Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Health and Social Care Bill: Legislative Consent Motion

3 February 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Mickey Brady
Mr Pól Callaghan
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr Paul Girvan

Witnesses:

Ms Joyce Cairns	)	
Dr Naresh Chada	)	
Dr Jim Livingstone	)	Department of Health, Social Services and Public Safety
Mr Eugene O'Loan	)	
Mr David Reilly	)	

The Chairperson (Mr Wells):

Before the Committee are David Reilly from the Department of Health, Social Services and Public Safety's (DHSSPS) legislation unit; Dr Jim Livingstone, who is the director of safety, quality and standards; Dr Naresh Chada, who is a senior medical officer; Joyce Cairns, who is from the workforce planning unit; and Eugene O'Loan, who is from the Departmental Solicitor's Office. Most of the witnesses have appeared before the Committee previously, and they know the routine. I suggest that you make a presentation for 10 minutes, after which I will open the meeting up to questions from members.

Mr David Reilly (Department of Health, Social Services and Public Safety):

Thank you for the invitation to provide the Committee with an update on the impact in Northern Ireland of the Government's review of arm's-length bodies, which arise from the provisions of the Health and Social Care Bill and require a legislative consent motion.

I work in the Department's legislation unit, and I am happy to deal with questions on the procedural aspects of the legislative consent motion. My colleagues from the main policy areas will cover questions on the arm's-length bodies that will be affected by specific provisions in the Health and Social Care Bill that are relevant to Northern Ireland. Dr Jim Livingstone from the Department's safety and quality directorate will cover bodies that deal with safety and quality matters; Dr Naresh Chada from the office of the Chief Medical Officer will cover the Health Protection Agency; Joyce Cairns from the workforce planning unit will cover bodies that are concerned with certain regulatory functions; and Eugene O'Loan from the Departmental Solicitor's Office will cover the technical aspects of the Bill.

The Committee may be aware that, in July 2010, the Government announced their intention to carry out a radical reform of the National Health Service (NHS), of which a key element was the streamlining of existing arm's-length bodies. The Department of Health identified a total of some 42 bodies that will be retained, abolished or have their functions transferred to another body or to the Department of Health. Most of the changes to those bodies will be given effect in the UK Health and Social Care Bill, which was introduced at Westminster on 19 January 2011. The Bill successfully completed its Second Reading on 31 January 2011, and it will move to Committee Stage in the next two weeks. That could last anything from one Committee meeting to several months for the Bill to progress through its Committee Stage, and, at this time, we have no further details on the timetable. However, given the Bill's size and complexity, it is not unreasonable to

expect that it will take a period of months.

I will provide the Committee with an overview of the provisions of the Bill that will impact on Northern Ireland and require a legislative consent motion. I will then take any questions that members may wish to ask. At the outset, I want to give members some context on the scope of the Bill, and, in particular, what it means for Northern Ireland. Where changes take place to arm's-length bodies, the underpinning principle adopted by the Department of Health and the Department of Health, Social Services and Public Safety is that there should be no changes to the type of services and expertise provided under the existing arrangements.

The Bill has 281 clauses and 22 schedules. However, it is important to stress that the vast majority of the provisions apply to England only and are not relevant to a legislative consent motion. The Bill will have an impact in Northern Ireland on those provisions that relate to devolved matters or which require specific amendments or references to legislation that apply in Northern Ireland. That has a particular relevance to arm's-length bodies that have a legislative basis to provide expertise or services on a UK-wide basis. Some of those arm's-length bodies play a vital role with legal, ethical, quality and safety issues that are associated with services, access and research. They also provide advice and guidance, regulation, inspection and monitoring and a measure of uniformity and public assurance across a wide spectrum of services in the UK as a whole. DHSSPS officials liaised with Department of Health colleagues to ensure that we maintain the expertise or services that are provided by those arm's-length bodies that will be affected by the changes. Indeed, that has been the main focus of DHSSPS engagement.

Under the proposals, the Health Protection Agency will be abolished as a non-departmental public body, and its functions will transfer to the new public health service in England. The Health Protection Agency provides a wide range of support and services that are a vital element of health protection throughout the UK. For that reason, departmental officials liaised closely with counterparts in the Department of Health and sought to agree the most appropriate means to preserve those, whether through the powers contained in the Health and Social Care Bill or by some other means. Such an arrangement reduces unnecessary duplication and makes good economic sense. It is also clear that Northern Ireland could never hope to replicate the range of experience and expertise that a UK-wide body can provide.

The Committee will be aware that any proposed changes to a Westminster Bill that relate to a

devolved matter or that require a specific amendment or reference to legislation that applies in Northern Ireland must be agreed by the Assembly by means of a legislative consent motion. It is primarily those provisions to which we want to draw the Committee's attention.

As a consequence of some of the reforms in England, the Bill will also make consequential amendments to legislation that applies in Northern Ireland. There are specific provisions in the Bill that trigger the need for a legislative consent motion, including the provisions to abolish the Health Protection Agency; those relating to radiation protection, for which the Bill confers radiation protection functions on the DHSSPS in so far as the exercise of those functions falls within the devolved competence; the provisions to confer biological substance functions jointly on the Secretary of State for Health and the DHSSPS; the revocation of the AIDS (Control) (Northern Ireland) Order 1987, as the monitoring arrangements for HIV/AIDS that that Order prescribes are now undertaken by other means; the provision for placing a duty of co-operation on bodies that exercise functions on health protection; and the provision for the Health Professions Council to make arrangements to provide administrative, technical or advisory services to any body or individual in maintaining registers of health or social work professionals and social care workers. Also included are those provisions on the funding and remit of the Council for Healthcare Regulatory Excellence, which, if the Bill is passed into law, will become known as the professional standards authority for health and social care; the provision amending the powers of the Pharmaceutical Society of Northern Ireland to allow it to hold voluntary registers; the provision to abolish the Office of the Health Professions Adjudicator; the provisions to enable the National Institute for Health and Clinical Excellence (NICE) and the Information Centre for Health and Social Care to enter into contracts with the DHSSPS when their status changes, by amending paragraph 8 of the Health and Personal Social Services **(**Northern Ireland**)** Order 1991**;** and the provision to enable the NHS commissioning board and Northern Ireland Ministers to make arrangements for the commissioning board to exercise its functions in the Health Service in Northern Ireland on behalf of Northern Ireland Ministers.

The Committee will also be aware that, on 27 October 2010, the Minister wrote to the Chairperson of the Committee to draw the Committee's attention to the outcome of the governance review of arm's-length bodies and the fact that the Health and Social Care Bill would have implications for Northern Ireland that may require a legislative consent motion. On 21 December 2010, the Minister wrote to the Chairperson again to inform the Committee about the view of the Department of Health on the provisions of the Bill that require a legislative consent

motion and to indicate that he agreed with the Department's view. The Executive gave their agreement to the principle of a legislative consent motion at their meeting of 13 January 2011.

The Department is preparing a legislative consent memorandum that will be sent to the Committee for consideration and clearance shortly. After that, the legislative consent motion will be tabled and scheduled for debate in the Assembly. It is our intention to schedule that debate before the dissolution of the Assembly.

The Chairperson:

It will be pretty tight to do all that before 26 March 2011.

Mr Reilly:

The legislative consent motion will be a simple motion that states what legislation that impacts on Northern Ireland will change as the result of the Health and Social Care Bill. The motion will also list the clauses in the Bill that will have an effect.

The Chairperson:

Do any of the other expert witnesses wish to add anything?

Mr Reilly:

The issues are fairly technical. The Health and Social Bill relates to England and will amend English arm's-length bodies. Therefore, it is only the impact on Northern Ireland of that change that needs to be considered.

The Chairperson:

We have had this before in the Assembly. It is quite a technical device, and it raises some interesting questions. What discretion do we have? What if we were to decide that this is a devolved institution, we are perfectly happy with how we are getting on and would prefer not to bother with any of this? Do we have that discretion, or are the changes being enforced on us?

Dr Jim Livingstone (Department of Health, Social Services and Public Safety):

Yes, we have that discretion. However, for example, the National Institute for Health and Clinical Excellence has a worldwide reputation. It gathers and investigates evidence on clinical practice and the best solutions for patients' needs and brings to bear a considerable expertise from

around the world. As a result, that body produces best practice guidance, which is designed for the Health Service in England but is also used in New Zealand, Canada and other countries. There is a simple reason for that international use of information: those countries do not need to spend £90 million a year running a similar service. It is an expensive process, and if we did not have access to that information, we would also need to spend £90 million a year, money that we do not have. Therefore, we want to be able to tap into that function and share in that expertise. However, we need a mechanism to do so and require the legislation that enables NICE to enter into a contractual relationship with us. We have that discretion, but exercising it would be highly dubious.

The Chairperson:

The big ticket item in all of this is the Public Health Agency. It must be the biggest spender in Northern Ireland when compared with the other bodies that you listed.

Dr Naresh Chada (Department of Health, Social Services and Public Safety):

I will clarify that. Mr Reilly spoke about the legislative consent motion and the Bill in general. It is worth clarifying the relationship between the DHSSPS and the Health Protection Agency, which is an extremely large organisation that has operated on behalf of the UK since 2003. It has a budget of approximately £350 million a year, employs between 3,500 and 4,000 people and carries out a large range of health protection functions in the UK and internationally. Its particular expertise is in the areas of infectious and communicable diseases, surveillance, radiation protection, chemicals and emergency preparedness.

The DHSSPS has worked with the Health Protection Agency since its inception, and the newly formed Public Health Agency also works closely with that agency. We have a memorandum of understanding with the Health Protection Agency that enables us to access its expertise across a range of issues, particularly for specialist areas that we could not hope to replicate locally in Northern Ireland. We hope, and are reasonably confident, that we will continue to receive the overall range of services that we have enjoyed in the past, and departmental officials are working closely with the Public Health Agency and the Health Protection Agency to ensure that that happens.

The Chairperson:

Are you saying that the abolishment of the Health Protection Agency will have no impact on the

day-to-day running of the Public Health Agency in Northern Ireland?

Dr Chada:

When the Health and Social Care Bill completes its passage and the new organisations are formed in England, we want to ensure that we are still able to access the range of scientific expertise that we have always been able to access to in the past.

The Chairperson:

Therefore, the work will continue as it is, and the protocols will allow us to continue to access the expertise and information flow in the rest of the UK. The changes will not dictate what we do in Northern Ireland.

Dr Chada:

No, they will not. Much of the health protection function is already being carried out in Northern Ireland by the Public Health Agency. We are concerned about and are working to continue to maintain the range of specialist expert services that we receive from the Health Protection Agency in England, which, as Mr Reilly explained, will be subsumed into a new public health service in England and will become part of the Department of Health.

The Chairperson:

Will our body remain as a free-standing organisation?

Dr Chada:

Yes, it will. The Public Health Agency will remain as a free-standing body and carry out its public health function as previously. We want to ensure that the Public Health Agency, the DHSSPS and the health and social care sector in Northern Ireland are able to continue to receive the range of expert advice that they need and that they are able to participate actively in it on a UK-wide basis through the Health Protection Agency.

The Chairperson:

You have concluded that we cannot take on any of those services ourselves. Given the economies of scale, they must be provided centrally.

Dr Chada:

Yes, it is because of economies of scale. The Health Protection Agency is going into the new English public health service. The Health Protection Agency was a conglomeration of a number of institutes and academic institutions that went back many years. We could not replicate its resources, expertise and research capability in Northern Ireland, and we need to be able to tap into it.

The Chairperson:

Last year, the Committee was quite impressed with the Public Health Agency's work on swine flu. We felt that its campaign saved lives and meant that people were not alarmed. This year, we were in a bit of a hiatus because of the lack of information, but now that that has been sorted out, things are moving in a positive direction. The concern is that we do not want that good work to be interrupted. I am reassured that it simply continues the flow of data rather than anything else.

Dr Chada:

The way in which both public health agencies are able to work collaboratively with other parts of the United Kingdom is important. The Health Protection Agency plays an important role in managing major public health issues such as swine flu and co-ordinating them across the United Kingdom. As you point out, Chairperson, surveillance and ensuring that we get good information, locally and from other parts of the country, are important. We can be reasonably confident that those relationships and data flows will continue.

Mrs O'Neill:

We are being asked to give our consent now at the Second Reading of the Bill. What if amendments with which we do not agree are made at Committee Stage?

Mr Reilly:

The legislative consent motion has not been to the Committee yet —

Mrs O'Neill:

I am sorry. I am talking about in England. The Bill has had its Second Reading in England, and we are being asked for legislative consent, or at least the motion will come before the Committee. If we give that legislative consent, and the Bill then goes to Committee Stage in England and amendments are made, will we have another chance to consent?

Mr Reilly:

You will indeed. If substantial changes are made to the legislation as it passes through the Westminster Parliament, further legislative consent motions will be brought. The legislative consent motion is our accepting that the changes should be made by the Northern Ireland Assembly but agreeing that they can be done by the UK Parliament. That is what the consent is about. If changes to the Bill are only technical, there may not be a further motion, but if a change is made that is substantive and changes policy, a further legislative consent motion may be made. The motion that I hope that we will bring to you very soon will be consent for the Bill as introduced and passed at its Second Reading. That is the first point at which the Committee agrees.

Mr Easton:

You seem to suggest that the Bill will have little impact on Northern Ireland. Will there be any costs or savings from this?

Mr Reilly:

At this point, we have not worked on the costs or savings. Importantly, the changes are taking place in England. All that we are doing is adjusting our arrangements to fit in with whatever new arrangements take place there. There should be no financial implications, but we are not clear about that. I do not think that it is clear even in England what savings will be made in the bodies that are changing. There is an issue with the savings that might be made by reducing the number of arm's-length bodies.

Dr Livingstone:

It only fair to point out that, at this stage, we are talking only about the Bill. The devil is in the detail, and when the regulations come through we will begin to see, at a practical level, what those changes might mean and how those organisations operate. As to costs, we pay to make use of NICE, the National Patient Safety Agency (NPSA) and various other functions. It would be foolish of me to suggest to the Committee that what we pay now will always be the same. It is a continuous process. We regularly negotiate with each of those organisations as to how much we pay. Usually, we pay a Barnett formula, depending on what their costs are. Sometimes, we have been successful in getting something lower than Barnett, and that is always our objective.

I do not know whether that would necessarily be a consequence of the changes that the Bill

proposes, but changes in regulations and in how the new organisations in particular operate may lead to us requiring quite difficult negotiations. We will still be able to access the same type of service. However, some of those bodies may seek to increase their charges, especially in the straitened times that we all face. We may have to face up to that.

Dr Deeny:

I am still a bit confused about this Health and Social Care Bill. It seemed to me that the Bill was going through Westminster because the Government wanted to slim down many arm's-length bodies. It certainly seems as if legislative consent is a good idea. If we do not do that, we cannot, for example, access NICE or the Health Protection Agency, and we do not have a big enough population to do this on our own.

In England, are the Government trying to slim down and even amalgamate some of the arm's-length bodies? If so, will we be unable to access certain agencies?

Dr Livingstone:

The answer is yes and no. For example, the NPSA is being abolished, and its constituent parts are being put into different organisations. A key element is the patient safety directorate, which monitors adverse incidents across the UK, of which there are about one million a year. From those incidents, the directorate derives information on patient safety and produces guidance. We then issue that guidance to the Health Service so that it has up-to-date information on how to avoid particular harm to patients. That function will go into the new NHS commissioning board, which will not be established for another year.

Part of the NPSA deals with confidential inquiries. New contracts are being put in place, and those inquiries will now be undertaken by a combination of Royal Colleges and universities. However, the NPSA would be managing those contracts. We are looking to see who will be managing that contract when the NPSA disappears, because we will be paying into that as well. Therefore, some of those functions will move around. We need to be able to access them wherever they are, because they are important to us.

Dr Deeny:

Can we do that if those organisations are gone completely in England?

Dr Livingstone:

Yes, we can, as long as the NHS commissioning board has the power to engage with us for the purposes of the patient safety function. The legislative consent motion enables that relationship to be maintained. Therefore, although we were dealing with many bodies, we are going to find ourselves dealing with a smaller number of bodies for the same functions. The functions will simply be distributed differently.

Mr Gallagher:

Does the Bill have any implications that might restrict our Department on guidance and guidelines on ethical issues such as abortion and euthanasia? Will you give us your view on that?

Dr Livingstone:

As I said, the legislative consent motion seeks to put in place a mechanism so that we can continue the relationships that we currently have with all those organisations and access the information that we need. On subjects such as abortion and euthanasia, an organisation such as NICE will produce clinical guidelines on best practice, some of which will be concerned with abortion. That is why NICE guidance does not automatically apply in Northern Ireland; it has to be subject to review by us so that we can ensure that it is legally applicable in Northern Ireland. Therefore, in the case of abortion and euthanasia, NICE guidance would not apply.

NICE guidance does not automatically apply to Northern Ireland. It is designed for England, and when it is published, the DHSSPS examines it to ensure that it is legally applicable in Northern Ireland and that there are no other infrastructure impediments. After that, we apply it in Northern Ireland.

Mr Gallagher:

Nothing in the Bill will change that?

Dr Livingstone:

No.

The Chairperson:

There has been a wee bit of concern about the Minister's lack of discretion on the issue of swine flu. For instance, if the Joint Committee on Vaccination and Immunisation (JCVI) says that

something is not to happen, it does not happen. If it says that a certain group of people must be vaccinated, they are vaccinated. Will anything that is being proposed bind us into a system in which we continue to lose discretion in situations in which there might be features particular to Northern Ireland? We might wish to take a different course of action to that being advised by one of the central bodies.

Dr Livingstone:

I can speak only about quality and safety issues with regard to the NPSA and NICE. We have absolute discretion. As I said, NICE guidance is legally binding only on the English Health Service. When advice is published, the DHSSPS has to decide whether to apply that advice in Northern Ireland, based on whether it is legal and fits with our policy framework. Nothing is binding. It is guidance, and we then choose whether or not to endorse it.

The Chairperson:

The Minister says that the JCVI states that we cannot vaccinate children under the age of five, and he is bound by that. There was no concept of considering the Northern Ireland situation: rules were rules. Many of those bodies lay down stipulations to the Northern Ireland Health Service. What power do we have to have our own brand on those stipulations?

Dr Chada:

We need to differentiate between the various types of guidance and, indeed, which organisation produces them. Dr Livingstone has already explained NICE guidance at great length, and it has some applicability in Northern Ireland, provided it is endorsed appropriately. More specifically, when it comes to vaccination policy, which is set on a UK-wide basis by the JCVI, different parts of the United Kingdom generally take that on board and design their vaccination programmes as appropriate to reflect it. There is usually not much room for discretion, because it is felt that it is in the best interests of the public health of the population.

The Chairperson:

Legally, if we had wanted to, could we have stepped outside the guidance?

Dr Chada:

I would need to clarify the legal position, because I am not necessarily aware of what it is. When I get more information from colleagues who are more involved in the vaccination programmes, I

will be happy to answer your question in more detail.

The Chairperson:

Of course, as it turned out, with hindsight, the advice was correct, so we had no discretion anyhow. However, had there been a particular trend in Northern Ireland, we might have wanted to take a different course of action.

Dr Chada:

In public health campaigns, particularly during a rapidly evolving situation such as flu, advice tends to change daily or weekly. I am not saying that it is bad practice to change a policy midstream, because it is sometimes necessary. On the other hand, bearing in mind the long-term view and after surveillance, the prevailing situation or emergency might change very quickly. Therefore, it is usually better to have a well-informed, scientifically appraised vaccination campaign that can be implemented on behalf of the population, because, as you said, sometimes mortality rates for different parts of the population can be affected on a short-term basis. Therefore, to change vaccination policy quickly, almost reactively, is not necessarily good public health practice.

The Chairperson:

Thank you for explaining that to us; it was useful. Are members content to allow the Department to proceed with the necessary legislation?

Members indicated assent.