Citizen Participation and Public Petitions Committee
Wednesday 5 March 2025
4th Meeting, 2025 (Session 6)

PE2071: Take action to protect people from airborne infections in health and social care settings

Introduction

Petitioner Sally Witcher

Petition summary Calling on the Scottish Parliament to urge the Scottish Government to:

- improve air quality in health and social care settings through addressing ventilation, air filtration and sterilisation;
- reintroduce routine mask-wearing in those settings, particularly respiratory masks;
- reintroduce routine Covid testing;
- ensure staff manuals fully cover preventing airborne infection;
- support ill staff to stay home;
- provide public health information on the use of respiratory masks and the HEPA air filtration against airborne infections.

Webpage https://petitions.parliament.scot/petitions/PE2071

1. The Committee last considered this petition at its meeting on 17 April 2024. At that meeting, the Committee agreed to write to the Scottish Government, the Royal College of Nursing, the Royal College of Physicians, Scottish Care, ALLIANCE Scotland and the Care Inspectorate.

2. The petition summary is included in **Annexe A** and the Official Report of the Committee's last consideration of this petition is at **Annexe B**.

3. The Committee has received new written submissions from the Care Inspectorate, Scottish Government, ALLIANCE, Scottish Care, Royal College of Nursing, the Petitioner, and the Royal College of Physicians of Edinburgh, which are set out in **Annexe C**.

4. Written submissions received prior to the Committee's last consideration can be found on the petition's webpage.

5. Further background information about this petition can be found in the SPICe briefing for this petition.

6. The Scottish Government gave its initial response to the petition on 15 January 2024.

7. Every petition collects signatures while it remains under consideration. At the time of writing, 732 signatures have been received on this petition.

Action

8. The Committee is invited to consider what action it wishes to take.

Clerks to the Committee
February 2025

Annexe A: Summary of petition

PE2071: Take action to protect people from airborne infections in health and social care settings

Petitioner

Sally Witcher

Date Lodged

6 December 2023

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to:

- improve air quality in health and social care settings through addressing ventilation, air filtration and sterilisation;
- reintroduce routine mask-wearing in those settings, particularly respiratory masks;
- reintroduce routine Covid testing;
- ensure staff manuals fully cover preventing airborne infection;
- support ill staff to stay home;
- provide public health information on the use of respiratory masks and the HEPA air filtration against airborne infections.

Previous action

I have:

- met with my constituency MSP, suggested PQs
- met and corresponded with lead officials on masking, ventilation, vaccination and clinical risk
- submitted FoI requests
- requested meeting with Antimicrobal Resistance and Healthcare Associated Infection Scotland (declined).
- I have met with the Director for Strategy, Governance and Performance at Public Health Scotland.

Background information

Infections like Covid, flu, Respiratory Syncytial Virus Infection, measles and TB spread by inhaling tiny airborne aerosols hanging in the air like smoke. Key ways to prevent it are to improve air quality and wear well-fitting respiratory masks. Reinfection increases risk of long-term serious damage potentially for anyone, to brain, heart, immune system, etc. Care workers top the long Covid league. Repeated illness and job loss put avoidable pressure on services. The rate of hospital acquired Covid infection has been shown to be higher than in the community (ARHAI ceased

collecting that data in March, prior to the removal of masking guidance in May). Clinically vulnerable people often must use care but some are cancelling essential health appointments. Transmission is often asymptomatic. Covid isn't seasonal. Routine testing is thus essential. There are many tools to protect health and the NHS. Only one is being used: vaccination – which is unavailable to many, including some clinically vulnerable people.

Annexe B: Extract from Official Report of last consideration of PE2071 on 17 April 2024

The Convener: PE2071, lodged by Dr Sally Witcher, is on taking action to protect people from airborne infections in health and social care settings. Jackie Baillie has endured our proceedings since her earlier contribution, to stay with us and contribute to our discussion of this petition, too.

The petition calls on the Scottish Parliament to urge the Scottish Government to improve air quality in health and social care settings through addressing ventilation, air filtration and sterilisation; to reintroduce the routine wearing of masks, particularly respiratory masks, in those settings; to reintroduce routine Covid testing; to ensure that staff manuals fully cover preventing airborne infection; to support ill staff to stay at home; and to provide public health information on the use of respiratory masks and high-efficiency particulate air—HEPA—filtration against airborne infections.

The Scottish Parliament Information Centre's briefing states that the highest-risk list ended on 31 May 2022, and that the guidance on extended use of face masks and coverings across health and social care settings was withdrawn on 16 May 2023.

The Scottish Government's submission explains that a robust process is in place for creating, updating, and removing Covid-19 guidance and that the information sources and decisions remain under continual review. Routine testing has now been paused, with the exception of such testing pre-discharge from hospitals to care homes and hospices.

On staff manuals, the Government explains that it has no ownership or control over the content of the "National Infection Prevention and Control Manual". It also notes that new guidance on ventilation for non-clinical workplaces was published in October 2022, which included refreshed advice on measures to improve ventilation for individuals and workplaces, as well as new guidance detailing the most appropriate use of air-cleaning technologies.

The petitioner has provided two written submissions, which are available to members in their meeting papers. She emphasises her concerns about the on-going risks of Covid-19 at a national level. She notes that the Public Health Scotland dashboard for acute hospital admissions revealed a higher rate over the winter just past than that when the mask guidance was withdrawn.

The petitioner highlights that an estimated one in 10 infections results in long Covid, and that care workers are disproportionately affected. She points out that NHS England has guidance on the use of HEPA filters and sterilisation in hospitals, whereas Scotland focuses on ventilation. On face masks, she highlights the Royal College of Nursing's support for reinstating mask wearing and that individual person-centred clinical risk assessment for respiratory protective equipment does not work when there is a risk for everyone in the environment. On public awareness, the petitioner asks why nothing has been done to share important information with the public about the on-going risks of Covid-19.

The Care Inspectorate has written to draw attention to its updated guidance, which makes it clear that care homes must not rely on mechanical ventilation only and must have the ability for fresh air to be provided. In response, the petitioner asks what the Care Inspectorate would consider to be adequate and suitable ventilation and how that is to be addressed and enforced.

The issues raised in the petition are similar to those on which we took evidence in respect of an earlier petition that was subsequently closed, on which we heard from long-term Covid sufferers on sustained issues arising from the former pandemic.

Before I ask members how we might proceed on the petition, I invite Jackie Baillie to address us again.

Jackie Baillie: I thank Dr Sally Witcher for bringing the petition to Parliament. I am one of the co-conveners of the Parliament's cross-party group on long Covid, so I am well aware of the calls to improve air quality in both health and social care settings and indoor settings such as schools. We have debated the issue in Parliament.

I was interested to read the Scottish Government's response, because it sets out quite clearly what it is not doing. Covid has not gone away. Just because the Scottish Government believes that nobody is still at risk does not make that true. Those who are immunosuppressed are still at risk of contracting Covid, and we must ask what we can do to protect them.

As I said, Covid-19 has not gone away. The clinical risk continues. There is a direct impact not just on someone's health but on the economy. Many of the statistics that we have seen in recent times, which show the number of people who are not employed, suggest that there is a problem that we must consider.

We also know that reinfection with Covid-19 increases someone's chances of developing long Covid, and, as Dr Witcher has said, one in 10 people are likely to get long Covid and suffer long-term symptoms.

The impact on the economy is significant and can be seen in our public sector as well. I recently attended a long Covid group in Inverclyde, and everyone at the table who had long Covid was a front-line worker. Whether they worked in a school or in a health and social care setting, they were the ones without PPE at the beginning, and they have been impacted the most. The issue is having a significant effect not just on the economy in its widest sense but on our public services and their ability to run.

No one is immune to the risk. All of us here could get Covid. Vaccination is now restricted to those over 75 and people who are immunosuppressed. Regular testing has been stopped in health and social care settings, so we do not know who has got it and whether they are passing it on, and the use of face masks and covering is no longer mandatory. That is an issue specifically in health and social care settings; I am not talking about what is happening in the wider population, where we do not even bother to count incidences anymore, so we do not know whether the rate is bad or not to any great degree.

The introduction of improved air quality in health and social care settings would be an important step in preventing people from being infected and reinfected with

Covid-19 and suffering the subsequent effects of long Covid. Other things that would make a huge difference include making PPE available to those who work with vulnerable people, bringing back testing so that we can monitor prevalence and direct our response, and supporting people at home.

In her submissions, the petitioner has shown that clinically vulnerable people are more likely to experience poorer outcomes as a result of Covid. They report that they feel that healthcare is unsafe and that action on clean air and the use of respiratory masks in healthcare settings would make a difference.

Of course, we are talking not only about Covid but about other respiratory illnesses. A study in Europe found that people who were exposed to dirtier air spent as many as four days longer in hospital and were 36 per cent more likely to need intensive care treatment. That shows that the petition's proposal works in relation to other illnesses as well. The research, which was published in the European Respiratory Journal, said that cleaner air brought health benefits that are almost as great as some of the medical treatments given to Covid-19 patients. However, in response to the petition's call for ventilation systems, the Scottish Government said that health boards should

> "use their delegated capital budgets to maintain their estates, replace equipment and minimise risk to patients, staff and visitors."

That is funny, because health boards are facing enormous budget pressures on a scale that we have not seen for a while, and they are going to be forced to make cuts to their existing budgets, with all capital projects basically halted. Therefore, without assistance and direction to do so, it will be almost impossible for health boards to fund the air filtration systems in hospitals that are needed to make clean air.

Of course, the issue is about not only hospitals but care settings, including care homes and care at home. Vulnerable people surely deserve a level of protection that reduces risk. For example, if someone who is immunosuppressed has carers coming in, PPE should surely be available. The Care Inspectorate's submission does not really consider that point at all, which is disappointing.

In closing, I will say that, in 2022, as a result of the expertise and learning that they acquired during the pandemic, and their awareness of the importance of good indoor air quality for health, Belgium passed a law to improve indoor air quality in all closed spaces that are accessible to the public. However, we seem not to have learned any lessons at all, and certainly none in relation to protecting those who are most vulnerable or are immunocompromised, and I hope that this petition will start the process of ensuring that the Scottish Government pays attention to what it needs to do.

The Convener: Thank you. This is our first consideration of the petition, and it may well be that there is further evidence that we would want to take and other views that we would want to hear. Do colleagues have any suggestions for action?

Foysol Choudhury: I suggest that we write to the Scottish Government to ask when its latest review of information sources and decisions relating to the pause in or

withdrawal of Covid-19 guidance took place, and what the outcome of that review was.

We could also write to stakeholders to seek their views on the action called for in the petition. Those stakeholders could include the Royal College of Nursing, Scottish Care and the Health and Social Care Alliance Scotland. We could also write to the Care Inspectorate to ask how "adequate and suitable" ventilation is defined in practice and how it assesses and enforces the ventilation standards.

The Convener: I am particularly interested in Mr Choudhury's suggestion in relation to the Care Inspectorate, which I think is quite right. "Adequate and suitable" is very vague terminology, and I would have thought that it is certainly not a benchmark against which any definable standard introduction could be monitored.

Maurice Golden: I think that we should also write to the Royal College of Physicians. In our correspondence to the Scottish Government, and perhaps to other stakeholders, we should include questions about monitoring indoor air quality, which could be relevant to what factors we might wish to consider in order to improve it. We need to get evidence on that.

The Convener: As there are no other suggestions, does the committee agree to proceed on that basis?

Members *indicated agreement.*

The Convener: We will keep the petition open, and we will begin our inquiry. I thank Jackie Baillie again for her participation.

Annexe C: Written submissions

Care Inspectorate written submission, 21 May 2024

PE2071/E: Take action to protect people from airborne infections in health and social care settings

As the independent scrutiny, assurance and quality improvement support public body for social care and social work in Scotland, we welcome the opportunity to inform continued consideration of PE2071.

How “adequate and suitable” ventilation is defined in practice

The reference to “adequate and suitable ventilation, heating and lighting” is taken directly from The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, which set out the requirements which must be complied with by providers of care services under Part 5 of the Public Services Reform (Scotland) Act 2010.

The Health and Social Care Standards, which we led the development of with Healthcare Improvement Scotland, set out what people should expect when using health, social care or social work services in Scotland. They are rights-based and written from the perspective of people experiencing care, placing emphasis on assessing experiences of people rather than compliance with set processes. Since they came into use in April 2018, we have incorporated these into our inspection methodology ensuring they inform our scrutiny and quality improvement support approach. The Scottish Government has indicated its intention to review the Standards, as recommended by the Independent Review of Inspection, Scrutiny and Regulation of Social Care in Scotland.

As set out in our previous submission, there are a number of relevant Health and Social Care Standards to consider in relation to the topic at hand:

- Standard 5.12 states: “If I live in a care home, I can control the lighting, ventilation, heating and security of my bedroom.”
- Standard 5.18 states: “My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells.”
- Standard 5.19 states: “My environment has plenty of natural light and fresh air, and the lighting, ventilation and heating can be adjusted to meet my needs and wishes.”

As the national scrutiny, assurance and quality improvement organisation for social care we support the implementation of good infection prevention and control (IPC) practice in registered services and we signpost and recommend that the national infection guidance is followed in this regard. Specific guidance on this can be found in the Care Home Infection Prevention and Control Manual (CH IPCM), which is

maintained by Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI).

As set out in the Manual: “Ventilation is also an effective measure to reduce the risk of some respiratory infections, by diluting and dispersing the pathogens which cause them. Consider opening windows and vents more than usual, even opening a small amount can be beneficial. Opening windows and doors may present security and safety issues and so a local risk assessment should always be undertaken.”

During every care home inspection, as a core assurance we observe the setting and physical environment. We would expect services to ensure natural ventilation wherever possible, though we understand that this is not always a straightforward judgement due to the nature of the physical environment and/or people’s personal needs and preferences. We note that ventilation is one of a number of mitigating factors in preventing the transmission of infection. For example, the CH IPCM states that hand hygiene is the “most important thing you can do to prevent the spread of infection in a care home”.

We stress, however, that requirements in relation to building standards (and ventilation provision in this regard) are set in building standards legislation, and do not sit within our remit. We also acknowledge that we are not the foremost authority in relation to the topic of ventilation and as such we signpost a range of other sources of appropriate guidance and information, including the Health and Safety Executive (HSE), the Chartered Institution of Building Services Engineers (CIBSE) and Health Facilities Scotland (HFS). We also draw attention to Scottish Government guidance for employers on improving ventilation and the supply of fresh air into the workplace. In addition, we note that our locus is restricted to social care settings and we would not have a role in relation to healthcare settings.

In relation to care at home, we would also expect good practice to be followed in line with the National Infection Prevention and Control Manual. We inspect care at home services and combined services, with infection prevention and control an area we look at as a core assurance. However, we would not make a judgement on ventilation as the home environment is not the responsibility of the care provider.

On the use of facemasks, Personal Protective Equipment (PPE) is the last level of control in the ‘hierarchy of controls’, as set out in the CH IPCM. In line with Scottish Government guidance, staff and visitors within social care settings do not need to routinely wear a face mask or face covering. For many, their social care setting represents their home, and we know how beneficial meaningful connection is to physical, mental and emotional health and wellbeing. We note that prolonged use of facemasks can inhibit communication, particularly for people living with dementia and communication difficulties, and be detrimental to wellbeing, resulting in increased levels of distress. However, services should continue to follow IPC guidance and a facemask should be worn where staff think there is a risk of the supported individual being exposed to infection, taking reasonable steps to explore alternative measures should a facemask create a significant communication barrier.

We would expect a care worker to wear a mask if the person they are caring for expresses a wish for them to do so.

How the Care Inspectorate assesses and enforces the ventilation standards

Responsive regulation enables us to assess risk, use professional judgement and be proportionate in our response and action. Supporting services to improve by signposting and providing professional and specialist advice enables them to adapt, learn and improve practice.

As such, when a service is not operating at the standard we expect, we seek to try and support improvement. Where this does not happen we have enforcement powers. We can impose extra conditions of registration, serve formal improvement notices requiring changes within a required timescale and cancel registration if an improvement notice is not complied with, subject to appeal to the sheriff. Closing a care service is not common and a last resort.

As mentioned previously, an observation of the setting and physical environment is conducted at every inspection of a care home service. If we become aware of a service not implementing good practice in relation to infection prevention and control, we would raise this with the service to find a resolution. If the necessary improvement is not forthcoming we may take action in line with our powers, as set out above.

Scottish Government written submission, 28 June 2024

PE2071/F: Take action to protect people from airborne infections in health and social care settings

Thank you for your follow-up email of 30 April 2024 on behalf of the Citizen Participation and Public Petitions Committee in relation to PE2071, regarding a call for the Scottish Government to take action to protect people from airborne infections in health and social care settings.

The committee has asked:

“The Scottish Government’s initial response to the Committee explained that there is a robust process in place for creating, updating, and removing COVID-19 guidance and that the information sources and decisions remain under continual review.

The Committee would welcome information on when the latest reviews of information sources and decisions relating to the pause or withdrawal of COVID-19 guidance took place and what the outcomes of those reviews were.”

This will be considered in response to both the extended use of facemask guidance in health and social care settings as well as COVID-19 testing policy.

Extended Use of Face Masks and Face Coverings across Health and Social Care Settings

The latest review on the extended use of face masks and face coverings guidance across health and social care settings occurred between March and April 2023. The agreed outcome of this review was to withdraw the Scottish Government's extended guidance, which took effect as of 16 May 2023.

This followed advice from National Services Scotland Antimicrobial Resistance Healthcare Associated Infection (ARHAI) and Public Health Scotland (PHS) that health and social care settings should revert to the National Infection Prevention and Control Manual (NIPCM) and the Care Home Infection Prevention and Control Manual (CH IPCM).

The NIPCM and CH IPCM provide evidence-based guidance on the use of personal protective equipment (PPE), including face masks and respiratory protective equipment (RPE) centred on clinical need and risk assessment.

COVID-19 Testing

The Test and Protect Transition Plan published in March 2022 and successive changes to testing policy confirmed that testing for COVID-19 would be kept under regular clinical review as pandemic conditions and associated threat levels changed. In the latest reviews (June 2023 and March 2024), PHS and ARHAI recommended pausing routine testing in health, social care and prisons settings, which was implemented in August 2023, and ending routine testing for care home residents discharging from hospitals or hospices, which will be implemented by 3 June 2024. These changes came after the agreement of Scottish Government clinical advisors, wide engagement with sectors and trade unions as well as consent from Scottish Ministers.

Earlier in the COVID-19 pandemic and before we had the benefit of vaccinations and treatments, widespread testing was required to reduce transmission, along with other protective measures. Fortunately, we're now in a very different position, with high levels of population immunity and effective treatments for COVID-19 having significantly reduced the direct harms of the virus.

Free testing has therefore ended for most people in Scotland and lateral flow tests are now being used in a much more targeted way to support clinical care and protect high risk individuals. Those eligible for COVID-19 treatments can access tests free of charge, and a list of eligibility criteria for treatment can be found on NHS Inform.

It is still recommended that those with symptoms should try to stay at home and avoid contact with others until recovered. This advice has been informed by expert public health advice and represents a proportionate approach to managing COVID-19. Nonetheless, we recognise that COVID-19 has not gone away, and further changes to testing continue to be kept under regular clinical review.

Respiratory Surveillance

As can be seen above, the extended use of face masks and face coverings across health and social care settings guidance and the COVID-19 testing policy underwent reviews prior to being withdrawn or paused. These reviews included receiving advice from both PHS and ARHAI as well as consideration of the epidemiological context.

The Scottish Government recognises that surveillance of respiratory infections is a critical part of our approach to monitoring and managing the spread and prevalence of COVID-19 and other respiratory viruses in Scotland. As such we support both PHS and ARHAI to undertake surveillance activity.

This surveillance helps us to determine the right public health strategies and timing to manage transmission in the community. PHS is responsible for delivering Scotland's National Respiratory Surveillance Plan (publichealthscotland.scot) with the support of the Scottish Government.

In Scotland, respiratory infection levels and their impact are monitored using various sources of data, including microbiological sampling and laboratory test results from community and hospital settings, NHS 24 calls, primary care consultations, and hospital admissions.

The intelligence generated from these different data sources provide a comprehensive picture of current respiratory illness in Scotland.

It may be helpful to note that epidemiological information on seasonal respiratory infection activity in Scotland including COVID-19 is published online by PHS in their National Respiratory Infection and COVID-19 Statistical Report (Viral respiratory diseases (including influenza and COVID-19) in Scotland surveillance report 16 May 2024 - Viral respiratory diseases (including influenza and COVID-19) in Scotland surveillance report - Publications - Public Health Scotland) with the data updated through the PHS interactive dashboard which can be found at https://scotland.shinyapps.io/phs-respiratory-covid-19/.

ARHAI is responsible for the development and publishing of the NIPCM. The NIPCM is updated in real time with any changes required to be made to guidance as a result of the quarterly evidence reviews and our three yearly full literature reviews. ARHAI Scotland also has the ability to monitor respiratory activity via the outbreak reporting tool which trigger considerations and discussions regarding any additional precautions.

The Scottish Government works closely with both PHS and ARHAI. If data gathered through routine surveillance indicates the need to consider enhanced public health mitigations (in this case the reintroduction of routine facemask/face covering use in health and social care settings) then PHS and/or ARHAI will offer this recommendation as part of their advice to Scottish Government to help shape any policy change.

I would like to thank you again for raising these concerns with the Scottish Government and I hope that you find this response helpful.

Chief Nursing Officer Directorate

ALLIANCE written submission, 28 June 2024

PE2071/G: Take action to protect people from airborne infections in health and social care settings

Thank you for your 30 April 2024 letter from the Citizen Participation and Public Petitions Committee. The Health and Social Care Alliance Scotland (the ALLIANCE) welcomes the opportunity to comment on petition PE2071.

The ALLIANCE and its members have emphasised that people continue to be directly and indirectly affected by COVID-19, especially disabled people, people with long term conditions, unpaid carers and the health and social care workforce[1]. Ongoing impacts, including non-COVID related health impacts, must be considered and addressed[2].

Despite the official end of shielding, many people continue to protect themselves from social contact, keeping away from possible infection[3]. They are not reassured that the removal of protections is safe or that they are considered in decision-making. We must listen to those with lived experience, designing support and permanent protections to allow them to enjoy their right to live well.

In our research, Health, Wellbeing and the COVID-19 Pandemic, people told us that they had requested that health services visit them at home as they were shielding, frightened to use public transport or have physical accessibility requirements, but were denied[4]. Many people still feel that they are "being left to fend for themselves" with limited prevention measures in place[5].

This unequal partnership in care, where people are not involved in decision-making regarding how their care is delivered, disempowers individuals and does not

[1] Health and Social Care Alliance (the ALLIANCE), "COVID-19", available at: COVID-19 - Policy and research (alliance-scotland.org.uk); Health and Social Care Alliance (the ALLIANCE)
[2] Health and Social Care Alliance (the ALLIANCE), *Putting people at the centre of an independent inquiry into COVID-19,* (2021) available at: Putting people at the centre of an independent inquiry into COVID-19 - Health and Social Care Alliance Scotland (alliance-scotland.org.uk).
[3] Health and Social Care Alliance (the ALLIANCE), *Living with COVID: an anthology,* (2022) available at: Living with Long Covid - an anthology - Health and Social Care Alliance Scotland (alliance-scotland.org.uk)
[4] Health and Social Care (the ALLIANCE), *Health, Wellbeing and the COVID-19: Scottish Experiences and Priorities for the Future,* (2021) available at: Health-Wellbeing-and-the-COVID-19-Pandemic-Final-Report.pdf (alliance-scotland.org.uk).
[5] Health and Social Care Alliance (the ALLIANCE), 'Living with COVID-19: Carers Parliament event report' (26 April 2023). Available at https://www.alliance-scotland.org.uk/blog/news/living-with-covid-19-report-highlights-continued-impact-of-covid-19-in-scotland/; Health and Social Care Alliance Scotland (the ALLIANCE) Briefing: Putting people at the centre of an independent inquiry into COVID-19, available at: https://drive.google.com/drive/folders/1WFwXX5Yzzxes__h8- UfTHa7qiaznEvzO.

recognise their expertise in their own health. It also does not adhere to the principles and practice of Realistic Medicine[6].

People need to be involved in the process of establishing and identifying their own acceptable risk levels. The voices of lived experience should be prioritised as an ongoing solution to infection prevention and control. These individuals and groups should co-produce all related prevention and improvement strategies[7].

Preventing infections, including COVID-19, in health and social care settings requires a multi-pronged, integrated approach alongside occupational health and safety measures. Appropriate safeguards to prevent the spread of COVID-19, repeat infections and developing long term conditions include, but are not limited to, surveillance and reporting, vaccine administration, HEPA filtration and ventilation improvements, and regular and inclusive public health communication[8].

In line with World Health Organisation (WHO) guidance, "adequate" ventilation equipped with HEPA filters, is a minimum rate of 60 litres of natural, mechanical or hybrid ventilation per second, per occupant[9]. Such a rate must be continuously maintained in all occupied patient and service user care areas. The guidance provides further information on filtration and ventilation in other public areas. Assessments and improvements of current Scottish guidance and systems, and future strategies, should be made assuming maximum occupancy of each area and the risk of infection for the most vulnerable patient or service user.

Experts have noted that mask wearing should also be reintroduced in health and social care settings and workplaces, alongside accessible personal protective equipment (PPE)[10]. Inclusive communication resources and best practice guidelines should be integral to mask policy and operational use in every setting where masking

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[6] Realistic Medicine Scotland, *Working Together to provide the right care for you,* (2024) available at: Realistic Medicine – Shared decision making, reducing harm, waste and tackling unwarranted variation.

[7] World Health Organisation (WHO), *WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions,* (2023) available at: WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions.

[8] World Health Organisation (WHO), *COVID-19 epidemiological update – 19 January 2024,* (2024) available at: COVID-19 epidemiological update – 19 January 2024 (who.int); Conway Morris, A., et al., *The Removal of Airborne Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and Other Microbial Bioaerosols by Air Filtration on Coronavirus Disease 2019 (COVID-19) Surge Units,* (2022) available at: Removal of Airborne Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and Other Microbial Bioaerosols by Air Filtration on Coronavirus Disease 2019 (COVID-19) Surge Units | Clinical Infectious Diseases | Oxford Academic (oup.com).

[9] World Health Organisation (WHO), *Strategic preparedness and response plan: April 2023 – April 2025,* (2023) available at: WHO-WHE-SPP-2023.2-eng.pdf; Ueki, H. et al, *Effectiveness of HEPA Filters at Removing Infectious SARS-CoV-2 from the Air,* (2022) available at: Effectiveness of HEPA Filters at Removing Infectious SARS-CoV-2 from the Air - PubMed (nih.gov).

[10] Greenhalgh, T., et al., *Masks and respirators for prevention of respiratory infections: a state of the science review,* (2024) available at: Masks and respirators for prevention of respiratory infections: a state of the science review | Clinical Microbiology Reviews (asm.org).

is required. These measures will protect people using services, health and social care workers, families and carers.

A blame-free system for managing health and social care staff exposure to COVID-19, and infectious illness generally, should be in place, promoting and supporting routine COVID-19 testing and reporting. The health and social care workforce should be encouraged to report both occupational and non-occupational exposures to COVID-19 and to stay at home if they have been exposed or feel generally unwell. In placing less emphasis on people as resources, and instead as humans, recruitment and retention in health and social care would ultimately improve[11].

With NHS and social care staff shortages being a concern pre-pandemic, these shortages will likely continue especially if recommended infection and control measures are not put in place. For example, in Scotland, the number of healthcare workers testing positive for COVID-19 was seven times higher than for non-essential workers[12]. Despite precautions taken, their households contributed to a sixth of COVID-19 hospital admissions. Recent estimates found approximately 122,000 NHS workers in the UK were living with Long Covid, with a prevalence of almost 14% at 12 weeks post-infection[13].

In research published by the ALLIANCE and Chest Heart & Stroke Scotland, participants were keen to see the lack of public awareness of the impact of infection, including Long Covid, remedied with health and social care professionals and across wider society[14]. Staff should be trained in infection prevention and control and supported decision-making. An aspect of this will be providing support and resources to people more susceptible to infection or who have Long Covid, using a human rights based approach rooted in choice, flexibility, dignity and respect[15].

With measures taken to control COVID-19 now removed, people told us that it now feels like public perception and public health messaging has shifted to the COVID-19 pandemic being over. Fewer people are wearing masks, yet some people, social

[11] Health and Social Care Alliance (the ALLIANCE), *Accessing Social Support for Long Covid,* (2022) available at: Accessing social support for Long Covid - Policy and research (alliance-scotland.org.uk).
[12] Mutumbudzi, M., et al., *Occupation and risk of severe COVID-19: prospective cohort study of 120 075 UK Biobank participants,* (2021) available at: Occupation and risk of severe COVID-19: prospective cohort study of 120 075 UK Biobank participants | Occupational & Environmental Medicine (bmj.com).
[13] NHS England, *Supporting colleagues affected by Long COVID,* (2021) available at: NHS England » Supporting colleagues affected by Long COVID.
[14] Health and Social Care Alliance (the ALLIANCE), 'Research report: Accessing social support for Long Covid', p.15. (1 June 2022). Available at: https://www.alliance-scotland.org.uk/blog/news/research-report-accessing-social-support-for-long-covid/.
[15] Health and Social care Alliance (the ALLIANCE), 'Health, Wellbeing and the COVID-19 Pandemic: Scottish Experiences and Priorities for the Future'. Available from https://www.alliance-scotland.org.uk/wp-content/uploads/2021/02/Health-Wellbeing-and-the-COVID-19-Pandemic-Final-Report.pdf

care staff and their unpaid carers remain at high risk of infection. Many unpaid carers and those they support feel left behind[16].

National public health messaging must be informed by human rights standards and principles, consider those who are likely to be more affected by any future public health crisis and inform the public of the importance of infection prevention measures[17]. Communications must be accessible, inclusive and consistent, recognising the disproportionate impact the COVID-19 pandemic has had and its long-lasting effects on different population groups, including reasons behind any reintroduction of infection prevention and control measures[18].

Comprehensive prevention and control measures that can limit the spread of viral diseases should be implemented alongside a ventilation strategy for health and social care settings and accompanying public health guidance and communications for staff and members of the public. Maintaining and improving infection prevention and control is key to creating a safe environment for all[19].

Scottish Care written submission, 28 June 2024

PE2071/H: Take action to protect people from airborne infections in health and social care settings

Scottish Care welcomes this opportunity to respond to Citizen Participation and Public Petitions Committee request of the petition PE2071: Take action to protect people from airborne infections in health and social care settings.

It is important to first contextualise our response, Scottish Care is a membership organisation and the representative body for independent sector social care services in Scotland. We represent over 350 organisations, which totals almost 900 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

The requests laid out in the petition are important steps towards better protection for people who work in health and social care and people who access the care and support. As we reflect on the pandemic and prepare for the future, it is crucial to adopt a balanced perspective that emphasises learning from our experiences,

[16] Health and Social Care Alliance (the ALLIANCE), 'Living with COVID-19: Carers Parliament event report' (26 April 2023). Available at https://www.alliance-scotland.org.uk/blog/news/living-with-covid-19-report-highlights-continued-impact-ofcovid-19-in-scotland/.
[17] Health and Social Care Alliance (the ALLIANCE), *Written evidence to Scottish COVID-19 Inquiry from the Health and Social Care Alliance Scotland (the ALLIANCE),* (2023) available at: ALLIANCE written statement to Scottish COVID-19 Inquiry - Health and Social Care Alliance Scotland (alliance-scotland.org.uk).
[18] Disability Equality Scotland, *Six principles of inclusive communication,* (2011) available at: The six principles of inclusive communication - Welcome to the Inclusive Communication Hub.
[19] World Health Organisation (WHO), *Strategic preparedness and response plan: April 2023 – April 2025,* (2023) available at: WHO-WHE-SPP-2023.2-eng.pdf.

leveraging scientific advancements, and respecting the rights and wishes of individuals, families and social care staff.

The pandemic provided a wealth of lessons that we must heed, to better respond to this petition. One primary lesson from this period is the importance of consistency, we cannot have a reapplication of past mistakes. During the pandemic, Scottish Care's members were at the forefront, caring for older people and those with disabilities in residential settings and/or in those individuals' homes. They relied heavily on government advice and epidemiological instruction to keep staff, families and those who accessed their care and support safe. Yet, the impact of following accepted 'clinical' advice was that in practice, in residential settings families were kept apart for unacceptable periods of time and that both staff and residents were not as protected as they might have been. Providers often found the guidance given by the government inconsistent, in part because the accepted 'science' was developing at the same rate as the guidance. This led to continuous U-turns in procedures and regulation, with care providers confused about conflicting accounts and requirements. Ultimately, providers were forced to apply a common-sense ideology plus the latest U-turn in instructions, which inevitably led to inconsistent application across Scotland.

Improving air quality in health and social care settings through addressing ventilation, air filtration and sterilisation is critical to the current and future response. The science which is needed to support this mandate must be clear, consistent and accepted by the key strategic partners in the delivery of care and support. To date, this is transparently not the case. We need to arrive at a context where the requirements around this mandate are co-produced by those who would be required to enforce it, such as care providers, owned by those most affected including staff and families and underpinned by accepted clear scientific evidence.

While science provides a critical foundation for effective response, it must be balanced with respect for individual rights and wishes. This is especially important in the context of mask wearing, which whilst clearly beneficial, has an impact on the wearer and on those who are supported. Respecting personal autonomy and ensuring informed consent are fundamental ethical principles that should guide our actions.

From Scottish Care's engagement with members, many in the sector felt that the pandemic had a negative impact on the recruitment and retention issues that had been slowly increasing over the past decade. The conditions of the pandemic catapulted many skilled and dedicated workers out of the social care sector. Issues of increased workloads stemming from regulatory and oversight pressures led to staff experiencing significant morale and burnout challenges, which stemmed from a continued sense of feeling undervalued and under-recognised for both their individual professionalism and their sector's role. The request and needs of staff must be balanced with the rights of individuals who receive care and support.

Additionally, for families and those who were supported the pandemic brought significant emotional and psychological stress. Not least through the enforced restrictions on visitations, which for instance although developed to prevent

transmission, also caused extreme distress. Nevertheless, we recognise that there are many with respiratory vulnerabilities who do not feel adequately supported or prioritised today in an environment which includes little of the pre-existent protective measures and which as a result places them at greater risk. As we move forward policies must strive to balance these at times conflicting needs.

This petition highlights the important role social care continues to play in protecting those who access care and support, especially those who are clinically vulnerable from airborne infections. If this petition is taken forward there needs to be clear, positive, and inclusive routes to ensure the social care and support workforce are not faced with increased responsibility without proper compensation and recognition. In addition, providing adequate protective equipment and mental health support would be essential steps in supporting social care staff while maintaining high standards of care. We support the petition's request to support ill staff to stay home.

The pandemic resulted in a social care landscape of reduced resilience and capacity. There are still concerns currently regarding the future of the social care sector given the need for urgent support and radical reform which values its contribution to society, national wellbeing and the economy. We have consistently outlined that Scotland currently has an unsustainable social care system. Requests to the Government to improve this system have been met with claims that there is no funding which can be allocated to bring forth the required improvements. The requests under this petition will require adequate and consistent funding to be effectively fulfilled. Private and third sector providers who are struggling to maintain their services cannot absorb the necessary costs for new ventilation, air filtration and sterilisation systems, respiratory masks; Covid testing and the financial support for ill staff to stay home. Without the required fiscal support and investment from central Government this proposal will negatively impact the viability of the sector. This could lead to significantly reduced levels of provision creating an even more fragile social system for people, with less choice for those who need the support and an attendant increased risk.

Royal College of Nursing Scotland written submission, 28 June 2024

PE2071/I: Take action to protect people from airborne infections in health and social care settings

Respiratory infections that spread and infect healthcare workers, patients and visitors in health and care settings result in staff becoming unwell and absent from work, outbreaks of infection, patient infection and deterioration in their conditions and delays to discharge. The Royal College of Nursing considers the prevention of infection a core element of patient safety that requires strong prevention and management actions.

The COVID-19 pandemic has shone a light on the risks faced by health professionals in all care settings and the need for rigorous and detailed health and safety procedures.

It is now widely accepted that both infectious droplets and smaller aerosols can be produced by people with a respiratory infection as part of activities of daily living (talking, breathing, coughing) in addition to care procedures described as aerosol generating procedures. This has resulted in a renewed focus on the role of air and 'airborne transmission' and its impact on the prevention of infection. The risk of airborne transmission is therefore a key aspect of health and safety risk assessment for health and care worker protection.

Statutory requirements

There is specific health and safety legislation and guidance, underpinning the issues raised in the petition, which the RCN expects employers to comply with at all times. This is detailed below with reference to approved codes of practice and guidance.

The first and absolute requirement to protect people from airborne infections in health and social care settings comes from the Health and Safety At Work Act etc 1974 which requires employers to protect employees and others from harm and to provide a safe working environment without risk, so far as is reasonably practicable. The specific sections which are relevant include:

- Section 2(1) It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.
- Section 2(2e) the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.
- Section 3(1) It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

The Management of Health and Safety at Work Regulations 1999 place a duty on employers to assess the risks to workers and any others who may be affected by their work or business.

They must identify what can cause injury or illness at work (hazards), consider how likely it is that someone could be harmed and how seriously (risk) and take action to eliminate the hazard, or if this isn't possible, take action to control/ mitigate the risk. There is a requirement to identify groups of workers who might be particularly at risk, such as young or inexperienced workers, new and expectant mothers, night workers, homeworkers, those who work alone and disabled staff.

The regulations state:

Risk assessment:

3. (1) Every employer shall make a suitable and sufficient assessment of:

a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; and

b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking,

for the purpose of identifying the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions.

Exposure to biological agents (which would include airborne infections) is specifically considered under the Control of Substances Hazardous to Health Regulations (COSHH) 2002 which state:

'Every employer shall ensure that the exposure of his employees to substances hazardous to health is either prevented or, where this is not reasonably practicable, adequately controlled.'

Biological agents include bacteria, viruses, fungi, cell cultures, parasites. The Approved List of Biological Agents (see below) provides more information on the classification of biological agents for risk assessment purposes.

If it is not possible to prevent exposure, the hazardous substance should be controlled by applying the principles of good practice. The principles consider the use of effective control options and specifically relate to the issues highlighted in the petitioner's calls. The control options focus on:

- eliminating hazardous substances from the workplace e.g. requiring staff to test and stay at home if unwell,
- engineering controls i.e. local exhaust ventilation to remove contaminants from the air/ provide a higher number of air changes per minute,
- the use of PPE e.g. respiratory protection such as FFP3 masks,
- the provision of information e.g. updating staff manuals and public health information.

Control is adequate when the risk of harm is, 'as low as is reasonably practicable'.

The Approved List of biological agents provides the classification of biological agents as referred to in the Control of Substances Hazardous to Health Regulations 2002 (COSHH). It is approved by the Advisory Committee on Dangerous Pathogens (ACDP) and is relevant to risk assessment for work with biological agents and the application of appropriate control measures. The classification which ranges from hazard group 1 to hazard group 4 specifically relates to the level of risk of infection to humans. Hazard group 1 agents are not considered to pose a risk to human health whereas hazard group 4 agents present the greatest risk. For example, SARS-CoV-2 is classified as hazard group 3, and Mycobacterium tuberculosis is also hazard group 3.

As a basic requirement for all workplaces, suitable and adequate ventilation of the workplace is considered in the Workplace (Health, Safety and Welfare) Regulations 1992. In a health and social care setting it should be considered alongside the requirements of COSHH specifically in relation to respiratory illness (virus/ bacteria etc). The regulations state:

Regulation 6 Ventilation

(1) Effective and suitable provision shall be made to ensure that every enclosed workplace is ventilated by a sufficient quantity of fresh or purified air.

The Approved Code of Practice (ACOP) – L24 - Workplace health, safety and welfare outlines the following requirements:

47 Enclosed workplaces should be sufficiently well ventilated so that stale air, and air which is hot or humid because of the processes or equipment in the workplace, is replaced at a reasonable rate.

48 The air which is introduced should, as far as possible, be free of any impurity which is likely to be offensive or cause ill health. Air which is taken from the outside can normally be considered to be 'fresh'. However, air inlets for ventilation systems should not be sited where they may draw in contaminated air (for example close to a flue, an exhaust ventilation system outlet, or an area in which vehicles manoeuvre). Where necessary, the inlet air should be filtered to remove particulates.

49 In many cases, windows or other openings will provide sufficient ventilation in some or all parts of the workplace. Where necessary, mechanical ventilation systems should be provided for parts or all of the workplace.

51 In the case of mechanical ventilation systems which recirculate air, including air-conditioning systems, recirculated air should be adequately filtered to remove impurities. To avoid air becoming unhealthy, purified air should have some fresh air added to it before being recirculated. Systems should therefore be designed with fresh-air inlets, which should be kept open.

Additionally in Scotland there are Scottish Health Technical Memorandums on the Ventilation for Healthcare Premises (SHTM 03-01) which cover ventilation design, validation, operational management and performance verification. Part A makes specific reference to airborne risks to staff 'who routinely work in areas where they may come into close contact with patients who have respiratory symptoms will be at risk of exposure to the microorganisms causing the symptoms'. They also highlight the importance of the maintenance of air handling units to reduce the risk of exposure to other microorganisms including legionella.

The maintenance and testing of any form of local exhaust ventilation system used to control contaminants is a requirement of COSHH and further detail is provided in the guidance document Controlling airborne contaminants at work: A guide to local exhaust ventilation (LEV) - HSG258 (hse.gov.uk). There is a statutory requirement for thorough examination and testing by a competent person with a maximum time between tests of 14 months.

The RCN recognises that much of the NHS Scotland estate, and many buildings used in independent health and social care, need investment, including to improve ventilation. We believe that cutting the capital budget is a shortsighted response to

the current financial challenges. Many of our members are working in outdated, and at time unsafe, facilities which are putting them and their patients at risk.

The RCN respiratory risk assessment toolkit

The RCN respiratory risk assessment toolkit supports members and employers on how to undertake a risk assessment to comply with health and safety legislation when a risk is present.

Designed to complement national and local guidance, this toolkit supports healthcare professionals manage infection risks associated with the transmission of common respiratory infections including COVID-19, Influenza, influenza like illness (ILI) and Respiratory syncytial virus (RSV). The toolkit also aids local decision making on the level of personal protective equipment (PPE) required to protect staff whilst at work.

As highlighted above, employers have legal duties and responsibilities to ensure they provide a safe and healthy workplace as far as reasonably practicable. The toolkit highlights both the duties of health professionals (health care workers, employers, health care leaders, and health and safety representatives) to support the identification and management of risks wherever health professionals' work.

The risk assessment process identified within the Risk Assessment Tool section is designed as a guide to help identify potential risks for the transmission of infection where staff work. Also within this section is a guide to identifying potential control measures including the correct level of respiratory protection that may be required. Another potential control measure which should be considered is whether engineering controls could be applied to reduce or remove the risk such as mechanical ventilation. It notes that ventilation is unlikely to be effective in removing the risk of COVID-19 transmission where care is provided when in close contact (within 2m) of a patient. The use of carbon dioxide monitors should be considered as an aid to the assessment of quality of ventilation in closed environments in addition to the use of air filtering/cleaning devices

If adequate control of exposure cannot be achieved by other means, suitable and sufficient Respiratory Protective Equipment (RPE), in addition to the other identified control measures should be provided (note a fluid repellent surgical mask (FRSM) would not be considered suitable in this instance).

As part of the risk assessment process, employers should provide suitable and sufficient information, instruction and training to employees/persons who may be exposed.

Supporting staff to stay home when unwell

It is important to note that individual staff who work whilst symptomatic with an acute respiratory infection are at risk of transmitting this to others in the workplace wherever that is. National guidance outlines actions for health and care staff to take, including when to stay at home, if not well enough to work and local policies should support this.

Managers should support staff to stay at home if they are unwell and staff should not feel pressured to work until well enough to do so. However, data shows that nurses often feel impelled to work while sick to help plug gaps in rotas and ensure patients receive the best possible care. A recent RCN member survey found that almost two thirds (64.4%) of respondents in Scotland reported that they had gone to work at least twice in the previous 12 months, despite feeling too ill to do so.

Petitioner written submission, 15 November 2024

PE2071/J: Take action to protect people from airborne infections in health and social care settings

UK Covid Inquiry

At this petition's heart lies profound disagreement with those responsible for UK-wide Infection Prevention and Control (IPC), regarding Covid-19 transmission – whether droplet/ contact or airborne - health impacts and protections; now playing out via the UK Covid Inquiry.

- Prof Clive Beggs and Dr Barry Jones/ Covid Airborne Transmission Alliance (CATA), explained Covid's airborne transmission, hence the importance of clean air and respiratory protective equipment (RPE). [See also DHSC 'Report to future CMOs' – Chapter 1 section 8]

- HEPA filtration units are "low hanging fruit" – cheap and easy to install. (Clive Beggs)

- "The rebuffing of many experts – clinicians, aerosol physicists, engineers - who disagreed, wholesale lack of accountability of the IPC cell" (CATA)

- "It was defined as aerosol transmitted from the very moment it came into the country…an airborne Highly Consequential Infectious Disease [HCID]." (CATA)

- UK IPC Cell Chair Lisa Ritchie nonetheless remained adamant transmission is droplet and contact, not airborne. The UK Health Security Agency's Susan Hopkins insisted that FFP3s gave no more protection than surgical masks (FRSM) in clinical practice, even if proven in laboratories (misunderstanding Randomised Controlled Trial limitations, e.g. testing parachutes!).

- Scotland's Chief Medical Officer (CMO) acknowledged long term health impacts and accepted that FFP3s protect better than FRSM against aerosols

- He and others cited discomfort/skin problems from wearing FFP3s. Lady Hallett intimated discomfort may be outweighed by significant risk. (Hopefully those working with such pathogens in laboratories take protection more seriously).

- The Welsh CMO claimed that downgrading severity arose due to insufficient capacity and it becoming clear that Covid could be treated like any normal respiratory disease, while demonstrating failure to engage with Long Covid. Dr Kevin Fong's testimony of the appalling impact and ICU expert Prof Summers' evidence on multiple non-respiratory damages caused, suggested otherwise.

FOIs

Scotland's Antimicrobial Resistance in Healthcare Associated Infections (ARHAI)'s National Infection Prevention and Control Manual (NIPCM) and literature reviews underpin UK IPC. Errors enabled by poor governance, accountability and quality assurance thus have major repercussions.

Scottish Government's (SG's) Chief Nursing Officer's (CNO's) submission confirmed ARHAI's IPC leadership role, claiming SG has "no ownership or control over NIPCM content". FOIs apparently contradict this:

> "ARHAI Scotland reports through NHS Scotland Assure Directorate Management Team who are accountable to NSS Executive Management Team into the NHS NSS Board. ARHAI Scotland also report directly to Chief Nursing Officer Directorate (CNOD) part of the Scottish Government."

ARHAI seemingly will not engage with wider stakeholders, SG's CNO distances themselves, the NHS NSS Board is ill-informed (no mention of significant risks as per Inquiry evidence, new data, etc at their meeting 27/09/24), Ministers nowhere to be seen. Where is public accountability?

SG says it took advice from ARHAI and Public Health Scotland (PHS) before withdrawing facemask requirements. Yet an FOI confirmed PHS "does not hold that information [on its advice]" and would not provide separate advice to ARHAI on health and social care setting IPC. More FOIs reveal the Care Inspectorate pushed for that guidance's removal, with provider bodies' support; seemingly prioritising anecdotal staff discomfort/difficulties over safety, thereby potentially exposing vulnerable people to significant risk of life-changing/ ending infection in their own homes.

Summer wave

PHS July 2024 wastewater charts showed Scotland experienced the highest Covid infection peak since 2022, alongside rapidly rising hospital admissions (likely under-estimated given asymptomatic transmission and that testing is no longer routine), positive swabs and deaths, with untold longer-term health damage. Nothing was done, except PHS 'paused' wastewater data publication.

No claim made when withdrawing facemask requirements holds true. Covid is not in a 'calmer phase' (PHS now acknowledges there are waves throughout the year), most have had no vaccine for ages, rapidly mutating immunity-evading variants anyway make lasting 'herd' immunity impossible, and there is ever-increasing

evidence of long-term harm. Another variant is already rising (https://theconversation.com/xec-what-you-need-to-know-about-the-new-covid-variant-239125).

In March 2024, special leave for NHS staff testing positive was removed: “There is no longer any requirement for staff to have a negative LFD test before returning to work.”

Unsurprisingly, a snap survey of almost 550 nursing professionals (https://www.nursingtimes.net/respiratory/covid-19-nurses-concerned-amid-summer-upsurge-16-08-2024/) found:

- 85% noticed a rise in recent workplace cases;
- 58% would welcome more Covid-19 prevention measures in their workplaces (22% unsure);
- 40% reported having had Covid-19 themselves this summer. Of those, 21% had attended work while infected with the virus;
- Many felt pressured to come to work even with Covid-19 and discouraged from testing themselves and patients.

RCN mentions that 64.4% of survey respondents in Scotland had gone to work at least twice in the last year despite feeling too ill.

How can IPC *guidance* override workplace health and safety *law*?

New data

Recent examples include:

Health impacts:

- Interdisciplinary review on Long Covid
- A synthesis of the state of scientific evidence on long COVID
- Long Covid in kids
- Does Covid lead to dementia?
- Immune system impact – new form of AIDS
- Molecular interaction causing thromboinflammation and brain damage (https://www.news-medical.net/news/20240829/Fibrin-fuels-thromboinflammation-and-brain-damage-in-COVID-19.aspx)
- Underlying mechanisms of ‘brain fog’
- Associations with accelerated ageing
- Long-Term Cognitive Impacts of Mild COVID-19 (https://scitechdaily.com/scientists-expose-long-term-cognitive-impacts-of-mild-covid-19/)

- Mild COVID-19 disrupts brain connectivity and reduces memory function in adolescents and young adults (https://www.news-medical.net/news/20241003/Mild-COVID-19-disrupts-brain-connectivity-and-reduces-memory-function-in-adolescents-and-young-adults.aspx)
- How Covid affects the heart

Protections:

- Comprehensive review confirms mask effectiveness, urges better design and policy support
- Simple measures lessen hospital-acquired COVID-19 infections
- Admission screening testing of patients and staff N95 respirators are cost-effective in reducing COVID-19 hospital-acquired infections
- N95 Masks Nearly Perfect at Blocking COVID
- Lessons from the COVID-19 pandemic for indoor air quality (https://www.science.org/doi/10.1126/science.adp2241)
- Air filter significantly reduces airborne SARS-CoV-2 in COVID-19 wards
- Recommitting to Ventilation Standards for Healthy Indoor Air Quality (https://www.science.org/doi/10.1126/science.adp2241)

Urgency

Nothing is done, despite vast new learning, WHO recognising aerosol transmission and its indoor airborne risk assessment in the context of SARS-CoV-2, continual waves, 8,024 UK deaths this year, mass sickness and disablement. Despite SG asserting that ARHAI's Manual is "continually under review"; SG "regularly reviews guidance as the pandemic situation changes and new emerging evidence is received", key NIPCM sections remain 'pending'. Meanwhile, ARHAI works on a massive Transmission-based Precautions Definitions literature review, citing evidence seemingly contradicting their Manuals.

This petition is a plea for urgent action; for those responsible for IPC to prevent and control airborne infections; for Scottish Ministers to take responsibility for devolved matters and for parliamentarians to hold them and key players to account.

The Royal College of Physicians of Edinburgh written submission, 16 January 2025

PE2071/K: Take action to protect people from airborne infections in health and social care settings

Thank you for your recent letter from the Citizen Participation and Public Petitions Committee. The Royal College of Physicians of Edinburgh welcomes the opportunity to comment on petition PE2071.

We recognise the concerns behind PE2017 and consider that this is an important area of health policy and practice which is of real interest to many members of the

public, patients and their families as well as health and social care professionals. In general terms, we understand that the current decision making processes around these matters aim to ensure an evidence-based approach and we would support this, but we understand that systems must be as flexible as possible to respond nimbly to developments and emerging evidence and epidemiological data at national and international levels.

With regard to the specific requests in the petition:

- We would support all appropriate measures to improve air quality in health and social care settings through addressing ventilation, air filtration and sterilisation. It is vital that all regulations in this regard for existing and new buildings within the NHS and social care settings must be followed completely. Regular inspections are an important part of ensuring that this is happening.

- Regarding reintroducing routine mask-wearing in NHS and social care settings, particularly respiratory masks, and reintroducing routine Covid testing, we are aware that all the agencies involved, including Antimicrobial Resistance Healthcare Associated Infection (ARHAI), the Scottish Government and the Chief Medical Officer Directorate, monitor the evidence extremely closely on an ongoing basis and we consider this is the correct approach. We would of course support any patient, relative or NHS or social care employee who wishes to use a mask in an NHS or social care setting and believe that they should have the full support of their employer in doing so. In addition, there is of course specific guidance in place for NHS staff regarding wearing masks in those circumstances where a patient is admitted with a known or suspected infectious airborne disease. Discretion on mask wearing may also be required during peak winter periods, when the circulation of respiratory viruses is normally higher. In saying so, we bear in mind the decision made by some hospitals in England to encourage mask wearing in January 2025, in order to prevent the spread of flu.

- In terms of staff manuals, we consider that these should be updated as regularly as possible to reflect the most recent guidance.

- We strongly believe that NHS and social care staff should be fully supported to stay at home when they are ill; this is in the best interests of staff members as well as patients. We recognise that many NHS and social care professionals are working under extreme pressure, often right through the year and not just at times of winter pressures. Many may feel uncomfortable or guilty taking time off and worry about the impact this could have on their colleagues but they must be encouraged to take sick leave if they require it and be reassured that employers have robust plans in place for cover. NHS and social care employers must ensure this is clearly communicated to staff.

- We would encourage all the relevant agencies including Public Health Scotland to continually assess what information is available for the public on these matters and the effectiveness of that information and be ready to consider renewing and updating this when appropriate.

In conclusion, we are pleased that this petition has raised the profile of the vitally important issue of airborne infections in health and social care settings. We hope that those bodies which have decision making powers in relation to the petition's specific points may be able to help provide further reassurance and detail on the extent of their ongoing work in these areas and ability to respond quickly and with flexibility to ensure evidence based best practice is being achieved consistently.