HEALTH AND SPORT COMMITTEE

Wednesday 16 January 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Jamie McGrigor (Highlands and Islands) (Con)
Irene Oldfather (Cunninghame South) (Lab)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Eric Baijal (Highland NHS Board)
Tom Bell (Royal Environmental Health Institute of Scotland)
Ron Culley (Convention of Scottish Local Authorities)
Dr Martin Donaghy (Health Protection Scotland)
Stephen Hendry (Food Standards Agency Scotland)
Robert Howe (South Lanarkshire Council)
Ken Jones (Scottish Borders Council)
Dr Christopher McGuigan (Consultants in Public Health Medicine)
Dr Alison McCallum (Lothian NHS Board)
Susan Pryde (Food Standards Agency Scotland)
Dr Andrew Riley (Scottish Directors of Public Health and Faculty of Public Health)
Dr Charles Saunders (British Medical Association Scotland)
Fraser Thomson (Society of Chief Officers of Environmental Health in Scotland)

CLERK TO THE COMMITTEE

Tracey White

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Emma Berry

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 16 January 2008

[THE CONVENER *opened the meeting at 10:02*]

Subordinate Legislation

Meat (Official Control Charges) (Scotland) (No 2) Regulations 2007 (SSI 2007/538)

The Convener (Christine Grahame): Good morning. I welcome members to the second meeting in 2008 of the Health and Sport Committee. I remind all members to ensure that their mobile phones are switched off. No apologies have been received.

Item 1 on the agenda is consideration of two negative Scottish statutory instruments. I propose to take each instrument separately.

The first set of regulations, SSI 2007/538, implements from 1 January 2008 the new rates in European regulation EC/882/2004 for official feed and food controls, and sets out new minimum charges for meat hygiene official controls at approved establishments.

The committee deferred consideration of the regulations from last week in order to seek clarification from the Subordinate Legislation Committee on two of the grounds on which that committee reported the regulations. A memorandum from the clerk to the Subordinate Legislation Committee is attached in the annex to paper HS/S3/08/2/1, together with the full text of the SLC's report on the regulations.

Stephen Hendry, who is from the animal, food chain and novel foods branch of the Food Standards Agency—that is quite a mouthful; I should not say that about food things—and Susan Pryde, who is also from the Food Standards Agency, are in attendance if members have any questions.

Ross Finnie (West of Scotland) (LD): The Subordinate Legislation Committee has raised some interesting points. I have not sought advice on annulling the instrument, because I think that the issues can be dealt with. It might be helpful if, for the record, the representatives of the Food Standards Agency could indicate when the agency will be able, with the assistance of the Government, to make the necessary changes to overcome the deficiencies that have been pointed out by the Subordinate Legislation Committee.

Stephen Hendry (Food Standards Agency Scotland): A further set of regulations is out to consultation and we are looking to make adjustments in line with the SLC's comments as soon as possible.

Ross Finnie: That is helpful.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): That answer might have superseded my comment. The conversion rate that is used is the one in the official published bulletin. Is that rate published annually, in September, or is it published quarterly? How will the exchange rate work? It will be quite bureaucratic and complicated if there is a different exchange rate every few months.

Stephen Hendry: I understand that the *Official Journal of the European Union* is published weekly, but the convention has been to take the published rate on the first working day in September each year and to use that rate for the next calendar year.

Dr Simpson: Will that put us in conflict with the European Union if the exchange rate changes in such a way that the charges fall below the minimum charges that the EU stipulates?

Stephen Hendry: The regulations continue the system that has been in place for many years. The EU regulation does not specify the method of calculation as the previous directive did. However, the agency has notified the Commission of the approach and, to date, has not received any comments on it.

Dr Simpson: So you assume that, because no comments have been received, the Commission is comfortable with the current arrangement and that it can continue.

Stephen Hendry: That is our understanding.

Dr Simpson: My only other comment is that it is interesting that, at a time when we are trying to control inflation, the charges are increasing by between 2.8 and 3.1 per cent. I simply make that comment for the record.

Mary Scanlon (Highlands and Islands) (Con): I raised the matter last week, so for the public record I ask Mr Hendry to give an explanation in relation to the points that the Subordinate Legislation Committee raised. It stated:

> "the lack of clarity … could affect the operation of the instrument."

Ross Finnie is more familiar with the points than I am, but they come down to the meaning of the terms "poultry" and "land mammals". What led to the confusion? What will the Food Standards Agency do before March to overcome it and ensure that the regulations operate effectively?

Stephen Hendry: The agency accepts that we could improve the drafting. We will try to do that in the next set of regulations, which we aim to produce around the end of March. We will take the points on board.

Mary Scanlon: The point was made last week by a member of the committee that the definitions in the regulations follow the definitions in previous instruments. What has changed that has led to a lack of clarity and will therefore affect the operation of the regulations? What needs to be corrected? I am not entirely clear about that.

Stephen Hendry: The regulations retain the current charging approach in Scotland. What has changed is that European regulation EC/882/2004 introduced terms, including "land mammals", that were not in the previous directive. We are trying to accommodate the terms in the EU regulation within the current charging structure.

Mary Scanlon: So there is a difference between the EU definitions and the definitions that have long been used in this country. Is that where the lack of clarity or the confusion has come from?

Stephen Hendry: It is a question of trying to accommodate the new terms. This is the first time that they have appeared.

Ross Finnie: Convener, that is not what the Subordinate Legislation Committee said. The terms "poultry" and "land mammals" are used in the body of the regulations and the definitions in the 2004 regulations are ascribed to those, but unfortunately schedule 2 to the regulations, which sets out the charges, subdivides poultry into turkeys et cetera; it also subdivides land mammals. The Subordinate Legislation Committee's point is that, although the schedule is perfectly clear, someone who was so minded could say, "Wait a minute. The heading 'poultry' has had ascribed to it a meaning that includes turkeys et cetera." The Subordinate Legislation Committee said that there could be confusion.

It seems to me that the schedule is capable of being challenged. Nevertheless, the Subordinate Legislation Committee is referring to the use of the EU regulation in the earlier definition. With respect, we now know that the issue is not about adopting the terms but about the fact that they are subdivided in the schedule, and it is from that that the confusion arises. That is set out in the paper from the Subordinate Legislation Committee, which I found helpful.

The Convener: Do you wish to respond, Mr Hendry?

Stephen Hendry: I have no further comments on that.

The Convener: I have not gone into the matter in detail, as other members have done, but are you telling me that forthcoming regulations will clarify the confusion?

Stephen Hendry: Yes.

The Convener: So two sets of regulations will coexist: one with confusion and one, we trust, without confusion.

Stephen Hendry: No. The next set of regulations will replace the current instrument.

The Convener: And that will come to this committee. We will be back again with turkeys and poultry.

Ian McKee (Lothians) (SNP): It is small turkeys.

The Convener: Thank you, Ian.

In the light of the discussion, does the committee agree to make no recommendations in relation to these regulations?

Members *indicated agreement.*

Infant Formula and Follow-on Formula (Scotland) Regulations 2007 (SSI 2007/549)

The Convener: This set of regulations implements directive 2006/141/EC, on infant formula and follow-on formula, and amending directive 1999/21/EC and Council directive 92/52/EEC, on infant formula and follow-on formula intended for export to third countries.

I refer members to paper HS/S3/08/2/2 for an abridged subordinate legislation briefing on the regulations, together with the full text of the Subordinate Legislation Committee's report. An additional briefing was provided by the Food Standards Agency on 15 January—that briefing has been circulated to members. I advise members that the clerks sought advice from the clerk to the Subordinate Legislation Committee in response to that information, and a memo from the clerk to the Subordinate Legislation Committee has also been circulated.

Susan Pryde, who is from the food standards, diet and nutrition branch of the Food Standards Agency, is in attendance and will answer any questions that members may have.

Mary Scanlon: The wording in the Subordinate Legislation Committee's report is similar to that in its report on the previous instrument. It says that the drafting of provisions could have been clearer and that there is an instance of defective drafting that might affect the operation of the regulations. I have not fully read every word, but I would like an assurance that the matters have been or are being addressed, in order that the regulations can be effectively implemented.

Susan Pryde (Food Standards Agency Scotland): We have tried, through our responses, to show that we are addressing all the concerns that were raised by the Subordinate Legislation Committee. On the error notice, we have said that we will rectify that as soon as possible. We have addressed most of the concerns that were raised.

The Convener: Do the committee agree to make no recommendations in relation to these regulations?

Members *indicated agreement.*

The Convener: We will suspend briefly to allow our next witnesses to come in.

10:13

Meeting suspended.

10:17

On resuming—

Public Health etc (Scotland) Bill: Stage 1

The Convener: First, I want to make sure that nobody will be embarrassed by having their mobile phone or their BlackBerry on—please would witnesses, committee members and members of the public ensure that those are switched off?

This is the committee's second oral evidence session on the Public Health etc (Scotland) Bill. At last week's meeting, the committee heard from the bill team and from witnesses with a particular interest in part 8 of the bill, which deals with the health effects of sunbed use. Today, we will discuss the bill in round-table format, with representatives—who, I am afraid, have been seated among the committee members—from two main groups that are affected by the bill: national health service boards and local authorities. There are also representatives of a number of disciplines within those organisations. We hope that by using the round-table approach, rather than the more traditional question-and-answer format of evidence taking, there will be more of a dialogue between the various witnesses.

The committee is here to listen, and we hope that the interaction between the groups will point us in the directions on which we should be focusing. I intend to move through the various parts of the bill, beginning with part 1. I will allow witnesses to comment first and then I will follow the usual format by asking committee members to indicate if they want to ask questions. I have a peach-coloured list that I am told is for witnesses, and a green list for committee members. Witnesses and members will go on the list, and we will do the usual. As time is pressing, it will be helpful if we have brief comments and crisp questions. Witnesses who wish to comment on a particular part should do so through the chair. I am sure that it will all settle down, even if nobody has done this before.

I will not make introductions—we can all see who everybody is from the nameplates. We will cut to the chase and start with part 1, on public health responsibilities. Does any of the witnesses wish to make any comments in relation to provisions in part 1 that should be drawn to the attention of the committee, so that any concerns can be flagged up to ministers?

Dr Charles Saunders (British Medical Association Scotland): The British Medical Association Scotland certainly welcomes the clarity that is being introduced on the division of

legal powers between local authorities and health boards. However, we would be concerned if the current good working arrangements between local authorities and health boards, in relation to environmental health officers, were to be lost.

Currently, environmental health officers do a large part, if not most, of the investigation into food-borne illness. It is important that that continues. Although there does not appear to be anything in the bill to prevent that from continuing, we would be concerned if, in line with the division of legal responsibilities, anyone got the impression that there was an intention to divide the working arrangements.

Dr Martin Donaghy (Health Protection Scotland): I support those comments. We welcome the distinction and we think that it will help, particularly in outbreak situations, to resolve some of the difficulties, such as those that occurred a few years ago when there was a major outbreak of E coli 0157 in Lanarkshire and central Scotland. We also want the current arrangements between local authorities and NHS boards to continue and to be strengthened, particularly in relation to food-borne infection.

The Convener: Can you elaborate on the difficulties that you mentioned?

Dr Donaghy: When there is an outbreak, particularly a significant outbreak, there needs to be clarity in the command-and-control arrangements so that it is clear who has overall responsibility for key decisions. Given that the major considerations in an outbreak relate to human health, the agency that has prime responsibility for meeting health needs—the NHS—should have prime responsibility for those arrangements. During the significant outbreak that I mentioned, at times there was confusion about responsibilities and about reporting, particularly on some of the issues related to the origin and distribution of food. We think that the provisions in the bill will help to overcome those difficulties.

Dr Eric Baijal (Highland NHS Board): I underline the importance of what Dr Saunders said. A helpful initiative that has been discussed is the joint employment of the medical officer of health, now known as the director of public health, by the local authority and the NHS. I appreciate that that is a little more complex when multiple local authorities partner the same NHS board. Greater Glasgow and Clyde NHS Board has a joint director of public health with Glasgow City Council. Perhaps not all my colleagues would support such a move, but a number of them would. I think that it would help to prevent some of the issues that Dr Saunders mentioned from arising.

Robert Howe (South Lanarkshire Council): From a local government perspective, I also support Dr Saunders's views. It is important to ensure that the bill does not impinge on the current working arrangements for food-borne infection investigations, which involve local authority officers. We are obviously looking at the people and premises split. The local authority officers should continue to do that work, albeit that the information will be managed and co-ordinated by health boards.

Mary Scanlon: I have a question for Dr Saunders, with his BMA hat on, about competent persons. A briefing from the BMA raises serious concerns about who should be a competent person. It states that a competent person should be a

"trained and experienced public health doctor or nurse."

Can you brief the committee on why you are so concerned about the designation of competent persons?

Dr Saunders: I assume that the details of the proposal will be available for stage 2, and we would certainly welcome the opportunity to submit additional evidence then.

We firmly believe that someone with clinical experience should undertake the role because the decisions or actions of the competent person will affect individual members of the public and, sometimes, patients. In our view, the only people who should be allowed to take such decisions or actions are either people who are properly trained and medically qualified consultants in public health medicine, or nurses with appropriate experience and training, who, by and large, would be the current nurse specialists in health protection who work at most health boards.

We want to ensure a balance between the protection of the public and the rights of the individual, and between the risks and benefits to both. We feel firmly that, because of the potential adverse effects on individuals, decisions should be made only by somebody who has experience of working with people when they are at their most vulnerable—for example, patients—and a professional obligation to do so properly, and who can be removed from their professional register if they fail to do that. We firmly believe that that essentially means a registered doctor or a registered nurse with appropriate experience.

Dr Baijal: I appreciate what Dr Saunders said, but using the definition "competent person" is helpful to us in the north of Scotland, where we deal with population supersparsity. There are something like six people or fewer per square kilometre there, compared with the Scottish average of 66 people per square kilometre. To maintain a service to people in outlying areas, we

need multiskilled, pluripotential people, so the definition "competent person", which would ensure that people have the appropriate competence, is helpful. Dr Saunders spelled out in detail the ways of evidencing such competence.

Mary Scanlon: That is helpful, but do the witnesses representing local authorities have concerns about the designation of a local authority competent person?

Robert Howe: We would certainly propose that environmental health officers would be the local authority competent persons. They have the appropriate skills, training and knowledge; no other local authority professional has the same skills and knowledge. As things stand, we do not envisage any move from that view.

Ross Finnie: I return to the first point that Dr Saunders made, which was specifically about food-borne disease but which impinged on the bill's attempt to clarify the division of responsibility between local authorities and health boards. Can the witnesses tease that out a little? The implication of Dr Saunders's comment seems to be that that clarity will be lost unless more detail is provided in the bill. It is difficult to imagine that, given the current degree of expertise in local authorities, they could meet the bill's requirement for them to co-operate with health boards.

The bill makes a clear distinction between responsibility for people and responsibility for premises. Are the witnesses concerned that, over time, there might be a diminution in the skills that local government environmental health officers possess and that that could result in a problem, unless the bill is clearer in relation to food-borne diseases?

Dr Alison McCallum (Lothian NHS Board): The current position is that, in an incident situation, the General Medical Council recognises the appropriate environmental health specialist as a member of the clinical team, so they have some status in such situations. In a reciprocal sense, directors of public health and consultants in public health have a formal role in the local authority. If there is a move to deformalise the current arrangements, problems may emerge over time, as has happened in other countries. The current arrangements work well, so we want the phrasing in the bill to be set out in a way that ensures that the current situation continues. Beyond the issue of food-borne disease, we work closely with our environmental health colleagues on environmental hazards to human health.

10:30

Dr Andrew Riley (Scottish Directors of Public Health and Faculty of Public Health): The bill is important to strengthening the relationships and capabilities for co-operation between health boards and local authorities. It is fair to say that, in several local authorities, differences of opinion have been expressed about the positioning of our environmental health colleagues. The competent person issue is crucial to emphasising how vital environmental health departments and officer experience are to implementing the bill. It is important that we take cognisance of that.

On co-operation between the two sides, it is easier for the local authority to designate a competent person, provided that environmental health officers are there and supported. The competent person debate has a different angle for health boards and for the short-life working group in which many people around the table have been involved. The focus has correctly been on how to define the duration and type of clinical experience that somebody needs to be a competent person. From a medical and nursing point of view, I fully agree with that. However, it is important to highlight the fact that, south of the border, non-medical public health specialists are becoming involved. The group's difficulty is determining how much public health experience is necessary for someone to qualify as a competent person. Work on the criteria for defining a competent person will go in that direction.

Dr Donaghy: Mr Finnie asked whether the bill could result in any future dilution of co-operation. To safeguard against that risk, the bill institutes greater formality and greater transparency in collaboration between boards, the NHS and local authorities on developing joint public health protection plans to make more visible how that function will be discharged. We hope that that will be one safeguard.

Under the current arrangements, the NHS and environmental health professionals have concerns about the capacity in local authorities to deal with environmental health in general. The Scottish Government is to create a working group to examine that. However, I see nothing in the bill that would impede further the development of the environmental health function. The greater clarity and the stronger duty to co-operate on protecting public health will help.

We need a competent person on the people side to assess the risk to public health, to assess whether how we are controlling that is proportionate and to communicate that in the legal process and to the public. The Faculty of Public Health, which trains professionals in those competences, has reached the view that being a doctor is not necessary to discharge those functions and receive specialist training. In England, specialist training in those functions is being developed for people who are not doctors.

My personal view is that the great majority of professionals who discharge the functions will continue to be doctors, but other professionals who are appropriately trained will be able to discharge the functions at a level that will be equivalent to that of doctors, if they are accredited through the training programmes.

The Convener: I call Dr Saunders, Dr Riley and then—I need my glasses to see the name—Dr McGuigan.

Dr Saunders: I should be grateful that I am sitting close to you, convener, so that you can call me to speak.

The Convener: You have such a gentle voice that I have to lean over to hear you.

Dr Saunders: There is no point in my repeating what I said about the competent person. As for Mr Finnie's question, the bill sets out clearly the legal powers and responsibilities—basically, NHS boards deal with people and local authorities deal with premises. It is quite important that nothing appears in the bill that suggests that the current working arrangements, which work well, should not continue.

I agree with what my colleague Martin Donaghy said about the concern that most local authority environmental health departments are underresourced for the job that they do.

Dr Riley: The Faculty of Public Health strongly supports the position on competent persons and medics, non-medics and nurses—that is, a multiprofessional basis for public health. The key thing is to ensure that the competent person—whoever they are—has adequate experience to undertake their tasks. That is already happening in England, but Scotland needs to satisfy itself on the criteria that we set.

Dr Christopher McGuigan (Consultants in Public Health Medicine): I echo the first point that Charles Saunders made. I represent the communicable disease and environmental health sub-specialist group of consultants in public health medicine. They are the people within the health boards who are responsible for co-ordinating the surveillance and incident-response function with regard to communicable diseases and environmental incidents. My group was strongly and consistently of the view that, to fulfil the role safely, a health board competent person needed to have clinical and public health skills, knowledge and experience and to work within the accountability frameworks that are provided by membership of the GMC or the Nursing and Midwifery Council.

Dr Simpson: Are our witnesses content with the current framework in the proposed primary legislation and that competent persons should be defined largely by subordinate legislation, or is the bill inadequate in anyone's view?

Dr Saunders: BMA Scotland would prefer the bill to specify doctors and nurses with appropriate experience, but we recognise that times change and that, in a number of years, the situation might have changed sufficiently for it to make more sense for other people to undertake that function. I think that that was the logic behind specifying competent persons in regulations rather than in primary legislation.

The Convener: Yes. One gets a bit hogtied with primary legislation. There is more flexibility in regulations.

We move on to part 2, "Notifiable diseases, notifiable organisms and health risk states", which takes us from section 12 to section 19. I understand that all the witnesses have copies of the bill in front of them. Just pitch in if you want to make a comment.

Dr Donaghy: My organisation is the national centre responsible for collating information on communicable disease and many of the health impacts of environmental hazards. We welcome the changes in part 2. First, they recognise the reality of how we monitor this health problem, particularly through the laboratory sector. Secondly, they align us with the responsibilities that are now placed on us to inform the European Union's European Centre for Disease Prevention and Control for a range of hazards to health, which are laid out in an EU directive. Thirdly, the provisions on health risk states give us the flexibility to monitor new illnesses and align us with our responsibilities under the World Health Organization's International Health Regulations (2005). Fourthly, they clarify individual professionals' duties and responsibilities in terms of risk to the public.

The provisions on non-human diagnostic laboratories may need to be strengthened. For example, in England, the Department of Health is considering broadening responsibility to laboratories that carry out tests on food. That is because hazards to health and risk to public health can often be detected initially in non-human health laboratories. We welcome the provisions in part 2 of the bill but think that there is scope to strengthen them in that area.

Dr Riley: On notifiable diseases, the proposed changes enable us to update the list of diseases, which was initially specified more than a century ago. The ability to regulate is absolutely key to that, so that we can change and update the list in real time, as it were.

Section 16, "Notifiable organisms: duties on directors of diagnostic laboratories" formalises what was a voluntary system. It also includes

public and private institutions, which strengthens the system, and that is important. The other view is that it gives us an ability to look at new, emerging organisms as well as re-emerging organisms, as we experienced recently in the Borders with the anthrax outbreak.

There will be quite a lot of debate about the health risk states. I support Dr Donaghy's comment about giving us flexibility if a person is known or suspected to have been exposed to

"(a) a highly pathogenic infection; and

(b) any—

(i) contamination;

(ii) poison;

(iii) other hazard",

and that flexibility is crucial.

Dr Saunders: We are not entirely sure that the provision on health risk states will work. A doctor is likely to suspect that someone might have a health risk state only if the person themselves brings it to the doctor's attention.

We are also concerned that, given the risk that the person who discloses the information might find themselves quarantined or put in detention, it is far less likely that they will seek help or medical advice. The provisions might have the opposite effect to the desired one, which is to reduce the risk to the public; they might actually increase that risk.

On the duties of directors of diagnostic laboratories, consultant microbiologists—who, as the bill stands, would be the people who would bear responsibility—have expressed a number of concerns. Many of them have told us that they do not have the managerial authority within laboratories to do what would be required. For that reason, it would be more sensible for the duty to be laid on the owner or manager of the diagnostic laboratory rather than the person who provides medical input to the laboratory.

The Convener: This has been quite an interesting area.

Dr Donaghy: The health risk state provisions pull Scotland into line with European and international regulations. They result from the severe acute respiratory syndrome outbreaks in Toronto and Hong Kong, when we had a new disease that was typified by a range of symptoms, but we could not call it a disease. Knowledge of cases of such illnesses needs to be fed into the public health system by individual practitioners to prompt action to control such problems. Therefore, the definition needs to broaden, away from "diseases" to "health risk states".

Secondly, control of SARS, which was a totally novel disease, the repercussions of which were unknown at the time and quite severe, was exercised by controlling the movement and mixing of contacts. Internationally, it was recognised that there was a need to know about cases and for contacts to be notified so that measures could be put in place.

The instigation of the move towards defining health risk states, rather than identifiable diseases, is a result of practical experience of controlling a totally novel disease that appeared in a population. The lesson from SARS, which spread rapidly through the world, is that Scotland cannot be exempt from that process.

10:45

Dr Riley: That is a perfect example of what I was talking about.

Dr Simpson: My concern relates to section 14(7), on page 9 of the bill, which states that the definition of "health risk state" includes "a highly pathogenic infection". I accept entirely the example that has been given, but does the definition include all notifiable diseases? Under the bill, "a highly pathogenic infection" or

"any—

(i) contamination;

(ii) poison;

(iii) other hazard,

which is a significant risk to public health"

constitutes a health risk. Who defines those terms? How, where and when are they defined? At the moment, the provision is written extremely broadly and seems to apply to all notifiable diseases. That is not what you are talking about, and it is not how I would expect health risk state to be defined. If it is defined as all notifiable diseases, the bill will place a massive burden on primary care, in particular, which will be the main point of contact.

Dr Riley: SARS has been given as an example of a new infection. The provision is intended to give us the ability to respond before a definitive diagnosis has been made. I was going to give the example of long-haul flights and viral haemorrhagic fever. Although a definitive diagnosis cannot be made immediately, it is clear that something is critically wrong. In such situations, we need to be able to define a risk state even without a definitive diagnosis. We can change and update definitions over time through regulations.

Dr Donaghy: The debate on how wide the definition of "health risk state" needs to be is crucial, but our experience of the unexpected is

that it will come from left field. There is a concern that defining "health risk state" too tightly could limit our capacity to respond. It will be defined by public health organisations, based on our practical experience of symptoms, signs and diagnostic tests. A health risk state may not meet the criteria for being regarded as a disease, as we may not find an organism. We need a backstop that will give us the ability to define a constellation of symptoms and signs and to conduct basic diagnostic tests that will indicate where we can take relevant action. We do not know what will happen in 10, 20 or 30 years. If we define "health risk state" too tightly, how we respond to a situation may be inhibited legally.

Dr Saunders: I repeat that we view the provision as unworkable. The definition of a health risk state is so vague as to be unusable. We would not have a problem if the bill said that a health risk state is anything that the Scottish ministers say it is in a particular situation. That would make sense, as it could be very specific and could be changed as and when needed. However, there are a vast number of highly pathogenic infections that are not easily transmissible from one person to another. My reading of the bill may be wrong, but I understand it to say that, theoretically, a registered medical practitioner should notify cases of every one of those. There would be so much noise in the system that the provision would not pick up what it is intended to pick up. We would prefer the bill to refer to conditions defined by the Scottish ministers, as and when that is necessary.

The Convener: Alternatively, the BMA could suggest to members an amendment to the provision.

Ian McKee: I want to pursue the same issue. The last item on the list of notifiable organisms that laboratory directors are responsible for notifying is

"Any other clinically significant pathogen found in blood".

My reading of that is that it is the duty of the laboratory director to decide what is a "clinically significant pathogen" rather than a matter of their being told whether there is any new addition to the list in schedule 1. It is a catch-all sentence, but it is the clinician or the laboratory director who must decide, which I would have thought gives scope for different laboratories to notify different things. After all, there are plenty of organisms that could be said to be clinically significant although one assumes that it is not the intention of the bill to capture them. Chlamydia and similar organisms are clinically significant and they are pathogens. Is that more than just an academic observation? Will the bill pose a problem for laboratory directors when it becomes an act?

Dr Donaghy: Let me clarify the difference between the provision on health risk states and that provision. The provision on health risk states is to enable cases to be notified when we do not know what the pathogen is, as happened with SARS. It is distinct from the laboratory provision. The World Health Organization and the international health regulations put the onus on states to have the ability to notify and respond when we do not know what the causative organism is and, therefore, do not have the laboratory test or laboratory provision. The clear lesson from SARS is that we need that.

The duty to notify any other organism that is detected in blood beyond those that are listed in the bill as being notifiable recognises that blood is sterile and that it should not contain an organism or pathogen. Were we to see in the isolate—as we sometimes see in relation to health-care associated infection—a pathogen appearing in the blood as a result or an unintended consequence of a health care procedure, the provision enables laboratories to notify that so that relevant action can be taken.

In certain instances, we will need rapid notification and a rapid response if we see a pathogen that is not on the list but is regularly being picked up in blood and could need a public health response.

Dr Baijal: I will develop in a little more detail some of the ideas that Dr Donaghy has expressed. Without disrespect to members, I think that it is important that the risk states are professionally defined, although politicians may wish to take action on professional advice. Health Protection Scotland is a national agency that co-ordinates surveillance, and health risk states will be detected and defined on the basis of surveillance and professional principles. As we have heard, that process must be able to adapt to a changing context, so it needs to be flexible.

The other issue that I want to mention is the speed of response. We would not want the process to be unduly protracted, as very quick action sometimes needs to be taken. The chief medical officer and his team have a role in providing advice.

Ian McKee: I can see the logic in bodies such as Health Protection Scotland telling laboratories that a circumstance has changed and that something should be notifiable. However, my reading of the bill is that directors of laboratories will make that decision rather than an outside agency—that is my point. I wonder whether that is the case or whether I have misread the bill.

Dr Riley: It will enable directors of laboratories to pick up novel issues—it is a positive development and a strengthening of the system.

Such issues must arise somewhere, and that may be in local laboratories. I again use our example of rare organisms turning up to illustrate the point. Instead of seeing the provision as an imposition, we should see the ability of lab directors to notify organisms about which they have concerns as a positive development.

The Convener: Does Dr McCallum want to come in now? I am sorry that I missed you out earlier.

Dr McCallum: No. Dr Riley picked up my point.

Dr Simpson: I am getting slightly confused. Two issues are involved. First, there is the issue of the organisms that come under section 16, "Notifiable organisms: duties on directors of diagnostic laboratories", to which Dr McKee referred. I understand fully Dr Riley's point that we should have a permissive system. However, the duties on the director require them to act.

If a director thinks a matter is important, they will report it, but if a director thinks that it is not all that important and fails to report it, they will be found to have failed in their duties under the act. That is quite different from encouraging laboratories to report. The catch-all provision should be written in such a way as to encourage laboratories to act. It could require them to do so, but a punitive duty is not appropriate.

That issue is separate from the definition of health risk states that I raised. Section 14 concerns the duties on medical practitioners and subsection (1) states:

"This section applies where a registered medical practitioner has reasonable grounds to suspect that a patient whom the practitioner is attending has been exposed to a health risk state."

Who will define that? Who will indicate to practitioners that they must give notice? I accept Dr Donaghy's point that there may be new pathogens that are not yet identified. However, someone somewhere in Health Protection Scotland will be advising ministers, who should then say that there is a problem and, rapidly after that, tell practitioners, "If this set of symptoms arises, we require you to notify." As it is drafted, the provision is too much of a catch-all and puts too much onus on practitioners. Much clearer guidance from the top must be built into the primary legislation.

I ask the witnesses to tell me if my reading of the bill is wrong, but that is how I read it.

Dr Riley: I have a brief example, which Martin Donaghy may want to pick up on. The clostridium novyi infection affected drug addicts in Glasgow. If we had not had international co-operation, it would have been incredibly difficult for us to get an identification of that.

Health risks should be defined locally, then nationally. Basically, one should work up the system until one gets a definitive diagnosis. In the Glasgow case, diagnosis was achieved only with international co-operation.

Dr Donaghy: The provision would work in the way in which Dr Simpson described. I return to the SARS outbreak. We did not know whether SARS would come to Scotland. A definition was reached internationally. It was sent to my organisation, Health Protection Scotland, and we then agreed it with the then Scottish Executive and cascaded it down the system through NHS boards and the hospital and general practitioner sector. Suspected cases were then notified to us on the basis of the clinical definition.

Similarly, as Andrew Riley said, when we had a significant outbreak among injecting drug users in Glasgow and 20 deaths, we did not know what the pathogen was, although we knew that there was a distinctive clinical syndrome. We cascaded through the system and asked people to notify so that we could investigate adequately and respond.

Our experience of SARS and clostridium novyi tells us that if we paint an adequate picture of the syndrome for doctors, they will notify. Recently, there was an unusual outbreak in the Bridge of Allan area, which was associated with an abattoir. For quite a few weeks, we did not know what the disease was, but it turned out to be a disease called Q fever. We were being notified on the basis of clinical syndrome, which is a state, not a specified disease. The international experience is that systems need to be underpinned with statutory provisions. That is the thinking behind the introduction of the bill.

Rhoda Grant (Highlands and Islands) (Lab): Could such matters be dealt with through advice from ministers and professionals? If the definition in the bill is too narrow, we will not pick up on new issues that come into the system, but if it is too loose it might lead to an awful lot of noise in the system, which might hide serious cases. Would it help if guidance were attached to the bill?

11:00

The Convener: I will group together questions on the issue.

Mary Scanlon: I make quite a narrow point. We are talking about a crucial aspect of the bill, which will depend on co-operation between health professionals and local government, so I am surprised that it says in the policy memorandum that the decision was taken to legislate

"to discontinue the fee payable to general practitioners for notification."

The bill depends on general practitioners. Will Dr Saunders say why there is a proposal to withdraw fees at such a crucial time?

Ross Finnie: In section 14(7), "health risk state" is defined as

"(a) a highly pathogenic infection; and

(b) any—

(i) contamination;

(ii) poison;

(iii) other hazard,

which is a significant risk to public health."

That is the only definition of "health risk state" in the bill—it is only referred to in section 104, "Interpretation". Given the definition's importance and the points that Dr Simpson has made, does the definition cover what witnesses think that it should cover, or do we need to do something to ensure that it covers the issues that have been raised?

Dr McGuigan: On that point, and on the point that was made about early notification of an outbreak, it is easier to describe the syndrome that we want doctors and health professionals and others to notify when we know what it is. However, early notification depends on someone having a hunch that there are two or more similar cases of something significant. It would be useful if the bill said that.

I make a more specific point, which relates to the removal of food poisoning from the list of notifiable conditions. Notification of suspected food poisoning has been a useful early indicator of possible outbreaks, but if we are not to be notified about such conditions it would be useful to replace that requirement with a more general requirement to notify as soon as someone suspects an outbreak.

We found out about the clostridium novyi outbreak only because a doctor became suspicious when there were two or three similar cases of people who were seriously ill in one hospital, although there had been cases prior to that.

Dr Riley: Richard Simpson and Ross Finnie made helpful points. On reflection, I think that the definition might need to be expanded, perhaps to say, "and/or contamination, poison and other hazard". A perfect example is the polonium poisoning case last year, which took a great deal of time to identify but was most definitely a health risk state.

The Convener: I bring in Dr Saunders and ask him to respond to Mary Scanlon's question about fees, as well as anything else that he wants to respond to.

Dr Saunders: We have significant concerns about the proposal to discontinue fees for GPs. If GPs are to notify in a timely way and maintain the system properly, they need to have the resources to do so. The discontinuation of the fees that enable them to provide that service would be unhelpful and should be reconsidered.

On health risk states, from what witnesses are saying it seems that there needs to be flexibility and that if there were a syndrome of symptoms that the Scottish ministers wanted doctors to notify, the Scottish ministers would issue guidance. I do not think that anyone has a problem with the issuing of such guidance, which will probably work very well. However, we have a problem with the definitions in the bill, which are so vague that doctors could probably be done for almost anything on most days of the week. If an issue is important enough to be notified as a health risk state, we feel that it should be specified centrally and details issued by Scottish ministers.

The Convener: I have a supplementary question on the issue that Ian McKee raised about the duties—it may be that we need to ask this of laboratory people—under section 16. A mandatory duty will be placed on directors of laboratories to inform the relevant persons within 10 days, beginning with the day of identification, when a notifiable organism is identified. We have already considered the problem of the catch-all in part 2 of schedule 1. However, section 17 will make it an offence for the director of a diagnostic laboratory to fail "without reasonable excuse" to provide such notification. Does the phrase "without reasonable excuse" provide sufficient protection—if I may put it that way—to a director of a laboratory? Before we speak to directors of laboratories, can anyone here comment on that? Does that change the status quo?

Dr Riley: As I said, we currently have a voluntary system of reporting for laboratories. Depending on circumstances, some laboratories could have withheld the reporting of such organisms. The bill formalises the approach. I take the point that is being made; I cannot comment on the legal implications of the wording, but the bill certainly formalises matters for laboratories.

The Convener: Under the current voluntary system—I do not know whether this has ever happened—if a director of a laboratory failed to notify that such an organism had been identified, he would still be breaching a duty of care.

Dr Riley: In my experience, the closest that we have come to that is when a laboratory has been unable to submit its report due to capacity reasons. That might well have compromised issues, but directors of laboratories are currently under no duty to notify because the system has been voluntary.

The Convener: That brings me to my next point. Mandatory and serious duties that will involve extra work are being placed on laboratories to report unknown contaminations, mutations, viruses and so on. The bill will require an awful lot of work from laboratories. Are laboratories sufficiently funded to fulfil the mandatory duties that will be placed on them and, indeed, to deal with the viruses and mutations such as avian flu that we have considered?

Dr Donaghy: Let me first comment on the current provision. At the moment, NHS laboratories voluntarily report such identifications—most of the data are captured by an electronic system. However, with the growth in private provision of health care, part of the reasoning behind the provisions in the bill is to extend the duty outwith the NHS so that we include all laboratories that identify hazards to human health from pathogens. On the NHS side, the bill will provide a statutory underpinning to what currently happens. I am not saying that such laboratories are currently well resourced—like any part of the NHS, they want more resources. The national centre that collates all the information has sometimes had difficulties attracting funding for information technology developments, but we have not seen any huge deficits in the voluntary reporting of NHS laboratories.

The second issue is that, under a European Community directive, the United Kingdom now has a duty to report to the European Centre for Disease Prevention and Control on almost 50 organisms. Therefore, we need that information to fulfil our requirements to the EC. It is thought that the provisions in the bill will provide us with a safeguard to enable us to fulfil that requirement. The problem would be that, if a laboratory were not to report, public health could be put at risk because we would not know about pathogens occurring in the population that present a risk to human health.

Dr Saunders: Most medical microbiology laboratories are significantly underfunded. They are not a very glamorous part of the service, and in fights for a share of the cake they tend to do less well than more highly regarded parts of the NHS. I do not know any laboratories that would say that they are adequately funded for what they are asked to do.

I said earlier that in many cases the microbiologist is not, in effect, the manager of the laboratory. There is either a non-medical manager or a clinical scientist in that position. It is slightly harsh to impose a potentially criminal sanction on someone who may not have the ability to perform the task that is required of them. Even if they have the managerial ability to perform it, they do not have sufficient control over resources to divert resources for that purpose.

Dr Donaghy said that reporting of notifiable organisms takes place already, by and large. That prompts the question: if the system is working fine, why does it need to be changed? Be that as it may, it is hard to see why failure to report should be a criminal offence. For NHS laboratories, it would be far more sensible for the matter to be dealt with as part of the NHS management and disciplinary systems that are already in place.

The Convener: Thank you for your interesting comments on this issue, which was first raised by Ian McKee.

We move to part 3 of the bill. I will entice members and witnesses by indicating that there will be a short break after we have considered part 3, on "Public health investigations", which consists of sections 20 to 30. I invite comments on those sections. Will the enticement of a break ensure that there are no questions?

Ken Jones (Scottish Borders Council): I fully support part 3 of the bill, which is well overdue: although I hope that it will not be used too often, it will be helpful when its use is required. However, when an investigation is carried out, the costs of analysing samples and taking any necessary remedial action may be significant. The bill appears not to say who will bear those costs. Will they be borne by local authorities, by health boards, by both jointly or even by the person who caused the incident? The committee may want to consider that.

The Convener: No member has indicated that they would like to ask questions or raise issues. I should not have alluded to tea and coffee. Perhaps I should do so more often—we would whizz through meetings.

We move straight to part 4, on "Public health functions of health boards", which runs from section 31—a large section—to section 66. Part 4 grants powers to various authorities. It makes provision for exclusion orders, restriction orders and other powers of compulsion.

Ross Finnie: The bill talks about excluding and taking powers over persons, but it is not entirely clear to me as a layman where the authority lies for dealing with premises. In other words, how would we exclude a property or a school? I understand why the bill is focused on taking powers to exclude persons, but there may be occasions when we want specifically to exclude premises. There may be existing powers with which I am not familiar, so I would welcome comments on the matter before we discuss the detail of part 4. The powers for which the bill provides are clearly appropriate, and we may want

to examine in detail why and how it deals with persons.

If, having examined premises, we wanted to exclude them, it is not clear to me how we would draw that distinction. Will the witnesses clarify that? Are there relevant powers in the bill? Given that we are trying to simplify a long list of old statutes, I wonder whether powers in relation to premises rather than persons ought properly to be within the mischief of the bill.

11:15

Dr Riley: That has been a subject close to my heart recently. In the anthrax investigation, we would have wished for such powers in order to quarantine two properties. Those powers did not exist for us, except indirectly through other legislation such as health and safety legislation. That was quite a weakness for us. We worked hard with our local authority colleagues to exclude the properties, but ended up only with voluntary exclusion for the second property, which was a village hall. I do not have the bill in front of me, but there is a section on premises that would cover this matter. I am sure that Ken Jones knows where it is—we could definitely have done with it a year ago.

Ken Jones: Section 27(2) gives power if a warrant is applied for. It says:

"left undisturbed…for so long as the investigator considers appropriate".

That relates to premises.

Dr Simpson: I am sorry, but that does not seem to exclude people. You are interpreting "undisturbed" as if it means that one cannot enter the premises, but one could go in and not disturb the premises: a forensic examiner entering the premises would do so in a way that did not disturb them. The section you refer to does not specifically exclude people.

Ken Jones: Sections 23 and 24 may give the powers to exclude persons.

The Convener: Another part of the bill talks about quarantining the premises, or putting a fence round them, as you did down in the Borders. Is that covered by sections 23 and 24? I think that that is Ross Finnie's point.

Ken Jones: I hope that is covered. It was only by voluntary agreement and, as Andrew Riley said, by using subordinate legislation that we managed to exclude those premises.

The Convener: You say that you hope so, so I assume that we can find it.

Ken Jones: I am sure that such a provision is in the bill. I will look for it during the tea break.

The Convener: We will park that one, unless we have a response—

Rhoda Grant: I think that the part Mr Jones is talking about is section 27(2)(b)(ii), which says:

"to be left undisturbed".

The Convener: I am sorry—would you point out where that is?

Rhoda Grant: It is at the top of page 18.

The Convener: I suppose that that might do it. The question then would be: what constitutes "premises"?

Dr Simpson: It is not clear.

The Convener: We will raise that issue elsewhere. I am not clear whether "premises" is defined—perhaps someone could direct me. If it is, that is all right. "Premises" might include a substantial surrounding area. As I recall from the Borders case, it went right down to the water.

Dr Riley: I would welcome clarification on that. Anything that strengthens the ability to exclude premises would be welcome.

Ken Jones: Section 103 of the bill defines premises thus:

"'premises' includes—

(a) any land or building; or

(b) any other place, including—

(i) a mobile home; and

(ii) a vehicle".

The Convener: Perhaps it should say "any prospective affected land or building" and so on. "Any land or building" is very wide.

Dr Simpson: I am not a lawyer, but the term "left undisturbed" seems different to me from a power to exclude. We may need to ask the minister when we take evidence from her.

The Convener: I agree.

Dr Riley: The discussion that we had when putting the exclusion in place included wording from health and safety legislation. The definition that we are talking about may exist there; if it does not, clarification would be helpful.

The Convener: I presume that if the definition exists in health and safety legislation, there will have been cases under that legislation and therefore there will be guidance about adopting the definition or using a different one based on case law.

Rhoda Grant: I would like information about how in practice the right to appeal against quarantine or hospital detention orders could be carried out. Obviously, someone who is making an appeal needs access to legal advice and the

courts. If they are deemed to be so infectious that they are quarantined or detained in hospital, how could that appeal process work?

Dr Riley: There have been a number of such cases. I am thinking of the multidrug-resistant tuberculosis examples in other countries. Under the old public health legislation, some people were detained in hospitals in our larger cities for non-compliance with treatment of tuberculosis, so examples can be given. The power in the bill is simply one to detain rather than to quarantine.

Rhoda Grant: Given that the bill also contains the right to appeal, how can a person appeal if he or she is infectious enough to be deemed to need to be quarantined? How would they safely access legal representation and the courts?

Dr Riley: I am not sure that I am the appropriate person to answer that.

The Convener: Dr McCallum, do you have an answer to that?

Dr McCallum: In practical terms, it is about making the individual aware of their right of appeal and ensuring that their access to legal representation is facilitated. My experience is that face-to-face contact at a reasonable distance is not a problem. Were it to present a problem, there are several modern technologies that could be used. If a person is to be detained, it is important to make appropriate advocacy available to them; that would be part of the practitioner's duty, even if it was not to be enshrined so clearly in law.

The Convener: Dr Saunders, do you want to come in here?

Dr Saunders: We have concerns about appeals. As we understand our reading of section 58 of the bill, which comes under the heading of "Appeals", it is extremely likely that the quarantine period would be over before any appeal was held. We believe that there should be an urgent appeals process within 48 hours so that people who are to be detained or put into quarantine have some legal redress.

Dr Donaghy: In practical experience, where people have been detained in hospital because of problems with tuberculosis, which is often concomitant with alcohol and drug abuse, access to the legal process has occurred through the mechanisms that Dr McCallum outlined. I am not saying that there are no problems, but we are not aware of any specific cases in which the infection risk inhibited the ability of the person who was being detained to relate to their legal representative. If there have been problems, they have been overcome.

Mary Scanlon: Are there issues concerning the time periods for exclusion, detention and quarantine? Complying with treatment has been mentioned, but I am wondering about a case in which the patient does not respond to treatment. I am slightly confused: I am not sure whether the period can be extended beyond 12 months. It seems to me that it cannot.

Dr Simpson: That was the point. At the moment, I think, detention can be for three months, then 12, so it can go to 15 months, by my reading of the bill. However, what happens in a multidrug-resistant tuberculosis case that is not responding and is still highly infectious? We are, in primary legislation, tying ourselves to 12 months—a fixed point. Should not the provisions include rights for the patient to have their case reviewed at regular intervals? That would be crucial. It would also allow society to say that if a person was still highly infectious, their being allowed back into the community could result in an outbreak of disease X. Do the witnesses have any comments on that?

Dr Riley: I am contributing rather a lot today.

For TB, it would be welcome and helpful to have the opportunity to renew an order if the requirement to detain was still apparent at the end of 15 months. That might represent a gap in the provisions.

The Convener: I ask somebody to point me to the section with the time periods in it. I have been wandering about several sections.

Mary Scanlon: It is section 49(7). Times are mentioned throughout that part of the bill.

The Convener: So the limit is absolute.

Dr Simpson: Yes—at the end of 12 months, that is the end of it, which does not sound medically sensible to me.

Dr Saunders: Section 49(7) refers to

"a continuous period exceeding 12 months".

My reading of that is that it would be perfectly feasible for somebody to be locked up for 12 months, let go for a couple of days and then locked up for another 12 months.

The Convener: Something might happen in those two days: they might be the crucial two days.

Dr Simpson: If such a person was to go to a concert, we would have a problem.

Dr Saunders: Absolutely. My other point is that TB is TB. The fact that a strain is multidrug resistant does not mean that it is any more infectious than ordinary drug-sensitive TB. BMA Scotland would have major concerns about somebody who has committed no crime but may pose a risk to other people being effectively incarcerated for life because of a condition that we will not be able to cure. We have major concerns that the balance between the risks for the public

and the risks for and benefits to the individual is not struck in the provisions. It would be better to take the time and effort to persuade people to comply with treatment voluntarily than it would be either to incarcerate them for long periods until they die or give up, or to use the threat of incarceration as a way of compelling them to undergo treatment.

The Convener: That is useful. I advise witnesses and committee members that we will also take evidence next week on the ethical and human rights issues that are raised by the balance for society between risk and deprivation of freedoms.

Dr Donaghy: Health Protection Scotland agrees that there are instances in which the person can remain a danger to the public. The point about multidrug-resistant TB is that although it is infectious, if a sufferer infects somebody, that infected person can then be treated. It is a different order of risk to the public if somebody infects somebody else with an organism for which there is no treatment—that is a greater public health risk. There are instances in which a further extension could be necessary. We agree with Dr Simpson's point. However, there must also be safeguards for the patient regarding appeal and on-going review.

The power to detain people in hospital, particularly if they have tuberculosis, is not uncommonly exercised, particularly in the west of the country, where there are one or two cases every year. I know from practical experience that the public health organisations, which often involve social work and the drug and alcohol agencies, go to extreme lengths to secure voluntary agreement for treatment. The institution of the legal process is regarded as a measure of last resort. People who are detained often live in hostels, in which the residents are probably most at risk from infection. Children are often involved in detention measures. However, detention is enacted as a measure of last instance, which is not taken lightly. We think that the new bill will underpin current measures and provide further safeguards to the public.

11:30

Dr Riley: Dr Saunders's important point illustrates an issue that we have debated a number of times. The right of an individual to appeal, refuse appropriate treatment and so on is accepted. However, it is equally important that we consider the impact of those rights on the rights of the population as a whole. The rights of an individual have been compromised if they come down with an infection from contact with an individual who refused appropriate treatment. The issue of the rights of the individual versus the rights of the general population is extremely important for the bill.

Dr Simpson: To extend that point, the bill as it stands proposes an inadequate review procedure and the proposed time constraints are far too tight. I am also concerned about section 31(5), which states:

"The board need not comply with subsection (3) or (4),"

which are to do with informing an individual and explaining to them what is happening. I understand the need to prevent absconding, but that does not alter the fact that, when individuals are confronted, they should be offered explanations. It is not good enough to say that a board "need not comply" with the requirement to explain if it thinks that a situation is urgent. We will deal with that proposal next week when we discuss ethics, but I cannot believe that the people who will give us evidence on ethics will accept that, even if the situation is urgent, a patient should be compulsorily treated without explanation. I find that subsection offensive. I do not know whether I am being too strong on it.

The Convener: No—I think the committee is generally a bit unsettled about the possible effects of certain proposals on the rights of individuals, particularly with regard to court processes and the legal protections that would be available to the individual in the face of what will undoubtedly seem to them to be a mighty machine.

Dr McCallum: The current process for detaining people is lengthy, cumbersome and inadequate, despite the excellent support of local authority lawyers and the NHS Central Legal Office. The bill will enable us to work with subsequent regulations to ensure that the process is improved. However, it is vital that, having improved the process, we are able to detain and treat people who refuse treatment.

There are two groups of such people, one of which comprises those whose judgment is clouded by their illness. We think that, with appropriate advice, we can use the Adults with Incapacity (Scotland) Act 2000 for that group. The second group comprises people who are recalcitrant; it is for this group particularly that we wish to use detention as a power of last resort. However, I do not see how, given an appropriate modernisation of the process of obtaining a detention order, there would ever be a reason in any of those situations not to discuss the matter with an individual or to ensure that they had access to appropriate advice.

The modernisation of one part of the process requires us to modernise the other part. Only in the current situation is it difficult to ensure that people have access to appropriate legal advice sufficiently rapidly. In the future, that will not be the case.

The Convener: I am getting my head round the distinction between compulsory detention and compulsory treatment. Please correct me if I am wrong, but I understand that there cannot be compulsory treatment. Treatment can be authorised by another person under the Adults with Incapacity (Scotland) Act 2000, depending on the individual's lack of capacity. However, if someone is capax, there cannot be compulsory treatment.

Dr McCallum: No.

The Convener: I have that clear in my head now.

Dr Simpson: I have no problem with the authorities moving swiftly and without having to wait for cumbersome legal processes to be followed, but I object to the waiving of the requirement to explain. Section 31(3) provides that

"The appropriate health board must, in so far as it is reasonably practicable to do so"—

that form of words always causes difficulties—

"explain to the person in relation to whom the relevant action is proposed—

(a) that there is a significant risk to public health;

(b) the nature of that risk; and

(c) why the board considers it necessary".

Section 31(4) deals with people with incapacity in a similar way.

However, section 31(5) provides that the board does not have to explain its action if it thinks that the matter is urgent. Under section 31(5),

"The board need not comply with subsection (3) or (4) where it considers that the risk to public health is such that the relevant action must be taken as a matter of urgency."

I am not concerned about the action being taken but about the need to explain the action to the individual. There is no excuse for not giving an explanation and there should be no absolution for anyone who fails to give an explanation. I would have thought that a doctor who did not offer an explanation would be up before the General Medical Council.

Dr Saunders: BMA Scotland supports that view. It would be utterly unacceptable to take such action without doing one's best to explain it to the person to whom it was being done.

Mary Scanlon: My memory is a bit vague, but I understand that the Mental Health (Care and Treatment) (Scotland) Act 2003 makes provision for compulsory treatment, for example force feeding. That might not be relevant to the bill.

Rhoda Grant: I understand why subsection (4) of section 31 might be waived under subsection (5) if there was a "matter of urgency", because the requirement to make contact with the third party who had responsibility for the adult with incapacity might slow things up. In the case of subsection (3) we are talking about a person who could be dealt with face to face, and I imagine that while the authorities were trying to take the person into quarantine they would explain what they were doing and why. However, subsection (4) provides for adults with incapacity or young children, who might not be able to understand the information, so a guardian or responsible third party would have to be contacted. The requirement in subsection (4) might need to be waived if the board had to act quickly and was not able to contact the third party. Do you understand what I mean, convener?

The Convener: I certainly do. All professionals have to exercise a degree of common sense because their actions are open to legal challenge if they do not take all reasonable steps. I am sure that professionals are aware of that.

We will come back to the issue. I suspend the meeting for five or six minutes and encourage witnesses to race members to the coffee and tea.

11:39

Meeting suspended.

11:53

On resuming—

The Convener: I am content for us to move on from part 4 to part 5. If members think of any further points, we can sweep them up at the end of the meeting. Is that acceptable?

Members *indicated agreement*.

The Convener: Part 5, "Public health functions of local authorities", comprises sections 67 to 74. It deals with some of the issues that have been raised relating to premises. After witnesses have spoken, we will take questions from committee members.

Robert Howe: I would like to clarify what would happen in practice. Section 67 is entitled "Provision of facilities for disinfection etc". I do not envisage local authorities purchasing all sorts of equipment that could decontaminate a range of substances. Instead, they will make appropriate arrangements—they will probably have a list of competent people who would be able to undertake such work. The cost to authorities of purchasing what in some cases would be fairly specialist pieces of equipment could be considerable. I make clear that authorities do not intend suddenly to purchase equipment that they do not have at the moment. Members need to consider whether they are satisfied with the wording of the bill or

whether they would prefer it to impose a duty on local authorities to demonstrate that they have made appropriate and sufficient provision.

The Convener: Are you referring to section 67(1)?

Robert Howe: Yes.

Ron Culley (Convention of Scottish Local Authorities): Generally, the Convention of Scottish Local Authorities does not think that significant costs will arise from the implementation of the bill. However, in circumstances where pressures are felt, it will reserve the right to engage with the Scottish Government on how best costs can be met. That point is set out in the concordat.

Tom Bell (Royal Environmental Health Institute of Scotland): This is probably an appropriate point for me to break my duck and say something.

The Convener: Do not feel compelled. However, I am sure that you have something worthy to say.

Tom Bell: I was conscious of the fact that I was taking up a space without saying much. We are talking about local authority resources, so it is appropriate for me to stress that the Royal Environmental Health Institute of Scotland has consistently expressed concern about the reduction in the number of environmental health officers who are working as public health professionals in the local authority sector. We are grateful to the Minister for Public Health for agreeing to facilitate the establishment of a short-life working group on environmental health, especially in the local authority sector. We will wait to see what that reveals, but it is important that I place on record the institute's concern about the number of EHOs working in local authorities.

Fraser Thomson (Society of Chief Officers of Environmental Health in Scotland): Most local authorities—certainly the urban ones—are fairly comfortable with their role as enabling authorities. We will be able to enable the provision of most of the facilities to which the bill refers. However, we have concerns about some island and very rural authorities where such facilities may not be readily available.

Dr Riley: The directors of public health fully support REHIS's position on environmental health officers and welcome the establishment of the short-life working group on environmental health. Our experience of decontamination in the Borders last year was that the input from the then Scottish Executive was extremely helpful. The approach of using a framework of specialist contractors worked extremely well. We were most grateful for the Executive's support in facilitating the process, which went relatively smoothly for us. I am sure that Mr Jones will back me up on those points.

The Convener: When will the short-life working group on environmental health to which you referred report?

Tom Bell: It is due to be convened in the next three or four weeks. There have been pre-meetings to agree the group's remit and membership.

Helen Eadie (Dunfermline East) (Lab): Dr Riley's explanation of what happened in the Borders was helpful, but that is only one instance. I am concerned about what will happen generally. Will the owners of the affected property be liable for the clean-up, or will the presumption always be that the Scottish Government is liable? There are some instances in which the costs will be small, but there are also instances in which the costs for property owners will be horrendous. Who will pick up those costs?

Dr Simpson: I want to respond to Dr Riley's point. Given that not all local authorities will acquire the equipment or expertise for disinfection and some may use external contractors, should such contractors be registered, so that their competence can be ensured?

Robert Howe: Members have raised several issues. Under the bill, the owner or occupier of the affected building would be responsible for carrying out disinfection or decontamination. If they could not be identified, it would fall to the local authority to carry out the work.

Dr Simpson asked whether contractors should be registered to ensure their competence. That is what I was alluding to. Perhaps the wording of the bill should be changed to do that. Obviously, we would want to ensure that we employed competent contractors to carry out decontamination work.

12:00

The Convener: We could not write that in, though. We could hardly specify that contractors must be competent because the implication would be that you were not employing competent contractors.

Robert Howe: No. It would be up to the local authority to ensure that competence.

Dr Riley: In our experience, cost recovery is a crucial issue. I believe that the Environmental Protection Act 1990 allowed for recovery of costs; that power should still be available to authorities. However, in the example that I gave, the costs of decontamination were huge and it was not felt appropriate to recover costs.

On the registration of contractors for decontamination, we approached the Government Decontamination Service, which has an existing framework of contractors for specialist equipment and services. That formal framework was extremely helpful to us. In effect, we tendered from that list and it was a relatively straightforward process.

Helen Eadie: I come back to the question about contractors. My concern is about the standard of work. Is there a way to monitor the work and ensure that it is done to a specific standard? As we all know, there are contractors and contractors and, when contractors have completed work, we sometimes find that it has not been done to a good standard.

Dr Riley: In our case, the Government Decontamination Service assessed each contractor before it got on the framework, so the contractors' standards were already analysed to a degree. We examined each tender and, with expert input from international authorities, were able to come to a decision as an incident control team to proceed with what we considered the best and most effective decontamination method. We had input from the framework and expert advice, which was an extremely good combination.

Dr Baijal: I reiterate what Dr Riley said about the Government Decontamination Service. It provides a form of quality assurance.

The Convener: That line of questioning is concluded. Are there any other questions on part 5?

Ken Jones: I have a point of information: I think that you will find that section 76 gives authorities the power to recover expenses that are incurred if a notice is served.

Ross Finnie: Sections 67 to 73 set out the powers that are available to local authorities and section 74 specifies that they are equally available in an emergency. Are witnesses satisfied as to the clarity of that section? Could they help me as to who would be the "authorised officer"—as opposed to "competent person"—who would be invested with the power to exercise the discretion to use those powers in an emergency?

The Convener: In other words, is the definition of "emergency" in section 74(7) enough? Are the witnesses content with that definition?

Ross Finnie: And who is the authorised officer?

Dr Simpson: The provision looks circular, because section 68(8) says that

"'authorised officer' means an officer … authorised … for the purposes of this section, section 69, 70, 71, 72, 73 or, as the case may be, 74"

and then those sections refer to "an authorised officer". It is rather circular and seems to be separate from the provisions on competent persons, which we discussed earlier.

Ken Jones: I think that you will find that the bill says somewhere else—I cannot find it at the moment, but I will look for it, if you wish—that local authorities must appoint authorised officers who, I assume, would be the authorised officers under those sections.

The Convener: I do not see anything in the definitions or the interpretation section.

Dr Riley: The definition of "authorised officer" needs to be a little flexible. Different circumstances might require different skills, skill mixes, capabilities and, obviously, organisations. There might be not one specific authorised officer but a range of them.

The Convener: Can you show me the section where "authorised officer" first comes into play?

Dr Simpson: It is section 68(8), page 46, line 35.

The Convener: That is not precise enough for me, I am afraid—I am only joking. It says:

"'authorised officer' means an officer of the local authority authorised by it for the purposes of this section".

I take it that you are saying that the local authority in any particular circumstance will define the professional discipline from which that person should come.

Dr Riley: That is my reading of it.

Dr McCallum: That is also my reading of it.

The Convener: As no one else wants to comment on that part, I move on to part 6, which is on mortuaries.

Mary Scanlon: Section 82(1) says:

"Each local authority must provide or ensure the provision"

of a mortuary. Section 83(1) says:

"Each health board must provide or ensure the provision"

of mortuaries. Will that lead to greater co-operation, to greater duplication, or to organisations passing the buck—or is it perfect in every way?

The Convener: Or something other than all the above.

Dr Riley: One section refers to the local authority and emergency provision, temporary storage and so on. Mortuaries to be provided by health boards are for persons who have died in hospital or whose bodies are brought to hospital. The services are therefore complementary rather than competitive, or examples of passing the buck.

Mary Scanlon: Is it necessary to have the two sections so that both local authorities and health boards must provide or ensure provision of mortuaries?

Dr Riley: The operative phrase is "ensure the provision". A major incident resulting in many bodies might require temporary facilities, but a hospital needs to be able to provide accommodation for anyone who dies in hospital or whose body is brought into hospital.

Dr Donaghy: I think that the provisions will help to stop what is often the current situation, which is people passing the buck. Previous legislation was quite woolly and the proposed approach of defining responsibilities and ensuring co-operation where it is needed will help. I think that the proposed provisions will help to stop the passing of the buck that has often occurred during the past few decades.

Fraser Thomson: What we will probably see in future as a consequence of the bill is service level agreements between health boards, local authorities and, perhaps, the fiscal service. That might be no bad thing.

The Convener: Does anyone else want to comment on part 6?

Ross Finnie: Just before I lose all these highly competent people, can they tell me why, if health boards and local authorities are required to designate a sufficient number of persons for the purpose of controlling public health and exercising the functions of the bill, there is a need for a separate authorised person to deal with part 4?

The Convener: Which section are you at?

Ross Finnie: I have gone back to the point that we were discussing earlier about sections 69 to 74 and how they talk about the use of an authorised person. Our attention was directed to the definition in section 68(8) of an "authorised officer". We talked about a "competent person", which is mentioned way back in sections 3 and 5, but the requirement is to appoint "competent persons" for the purpose of discharging all the functions of the bill, which includes part 4. It is not clear, so I would be grateful if a practitioner would assist me with why we need two separate types of person.

The Convener: Dr Riley and Mr Jones are willing to answer.

Dr Riley: I will certainly have a go at that. The "competent persons" issue relates to those functions that are detailed in section 3. The health boards are required to provide a 24/7 service, so they will need more than one "competent person" to maintain such a rota. I think that that is why the reference is to "persons" in that instance.

The reference to "authorised" persons later in the bill relates to the carrying out of specific functions—for example, specialist contractors or investigators may be needed. That is a totally different function from the "competent person" one. There are two different functions; the terminology may not be separate enough, but the functions are certainly separate.

Ken Jones: I agree with Dr Riley. It may be that the "competent person" in a local authority must have a specific qualification, but an "authorised officer" may be authorised only to undertake the requirements of the bill. That is similar to the authorisations made under the Smoking, Health and Social Care (Scotland) Act 2005; it may be the intention of the bill to do the same.

The Convener: I think that I will have to read the *Official Report* for clarification.

Ross Finnie: Section 5(3) refers to

"the functions conferred on a local authority … by virtue of this Act".

There are to be "competent persons" to discharge the functions conferred, according to section 5(2), on a "local authority competent person".

Ken Jones: The local authority may be required to appoint not only an environmental health officer but a consultant in public health medicine to act for it in emergency situations.

Ross Finnie: That would be a function of the bill.

Ken Jones: Yes.

Ross Finnie: But that would be a "competent person".

Ken Jones: That is what I am saying. That is what a "competent person" would be—I agree with you.

The Convener: I am feeling—

Ross Finnie: Sorry, I will not pursue it. I have had the opinion.

The Convener: Just bear with me a second. I will take Mr Howe, then Richard Simpson. Frankly, I am beginning to get my "competent" and my "authorised" knitted together in a woolly fashion. I am completely lost now.

Ross Finnie: Knit one, purl one.

The Convener: Exactly.

Robert Howe: I hope that this will clarify matters. The "competent persons" are the people appointed by health boards and local authorities, whereas the "authorised" persons are those who, as in section 5, could be external contractors who are authorised by local authorities to carry out the appropriate work.

The Convener: Would they be authorised by the "competent persons", though? Could they be?

Robert Howe: Yes.

The Convener: I am beginning to get there.

Dr Simpson: I think that that is now clarified. A "competent person" may also be an "authorised officer".

The Convener: Oh, please!

Dr Simpson: But an "authorised officer" need not necessarily be a "competent person", except in respect of what they undertake.

The Convener: I can see some kind of parlour game arising here. We shall read the *Official Report* for further clarification, if required.

Dr Simpson: The serious point is that there should be clearer definitions in the back of the bill. The lack of clarity is unacceptable.

The Convener: And it is becoming less clear, although I am grateful to Mr Howe—I followed that bit and I am hanging on to it grimly. Is there anything else?

Mary Scanlon: I have a point for clarification from sections 87 and 88. I wonder whether the proposal to apply to a sheriff for an order to remove bodies to mortuaries arises from a current issue. Why is it necessary to bring in a sheriff? Cannot such arrangements be agreed currently between local authorities and health boards? Is the proposal a new one that is deemed to be necessary?

The Convener: Does the provision just reflect current practice or legislation? Can anyone help us on that?

Dr Riley: It reflects current practice because we sometimes have to apply to a sheriff. I am afraid that I cannot answer the specific question about whether the provision is new. I cannot think of a precedent.

Dr Donaghy: I, too, cannot answer that in detail.

Dr Simpson: I wonder whether we could ask for comments from those of the Muslim faith on sections 87 and 88, regarding how the provision might affect them because of their requirements for rapid burial.

12:15

The Convener: Absolutely. We will discuss that later when we discuss witnesses.

Ross Finnie: I am sorry, but I am having difficulty with getting "officer" or "local authority" to be the same as a third-party contractor.

The Convener: Can we please move on to part 7? Does anybody have any comments or questions on this short part, which is on international health regulations?

Mary Scanlon: When we took evidence from Kenneth Macintosh and others, we heard that some local authorities currently regulate, monitor or audit sunbed parlours.

The Convener: We are not considering that part of the bill.

Mary Scanlon: Sorry. Am I at the wrong part?

The Convener: We are considering part 7, although I am happy to move on to sunbeds—I do not mean physically. I should rephrase that.

Helen Eadie: That is Tommy Sheridan, convener.

The Convener: We will move on to part 8. Mary Scanlon wants to ask about sunbeds.

Mary Scanlon: Does anyone around the table who represents a local authority think that the current monitoring or inspection of sunbed parlours is sufficient? Is part 8 necessary? We have heard that different local authorities take different approaches.

Robert Howe: Some authorities have created their own byelaws to deal with sunbeds, but I cannot go into detail on that. I think that the proposals would be welcome, because the bill would create a level playing field throughout the country. They would ensure that consistent standards are applied throughout the country, as opposed to some authorities applying standards and others not doing so.

Mary Scanlon: Would you prefer a licensing regime, or could compliance be based on the complaints that are received?

Robert Howe: I would prefer a licensing regime.

Fraser Thomson: So would I. My authority recently produced a report on sunbed parlours—

The Convener: What is your authority?

Fraser Thomson: Fife Council. We looked at around 80 premises. People were quite shocked that about 53 per cent of staff in those premises had received no training whatsoever. Some 37 per cent of the premises had no evidence that their equipment had been maintained and only 23 per cent had had risk assessments. There is real feeling about the matter. Our elected members would wish to pursue a byelaw if a licensing regime is not introduced in due course.

Ron Culley: I would be happy to explore with COSLA's elected members whether licensing is preferable. We can do that through COSLA's health and well-being executive group, which will meet shortly. That would allow COSLA to articulate a definitive political position on licensing.

Tom Bell: The Royal Environmental Health Institute of Scotland supports regulation. We support a licensing scheme and are keen to ensure that, in light of the existing licensing under the Civic Government (Scotland) Act 1982, local authorities are not weakened by national legislation.

The Convener: Did you mention existing licensing?

Tom Bell: I think that Fraser Thomson and Robert Howe said that there is licensing by certain local authorities under the Civic Government (Scotland) Act 1982. The Royal Environmental Health Institute of Scotland is keen to ensure that that arrangement is not weakened and that any new legislation enhances existing provisions.

The Convener: Right. So the provisions would undermine or supplant provisions relating to local authorities that carry out the equivalent of licensing through their byelaws.

Tom Bell: Exactly.

The Convener: That is interesting.

We will now move on to part 9, on statutory nuisances. No more jokes about politicians, please. I invite comments.

Fraser Thomson: The imposition of the fixed penalty notice might cause local authorities a problem.

The Convener: Which section is that in?

Fraser Thomson: Section 95. It might cause local authorities some difficulties. It also has some benefits. Local authorities are well used to applying fixed penalties in situations where there is an immediate effect, such as people dropping litter or a speeding fine in cases where no one is injured.

In cases of public health, however, the situation could be slightly different. Sometimes, the consequences at the start of the situation are no longer evident later on. A local authority may serve a fixed penalty notice on an owner or business. If they pay the penalty, they are relieved of further legal action. A public health situation could expand and might damage the local community, which could then expect some sort of justice to take place through the courts. Unfortunately, that would not be available to the local authority if—with the best of intentions—it had previously served a fixed penalty notice. That is an area of concern among some local authorities.

The Convener: Is that the position for any fixed penalty notice in respect of any offence? Does it wipe the slate clean as far as the offence in question is concerned? Would there need to be some further basis for a charge to be brought? It is no different from any other usage of a fixed penalty notice.

Fraser Thomson: The difference is that in most cases that we have been dealing with we have been pretty certain that there are no further consequences. If someone drops litter or is caught speeding but has not injured anyone, it means a slap on the hand and that is an end to it. In the sort of case that we are discussing, the consequences could grow. We will not necessarily know all the circumstances. The concern is that we will apply something that is intended to address a relatively minor situation but things may grow. That is the difference.

Rhoda Grant: I would like to hear some comments on section 92, on "Artificial light nuisance". The definition of artificial light that causes a nuisance appears to be very broad. It is about terminology: your nuisance may be my health and safety lamp. Will a lot of extra work be created by people complaining about light pollution? The organisation concerned might use the defence that the light is needed for health and safety or security reasons.

Robert Howe: I do not envisage that creating a tremendous increase in work activity. With all nuisance legislation, local authorities must act responsibly and evaluate whether something is an actual nuisance. Each individual circumstance must be viewed on its merits. A nuisance is not something that can simply be identified as such 100 per cent of the time and in 100 per cent of circumstances; some professional judgment is required.

We must remember that legislation is being applied. A case could be taken to a court of law later if that legislation is not complied with. Authorities must be certain that what they are serving notice on is reasonable. They must not do it lightly. The nuisance provisions in existing legislation—artificial light nuisance now having been identified as another type of nuisance—will still apply. It is a matter of local authorities acting responsibly. I do not have any difficulties with that at present.

Ken Jones: I agree with that. I do not think that there will be many cases where we have to serve notice, although there are people who suffer sleep deprivation because neighbours are careless and leave lights shining into bedrooms all night. There will not be many cases, but the bill would bring our legislation into line with that which applies in England. That could be useful.

Ross Finnie: In section 96, which gives local authorities powers over sewerage nuisance, does the definition of "sewerage nuisance" include not only spillages from sewage-works but odour?

Ken Jones: No, it does not include odour. There is a code of practice that deals with odour from sewage-works, with which local authorities are required to comply.

Ross Finnie: But the fact that section 96(2)(b) says,

"in respect of which a sewerage code applies"

means that it does apply to odour.

Ken Jones: There is a different code that deals with odour.

Ross Finnie: A different code?

Ken Jones: Yes. Odour from a sewage-works is dealt with separately under a code of practice specifically on odour.

Ross Finnie: Does that confer powers on local authorities to act?

Ken Jones: Local authorities must act in conjunction with Scottish Water—discussions must take place with Scottish Water before any authority can act.

The Convener: Section 96(2)(b) refers to "a sewerage code". Should sewerage nuisance be defined in some other way?

Ken Jones: No, I do not think so; I think the present definition is sufficient.

The Convener: As there are no supplementaries, we will move on to part 10. Do members have any questions? Do witnesses have any comments?

As regards the disclosure of information on an individual, my understanding is that the Data Protection Act 1998 will apply. Would it be presumptuous to say that, under freedom of information, all such information will be obtainable in due course?

Dr Donaghy: On your first point, we must adhere to the data protection provisions, although there are certain occasions on which they are superseded by the need to divulge information for public health reasons. That comes back to the balance between the rights of individuals and the rights of the community.

The Convener: Is naming a person in order to establish contacts an example of that? Can you give me a concrete example?

Dr Donaghy: If we can justify the sharing of information for action within a health team, we can share that information beyond the health team.

On freedom of information, a balance must always be struck. We cannot give the names and addresses of individuals, but we can provide collated information. It becomes more difficult to strike that balance when small clusters of individuals in small areas are involved. The issue has been tested recently, not by our organisation, but by an organisation called the Information Services Division in a court case on the divulgement of information on clusters of leukaemia patients in the Dumfries and Galloway area. That case has gone through the Court of Session and I believe that an appeal has been made to the House of Lords to clarify the position.

The Convener: To determine the extent to which individuals can be identified.

Dr Riley: Occasionally, we have to use identifiable information. The anthrax case is an example of a case in which we were not able to identify people who had had contact with the house in question without public divulgement of information.

The GMC's "Good Medical Practice" code discusses the circumstances in which it is appropriate to breach confidentiality, which include situations in which the safety of the public or individuals needs to be protected.

Dr McCallum: Oversight of the systems in place for the sharing of confidential clinical information and the circumstances in which that can be done rests with NHS boards' Caldicott guardians, who are either the director of public health or the medical director. Decisions on the divulgement of someone's NHS unique identifier or any application to share it are a directly delegated responsibility of the director of public health and are covered by national oversight mechanisms. The governance of that area may not be known to people outside the NHS as well as it should be, but there is a clear structure in place, which is regularly challenged and tested.

The Convener: That is helpful. Section 98 refers to

"any relevant authority".

What is the local authorities' position on the sharing of information and data with other local authorities to protect individuals?

12:30

Dr McCallum: The members of any incident team or problem assessment group clearly function as a clinical team. Information may be confidential to that group or team but would be expected to be shared as appropriate.

There are similar arrangements for other issues that would impact on that under our data-sharing partnerships, which are partnerships between the local authority, the health board, the police and, in certain circumstances, the voluntary sector. There are clear Government guidelines on the circumstances in which sharing of information

takes place, how it is held and how its security is maintained. In Scotland, we have received plaudits for the quality of the governance on that and the diligence of the people who are involved in ensuring that it takes place.

Dr Riley: Data-sharing protocols and agreements are in place. I remind the committee that data sharing for case investigation already takes place routinely between the health service and local authority environmental health departments. There are well-established processes for it and the principles are observed on both sides.

The Convener: Thank you. That is helpful, as we are in the sensitive area of the balance between the rights of individuals and the rights of the community at large.

I think that that concludes the questioning.

Dr Saunders: I am afraid that you were far too quick for me on part 4. Would it be possible to raise two or three questions?

The Convener: Yes. I call my colleagues to attention.

Dr Saunders: I have comments on sections 33 to 35, which concern medical examinations. It is worth noting that "medical examination" does not need to mean examination by a doctor. The BMA believes that there should be a mechanism to appeal any enforced medical examination under part 4 before the person is compulsorily examined. As the bill stands, there is not. The person who is to be compulsorily examined—or their parents, if it is a child—should have every opportunity to present to a sheriff reasons why the examination should not happen.

We also believe that exactly what investigations and procedures can and cannot be done compulsorily should be set out in regulations. The bill gives the person who is undertaking the examination enormous leeway.

I would like to bring up one other item on the enforcement of orders. Would you like me to do that now? Shall I do it all together?

The Convener: Yes. If anyone wants to comment, they can do so. Simply having the points on the record might be sufficient. What section are you referring to?

Dr Saunders: Sections 40 and 42. The bill would allow a large number of individuals, including officers of a health board or local authority, to enforce orders. To give a perhaps slightly absurd example, the health board's director of finance could forcibly arrest and detain an individual and escort them to a hospital for treatment. We are firmly of the belief that if there is to be any enforcement of restrictions on individuals—for example bringing them back to detention or putting them there in the first place—

The Convener: If that is section 40(4), we have already considered the issue. Ross Finnie and others have raised the point that the section is a bit clumsy and we are not clear whether the sheriff should designate the appropriate person in those circumstances. As currently drafted, that is not the case.

Are you referring to section 40(4):

"A person may be removed to a place in which the person is to be quarantined by …

(c) an officer of a local authority"?

Dr Saunders: Yes, or

"(b) an officer of the health board".

The Convener: We are aware of that, but I am glad that you have drawn attention to it. We are aware that there is some confusion about whether the sheriff would say, "I consider it should be A, B, C, D or E." The way it is written, the persons listed are mandatory and the sheriff can authorise anyone else if he does not feel that they are appropriate. We are aware of the concerns about the wording.

Dr Saunders: We would not remove people by force. We would expect the police to do that.

The Convener: Thank you. We appreciate the difficulties with that.

Fraser Thomson: I will refer briefly to the joint health protection plans under section 7, which places a duty on each health board to prepare such plans in consultation with the relevant local authority. At present, for joint health improvement plans, health boards go well beyond simply consulting local authorities; it is very much a joint approach. Could that be reflected, rather than just a provision that boards will consult us, which means that they could listen to us and then choose to go in a different direction if they felt it appropriate?

The Convener: That is a fair comment.

Dr Riley: I certainly support that. The health protection plan should be a joint plan.

I will make a comment about medical examinations.

The Convener: Which section is that?

Dr Riley: Sections 33 and 34. The issue is that "medical examination" is defined in the International Health Regulations (2005) as

"the preliminary assessment of a person by an authorized health worker",

who may be a medic, a suitably trained nurse or other health worker. A range of health

professionals are able to do a medical examination and there is an issue about whether a medical examination under the bill must be done by a doctor. There are plenty of precedents for non-medics such as nurses doing medical procedures such as endoscopies. They are well-established procedures, so they do not necessarily have to be done by medics.

The Convener: If there are no other sweeping-up issues, I will close the meeting. It is like being an auctioneer—going, going, gone. As soon as I say that I am winding up, somebody has a question.

I thank all the witnesses for giving their evidence, which is extremely useful to us. That brings us to the end of the meeting.

Meeting closed at 12:37.

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