

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

The Institute does not support the transfer of legislative powers for the 'people domain' from local authorities to the NHS.

The three domains of Public Health described in this consultation document are inextricably linked and should remain the duty of the local authority. Whilst on paper it may seem reasonable to split the domains, it is impossible to envisage a scenario where this could actually work in practice.

The potential split of responsibilities is contrary to the principles of 'Better Regulation'.

There is concern that enforcement of the people domain could raise ethical issues for clinical practitioners, loss of confidence by patients, perceived loss of confidentiality.

Environmental Health Officers (EHOs), whose training is regulated by Royal Charter, are working at local level and are already competent and trained in these matters. This potential change will have an impact on the long standing academic degree courses, the Scheme of Practical Training and Professional Examinations currently undertaken by EHOs. It would be unsatisfactory to remove these duties to officials who have no experience or training in this enforcement responsibility.

The cost of training and assessment of NHS staff should also be considered if this potential transfer of duties takes place.

There has been no discussion about how NHS officials will manage day-to-day issues connected with the people domain e.g. how they administer exclusions without consultation with the local authority, how they monitor and follow up exclusions and what powers they will have in connection with e.g. residences, food premises, workplaces, all of which currently lies with the EHOs of the local authority. There is potential for conflict with the administration of statutory functions under other existing legislation, particularly the Food Safety Act 1990 and the Health and Safety at Work etc Act 1974, currently enforced by EHOs.

The Institute believes that enforcement duties undertaken by a central legal unit would be most unsatisfactory when dealing with local public health matters.

The Institute recommends that existing legislative responsibilities should remain and would be much improved by better collaboration and joint training with NHS colleagues.

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

The Institute recommends the updating and retention of sections 27, 30 and 35. Sections 50, 65 and 66 could be repealed as being no longer relevant.

The sections listed in Table 2 should be updated and retained. The Institute would query the inclusion of ships in the definition of a house in relation to Section 51.

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

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

The Institute is in agreement with the introduction of the Joint Health Protection Plan within the local Community Planning framework. The Joint Health Protection Plan should be a discrete plan, separate from the Joint Health Improvement Plan.

The Institute agrees with the terms set out in paragraph 3.17 and would add that the Chief Environmental Health Officer of the local authority should be a specific designation in the legislation and that this post holder should be required to embed health protection in the his/her service plan. This would then be linked directly to the Joint Health Protection Plan.

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

The Institute agrees to the repeal of the AIDS (Control) Act 1987.

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

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

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

It is the view of the Institute that the role of the 'Designated Medical Officer' should be repealed in favour of the designation of a 'competent person'. The qualifications and experience of the 'competent person' requires to be assessed and accredited and be subject to a scheme of continuing professional development to ensure credibility of the appointee.

The line of responsibility should be determined in the local Joint Health Protection Plan.

If this post is a joint appointment between the local authority and the NHS, then this would further obviate the need for the removal of the people domain to the NHS. A joint appointment would also ensure collaboration and communication on health protection matters.

If the DMO role is retained, the job title suggests that the post holder is medically qualified. This would need careful consideration in light of the emerging 'multi disciplinary' public health workforce.

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

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

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

Certain outcomes, including those which restrict liberty should require input from a competent person with defined qualifications. These should be defined in regulations or guidance to allow change if circumstances change.

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*
- b) identifies three types of notifiable conditions:*
 - diseases, e.g. tuberculosis*
 - organisms, e.g. Clostridium botulinum*
 - "health risk states", e.g. close contacts of SARS cases*
- 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*
- d) includes the option to place a statutory duty on doctors to inform the patients of the notifiable condition as soon as possible*
- e) defines a "reportable hazard" as any micro-organism or environmental hazard*
- 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*
- g) specifies the reportable hazards and the details required, including to comply with EC and WHO requirements*
- h) specifies a time limit for notification and reporting in regulations*
- i) specifies a penalty for not notifying in regulations*
- j) discontinues current arrangements for payment of a fee per notification to general practitioners.*

The Institute supports these proposals.

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*
- d) does not require consent for notification since it will be a legal requirement to notify and report*
- e) specifies a time limit for notification and reporting in regulations*
- f) specifies a penalty for not notifying in regulations.*

The Institute supports these proposals.

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.*

The Institute supports these proposals.

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

The Institute supports the inclusion of sexually transmitted infections in the reporting system.

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

The Institute has no comment on this issue.

Question 3

Investigation Options

Views are invited on whether:

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

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*

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

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.

There should be a duty to divulge information, where it is deemed necessary for an investigation. Powers to require information should be made available, but only used in circumstances that are certified by the 'competent person' and/or the Chief Environmental Health Officer. An appeal should be made directly to the Sheriff.

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

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

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

4.4 whether exclusion orders should:

- i) apply to specified states and/or organisms and or activities*
- ii) have penalties for non-compliance*

4.5 whether there should be penalties for non-compliance

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

The Institute supports these proposals.

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

The Institute does not support the removal of legislative powers for the people domain from the local authority to the NHS, so therefore, can not support this intervention.

*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
b) an appeal system*

The Institute supports this proposal.

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

The Institute does not support this proposal. The Institute's view is that, in certain circumstances, the 'competent person' should have the power to require a person to have medical treatment, if this is in the public interest.

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
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*

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

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;*
- (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"*

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*
- 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*
- 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*

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.

The Institute broadly supports these proposals but believes that the time is right to expand the statutory nuisance regime. Statutory nuisance provisions contained within the Environmental Protection Act 1990 should be repealed, updated, expanded and included in the proposed new Public Health Act.

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

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

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.

Whilst this is a local authority service provision matter, the Institute would comment that only two local authorities provide mortuary services and these appear to work well. In the rest of Scotland ad hoc arrangements exist at local level.

The issue of mortuary provision should be decided at local level and be included in the local Joint Health Protection Plan.

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

7.2 how they might be strengthened.

In Scotland port health duties are administered by 14 Port Local Authorities covering both sea and airports. The legislative duties tend to be added on to the normal land-based duties of EHOs in these areas. Port health responsibilities have a low profile in some services.

The port health function covers communicable disease control and disposal of the dead, as well as sanitation inspections, water sanitation, fishing and food controls, de ratting, pest control and air pollution issues. All of these include all public health domains.

The service in Scotland generally works well although tends to be more reactive, as there is little capacity within local authorities for more routine surveillance work. Service provision does vary across the country and capacity to respond to incidents is in doubt.

Recently the Scottish Port Local Authority Network (SPLAN) was created to allow a forum for dialogue and to develop consistent approaches to service delivery.

The Institute recommends more collaboration on port health matters and greater collaboration across the UK to ensure consistency and improvements in port health/public health.

The role of port health will be strengthened if the word 'health' was inserted into terminology i.e. port health local authority.

The Institute would draw attention to the Port Health Benchmarking exercise carried out in 2002 by the UK Association of Port Health Authorities (APHA) and the good practice guides produced.

In addition, the Institute would draw attention to the Memorandum of Understanding (MoU) drawn up by APHA with the Maritime and Coastguard Agency (MCA) on issues relating to food safety and detention of vessels.

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

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

a) a separate health board or local authority

b) a newly-created public health forum or board

c) another arbitrator

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

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

The Institute's view is that there should be a presumption of the ability to pass on relevant information to others where it is deemed essential by the 'competent person', in certain circumstances, and only then where there are safeguards in place with regard to human rights.

Outbreak and incident reports are already the subject of reports to NHS Boards and the Councils of local authorities and are therefore, in the public domain.

It would be sensible to share incident reports through appropriate channels to specific professional groups e.g. the Managed Public Health network, to encourage information sharing and learning outcomes.

The Institute's view on enforcement against one's own organisation is that this is an issue that regularly causes conflict of interest, particularly in local authorities where EHOs are often prevented from taking action against managers of other departments.

The Institute could act as an independent arbiter.

The Institute would ask whether the time is right to relocate the Environmental Health function in Scotland and to develop a more streamlined health protection structure for the future.

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

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

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

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

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 Institute supports these proposals but would comment that there could be issue with the Regulation of Investigatory Powers (Scotland) Act 2000 and the use of monitoring or surveillance measures in legal proceedings.