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Your Ref
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Dear Mr Doohan

We are grateful to the Scottish Executive for the opportunity to respond to the consultation document "Public Health Legislation in Scotland".

We have considered the document in detail and broadly agree with its main proposals – updating the legislation and defining the responsibilities of NHS boards and local authorities.

We agree, in particular, to the principle that the NHS Boards should be responsible for enforcement issues in relation to people and the local authority should be responsible for enforcement issues in relation to property and premises.

We agree in general terms with what is set out in the consultation document unless contrary views are expressed in our answers to the consultation questions.

Our answers to the questions are as follows:

- 1.1 In general we agree with the proposals as explained above, however, in outbreak situations where either the police or the NHS Board is the chief investigator (paragraph 3.14), we believe that the term "co-ordination of activities of all responders" should be changed to "direct the activities of all responders". This would help to reduce the occurrence of situations where weak governance and accountability structures fail to expedite investigations in the manner required in major outbreak situations. We are not reassured that the development of local health protection plans will fully address this without the legislation being clear on this issue. Also, the division of responsibility between people and property is not always clear cut as in the situation in the Borders during the investigation of premises for Anthrax, where no people were ill, but the risk was to people. The NHS Board led, but had no designated power in the investigation. The legislation should define the persons and property distinction taking account of the less clear cut instances such as described above to guide the development of Local Health Protection Plans.

- 1.2 We agree that the provisions mentioned in Annex D could usefully be updated and retained in new legislation. However, we consider that the details of these reforms are a matter for the Scottish Executive's legal advisers.
- 1.3 We agree that there should be a requirement for the production of local health protection plans as this could fill a gap in the strategic requirement in the preparation of health plans. It should not be essential to update them annually if there is no need for material change. While it would be helpful to review any need for change on an annual basis we wish to avoid unnecessary bureaucracy.
- 1.4 The joint health protection plans or statements could be useful in laying down minimum requirements for health protection. A major incident needs capacity and manpower. In local authorities this is being eroded to social work and education, with less resources being designated to health protection issues. Therefore, identification of the basic minimum requirements for public safety could usefully strengthen health protection powers.
- 1.5 We consider that the AIDS (Control) Act should be repealed in Scotland as circumstances have changed considerably since the introduction of the Act and the question of controlling AIDS should be viewed as part of a wider strategy of controlling blood borne virus infections. Including it in the context of a local health protection plan would serve to maintain its high profile amongst both health boards and local authorities, rather than the current situation of "how we spent".
- 1.6
 - a) The retention of the DMO role is not vital but a medically qualified consultant in public health should always lead the health protection function at NHS Board level. An analogy may be drawn between the qualification requirements as set out in the Mental Health Acts (Scotland) and that required for taking action to protect public health.
 - b) If the DMO role is maintained we do not think there is a need for a joint appointment if roles are clear.
 - c) We do not consider that qualifications should be defined in law or regulations, other than that the person should be suitably qualified, as this reduces the amount of regulation or legislation required. Legislation should be made only where necessary.
- 1.7 We agree that legislation requiring certain outcomes including those restricting liberty need input from competent persons. We do so because, particularly in restriction of liberty, there are issues arising under the Human Rights Act 1998. To protect those liberties it would be necessary to have clear legal provisions. An analogy might be the provisions set out in the Mental Health Acts (Scotland) in relation to restriction of liberty to persons with mental disorders.

1.8 Such qualification should be defined in regulations, not guidance, as guidance is less permanent. Regulations are needed in areas such as restriction of liberty to increase this safeguard to citizens. These regulations should define the requirements to meet the level of competence required to take responsibility for public health decisions e.g. medically qualified and accredited by a medical royal college as suitably qualified to carry out public health work.

1.9 We agree that Scottish Ministers should retain powers to intervene following the principles already established in legislation.

2.1

- a) We believe that the aim of legislation should be to protect the population from imminent or serious harm. Therefore, we are supportive of the reporting of notifiable conditions or hazards where these conditions occur. Legislation should be designed to take into account the emergence of new infections and potential health consequence of these. We believe that statutory notification is useful for routine surveillance purposes, but in outbreak situations, or where newly emerging infections, which, are a serious health threat are first identified urgent communication is required. In these instances normal reporting mechanisms will be superseded by the need for urgent telephone communication between relevant professionals.
- b) We believe that there is benefit in including the notification of clearly defined diseases e.g. tuberculosis, but not “food poisoning” as this cannot be clinically diagnosed and includes any disease thought to be due to the consumption of food. Most cases of food poisoning are not bacteriologically confirmed and may be due to other conditions, which have no bearing on food. There would be benefit in including the notification of certain organisms, and potentially of “health risk states” providing there was a defined risk to the health of the public and the purpose of the notification was to protect the public from imminent or serious harm.
- c) We agree with the provision that such notification if purely to protect the population from imminent or serious harm should not require consent.
- d) We believe that this should remain an issue of judgement, as some patients will have life limiting conditions such that exposure to a given risk will not materially affect the quantity or quality of life of a given individual.
- e) We believe that a reportable hazard should only include those micro-organisms or environmental hazards where there is a defined recognised risk to public health.
- f) Where this hazard is detected, for instance, in routine food sampling and is a potential cause of ill health this should be a statutory duty.
- g) We believe that all reporting should comply with EC and WHO requirements.

- h) We believe that specifying a time limit for notifications is a useful measure.
- i) This may be of limited value as no penalty has been enforced since the introduction of requirements to notify given medical conditions.
- j) We agree with the discontinuation of a payment of a fee per notification for general practitioners.

2.2

- a) We do not support proposals for including non-communicable diseases in public health legislation, as the aim of this legislation is to protect the population from health threats to which they are exposed, not to carry out surveillance for a range of non-communicable diseases and lifestyle issues.
- b) We do not agree with this proposal as other disease registers are available which can fulfil this purpose and pursuance of this route may result in individuals being unwilling to share specific health risks with their medical providers.
- c) As above
- d) As above
- e) As above
- f) As above

2.3 We believe that all of issues a) – e) should be considered prior to making a new hazard reportable.

2.4 We believe that sexually transmitted infections should be reported. We acknowledge that some health professionals will have reservations about this, however, the very act of making exception for specific diseases may serve to increase stigmatisation by reinforcing prejudices. Also as the majority of sexually transmitted infections (e.g. Chlamydia) are treated outwith a genitourinary medicine (GUM) clinic setting, there is little advantage in treating the proportion reported by GUM in a different manner to those detected and treated by the majority component of the health service.

All NHS staff who handle patients data should be aware of the need to observe strict patient confidentiality, and making that infection notifiable should have no effect on the quality of care including the need to observe confidentiality with patient data. We believe that criminalisation of transmission of sexually transmitted infections, as has occurred for HIV and Herpes, is not conducive to notification of sexually transmitted infections and may present ethical dilemmas for health care workers.

- 2.5. No other options for surveillance were identified for consideration.
- 3.1 This approach seems sensible and should be supported. It is recommended that the director of public health or a medical director of the board should be fully briefed on why this information is required when considering legal action.
- 3.2 We believe that all the criteria listed are appropriate triggers for requesting the release of such information.
- 3.3 Given that there is a potential for interference with the liberty of the subject, we feel it would be appropriate that the NHS Board obtains a warrant from the Sheriff.
- 3.4 If the NHS Board is required to make application to the Sheriff in the first instance, there will be no need for an internal appeal procedure. As it is envisaged that such warrants would be granted on an emergency basis without necessarily hearing the person involved, appeal could be from the decision of the Sheriff to the Sheriff Principal. We recommend that any such appeal should be heard within a 12-hour period.
- 4.1 We think that the introduction of such legislation is a good idea, particularly as no such orders exist at the moment, and emerging infections have highlighted weakness in our current instruments to control the spread of infectious disease.
- 4.2 These criteria appear to be both reasonable and appropriate.
- 4.3 We think there is a case for extending the application of exclusion orders to include all schools, nurseries and pre-school groups, and travelling on public transport. However care should be taken as to exactly what venues would be appropriate and the views of potential affected persons should be considered before extending exclusion orders to those situations. All action taken should be proportionate to the risk. Additionally, the wider the exclusion order, the more difficult it will be to enforce.
- 4.4
- i) We agree with these proposals
 - ii) We agree with these proposals
- 4.5 We agree with the introduction of appropriate penalties
- 4.6 We think that, as a general principle, compensation payments should be extended to all groups liable to be excluded under exclusion orders or affected by other orders.

- 4.7 We agree that if enforcement powers are transferred directly to the NHS Board, then the Board should be under a legal duty to compensate.
- 4.8
- a) We agree that legislation should provide for the introduction of detention orders covering the matters specified in this question.
 - b) We agree that a suitable appeal system should be introduced.
- 4.9 We agree with this proposal.
- 5.1 We agree
- 5.2 We agree with such proposals.
- 5.3 These specific nuisance provisions should not be retained to the extent that they duplicate and cover general nuisance provisions covered in the Environmental Protection Act 1990. If necessary, consideration should be given to amendment of the nuisance provisions in the 1990 Act to cover any of these specific provisions if it is thought that they do not come within the terms of the existing legislation.
- 5.4 This appears to be a suitable definition.
- 5.5 We believe these recommendations are appropriate.
- 5.6 We agree that the existing statutory nuisance regimen should be extended to include light and insect nuisance. We are not at this stage able to identify any other areas of nuisance that should be added to the statutory nuisance regimen.
- 6.1 We believe that the question of who owns and operates the mortuaries is of lesser importance than ensuring that they are managed to appropriate standards and meet full technical requirements. It is also important that the operator makes provision for surge capacity such as may be required during a winter flu epidemic. These extra storage facilities will also require to be properly managed to meet current legislation.
- 6.2 Management of mortuary premises should be carried out as a public service by whoever operates them. However, where work which is carried out on a private basis by individuals, for instance on behalf of the procurator fiscal, it should be the responsibility of that agency to provide full reimbursement.

- 6.3 We agree that the provisions identified in Annex I should be updated and retained in new legislation. There should be suitable safeguards in relation to cremation where family and religious wishes may be opposed to this method of body disposal.
- 7.1 At the moment the port health regulations are fragmentary, and similar issues are being dealt with in different ways in various parts of the country. Lack of appropriate legislation in relation to “off shore installations” and vessels outwith three nautical miles of the coast are also major weaknesses as, for instance, outbreaks of gastroenteritis and respiratory illnesses e.g. Legionella, frequently occur on ships with subsequent morbidity and mortality. Each of these areas requires to be addressed.
Additionally, a person who is an illegal immigrant, but presents with a similar illness to a UK resident at the same port will be managed in a different manner and possibly by different personnel.
- 7.2 Port health would benefit from a co-ordinated approach throughout the country, which also took into account the requirements of the Immigration Act. It should include all vessels in British waters including off shore installations. Regulations should include suitable measures to prevent the potential importation of all new and emerging diseases into the United Kingdom. The authority to carry out appropriate medical examinations by suitably qualified persons and the institution of appropriate control measures should be included. Port health regulations need to take into account the differing needs of sea ports, marinas and airports, and should comply with the requirements of the WHO 2005 International Health Regulations.
- 8.1 We agree with the proposal to extend legislation similar to regulation 12 in England and Wales with appropriate safeguards.
- 8.2 We propose that Health Protection Scotland investigate Boards’ handling of an investigation where this is considered necessary. It is not anticipated that a Board would have significantly robust procedures to investigate its own affairs.
- 8.3 We agree with this proposal. We also believe that the Local Health Protection Plans should include guidance on informing the public, rather than making this a statutory duty.
- 9.1 We are of the opinion that the proposed statutory split between governance and penalties is satisfactory.
- 9.2 We agree.
- 9.3 It would be helpful for the legislation to include those penalties so that the persons who do not comply with the tasks put upon them clearly know the potential consequences. As a general rule a fine would be an appropriate penalty and that imprisonment should be avoided.
- 9.4 We agree.

9.5 We agree that additional enforcement measures would, in suitable cases, be appropriate. It would not, for example, always be necessary for a person to be imprisoned, if the same objectives could be met by these alternative means. Provision should also be made in appropriate cases for warrants for conveyance of persons caught, for example to a place of quarantine. In cases of that nature, it would be wholly inappropriate to leave the only penalty as a fine or imprisonment.

We trust that the above comments will be helpful to the Scottish Executive in taking forward the necessary legislative amendments to Public Health Legislation in Scotland. We think that it would be of benefit to the public of Scotland if public health legislation could be set out clearly and concisely in a modern statute, which replaces the relevant provisions of the 1897 Act, and other related legislation. Sections 72-189 of the Act would presumably require to remain until other legislation could be considered for replacement of these provisions, which in themselves are not exclusively matters of public health. The large amount of additional legislation which has been introduced since the original 1897 Act was enforced has led to confusion and uncertainty over the current law, and greater clarity could be introduced if this legislation was appropriately replaced.

Yours sincerely



T A DIVERS
Chief Executive