asymptomatic* individuals. The paper also highlighted that most transmission may be caused by droplets rather than aerosols (the exact balance remains unknown) and that droplet release into indoor environments is an important source of infection.

SAGE considered the issue of the wearing of masks by the public in community settings at its meeting on 21 April 2020 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/888799/S0396_Twenty-seventh_SAGE_meeting_on_Covid-19.pdf]. It concluded that there was "weak" evidence on the effectiveness of masks for source control but did remark on the consideration that infectiousness (virus shedding) in COVID when asymptomatic does appear to be different from other respiratory illnesses.

However, SAGE did not consider the issue of visitors wearing masks until its meeting on 11 June (after the Secretary of State announcement). It was prompted to do so by concern over nosocomial transmission and the role that asymptomatic infected visitors might play in introducing COVID into hospital environments.

There were at least two papers referred to by SAGE in reaching its recommendation on mask wearing in hospital settings. Of those only one is in the public domain [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895818/S0485_EMG_SARS-CoV-2_in_the_hospital_environment.pdf]. This paper from a number of SAGE sub-groups identified the same issues as those highlighted in the DELVE report – theoretical benefits for face coverings in reducing viral shedding by visitors to hospitals. It was, however, tentative in its support for the use of face covering by members of the public stating only that it *"is reasonable to consider the … use of … face coverings by the public … in hospitals".*

Welsh Guidance on the Use of Face coverings

Advice was provided to Welsh Government from the Technical Advisory Group in June on the scientific evidence underpinning the use of face coverings. [https://gov.wales/technical-advisory-cell-use-face-coverings-context-covid-19]

This advice informs the Welsh Government policy around the use of face coverings. It is a high level summary of the evidence rather than a comprehensive literature

review. Perhaps unsurprisingly, since it draws on the same source material, it reiterates the points made in the reports referred to above:

- The wearing of face coverings is likely to benefit others more than the wearer.
- Policy needs to consider how people will get access face coverings as well as the situations in which they should wear them. There also needs to be consideration about how masks are used to be effective and their disposal or cleaning.
- Face coverings are not a substitute for social distancing, hand washing and other mitigating measures. The TAC advice suggests that the benefit of mask wearing might be lower than these other measures.
- Consideration of the contribution of face coverings to overall COVID transmission reduction is important to set against the dysbenefits of mandating the wearing of face coverings.
- The guidance considers it feasible that a face covering might reduce transmission of SARS-CoV-2 provide certain provisos around mask construction and wearing are satisfied.

The guidance indicates that there is an expectation that more information on the likely benefits of face masks will emerge.

Importantly, the guidance acknowledges that even with mandatory mask wearing there are groups who will be exempted from wearing face coverings. These groups include children and the elderly or those with cognitive impairment, those with skin conditions. Those with hearing impairment or who are D/deaf and who may be reliant on lip reading from effective communication will be disadvantaged by a policy requiring face coverings to be worn.

There is a difficulty in ensuring that face coverings are constructed in such a way as to provide a minimum effective level of protection. The World Health Organisation (WHO) [https://www.who.int/publications/i/item/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak] has provided some guidance on the construction and use of face coverings and the relative performance of different materials but how this relates to the real-world performance of non-certified face coverings (and thus to their likely benefits) is not straightforward.

Framing Policy for the use of Face Coverings during COVID-19

Consideration of the policy around face coverings is currently framed in terms of the infection control effects. That is to say that the current attitude in Wales is around 'how much will my individual risk be reduced if I or others are required to wear masks?' and 'what is the evidence to support such an intrusion?'

There is a school of thought that is captured in a BMJ article [Greenhalgh T et al; *Face masks for the public during the covid-19 crisis* BMJ 2020;369:m1435 doi: 10.1136/bmj.m1435] that because wearing a face covering is highly feasible and practicable and has low detriment to wearers and others that it should be mandated even if the benefit in terms of transmission reduction is low. The overall population benefit if uptake of mask wearing is high is *likely* to be worthwhile (but is not proven). The extent of any benefit to mask wearing in the community in general is not likely to be high in comparison with other measures (especially social distancing) and the

benefit is likely to be unevenly distributed within the population. The specific instance of mask wearing by visitors in hospital settings is supported by weak evidence. This is not direct evidence but an extrapolation to predict a benefit for the wearing of face coverings for short duration exposure in high risk settings where the prevalence of COVID-19 disease is high in the community.

Drivers for the wearing of face coverings during the COVID -19 pandemic include normal cultural practice in relation to respiratory disease (such as in many Eastern Asian countries), a desire to implement a feasible and practical response with the intent of reducing transmission (in some European and Middle Eastern countries). Additional elements to the policy space are the need to reduce public consumption of masks during a time of global pressure on supplies to assist in provision to clinical situations and the desire to promote self-help approaches as part of an overall strategy for compliance with disease control measures.

There are some studies (included in the reviews referred to above) which suggest that wearing a mask does not reduce and might increase the risk of transmission of respiratory infection but the reasons for this are not clear. It may arise from incorrect mask usage that permits masks to act as a vector for infection or it may arise from compensatory increase in risk behaviour.

However, there does not appear to be any evidence to support the assertion that wearing of masks leads to a loss of attention to other mitigating measures such as social distancing or hand hygiene. Indeed, wearing a face covering may have no direct impact on other hygiene measures or may reinforce them – we don't know. [Mantzari E; Rubin GJ; Marteau TM *Is risk compensation threatening public health in the covid-19 pandemic?* BMJ 2020;370:m2913 http://dx.doi.org/10.1136/bmj.m2913]

For a policy of mandatory face covering to be effective it needs to be framed in a way that highlights benefits and makes it relevant to the wearer. In the UK where there is no established tradition of mask wearing this might be seen as difficult but mask wearing has become established as a social norm in many settings in England as a result of policy. Resistance to mask wearing is likely to be overstated and a policy of educating non-compliant individuals is likely to be effective, rather than an enforcement approach. [van der Westhuizen et al *Face coverings for covid-19: from medical intervention to social practice* BMJ 2020;370:m3021 http://dx.doi.org/10.1136/bmj.m3021]

Issues to be considered in arriving at a policy position

In considering whether we should adopt a policy of mandatory mask wearing for visitors to our hospitals there is a number of questions to be addressed in addition to considering the strength of the evidence supporting such a policy.

a) What is the purpose of considering a local policy on face covering wearing by the public? Who are we aiming to protect and how and to what extent does a local policy support this objective? There would need to be a clear rationale for departing from Welsh Government policy, for example, in terms of higher risk locally than elsewhere in Wales.
b) Would we extend that policy to include the wearing of face masks by staff (as in England) and if not how would we justify the variance in approach?
c) Are other parties harmed in some way by the policy and is that harm or intrusion justified by the likely benefits sought or can it be otherwise mitigated? Can the policy be applied in a near universal fashion or are

exceptions and the associated impact on the overall policy effectiveness justifiable and acceptable?

d) Who is responsible for the provision of the masks and bears the cost? Can we ensure a consistent and regular supply of masks that are suitable for the intended purpose? Can this supply be distributed in such a way as to ensure equitable access? Will increased mask consumption have an impact on our ability to protect staff during clinical tasks?
e) Should we be requiring out-patients who attend our facilities to wear masks (SBUHB provided) to reduce the risk of transmission to our staff? And/or the risk of transmission to other patients (to whom we owe a duty of care)?

The aim of the policy of promoting face mask wearing in the public is to reduce the risk of asymptomatic infected public spreading the virus to others while indoors in settings where other mitigation measures are likely to be compromised.

Currently we have low levels of disease in our community and so the immediate direct benefit of mask wearing is likely to be low.

3. GOVERNANCE AND RISK ISSUES

The risks associated with this decision fall into two broad areas: firstly, the corporate risk associated with departure from Welsh Government policy around face coverings in the NHS; and secondly, any risk associated with a perceived or actual increased likelihood of viral transmission within our hospitals by not adopting this policy.

4. FINANCIAL IMPLICATIONS

Adoption of a policy is likely to have financial implications associated with an increased use of PPE dependent upon the final framing of any policy – ie whether such a policy mandates use of PPE for staff greater than currently and/or provides access to PPE for public visiting our sites. A policy that requires use of a face covering (not supplied) by visitors is less likely to have significant financial implications.

5. RECOMMENDATION

The Committee is invited to consider the questions posed above and in particular arrtive at a position on:

a) Whether there is a clear benefit in implementing a local policy on face coverings for hospital visitors?
b) Whether to proceed in developing a local policy on face coverings for hospital visitors
c) The implications for staff use of masks or face coverings of such a policy

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☒

Quality, Safety and Patient Experience

A policy may be perceived as improving the care environment by reducing risk of nosocomial infection and thus increasing patient safety. Having visitors and out-patients wearing masks may act as a disincentive to attend hospitals by reinforcing a perception of hospitals as 'risky environments'. There is a risk that mask wearing will adversely impact on communication within consultations.

Financial Implications

The development of a policy will have financial implications in terms of increased consumption of PPE.
This is dependent on the final scope of the policy and in particular whether staff use of PPE is mandated for the duration of shifts in all areas of hospitals. (as per England)
Information on the likely additional costs will be available from experience in England.
This expenditure would not feature in current budgets.

Legal Implications (including equality and diversity assessment)

Health and Safety legislation and Equality legislation are both relevant to inform the drafting of any final policy.
In particular, considerations around the extent of the risk being mitigated through any mandatory policy and its impact in groups with qualifying characteristics – eg those who are deaf.

Staffing Implications

There are unlikely to any significant implications for staffing.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

○ **Long Term** – This policy might be seen as reducing the longer-term impact of COVID-19 in our communities by reducing the incidence. ○ **Prevention** – This approach in theory supports a preventive approach but evidence of effectiveness is currently lacking. ○ **Integration -** Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their other objectives, or on the objectives of other public bodies. ○ **Collaboration –** Such an approach could be seen as engaging with the public around wider preventive measures and supporting self-care during the pandemic. ○ **Involvement –** Policy development would allow for engagement with diverse groups, including those adversely impacted by the policy, and any policy involving staff would be developed in partnership with staff side.	
Report History	This is the first report on this topic.
Appendices	References are accessible through the URLs provided within the text and contain the detailed evidence reviews.