Petitioner submission of 13 February 2024

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

1. Background

As confirmed by a lead official from the World Health Organisation (WHO), we are still in a pandemic. The PHS dashboard for acute hospital admissions reveals a higher rate over this Winter than when extended guidance on masks was withdrawn (May 2023) and shows, unlike other respiratory infections, Covid-19 is not seasonal.

Also unlike other respiratory conditions it is not just a respiratory infection but a coagulative, neuropathic disease, affecting any part of the body and dysregulating the immune system, provoking widespread damage and making it harder to repel other infections. An estimated 1 in 10 infections result in long Covid, often irrespective of severity of acute infection, age or clinical status. Risks of long-term disability and death rise with reinfection. Professions with high exposure risks, notably care workers, experience disproportionately high rates and receive little support. Repeated illness and long-term health impacts inevitably compound pressure on the NHS, lower economic activity and life expectancy. Data on hospitalisation/ deaths from sequelae is not tracked. Only reporting on acute, identified, infection provides an incomplete picture of damage to public health generated by infection prevention and control (IPC) failure.

2. Vaccination

Scottish Government (SG) counterargues “the success of the vaccine programme” and availability of treatments has neutralised clinical risk except for immuno-suppressed people. Others in the former Shielding Group (notably younger people with comorbidities/ extensive pre-existing clinical damage) have not recently been eligible for boosters, and never were for antivirals, placing them at considerable risk. Vaccines do have the capability to reduce severity of acute infection and probably likelihood of Long Covid. Yet, protection only lasts a few

months, needs constantly updated against new variants and immunity from reinfection is short-lived. Boosters have been unavailable to most people for some time or to children, despite evidence of benefits. Yet, JCVI suggests the Autumn 2024 programme be even more limited due to 'cost-effectiveness'; a calculation meriting investigation. Even if boosters become purchasable, health inequalities will increase. Having put all its eggs in the vaccination basket, government removes the basket.

Misunderstanding of risk - just inability to generate antibodies, not intolerance to additional damage; just pre-existing clinical, not consequence of reinfection - increases the high clinical risk population. The mere existence of a vaccination programme and treatments provide no grounds for abandoning preventative measures. "Living with Covid"- not prioritising preventative action and treating Covid like another, acute, usually mild, seasonal respiratory infection - causes more people to die with Covid, or lead restricted, precarious lives.

3. Antimicrobial Resistance and Healthcare Acquired Infections (ARHAI)

SG 'follows the advice of ARHAI': a remarkably influential body, also driving IPC policy in the UK nations who adopted the National Infection Protection and Control Manual (NIPCM) and ARHAI evidence. Yet, the NIPCM has incomplete chapters and says very little on preventing airborne infection.

Few will have heard of ARHAI, a far from transparent body. The process of developing and reviewing the NIPCM appears largely internal to NHS and professional bodies, without representation from scientists, aerosol physicists, ventilation engineers, Trades Unions, patient groups or research methodology experts. It is deeply concerning that SG has "no ownership or control" over NIPCM content, removing ARHAI and the NIPCM from democratic accountability. Is NHS Scotland marking its own homework? Its extraordinarily poor quality provides no sound basis for action.

4. Ventilation, air filtration and sterilisation

NIPCM Chapter 4 on "Infection control in the built environment and decontamination"- has just been a tiny 'repository of information' on other matters since 2022. Yet, the role of clean air in preventing airborne infection is unequivocal. While SG and NHS bodies' focus on ventilation, NHS England also has guidance on the use of HEPAs and sterilisation in hospitals.

Like ARHAI, NHS ASSURE seems to be a closed, untransparent body with an out-of-date website. Its role seems be new build and project management. A trawl revealed some ventilation equipment reviews, and one study on far UVC light. There were no hits in the NHS Scotland publications database on HEPAs. Meanwhile, in England research by Cambridge University and Addenbrookes has found air filters significantly reduce the presence of SARS CoV2 in Covid wards. There is research on their role in care homes, while the Care Inspectorate's "Building Better Homes" (2018!) only refers to ventilation in new builds and conversions.

5. Facemasks

When removing extended guidance, SG claimed 'the pandemic is in a calmer phase'. It is debateable how it knew when much data collection had ceased (contrary to WHO entreaties). It clearly has not been 'calmer' recently. WHO called for reinstatement of mask-wearing; echoed by the RCN. SG and ARHAI seem highly selective about which WHO guidance they follow.

ARHAIs advice to SG on removing guidance (FOI) claims a "paucity of evidence" on its benefits. There is no acknowledgement of robust evidence on protective efficacy of masks, particularly well-fitting respiratory. Studies cited as supporting detrimental effects of maskwearing hardly refer to masks.

Problematically, ARHAI uses SIGN methodology, prioritising meta-analysis of randomised control trials and unsuited to assessing masks, where RCTs have multiple variables, or safety of equipment.

6. Increasing risk

Current practice increases risk of outbreaks:

- Respiratory protective equipment (RPE) is only considered when admitting patients with known/ suspected airborne infection. Yet, up to 60% of transmission may be asymptomatic.
- Risk is not just to staff but patients and visitors; not just clinical but environmental – in the air. That is why individual, person-centred clinical risk assessment for RPE and testing is nonsense.
- Testing of symptomatic staff is paused, advice is that there is no need to test and work if feeling well enough, risking unwittingly exposing patients and colleagues.
- There are reports of staff being pressurised to work with infected patients, without adequate PPE.
- Whether to risk exposing patients and colleagues should surely never be a personal choice
- SG confirms they provide no advice to the general public on clean air or respiratory masks.