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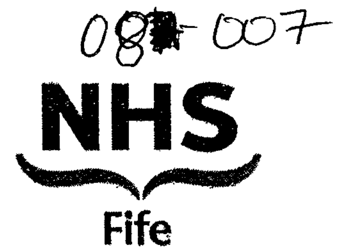

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| Date | 22 November 2006 |
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| Our Ref | MR/AH |
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Dear Sir

Please find enclosed my response to the Consultation Document on Public Health Legislation in Scotland. I also enclose a completed respondent information form.

Yours sincerely

Mike Roworth
Consultant in Public Health Medicine

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## COMMENTS ON CONSULTATION DOCUMENT ON REVIEW OF PUBLIC HEALTH LEGISLATION IN SCOTLAND

### QUESTION 1: ORGANISATIONAL AUTHORITY

1.1 I agree with the proposal to assign legislative powers in relation to people to NHS Boards; and for property and premises to local authorities with the proviso that the resources to carry out this function needed to be allocated to NHS Boards appropriately.

1.2 I agree that the legislation in tables 1 and 2 of annex D should be updated as described.

1.3/4 I disagree with the requirement for the production of local health protection plans and statements. I think that this would be a paper exercise and would not necessarily lead to any improvement in practice. Some of the sub headings in paragraph 3.17 are too vague: others would merely be a restatement of the new legislative position.

1.5 The Aids (Control) Act 1987 act should be repealed. This serves no clear purpose.

1.6a The provision and statutory role of the designated Medical Officer should be retained in a new legislation but redefined to take account of whatever legislative powers are transferred to NHS Boards and the final version of the legislation.

1.6b I do not agree that the DMO role should be a joint appointment between local authority and NHS. This would not be necessary if powers are transferred to NHS Boards.

1.6c: I agree that the qualifications of professionals eligible to fulfil the role of designated Medical Officer (however this is finally defined) should be clearly defined and enshrined in legislation.

1.7: I agree that legislation should require certain outcomes, including those which restrict liberty, need input from a competent person and in particular, a professional with defined qualifications. I would add that those outcomes which would restrict liberties should require the signatures of two suitably qualified and competent individuals (as opposed to Section 47s under the national Assistance Act, which only need one Proper Officer's signature).

1.8: These qualifications should be defined in regulations.

1.9: I agree that Scottish Ministers should retain the power to intervene in public health matters as already established in current legislation.

## QUESTION 2: NOTIFICATION

2.1: I agree with the concept of a two-tier system of notification and reporting. I would expand the criteria for notification to include the need for urgent or specific action in respect of a named individual. The inclusion of 3 types of notifiable conditions i.e. diseases, organisms or health risk states seems reasonable, though consideration needs to be given to the way in which information about health risk rates would flow. In many situations, for example, the investigation of a CJD case or a SARS case, these individuals would be identified by public health so it is not clear who would be notifying to whom.

I agree that notification should not require consent.

I agree that a statutory duty should be placed on doctors to inform patients of their notifiable condition as soon as possible.

I agree with the definition of a reportable hazard and the proposals to place a statutory duty on organisations involved in testing 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. I agree that the system should specify what the reportable hazards are and what are details required. I think believe that this should be anonomysed data since no specific action in respect of an individual is required.

I agree that a time limit for notification and reporting should be specified in regulations.

I agree that there should be penalty in the legislation for not notifying.

I have no view about whether or not current arrangements for paying a fee to GPs for notification should continue.

2.2 disagree with developing an additional notification system for non-communicable diseases. This is clearly not a health protection issue. Moreover, it is difficult to envisage what urgent action would be required on receipt of a notification of someone with, for example coronary heart disease. Primary care already has systems in place to identify and manage patients with a range of high risk conditions and there would be little point in duplicating this.

2.3 I broadly agree with the listed criteria that need to be considered before a new conditional hazard is made notifiable, but I would add the operational scope for taking specific action in respect of an individual or contacts of that individual to this list. For some conditions e.g. tuberculosis, it is clear that there is specific, though not necessarily urgent, follow-up. At the other extreme there is no specific follow up for an individual with chicken pox so there is no need for a clinician to notify a named individual with this condition.

2.4 In my view, sexually transmitted infections should probably continue to be excluded from any new notification system. In addition to the cultural and moral sensitivities described, contract tracing is currently carried out at GUM clinic level rather than at public health / Board level, so this should continue.

The current list of notifiable diseases needs to be examined against the agree criteria to determine whether or not they stay notifiable or are relegated to reportable conditions when assessed against the criteria for notification; or whether they can be dropped altogether, taking into account their current prevalence and relevance to modern day disease taxonomy.

2.5 No comment

## QUESTION 3: INVESTIGATIVE OPTIONS

I find this chapter a little abstracted, and it is not clear from the wording of the text whether or not this is a problem significant enough to require legislation and as such the proposals are somewhat Draconian. In operational terms I foresee difficulties over the precise definition of the triggers required to evoke the proposed powers. I also think that the statements about the need for quick, simple and prompt procedures for obtaining information though the courts or appeal procedures are wishful thinking.

## QUESTION 4: STATUTORY POWERS FOR HEALTH PROTECTION

4.1 I agree that legislation should provide the introduction of quarantine for a period of up to 21 days, with provision for renewal or extension.

4.2 The criteria described in paragraphs 6.9 and 6.12 seem reasonable and proportionate.

4.3 I agree that exclusion orders should be applied more widely as described.

4.4 I agree that exclusion orders should be applied to specified states and/or organisms and / or activities, otherwise these orders would be too open-ended.

4.5 Non-compliance with exclusion orders under regulations must, of necessity, have attached penalties.

4.6 I agree that compensation payments should extend to all groups liable to be excluded under any exclusion orders or affected by other orders.

4.7 Payment of compensation should rest with the enforcing authority. If person issues transfer from local authority to the NHS then payment issues should do so correspondingly

4.8 Existing legislation provides for the removal of individuals to a suitable place if they fail to comply with medical treatment. See section 54 of the 1897 Public Health Act. This needs to be brought up to date.

4.9 I agree that individuals cannot be compelled to seek medical treatment but the legislation which prevents the public health consequences of this individual decision need to be in place, as in 4.8 above.

## QUESTION 5: ENVIRONMENTAL HEALTH CONCERNS AND NUISANCE

I don't feel particularly qualified to comment on any of the questions relating to this chapter.

## QUESTION 6: MORTUARIES AND CREMATION

No opinion on this section.

## QUESTION 7: PORT HEALTH

My experience of Port Health and Port Health issues is confined entirely to the assessment of landed immigrants for the presence of tuberculosis. This would seem to be a rather haphazard system with referral for screening depending on where and when the immigrant arrives in the UK. Strengthening of TB screening procedures at airports in the UK would require an increase in staffing levels to 24/7 at all international airports.

## QUESTION 8: SAFEGUARDS

8.1 I agree that there should be legislation Scotland equivalent to Capital R regulation 12 in England and Wales.

8.2 It is not clear here whether new legislation to deal with the issue of conflicts of interest when a local authority is involved in an incident is being proposed or whether there is to be a change in guidance. Currently conflicts of interests are already acknowledged and addressed within the workings of an ICT. It is difficult to see what further internal procedures could be introduced. It is not clear what the issue is here either in terms of whether or not the current system is working well, so it is difficult to comment.

8.3 I disagree that ICT reports are usually sent to a limited audience, as described in paragraph 10.13 of the background text. ICT reports of significant incidents are generally made widely available, including to members of the public. Moreover, they are available to anyone under FOI Legislation, so I am not clear what the proposal in this paragraph would add. It is not clear whether this is proposed as legislation or amendment to existing guidance.

**QUESTION 9: TASKS AND OFFENCES OPTIONS**

My main difficultly with this section is seeing the benefit of having regulations if they are not in someway enforced, either by financial or other penalties. This being the case, in my view all of the actions which are included in the final version of these regulations should be compulsory and failure to comply with them should, at the very least on paper, result in some sort of fine or other penalty.

I would add a sixth criterion to paragraph 11.6 on principals for enforcement: namely the enforceability of legislation. There seems little merit in having a law which is unenforceable.

**Mike Roworth**
**22 November 2006**

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# Scottish Executive

## Consultations



## Public Health Legislation in Scotland: A Consultation



### RESPONDENT INFORMATION FORM

**PUBLIC HEALTH LEGISLATION IN SCOTLAND: A CONSULTATION**

Please complete the details below and return it with your response. This will help ensure we handle your response appropriately. Thank you for your help.