PUBLIC HEALTH ETC. (SCOTLAND) BILL

POLICY MEMORANDUM

INTRODUCTION

1. This document relates to the Public Health etc. (Scotland) Bill introduced in the Scottish Parliament on 25 October 2007. It has been prepared by the Scottish Government to satisfy Rule 9.3.3(c) of the Parliament's Standing Orders. The contents are entirely the responsibility of the Scottish Government and have not been endorsed by the Parliament. Explanatory Notes and other accompanying documents are published separately as SP Bill 3–EN.

BACKGROUND AND BILL OVERVIEW

2. We live in a world which is increasingly accessible, largely due to the ease with which we can now travel overseas. Although this brings significant advantages, it also requires us to reconsider how best to protect people living in Scotland from the global spread of disease and contamination, the consequences of which can be significant. This requirement has been brought into sharp focus in recent years: for example in planning for a pandemic flu outbreak; through the rise in bio-terrorist incidents; and through the spread of Severe Acute Respiratory Syndrome (SARS) from the Far East to Canada, which resulted in 774 deaths in 26 countries. Scotland itself was the location of an anthrax incident in 2006, which required the decontamination of premises.

3. Internationally, our collective degree of exposure to disease and contamination, and the lessons learned from the serious consequences of SARS have led countries to recognise the need for co-operation in reporting on and preventing or limiting the spread of disease and contamination. The International Health Regulations (IHR 2005), agreed by the World Health Organisation (WHO) and brought into effect on 15 June 2007, put in place a framework to allow this co-operation to take place. The regulations aim to prevent the international spread of disease whilst also seeking to limit the disruption of international traffic and trade, and require countries to report all events that could result in public health emergencies of international concern. They are a considerable and welcome step forward in the drive to protect public health.

4. Existing Scottish public health legislation dates back to the late 19th century, when the main threats to public health were different. This legislation is no longer sufficient to ensure the best possible level of health protection in Scotland. To be able to respond quickly, decisively and comprehensively to existing and emerging public health threats, Scotland needs modern laws that clearly set out the powers and responsibilities of individuals, public health professionals and organisations.

5. The Bill will redefine and clarify the relationships between Ministers, health boards and local authorities in protecting public health. It will strengthen the role of health boards and reflect institutional changes, such as the establishment of the NHS (which post-dates the current legislative framework). It will amend current arrangements for statutory notification of diseases and introduce statutory notification of organisms and health risk states, which will aid the early detection of disease and its subsequent public health risk. In addition, the Bill will update and improve for Scotland the statutory nuisance regime in the Environmental Protection Act 1990. It also contains provisions to ensure that those who use sunbeds are advised of the associated risks.

6. The Bill seeks to maintain and respect an appropriate balance between the goal of protecting public health in Scotland from known and unknown threats, and the liberty and rights of individuals. Protecting public health adequately requires flexible powers capable of dealing with the very wide range of circumstances that may arise. Communicable diseases constantly change and adapt. Some public health incidents can be of serious and immediate concern to an individual and their close family, for example, but may not be a threat to the general public. Equally, we need to ensure that powers are sufficient to protect the population in circumstances where disease or contamination have much wider implications. Whilst Civil Contingency legislation is currently in place, the emergency powers therein are wide-ranging and powerful, and should not be used except under extreme circumstances. The Public Health etc. (Scotland) Bill will allow us to fill the existing gap.

7. The Bill sets out a range of powers, including powers to quarantine an individual, to detain an individual in a hospital and to require a medical examination, from which the most appropriate can be chosen to deal with a particular situation. Some of the powers in the Bill are new, others already exist. It should be emphasised, however, that the stronger powers of quarantine, detention and medical examination will only be used where individuals do not accept constraints voluntarily and who, by their actions, put the wider population at significant risk. Many other countries, including Finland, Ireland, Norway, Australia, Canada, Singapore and the USA have similar systems in place to protect public health.

8. This memorandum sets out the details of the consultation process, alternative approaches considered for updating the legislation, and the policy objectives for each policy area of the Bill: protection of public health in Scotland (including information on the health effects of sunbeds), and amendments to Part III of the Environmental Protection Act 1990 and amendments to the Water Services etc. (Scotland) Act 2005. The effects of the Bill on equal opportunities, human rights, island communities, local government, sustainable development etc. are summarised at the end of the document.

CONSULTATION

9. The Scottish Executive Health Department undertook a comprehensive programme of consultation on proposals to consolidate and completely update public health legislation in Scotland, which had been drawn up by a Public Health Legislation Review Group co-chaired by Deputy Chief Medical Officers and the then head of the Scottish Executive's Public Health Division. The Group included representatives from the public health field, the wider NHS, local authorities, the environmental health profession and the Scottish Consumer Council, and reviewed public health legislation in Scotland. The Group set out its proposals for change in a document that was issued for consultation between 27 October 2006 and 12 January 2007.

10. The consultation document sought the views of public, private and voluntary organisations as well as the general public on a variety of topics. It described proposals to set out more clearly the roles and responsibilities for public health protection, largely between local authorities and health boards. It proposed a new system of statutory notification and reporting, to ensure that diseases and conditions that pose a significant risk to public health are treated efficiently and urgently. Other proposals included strengthening powers to obtain information, and allowing for quarantine or exclusion of people in cases of significant public health risk, whilst at the same time confirming that safeguards are in place to ensure powers are not abused. The consultation document discussed enhancing the statutory nuisance regime of the Environmental Protection Act and also asked who should be responsible for mortuary provision in Scotland. The consultation did not cover the provision of information on sunbeds for sunbed users.

11. Approximately 400 copies of the consultation document were distributed to a wide range of stakeholders, including local authorities, professional bodies, equality groups, individuals, voluntary organisations and health boards throughout Scotland. Electronic copies were also distributed. The consultation process ended on 12 January 2007, and although several responses were received after that date, all were fully considered. A total of 98 responses were received. One-quarter of the responses were from local authorities, which comprised the biggest group of respondents. The next largest group of respondents was NHS bodies (largely health boards). Other respondents were from voluntary organisations (e.g. Waverley Care, and Cancer Research UK); representative bodies (e.g. the British Medical Association, and the Law Society of Scotland); environmental groups (e.g. the Scottish Environment Protection Agency); Parliamentarians; academics; statutory bodies (e.g. the Disability Rights Commission, and Health Protection Scotland); professional organisations (e.g. the Royal Pharmaceutical Society of Great Britain; and individuals.

12. In addition, a series of 5 public seminars was held to discuss the consultation proposals with members of the public and with public health professionals, one each in Aberdeen, Dundee, Edinburgh, Glasgow and Inverness. Adverts were placed in local papers to generate interest in attending these seminars, which aimed to complement the written consultation by facilitating discussion on key areas for action that had been identified in the consultation paper. The seminars comprised a number of short presentations on the background to the public health review and the key proposals, followed by an open session of questions and answers to allow attendees to raise concerns and feed in their views. 180 people took part in the seminars.

13. The Executive published the report on the analysis of responses to the consultation on Friday 30 March 2007. A link to the web address was sent to the 98 individuals and organisations that responded to the consultation. The report set out in detail the views of the various consultees on the Executive's proposals. The report can be accessed at http://www.scotland.gov.uk/Publications/2007/03/30093343/0.

14. Consultation responses acknowledged the need for updated public health legislation and were broadly supportive of the measures outlined in the consultation document. Analysis of the responses to the consultation highlighted the need for further work with stakeholders to clarify and refine what was being proposed. The further work is reflected in the Bill, as introduced. It was taken forward with individuals, relevant organisations and through a Public Health Legislation Reference Group, which comprised professionals working in the public and

environmental health fields, the British Medical Association, the Health and Safety Executive, the Food Standards Agency, the Crown Office and Procurator Fiscal Service (COPFS), the Association of Chief Police Officers in Scotland and the Convention of Scottish Local Authorities (CoSLA). In particular, the work concerned the extent of the transfer of powers from local authorities to health boards and the proposed role of local authority and health board 'competent persons'. In addition, specific proposals in respect of the statutory responsibility for mortuary provision and a new system of environmental health concern management were amended as a direct result of stakeholder engagement.

ALTERNATIVE APPROACHES

Protection of public health

Continuing with existing legislation

15. It would have been possible to continue with existing legislation, but this was not considered a viable option. Lack of clarity about roles and responsibilities would remain, and the role of the NHS in protecting public health would not have been adequately taken into account. Nor would Scotland have the powers needed to be able to respond quickly and effectively to public health threats.

Amending existing legislation

16. Because of the age of the existing legislation and the number of statutes involved, amending existing legislation was not considered to be a viable alternative approach. Old law is not particularly easy to read and understand, and there can be confusion about what it means. In addition, legal public health functions are the responsibility of local authorities, pre-dating the establishment of the NHS, and takes no account of the role of the NHS in protecting public health.

17. For example, ways in which existing legislation could be updated and amended include:

(a) Local authorities retaining responsibility for actions requiring Designated Medical Officer (DMO) support from health boards. This alignment of responsibilities would not reflect the current role of the NHS in preventing communicable diseases, preventing the spread of communicable diseases, providing care and treatment for those with communicable diseases, and providing a response to such incidents. Updating existing legislation along these lines would lead to a continued blurring of roles and responsibilities between health boards and local authorities, which has led to problems in the past. Clear lines of responsibility and accountability at local level will lead to more efficient and effective handling of public health incidents. This approach works elsewhere, such as in mental health legislation, where the NHS is solely responsible for its actions, including those that deprive individuals of their liberty, and the legal consequences of such actions.

(b) Limiting statutory powers of intervention to a defined number of notifiable diseases. Again, this approach would not take fully into account the ever-evolving nature of communicable diseases. The evolving nature of disease has been recognised by IHR 2005, where the approach has moved from one dealing with a number of named diseases

to a broad, risk-based approach. It is important that any statutory system has the scope to deal with new and emerging public health threats.

(c) Assigning responsibility for mortuary provision to one statutory organisation. This was set out in the original consultation proposals. However, further work with stakeholders indicated that if the legislation were to be updated and consolidated in line with this approach, and the statutory duty to provide mortuaries and post-mortem facilities imposed on local authorities or health boards, although it would simplify arrangements, it would not necessarily have resulted in a service that works well at a local level, taking local complexities into account. The provisions included in the Bill were proposed by stakeholders and provide a statutory underpinning to arrangements that have evolved since the 1897 Act, reflecting the involvement of both local authorities and the NHS in dealing with dead bodies.

Provision of information on the effects on health of sunbed use

18. Alternative approaches to legislating on the provision of information to users of sunbeds were considered, including asking operators to voluntarily provide information. However, there was a strong view that a voluntary approach would not meet the policy objective and that the approach taken in the Bill, requiring persons to provide information, would be the most effective.

Statutory nuisances

19. An alternative approach of environmental health concern management, enshrined in public health legislation, was considered as part of the consultation proposals to plug the gaps in the law to deal with threats to public health from the environment. This would effectively provide a backstop in protecting the public from any health-damaging aspect of the environment, where other remedies are inappropriate. However, further work with stakeholders revealed that the gaps in current legislation could more effectively be addressed through a number of amendments to Part III of the Environmental Protection Act 1990. These amendments are incorporated within Part 9 of the Bill.

POLICY OBJECTIVES – BACKGROUND

Protection of public health

20. Scotland's current public health legislation dates back to the late 19th century. In recent years a number of events have highlighted gaps and uncertainties in the law. These include a number of outbreaks of *E. coli* O157; the 2003 epidemic of SARS; the 2006 anthrax case in the Borders; and the re-emergence of infections such as tuberculosis, which may be multi drug resistant.

21. To be able to respond quickly, decisively and comprehensively to existing and emerging public health threats, Scotland needs modern laws that clearly set out the powers and responsibilities of individuals, public health professionals and organisations.

22. Regarding protecting public health, the Bill will:

(a) extend the scope of the current legislation beyond infectious diseases, to include action to protect against contamination (biological, chemical or radiological);

(b) clarify the roles and responsibilities of the Scottish Ministers, health boards and local authorities for public health protection purposes;

(c) define the functions of "competent persons" acting on behalf of the health board or the local authority. This will improve the scope to appoint the right person with the right skills to these roles and ensure that persons with the right training and competencies will carry out these actions;

(d) set out notification arrangements for infectious diseases, organisms and health risk states, while allowing the Scottish Ministers the power to vary, by regulation, the notification arrangements and conditions to be notified. This will ensure maximum flexibility in future;

(e) introduce statutory powers for public health investigations;

(f) update and strengthen existing powers of health boards to extend the exclusion of persons from school and work, where there is a risk to public health, to a wider range of settings, and to restrict activities;

(g) introduce new powers to quarantine persons in defined circumstances and where there is significant risk to public health, on order from a sheriff;

(h) update existing power to remove and detain in hospital a person suffering from a serious infectious disease or who is contaminated, where there is a significant risk to public health, on order from a sheriff;

(i) update existing power to require a person to have the least intrusive or invasive medical examination possible to achieve the public health outcome, without consent, in defined circumstances, and where there is significant risk to public health, on order from a sheriff;

(j) introduce a new power to require a person to be disinfected, disinfested or decontaminated, in defined circumstances and where there is significant risk to public health, on order from a sheriff;

(k) update local authority public health protection powers with regard to premises and property;

(l) clarify and provide statutory underpinning for the responsibility for the provision of mortuaries, by placing a statutory duty on health boards to ensure mortuary provision for hospital-related deaths and a statutory duty on local authorities to ensure mortuary provision for other deaths;

(m) introduce a general regulation-making power to give effect to international obligations and recommendations; and

(n) introduce a new power to require operators of sunbed premises to provide information to the users of those premises about the effects on health of the use of sunbeds.

23. The policy intention is that the powers described in (g) to (j) above will only be exercised in circumstances where a person does not accept constraints voluntarily and where they pose a significant risk to public health. In terms of the powers available at (f) above to exclude persons

from wider settings and to restrict activities, a duty is placed on health boards to impose the least restrictive order necessary to protect public health.

Amendments to Part III of the Environmental Protection Act 1990 and to the Water Services etc. (Scotland) Act 2005

24. Part III of the Environmental Protection Act 1990 ("the 1990 Act") contains provision in relation to statutory nuisances. Section 79 of the 1990 Act specifies what constitutes a statutory nuisance, and imposes an obligation on local authorities to inspect their areas to detect statutory nuisances and to investigate complaints of statutory nuisance. Where satisfied that a statutory nuisance exists, section 80 of the 1990 Act provides that the local authority shall serve an abatement notice requiring the nuisance to be abated, specifying what needs to be done to abate, and the time in which the requirements of the abatement notice must be complied with. Non-compliance with the requirements of an abatement notice is an offence (section 80(4) of the 1990 Act), and a local authority has powers to abate any statutory nuisance itself and recover its costs in situations where a person upon whom an abatement notice has been served fails to comply with it (section 81(3) and (4) of the 1990 Act).

25. The statutory nuisance regime in Part III of the 1990 Act was amended as regards England and Wales by the Clean Neighbourhoods and Environment Act 2005 ("the CNE Act"). The Act updated the statutory nuisance regime in the 1990 Act as regards England and Wales by adding insects and artificial light to the list of statutory nuisances specified in section 79(1) of the 1990 Act. In addition to specifying these additional statutory nuisances, the CNE Act amendments also made provision to exclude certain matters from the light and insect nuisance provisions. These amendments created a legislative gap as regards Scotland, particularly in view of increased numbers of complaints in these areas in recent years. The provisions in this Bill seek to close this gap and provide equivalent powers for local authorities in Scotland to abate such nuisances as and when they arise. There is also a need to update the 1990 Act as regards Scotland in relation to nuisance associated with water, similar to the powers currently available to local authorities in England and Wales.

26. The relevant provisions in the Bill will:

- constitute insects, artificial light, and nuisance associated with water as statutory nuisances for the purposes of Part III of the 1990 Act, similar to legislation in England and Wales;
- introduce a regulation-making power to amend the statutory nuisance regime in Part III of the 1990 Act in the future;
- introduce a new fixed penalty regime for non-compliance with an abatement notice served under section 80(1) of the 1990 Act; and
- amend the Water Services etc. (Scotland) Act 2005 in relation to enforcement of the sewerage code.

POLICY OBJECTIVES – DETAIL

Part 1 – Public health responsibilities

27. The Public Health (Scotland) Act 1897 gives local authorities powers and duties to protect public health. Existing provisions in the National Health Service (Scotland) Act 1978 require Scottish Ministers and health boards to provide a health service and to promote health improvement.

28. This Part of the Bill imposes on Scottish Ministers, health boards and local authorities the duty to continue to make provision for the purpose of protecting public health in Scotland. In this context, protecting public health is defined as *the protection of the community (or any part of the community) from infectious diseases, contamination or other hazards which constitute a danger to public health. This includes the prevention of, the control of, and the provision of a public health response to such diseases, contamination or other hazard.* The duties are without prejudice to existing provisions in the National Health Service (Scotland) Act 1978. In addition, Scottish Ministers will have the power to direct health boards and local authorities in the exercise of their public health functions, including the power to intervene and to direct resources, as necessary.

29. The Bill will clarify roles and responsibilities for protecting public health, and duties will be assigned to health boards and local authorities on a corporate basis. Duties connected to "people" are assigned on a corporate basis to health boards, and those connected with "premises" and "property" are assigned to local authorities. Clearly assigning primary responsibility for these duties among health boards and local authorities will aid transparency and accountability, whilst facilitating joint working and maintaining the flexibility required to respond decisively to new developments and challenges.

30. The Bill will define the actions for which professional input is required, e.g. when powers may be used to restrict personal liberty or impose obligations on individuals in relation to their premises, and places a duty on health boards and local authorities to ensure a person with appropriate professional competence carries these out. Appointment of "competent persons" by health boards and by local authorities will future proof the legislation and maintain the strength of the public health protection workforce by ensuring a legal framework that can tolerate unknown but possible changes to health professionals' training systems. These persons would be suitably qualified to carry out the functions/responsibilities assigned to them by a health board or local authority under this legislation and future enactments. The qualifications, training and competencies required of the "competent person" will be set out in regulations.

31. In addition, the Bill will place an explicit duty of co-operation between health boards and local authorities in undertaking public health protection functions and for them to jointly plan for health protection purposes. This does not mean that co-operation does not already exist between health boards and local authorities in the exercise of all public health functions. Inclusion of this duty on the face of the Bill emphasises the need for these organisations to continue to work closely together in protecting public health, and provides a framework for health boards and local authorities to work together more effectively.

Part 2 – Notifiable diseases, notifiable organisms and health risk states

32. This Part of the Bill updates the current statutory arrangements for the notification of infectious diseases, where the legal requirement to notify certain infections stems from the Infectious Disease (Notification) Act 1889, and the voluntary reporting of organisms by NHS-linked laboratories. A list of notifiable diseases has existed since 1889. It is currently possible to add diseases to the list but not to remove them, and the list now consists of 33 clinical conditions, most of which occur infrequently (if at all). A fee may be paid to general practitioners for each notification. In existence in Scotland since 1974, there is an additional list of reportable infections which have been confirmed in a laboratory. This is not a legislative requirement, but provides a basis for monitoring infections. Indeed, current practice in many NHS-affiliated laboratories is to orally report an organism as soon as practicable following confirmation, and this is followed by a weekly summary of confirmed organisms. However, this is not the case for diagnostic laboratories who examine samples for private businesses.

33. Immediately after the close of the public consultation, a short-term expert working group was set up to advise on new notification arrangements. The group comprised Directors of Public Health, a consultant microbiologist, a medical ethicist, and colleagues from the Royal Environmental Health Institute of Scotland (REHIS) and Health Protection Scotland (HPS). On the basis of their advice, which was informed by responses to the public consultation, the decision was taken to legislate as follows:

- statutory notification of certain infectious diseases, health risk states (e.g. a person who has travelled on the same bus as someone with a highly pathogenic infection, or who has come into direct contact with a poison) and organisms which require urgent public health action.
- contamination by chemicals and radiation to be included, to meet the IHR 2005-widened definition of disease.
- to discontinue the fee payable to general practitioners for notification.

34. The Bill places a duty on all registered medical practitioners to notify confirmed or suspected diseases and health risk states in writing to their local health board within 3 days of forming their suspicion and requires for oral notification to take place sooner, as appropriate. The Bill places a duty on clinical directors of all diagnostic laboratories to notify confirmed organisms to their local health board within 10 days of confirmation. Again, oral notification may be required sooner than 10 days. Health boards will have the duty to onwards report to Health Protection Scotland (which is legally part of the Common Services Agency) within the week of original notification (or as soon as practicable afterwards). Arrangements will be put in place for those cases when someone falls ill when outwith the area of their normal health board area.

35. The Scottish Ministers will have the power to vary, by regulation, the lists of notifiable diseases and organisms and all other aspects of notification (such as the form of notification, information to be included, timescale for notification).

36. The capacity for new public health threats to arise is real, as seen in recent years with H5N1 infection in humans. Diseases are evolving and we need to be able to tackle them. The

current mixture of statutory and non-statutory reporting can cause confusion and blur reporting lines. The Bill will replace this with a system that removes ambiguity regarding who should notify and what should be notified. By imposing statutory duties on all public and private institutions, the legislation will help ensure that action can be taken as quickly as possible to minimise any risk to public health. The notification arrangements set out in the Bill, and the duty to report health risk states (as defined in the Bill), will facilitate the early detection of risks to public health. The ability of the Scottish Ministers to vary notification arrangements and conditions to be notified will give maximum flexibility to update the legislation to deal with new and unforeseen public health threats, without the need for primary legislation, particularly if there were a requirement to act at very short notice.

Part 3 – Public health investigations

37. Existing public health legislation makes no specific provision regarding the undertaking of public health investigations. *Guidance on the Roles and Responsibilities of Incident Control Teams,* issued by the Scottish Executive Health Department in 2003, provides a framework for how NHS Boards should discharge their functions in relation to incidents that present actual or potential risks to public health. The Food Safety Act 1990 provides a framework for investigations with regard to the production, processing, storage, distribution, or sale of food. The Health and Safety Executive (HSE) investigates health concerns on any health matters on behalf of employees, within the framework of the Health and Safety at Work Act 1974 (HSAWA) and the accompanying regulations. There are also relevant investigatory powers within environmental health legislation. However, the nature and urgency of some public health investigations, which seek to prevent or reduce the spread of an infectious disease or contamination, is such that it is useful to set out public health investigation powers in this Bill, to ensure maximum flexibility in dealing with public health incidents and to ensure that any legislative gaps are addressed.

38. This Part of the Bill defines the existence of a public health incident as a person having an infectious disease or there being reasonable grounds to suspect that a person has an infectious disease; a person having been exposed to an organism which causes an infectious disease or there being reasonable grounds to suspect that a person has been so exposed; a person having been contaminated or there being reasonable grounds to suspect that a person has been contaminated; a person having been exposed to a contaminant or there being reasonable grounds to suspect that a person has been so exposed; any premises or any thing in or on premises having been infected, infested or contaminated, or there being reasonable grounds to suspect that any premises or thing is so infected, infested or contaminated; and there being reasonable grounds to suspect that any of these circumstances is likely to give rise to a significant risk to public health. It sets out the powers available to those investigating a public health incident. The composition of an Incident Control Team (or Outbreak Control Team) assembled to handle a public health incident may change from when it first comes together, as the need to involve professionals from different areas of public health changes as a public health incident is managed. Investigators could be appointed by the Scottish Ministers, Health Protection Scotland (under its legal identity the Common Services Agency), a health board, a local authority or two or more of these persons acting together.

39. The Bill provides the following powers to those investigating a public health incident:

- power of entry to a premises at reasonable times in the absence of consent or where the premises are unoccupied (temporarily or permanently), or where application for admission would defeat the object of the investigation. In emergency situations (if there were a serious risk to human health and immediate access was necessary), power of entry could be used without recourse to the sheriff and at any time;
- to make such examination and investigation which may be necessary;
- to obtain and take samples; take measurements and photographs etc as may be required;
- to dismantle equipment or subject equipment to any process or test;
- to take possession and detain articles for as long as necessary for examination purposes and for availability for evidence;
- to obtain information, including the production of records, including electronic records.

40. It will be an offence not to comply with the requirements of the investigation, or to obstruct an investigator in the course of his or her duty. There will be compensation arrangements for any loss or damage caused in the course of a public health investigation.

41. Including powers for public health investigations on the face of the Bill will ensure comprehensive coverage and provide maximum clarity and flexibility to those who will be involved in the investigation of public health incidents. Although there will be some overlap in powers between different pieces of legislation, this gives investigators more flexibility and a range of powers to deal with what may be a multi-purpose investigation. For example, following an outbreak of *E. coli* O157 an investigator may wish to use food safety investigation powers in tandem with his or her public health investigation powers.

Part 4 – Public health functions of health boards

42. The majority of the powers in this Part of the Bill already exist, but pre-date the establishment of the NHS and are currently local authority powers. Because the Bill aims to update and consolidate existing legislation and at the same time assign functions corporately, many of the existing local authority powers will be transferred to health boards. This Part of the Bill outlines both existing and new functions that are assigned to health boards.

43. Powers within the Public Health (Scotland) Act 1897 ("the 1897 Act") include:

- the removal of an infected person without proper lodging to a hospital;
- penalties for sending children with an infectious disease to school;
- prohibitions on infected people carrying out a business that would be likely to spread the disease.

44. The Public Health (Scotland) Act 1945 ("the 1945 Act") provides a general power to Scottish Ministers to make regulations for the treatment of persons affected by any epidemic, endemic or infectious disease, and for preventing the spread of such disease; and for preventing

danger to public health from vessels or aircraft arriving at or leaving any place. Currently, powers to quarantine someone are available within regulations specifically in relation to vessels and aircraft only. The Public Health (Aircraft) (Scotland) Regulations 1971 and Public Health (Ships) (Scotland) Regulations 1971 ("the Aircraft and Ships Regulations") permit the medical officer to detain, to examine, and take certain reasonable measures to prevent the spread of infection relating to smallpox, plague, cholera and yellow fever. Part 2 of the Civil Contingencies Act 2004 includes a power to quarantine people who are thought to have been exposed to an infectious disease in emergency situations.

45. Regulation 6 of the Schools General (Scotland) Regulations 1975 states that the education authority shall implement the advice of the DMO in closing state schools and excluding pupils in order to prevent the spread of disease or other danger to health. There is local guidance on the exclusion of children from nurseries and schools with a variety of conditions, but no legislative backing.

46. Section 71 of the Health Services and Public Health Act 1968 ("the 1968 Act") provides that a DMO may, with a view to preventing spread of an infectious disease, request by notice in writing that a person discontinue their work. The local authority is required to compensate a person who suffers any loss in complying with that request.

47. The Bill re-frames the legislation in this area in order to unify, strengthen and clarify the powers available. Although some of the existing public health powers relating to people (as outlined above) are currently the responsibility of local authorities, the organisational responsibility for exercising these powers will transfer to and align with health boards.

48. The Bill enhances the powers of exclusion beyond work and school to other settings and gives health boards new powers to restrict activities. It introduces powers of quarantine, and powers to remove and detain people in hospital, and the ability to undertake certain procedures (such as disinfection, disinfestation and decontamination) where there is a significant risk to public health. All of these powers will now lie with health boards, and, in the case of medical examinations, quarantine and removal and hospital detention, will require to be authorised by a sheriff. Individuals who break the terms of orders or who wilfully obstruct a person in the execution of an order will be committing an offence. However, appeals procedures will be in place for all of these health board powers.

49. In practice, people work with and co-operate with requests from public health professionals, and although many powers exist they are used very rarely. The Bill will continue to require defined circumstances for powers to be used, and in the majority of cases application to the sheriff will be required before action can be taken. This provides a safeguard against possible inappropriate use of what are wide-ranging powers. However, to be responsible for protecting public health it is important to be prepared to take steps to contain any future public health threat without having to rely solely on voluntary measures.

Medical examinations

50. The power to make application to the sheriff to order someone to undergo a medical examination already exists under the 1968 Act, although it is very rarely used. A medical examination would not directly reduce the risk to others, and isolation measures may well still

need to be applied. In addition, those undergoing medical examinations may find some measures more intrusive than others. However, it is possible that the findings from a medical examination could help to ensure that any further action taken be proportionate to the risk involved. It might establish, for example, that a person concerned did not pose any risk to others. This power could be used in situations such as where someone has just arrived in Scotland and has become increasingly unwell during their journey, but is unwilling to undergo a medical examination on entry to Scotland. To ensure that the person is not of high risk to close contacts, there may be a need to apply for an order for that person to undergo an examination to determine as quickly as possible the cause of illness and minimise the risk to the wider population.

51. The Bill will require a medical examination to be carried out without using invasive or intrusive procedures, unless the doctor considers that it is necessary to use such a procedure. However, where invasive or intrusive procedures are considered necessary, the least intrusive and invasive method must be used.

52. It is important and appropriate that Scotland retains the full range of health protection measures at its disposal to protect its population from the spread of disease, including retaining the current power to have someone medically examined on an order from a sheriff. The order would not compel a doctor to carry out an examination, but would compel an individual to undergo an examination.

Exclusion orders and restriction orders

53. Current legislation enables individuals to be excluded from school and work settings in the event that they have an infectious disease that poses a risk to public health.

54. It is important to be able to minimise the risk of an individual who is known to have a disease or has been contaminated and poses a significant risk to public health. The Bill will extend exclusion to cover individuals who are contaminated and who pose a significant risk to public health and need to be excluded from places in order to avoid or minimise that risk. It will extend exclusion to settings other than work and school, to other places where they may pose a risk to public health, e.g. nurseries and playgroups, private schools, other places where large numbers of people might congregate.

55. Another gap in current legislation is that regarding restricting activities where there is a significant risk to public health. The Bill will introduce restriction powers to cover individuals who have or are suspected of having a disease or being contaminated and who pose a significant risk to public health and need to have their activities restricted in order to avoid or minimise that risk. The activities that would be restricted could include activities such as giving blood or making sandwiches for a church fete.

Quarantine orders

56. The power to quarantine individuals is new. Existing powers of quarantine within the Aircraft and Ships Regulations are limited to very few diseases, and although powers of quarantine within Civil Contingencies legislation relate to infectious diseases, this would only apply in emergency situations. There is clearly a gap in existing legislation, which leaves us

vulnerable in some public health situations, which other countries have sought to address through use of quarantine powers.

57. The purpose of quarantine is to protect the public through the identification, monitoring and management of persons who have potentially been exposed to, or display symptoms of, an infectious disease, organism or contamination and who are a significant risk to public health.

58. Powers of quarantine exist in a number of countries including Australia, Canada, Singapore and the United States. Powers of quarantine have been used to good effect in recent years in controlling outbreaks of SARS and influenza caused by the H5N1 virus. For example, during the 2003 SARS outbreak, several countries, including Canada and Singapore, instituted maximum health measures, including quarantine, to prevent the further spread of the disease. In Canada, Ontario took the additional step of making SARS a reportable, virulent, communicable disease, under Ontario's Health Protection and Promotion Act. This allowed public health officers in Ontario to issue orders to stop infected persons from engaging in activities that transmit SARS. In 2006 Canada updated its Quarantine Act to provide the flexibility and response tools required to address communicable disease outbreaks that are occurring in an age where travel times are measured in hours rather than weeks.

59. The decision to order quarantine will not be taken lightly. If a person refuses to voluntarily undergo quarantine, an application to the sheriff and the resultant order will specify the restraints on liberty, which would vary according to the disease. These are likely to include no contact with individuals outside the household and require regular contact with health professionals for monitoring purposes. This would be for a period not exceeding 3 weeks, after which an application to extend the order would be required. The individual would have the right of appeal at each stage.

Compensation

60. Compensation will be available from health boards for individuals who comply with exclusion, restriction and quarantine orders or who otherwise voluntarily follow health board advice and are able to demonstrate a subsequent loss from so doing. The function of providing compensation is currently carried out by local authorities (section 71, 1968 Act), but will be transferred to health boards.

Removal to and detention in hospital

61. This power already exists. Removal to and detention of a person in hospital can be required where that person is not in a situation to self-quarantine, e.g. is homeless or lives in multi-occupancy accommodation. The Bill will allow health boards to apply to the sheriff for an order to remove to and detain in hospital a person who is already diagnosed with an infectious disease or has been contaminated with a substance, either of which causes a significant risk to public health and where it is necessary to avoid or minimise that risk, for that individual to be detained in hospital. Detention would be used for the minimal period necessary to remove the risk of further spread of such a disease or contamination to the wider public, for a period not exceeding 3 weeks in the first instance, after which an application to extend the order would be required. Longer term detention in exceptional circumstances where an individual continues to

pose a significant risk to public health would also be possible. For short term or exceptional detention, the individual would have the right of appeal at each stage.

62. Once in hospital an individual may be persuaded to receive the treatment necessary to improve their condition and reduce the risk to the wider population. Individuals, of course, retain the right to refuse treatment and will never be coerced into treatment.

Part 5 – Public health functions of local authorities

63. This Part of the Bill updates existing provisions from the 1897 Act and outlines the functions of local authorities relating to the disinfection, disinfestation and decontamination of premises and things. As with other Parts of the Bill, there are potential areas of overlap with other pieces of legislation, and the powers will require to be used with due regard to those other enactments.

64. The setting out of local authority powers with regard to premises and things for the purpose of the protection of public health should enable such incidents to be handled more speedily and effectively in the future. For example, the recent anthrax incident in the Borders highlighted the uncertainties in the statutory underpinning of actions that were necessary to remove public health risks from premises and things. Provisions in the Bill aim to remove that uncertainty.

65. Each local authority must provide or ensure the provision, for its area, of facilities for the disinfection, disinfestation or decontamination of premises and things and the destruction of things that are infected or contaminated, and the means for transporting infected or contaminated things to such facilities.

66. Local authorities will have the power to serve notice on the owners or occupiers of premises to undertake disinfection, disinfestation or decontamination, where premises (or things on premises) are infected or contaminated, and it is necessary for this action to be taken in order to prevent the spread of infectious disease or contamination. This may result in one of 3 outcomes:

- the owner or occupier may undertake the work themselves;
- if the owner or occupier does not undertake the necessary disinfection, disinfestation or decontamination, etc., then local authorities may carry out the work with the permission of the owner or occupier; or
- if the owner or occupier does not undertake the necessary work, local authorities may go in and do the work themselves. If local authorities encounter obstruction or resistance, local authorities may apply to a justice of the peace or a sheriff for a warrant to undertake the work, if it is necessary in order to prevent the spread of infectious disease or contamination.

67. In addition, where the premises which are involved are dwellinghouses, local authorities will have the power to enter them, but only with the occupier's consent, having given 48 hours' notice to the occupier.

68. However, if a local authority considers that there is an emergency, then they may enter premises or dwellinghouses at any time. If premises or a dwellinghouse are unoccupied at the time of entry, then the authorised officer must leave the premises or dwellinghouse as effectively secured against unauthorised entry as when the premises or dwellinghouse was entered.

69. If, during disinfection, disinfestation or decontamination of premises or things unnecessary damage is caused, then local authorities will be liable to compensate persons for such unnecessary damage caused when exercising these powers.

Part 6 – Mortuaries etc.

Provision of mortuaries

70. There is currently no statutory duty to provide mortuaries or post-mortem facilities in Scotland. Current legislation relating to mortuary provision is the 1897 Act. Section 68 of that Act states that local authorities *may provide and fit up a proper place or places for the reception of dead bodies before interment and may make byelaws with respect to the management and charges for the use of the same*.

71. Consequently, no organisation is under a statutory duty to provide or ensure provision of mortuaries and post-mortem facilities, which is needed. Arrangements that have evolved since the 1897 Act are complex. There are four city mortuaries in Scotland: in Aberdeen, Dundee, Edinburgh and Glasgow. These were all originally owned and run by local authorities. In Aberdeen and Edinburgh the city mortuaries are still owned and run by the local authorities. In Glasgow and Dundee the city mortuaries are owned, staffed and run by local police forces / Joint Police Boards. In areas with no city mortuary, NHS hospitals provide mortuary and post-mortem facilities (and are paid a flat-rate fee by the Crown Office and Procurator Fiscal Service (COPFS) for the use of mortuary and post-mortem facilities).

72. Original proposals in the public consultation suggested that the NHS should hold the statutory responsibility for the provision of mortuaries. Further extensive work with stakeholders suggested that this was not the best way forward, because it did not fully take into account current service provision. Alternative proposals have evolved that provide greater clarity of statutory responsibility and which will have minimal impact on current arrangements for mortuary provision, where these are working well.

73. The Bill therefore sets out the statutory duty on health boards and local authorities to provide or ensure provision of mortuary and post-mortem facilities. It places a duty on health boards to provide or ensure the provision of mortuaries and post-mortem facilities for hospital-related deaths and a duty on local authorities to provide or ensure the provision of mortuaries and post-mortem facilities for all other deaths, including those reported to the Procurator Fiscal. The Bill also provides a duty of co-operation between health boards and local authorities to comply with this provision.

Protection of public from risks arising from bodies

74. In addition, the Bill updates current legislation regarding the handling of dead bodies in order to reduce the risk to public health. It confines provisions to those areas where it is felt

there is most risk. If a health board considers the body of a person who died of an infectious disease or who was infectious or contaminated is a significant risk to public health, the board may direct that the body must not be removed from a hospital without its written authorisation, and may be removed only for the purpose of immediate disposal, including preparation for disposal. Separately, if a body is retained in premises, and there is consequently a significant risk to public health and the local authority considers that appropriate arrangements have not been made for the disposal of the body, the local authority may apply to the sheriff for an order to remove the body to a mortuary and to dispose of the body by burial or cremation. The legislation also takes into account the concerns of undertakers and those required to handle dead bodies that they are informed of the risks involved and are able to take the necessary precautions to prevent any threat to public health. Health boards will have a duty to inform persons handling the body of a person who has died from an infectious disease or contamination (or was infected or contaminated at time of death) of that fact. This will enable those handling the body to take necessary precautions to reduce the risk to their (and public) health.

Part 7 – International Health Regulations

75. The purpose and scope of IHR 2005 are to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade. They are updated from International Health Regulations (1969), which addressed only four diseases: cholera, plague, yellow fever and smallpox.

76. This Part of the Bill introduces a regulation-making power to give effect to International Health Regulations (IHR) 2005 (and subsequent amendments) in Scotland. This will, in particular, update the existing Public Health (Ships) (Scotland) Regulations and Public Health (Aircraft) (Scotland) Regulations.

77. As part of the UK, Scotland is required to implement IHR 2005. In addition, a number of provisions in the Bill contribute to implementation of IHR 2005. Article 13 of IHR 2005 states that each State Party shall strengthen and develop and maintain the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern. The whole of this Bill will enable Scotland to do this. In particular, there are more specific provisions in IHR 2005 with regard to health measures on arrival and departure to a country under article 31 (if a traveller fails to undergo a medical examination a State may compel such an examination, and also compel the traveller to undergo isolation, quarantine, or place the traveller under public health observation). Provisions in the Bill relating to medical examination, quarantine, detention and restriction orders put in place the mechanisms necessary for Scotland to implement this (and many similar provisions in other articles) in accordance with IHR 2005.

Part 8 – Information on health effects of sunbeds

78. This Part of the Bill requires operators of sunbed premises to provide information to the users of those premises about the effects on health of the use of sunbeds. There has been an increase in the frequency of skin cancers over the last 10 years, by 46% for men and 21% for women. Evidence suggests that there is a risk of melanoma in people who first use sunbeds in their teens and early twenties. It is sensible to provide information to users of sunbed salons of the risks they are taking when using sunbed machines, similar to information provided to people who smoke or drink alcohol regarding the risks of undertaking those activities. The Scottish

Government is still considering its options on this issue, which will be developed further as the Bill progresses through the Parliament.

Part 9 – Statutory nuisances

79. The consultation for the Bill sought views on whether there were gaps in current legislation which regulates nuisance and threats to public health from the environment. It proposed adding artificial light and insects to the existing statutory nuisance regime provided for under Part III of the 1990 Act. A gap in legislative terms had already been identified as regards Scotland, provision having already been made in this regard for England and Wales.

80. It is considered desirable to introduce insect and artificial light as statutory nuisance provisions to the Part III regime in Scotland. It has been a long standing commitment within Government and is in line with the amendments introduced elsewhere in the UK. The approach proposed in the Bill provides for a much reduced list of exemptions from the application of the insect and artificial light statutory nuisance regime when compared with the equivalent provisions in England and Wales. Instead of specifying a list of exemptions, reliance is put on the availability of the best practicable means defence for the new statutory nuisances. The intention is to give local authorities in Scotland flexible and comprehensive powers to effectively deal with those statutory nuisances in their areas. In addition, any land covered with water which is in such a state as to be prejudicial to health or a nuisance has been added to the nuisance regime. This is to plug another perceived gap, when provision in the Public Health Act 1936 was not included in the 1990 Act, as it applies to Scotland. Whilst it is recognised that the Scottish Environment Protection Agency are the main enforcement body of the water environment in Scotland, evidence from other parts of the UK illustrate that there can be perceived nuisances, not related to pollution or water quality, from ponds and ditches and other bodies of water, which will come under local authority jurisdiction.

81. Insects, artificial light, and nuisance associated with water are constituted as statutory nuisances in this Bill, a reflection of how these matters have led to more complaints in recent years, not least due to societal and climate change, but also reacting to perceived gaps in the 1990 Act. But reacting in legislation to these complaints has taken time because a suitable primary legislative opportunity has not arisen until now. New nuisances could arise in the future, or there may be a need to amend the circumstances associated with the existing statutory nuisance regime. Rather than having to wait for a suitable legislative vehicle to respond to future statutory nuisances, it is sensible to introduce an approach that will allow changes to be made more efficiently though secondary legislation. Thus the Bill contains provision to enable new statutory nuisances to be added to those specified in section 79(1) of the 1990 Act, as well as changes to conditions associated with nuisances by regulations made by Scottish Ministers.

82. The enforcement provisions in Part III of the 1990 Act have been the subject of criticism. The provisions require an abatement notice to be served by a local authority where it is satisfied that a statutory nuisance (within the meaning of section 79 of the 1990 Act) exists. Where the abatement notice is not complied with, a criminal offence is committed and prosecution may follow (section 80(4) of the 1990 Act). However, the system is considered cumbersome and the Bill introduces complementary provisions to enable local authorities to offer a fixed penalty as an alternative to prosecution, and which is also intended to act as a deterrent for non-compliance with abatement notices. The proposed fixed penalty levels are £150 for all premises other than

industrial, trade or business premises, where the penalty is set at £400. The penalties are set at an amount which is considered to comprise a sufficient deterrent such as to secure abatement. The effect of fixed penalty deterrents has been successfully demonstrated in the Antisocial Behaviour etc. (Scotland) Act 2004 noise provisions, where an initial warning notice has resulted in compliance in the vast majority of cases, and fixed penalties have been given to fewer than 1% of offenders. The penalty levels proposed in the Bill are set at 1% and 3% of the maximum available fine on conviction for non-compliance with an abatement notice for industrial, trade and business premises, and all other premises, respectively.

83. In addition, the Bill amends the Water Services etc. (Scotland) Act 2005 ("the 2005 Act"). Sections 25 and 26 of the 2005 Act make provision in relation to sewerage nuisances and enable Scottish Ministers to make an order containing a Sewerage Code. Section 25 of the 2005 Act was commenced on 10th February 2005, and Ministers made an Order containing a sewerage Code of Practice in respect of odour on 15th March 2006 (SSI 2006/155). However, prior to commencement of section 26 of the 2005 Act, a technical legal issue arose, which meant that if the provision had been commenced for all purposes, it would have resulted in the dis-application of the 1990 Act to sewerage nuisances not dealt with by that Code. Thus, the Bill contains provision to ensure that the wholesale commencement of section 26(10) of the 2005 Act will not result in the dis-application of the Part III regime to sewerage nuisances, except where such nuisances are the subject of an order made under section 25(1) of the 2005 Act containing a Code of Practice.

84. In summary, the provisions to amend the 1990 Act are designed to complement the existing provisions in Part III of the 1990 Act, add a quick and effective deterrent enforcement procedure in fixed penalties and include a regulation-making power to cover any new perceived nuisances, or to change the conditions associated with existing nuisances. Associated guidance will be issued to clarify further how new nuisance provisions will operate.

Part 10 – General and miscellaneous

85. This Part of the Bill sets out provisions with regard to equal opportunities; the disclosure of information; liability of persons exercising functions under the Bill; offences by bodies corporate; penalties for offences under the Bill; regulations and orders; the meaning of "premises"; interpretation; minor and consequential amendments; repeals, revocations and saving; Crown application; and short title and commencement.

86. Some of the offences in the Bill could have wide-ranging and extremely serious implications for public health; others may not be as significant. Much will depend on the circumstances of each case. Bearing these differentials in mind, the penalties under the Bill will give COPFS the maximum discretion to prosecute as appropriate, depending on the nature of the crime. For all offences in each part of the Bill the penalty available is summary conviction to a fine not exceeding the statutory maximum (£5,000), or 12 months' imprisonment, or both, or on indictment, unlimited fine or up to 5 years' imprisonment. These penalties reflect the changes brought about by the Criminal Proceedings etc. (Reform) Scotland Act 2007.

EFFECTS ON EQUAL OPPORTUNITIES, HUMAN RIGHTS, ISLAND COMMUNITIES, LOCAL GOVERNMENT, SUSTAINABLE DEVELOPMENT ETC.

Equal opportunities

87. The Bill's provisions are not discriminatory on the basis of age, gender, race, disability, marital status, religion or sexual orientation.

88. We carried out an equality impact assessment (EQIA) on policies included in the Bill, specifically focussing on policies for notification of diseases, requesting medical examinations or voluntary quarantine, all of which directly impact on individuals, rather than on other policies in the Bill (which clarify roles and responsibilities of public health professionals in the event of a public health incident).

89. By undertaking the EQIA we identified where the different equality groups (on age, race, religion, sexual orientation, gender and disability) might be disproportionately impacted, and have considered measures that could be used to mitigate any such impact. These include being aware of cultural and religious sensitivities, being aware of the needs of different groups if individuals undergo voluntary quarantine (for example, the needs of a disabled person complying with a request to undergo quarantine may be very different than those of an able bodied person), and the potential need for written information to be provided in different languages and formats. We actively sought to include equality group representatives from the voluntary sector in our continued discussions and consultation as the Bill developed.

Human rights

90. The Scottish Government is satisfied that the provisions of the Bill are compatible with the European Convention on Human Rights. In reaching this conclusion, particular consideration was given to the provisions in the Bill relating to quarantine, detention, medical examination, local authority powers to enter and undertake works as well as powers of entry in respect of public health investigations.

91. It is important to note that the purpose of the Bill is to protect the public from significant public health risks and the Convention itself envisages that certain rights can lawfully be interfered with on public health grounds.

92. In considering the provisions relating to quarantine, detention, and medical examinations the principles of Article 5 and Article 8 of the Convention were considered in detail. Article 5 provides that no one shall be deprived of his liberty except in certain cases, and in accordance with procedure prescribed by law. The lawful detention of persons for the prevention of the spreading of infectious diseases is a case permitted by the Convention.

93. Article 5 further provides that everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. The provisions relating to quarantine and detention comply fully with these aspects of the Convention. The deprivation of an individual's liberty occurs under the Bill only if it is determined that such

deprivation is necessary to prevent the spread of disease. The Bill provides full rights of appeal in respect of such orders at every stage.

94. Article 8 of the Convention provides that everyone has the right to respect for his family and private life, home and correspondence and there shall be no interference with this right except such as in accordance with the law and is necessary in the interests of public safety and for the protection of health, amongst other matters. It is considered that the provisions relating to detention, quarantine and medical examination engage Article 8 but again it has been concluded that under the Bill any interference is for a legitimate aim, namely that of the protection of health and as such can be justified and raises no issue of compatibility with the Convention.

95. The right to appeal any decisions made in relation to detention, quarantine or medical examination is available at every stage of proceedings thus ensuring the lawfulness of the procedure.

96. Consideration was also given to the human rights implications arising from the provisions relating to the powers to enter premises in Part 3 of the Bill in connection with public health investigations, and in Part 5 of the Bill in connection with the powers of a local authority to enter premises to disinfect, disinfest or decontaminate the premises or anything in them. Exercising these powers could give rise to an interference with the enjoyment of possessions of the person concerned within the meaning of Article 1 Protocol 1, or might infringe Article 8(1) of the Convention (the right to respect for private and family life, home and correspondence).

97. A state can only justify an interference with the enjoyment of possessions if it can show that a fair balance has been struck between the community interest and the rights of the person entitled to the enjoyment of the property. The powers in Part 3 and 5 of the Bill are justified due to the public interest in investigators being able to carry out effective public health investigations, or to prevent the spread of infectious disease by disinfecting property, and any interference with the peaceful enjoyment of possessions is a proportionate interference with property rights. Safeguards are built into the legislation to minimise the impact on individuals and there is provision for compensation to be paid in certain cases where there has been loss or damage to property.

98. In terms of compliance with Article 8(1) the European Court of Human Rights has taken the view that that house searches and seizure of property can be justified only if they are for the purpose of achieving a legitimate social aim, permit only proportional interference and contain appropriate safeguards. Under the Bill, any interference would be for the legitimate aim of protecting public health and given that there are adequate procedural safeguards contained in the Bill, we are satisfied any interference with a person's rights under these parts of the Bill does not go beyond what is necessary and proportionate and is accordingly fully compliant with the Convention.

Island communities

99. The provisions of the Bill apply equally to all communities in Scotland. Place of residence is not a factor in relation to the protection and prevention of disease. Clarifying the

roles and responsibilities of public health professionals will benefit the island communities to the same extent as mainland communities.

Local government

100. CoSLA and local authorities have individually and collectively been consulted throughout development of the Bill. The Scottish Government is satisfied that the provisions in the Bill will have no detrimental impact on local authorities. By placing a duty on health boards and local authorities to co-operate with each other in relation to planning to protect public health, the Bill will facilitate greater co-operation between public health professionals who work across each organisation. The Bill highlights the significance of local authorities in protecting public health and the importance of the environmental health profession. With regard to the statutory nuisance aspects of the Bill, local government will be able to pursue nuisance issues that they cannot do at present, and will have more choice and flexibility for enforcement of the statutory nuisance provisions overall.

Sustainable development

101. The Bill will have no negative impact on sustainable development.

102. The environmental impact of the policies included within the Bill have been considered. The Scottish Government considers the policies within the Bill as a qualifying plan within the meaning of section 5(4) of the Environmental Assessment (Scotland) Act 2005. However, having considered, in particular, the plan against the characteristics specified in Schedule 2 to the 2005 Act, we concluded that the plan for the Bill is likely to have minimal effect in relation to the environment, and as such is exempt for the purposes of section 7 of the 2005 Act. Discussions with the three Strategic Environment Assessment (SEA) consultation authorities, Scottish Environment Protection Agency (SEPA), Scottish Natural Heritage (SNH) and Historic Scotland, confirmed exemption at the pre-screening stage.

This document relates to the Public Health etc. (Scotland) Bill (SP Bill 3) as introduced in the Scottish Parliament on 25 October 2007

PUBLIC HEALTH ETC. (SCOTLAND) BILL

POLICY MEMORANDUM

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