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

Petitioner submission, 5 April 2024

1. SPICe briefing

a) The pandemic is not over

SPICe's role is "to provide impartial, factual, accurate and timely information and analysis" to Members and Parliament. It is surprising and unfortunate that their briefing on this occasion does not meet their usual high standards, notably where it states:

> "The Scottish parliament has not undertaken any work on the specific issues raised in the petition **since the end of the pandemic**".

It is similarly inaccurate to refer to the shielding list **'during the pandemic'**. We are still 'during the pandemic'.

SPICe needs to explain why it disagrees with the World Health Organisation's repeated statements that **the pandemic is not over**, notably in May 2023 and recently in Indoor airborne risk assessment in the context of SARS CoV2. NB this publication also makes clear that transmission is airborne (so clean air and respiratory masks are key protections).

b) High clinical risk continues and increases

If risk no longer exists neither does the case for protections nor this petition. It is therefore regrettable that the briefing inaccurately reports that Scottish Government's press release on cessation of the Highest Risk List states the risk of hospitalisation or death from the virus was no greater for those on the list than for the general public. Instead it says the 'vast majority' – a claim which analysis of their evidence review does not support.

Subsequently the Scottish Government's attempt to negate the continued reality of high clinical risk has been further undermined by research showing that people with pre-existing health conditions continue to be over-represented in Covid mortality and Long Covid data. However, evidence has also accumulated of how reinfection increases risk of sequelae including Long Covid and access to vaccination has been restricted. Thus, far from neutralising high clinical risk, the population experiencing it – potentially anyone - continues to expand.

Recent parliamentary activity

As SPICe has not understood the relevance of protections to people with Long Covid it has missed the fact that this petition, the ongoing need for protection from reinfection (including HEPA) and devastating consequences of failure were raised in a recent parliamentary debate.

2. Care Inspectorate submission

a) Health and social care standards – safety and rights

Standards related to ventilation where it concerns resident comfort and personal control are referred to. Those concerning safety and related rights are not e.g.:

4.1 My human rights are central to the organisations that support and care for me.
4.2 The organisations that support and care for me help tackle health and social inequalities.
5.19 My environment is secure and safe.

Action set out in the petition, to protect residents, workers and visitors from airborne infections, is directly relevant to these standards. What does the Care inspectorate regard as “adequate and suitable” ventilation? How does it assess and enforce this? Why no mention of HEPA, UVC and CO2 monitoring?

b) Social care at home

People’s own homes can be social care settings and the Care Inspectorate’s remit also covers these service-providers. How do safety and rights standards apply there?

c) Denying personal choice to self-protection

What can any health or social care user do if forced to interact with potentially infected unmasked workers in health or social care settings? Why is it acceptable for some people to exercise personal choice that denies others the personal choice to protect themselves – even in their homes?

3. Protection - a health equalities issue

Failure to protect generates massive health inequalities (aside from those raised in the Long Covid debate). Polls carried out by Clinically Vulnerable Families found that:

- 98% feel healthcare is unsafe (March 2024, 534 Clinically Vulnerable people)
- 90% have or would delay or cancel medical appointments due to high Covid risk (November 2023, 827 Clinically Vulnerable people)

I asked on Twitter (https://twitter.com/SalWitcher/status/1775466734750724338)(03/04/24) what are the key inequalities still experienced by people at high clinical risk, with Long Covid or household members. The huge response featured repeated calls for action on clean air and use of respiratory masks in healthcare settings, with many distressing personal accounts of the impact of failure to act.

Covid-safety is a significant equalities issue; one that Scottish Government Ministers and all who proclaim commitment to equality need to act on to have any credibility.

4. Scotland’s lead on Infection Prevention and Control (IPC) across the UK

What happens in Scotland has ramifications beyond Scotland. Of course nations have devolved responsibilities for health (something Scotland has often forgotten when bad practice has been led by the UK Government). This has prompted very similar petitions to the UK and Welsh Governments.

All governments have abysmally failed to provide accurate public health information on the reality of ongoing risk; instead minimising risk and perpetrating disinformation. General public awareness of why actions called for in the petition are important is therefore negligible.

5. Key points

a) Why are Scottish Government, NHS Assure/ ARHAI and the Care Inspectorate not taking seriously the key contributions to clean air of HEPA air purifiers, UVC air sterilisation and CO2 monitoring?
b) How can individualised 'person-centred' approaches to risk assessment, and relacing collective public health and IPC policy with personal choice, logically ever work where it concerns infection spread through air we share? Risk will **always** extend beyond the individual. Personal choice impacts on others, including depriving them of personal choice to protection from airborne infections.
c) Why, as it confirmed, has Scottish Government done nothing to empower the public with critically important information about respiratory masks and HEPA air filtration, testing, etc, and the reality of ongoing risks, potentially to everyone, that necessitate them? Why is it content for people to be repeatedly reinfected, despite the consequences of accumulating clinical risk, to economy and education?
d) Why the failure to recognise that clean air and mitigations for Covid-safety more generally are equalities and human rights issues? NB not because people are compelled to protect others but for those compelled to be in unsafe environments due to other people's personal choice not to protect them from risk of harm - never more so than in health and social care settings where clinically vulnerable people are disproportionately likely to be.