

Public Health Legislation in Scotland: A Consultation

QUESTION 1

Organisational Authority

Views are invited on:

1.1 the proposal to assign legislative powers in relation to people to NHS Boards and for property and premises to local authorities, as set out in Tables 1 and 2 in Annex C

This is accepted in principle, however it is suggested that the new Act should be enabling legislation and that the powers as set out in tables 1 and 2 in Annex C should form part of the Regulations under the Act rather than part of the Act itself. Resources both human and financial will be required for the NHS to perform this duty.

1.2 whether the provisions in Tables 1 and 2 in Annex D could usefully be updated and retained in new legislation

Generally agree with this approach.

1.3 whether there should be a requirement for the production of local Health Protection Plans and Statements, to be incorporated within Community Plans or Health Improvement Plans/Local Delivery Plans

It is accepted that there is a requirement for a Health Protection Statement of responsibilities and Plan for implementation. These should be "free standing" document (s) as the health protection aspects of public health are important in their own right. Health protection issues should continue to feature in the Director of Public Health's Annual Report. The minimum requirements of the plan should be part of the Regulations and not the Act.

1.4 whether the issues to be covered in Plans/Statements should include the matters covered in paragraph 3.17

This is a reasonable core. There should also be a requirement for an explicit joint programme of work.

1.5 whether the AIDS (Control) 1987 Act should be considered for repeal in Scotland

The AIDS (Control) 1987 Act should be repealed and a more flexible system for reporting by NHS Boards, and other relevant organisations, should be developed. Previously HIV / AIDS prevention funding was allocated to NHS Boards. Such funding is now part of more general blood borne viruses prevention funding and there would be value in a reporting system being developed that covers HIV, hepatitis B and hepatitis C prevention, protection, treatment, care and support activities, and which requires details of how funding has been allocated. The reporting system developed should support clinical and public health audit.

1.6 (a) whether the provision and statutory role for a DMO should be retained in new legislation

Yes this should be retained and based on the role and qualifications. See 1.6 (c)

1.6 (b) if the role is retained should this role be a joint appointment between LA and NHS

Not necessary if the roles and competencies are clearly specified.

1.6 (c) if the role is retained, should we define qualifications/professions eligible to fulfil this role

As in 1897 and 1974 there remains the need for both recognised advocates for the health of the public and competent trusted individuals able to enact powers to protect health when judged necessary.

When much of Public Health moved from Local Authorities to the NHS in 1974 these roles were largely split necessitating the creation of the Chief Administrative Medical Officer (CAMO)/Director of Public Health (DPH) and Designated Medical Officer (DMO).

Although most Directors of Public Health now delegate DMO functions to other Consultants in Public Health Medicine they are Designated Medical Officers with statutory responsibilities to both the NHS and Local Authority. This was highlighted by the Chief Medical Officer (CMO) in the Review of the Public Health Function in Scotland (1999) Section 3 paragraph 125/6. Loss of this link could weaken the collaboration necessary for health protection and weaken the Director of Public Health's links with Local Authorities more generally.

The Director of Public Health should, in the new legislation, remain the designated public health officer to the NHS and designated medical adviser to the Local Authority on both health protection issues (including property and premises) and health/wellbeing improvement. In the NHS context this would ensure a competent officer for discharging statutory powers such as exclusion from work, school or nursery, and for the Local Authority access to medical public health advice in discharging their responsibilities with regards to premises and property.

In parallel with this we would suggest that a Designated Environmental Health Officer be created in each Local Authority (or jointly where there are many) to ensure a competent person for discharging statutory powers around premises and property and to give the NHS access to professional environmental health advice in discharging their responsibilities to people. This officer should, for purposes of public confidence be a qualified Environmental Health Officer.

The designated public health officer/medical adviser (also known as the Director of Public Health) should be medically qualified and also accredited in Public Health Medicine. Public health accreditation (currently via the Faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom) would be necessary for the Director of Public Health's role in advising the NHS on their statutory obligations in the new Act. In discharging the proposed powers relating to people, clinical judgements regarding both personal and public health risks require to be made. It is difficult to conceive how a publicly trusted decision could be made by a non-medically qualified individual.

Moreover much is made of the need to future proof the legislation. The basic components of medical education have been constant for many years. An understanding of diseases, their effects on people, and the available measures to reduce their impact are found in medical practitioners.

When coupled with the medical profession's highly regulated reputation and record of public trust, retaining a requirement for a public health qualified medical practitioner should ensure public confidence in the application of relevant powers for several years to come. Moreover the current requirements for a medically qualified DMO have not, to our knowledge, led to loss of confidence in the current provisions over 100 years or so.

1.7 whether legislation should require that certain outcomes, including those which restrict liberty, need input from a competent person and, in particular, a professional with defined qualifications

It is imperative that the qualification of those who restrict liberty should be explicit in the Regulations and, thus, enforceable

1.8 if so, whether these qualifications should be defined in regulations or guidance

Regulations should state a medically qualified practitioner with a Public Health accreditation. See also the response to 1.6(c)

1.9 whether powers for Scottish Ministers to intervene in public health matters should follow the principles already established in legislation

Ministers must have the power to intervene when a failure to apply the Regulations poses a threat to Public Health or when the Regulations are found not to meet some new or emerging threat.

Question 2

Notification Options

Views are invited on:

2.1 a new system of statutory notification to public health agencies, which:

a) has two lists: one on notifiable conditions and the second on reportable hazards

Agree with the need to update the list of statutory notifiable diseases. Support the need to have reportable hazards. If there are serious public health risks this will not require consent. However it is essential that these are kept to a meaningful and manageable number otherwise, despite the legal duty, the requirement to notify may be ignored.

b) identifies three types of notifiable conditions:

a) diseases, e.g. tuberculosis

b) organisms, e.g. Clostridium botulinum

c) "health risk states", e.g. close contacts of SARS cases

Agree with the first of these two. We believe that "health risk states" requires closer definition.

c) does not require consent for notification since it will be a legal requirement to notify and report to NHS Boards or other appropriate authority

Agree strongly

d) includes the option to place a statutory duty on doctors to inform the patients of the notifiable condition as soon as possible

We agree that it is essential that a doctor notifies the patient of the notifiable condition as soon as possible but feel that this is the normal duty of a doctor under his/her GMC obligations as a professional.

It is essential that those "at risk" are also notified as soon as possible

The requirement to notify "hazards" is welcomed. It would be helpful to have a list of notifiable conditions and hazards as part of the Regulations

e) defines a "reportable hazard" as any micro-organism or environmental hazard

This definition is much too broad in scope and needs to be more specific and based on serious public health risk.

- f) places a statutory duty on public and private sector organisations involved in testing for the presence of micro-organisms and environmental hazards in human, water, food and environmental samples to report on a defined regular basis to a named public health agency, the numbers and details of samples in which a reportable hazard is detected**

Agree, but this needs to be specific and must relate to hazards that have a serious public health risk.

- g) specifies the reportable hazards and the details required, including to comply with EC and WHO requirements**

Agree

- h) specifies a time limit for notification and reporting in regulations**

Needs to also emphasize that some notifications should be urgent and by phone or e-mail as soon as possible to ensure optimal response to outbreaks.

- i) specifies a penalty for not notifying in regulations**

Agree particularly for organisations

- j) discontinues current arrangements for payment of a fee per notification to general practitioners.**

Agree.

Future arrangements need to take account of the GMS contract, current arrangements which still pertain in some boards, linkage of laboratory and other systems to public health and that the first awareness of organisms is from microbiology services.

2.2 proposals for developing an additional notification system for non-communicable diseases that:

- a) defines the "statutory reportable conditions"**

- b) places a statutory duty on public and private sector organisations involved in caring for individuals suffering from the disease or investigating its extent in a population to report on a regular basis the numbers and details about those suffering from the disease and specified factors involved in its causation**

- c) specifies the diseases and the details required or the specific measurable factors leading to their occurrence to be reported**

Agree to (a), (b) & (c) from a public health perspective

It would be useful to have an additional notification system for defined diseases such as cancer, heart disease, stroke, chronic obstructive airways disease and alcoholic liver disease.

- d) does not require consent for notification since it will be a legal requirement to notify and report**

Agree, but there needs to be adequate consultation to inform the public and reconcile concerns.

e) specifies a time limit for notification and reporting in regulations

Agree

f) specifies a penalty for not notifying in regulations

There is a difference between “notification” and “reporting”. This section should come under the heading of “reporting” with perhaps an annual download of data. Notification implies urgency and whilst the conditions highlighted are serious, their reporting is not urgent.

This may be a useful initiative for developing more timely morbidity statistics than the current proxy of mortality statistics. It could be a very useful PH tool e.g. for service planning, and would presumably ultimately be a means of contributing to the World Health Organization, European Union and OECD health indicators. These should be very useful to Scotland for making comparisons with similar populations elsewhere and seeking reasons for the health differences between them which could then inform PH planning.

2.3 the proposal that the key issues to be considered prior to making a new condition or hazard reportable should be:

- a) cultural and moral sensitivities**
- b) public health significance**
- c) current ethical and legal guidance**
- d) commercial considerations**
- e) resource and quality issues.**

Cultural and moral sensitivities and commercial considerations should be considered. However, protecting health should be the paramount consideration.

2.4 whether to continue to exclude sexually transmitted infections from any new notification system and whether any other disease or condition be excluded

Under EU legislation Scotland will be required to report the following key sexually transmitted infections (STI) – HIV, Chlamydia, gonorrhoea and syphilis. The quality of STI reporting systems in Scotland is currently good, the STI surveillance infrastructure has been strengthened in recent years, and the quality of STI surveillance is expected to improve further over the next five years as a new Scottish sexual health information management system is commissioned.

Sexually transmitted infections should not continue to be excluded. We do feel there is a compelling argument to differentiate important sexually transmitted infections from other important communicable diseases, given their transmissibility and capacity to cause significant morbidity and mortality.

2.5 whether there any other legislative options for surveillance which should be considered

No comment

Question 3

Investigation Options

Views are invited on whether:

3.1 legislation should make it a statutory duty to divulge information during outbreaks or incidents

This approach seems appropriate. In Scotland the Incident Management Team Leader is currently medically qualified and experienced in Public Health Medicine. They would seem an appropriate person having taken advice from environmental health colleagues to approach the Sheriff for such an order.

3.2 the triggers necessary for such action might be:

- a) a significant public health incident or outbreak**
- b) involvement of a notifiable disease, or organism or health risk state**
- c) the seriousness of outbreak or incident in terms of morbidity, mortality or potential health risk**

These seem reasonable triggers.

3.3 the need for such information should be certified by the Chief Executive of the NHS Board, or a case made by the competent person, or whether this should be the Sheriff

This should be a power of last resort and it is essential that it is incorporated into the Act. There is a need to clarify whether or not this refers to obtaining information from people about their contacts or about suppliers from premises or both. It is accepted that the quickest option in the event of refusal to co-operate is to the Sheriff.

3.4 an appeal system or structure should be available against the duty to divulge, involving either reference to the chair of the NHS Board, and thereafter to the Sheriff, if necessary, or in emergency situations, direct to the Sheriff.

The appeal should be to the Sheriff Principal.

Question 4

Statutory Powers for Health Protection

Views are invited on:

4.1 whether legislation should provide for the introduction of quarantine orders for a period of up to 21 days, with provision for renewal or extension

This legislation is required in the context of new and emerging communicable diseases. There are very few diseases that are severe enough to justify this, but with the virulence of emerging diseases such as was SARS, and the threat of bioterrorism e.g. smallpox, it is a power that is necessary for the rare occasions of need.

4.2 whether quarantine orders should only be applied where the criteria in paras 6.9 and 6.12 are met

Maybe.

4.3 whether exclusion orders should apply more widely to include, e.g. work, social and religious events, neighbours, travelling and other activities

The order application should be commensurate with the risk, appropriate to the disease and risk of spread, and therefore the options need to be wider than is currently possible.

4.4 whether exclusion orders should:

- i) apply to specified states and/or organisms and or activities**

Needs to be appropriate to the disease or exposure in question, but should not be too prescriptive since new diseases may emerge.

ii) have penalties for non-compliance

Yes otherwise exclusion will have no power. There are often social and other drivers to resist meaningful exclusion. This should link to powers of quarantine if exclusion is not adhered to.

4.5 whether there should be penalties for non-compliance

Penalties for non-compliance are supported; there is concern about how this would be policed.

4.6 whether compensation payments should extend to all groups liable to be excluded under exclusion orders or affected by other orders

Ideally yes but important to model this as this may not be practical or affordable in certain scenarios. This would reduce undue hardship and is to be encouraged

4.7 whether the payment of compensation should become the duty of the NHS, rather than the LA as currently, given the proposed transfer of powers in relation to people to the former; if recommended, this change would require NHS Boards to be insured against compensation claims

No. We do not believe that decisions to include and to compensate should be taken by the same organization since conflicts of interest may arise. We suggest that other agencies might be a more appropriate way to manage compensation payments.

4.8 whether legislation should provide for the introduction of detention orders, covering:

a) the removal to a suitable place of those who risk spreading disease by virtue of being a contact or those with an infectious disease who refuse to comply with a quarantine order or medical advice

While ideal, this is impractical unless there is provision of a place where this activity can be undertaken.

b) an appeal system

There has to be an appeal mechanism to make the legislation CHRE compliant.

4.9 the proposal not to seek powers to require a person to have medical treatment

Agree.

There needs to be a provision in the Regulations to determine how far examination should go. For example at what point, if any, can the authorities demand blood and tissue sampling. The Regulations should state the minimum requirements for diagnosis

There may also be an issue about children whose parents hold views against treatment in the face of strong evidence to the contrary.

Compulsory treatment is a human rights issue however compulsory detention may be the unavoidable effect of non compliance.

Question 5

Environmental Health Concerns and Nuisance

Views are invited on:

5.1 whether it is perceived that there is a gap in legislation to deal with threats from the environment

Agree with the need to update legislation.

5.2 if so, what are your views on introducing provisions on "environmental health concern" in new public health legislation: these provisions would be totally separate from the Environmental Protection Act 1990

Agree with this.

5.3 should any of the components of the Public Health (Scotland) Act 1897 outlined in Annex H be retained or amended

No comment

**5.4 whether the definition of an "environmental health concern" could be:
"any exposure pertaining to the physical environment of any premises, which is:
(a) discernable to the unaided senses;**

There is a concern that discernable to the unaided senses should have appropriate consideration

**(b) of such a nature, so located; and
(c) having such temporal characteristics as to engender material discomfort or be prejudicial to the psychological or physical health and wellbeing of a person without unusual sensitivity to that particular exposure"**

The reference to psychological or physical health should be deleted with the emphasis being on prejudice to wellbeing. Ascertaining that a "concern" is affecting the wellbeing of people without unusual sensitivity may well be more practical than attempting to show effects on physical or mental health where any hard evidence of such is lacking. If there is genuine health damage the activity/emission could still be halted, but should then lead to more permanent control through the EPA as a recognized environmental cause of ill health. It would be helpful to have some reflection of the level of discomfort and the proportion of people exposed experiencing this.

If you consider that there is a better term than public health 'concern' which covers the issues described, then please let us know

5.5 whether the new system of environmental health concern management could include:

a) public (individual or group) report to the local authority

This is important as this is the basis for a benchmark.

b) joint assessment by local authority and NHS public health staff of the risk, based on the precautionary principle and agree actions with the community

Agree it is necessary to involve the community affected in this assessment.

c) proportionate action by local authority, based on adequate legal sanctions, including abatement or prohibition orders similar to those used currently, or in food standards legislation

Agree.

5.6 whether the time is also right to expand the statutory nuisance regime in the Environmental Protection Act 1990 to include light and insect pollution; and are there any other areas of nuisance that should be added now

These should be added to allow action via current legislation.

Question 6

Mortuaries Options

Views are invited on whether:

6.1 the routine responsibility for resourcing and provision of mortuaries in Scotland should become the responsibility of NHS Boards

This is now appropriate but will require to be properly resourced.

6.2 the NHS should be allowed to charge the police for the use of mortuaries

Yes this currently happen for fiscal cases?

6.3 the provisions identified in Annex I should be updated and retained in new legislation with provision, in particular, made for cremation to take place as appropriate.

Yes

Question 7

Port Health As stated above, specific measures which need to be brought into place to better reflect IHR are currently being considered.

However, it would be useful to hear your views on:

7.1 how well you consider the current port health arrangements work in Scotland; and

No port of significance in Lanarkshire, therefore no comment

7.2 how they might be strengthened.

Clarity of duties and training and professional requirements for staff should be made explicit.

Question 8

Safeguards

Views are invited on whether:

8.1 legislation should contain provisions similar to Regulation 12 in England and Wales, allowing the passing on of information beyond the health protection team by a competent person in specific circumstances

This is helpful. This activity is already undertaken but inclusion in the Act would give it authority and it should only be given on the basis of serious risk to the public health.

8.2 issues of enforcement against one's own organisation should be handled by:

a) a separate health board or local authority

- second choice if (d) ineffective

b) a newly-created public health forum or board

Not required mechanisms already in place.

c) another arbitrator

– not required

d) robust internal procedures that protect and separate conflicts of interest

- first choice

OCT procedures should ensure this in all cases.

8.3 outbreak and incident reports should be circulated to a defined audience.

Yes but the issue is the definition of the audience. More clarity is needed around the defined audience.

Question 9

Tasks and Offences Options

Views are invited on:

9.1 whether the proposed statutory split between governance and penalties is satisfactory, or whether an alternative approach might be preferable

This seems reasonable.

9.2 whether penalties should only be applied to the non-completion of tasks in List B

Agree.

9.3 whether legislation should include penalties for non-compliance with tasks

Agree.

9.4 if so, whether List A infringements might be addressed through the health governance framework, with List B breaches liable to attract either a monetary penalty or, in serious cases, a term of imprisonment

There is a lack of clarity in the two lists. We feel that list B should attract penalties.

9.5 whether legislation should include provision for any other enforcement measure, such as:

a) electronic tagging

b) video monitoring

c) public health monitoring

The inclusion of this gives rise to some concern about the proportionality of the enforcement suggested. May be required in case of serious disease with serious public health risk. The meaning of the term 'public health monitoring' in this context is not understood.

Additional Comment

We wish to make an additional comment about private practitioners and would suggest private practitioners should be required to keep a cumulative list of their patients seen which could be accessed if required.

The reason behind this is that if there is a case of a dentist having an infectious disease such as Hep B, an initial approach is made to NSS for the list of the dentist's NHS patients against which the current list of say Hep B affected patients are compared. This ensures that there

are preliminary investigations made without resorting to wading through all the records in the practice.

However there is no central list of private patients and it would be helpful if private practitioners were required to keep a cumulative list of patients which could be accessed if required.

A handwritten signature in black ink, appearing to read "Kenneth O'Shea". The signature is written in a cursive style with a horizontal line underneath the name.

NHS Lanarkshire Board

11 January 2007