PUBLIC HEALTH LEGISLATION IN SCOTLAND: A CONSULTATION

QUESTION 1: Organisational Authority

1.1 This is a major proposed change to current practice. I presume that in preparation for this document the model has been assessed in recent case studies such as E-coli in Fife, Anthrax in the Borders etc to confirm this would be an improvement on current practice and to assess implications arising from this change in duties. If not, this should be done.

It would be impossible for NHS Boards to undertake these proposed additional duties without sufficient additional resources. Resources may need to be transferred from Local Authorities to NHS Boards. However more than a straight transfer will be required as overall this will not be cost neutral. NHS Boards will incur set up costs and local authorities may have made efficiency savings e.g. some members of staff currently deal with people as well as premises and property and their services will need to be retained.

Clarification would be required over which organisation chairs any OCT investigation. Whilst most incidents involve some combination of people and premises and possibly property, if it was deemed that it was primarily a premises or property issue it could be argued that the local authority should lead the OCT investigation. This would be a dramatic change to current guidance and the position that the NHS should continue to lead OCTs should be clarified.

In Section 3.10 (which I do not see mentioned elsewhere in the document) is not clear how the NHS would medically examine someone if that person refuses an examination. In Annex C Table 1 public health may lead and organise an examination but an examination would need to be carried out by a Clinician (Annex C Table 1), if practically and ethically possible.

1.3 One of the main risks to the proposal is the distancing of local authorities and NHS Boards. A memorandum of understanding would be required, perhaps five yearly.

1.6a Yes though the exact title is not important. Local authorities with their new duties will still require advice with relation to properties and premises.

It might also be sensible to have a designated Environmental Health Officer to provide advice to the NHS.

1.6c Yes

1.7 Of course they need to be 'competent'. The definition of competence

is vital. I would recommend that legislation which includes restriction of liberty requires signatures of two competent individuals and should also be consistent, where possible, with Mental Health Legislation. A competent person should be a senior Public Health Consultant with a *clinical qualification*.

I note that whilst Chapter 3 discusses the value of specialists including in restriction of personal liberty, section 4.7 states that for notification urgent public health action needs to be taken by a clinical professional.

QUESTION 2: Notification Options

2.1 Any new lists of notifiable conditions must be consistent with IHR 2005 and must include sufficient flexibility for new diseases states and organisms identified after the law has come into effect i.e. flexibility must be available to add to the list.

Notification definition in 4.8 is not suitable and is currently so wide that a disease such as lung cancer with known risk factors could fit the definition. Conditions should be notified on suspicion. The definition specified others being exposed to the hazard thought to be the cause of the individual's disease but makes no mention of the risk of ongoing transmission from the person.

Clear definitions or guidance around health risk states would be necessary to ensure these are limited to those with significant risk to the public health.

Doctors should be encouraged to inform patients of the notifiable conditions as soon as possible but I am not convinced that this should be statutory as there may be some rare circumstances when this is not appropriate

2.1f Should this occur there would need to be very clear definitions of what needs to be reported.

2.1h Yes, the timeliness of notifications is important. However there needs to be some flexibility to allow late notification for purposes of national surveillance and occasionally for public health action e.g. Borders anthrax.

2.1I Yes

2.1j Yes

2.2 Whilst good quality surveillance for non communicable disease including cancer; coronary heart disease etc has important public health benefits and, recognising the risks of poorer quality data since

the advent of the GMC Guidance, making these conditions legally notifiable would raise major ethical considerations about the use of personal data and confidentiality. It is not clear what the added value would be as historically notification does not imply high compliance unless there is a high penalty.

Currently, and I see no change to this in the proposals, notification includes full personal details which are not absolutely necessary for the purposes of non communicable disease surveillance. Neither individual nor urgent Public Health action is required.

It is likely that voluntary reporting of these conditions in the past was better than reporting of many of the notifable disease. Perhaps there should be another legal system.

2.4 The rationale for legal notification is that public health action is taken. For sexually transmitted infections contact tracing is carried out at GUM clinic level and I would be concerned that making these diseases notifiable could result in reluctance by patients to come forward, be diagnosed and treated and therefore result in public health disbenefit.

Public Health do not need to know about individual cases but timely surveillance is important in order to identify and manage increases in incidence and outbreaks which may require Public Health action.

Clearly there are some difficult cases where a person will not divulge all of their contacts to the GU clinic or may continue high-risk behaviour. Obviously legislation exists in Scotland cf Kelly case and further legislation may well be helpful but not through making all sexually transmitted infections notifiable.

QUESTION 3: Investigation Options

Yes – This may be helpful in certain unusual circumstances. However this proposal might be practically very difficult to implement in a timely fashion particularly as there should be right to appeal. Perhaps it is more appropriate that all parties should have a statutory duty to co-operate and to respond fully to all reasonable requests for information from an OCT (definition of reasonable request would be required).

QUESTION 4: Statutory Powers for Health Protection

A key issue of isolation whether at home or in another setting is of the definition of a serious or severe infection or serious risk to the public. Two wordings are used within the document. In section 3.10 it states a serious risk to the public whereas in 6.4 the wording is suffering from a severe infection

which poses a risk to others through person to person spread. The definition of severe infection and serious risk to others must be clarified with guidance.

4.1 Yes – It should be made clear that this is for exceptional circumstances only (see comments on definition above).

4.2 Yes

4.3 Yes – particularly this should include pre-school facilities etc

4.5 Yes

4.6 Yes – which should include parents of excluded children

4.7 Yes – if the duties change. Funding would be required

4.8 Yes – noting that the place detained maybe a place other than a hospital. For instance prisoners maybe quarantined within their own cell. The key difficulty as always with these orders is ensuring and enforcing that the patient remains in that place. Hospitals are designed to treat patients including with infectious diseases but are not designed, and neither are their staff, for enforcing detaining. It would be helpful to have one order so that if the patient absconds perhaps repeatedly within the 21 day period they can be readmitted to the place e.g. hospital without reapplying for a detention order. It is essential there is an appeal system.

4.9 Yes

QUESTION 5: Environmental Health Concerns and Nuisance

5.4 This definition is very wide.

5.5 With the wide definition and if there is public reporting this could lead to a huge number of assessments by local authorities and public health.

QUESTION 7: Port Health

Current port health arrangements do not appear to work well in Scotland. Clarification is required. I agree with the suggestions made by the Scottish CHPMs, (CD & EH) Group. It is important that arrangements are consistent with the review of port health in England. For instance ships on short cruises often prone to noro virus outbreaks stop frequently at numerous ports around the UK and consistency of approach would be helpful.

Provision of reception areas would be helpful particularly for those who are advised not to travel further. The key importance of these areas however is to

limit the spread of infection. When planes are detained through port health regulations all passengers are kept on the plane if there is suspicion of one infectious case. The spread of infection would be considerably reduced if passengers could be taken off to a reception centre.

I agree with CHPMs that review needs to take account of the implications of increasing passenger transport and that passengers could have originated from anywhere in the world.

Clarity of responsibilities of the Immigration Service screening of immigrants and action on results would be helpful. Definition of Port Health Service and training in professional requirements for Port Health staff would also be important. I further agree with the DsPH response that there is potential for a single Scottish service.

QUESTION 8: Safeguards

8.1 Yes

8.2 Rebust internal procedures that protect and separate conflicts of interest are the key. Public health specialists are trained in this field and are frequently used for instance in the investigation of health care associated infection outbreaks. HPS would usually be involved as an external agency. There would be real practical difficulties in another Health Board or local authority carrying out this role including the need for local knowledge as well as a time away from their own duties. Whilst the Chair of the management team could be external it might be difficult to find people willing to do this because of the time and other implications.

8.3 Circulation of reports to a defined audience might allow more candid accounts of outbreaks which would allow greater learning. However currently reports may be presented to the Board (as public documents) and can be requested by the public through Freedom of Information. Arguably there is a legitimate public interest in an outbreak report.

Dr LORNA WILLOCKS
CONSULTANT IN PUBLIC HEALTH MEDICINE
NHS LOTHIAN