

**THE PUBLIC HEALTH ETC.
(SCOTLAND) ACT 2008
DESIGNATION OF COMPETENT
PERSONS REGULATIONS 2008**

**REPORT OF CONSULTATION
FINDINGS**

OCTOBER 2008

**PUBLIC HEALTH AND SUBSTANCE
MISUSE DIVISION**



THE PUBLIC HEALTH ETC. (SCOTLAND) ACT 2008 DESIGNATION OF COMPETENT PERSONS REGULATIONS 2008

REPORT OF CONSULTATION FINDINGS

Introduction

1. This paper reports on the findings of a consultation on draft Regulations on the qualifications and other requirements of health board and local authority competent persons to be made under the powers contained in The Public Health etc. (Scotland) Act 2008. No part of the Act has yet come into effect.

2. A copy of the draft regulations is at **Annex A**. Individual responses (where the respondent has agreed to the response being publically available) can be accessed at <http://www.scotland.gov.uk/Publications/2008/10/09120304/0>. The Act can be accessed at http://www.opsi.gov.uk/legislation/scotland/acts2008/pdf/asp_20080005_en.pdf

Background

3. Under current arrangements, the standard of health professional competency to act under public health legislation derives primarily from a doctor filling a certain post in public health (usually a consultant in public health medicine) and/or meeting a competency standard as a Designated Medical Officer. This title was created to carry out the functions requiring medical input in the Public Health (Scotland) Act of 1897 and is used to refer to doctors, designated by the health board and deemed suitably qualified to carry out legislative duties in health protection on behalf of the local authority. There is no equivalent 'competency' standard for environmental health officers in local authorities.

4. The Public Health etc. (Scotland) Act, which repeals the 1897 Act, assigns functions to health boards and local authorities on a corporate basis. However, it defines the actions for which professional input is required (such as when powers are used to restrict personal liberty or impose obligations on individuals in relation to their premises), and provides that these functions must be carried out by 'competent persons'. The aim is to ensure that the persons recommending action in such circumstances have the necessary professional skills and expertise to do so.

5. Sections 3 and 5 of the Act provide that health boards and local authorities must designate a sufficient number of competent persons for the purpose of exercising the public health functions assigned to them in the Act, and that Scottish Ministers may prescribe the qualifications, experience and training of such competent persons in regulations.

6. The draft regulations were developed following the deliberations of a working group of experts in public health and were the subject of consultation with key stakeholders between 4 June and 4 September 2008.

Summary of responses

7. A total of 55 responses were received. Table 1 below sets out the category of respondents.

Table 1: Category of respondents

Local government, i.e. local authorities, environmental health departments, Society of Chief Environmental Health Officers (LG)	19
NHS, i.e. health boards, NHS organisations and professional groupings (NHS)	11
Environmental bodies (Env)	3
Trade/representative bodies (Rep)	2
Individuals (Inds)	7
Professional organisations (Prof)	11
Other organisations (Others)	2
Total	55

8. **Annex B** lists the respondents under each category. **Annex C** provides a summary of the numbers of responses under each question asked. As noted in the Annex, only 'yes' and 'no' responses were counted. The variation in total answers for each question is accounted for by those who had 'no comment', mainly due to lack of knowledge in the subject area.

9. The responses are considered in detail below under each question heading.

Q1. Are you content that the qualifications, training and experience outlined in the draft regulations are sufficient for the competent persons to be able to carry out the functions set out in the Public Health etc (Scotland Act)?

Health Board Competent Persons (HBCPs)

10. Sixteen (50%) of the 32 respondents to this question indicated that they were content with the qualifications etc. set out in the draft regulations. These comprised 6 local authorities, 3 NHS -related organisations (Scottish Directors of Public Health Group, NHS Lothian, NHS Highland), 1 environmental body, 2 individuals, 3 professional organisations and 1 other organisation (the latter 4 organisations who responded were not directly involved in health protection work). The majority did not provide supporting comments and some of those who indicated that the qualifications, training and experience were sufficient to carry out the functions set out in the Act (including the 3 NHS-related organisations), also suggested that some improvements might be made. These suggestions are included in the key points set out in paragraph 12 below.

11. Sixteen respondents (50%) were not content with all of the qualifications etc. for health board competent persons set out in the draft regulations. These comprised 7 NHS-related organisations (including the Scottish Consultants in Public Health Medicine (CD&EH) Group (SCPHM), the Health Protection Education Advisory Group (HPEAG) and NHS NSS), 1 local authority, the 2 representative bodies (BMA and RCN), 3 individuals and 4 professional bodies (the Faculty of Public Health, the UK Public Health Register, the Nursing and Midwifery Council and the Royal College of Physicians of Edinburgh (RCPE)).

12. There was a wide variation in the reasoning provided as to why respondents were not content with the qualifications set out in the regulations. Some respondents commented on only one particular qualification, whilst others commented on all, or provided very general comments. The following is a summary of the key points made:

- Some of the powers conferred on HBCPs are extensive and, as such, the competent persons should have clinical skills as well as public health skills. The BMA commented that ‘competent persons must have adequate experience of treating and caring for patients in order to be able to strike a reasonable balance between the risks and benefits of measures to protect the public health against the damage and distress potentially experienced by an individual’. This view was supported by a number of those not in agreement with the draft proposals, including the SCPHM and the RCPE.
- On the other hand, the UK Public Health Register agreed with the statement in the consultation documentation that ‘the role of the competent person is not one of diagnosing or treating patients, but more one of risk assessment and risk management’. The Register, in its response, maintains that it is the totality of skills of a person that is required and that it is appropriate for those on the Register to be designated as HBCPs; that the Faculty of Public Health of the Royal Colleges of Physicians as the professional qualifying body and the Public Health Register as the Regulatory body, accept full equivalence within multidisciplinary public health, the criterion for application for a consultant post necessitating being on either the GMC or Public Health Register. However, a couple of responses picked up on the issue that there were 2 portfolio routes, generalist and defined, and that it was the generalist route which was the relevant one for this purpose.
- There were concerns over the perceived lack of mandatory regulation of those on the UK Public Health Register. This concern was expressed by the BMA, the SCPHM, the RCPE, NHS Grampian and the health protection teams in Glasgow and Fife. The Faculty of Public Health and the Scottish Directors of Public Health Group sought clarification on the issue. In its response, the UK Register indicated that it was a recognised regulatory body and specialists are ‘registered’ with it. They advise, therefore, that the term ‘accredited’ used in draft regulations 3(e) and 3(f) is wrong, and should be changed to ‘registered’. They also indicate that, as with all regulatory bodies, there is a power to admit to the Register and to remove people from the Register. There is a Memorandum of Understanding with both the GMC and the GDC. Continuous professional development (CPD) is recommended for registrants and the Faculty’s interim statement on revalidation indicates that it will, in agreement with the GMC and other Regulators, recommend a full system of revalidation.
- The UK Register and the Faculty of Public Health consider that the additional work experience required in draft regulation 3(f), for those who gain access to the Register by the portfolio route, discriminates against senior people who have been through a rigorous assessment process via an extensive portfolio submission to be recognised as consultant status in public health, and that these are equivalent to those who have gone through a prospective training programme. The Register and Faculty consider that to request two years’ experience from those at consultant level is not acceptable.
- A number of respondents indicated that ‘health protection’ had to be more clearly defined to ensure that it meant the public health aspects of health protection, rather than, e.g. the technical aspects of infection control.
- Current wording will allow for individuals to meet the criteria to be designated as HBCPs on past experience – particularly in relation to Regulation 3(c). A number of comments, including from the BMA, the Faculty of Public Health, NHS NSS and the HPEAG, supported the demonstration of current experience in health protection, e.g. through CPD or to have a minimum of 6 months’ experience in unsupervised health protection on call in the last 2 years. NHS Grampian also commented that assessment of competence, over and above duration of work experience, was necessary for those who had not demonstrated their competence through completion of public health training and had a minimum of 6 months’ experience.

- A few respondents suggested that there should be formal training in the Act before being deemed competent. Others recognised that the qualifications set out are the minimum criteria for consideration by health boards and that it is for boards to select appropriate individuals from all those eligible for the task. It would also be for the health boards to ensure that, at regular intervals, individuals are assessed to ensure that they remain up to date and competent, including registration with the appropriate regulator.
- There were suggestions that other healthcare professionals might be designated, e.g. GPs, occupational health physicians/nurses, and consultant medical microbiologists. This was considered to be most useful in smaller, rural or island boards where there can be staffing problems and a broader range of skills and local knowledge is important. However, others indicated that these professionals would still require to have the necessary health protection training, ongoing health protection CPD and assessment of competence.
- The draft regulations state that a HBCP must be employed by a specific health board. There was general concern that this would not provide for situations where cover is provided by another health board or by university staff. It was suggested, therefore, that there was a need for a formal contract to be in place or, to cover the latter situation, the regulations should provide for those holding ‘honorary contracts’ with a HB.
- The 6 month/2 year training difference between medical and nursing staff is inconsistent. There were mixed views as to whether this was justified. There was comment that a minimum of 6 months’ experience was sufficient, provided that the experience was recent and included being ‘on call’. The Nursing and Midwifery Council asked why midwives were not included. There were, however, more views supporting a higher level of qualification for nurses, including from the RCN, NHS NSS and the Scottish Directors of Public Health, who judged that the current draft qualifications did not ensure the appropriate competencies to take on the wide-ranging duties associated with the role. Whilst an alternative route would be to include those designated as Advanced Practitioner in Public Health on the NMC Register, the RCN recognised that this approach could not be pursued until the issue of formal registration was finalised. As an interim measure, the RCN recommended re-drafting regulation 3(c) to reflect a more formal training route, such as an MSc in Public Health or equivalent, in addition to registration as a nurse with the NMC.
- Further clarification is necessary for situations in which a nurse, designated as a competent person under the regulations, acts as first on-call, but could potentially be responsible to a consultant who was not designated.
- ‘Work experience’, as set out in regulations 4 (a) and (b), should be redefined to ensure that the work experience has been supervised, recent and attested as being of an appropriate standard for demonstration of competence.

Local Authority Competent Persons (LACPs)

13. Twenty-four (63%) of the 38 respondents to this question supported the qualifications for LACPs set out in the draft regulations. These comprised 12 local authorities, 3 NHS-related organisations, 2 environmental bodies, 2 individuals, 4 professional organisations and 1 other organisation. There were few additional comments provided, but the following reflects the points made:

- The qualifications, training and experience as outlined in the draft appear to be sufficient for the competent persons to carry out the functions as set out in the Bill. It is, however, important that

any training/experience should be backed up with a concrete and ongoing demonstration of CPD which is duly recorded and certified.

- The maximum discretion should be available within the corporate body for the Council itself to prescribe who it wished to discharge the duties.
- One respondent, whilst initially indicating a preference that a scheme of CPD should be introduced in relation to the competent person, also made the point that a number of people are not members of either the Royal Environmental Health Institute for Scotland (REHIS) or the Chartered Institute of Environmental Health (CIEH), but are still perfectly competent to carry out the tasks required of them, therefore coming to the conclusion that a scheme of CPD may be inappropriate.

14. Fourteen (37%) of those who responded to this question indicated that they did not agree with the proposed qualifications for LACPs set out in the draft regulations. These comprised 7 local authority respondents, including the Society of Chief Officers of Environmental Health (Society of CEHOs)), 2 NHS related organisations, 3 individuals and 2 professional organisations, including REHIS.

15. The key points made by those who were not content are as follows:

- All but two of the respondents agreed that the LACPs should be Environmental Health Officers. The majority of negative responses were concerned that 2 years' experience would not be sufficient or appropriate to carry out the functions assigned to LACPs set out in the Act. These respondents recommended a minimum of 3 years experience, but preferably 5. The minimum of 3 years was seen as configuring with the REHIS Scheme of Practical Training and Chartered Status for EHOs.
- Ten of the 14 responses recommended that, to ensure that the competencies and qualifications are current, that the designated person should also hold chartered status with REHIS. The point was made that chartered status requires completion of CPD within a 3-year cycle, ensuring officers are up-to-date in the broad range of public health duties covered by the Act.
- The HPEAG was content with 2 years' experience, but suggested that work experience should be stipulated as being in health protection. Work experience in health protection was also mooted by NHS NSS.
- There was some support in the responses that a LACP should operate at a reasonably senior management level, e.g. Head of Services, CEHO, Team Leader, Principal Officer etc., and be responsible for directing investigating officers.
- One local authority suggested that, in addition to EHOs, an existing senior manager with over 5 years' public health management experience would also be appropriate (i.e. 'grandfather' rights).
- The Faculty of Public Health supported requirements for CPD, although did not specify what these might be. It was also recognised by one respondent that a number of EHOs were not members of either REHIS or CIEH, but were still competent to carry out the tasks required of them under the Act. It was therefore suggested that it may be inappropriate for a scheme of CPD to be part of the competent person requirement.
- It was recognised that some local authorities would need time to meet a standard which involved chartered status and it was suggested by a few respondents that the regulations should accommodate this by allowing a transition period of 3 years in which to comply.

- There was some confusion as to whether the term ‘accredited by REHIS’ should be interpreted as holding a qualification from REHIS such as the Diploma in Environmental Health or whether it meant compliance with the REHIS approved scheme of continuing professional development.
- Two respondents sought clarification regarding the use of technical officers, although the responses suggested a lack of understanding as to the role of the LACP, as set out in the Act. Caution was also suggested with regard to the potential for vested interest by REHIS in the professional protection of its members, via accreditation.

Q2. Are you content that the competent persons will be regulated by professional regulatory bodies as well as by health boards and local authorities?

16. 36 responses were received. 33 (92%) were content, 3 (8%) were not. The key points raised were as follows:

Health Board Competent Person

- A number of ‘yes’ responses were based on the HBCP being on the medical or nursing register. There was general contentment that clinicians work within the wider accountability framework of the GMC and NMC. There was, however, concern re the regulation of non-clinicians and that until registration is mandatory, the UK Public Health Register cannot claim a credible regulatory function. See bullet point 3 under paragraph 12 above.

Local Authority Competent Person

- Some local authority responses indicated that REHIS has a role to play in ensuring the competency of officers obtaining EHO qualifications. It will be the main responsibility of the local authority, however, to ensure the ongoing competency of those officers it delegates under the Act.
- A number of responses indicated that it was unclear how the LACP would be regulated by professional regulatory bodies. For example, Highland Council pointed out that the proposed regulations would not allow regulation by the professional body as REHIS (or equivalent body) have very limited control over a person operating as an EHO who is not a member of that body. Only members of REHIS are regulated directly by the body and only Chartered EHOs are subject to the CPD requirements.
- Some commented that the requirement of EHOs to have chartered status would ensure appropriate regulation.

Q3. Given that the regulations, as currently drafted, will allow individuals to be identified as competent persons in more than one health board or local authority, do you believe your health board or local authority will be able to designate an appropriate number of competent persons?

17. 35 responses were received, with only 1 negative response in relation to HBCPs. In general, comments were favourable, indicating that shared services and cross boundary working could be accommodated in the arrangements. There was some concern, however, about the ability of boards in remote and rural areas being less well placed and also that future restrictions placed on the NHS by working time directives may have an affect. It was also pointed out that competent persons from other areas would require some form of contract of employment.

Q4. Are there other professionals you consider would be appropriate to undertake the role of the competent person and what qualifications do they have?

Health Board Competent Person

18. 24 responses were received in relation to the HBCP, 16 (67%) indicating that there were no other suitable professionals and 8 (33%) advocating that other appropriate professionals could have a role.

- It was suggested that it might be helpful in rural and remote areas for GPs, other physicians or microbiologists with the necessary health protection training and experience to be designated HBCPs. It was recognised, however, that if this was to entail the same 2 years' experience as required for other professionals set out in the draft regulations, this issue might be an insurmountable problem.
- The Nursing and Midwifery Council asked why midwives had been excluded from regulation 3(d).

Local Authority Competent Person

19. 34 responses were received in relation to the LACP, 30 (88%) indicating that there were no other suitable professionals and 4 (12%) advising that there were other professionals who might be designated as competent persons.

- One respondent suggested that the particular profession should not be specified so strictly and that it should be for the corporate body to determine who was suitably qualified to carry out the functions set out in the Act.
- A couple of responses suggested that some local authority non-EHO technical staff could be designated. However, there was some misunderstanding shown within the responses as to the role of the LACP within the legislation.
- Scottish Water queried whether further consideration should be given to other specialist groups, such as the public health team in Scottish Water and other professionals, who liaise with primary care and environmental health on matters such as drinking water quality.

Q5. The draft regulations provide that health boards and local authorities must maintain lists of competent persons. We envisage that these will be signed off at Board or Chief Executive level, and that this would be contained in guidance. Are you content that this process provides sufficient accountability at a local level for designation of competent persons?

20. 37 (93%) out of 40 responses were content. The need for sign off at Board or CE level was recognised as important in terms of accountability.

21. One respondent suggested that either the Director of Public Health or a Consultant in Communicable Disease should countersign the HBCP list. An individual commented that it was not clear what criteria the Board would use to assess competence.

22. In respect of the LACP list, one respondent suggested that approval by the CE would leave the option available to the CE as to whether to have any decisions ratified by the appropriate committee. Another suggested that prior approval by the appropriate committee should be required. Another suggested that an alternative would be the appropriate elected member forum. It was also suggested that, in practice, it is likely that the task would be delegated to Director of Service, who has delegated authority in these matters. Highland Council suggested that local authorities use their existing delegation/authorisation schemes to maintain a list, or a list signed off by the CE or appropriate committee be maintained.

23. Other relevant comments (not already reported)

- There is a need for a legal duty on health boards and local authorities to maintain and review the lists of competent persons on a regular basis. This would ensure that lists were up to date and that individuals retained knowledge and skills.
- The RCN also recommended that the regulations should be clarified to emphasise that the listing as health board competent person is an issue of mutual agreement between the HB and the individual appointed. It was therefore suggested that regulation 2(3) should be redrafted to read ‘A person shall be listed as a health board competent person for as long as the health board considers the listing appropriate *and for as long as the person agrees to the listing*’.
- The General Medical Council pointed out a minor point of terminology, suggesting that in draft regulation 3(b), the phrase ‘in the GMC’s specialist register for public health medicine’ should read ‘in the GMC’s specialist register in the speciality of public health medicine’.
- NHS NSS suggested that consideration should be given to amending regulation 4(b) to read ‘work experience in health protection in a Special Health Board *or the Agency* in Scotland, or Special Health Authority in England or Wales, or equivalent’. The point being that the Agency undertakes such work on a national basis and therefore should be recognised as a relevant authority for the gaining of such work experience. There would be a consequential amendment required to regulation 1(2) to refer to the ‘Agency’ as being defined in the NHS(S) Act 1978. (i.e. the Common Services Agency)
- Also in relation to regulation 4(b), it was suggested that Northern Ireland should be included.
- The Food Standards Agency suggested some minor drafting changes to regulations 5 and 6.
- The distinction between competent persons and authorised officers needs to be made clearer in any guidance issued. Will the competent person also be an authorised officer?

Next steps

24. The findings from the consultation will be considered by a Working Group advising on the implementation of Part 1 of the Act and thereafter by Scottish Ministers. The Regulations will then be finalised, taking into account the responses received and the views of the Working Group. It is currently planned that Part 1 of the Act, including The Public Health etc. (Scotland) Act Designation of Competent Persons Regulations 2008 should come into effect on 1 October 2009. This will give health boards and local authorities 6 months in which to draw up approved lists of competent persons before the key health protection provisions requiring input by competent persons, come into effect on 1 April 2010.

25. A copy of the updated regulations and appropriate guidance on this and other aspects of Part 1 will be issued to relevant stakeholders, including those who responded to the consultation.

SCOTTISH STATUTORY INSTRUMENTS

2008 No.

PUBLIC HEALTH

The Public Health etc. (Scotland) Act Designation of Competent Persons
Regulations 2008

<i>Made</i> - - - -	2008
<i>Laid before the Scottish the Scottish Parliament</i>	2008
<i>Coming into force</i> - -	2008

The Scottish Ministers make the following Regulations in exercise of the powers conferred by section 3(4) and (5), and section 5(4) and (5) of the Public Health etc. (Scotland) Act 2008, and all other powers enabling them to do so.

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Public Health etc. (Scotland) Act Designation of Competent Persons Regulations 2008 and shall come in to force on

(2) In these Regulations—

“the Act” means the Public Health etc. (Scotland) Act 2008;

“Health Board competent person” is given the meaning in section 3 of the Act;

“Local authority competent person” is given the meaning in section 5 of the Act;

“Health Board” and “Special Health Board” are as defined in the National Health Service (Scotland) Act 1978;

“Local Authority” means a council constituted under section 2 of the Local Government Etc. (Scotland) Act 1994;

“UK Public Health Register” means the register of public health specialists established in 2003 by the Faculty of Public Health, the Royal Institute of Public Health and the Multidisciplinary Public Health Forum.

List of Health Board Competent Persons

2.—(1) Each Health Board in Scotland must maintain a current list of health board competent persons for that Health Board area to carry out the functions conferred by the Public Health etc. (Scotland) Act 2008 and any other enactment.

(2) A person who is in receipt of the relevant qualifications set out in Regulation 3 may be listed as a Health Board competent person if a Health Board designates that person as a competent person for that Health Board’s area.

(3) A person shall be listed as a health board competent person for as long as the health board considers the listing appropriate.

Qualifications for Health Board Competent Persons

3. For a person to be eligible for designation as a Health Board Competent Person, that person must—

(a) be employed by a Health Board in Scotland; and

(b) be a registered medical practitioner on the General Medical Council’s Specialist Register for public health medicine with a minimum of 6 months’ work experience in health protection; or

- (c) be a registered medical practitioner who has held a substantive consultant post in the UK NHS in public health medicine prior to 1st January 2008; or
 - (d) be a nurse, registered with the Nursing and Midwifery Council, with a minimum of 2 years work experience in health protection; or
 - (e) be accredited as a public health specialist on the UK Public Health Register, having gained access to the Register by the training route, with a minimum of 6 months' work experience in health protection; or
 - (f) be accredited as a public health specialist on the UK Public Health Register, having gained access to the Register by the portfolio route, with a minimum of 2 years' work experience in health protection.
4. For the purposes of these regulations 'work experience in health protection' means—
- (a) work experience in a health protection team in an NHS Board, or equivalent; or
 - (b) work experience in health protection in a Special Health Board in Scotland or Special Health Authority in England and Wales, or equivalent.

List of Local Authority Competent Persons

5.—(1) Each local authority in Scotland must maintain a current list of local authority competent persons for that local authority to carry out the functions conferred by the Public Health etc. (Scotland) Act 2008 and any other enactment.

(2) A person who is in receipt of the relevant qualifications set out in Regulation 6 may be listed as a local authority competent person if a local authority designates that person as a competent person for that local authority area.

(3) A person shall be listed as a local authority competent person for as long as the local authority considers the listing appropriate.

Qualifications for Local Authority Competent Persons

6. For a person to be eligible for designation as a local authority competent person that person must—
- (a) be employed by a local authority in Scotland; and
 - (b) be an environmental health officer, accredited by the Royal Environmental Health Institute of Scotland (or equivalent body), with a minimum of 2 years' experience working as an environmental health officer within a local authority or equivalent.

Authorised to sign by the Scottish Ministers

St Andrew's House,
Edinburgh

2008

Local Government (LG)

Aberdeen City Council
Angus Council
Argyll & Bute Council
City of Edinburgh Council
Comhairle nan Eilean Siar
Dundee City Council
East Ayrshire Council
East Lothian Council
Falkirk Council
Glasgow City Council
Glasgow City Council Technical Officers
Midlothian Council
North Lanarkshire Council
Scottish Borders Council
Society of CEHOs
South Ayrshire Council
The Highland Council
West Dunbartonshire Council
West Lothian Council

NHS (NHS)

NHS Fife - Health Protection Team
NHS Grampian
NHS Greater Glasgow and Clyde –Public Health Protection Unit
NHS Highland
NHS Lothian
NHS Health Scotland
NHS National Services Scotland
Health Protection Education Advisory Group
Health Protection Nurse Specialists
Scottish Consultants in Public Health Medicine (CD&EH) Group
Scottish Directors of Public Health

Environmental Bodies (Env)

Environmental Protection UK
Scottish Environmental Protection Agency
Scottish Water

Representative Bodies (Rep)

British Medical Association
Royal College of Nursing

Individuals (Inds)

7 individuals responded

Professional Organisations (Prof)

Association of Chief Police Officers in Scotland

British Association for Counselling and Psychotherapy
Faculty of Public Health
General Medical Council
Nursing and Midwifery Council
Optometry Scotland
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal Environmental Health Institute for Scotland
Royal Pharmaceutical Society
UK Public Health Register

Other Organisations (Others)

Food Standards Agency
Scottish Council on Human Bioethics

SUMMARY OF COLLATED DATA FOR 52 RESPONSES

It should be noted that only the ‘yes’ and ‘no’ responses were used in these tables. The variation in total answers for each question are accounted for by those who had ‘no comment’, mainly due to lack of knowledge in the subject (e.g. a local authority answering on health board competency), and therefore this data was not used in this summary.

Q1. Are you content that the qualifications, training and experience outlined in the draft regulations are sufficient for the competent persons to be able to carry out the functions set out in the Public Health etc. (Scotland) Act?

	<u>Health Board Competent Person</u>		<u>Local Authority Competent Person</u>	
Yes	16 (50%)	No 16 (50%)	Yes 24 (63%)	No 14 (37%)
LG	6	0	12	7
NHS	3	7	3	2
Env	1	0	2	0
Rep	0	2	0	0
Inds	2	3	2	3
Prof	3	4	4	2
Other	1	0	1	0

Q2. Are you content that the competent persons will be regulated by professional regulatory bodies as well as by health boards and local authorities?

Yes	33 (92%)	No 3 (8%)
LG	12	2
NHS	8	0
Env	1	0
Rep	1	0
Inds	5	0
Prof	5	1
Other	1	0

Q3. Given that the regulations, as currently drafted, will allow individuals to be identified as competent persons in more than one health board or local authority, do you believe that your health board or local authority will be able to designate an appropriate number of competent persons?

Yes	35 (97%)	No 1 (3%)
LG	17	0
NHS	9	0
Env	0	0
Rep	0	0
Inds	4	1
Prof	5	0
Other	0	0

Q4. Are there other professionals you consider would be appropriate to undertake the role of the competent person and what qualifications do they have?

	<u>Health Board Competent Person</u>		<u>Local Authority Competent Person</u>	
Yes	8 (33%)	No 16 (67%)	Yes 4 (12%)	No 30 (88%)
LG	1	3	3	15
NHS	3	6	0	5
Env	0	1	0	1
Rep	0	0	0	0
Inds	2	2	1	4
Prof	2	4	0	5
Other	0	0	0	0

Q5. The draft regulations provide that health boards and local authorities must maintain lists of competent persons. We envisage that these will be signed off at Board or Chief Executive level, and that this would be contained in guidance. Are you content that this process provides sufficient accountability at a local level for designation of competent persons?

Yes	37 (93%)	No 3 (8%)
LG	15	1
NHS	9	0
Env	1	0
Rep	1	0
Inds	3	2
Prof	7	0
Other	1	0