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

Petitioner written submission, 07 January 2026

Previous submissions have provided valuable information on the current state of play regarding areas addressed in the petition. Disappointing, critically important matters revealed, requiring urgent investigation, have not been pursued.

The 24/09/2025 evidence session underlined that submissions have not been taken on board. The question to the Cabinet Secretary, framed in the past tense — "How does the Cabinet Secretary see the NHS's ability to recover from the problems of Covid, which **were**, plainly, all-engulfing?" — and his response, ignored evidence presented that the pandemic remains ongoing, as do its wide-ranging cumulative health impacts (now almost 500,000 studies[1]), including immune system damage that makes it harder to fight off infections, with the consequent ongoing engulfing of the NHS. Across many datasets covering illness prevalence, disability, labour-force inactivity due to sickness, and disability-benefit expenditure a similar trajectory appears - roughly flat/ slightly rising baselines, flattening or falling in 2020–21, followed by sharp increases. Coincidence? I think not.

Annual Winter crises

Like previous Winters since lockdowns, this year the NHS has been overwhelmed by airborne infection without preventative action until mid-crisis, despite monitoring showing its approach. Had actions in the petition been in place, much could have been prevented. It is like watching a preventable car crash in slow motion; like knowing water is contaminated with cholera yet only thinking about whether to clean it once in the middle of a major outbreak, then opening a window. **How can this still be happening?**

Yet again, Public Health Scotland (PHS)'s advice to the public[2] was largely based on droplet/ contact transmission (hand-washing, covering mouth/ nose, binning tissues) when it is well established that flu, like Covid and RSV, spreads primarily via the airborne aerosol route. There was no reference to testing or air cleaning, though suggested that if symptomatic people must go out, they consider a 'face-covering' (unspecified) and avoid contact with higher clinical risk people. And what are they supposed to do?

ARHAI

Previous submissions, FOIs, make clear that Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) [3], from whom PHS confirms it takes its lead, lies at the heart of airborne Infection Prevention and Control (IPC) failure in

[1] https://www.ncbi.nlm.nih.gov/research/coronavirus/

[2] https://publichealthscotland.scot/news/2025/december/phs-urges-simple-steps-to-reduce-spread-of-flu-over-festive-period

[3] https://www.nss.nhs.scot/departments/antimicrobial-resistance-and-healthcare-associated-infection-scotland/

Scotland. They reveal an extraordinary failure of governance oversight, no government responsibility or parliamentary and public accountability, with dire consequences for public and economic health and the NHS.

Despite assurances[4] to expand involvement and greater transparency, despite repeatedly contacting ARHAI and many FOIs, I can still find no evidence of expert input and quality assurance on airborne infection IPC e.g. aerosol physicists/ chemists, industry standards, air-cleaning technology, or people with lived experience of high clinical risk.

PHS advice to the public and ARHAI's to health and social care staff remain based on incorrect understanding of transmission as droplet/ contact. Chapter 2 ("Transmission-based precautions"[5]) of its manual offers no guidance on airborne aerosol infection, just flags its reviews of transmission definitions, particle size and mask types — issues already extensively researched and concluded upon. Even during periods of high respiratory infection, health boards are only advised to consider surgical masks not designed for airborne respiratory infection protection.

Six years after an airborne pandemic arrived, it beggars belief how out-of-date, inaccurate and incomplete their manual is. ARHAIs mission "To enable Scotland to have a world leading approach to reducing the burden of infection and antimicrobial resistance." has singularly failed.

Submissions exposed that ARHAI, its processes and expertise urgently need a root and branch overhaul yet no one in Government is taking responsibility. Why has the Committee not pursued this?

IPC strategy

In subsequent evidence-session correspondence, the Cabinet Secretary states that IPC in NHS buildings, "ensuring people are able to continue to access safe and effective care is a priority for the Scottish Government". He cites two workforce IPC strategies where I can find no reference to airborne transmission. He says a 10-year IPC strategy is due out in Spring 2026.[6] **What kinds of expertise have contributed?** The CNOs last submission acknowledged Scottish Government past failures on involving people with lived experience and claimed they had "started the initial planning for ensuring participation and engagement with the public and undertaking an equality impact assessment in the development of the future 'Infection Prevention and Control Strategy' for Scotland involve". **Where is it? How have we been involved?**

Recent FOIs and correspondence reveal Scottish Government has not grasped the substantial differences between IAQ and outdoor air quality challenges and solutions, or the importance of IA cleaning technologies beyond ventilation.

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[4] CNO submission to Committee 25/03/ 2025: https://www.parliament.scot/-/media/files/committees/citizen-participation-and-public-petitions-committee/correspondence/2023/pe2071/pe2071_l.pdf

[5] https://www.nipcm.hps.scot.nhs.uk/chapter-2-transmission-based-precautions-tbps/

[6] https://www.parliament.scot/-/media/files/committees/citizen-participation-and-public-petitions-committee/correspondence/cabinet-secretary-for-health-and-social-care-to-cpppc.pdf

Incredibly, even their respiratory infections action plan makes no mention of IAQ[7]. Their approach appears rudimentary: 'address outdoor air quality and ventilate', lagging very far behind current knowledge and best practice.

IAQ expertise

Yet, there is vast IAQ expertise, including large networks across Scotland and the UK[8], and major developments in air-cleaning technology, ventilation, filtration, sterilisation and monitoring (also improvements to respiratory mask design).

UKHSA recently published its: **Response to the Air Quality Expert Group (AQEG) report on indoor air quality** [9]. This focuses on airborne pollution, highlighting that elevated concentrations in UK schools and hospitals are of particular significance as occupied by more vulnerable groups (p10), also noting the relevance of 'bioaerosols' – airborne viruses and bacteria, though paying them less attention.

I was recently appointed to the **Global Commission for Healthy Indoor Air**[10] comprised of 200+ experts from 40 countries, to develop a global framework for action and national-level blueprints, launched during the UN Assembly in New York, alongside a global pledge positioning healthy indoor air as a human right[11].

Expertise is plentiful. Why has Scotland made such little use of it?

[7] See chapter 2, 1.2 in particular https://www.gov.scot/publications/respiratory-care-action-plan-scotland-2021-2026/pages/5/

[8] Scottish researcH partnership for Air Pollution health Effects (SHAPE), The UK Indoor Environments Group (UKIEG), the Covid-19 Airborne. Transmission Alliance (CATA), UKRI Clean Air Programme, among others.

[9] 18/12/2025 https://www.gov.uk/government/publications/comeap-response-to-aqeg-report-on-indoor-air-quality/response-to-the-air-quality-expert-group-aqeg-report-on-indoor-air-quality

[10] https://www.wellcertified.com/global-commission)

[11] https://www.airclub.org/