Session 2007/2008

First Report

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Report on Health (Miscellaneous Provisions) Bill (NIA 2/07)

TOGETHER WITH THE MINUTES OF PROCEEDINGS, MINUTES OF EVIDENCE AND WRITTEN SUBMISSIONS RELATING TO THE REPORT

Ordered by Committee for Health, Social Services and Public Safety to be printed 11 October 2007
Report: 01/07R (Committee for Health, Social Services and Public Safety)

MEMBERSHIP AND POWERS

The Committee for Health, Social Services and Public Safety is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of the Belfast Agreement, section 29 of the Northern Ireland Act 1998 and under Standing Order 46.

The Committee has power to:

- Consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- Consider relevant secondary legislation and take the Committee stage of primary legislation;
- Call for persons and papers;
- Initiate inquires and make reports; and
- Consider and advise on any matters brought to the Committee by the Minister for Health, Social Services and Public Safety

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The membership of the Committee since 9 May 2007 has been as follows:

Mrs Iris Robinson MP (Chairperson)
Ms Michelle O'Neill (Deputy Chairperson)

Mr Thomas Buchanan Mrs Carmel Hanna
Rev Dr Robert Coulter Mr John McCallister
Dr Kieran Deeny Ms Carál Ní Chuilín

Mr Alex Easton Ms Sue Ramsey
Mr Tommy Gallagher

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Executive Summary

1. The Bill has three main purposes. These are to -

- amend the provisions of the Health and Personal Social Services (Northern Ireland) Order 1972 in relation to the regulation of the four family practitioner services: general practitioners; opticians; pharmacists; and dentists;
- set out a legislative base for a new contract for dental practitioner services; and
- amend the Smoking (Northern Ireland) Order 2006 to make provision to permit smoking by performers taking part in performances if artistic integrity so requires.

2. The Committee agreed that it was content with clauses 1 to 14, 16 to 20, and Schedules 1 and 2. It was opposed to clause 15 which proposed an amendment to the Smoking (Northern

Ireland) Order 2006 to permit smoking by those taking part in performances. The Committee noted that the Minister had indicated during the Second Stage of the Bill that he was also opposed to the inclusion of this clause in the Bill and that he was minded to table an amendment setting out his opposition to clause 15 during Consideration Stage of the Bill. The Committee agreed that it would oppose clause 15.

Enabling powers

3. The Committee noted that the Bill would introduce enabling powers to make regulations in a number of areas such as the conditions under which a suspension of an individual practitioner could take place; the details of the rights and obligations under the new General Dental Services contracts and the criteria under which persons not ordinarily resident in Northern Ireland would not be charged for services. The Committee looks forward to receiving the policy proposals for these regulations in due course, which it will scrutinise very carefully.

Introduction

1. The Health (Miscellaneous Provisions) Bill (NIA 2/07) (the Bill) was referred to the Committee for consideration in accordance with Standing Order 31(1) on completion of the Second Stage of the Bill on 19 June 2007.

2. The Minister for Health, Social Services and Public Safety (the Minister) made the following statement under section 9 of the Northern Ireland Act 1998:

"In my view the Health (Miscellaneous Provisions) Bill would be within the legislative competence of the Northern Ireland Assembly."

3. The stated purpose of the Bill is as follows:

1) To amend the Health and Personal Social Services (Northern Ireland) Order 1972 in relation to the provision of health care;

2) To amend the Smoking (Northern Ireland) Oder 2006 to provide in certain circumstances premises may not be smoke-free in relation to performers; and

3) For connected purposes.

4. During the period covered by this Report, the Committee considered the Bill and related issues at 8 meetings - on 24 May 2007; 21 and 28 June 2007; 5 July 2007; 6, 13 and 20 September and 11 October 2007. The relevant extracts from the Minutes of Proceedings for these meetings are included at Appendix 1.

5. The Committee had before it the Health (Miscellaneous Provisions) Bill (NIA 2/07) and the Explanatory and Financial Memorandum that accompanied the Bill.

6. On referral of the Bill to the Committee after Second Stage, the Committee wrote on 20 June 2007 to key stakeholders and on 20 June 2007 inserted advertisements in the Belfast Telegraph, Irish News and News Letter seeking written evidence on the Bill.

7. A total of 24 organisations responded to the request for written evidence and a copy of the submissions received by the Committee is included at Appendix 3.

8. On 24 May 2007 prior to the introduction of the Bill the Committee took evidence from Departmental officials about the policy behind the Bill and its general provisions. Following the referral of the Bill for Committee Stage the Committee took evidence from the British Medical Association and the British Dental Association on 21 June; the Pharmaceutical Society, the Health and Social Services Councils on 28 June, and the Theatrical Management Association, Arts Council and Smokefree Northern Ireland Coalition on 5 July. Officials from the Department were present at each of these evidence sessions. The Minutes of Evidence are included at Appendix 2.

9. The Committee began its clause by clause consideration of the Bill on 6 September and concluded this on 20 September 2007 – see Appendix 2.

Extension of Committee stage of the Bill

10. On 1 October 2007, the Assembly agreed to extend the Committee Stage of the Bill to 7 November 2007.

Report on the Health (Miscellaneous Provisions) Bill

11. At its meeting on 11 October 2007, the Committee agreed its report on the Bill and agreed that it should be printed.

Consideration of the Bill

12. On 24 May 2007, prior to the introduction of the Bill, the Committee took evidence from Departmental officials on the general proposals for the Bill – see Appendix 2. The Committee noted that the Bill had three main aims.

13. At the evidence session, the Committee discussed with officials a number of issues including the proposed changes to the organisation of dental services which would allow the Health and Social Services Boards to provide services either through contracts with individual practices or to directly employ dentists to provide dental services; the provision for regulations to allow suspension of a listed practitioner directly by a Board and the proposed amendment to the Smoking (Northern Ireland) Order 2006 to permit smoking by those taking part in performances if required for artistic integrity. Committee members expressed strong opposition to the proposed exemption to the smoking ban.

14. At the Second Stage of the Bill on 19 June 2007 the Committee referred to the comments by the Chief Medical Officer the previous week when he told the Committee "From a public health perspective … I could not support the introduction of such a provision". The Committee welcomed the announcement by the Minister of his intention to drop the proposed exemption on smoking.

Evidence from the British Medical Association and the British Dental Association

15. On 21 June 2007 the Committee took evidence from the British Medical Association (BMA) and the British Dental Association (BDA) – see Appendix 2. The BMA advised the Committee that it supported the provisions of the Bill which allowed for the inclusion of practitioners on a single performers' list; the removal of the sanction of local disqualification from the powers of the Health Service Tribunal and the repeal of the powers held by the Department to specify the age at which GPs must retire. However, the BMA outlined a number of concerns about the proposals to extend the powers of a Health and Social Services Board to suspend a practitioner before

referral to the Tribunal, the lack of an appeal mechanism and advised the Committee that it was opposed to the proposed amendment to the Smoking (Northern Ireland) Order 2006. The BMA also drew attention to the lack of any recognition in the Bill to the role of professional regulatory bodies such as the GMC and the medical defence organisations (MDOs).

16. The BDA also raised similar concerns about the proposals for the suspension of practitioners and about the introduction of an additional ground, that of unsuitability by virtue of professional or personal conduct, under which a Tribunal may deal with a practitioner. The BDA was also concerned that the Bill contained a number of enabling powers and that the regulations made under these powers would be subject, in the Assembly, to negative and not affirmative resolution.

Evidence from the Pharmaceutical Society of Northern Ireland and the Health and Social Services Councils

17. The Committee took evidence from these groups on 28 June 2007 – see Appendix 2. The Pharmaceutical Society was concerned about the proposals in the Bill to increase the remit for sanctions of the Health and Social Services Boards. The Society was of the view that this proposal would add an additional layer of regulation and duplicate already established procedures.

18. The Health and Social Services Councils (the Councils) advised the Committee that they supported the proposals to confer on each Health and Social Services Board a new specific duty to provide or secure the provision of primary dental services within its area. In addition, in relation to the proposals to move away from the current arrangements which link the calculation of dental charges to the remuneration of a dental practitioner, the Councils considered that the new contract should review dental charges. On the issue of disqualification by the Tribunal, the Councils strongly supported the proposal for the inclusion of an additional ground, that of unsuitability by virtue of professional or personal conduct.

Evidence from the Theatrical Management Association, the Arts Council of Northern Ireland and the Smokefree Northern Ireland Coalition

19. The Committee took evidence from these groups at its meeting on 5 July 2007, on the provisions in the Bill to permit smoking by those taking part in performances if artistic integrity so required – see Appendix 2. The Theatrical Management Association and the Arts Council of Northern Ireland argued strongly for the inclusion of the proposed amendment to the Smoking (Northern Ireland) Order 2006 given what they considered to be the unique circumstances of theatre, film and television, where smoking was required to establish character, period, historical accuracy or setting. If this was not possible both groups asked that, as an alternative, consideration be given to permitting the use of herbal cigarettes in performances.

20. The Smokefree Northern Ireland Coalition advised the Committee that it regarded performers, as set out in the Bill, as another workforce which should be protected from the effects of passive smoking. It pointed out that the proposed exemption was not limited to performances in theatres but was a loose definition that could cover a performance in any venue including a performance in a public house, a hall or school. In addition the Coalition was concerned that the term 'artistic integrity' had not been defined. It was opposed to the use of 'herbal' cigarettes because of the absence of evidence about whether herbal cigarettes pose a danger to health and the difficulties it could cause for enforcement of the smoking ban.

Clause by clause consideration of the Bill

21. The Committee undertook its clause by clause scrutiny of the Bill on 6, 13 and 20 September – see Minutes of Evidence in Appendix 2.

Clause 1 – persons performing primary medical services: listing subject to conditions

22. The Committee discussed the concerns raised by the BMA about the absence of any appeal mechanism in relation to the proposal for suspension. The Committee noted that clause 1 would enable the Health Boards to move from a four list system to one regional list and would introduce powers of conditional inclusion and contingent removal. It would allow the Boards the flexibility to introduce conditions rather than take a decision to suspend. The Department advised that the Bill did not contain the detail of conditions that could apply when a suspension would take place and that such detail would emerge in the regulations which would subsequently be made and come before the Committee for consideration. The Committee agreed to clause 1.

Clause 2 – provision of dental services

23. The Committee discussed the proposed new arrangements for the provision of general dental services and noted that these would introduce a range of regulation-making powers. The Committee raised concerns about the lack of health service dentists in many areas and noted the proposals in the Bill which would place a duty on the Health Boards to provide services in their areas and would give the Boards the power to decide where practices could be located. It was advised that the proposed new contracts would not be set out in the ensuing regulations but the underpinning framework would be. In addition, the Department was negotiating a Northern Ireland wide contract with the BDA under which everyone would work to the same terms and conditions.

24. The Committee asked officials about the concerns which the BDA had raised, in its written submission and when it gave evidence to the Committee (see Appendices 2 and 3) about the proposed procedures for the adjudication of any disputes that may arise and its suggestion that the Department should appoint an independent person or panel. It was advised that this issue would be covered by regulations which would be submitted to the Committee for scrutiny. The Committee agreed to clause 2.

Clause 3 – general dental services: transitional

25. The Committee considered the matter raised by the BDA about the use of negative, as opposed to affirmative, resolution for any order made under this clause once in force. The Committee noted that under the negative resolution procedure, it would have an opportunity to table a motion seeking the agreement of the Assembly to the annulment of a Statutory Rule if it considered this was required. The Committee agreed to clause 3.

Clause 4 – charges for dental services

26. The Committee noted that the clause made provision for i.a move away from the current arrangements linking the calculation of dental charges to the remuneration of a dental practitioner; ii. exemption from dental charges and iii. the making and recovery of relevant dental service charges. The Committee was concerned that there was no exemption for those aged 65 years and over and was surprised that none of the groups who had responded to the consultation carried out by the Department on the Primary Dental Care Strategy had raised this

issue. It discussed the further advice received from the Department that only 31% of those aged 65 and over were registered with a dentist and it was estimated that it would cost £3.8million to provide free dental care for those who had to pay fees. In addition, if all those who were eligible to register with a dentist did so, and if those over the age of 65 were exempt from paying dental charges, the estimated cost would be in the region of £10 million. The Committee was advised that around 35% of those aged 65 and over who were registered with a dentist were exempt from paying fees. The Committee agreed to clause 4.

Clause 5 – provision of dental services: Article 15B arrangements

27. The Committee was advised that clause 5 made minor technical amendments to existing provisions in the Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order) and was intended to change the term 'personal dental services' to 'primary dental services'. The Committee agreed to clause 5.

Clause 6 – revocation of power to make pilot schemes for provision of dental services

28. The Committee discussed this clause which would remove the power to make pilot schemes for the provision of personal dental services and the proposal from the BDA in its written submission (see Appendix 3) that the regulations should allow for the piloting of the new contract. Members noted the advice from the Department that it had agreed with the BDA that the new contract would be piloted before it was rolled out formally. The Committee agreed to clause 6.

Clause 7 – assistance and support for persons providing primary dental services

29. The Committee was content with the provisions of this clause which would give the Health Boards the power to assist and support providers and prospective providers of primary dental services eg by appointing a locum to maintain continuity of services. The Committee agreed to clause 7.

Clause 8 – ophthalmic services

30. The Committee noted that the clause made provision for inclusion on a performers' list for Northern Ireland of persons providing general ophthalmic services, including conditional inclusion and contingent removal and for their suspension by the Health Boards. The Committee agreed to clause 8.

Clause 9 – local optical committees

31. Officials advised that the clause made provision for ophthalmic medical practitioners to be included on local optical committees. The Committee discussed the proposal made by Optometry Northern Ireland in its written submission (see Appendix 3) that dispensing opticians should have a statutory right to membership of local optical committees. It considered the further advice from the Department that dispensing opticians could hold a contract with a Health Board if they owned a practice and employed an optometrist to conduct eye tests and prescribe but noted that there were only a handful of such dispensing opticians in Northern Ireland. The Committee agreed to clause 9.

Clause 10 – pharmaceutical services

32. The Committee considered the clause which made provision for inclusion on a performers' list for Northern Ireland of pharmacists, including conditional inclusion and contingent removal and for their suspension by the Health Boards. Members discussed the concerns raised by the Pharmaceutical Society of Northern Ireland that this would add confusion in relation to the regulation of pharmacists and would cause duplication. The Committee noted the advice from the Department that a Board would only contemplate suspending a pharmacist in exceptional circumstances and that each suspension would be considered on a case by case basis. The Committee agreed to clause 10.

Clause 11 – disqualification by the Tribunal

33. The Committee noted that the clause introduced Schedule 1 of the Bill. The Committee agreed to clause 11.

Clause 12 – charges for services provided to persons not ordinarily resident in Northern Ireland

34. The Committee discussed the provisions of this clause which would allow the Department of Health, Social Services and Public Safety to determine that, on humanitarian grounds, a person who has been allowed to enter the country for a course of treatment should not be charged for it. Members were informed that regulations would set down the criteria under which this would operate. The Committee agreed to clause 12.

Clause 13 – retirement of practitioners

35. The Committee considered this clause which provided for the removal of the restriction requiring that dental practitioners retire at 70 years of age and that this did not comply with the Employment Framework Directive (2000/78/EC) preventing discrimination on, inter alia, the grounds of age. The Committee agreed to clause 13.

Clause 14 – minor and consequential amendments

36. The Committee noted that this clause made technical amendments necessary for the interpretation of the 1972 Order. The Committee agreed to clause 14.

Clause 15 – smoking: exemption for performers

37. The Committee considered the representations made by the Theatrical Management Association and the Arts Council that this clause, which was intended to amend the Smoking (Northern Ireland) Order 2006 and would permit smoking by those taking part in performances if artistic integrity so required, should be included in the Bill. The Committee also considered the views of the Smokefree Coalition and noted that the Minister had indicated that he was minded to table an amendment to the Bill at Consideration Stage opposing the inclusion of this clause in the Bill. The Committee concluded that it would oppose clause 15.

Clause 16 – interpretation

38. The Committee agreed to clause 16.

Clause 17 – supplementary provision

39. The Committee agreed to clause 17.

Clause 18 – repeals

40. The Committee agreed to clause 18.

Clause 19 – commencement

41. The Committee agreed to clause 19.

Clause 20 – short title

42. The Committee agreed to clause 20.

Schedule 1 – amendments to schedule 11 to the 1972 Order

43. The Committee agreed to schedule 1.

Schedule 2 – repeals

44. The Committee agreed to schedule 2.

Minutes of Proceedings relating to the Report

Thursday, 24 May 2007
Room 135, Parliament Buildings

Present: Mr Thomas Buchanan MLA
Rev Dr Robert Coulter MLA (In the Chair)
Dr Kieran Deeny MLA
Mr Alex Easton MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Ms Carál Ní Chuilín MLA

In Attendance: Mr Alan Patterson (Principal Clerk)
Mr Hugh Farren (Clerk)
Ms Hilary Bogle (Assistant Clerk)
Ms Vicky Surplus (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Scott Leeman (Clerical Officer)

Apologies: Mrs Iris Robinson MP MLA (Chairperson)
Mr John McCallister MLA
Miss Michelle O'Neill MLA (Deputy Chairperson)
Ms Sue Ramsey MLA

8. Evidence session on the Health (Miscellaneous Provisions) Bill

Members noted the Briefing Paper from the Department.

Members took evidence from the following witnesses.

Ms Christine Jendoubi, Director of Primary and Community Care

Mr John Farrell, Assistant Director, Primary and Community Care

Mr Donncha O'Carolan, Acting Chief Dental Officer

Mr Robert Kirkwood, Deputy Principal, General Medical Services

4.22pm – Mr Gallagher left the meeting

4.26pm – Mr Gallagher returned to the meeting

The Chairperson thanked the witnesses for attending.

[Extract]

Thursday, 21 June 2007
Senate Chamber, Parliament Buildings

Present: Mrs Iris Robinson MP MLA (Chairperson)
Mr Thomas Buchanan MLA
Rev Dr Robert Coulter MLA
Dr Kieran Deeny MLA
Mr Alex Easton MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Mr John McCallister MLA
Ms Carál Ní Chuilín MLA

In Attendance: Mr Hugh Farren (Clerk)
Ms Hilary Bogle (Assistant Clerk)
Ms Vicky Surplus (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Miss Michelle O'Neill MLA
Ms Sue Ramsey MLA

The meeting commenced at 2.38pm in open session.

5. Committee Stage of the Health (Miscellaneous Provisions) Bill

Evidence session with the British Medical Association

Members took evidence from the following witnesses:

Dr Brian Patterson, Chairman, British Medical Association Northern Ireland Council
Dr Brian Dunn, Chairman, British Medical Association Northern Ireland General Practitioners Committee
Dr Brian Best, Secretary, British Medical Association Northern Ireland
Mr Ivor Whitten, Assembly and Research Officer, British Medical Association Northern Ireland

The Chairperson thanked the witnesses for attending.

3.22pm Mr Gallagher left the meeting.

Evidence session with the British Dental Association

Members took evidence from the following witnesses:

Ms Claudette Christie, Director, British Dental Association Northern Ireland
Mr Seamus Killough, Chair, British Dental Association Northern Ireland Council

3.34pm Mr Gallagher returned to the meeting.
3.44pm Mrs Hanna left the meeting.

The Chairperson thanked the witnesses for attending.

[Extract]

Thursday, 28 June 2007
Great Hall, Magee Campus, University of Ulster

Present: Mrs Iris Robinson MP MLA (Chairperson)
Mr Thomas Buchanan MLA
Dr Kieran Deeny MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Mr John McCallister MLA

In Attendance: Mr Hugh Farren (Clerk)
Ms Hilary Bogle (Assistant Clerk)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Rev Dr Robert Coulter MLA
Mr Alex Easton MLA
Ms Carál Ní Chuilín MLA
Miss Michelle O'Neill MLA
Ms Sue Ramsey MLA

The meeting commenced at 2.25pm in open session.

5. Committee Stage of the Health (Miscellaneous Provisions) Bill

Evidence session with the Pharmaceutical Society Northern Ireland

Members took evidence from the following witnesses:

Mr Raymond Anderson, President, Pharmaceutical Society Northern Ireland.
Dr Kate McClelland, Council Member, Council for Healthcare Regulatory Excellence (CHRE) and representative of the Pharmaceutical Group of the European Union (PGEU).
Mr Raymond Blaney, Director, Pharmaceutical Society Northern Ireland.

The Chairperson thanked the witnesses for attending.

Evidence session with the Health and Social Services Councils

Members took evidence from the following witnesses:

Ms Stella Cunningham, Chief Officer, Southern Health and Social Services Council.
Ms Maggie Reilly, Chief Officer, Western Health and Social Services Council.
The Chairperson thanked the witnesses for attending.

[Extract]

Thursday, 5 July 2007
Senate Chamber, Parliament Buildings

Present: Mrs Iris Robinson MP MLA (Chairperson)
Mr Thomas Buchanan MLA
Rev Dr Robert Coulter MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Mr John McCallister MLA
Ms Carál Ní Chuilín MLA
Miss Michelle O'Neill MLA
Ms Sue Ramsey MLA

In Attendance: Mr Hugh Farren (Clerk)
Ms Hilary Bogle (Assistant Clerk)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Dr Kieran Deeny MLA
Mr Alex Easton MLA

The meeting commenced at 2.36pm in open session.

5. Committee Stage of the Health (Miscellaneous Provisions) Bill

Evidence session with the Theatrical Management Association

Members took evidence from the following witnesses:

Mr John Botteley, Theatre Director, Grand Opera House, Member of the Theatrical Management Association.

Mr Nick Livingstone. Arts Council of Northern Ireland

The Chairperson thanked the witnesses for attending.

Evidence session with the Smokefree Coalition

Members took evidence from the following witnesses:

Dr Brian Gaffney, Chief Executive, Health Promotion Agency

Mr Gerry McElwee, Head of Cancer Prevention, Ulster Cancer Foundation

Mr Sean Martin, Chief Environmental Officers' Group

3.25pm Mr Gallagher and Ms Ramsey left the meeting.
3.35pm Ms Ramsey returned to the meeting.
3.40pm Mr Gallagher returned to the meeting.
3.45pm Ms O'Neil left the meeting.

The Chairperson thanked the witnesses for attending.

[Extract]

Thursday, 6 September 2007
Senate Chamber, Parliament Buildings

Present: Mrs Iris Robinson MP MLA (Chairperson)
Rev Dr Robert Coulter MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Mr John McCallister MLA
Ms Carál Ní Chuilín MLA
Miss Michelle O'Neill MLA
Dr Kieran Deeny MLA
Mr Alex Easton MLA

In Attendance: Mr Alan Patterson (Principal Clerk)
Mr Hugh Farren (Clerk)
Mrs Noelle Bourke (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Ms Sue Ramsey MLA

The meeting commenced at 2.45pm in open session.

6. Committee Stage of the Health (Miscellaneous Provisions) Bill

The following witnesses attended:

Christine Jendoubi Director of Primary and Community Care

John Farrell Assistant Director, Primary and Community Care

Robert Kirkwood Departmental Bill Team

Donncha O'Carolan Acting Chief Dental Officer

The Chairperson referred the members to a clause by clause briefing paper provided by the Department explaining the purpose of each clause, along with a copy of responses received from relevant bodies, which issued on 29/8/07 and the Clerks briefing paper and suggested questions.

Clause 1 (Persons performing primary medical services: listing subject to conditions.)

Question, That the Committee is content with clause 1 as drafted, put and agreed to.

4.18pm Dr Deeny left the meeting

Clause 2 (Provision of Dental Services)

Question, That the Committee is content with clause 2 as drafted, put and agreed to.

4.22pm Dr Deeny rejoined the meeting

The Committee agreed to continue consideration of Bill at its next meeting.

[Extract]

Thursday, 13 September 2007
Room 135, Parliament Buildings

Present: Mrs Iris Robinson MP MLA (Chairperson)
Mr Thomas Buchanan MLA
Dr Kieran Deeny MLA
Mr Alex Easton MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Mr John McCallister MLA
Ms Carál Ní Chuilín MLA
Ms Sue Ramsey MLA

In Attendance: Mr Hugh Farren (Clerk)
Mrs Elaine Farrell (Assistant Clerk)
Mrs Noelle Bourke (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Miss Michelle O'Neill MLA

The meeting commenced at 2.39 pm in closed session.

The meeting moved into public session at 2.57 pm.

6. Committee Stage of the Health (Miscellaneous Provisions) Bill

The following witnesses attended:

Christine Jendoubi Director of Primary and Community Care

John Farrell Assistant Director, Primary and Community Care

Robert Kirkwood Departmental Bill Team

Donncha O'Carolan Acting Chief Dental Officer

The Chairperson referred the members to a clause by clause briefing paper provided by the Department explaining the purpose of each clause, along with a copy of responses received from relevant bodies, which issued on 29/8/07 and the Clerks briefing paper and suggested questions.

The committee commenced formal clause by clause consideration of the Health (Miscellaneous Provisions) Bill at Clause 3 as Clause 1 and 2 had been agreed at the previous meeting.

Clause 3 (General Dental Services: Transitional)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 4 (Charges for Dental Services)

Clause 4 deferred for further consideration

Clause 5 (Provision of Dental Services: Article 15B Arrangements)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 6 (Revocation of power to make pilot schemes for provision of personal dental services)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 7 (Assistance and Support for Persons Providing Dental Services)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 8 (Ophthalmic Services)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 9 (Local Optical Services)

Clause 9 deferred for further consideration

Clause 10 (Pharmaceutical Services)

Clause 10 deferred for further consideration

Clause 11 (Disqualification by the Tribunal)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 12 (Charges for Services Provided to Persons not ordinarily resident in Northern Ireland)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 13 (Retirement of Practitioners)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 14 (Minor and Consequential Amendments)

Question: That the Committee is content with the clause as drafted, put and agreed to.

The Committee agreed to continue consideration of Bill at its next meeting.

[Extract]

Thursday, 20 September 2007
The Board Room, Craigavon Area Hospital

Present: Mrs Iris Robinson MP MLA (Chairperson)
Ms Michelle O'Neill (Deputy Chairperson)
Mr Thomas Buchanan MLA
Dr Kieran Deeny MLA
Mr Alex Easton MLA
Mr Tommy Gallagher MLA
Mrs Carmel Hanna MLA
Ms Carál Ní Chuilín MLA
Ms Sue Ramsey MLA

In Attendance: Mr Hugh Farren (Clerk)
Mrs Elaine Farrell (Assistant Clerk)
Mrs Noelle Bourke (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Rev Robert Coulter MLA
Mr John McCallister MLA

The meeting commenced at 2.40 pm in public session.

5. Committee Stage of the Health (Miscellaneous Provisions) Bill

The following witnesses attended:

Christine Jendoubi Director of Primary and Community Care

John Farrell Assistant Director, Primary and Community Care

Robert Kirkwood Departmental Bill Team

The Chairperson referred the members to a clause by clause briefing paper provided by the Department explaining the purpose of each clause, along with a copy of responses received from relevant bodies, which issued on 29/8/07 and the Clerks briefing paper and suggested questions.

The committee commenced formal clause by clause consideration of the Health (Miscellaneous Provisions) Bill at Clause 4, 9 and 10 as they had been deferred for further consideration at the previous meeting.

Clause 4 (Charges for Dental Services)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 9 (Local Optical Committees)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 10 (Pharmaceutical Services)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 15 (Smoking: Exemption for Performers)

Question: That the Committee is opposed to the clause as drafted, put and agreed to.

Clause 16 (Interpretation)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 17 (Supplementary Provision)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Clause 18 (Repeals)

Question: That the Committee is content with the clause as drafted, put and agreed to

Clause 19 (Commencement)

Question: That the Committee is content with the clause as drafted, put and agreed to

Clause 20 (Short Title)

Question: That the Committee is content with the clause as drafted, put and agreed to.

Schedule 1 – Amendments to Schedule 11 to the 1972 Order

Question: That the Committee is content with the schedule as drafted, put and agreed to.

Schedule 2 – Repeals

Question: That the Committee is content with the schedule as drafted, put and agreed to.

6. Motion for Extension to the Committee Stage of the Health (Miscellaneous Provisions) Bill

Members agreed the motion to extend the Committee Stage of the Bill to 7 November 2007.

[Extract]

Thursday, 11 October 2007
The Senate Chamber, Parliament Buildings

Present: Mrs Iris Robinson MP MLA (Chairperson)
Dr Kieran Deeny MLA
Mr Alex Easton MLA
Mr Tommy Gallaher MLA
Mrs Carmel Hanna MLA
Ms Carál Ní Chuilín MLA
Ms Michelle O'Neill MLA (Deputy Chairperson)
Ms Sue Ramsey MLA

In Attendance: Mr Hugh Farren (Clerk)
Mrs Elaine Farrell (Assistant Clerk)
Mrs Judith Murdoch (Assistant Clerk)
Mrs Noelle Bourke (Clerical Supervisor)
Mr Mark McQuade (Clerical Supervisor)
Mr Joe Westland (Clerical Officer)

Apologies: Mr Thomas Buchanan MLA
Rev Robert Coulter MLA
Mr John McAllister MLA

The meeting commenced at 2.34 pm in public session- Deputy Chairperson in the chair

9. Consideration of Draft Report on the Committee Stage of the Health (Miscellaneous Provisions) Bill

The Committee considered the Draft Report on the Committee Stage of the Health (Miscellaneous Provisions) Bill paragraph by paragraph. The Committee agreed the main body of the report:

Paragraph 1- 5, read and agreed
Paragraph 6-11, read and agreed
Paragraph 12-14, read and agreed
Paragraph 15-17, read and agreed

Paragraph 18-19, read and agreed
Paragraph 20-23, read and agreed
Paragraph 24-26, read and agreed
Paragraph 27-30, read and agreed
Paragraph 31-34, read and agreed
Paragraph 35-43, read and agreed

The Committee agreed the Executive Summary

Paragraph 1-3, read and agreed

The Committee agreed that Appendix 1 to 5 be included in the report.

The Committee agreed that an extract of today's Minutes of Proceedings should be included in Appendix 1 of the report and were content that the Chairperson agrees the minutes relating to this to allow them to be included in the printed report.

The Committee ordered the Report on the Health (Miscellaneous Provisions) Bill (NIA 2/07) to be printed.

[Extract]

Appendix 2

Minutes of Evidence

Thursday 24 May 2007

Members present for all or part of the proceedings: The Acting Chairperson (Rev Dr Robert Coulter)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mrs Carmel Hanna
Ms Carál Ní Chuilín

Witnesses:

Mr John Farrell Ms Christine Jendoubi Mr Robert Kirkwood Mr Donncha O'Carolan	Department of Health, Social Services and Public Safety

1. The Acting Chairperson (Rev Dr Robert Coulter): The health (miscellaneous provisions) Bill will be the first piece of primary legislation to come before the Committee for Health, Social Services and Public Safety. It will be introduced in the Assembly on 5 June, which is not far away. The Committee will then be required to work on the Committee Stage of the Bi ll. That will mean going through the Bill line by line and clause by clause. Those who have gone through that process before know that it can be harrowing. We must decide whether to support each clause or to recommend a change.

2. We are glad to have officials here today. They will explain the policy behind the Bill and go through its general provisions. Members have received a paper on suggested issues for discussion, a departmental briefing paper, which contains the draft Bill, and the explanatory and financial memorandum.

3. I welcome the witnesses. Given what I have just said, we are delighted to have you with us in order that you can give us a steer on the Bill. Instead of taking time to welcome you individually, I will leave it for you to introduce and say a word or two about yourselves.

4. Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): I am Christine Jendoubi, and with me is Robert Kirkwood, who has been responsible for producing the instructions on the legislation and preparing the explanatory and financial memorandum. Donncha O'Carolan is the acting Chief Dental Officer, and John Farrell is assistant director of primary and community care. We are pleased to be here.

5. Shall I begin by speaking about the Bill?

6. The Acting Chairperson: Yes. We are strapped for time; if I restrict you, it is not because I am trying to get rid of you. Will you compress your contributions a little?

7. Ms Jendoubi: We can be quick.

8. The Acting Chairperson: We will loose you and let you go.

9. Ms Jendoubi: Although the Bill has the words "miscellaneous provisions" in its title, it has three main functions.

10. Some patient-safety issues arose out of the Shipman inquiry. As a result, the Bill will primarily allow health and social services boards to suspend all family practitioners — GPs, dentists, opticians and pharmacists — pending a hearing by a professional regulatory body, a court case or the Health Service tribunal. Currently, the boards do not have the power to do that; they cannot suspend practitioners until after a hearing. However, given that it may take a couple of months or longer for a case to be heard by a regulatory body, an element of risk remains.

11. Dr Deeny will be familiar with the concept of the performers list, but other members may not be. Each health and social services board maintains a performers list of GPs, who cannot practice unless they are on it. The Bill will allow for a single performers list for each medical profession in Northern Ireland. Currently, the boards maintain a list of GPs, and the Central Services Agency (CSA) maintains a list of pharmacists, dentists, and opticians. In future there will be one performers list for all professions, and no one will be able to practice unless they are on it.

12. In addition, the Bill will allow the boards to place conditions on whether someone is accepted on to the list. That cannot be done now — people are either on the list or off it. In future you might have a board allowing a GP to practice provided that he or she completes a catch-up course on, for example, minor surgery.

13. The Bill also gives new powers to the Health Service tribunal on the disciplinary matters that it can deal with and the cases that it can hear. There is a new ground for misconduct: unsuitability by virtue of personal and professional conduct. The tribunal's powers will also extend to cover applicants on a list, which is not the case at the moment, and locums.

14. The other main provisions in the Bill are around providing a legislative base for the dental services contract, to allow boards to enter into a contract with dental practices and individual dentists.

15. One of the reasons the Bill is called "miscellaneous" is that it includes a minor amendment to the smoking legislation to will allow performers on a stage to smoke if the

artistic integrity of the performance requires it. That is a provision that was brought in in England but not in Wales. The previous Administration decided that they would like to bring it in here. That is obviously a matter for the Committee to contemplate.

16. There are a couple of other minor things in the Bill. In accordance with the EU working legislation it removes the Department's right to make regulations on retirement ages for doctors and dentists. At the moment there is a prescribed retirement age of 70 for dentists, but one has not been prescribed for doctors. That right has now been removed altogether.

17. There is also a provision to bring Northern Ireland into line with the rest of the UK in allowing exemptions from Health Service charges for overseas visitors on exceptional humanitarian grounds. For example, if a ship in Belfast harbour went on fire and crewmen had to be taken into hospital for more than emergency care, they would no longer be charged for the additional care.

18. Those are the main provisions of the Bill. I am happy to take questions.

19. The Acting Chairperson: What has caused the apparent delay between the consultation in 2005 and the introduction of the legislation?

20. Mr Kirkwood (Department of Health, Social Services and Public Safety): The consultation in 2005 was a 12-week consultation. The provisions in the Bill had to be drafted and taken forward and consulted on again. That happened in August-October 2006. The time taken for the legislative process, including drafting, was necessary. After October 2006 it was drafted as an Order in Council. The Order was made at Westminster in December, and would have made it through the Westminster process, but devolution came along, initially in March, and was then put back a further six weeks. That is what caused the extended timeframe for bringing the Bill before the Assembly.

21. The Acting Chairperson: So it is purely and simply drafting that held it back?

22. Mr Kirkwood: Yes. There are set procedures for taking primary legislation through. To draft a Bill and take it through the Assembly process takes a year to a year and a half.

23. Ms Jendoubi: The standard time is 68 weeks.

24. The Acting Chairperson: It still baffles me why it took so long.

25. Mr Gallagher: I would like to know whether this change in legislation will do anything to address the problem of the scarcity of NHS dentists. It is particularly serious in the west and around the border areas. There are reasons for that. There is a need for urgent action on this, because there are quite serious implications for health.

26. Is local commissioning, either through contracts or directly employed dentists, going to help to make more NHS dentists available in order to enable certain groups of people, such as rural dwellers and the elderly, to get access to treatment that they do not have access to at present?

27. Mr O'Carolan (Department of Health, Social Services and Public Safety): It will improve the situation. Dentists can currently set up wherever they want and treat whomever they want; that is the way their contract is posed. The new contract will reverse that to enable the boards to have a part in local commissioning. They will have a set amount of money for a particular area — for example, the west. If dentists decide that they do not want to sign up to these contracts, the board can then put them out to tender to other dentists or corporate dental bodies, or directly employ its own dentists. The boards themselves would not actually employ the dentists; it would be done through the trusts or through some of the agencies.

28. That process is already in place. The Northern Health and Social Services Board, through the Dalriada Urgent Care co-operative, has already advertised for a salaried dentist, and

the Western Health and Social Services Board has a bid with us at the moment for six salaried dentists. I am aware that that is particularly focusing on the Fermanagh and Tyrone areas.

29. Therefore, local commissioning will shift the balance of power — instead of dentists being able to make all of the decisions, a lot more power will be put into the hands of the boards or successor bodies such as local commissioning groups, who will be given the authority to direct the resources to the areas in most need.

30. Mr Gallagher: Thanks. I do not want to suggest that there is a dispute between the Department and the dentists — that was not the purpose of the question. As regards the bid for dentists that is with the board in relation to the west, does that bid have to wait until the legislation is implemented?

31. Mr O'Carolan: No. We can proceed in the interim.

32. Mr Easton: I do not understand why there is a provision in the Bill to allow performers to smoke on stage —somebody must not have had a job to do.

33. Ms Jendoubi: I could not comment on that.

34. Mr Easton: I have a problem with actors being allowed to smoke on stage, as it will mean that that smoke is filtering out into the crowd. That is passive smoking and is something that we are meant to be cutting back on. I do not understand why it has to be in this legislation just because England has it. It is a hypocritical stance to be taking on the issue. I am opposed to it, and to be honest, I think it is stupid. I hope that no-one minds me saying that but that is my opinion.

35. Ms Jendoubi: The provision is in the Bill because that was the wish of the previous Administration. The current Administration is entirely at liberty to take a different view.

36. Mr Easton: As smoking is to be stamped out in order to try to improve people's health, I do not think that this clause should be included in the Bill. I will be pushing to get rid of it.

37. The Acting Chairperson: I presume since the clause is in the Bill, it has the support of the Minister. Is that the case?

38. Ms Jendoubi: The Bill is before the Assembly in its present form because it was prepared for Westminster and could be presented intact. Mr McGimpsey's view on the provision for smoking by actors in performances is that it is there pro tem until the House gets the chance to discuss it. I would not suggest that he is hugely in favour of it.

39. The Acting Chairperson: Thank you. That was my own impression also.

40. Mrs Hanna: I welcome what has been said about the career prospects of National Health Service dentists. However, I still think that there are issues — for you and for this legislation — about motivating and reimbursing dentists so that they do not vote with their feet and go into private practice.

41. Dentists need to be doing more than just filling teeth; there needs to be good dental-health promotion. A lot more needs to happen, because there are literally queues outside the few remaining National Health Service dentists.

42. This particularly affects young people who are working in low-paid jobs and who have to pay for treatment. There are cases in which people may need root canal surgery, or something else that costs quite a bit of money. People can be in pain and need treatment but they cannot afford it because of the amount of money involved in paying for private treatment. It could cost over £100, and that is a lot of money to those who are not earning much. Therefore, people's teeth are actually decaying because of the lack of dental practices. Although what has been said is welcome, we must watch and see what happens.

43. Mr O'Carolan: The Department launched the primary-dental-care strategy, which will fundamentally shift the way in which dentists are paid. At the moment they are paid on a piecework basis — there is a fee for each item of work they do. Under the new system, a block payment will be made for a dentist's time, rather than for his volume of work. That will free up time for dentists to look at preventative care, which was mentioned by Mrs Hanna. We have very poor oral health — the worst in the whole of the UK and Ireland. Our system is purely treatment-focused at the moment. However, if dentists were paid for their time rather than for the work done, it would allow them to focus more on prevention.

44. Mrs Hanna is correct in that there must be an attractive remuneration system for dentists, otherwise they will walk away from the Health Service — and market forces dictate that there is quite a large private market for them to walk into. There is a limited amount of money in the pot and it must be used efficiently and effectively. Dentists are essentially on a treadmill. Going for the block payment would take them off that treadmill, although there is obviously a lot of treatment work to be done also. In addition, their contract should be much more attractive than it is at present.

45. Mrs Hanna: I welcome that, and I will watch this space for improvements.

46. Under what circumstances would a GP be suspended? I agree that after the Dr Harold Shipman case there must be conditions and safeguards. However, I presume that there must be good reasons for suspending a GP.

47. As regards smoking by performers in performances, I cannot understand why someone cannot hold a fag up and huff and puff and pretend to be smoking, without having to have real smoke. It does not make sense to me.

48. Mr Kirkwood: As regards the power to suspend, which is included in the primary legislation, the details of the circumstances when a board can suspend and how long it can suspend for will be set out in regulations, which will go into more detail. The Department will also send out detailed instructions to each health and social services board. The guidance will not be totally restrictive but will set out in detail when suspension should be applied. It is certainly not a power that will be applied willy-nilly.

49. Mrs Hanna: It would probably include early warnings, would it?

50. Mr Kirkwood: Yes. It is a power that will enable an authority to act swiftly, while a case is being investigated and taken to a tribunal or to a professional body. It is not to be used off the cuff. There must be regulations and guidance in place.

51. In relation to the exemption for performers as regards smoking, the Bill was hijacked — if you like — to be used as a vehicle to take that provision forward. The provision is already in the Health Act 2006 in England, and allows for smoking in performances if that helps the artistic integrity of a play. [Inaudible.]

52. Ms Ní Chuilín: There will be more dentists leaving the Health Service. However, I am concerned about the number of teeth being extracted from young people. In one part of west Belfast, 70% of the children have had two or more extractions, and many of them were not registered with dentists. I am hoping that this legislation will enable a more holistic approach to be taken to get children registered with dentists and have better oral care. There has been a lot of consultation and some promotion on that subject. That statistic is not only shocking, but is an indictment of the Health Service as a whole.

53. My other question relates to the Dr Harold Shipman case. Proposals were introduced in England — and possibly the rest of Britain — but not here. What implication has that had for boards here as regards lessons learned?

54. Mr Kirkwood: It was introduced in England and Wales and subsequently in Scotland. The Bill will bring us into line with the rest of the UK. Although the provision is not yet in

force in Northern Ireland, a board can initiate a procedure to have a practitioner removed from the list if it has doubts about that practitioner's ability or about another factor relating to him or her.

55. Ms Jendoubi: It could be done through the regulatory body.

56. Ms Ní Chuilín: Therefore, it is regulated.

57. Ms Jendoubi: Yes.

58. Ms Ní Chuilín: That is the point that I am getting at.

59. Mr Kirkwood: It will be a quicker process.

60. Mr O'Carolan: I want to pick up on your important point about dental health. We will not necessarily improve the dental health of the population through the dental contract — that is only one factor. Dental health is affected adversely by poor diet and is enhanced by other factors, such as the use of fluoride toothpaste and fluoridation in the water supply.

61. Ms Ní Chuilín: Poverty is an issue as well.

62. Mr O'Carolan: Absolutely. Dental health is affected by lifestyle and factors such as deprivation. Apart from introducing a dental contract that will have a preventative element, for the good of public health, we must change the population's diet. For the past four years, we have implemented fluoride toothpaste schemes in the 20% most deprived wards. We must link in with general public-health initiatives and with programmes that address health issues such as obesity and diabetes — for example, drinks and foods that have a high sugar content also cause dental decay. The Republic of Ireland has only half the tooth decay of Northern Ireland — purely because of water fluoridation.

63. Dr Deeny: If I ask only about GPs, it might be perceived as a conflict of interest. As for the retirement of GPs — all the GPs whom I know want to leave the profession. The age to which they will work is not an issue.

64. My questions address the removal of a health professional. First, it is good that performance is streamlined across the profession and that everybody is assessed? GPs are appraised every year; I am due to have my work appraised quite soon. Will all the professions be appraised?

65. The medical profession deserves respect, but Harold Shipman brought dreadful shame on it — he was the greatest mass murderer on this part of the planet. You say that the health and social services authority will be given powers. How will the powers be applied when we have one health and social services authority and seven local commissioning groups (LCGs)? Will the power to remove a person from his or her job be delegated to the LCGs? What qualifications will those who will deal with complaints against GPs have? On what basis will an investigation be triggered? Will it be based on one patient's complaint? There must be scrutiny.

66. GPs should be made accountable for any wrongdoing. However, there are malicious complaints. I hope that GPs will not be subjected to such intense scrutiny on the basis of one complaint. Will power be delegated to the LCGs or to the health and social services authority, and on what basis? Lastly, will all health professionals be appraised annually?

67. Ms Jendoubi: You will have noted from the detail in the Order that there is a huge number of regulations. Similar issues in the regulations will be brought to the Committee and to the Assembly to be resolved.

68. Will power to suspend be delegated to local commissioning groups (LCGs)? No. In our view, there should be one performers' list, and being placed on, or removed from, that list should be a matter for the strategic health authority. The Bill still refers to the boards

simply because we cannot anticipate the will of the Assembly as regards the regulatory reform Order that will come before it very shortly. I do not think that anybody would see this as a matter that should be delegated. As the performers' list will be maintained centrally, the process of adding to it, or removing from it, must be conducted centrally, too.

69. When would the power to suspend health professionals be used? As Mr Kirkwood said, lots of regulations and guidance will be issued in that regard. Would the power be used when dealing with one complaint? Regulations notwithstanding, that would depend on the nature of the complaint and the circumstances, and the board would have to make a mature, proper decision taking those factors into consideration. For example, a single complaint could be so damning that the board would have no choice but to suspend the practitioner.

70. Mr John Farrell (Department of Health, Social Services and Public Safety): It is also important to emphasise that the suspension would be seen as a neutral act until the investigation had been completed and the case brought before the tribunal or the regulatory body.

71. Dr Deeny: In other words, the health professional would be suspended until proven innocent or guilty. Is that right?

72. Mr Farrell: Any decision on whether to suspend a health professional would depend on the nature of the incident brought before the board or the new authority. However, at that stage, any suspension would be seen as a neutral act and would not reflect a practitioner's guilt or innocence; no judgement could be reached until the investigation had been completed. However, if an incident had implications for patient safety, the board or authority would have a responsibility towards patients. If, for reasons of patient safety, the most appropriate course of action were to suspend a GP, dentist or whoever until the investigation was completed, that is what would happen. However, at that stage, the suspension would be considered a neutral act.

73. Mr Kirkwood: The legislation also provides for —

74. Dr Deeny: I am concerned about the power to suspend.

75. Mr Kirkwood: The finer details of the suspension procedure will be set out in regulations, and the General Practitioners Committee (GPC) will be consulted on the provisions that should be included. The Bill provides the enabling power to set out in regulations how the suspension would work. Should the Bill ever receive Royal Assent and become an Act, it would not mean that boards could suspend a practitioner on a whim — they could not.

76. The regulations will set out the details of how a suspension should be conducted, and guidance will also be issued. The profession will also be consulted on this matter. We are going no further than England, Scotland and Wales: this legislation is already in place there, and, as far as I am aware, it is working reasonably well.

77. Dr Deeny: We all know what the public think when a doctor is suspended — he or she is considered to be guilty before even being tried. It would be dreadful if a situation arose whereby a practitioner was suspended and later found to be innocent of the charge. In England, unfortunately, a GP committed suicide because he was accused of an offence of which he was later found innocent in court. He had endured the terrible trauma of suspension and had been tried by the media.

78. Mr Kirkwood: Again, that consideration must be weighed against the board's duty to act responsibly. As Ms Jendoubi said, at present, a practitioner against whom an allegation has been made could continue to practise for a period of eight or 12 weeks until the case comes in front of a professional body or a tribunal.

79. Is that a good thing? Not if the practitioner is another Harold Shipman. On the other hand, however, one has to judge that against blackening someone's name unreasonably. Those are the issues that will have to be teased out when the regulations are written and the policy behind the intention of those regulations is expressed. That is for a later date; the Health (Miscellaneous Provisions) Bill merely introduces the power to make those regulations.

80. Mr Buchanan: I have some concerns about dental matters, particularly in relation to NHS patients and the salaries paid to dentists. Will there be adequate funding to ensure that NHS patients can expect the same service as those people who pay for their dental treatment, and not just a basic service? How far do the proposed changes replicate the changes in dental services in England and Wales? What consultation was carried out on the issue? What views were expressed by patient representative bodies and by dental practices?

81. The other issue is the smoking ban. If the ban that has recently been introduced in Northern Ireland is to be effective, the proposals intended for inclusion in the Bill are entirely wrong. They are ludicrous, and I will oppose them. What pressure has been brought to bear to introduce the specific exemption that is before us?

82. Mr Kirkwood: In relation to smoking?

83. Mr Buchanan: Yes.

84. Mr Kirkwood: No pressure has been brought to bear. It was the will of the previous Administration that we should follow English legislation. The Health Act 2006 contained similar provisions, and that is why the exemption appears in the proposed legislation. It is as simple as that.

85. Mr Farrell: The exemption was in the legislation when it was introduced as an Order in Council at Westminster. When the responsibility fell to the Assembly to enact the legislation, the exemption was included.

86. Mr O'Carolan: Mr Buchanan raised some points relating to dentists' salaries, changes to the dental service in England and Wales, and the consultation process. Health Service patients have access to the same range of treatments as those who pay for their dental work. Health Service-salaried general dental practitioners charge the same fees as independent general dental practitioners. That is a very important principle.

87. The point is that if dentists continue to leave the Health Service, money will, potentially, remain unspent. Why not reinvest that in the service and employ dentists directly? In that way, at least, the public are guaranteed access to Health Service dentistry.

88. Mr Buchanan: Yes, but why are dentists leaving the NHS? It is simply because the amount of money allocated is insufficient to do the job. If dentists are employed on a salaried basis, and the same amount of money is allocated for each procedure, it will mean that NHS patients will receive only a basic service. They will not receive a proper service, because the money is not there.

89. Mr O'Carolan: We intend to transform the way in which dental practitioners are remunerated. At present, dentists are only paid for what they do, with a block payment on top. Largely, however, the money is spent on fees for each item of service. We are going to move away from that, so that we are paying for their time, rather than the volume of work that they produce. That will be the same whether the practitioner is a salaried or an independent dentist.

90. It is not a matter of simply saying that the system is underfunded. There is a huge private market. People want their teeth whitened, or to have cosmetic veneers. They want white fillings for their back teeth, and the private market can command high fees for that type of work.

91. We cannot compete with the private market. There simply is not enough money in the Health Service for that. Dentists have a choice between doing private or public work, unlike in medicine, where the same private market does not exist. Public resources must be used effectively.

92. To respond to the point that was made about the changes that have taken place in England, the principle is the same in so far as dentists are moving from a piecework system of payment to a time-to-clock system, but that is where the similarity ends. In England, performance is measured using UDAs. That unfortunate term stands for "units of dental activity". Block contract is now used, but dentists' pay is measured by their output. We do not want to go down that route; we want to pay dentists for their time and insert appropriate performance measures so that we achieve what we want.

93. The strategy for the consultation was issued in December 2006, and the consultation period concluded in March 2007. There were about 46 replies, which were largely supportive.

94. Dr Deeny: There are changes in the way in which dental services are being organised, and the issue of out-of-hours work must be considered. It is not uncommon for patients to have a treatment, such as repair of a dental abscess, during the day, only to discover later that evening when a complication arises that they have no access to a dentist. They then ring an out-of-hours GP, who must clear up the mess. If people are to access good healthcare — including dental healthcare — under the NHS, they should have access to a dentist who can work out-of-hours, just as GPs do. That must be part of future plans.

95. Mr O'Carolan: Out-of-hours work is written into dentists' contracts, and they are supposed to provide that service.

96. Dr Deeny: That does not happen in my area.

97. Mr O'Carolan: There are pain-relief clinics in the Eastern, Northern and Southern Health and Social Services Boards. Craigavon Area Hospital, Braid Valley Hospital in Ballymena, and Belfast City Hospital all run pain-relief clinics.

98. However, you are absolutely right: as is stated in the primary dental care strategy, the onus will be on the health boards to provide out-of-hours emergency dental services, because that is written into their contracts. That means that a consistent approach will be adopted.

99. You are correct to say that there is no pain-relief clinic in the Western Health and Social Services Board; however, there is a rota system that can be used to provide cover. I worked in Derry for 15 years, where a rota was in place to cover the city side. The extent of the rota is left up to individual towns, and in places it is patchy, as you have pointed out. Under the new system, the onus will be on the health boards — rather, the proposed health and social care authority, which will replace the four boards — to provide a consistent and uniform out-of-hours service across Northern Ireland.

100. Dr Deeny: Can that be insisted on?

101. Mr O'Carolan: Those terms are written into the contract, and that places a duty of responsibility on the boards, and on the future authority. It is not optional — it must be included in the contract.

102. Dr Deeny: Whom can I expect to take responsibility at weekends? Do I go to the Sperrin Lakeland Health and Social Care Trust or to the Western Board?

103. Mr O'Carolan: At present, if a patient is registered with a dentist, that dentist has a duty to provide out-of-hours care seven-days-a-week but not 24 hours a day. A problem arises when a patient is not registered with the dentist, because, at present, there is no out-of-hours relief-of-pain clinic in the Western Board. There is provision in the Eastern, Northern and Southern Boards. In those boards, it does not matter whether

patients are registered: if they have a dental emergency and go to the designated site in their area, they will be seen.

104. Dr Deeny: I am not proposing to move house. In short, out-of-hours care is not happening in the west. That means that a patient who telephones our out-of-hours service cannot get a dentist. Where do we go from there?

105. Mr O'Carolan: I do not know whether that is true. When I worked in Derry, there was a dentists' rota for both the city side and for the Waterside, so the city was covered. When I worked there, the Western Health and Social Services Board received very few complaints.

106. Dr Deeny: There is more to the west than Derry.

107. Mr O'Carolan: That is correct. I cannot speak for practices in Omagh and Enniskillen, because I didn't work there. Under the Western Board's contract, however, dental practices there should be providing out-of-hours care for their patients if those patients are registered.

108. The Acting Chairperson: That was very enlightening for us. No doubt, other questions will arise as the matters in question progress. Thank you very much for coming in to help the Committee with this matter.

Thursday 21 June 2007

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mr Thomas Buchanan
Rev Dr Robert Coulter
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mrs Carmel Hanna
Mr John McCallister
Ms Carál Ní Chuilín

Witnesses:

Mr Brian Best Dr Brian Dunn Dr Brian Patterson	British Medical Association
Mr Ivor Whitten Ms Claudette Christie Mr Seamus Killough	British Dental Association Northern Ireland
Mr Bryan Bailie Mr John Farrell Mr Robert Kirkwood	Department of Health, Social Services and Public Safety
Mr Donncha O'Carolan	Acting Chief Dental Officer

109. The Chairperson (Mrs I Robinson): Should Committee members have any queries about the Health (Miscellaneous Provisions) Bill, departmental officials are standing by. I welcome Mr John Farrell and Mr Bryan Bailie, who are assistant directors of the primary and community care directorate, Mr Donncha O'Carolan, who is the acting Chief Dental Officer, and Mr Robert Kirkwood of the departmental Bill team.

110. I welcome our Witnesses:

111. Dr Brian Patterson, who is chairman of the Northern Ireland council of the British Medical Association (BMA); Mr Brian Dunn, who is chairman of the Northern Ireland general practitioners' committee of the British Medical Association; Mr Brian Best, who is secretary to the British Medical Association Northern Ireland; and Mr Ivor Whitten, who is Assembly and research officer with the British Medical Association Northern Ireland. There are a lot of Brians with us today — it must have been a popular name, although I will not ask in which year. [Laughter.]

112. I would appreciate it, Dr Patterson, if you would deal specifically with the Health (Miscellaneous Provisions) Bill and indicate which clauses, if any, the British Medical Association Northern Ireland would like to see amended. We will allow 10 minutes for a presentation and then members will have about 20 minutes to ask questions. I am sorry that time is limited, but several presentations on the Bill are yet to be made to the Committee.

113. Dr Brian Patterson (British Medical Association Northern Ireland): Thank you, Chairperson. I must waste a minute of our time, because this is the first opportunity that BMA Northern Ireland has had to offer the Committee some information on its role. We are grateful for the chance to talk to the Committee, and we hope that this meeting will be the first of many.

114. Many people know that the BMA is a trade union for doctors, but it is also a professional organisation with many other interests. The BMA represents the majority of doctors in Northern Ireland — both qualified doctors and medical students — and it acts as the voice of the medical profession by highlighting issues to politicians, the public and the media on a wide range of matters, such as public health, medical ethics and the state of the National Health Service.

115. The BMA has more than 4,000 members in the Province. It has crafts, or branches of practice, that represent consultants, general practitioners, staff and associate specialists, junior doctors, public-health doctors, medical academics and medical students. The BMA carries out a vast array of work on behalf of those professionals.

116. The BMA is the only registered trade union that can negotiate on behalf of doctors. However, it also produces a wide range of policies on public health, ethics and the state of the Health Service, and it publishes widely through the 'British Medical Journal'. BMA policy on the Health Service dictates much of what we will refer to in our presentation.

117. The BMA's view is that the Health Service must be free at the point of delivery; be centrally planned and adequately funded; provide equality of access, regardless of locality or income; be based exclusively on clinical priority; provide an equal standard of care for patients; ensure equality of health outcomes; and not discriminate on grounds of race, age, disability or religion.

118. The BMA is a voluntary professional organisation that operates at home and abroad. Apart from its trade union function, it has a scientific and educational ethos; it is a publisher and a limited company. The vast majority of the BMA's work is self-funded. However, the BMA does not register or discipline doctors — people are frequently confused about that.

119. Thank you, Chairperson, for allowing me to deliver that preamble. I shall ask Dr Dunn to outline the provisions in the Health (Miscellaneous Provisions) Bill with which we agree and disagree.

120. Dr Brian Dunn (British Medical Association Northern Ireland): I am chairman of the Northern Ireland general practitioners' committee of the BMA. Although that is a

subcommittee of the organisation, it represents all GPs in negotiations with the Department of Health, Social Services and Public Safety, whether they are BMA members or not. I am here principally as a doctor. Although we represent doctors, our primary interest is in patient safety and in delivering a good service to patients.

121. There are some positive elements in the Bill, and some with which we are not as happy. First, on the positive side, paragraph 1(2) of schedule 1, which concerns the inclusion of practitioners on a single performer list in each health and social services board, makes practical sense. That will ease the eventual amalgamation of all the boards into the new health and social care authority. Schedule 1 amends schedule 11 to the Health and Personal Social Services (Northern Ireland) Order 1972.

122. Secondly, paragraph 3(3) of schedule 1 removes the sanction of local disqualification from the powers of the Health Service tribunal. The BMA agrees that, if a practitioner is deemed unfit to be included on one board's list, it would be inappropriate to include him or her on any other board's list.

123. Thirdly, clause 13 repeals article 4 of The Health and Medicines (Northern Ireland) Order 1988, which empowered the Department to specify the age at which GPs must retire. The current retirement age is 70, and, in order to comply with the European directive on age discrimination, it is right that that power should be repealed. However, we are happy that appraisal and revalidation processes will ensure that doctors, no matter their age, will be permitted to practise.

124. There are provisions in the Bill with which we are unhappy. Paragraph 8(4) of schedule 1 extends the powers of a health and social services board to suspend a practitioner before referral to the tribunal. Suspension is a rare occurrence, and many safeguards are in place to ensure that patient safety is maintained. In employment law, suspension, pending the investigation of an allegation, is normally viewed as a neutral act. That would be in the case of a serious allegation. In the interest of all parties, the person under investigation would be temporarily suspended or excluded from his or her employment — with pay and benefits — but would not be deemed guilty or innocent until a judgement had been made.

125. The problem with boards having the new power is that they would not be required to put an allegation before the tribunal in order to impose a suspension. However, they could do so before a tribunal had seen the evidence on which the allegation had been made. A guidance framework on how that should be done must be negotiated. The BMA is concerned about patients' safety, and it recognises the need to give them confidence that the service that they receive is of the utmost standard and is delivered by GPs who work to a consistently high level.

The BMA is also concerned about the possible effect that suspension would have on a GP before the tribunal could fully investigate the case. The BMA contends that the statement that suspension is a neutral act is incorrect. In the recent case of Mezey vs South West London and St George's Mental Health NHS Trust, the judgement of Lord Justice Sedley was that, in relation to the employment of a qualified professional in a function which was as much a vocation as a job: "Suspension changes the status quo from work to no work, and it inevitably casts a shadow over the employee's competence. Of course this does not mean that it cannot be done, but it is not a neutral act."

126. The BMA is mindful of a board's power to impose specific restrictions on a practitioner if he or she is to be retained on a performer list. The alternative of placing conditions on practitioners might be a way in which to avoid total breakdown of practitioner/patient trust. That may also help in rural areas, where many GPs work single-handedly. However, a guidance framework for that process must be negotiated. That is important in small towns. If a GP were suspended, it would not take long for

everyone to find out what has happened. Many local people might know before the doctor's husband or wife.

127. The BMA is also unhappy about clause 1, which deals with the extension of powers to allow boards to make payments to suspended practitioners. That clause will amend article 57G of the Health and Personal Social Services (Northern Ireland) Order 1972, which deals with persons performing primary medical services. The extension of the ability to pay suspended practitioners is welcomed as a matter of course. However, clarification is required on the framework for that process and the extent to which it would cover the cost of the suspended practitioner. The impact of the redistribution of service provision on other partners in a GP practice to cover for the suspended GP and the cost of a locum to replace the suspended GP for the duration of the suspension require close examination so that a suspension does not penalise the practice or adversely affect the provision of primary healthcare services to patients. As a minimum, boards must be responsible for the full costs.

128. Paragraph 1(5) of schedule 1 introduces an additional ground on which the Health Service tribunal may deal with a practitioner who has been referred to it; namely

"the person concerned is unsuitable (by virtue of professional or personal conduct)".

129. The definition of that third ground for disqualification — the other conditions being fraud and prejudice to the efficiency of services — lacks clarity.

130. The BMA wants to examine closely that third ground for disqualification in order to establish how it would impinge on investigations by professional regulatory bodies, such as the General Medical Council, into fitness to practise, as set out in the Medical Act 1983. Such bodies have clear definitions and sanctions for such conduct. More detail on how the new power would differ significantly from the provisions relating to fitness to practice is required.

131. Dr Patterson: I want to mention two matters in the Bill that are not specific to GPs. First, clause 15 proposes an amendment to The Smoking (Northern Ireland) Order 2006, which would permit

"those participating as performers in a performance"

132. to smoke

"if the artistic integrity of the performance makes it appropriate for them to smoke".

133. Members will be aware that the BMA, along with many others, campaigned successfully to have smoking banned in public and enclosed workplaces. We consider the proposed change to be cosmetic, and we have heard the same news as the Committee that the clause will be removed. However, we are concerned that the proposal, and others that may follow, are attempts to dilute the power of the 2006 Order. Passive smoking has been shown to kill. No matter where it takes place, it is somebody's workplace. Someone must clean up after folk. The BMA welcomes the Minister's commitment to remove clause 15 from the Bill.

134. The Bill and its explanatory and financial memorandum do not appear to recognise the role of professional regulatory bodies such as the GMC and the medical defence organisations (MDOs). We ask that the Committee consider that point. Moreover, any changes that the Bill might make to the tribunal must be consistent and compatible with existing regulatory procedures.

135. The Chairperson: Thank you. It was interesting to hear the GPs' committee's perspective. I will open the floor to members' questions.

136. Mr Easton: What measures, instead of or alongside suspension, would you like to see imposed on a practitioner who does something wrong, be it serious or otherwise?

137. Dr Patterson: The severity of the measure should depend on what has happened. For instance, if a doctor's competency in dealing with children's problems has been questioned, there is no reason that that doctor should not deal with adults. Indeed, the community would be better served if that doctor were only restricted from dealing with children.

138. Dr Dunn: I agree. We do not want patient safety to be compromised, but the fact that the board can suspend a practitioner before his or her case goes before the tribunal is akin to taking a sledgehammer to crack a walnut. Even appearing before the tribunal is an infrequent occurrence; it has met only twice in the past few years. Boards can use many informal methods to address cases about which they have concerns, and their close work with practices suggests that they use those methods all the time. The BMA, the local medical committees and we GPs work with the boards, and if problems arise, we visit the relevant practices. There are, therefore, more informal and effective ways than suspension in which to deal with problems.

139. Mr Easton: Am I correct in saying that you do not wish to see suspension ruled out but that other measures should be considered alongside it?

140. Dr Dunn: Absolutely. If patient safety were compromised, we would not object to the suspension of the practitioner involved.

141. Mr Easton: Does that mean that you want to see other measures alongside suspension?

142. Dr Dunn: Yes.

143. The Chairperson: You suggest in your briefing paper that conditions, rather than automatic suspension, could be placed on practitioners who are under investigation. How would that work, and what sort of conditions do you propose?

144. Dr Patterson: There have been several examples of doctors who have been addicted to drugs, for instance, and they have been allowed to continue practise but with restrictions being placed on their supervisory role in the use of controlled drugs. The measures that are imposed on a practitioner will depend on his or her problem, but there are ways in which to deal with several situations. Requests for a practitioner's suspension are usually based on his or her underperformance or on illness. Total suspension may be the only answer in some cases, but I am concerned that, if boards were given the power to impose suspensions, it would be their first rather than their last course of action. That would serve neither the people whom we represent nor the patients.

145. The Committee has heard the argument about a "neutral act". I work as a GP in a rural area, and if I were suspended, the local people would probably know about it before I did: that would not be a neutral act in the community. There are many rural communities in Northern Ireland.

146. The tribunal has met only twice since 1978, so that shows the extent of the issue. I contend that it is more important to ensure that the tribunal's activities are timely and sensitive than to set up more bureaucratic machinery, which may be inappropriately used.

147. Ms Ní Chuilín: As I said during the debate on the Bill's Second Stage on Tuesday, I am concerned that the legislation may be open to misinterpretation. I would struggle to come up with a case in which suspension could be deemed a neutral act, regardless of the profession involved. I am not saying that suspensions are never required, and I

understand that patient care is paramount. However, unless clear guidelines and boundaries about what can and cannot be done are produced, I would have concerns.

148. I am not saying that the trusts could be abusive — I do not wish to suggest that. However, the guidelines must be robust and clear, and leave no room for confusion. I have not even read the legislation in great detail, yet already I am confused. As I have said, the legislation is open to misinterpretation. As a new MLA, I have not read much legislation. However, I have read for most of my adult life, and I still have to jump backwards and forwards through the Bill to understand what it means. The Assembly is responsible for introducing legislation, so the Bill should be much clearer. I would appreciate it if the witnesses could provide me with more information, but I want to put on record my concern that the provision could be open to misinterpretation.

149. Dr Patterson: We entirely agree; that is one of the reasons why we are here. People will point to serious cases from the past, with the classic one being the Harold Shipman case. He is a blight on general practice to this day, and he is long gone. The problem was not the absence of processes, but the failure to make the existing processes work, either by not implementing them in time or by not implementing them at all.

150. We are content that safe processes are already available. We may need to consider how they can be operated and used more effectively. The Health Service tribunal has sat only twice since 1978, but that is probably not a fair reflection on the need for tribunals since then. We perhaps need to look at how the existing processes work rather than adding another tier of bureaucracy, which could be accidentally misused.

151. The Chairperson: Is the BMA concerned that that provision could open the floodgates for people to make allegations against their GPs or other medical staff who deliver front-line primary care?

152. Dr Patterson: That depends. There have been questions about so-called soft evidence, which concerns us. The well-known principle of innocent until proven guilty is accepted by most democracies. The provision smacks a little of treating people as guilty before innocence can be proven, and that concerns us.

153. Rev Dr Robert Coulter: My position on the matter is clear, and it on record in Hansard. I am concerned about non-medical people being given the opportunity to suspend medical practitioners. In light of that, if this provision is removed from the Bill, how do you see the partnership working among the existing disciplinary organisations that medical people control and the boards and civil servants?

154. Dr Patterson: I will answer first, and Dr Dunn may wish to comment as well.

155. On the composition of the tribunal, no one could now sustain an argument that only medical people can have a say in such matters. However, the composition must represent a balance of people from medical and non-medical backgrounds. The tribunal has that balance.

156. As for the regulatory bodies, the GMC is undergoing a revolution in that it is no longer a doctors' organisation that regulates doctors, and there are radical proposals ahead for that body. There is talk of no one scrutinising the profession, but other regulatory bodies exist. The National Clinical Assessment Service (NCAS) is a broad church, as is the Regulation and Quality Improvement Authority (RQIA), which is the regional quality inspection body in Northern Ireland.

157. Numerous checks and balances are available, and they seem to work. However, it will be for the Assembly to decide whether additional measures are necessary. We must examine the existing available measures and make them work to the best of their

capacity. The danger in having many organisations and measures in place is that they might leave it to one another to address matters.

158. Rev Dr Robert Coulter: Could you provide the Committee with a steer on how you see the tribunal working?

159. Dr Dunn: We do not have a problem with the Health Service tribunal. If a practitioner is suspended by the tribunal, pending investigation, we do not have a problem with that. We worry about practitioners being investigated on flimsy evidence before suspension happens.

160. As Dr Patterson said, a raft of people are regulating what happens in general practice. Complaints procedures are in place, so if patients are not happy, they can make a complaint, which would be investigated by the complaints panel of the area board.

161. Our worry is that the legislation is being introduced only because it has been introduced across the water — it is really English legislation. The Bill adds nothing to the regulation of the medical profession here; instead, it may make regulation more difficult by instituting suspension rather than remedial procedures.

162. The majority of suspensions on grounds of medical practice are usually due to illness. General practice, believe it or not, is a stressful job with a high incidence of stress, alcohol abuse, etc. Most GPs underperform for those reasons, and they do not require discipline, but help. Some GPs may not be in a position to benefit from full remedial processes, but there are enough hurdles for GPs to jump over as things stand. The Bill is simply replicating what has happened in England. There are enough processes in place in Northern Ireland to protect the general public.

163. Mrs Hanna: Should health and social services boards not have the power to suspend GPs? I thought that they had suspended GPs in the past.

164. Dr Patterson: The profession has always worked with the boards to persuade people to opt for voluntarily suspension. Only the tribunal and the GMC can suspend a GP, but, in the Province, where everyone knows one another, we have always managed to make the system work without any formal powers, and secure help for people when appropriate. Formal powers do exist, but the difficulty for the boards is that they cannot invoke those powers; they have to go through the tribunal or the GMC.

165. Mrs Hanna: Which body is the profession's real disciplinary body: the tribunal or the GMC? If there were a serious allegation, to which body would one go first?

166. Dr Patterson: That depends. If the malpractice were serious enough —

167. Mrs Hanna: Whose takes the decision?

168. Dr Patterson: The only organisation with the ability to withdraw a doctor from doing his work is the GMC, which can remove him from the medical register. However, before that point is reached, the tribunal has the power of suspension.

169. Mrs Hanna: If someone is concerned about a colleague and believes that that person is unsafe to practise, for whatever reason, whom should they contact?

170. Dr Dunn: Dr Patterson and I have both been involved in this area. Frequently, representatives from the local medical committee and the board will visit a practitioner, point out the concerns that have been expressed and tell the person that he or she would be better not practising. If the practitioner accepts that advice, the board would usually arrange for locums to run the practice, and, if a mental-health problem were involved, attendance at a psychiatrist would be encouraged until the problem is resolved. If the practitioner were deemed dangerous and would not accept the advice, he would be reported to the GMC. I have had to do that.

171. Mrs Hanna: It has been said that doctors should take decisions for themselves. I think that there has to be a certain amount of independence, and it has been said that there are some independents on the tribunal. However, at times, there must be someone from outside who can take decisions. Lines of authority must be clear for the safety of patients and doctors and for public confidence. We can get bogged down in the language of legislation, and it can be difficult to pick up exactly who is accountable, particularly when people raise a variety of concerns.

172. Dr Patterson: The tribunal comprises predominantly laypersons, but doctors are involved too. The GMC's fitness to practise committee comprises 50% doctors and 50% lay people. Therefore, the days are gone when only doctors regulated doctors, and we do not advocate that. However, as doctors, we feel that we have something to contribute to the decision-making process.

173. Mrs Hanna: It can be difficult to ascertain who holds accountability because there seems to be three or four bodies involved.

174. Dr Patterson: I agree, and we do not need another one.

175. Dr Deeny: I hope that I do not have a conflict of interest, but I agree that doctors must be accountable to their patients.

176. My question has, perhaps, been answered in reply given to Bob Coulter. It concerns me greatly that boards will take over the investigative role completely. First, the boards are supposed to be being replaced by local commissioning groups. What will happen if that takes place? Secondly, what do you see as the roles of the GMC and the Medical Defence Union (MDU)?

177. Dr Patterson: I will answer the latter question. The GMC must be able to remove a doctor's registration. It also must have the ability to assess a doctor's fitness to practice before that becomes an issue involving registration and make recommendations that either the doctor's practice be restricted, as we said earlier, or that the doctor needs some remedial action. The GMC must be able to insist on that. All those powers do exist, but they will be strengthened through the ongoing Donaldson Review, and that is important.

178. The MDU must be involved, purely because, if a doctor were suspended, it would act in his defence. It would examine the issues and try to defend or advise the doctor. It has a vast array of knowledge, based on the cases that it has dealt with over the centuries. The Assembly and the Committee would find the organisation's guidance invaluable on what can go wrong and what the deficiencies would be in trying to fix them.

179. Dr Dunn: The boards will be replaced by the health and social care authority (HSCA), and it will have exactly the same powers. Like Mrs Hanna, we are concerned about legislation. Legislation can seem reasonable until someone on a board interprets it in a totally different way. What can seem a benign provision in legislation can become draconian when someone who does not understand the issues implements it.

180. Dr Deeny: I have two follow-up questions. Would it be a good idea for the public to be made more aware of the process, and should the process stay the same, with the tribunal being shared between medical professionals and others?

181. Members of the public are concerned because they are not sure what happens when a complaint is made against a GP. Would it not be a good idea to make the public aware of the process?

182. Dr Patterson: We would have no difficulty introducing a programme of information for the public. I doubt whether members of the public are aware that the

tribunal exists. The majority are aware of complaints procedures, and we have a duty to advertise those. That could be strengthened.

183. These issues are vital, but, to put them in perspective, they are rare. However, the public should be made aware of the procedures, and public representatives should know how to advise their constituents if they need to make a complaint. The difficulties occur when people do not know what to do. The procedure is complex, but it could be even more so if other options were put on the table. We need a programme of information, so that patients and their representatives know what to do in certain situations. If, for example, patients suspected a doctor of "doing a Shipman", to whom would they turn? That is important.

184. However, the biggest task is in making people aware of the initial complaints process. It is vital that we improve that, rather than add more complications.

185. Dr Dunn: I support that, because members of the public are sometimes their own worst enemies. Obviously, doctors develop professional relationships with patients, and sometimes those patients can be too understanding. I have known doctors who have been underperforming, but their patients have excused them. It would be worthwhile publicising what should be done. The measures should not be seen as draconian. If a doctor is underperforming for a reason, he can receive help, and that information would help patients.

186. I can talk about an incident that happened years ago because the person involved is dead. One of a particular doctor's patients used to describe him as a great doctor when he was sober. The patient was excusing him, and that is understandable. The BMA would not excuse him, but his patients let him get away with that because of their relationship with him.

187. Patients need to know how to address issues. We are in favour of not hiding anything. We want patients to have the service they deserve and to know what to do if they do not get that service.

188. Mr Buchanan: As regards the answer given to Alex Easton about automatic suspension, which the BMA may feel reluctant about, or feel that other practices could be in place, it was said that if a doctor showed incompetence in treating or diagnosing children, that should not prevent him from working with adults.

189. If such a thing were to happen in a practice, especially in a rural area, where a fair percentage of that practice would be taken up by children's services, it would have an added, knock-on effect in that area and would cause concern and discontent. Automatic suspension would not cause the same disruption.

190. Mr Patterson: There are two ways of looking at that. It would be even more disruptive in a rural area if a doctor's total capacity were removed. That would leave a deficiency that might be difficult to fill in the present environment. It would be better to leave some capacity in place and find an alternative way to meet the deficit.

191. However, that may not always be possible, and I accept the example given by Mr Buchanan. In such a case, it may not be possible to have a partial suspension: it may have to be total. But the opportunity to save some service provision, where possible, ought to be taken, or a community could be left even more vulnerable. That may not always be appropriate, but it is an important consideration.

192. Dr Dunn: Northern Ireland has about 120 locum doctors, but ask any GP about how easy it is to employ one and he will tell you that it is absolutely impossible. It is not easy to replace a GP quickly. Patients could be left without a service or with a service in which they would have a different doctor every day, and where there would be no continuity of care.

193. Dr Patterson: There are examples in secondary care where that can happen. There have been cases in which consultants have raised questions about the ability of a surgeon to carry out a procedure but the surgeon has not been suspended from doing all procedures. He would have been suspended from that procedure, or from operations but would have still been able to work in outpatients. Total suspension should not be a simple or first option. It should be the last resort.

194. Mr Gallagher: There are high standards among GPs and there have been very rare occurrences when the tribunal procedure has had to be invoked. The difficulty with suspension is that individuals are presumed guilty until proven innocent. The alternative would be to leave things as they are but make people more aware of current procedures in order to engender the greater confidence that has been talked about.

195. Is there a rule about how late, or how soon, a tribunal comes into play after a report or serious complaint about an incident? If the doctor involved decided to engage in a series of ploys to delay the hearing for as long as possible, what would happen, and are you happy with that situation?

196. Dr Patterson: Dr Dunn and I have been involved with systems that were frustrating in the length of time they took. Making a tribunal, which is the first real port of call, more responsive and timely would solve that problem.

197. It could be done, and it would be fairer than holding some sort of kangaroo court before the tribunal had time to consider a case. It would also be much fairer way of tackling the issues in that the tribunal would hear not only from a board official but from professional and lay representatives also. The current process needs to be strengthened and made more efficient and responsive — we are strong advocates of that. As a second line to what we are doing, it would also make people aware of the process.

198. However, we need to put the matter in perspective. What is the size of the problem that we are trying to address? Should that problem be addressed using the proposed legislation, or do the planned provisions simply mimic what has happened elsewhere? We are a fairly unique community and — thankfully — we can now make our own decisions about such matters, so we can have this discussion rather than just blindly follow others.

199. Both Dr Dunn and I have been frustrated by the fact that the process is not as quick as it should be. It needs to be quicker in order to protect people. However, the issues need to be solved through the proper people — lay representatives and the profession — working together rather than by simply allowing some official to make a judgement.

200. Dr Dunn: We are not trying to cloud the issue or to delay matters. As Dr Patterson said, we have been frustrated in the past, and we want a system whereby cases are dealt with quickly.

201. The Chairperson: Gentlemen, I hope you feel that you have been given a fair hearing. It is lovely to see you all again. We will no doubt see much more of each other as time goes past. Thank you very much for coming and God bless.

202. The Chairperson (Mrs I Robinson): Welcome Ms Claudette Christie, the director of the British Dental Association Northern Ireland, and Mr Seamus Killough, the chair of the British Dental Association Northern Ireland council. Ms Christie will make a 10-minute presentation, which will be followed by questions from members. I ask Ms Christie to deal specifically with the provisions in the Bill and to indicate which clauses, if any, should be amended. Questions from members should preferably be aimed at further elaboration or clarification of the specific issues. After the 10-minute presentation, there will be approximately 20 minutes for questions.

203. Ms Claudette Christie (British Dental Association Northern Ireland): We are pleased to be here, and I thank the Committee for the invitation.

204. To give some overview, the British Dental Association (BDA) is the professional association and trade union for dentists. We represent more than 20,000 dentists across the United Kingdom and the majority of dentists in Northern Ireland. We are delighted to be giving evidence to the Committee, and we have provided a supporting written submission.

205. Normally, we lobby politicians to recognise the problems that the public face in accessing dental services, and we will look to the Committee for similar recognition of those issues. We want to work towards ensuring that Northern Ireland develops a properly resourced dental service that provides the public with high-quality dental care that meets the needs of patients and, ultimately, improves the appalling oral-health record in Northern Ireland.

206. Northern Ireland's oral health is the worst in the UK, and it compares poorly with that of the Republic of Ireland. Northern Ireland's 12-year-olds have more than double the level of tooth decay than their peers in the rest of the UK. Tooth extraction is the largest single reason that children in Northern Ireland receive general anaesthesia. Poor oral health affects people's general health and life chances. BDA Northern Ireland believes that steps should be taken to address and reduce those inequalities.

207. I am sure that the Committee is aware that a primary dental care strategy for Northern Ireland was launched in 2006. That strategy proposes fundamental changes to the way in which dentistry is provided. It includes the introduction of local commissioning and a new contract for high street dentists. Indeed, some of those matters are covered in the Bill. The strategy offers a unique opportunity to transform dental provision in Northern Ireland and to address the poor oral health that prevails.

208. The costs of running a dental practice have continued to outstrip the funding that is provided to manage it. The symptom of that is now much more apparent in Northern Ireland, as patients find it much harder to get access to Health Service dental care. The BDA is concerned about that, as well as about the historic underfunding of dentistry and the growing demands on the profession that make that access increasingly difficult.

209. Dentists have a crucial role to play in patient education and in the promotion of good oral health. For instance, dentists detect the majority of mouth cancers during routine patient examinations. Oral health promotion and preventive dental care require dentists to spend adequate time with their patients. However, the ability to do so is currently missing. More than two thirds of high street dentists in Northern Ireland believe that they are unable to spend sufficient time with individual patients in order that they can take a more preventive approach to care. The BDA, therefore, calls on the Northern Ireland Assembly to ensure that any new arrangement proposed by the primary dental care strategy should improve oral health and assure the quality of dental care that is provided to the public. New arrangements should address the escalating costs that dental practices experience in providing that service, and they should ensure stability for and give additional funding to dentistry.

210. The representatives of the BMA said much of what we would say about the Bill, and we are grateful for that. Although the BDA recognises that changes to the powers of the Health Service tribunal and boards are necessary, we are concerned at the introduction of an additional ground under which a tribunal may deal with a practitioner. That ground is unsuitability by reason of professional or personal conduct, and it needs to be clarified.

211. The Bill also fails to recognise the role of the UK regulatory body for dentists, the General Dental Council. There is a proposal to extend the categories of person who are subject to the jurisdiction of the tribunal. The BDA requires clarification on how that will

be extended and to whom. For example, the General Dental Council is about to register by statute dental care professionals. Clarification is needed on how that will be progressed.

212. Like the BMA, the BDA is concerned at the proposal that a local practitioner can be suspended without the right of appeal once a board has decided that there is a case to answer. It is inappropriate to classify that as a neutral act. It can never be a neutral act to suspend someone and withdraw his or her ability to make a living and provide a service to, for example, a local community. A right of appeal and a review mechanism should be attached to that local suspension. The local impact of suspension should also be addressed.

213. We echo what the BMA delegation said about payments to suspended practitioners. It is imperative that there is clarity about the payments that suspended dentists receive. Suspension must not penalise the practice or the service delivery. Although that is appropriate for all communities, it may have more of an impact on rural communities.

214. Many of the primary dental service provisions are already in place in England, but in a different way. BDA Northern Ireland accepts that there are provisions in the Bill that would facilitate local commissioning, which can take place in various ways. Northern Ireland does not have to follow the same format that exists in England and Wales, although there are lessons that can be learned. Therefore, the proposed addition of article 61E to the Health and Personal Social Services (Northern Ireland) Order 1972 — "General dental services contract: disputes and enforcements" — BDA Northern Ireland requests full consultation on the proposals, so that there will be a meaningful resolution of disputes with contracts.

215. With regard to transitional arrangements, it is imperative that any new contract arrangements are not to the detriment of existing dental service providers. Funding that is dedicated to the provision of dental services must be ring-fenced for that purpose over the transitional period, so that no problems arise in that time.

With regard to disputes over contracts, BDA Northern Ireland suggests that there is professional involvement when resolving disputes. That also applies to the application of a test period in developing a new contract. Clause 3(7) of the Bill says: "An order made under this section shall be subject to negative resolution."

216. Legislation arsing from the Bill should be subject to the affirmative resolution procedure and should include consultation with BDA Northern Ireland.

217. To secure future public dental services, it will be imperative that all the demands and requirements to provide a new contract are taken into account. That will require an investment framework.

218. The Assembly must acknowledge the poor state of dental health in Northern Ireland and recognise that investment is needed to secure dental services to the public in the future. The cost of change may also be an issue to consider.

219. We are opposed to clause 15 of the Bill because smoking is detrimental to oral health.

220. BDA Northern Ireland would like dental public health included, or at least clarified, in the Bill. It is not mentioned in the Bill, despite its input being necessary to secure a dental contract that meets needs of patients in Northern Ireland.

221. The Chairperson: How much does it cost to train a dentist? If there is significant public investment in training dentists, does the public not have a right to expect that those who are trained should work in the NHS?

222. Ms Christie: I do not know what the cost of training a dentist is. As with all students who go through publicly funded tertiary education, there is no obligation to go into public-service employment.

223. The Chairperson: It was mentioned that BDA Northern Ireland is not happy with the negative resolution provision. If that were changed, and the right of appeal against suspension were afforded, would you be happy with the wording?

224. Ms Christie: We will consider asking for regulations to be subject to affirmative resolution. The regulations that govern dentistry are of primary importance, and, therefore, the issue should be brought to the Assembly so that a full debate can take place.

225. Dr Deeny: As a health professional, I agree with what has been said. There is a concern that health professionals are treated as guilty until proven innocent, and that it almost amounts to a trial by media. However, openness is also important. The public should be aware of what action they should take if they want to make a complaint against a health professional.

226. I have a responsibility to report any colleague whom I believe to be underperforming. If there is an instance of negligence, I would also be held responsible if I had failed to report that doctor. Is that the case with dentists?

227. Funding has been mentioned, and it has been said that the dental service is chronically underfunded. Lack of funding is a problem for all Departments, in various areas. What is the difference between private dental work and National Health Service dental work? Furthermore, how could the funding difficulty be alleviated or resolved?

228. Ms Christie: If a colleague were underperforming, as with doctors, dentists would have a professional, ethical duty of care to make their concerns known. That can be done in a number of ways, including through talking to colleagues, highlighting the problem to the board, talking to the medical indemnifiers, and so on.

229. I have been asked what impact underfunding has on the dental service. We are aware of the impact, because patients are telling us that they are finding it harder and harder to receive Health Service dental care. That is frustrating for patients, but it is also frustrating for dentists. That situation has arisen as a direct and long-standing result of the contracts under which dentists work.

230. Dentists are paid fees, which are set by Government, for the treatment that they carry out. Out of those fees, dentists pay all their expenses, including building expenses, staff and equipment costs, any costs for meeting the legislative and regulatory burden, such as to comply with health and safety requirements, and so on. The fees for treatment are depressed and have not kept pace with expenses — never mind with other factors such as modernisation. The result is that dentists must work faster in order to meet their expenses. That creates a treadmill effect, which has been well recognised by the Audit Commission. The situation that a professional should have to work in this way is not sustainable. Therefore, for those reasons, dentists are forced to leave the Health Service.

231. BDA evidence shows that dentists are reluctant to leave the Health Service. However, they do so to enable them to give patients more time, more choice and an improved service.

232. Rev Dr Robert Coulter: Thank you for attending the Committee.

233. What would be a suitable contract for a dentist?

234. Ms Christie: Negotiations with the Department are ongoing. Therefore it may be out of turn to talk about a suitable contract.

It may be helpful to highlight a comment to the Committee by the acting Chief Dental Officer on 24 May 2007, when he said: “we want to pay dentists for their time and insert appropriate performance measures”.

235. The entire focus of the current dental contract is about treatment, but that treatment must have prevention as its basis. Without that focus on prevention, Northern Ireland will continue to have the worst dental health in the UK and Ireland, and that is inappropriate.

236. Moreover, Northern Ireland’s young population continues to have poor dental health. There are also people in the older population who have complexly restored mouths, and they have more teeth than our parents have or had. There are problems at both ends of the spectrum. It is therefore imperative to prioritise the need for improved oral health. In order to do that, prevention must lie at the basis of the contract.

237. However, resources and innovative measures will be required for that to happen. Any new system should be fully piloted and tested before it is rolled out. The Committee will have a key oversight role to play in order to ensure the development of a properly resourced public Health Service for patients of which dentists will want to be part.

238. Mr Seamus Killough (British Dental Association Northern Ireland): It is not only the message of “clean your teeth twice a day” that must be conveyed. Any new contract must recognise the role of dentists in all areas of prevention — be it smoking cessation, oral cancer screening, fluoride advice — and the contribution that they can make.

239. Heart disease and cancer are the biggest causes of death in the developed world, and smoking and poor diet are two key risk factors associated with those conditions. However, smoking and poor diet also relate to dentistry; for example, gum disease can occur as the result of smoking, and dental decay can occur as the result of a poor diet. Dr Coulter has an excellent article in the ‘Coleraine Chronicle’ this week, headlined, “Diet, diet and diabetes”. He gives an insight, along with excellent commentary, on the alarming increase in those who suffer from diabetes.

240. A small number of risk factors impact on a large number of diseases. Oral-health promotion is, and must be, linked to general health promotion. In order to incorporate the prevention of dental decay into the practice, it must be recognised in any payment system.

241. The Chairperson: While the officials are present, I wish to clarify an issue under clause 2.

242. What determines whether regulations are subject to negative resolution or affirmative resolution? If that were to be changed in the Bill, would it strengthen or weaken the reasoning behind the negative resolution procedure?

243. Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): Statutory rules subject to negative resolution is more frequently used, with 90% of rules being made under that procedure. That requires the Statutory Rule to be laid before the Assembly as soon as possible after it is made. The Committee for Health, Social Services and Public Safety decides whether it wishes to consider the Statutory Rule, and it can call officials if required. The Committee could then table a motion to annul the Statutory Rule.

244. The main difference between negative resolution and affirmative resolution is that the affirmative resolution procedure requires a Statutory Rule to be approved by the Assembly before it is made. That is the main difference. The majority of secondary legislation made during the previous period of devolution was made under negative resolution. The Committee can still consider the rule and, if so desired, the Committee could pass a motion to annul the Statutory Rule, even though it is made.

245. The Chairperson: The Committee will have a chance to discuss that when it scrutinises the Bill at Committee Stage.

246. Thank you, Ms Christie and Mr Killough, for your attendance and for making your presentation.

Thursday 28 June 2007

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Tommy Gallagher
Mrs Carmel Hanna
Mr John McCallister

Witnesses:

Mr Raymond Anderson Mr Raymond Blaney Dr Kate McClelland	Pharmaceutical Society of Northern Ireland
Ms Stella Cunningham	Southern Health and Social Services Council
Ms Maggie Reilly	Western Health and Social Services Council
Mr John Farrell Mr Robert Kirkwood	Department of Health, Social Services and Public Safety

247. The Chairperson (Mrs I Robinson): The departmental officials attending today's Committee meeting are Mr John Farrell, an assistant director of the primary and community care directorate, and Mr Robert Kirkwood, from the departmental Bill team. They are on hand to offer advice.

248. I welcome the representatives of the Pharmaceutical Society of Northern Ireland, who are here to give evidence. Mr Raymond Anderson is president of the society, and Mr Raymond Blaney is its director. Dr Kate McClelland is a member of the Council for Healthcare Regulatory Excellence (CHRE) and is a representative of the Pharmaceutical Group of the European Union (PGEU). I would not like to try to say that mouthful if I had a drink on me.

249. I ask you to deal specifically with the Health (Miscellaneous Provisions) Bill, and the clauses in the Bill that you would like to see amended, if any. You have 10 minutes to make your presentation, and then we will have approximately 30 minutes for a question and answer session.

250. Mr Raymond Blaney (Pharmaceutical Society of Northern Ireland): Thank you for saving me from making the introductions, especially for the Pharmaceutical Group of the European Union. The Pharmaceutical Society of Northern Ireland is grateful for the opportunity to make a presentation and give evidence to the Committee today.

251. The society is the regulatory and professional body for pharmacists and pharmacies in Northern Ireland. We currently host a register of 1,898 pharmacists and 529 pharmacies.

252. Although pharmacists are not numerous in Northern Ireland, the discipline is not small in reputation. Queen's University is regarded worldwide as one of the top

universities for pharmacy education. Its degree course has been provided since 1929, which makes it one of the oldest courses in the United Kingdom.

253. Almac Group Ltd, which was established in 2001 and is based in Craigavon, bought over Galen Holdings plc in 2004. It is now a $600 million company, employing almost 2,000 people across the US and Europe. Almac offers an unparalleled range of pharmaceutical services on a global scale.

254. Northern Pharmacies Ltd was established in response to the need to provide pharmacy services in areas that did not generate natural business opportunities. Established in 1968 to serve Craigavon, it now has three further pharmacies in Greyabbey, Poyntzpass and Cullyhanna, and its turnover in 2006 was about £2·6 million. Profits are either reinvested into the organisation or it divests itself of them through its charitable organisation, which helps to promote pharmacy practice and education, supporting the advancement of the profession.

255. The Pharmaceutical Society of Northern Ireland has existed since 1925, and, over that period, it has established itself firmly as the lead regulatory body for the profession. Public safety is never compromised when considering the regulation of the profession. It demonstrates its commitment to the public by operating an independent statutory committee structure and an independent inspectorate. It is the only nation-specific healthcare regulator and the only regulatory body to have an independent inspectorate regime.

256. The society, like the profession, is undergoing a period of change. The legislation under which it was established, The Pharmacy (Northern Ireland) Order 1976, is no longer appropriate for the profession and the practices that we regulate today. The recent publication of the Government White Paper, 'Trust, Assurance and Safety — The Regulation of Health Professionals in the 21st Century', is the culmination of the work of Foster and Donaldson in response to the Shipman, Kennedy, Kerr/Haslam, Ayling and Neale Inquiries. All recognised the need for regulatory bodies to have the necessary and appropriate structures in place to adapt to modern healthcare practices to ensure the confident delivery of patient safety.

257. Although the recommendation is, ultimately, that the regulatory and professional representation rules must be split, the Pharmaceutical Society of Northern Ireland acknowledges that this is an ideological position rather than one evidenced in fact. The Harold Shipman case occurred despite the separated functions, and Dame Janet Smith's report praised the independent inspectorate system while acknowledging that the system was only sustainable in a region of the size of Northern Ireland.

258. The current legislation restricts the society's role in defining the structure and make-up of the society's council; namely, by excluding lay representation. It defines the register of pharmacists as only practising pharmacists, not allowing for those who are non-practising or retired. The range of sanctions that is available to the council is also restricted, because it can only recommend striking off or retaining pharmacists on the register. Remaining outwith our legislated remit are the rehabilitation of professionals and support; the interim measures of supervision and support; continuing professional development; and registration of technicians.

259. The Pharmacists and Pharmacy Technicians Order 2007 has enabled the Royal Pharmaceutical Society of Great Britain (RPSGB) to advance its powers. It has provided a legislated arrangement that, arguably, provides greater patient protection in Great Britain than we enjoy in Northern Ireland. For example, if the Pharmaceutical Society of Northern Ireland made a direction to remove a pharmacist from the register, that person would still be entitled to practise for up to a further three months, allowing them the right to appeal the statutory committee's decision. However, in Great Britain, if

appropriate, the individual may be instructed that he or she may not practise during that period. The 2007 Order does not remove their right of appeal.

260. The regulatory environment is changing, and the society is ready for the challenge. It has begun the process of reforming its organisation, has participated fully in Lord Carter's working group and continues to work with the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Health in Great Britain to establish the most effective regulatory solution for Northern Ireland.

261. The society has set up its own working groups to focus on the areas of governance, legislation, functions, registration and education in Northern Ireland. A one-size-fits-all solution to UK-wide healthcare regulation would not necessarily be the most appropriate route to go down. It is important to take into consideration the differences between Great Britain and Northern Ireland in order to ensure that a Londoncentric position is not foisted on Northern Ireland's patients. It is essential that those differences are recognised and, where appropriate, protected.

262. Northern Ireland is the only UK nation with an EU land border. The relationship with the Republic is important from a regulatory and employment perspective. Without a clear and agreed regime in place for cross-border treatment and drug control, the Province could be more exposed than any other UK nation. Northern Ireland's pharmacies have a footfall of 123,000 patients daily. Nearly 29 million prescriptions were dispensed in 2006. Through initiatives such as the minor ailment scheme, the management of prescribed medicines and chronic conditions, and the support offered to guide patients towards healthier lifestyle choices — smoking-cessation clinics, and so on — community pharmacy is becoming increasingly focal.

263. Northern Ireland has a ratio of 61:39 independent to multiple pharmacies compared with the GB ratio of 52:48. The nature of the pharmacy as part of the community is an essential factor that makes Northern Ireland's pharmacies so successful across all sectors: specialist; hospital; academia; industry; and community. Pharmacists tend to offer the last opportunity in the dispensing chain to correct an error or to hear about patients' concerns. Often, it is during a one-to-one conversation between a patient and his or her pharmacist that a side effect is discussed or a worry is shared that can significantly impact on the patient's treatment. That is not to say that errors do not occur; however, in considering risk management, the society has expressed its concerns about the proposal to allow remote pharmacy supervision.

264. In the society's opinion, the question is about the need to balance the desire to provide greater clinical care in the community with the need to manage the risk of increased exposure to dispensing errors. Those issues can be mitigated to a degree by improving and raising standards and processes in pharmacies. In order to implement that, the society is working closely with the Department, to which it has submitted a business plan for the introduction of standards measurement across community pharmacy, the concept of which the society intends to roll out to hospitals.

265. A further step would be to ensure that all pharmacies have two pharmacists in the practice, that a co-operative arrangement be introduced among local pharmacies or simply that a locum be employed to cover the time when clinical practice means that a pharmacist will be off the premises.

266. The profession welcomes the fact that the Government have requested an increasing breadth of services from it in order to ease the pressure on the Health Service. However, that must be done in a considered and supportive way that will not compromise patients' safety. The society believes fundamentally that the introduction of the "absent pharmacist" could be abused in such a manner that it would not achieve the intended aims; rather, patients could suffer as a result.

267. The Department undertook a survey in 2006 on public attitudes to health and social services in Northern Ireland. The results for pharmacies spoke volumes: 99% of patients were satisfied with pharmacy services; 96% were satisfied with the general attitude of pharmacists; and 18% of service users called for better access to services. The ambition must be to continue to achieve that level of satisfaction and to consider how the needs of the 18% of patients who require greater access can be better satisfied. Would that be achieved by the introduction of remote supervision? It may appeal to the larger corporate organisations that wish to centralise their superintendent- or responsible-pharmacist role across the UK. However, would that satisfy corporate efficiency goals or effective patient-treatment objectives?

268. As for increasing a health and social services boards' remit for sanctions, we understand the premise for that, but we do not consider it necessary for a board to go beyond the remit of its employer disciplinary systems.

269. The Pharmaceutical Society of Northern Ireland holds a central register of pharmacists, and a statutory committee process is in place. It is important for patients and professionals that the Government support the regulatory bodies that statutorily provide a service rather than look elsewhere to bolster regulatory practice.

270. We urge the Committee to consider the legislative powers that are granted to the society as a primary objective, and to support the tasking of the boards to work with the society to reflect its standards in their disciplinary procedures. That approach would ensure clarity for patients and professionals alike rather than duplicate what is already established or potentially create a situation in which two professional disciplinary systems that are neither compatible nor consistent are in place.

271. A health and social services board could, for example, instruct that a person be suspended or removed from its list. The statutory committee could determine that an issue does not warrant removal from the register but may agree that a person should be suspended. However, our powers do not allow for that. Therefore a pharmacist who is considered unemployable by a board could be retained on the society's register. As a result, that person would have extremely restricted employment opportunities. That dilemma is not far-fetched, and has been experienced by other healthcare regulators. That is not helpful to the profession, the patients or the public purse.

272. In order to address regulatory processes, we must deal with the issues that the professional regulatory body has been raising. Another layer of regulation must not be introduced. When the regulatory issue arose in Great Britain, the Better Regulation Task Force advised that another layer of regulation should not be adopted. We ask the Committee to consider what is best for patient care: a strong regulatory body with appropriate legislative powers, or an additional layer of regulation that could add confusion.

273. The society, which has been in existence for more than 80 years, recognises the demand for reform and broadly welcomes the changes that are recommended in the White Paper. We have a difference of opinion about the implementation of a solution across the UK, and ask for the Committee's support to ensure that everything possible has been done to provide the best solution for patient safety and care in Northern Ireland.

274. Devolution provides us with the opportunity to make our own determinations, and to focus on and address local issues. As the specific regulator for pharmacy in Northern Ireland, the society requests that the Committee recommend that legislative limitations and inadequacies be addressed as a priority in order to provide the optimal regulatory provision in Northern Ireland.

275. Representatives of the Department — Mr David Bingham, Dr Norman Morrow and Ms Joyce Cairns — are assisting with that process. We urge the Committee to

request that addressing legislative limitations and inadequacies be made a priority so that we can be confident that the best solution is in place for patients and the profession.

276. The Chairperson: Thank you, Mr Blaney. How many pharmacists have lost their livelihoods since the society was established?

277. Mr Blaney: On average, there are two or three statutory committee hearings in Northern Ireland per annum. I estimate that an average of 75% of pharmacists who are called before the committee remain on the register. I do not have accurate figures with me.

278. The Chairperson: How do you respond to the accusation — I am playing devil's advocate — that the society is looking after its own fiefdom, and does not want others involved in overseeing the workings of pharmacists?

279. Mr Blaney: There are two responses to that. First, I am the director of the Pharmaceutical Society of Northern Ireland, but I am not a pharmacist. The society is demonstrating that it wants to change.

280. In dealing with current legal limitations, we try to think outside the box to encourage the involvement of lay members.

281. Secondly, a regulator cannot operate effectively without there being a connection with the professional body that it is attempting regulate. If there is no such connection, regulation from afar will not necessarily be effective or relevant.

282. Our primary objective is not to protect the profession but to ensure patient safety. That is done by representing the profession, promoting better standards, and ensuring that the requisite support exists to allow the optimal delivery of services that members want for patients. Pharmacists do not enter the profession without adhering to those core principles. If they did not hold to those principles, they would probably end up before the statutory committee.

283. Dr Deeny: Thank you, Raymonds and Kate. We had three Brians before us last week, and now we have two Raymonds.

284. As a health professional, I have an interest in this matter. Moreover, my father was an old-time pharmacist who worked closely with the community in Downpatrick for years.

285. Earlier this week, I read in a GPs' magazine that health professionals seem to spend more time in seminars, learning how to administer the Health Service, than working with patients, so I take your point that new measures may simply be another layer of bureaucracy to ensure safety. With that in mind, but conscious that patient safety is paramount and that balanced decisions are required because one is dealing with someone's livelihood and reputation, you mentioned that you could strike members off or retain them. That seems to be a case of one extreme or the other. What options can you suggest to achieve a balance?

286. Furthermore, having worked as a GP in primary care for well over 20 years, and with pharmacy in my blood, I ask what the future holds for pharmacists. The Chairperson mentioned that new hospital wards resemble those in the US. Whether our hospitals wards are copying the US model, I do not know. I have been to the US a few times, and I like the way that pharmacists take responsibility for advice that can be dealt with at their level, rather than having to organise appointments with GPs or trips to hospitals. Do you see such practices as part of the future? If the concept of administration of risk is imposed on Northern Ireland as part of a UK-wide extra layer of bureaucracy, will the community care that I witnessed while growing up be lost, and will community

pharmacies continue to play a proactive role alongside GPs and primary healthcare professionals?

287. Mr Raymond Anderson (Pharmaceutical Society of Northern Ireland): To the comments that Raymond Blaney and the Chairperson have made, I would add that the independent inspectorate separates —

288. The Chairperson: We are having difficulty hearing you, Mr Anderson. Will you speak up a wee bit?

289. Mr Anderson: There is an independent inspectorate that does not sit within the purview of the Pharmaceutical Society of Northern Ireland. If pharmacists engage in malpractice, the inspectorate, which is based in the DHSSPS, will carry out an inspection. The profession is separate from that process, and it is the inspectorate that would bring any cases before our statutory committee. Inspections and the regulatory function of the society are separate, and the existence of the independent inspectorate should dispel any sense that we protect ourselves. During the Shipman Inquiry, the inspectorate was acclaimed by Dame Janet Smith as a good system for regulating professionals.

290. In response to Dr Deeny's question, my answer is that the society is aware that the sanctions available to it are limited. The organisation is in discussion with the Department about that. The Royal Pharmaceutical Society of Great Britain has introduced the section 60 Order — The Pharmacists and Pharmacy Technicians Order 2007 — which is known as such because it was made in exercise of the powers conferred by section 60 of the Health Act 1999, and has increased its range of sanctions. Those sanctions can include suspension, but they may also involve retraining, supervised training, revalidation or time off the register in which pharmacists must prove their fitness to be placed back on it. Those sanctions are not available to us yet, but we want to see them introduced.

291. However, when considering whether we should adopt the UK-wide regulation process, it must be remembered that we have a land border with another EU country. That may lead to the movement of drugs, pharmacists and prescriptions across the border daily. Pharmacists here are not allowed to dispense any prescriptions that have not been prescribed by a general practitioner who is on the General Medical Council (GMC) list. The EU has taken a case to the Cabinet Office and to the UK Government. That case is being challenged in the European Court of Justice (ECJ). If the policy were to be changed, it would open up the movement of prescriptions across the border between North and South. Pharmacists could be faced with regulating and managing that daily, as could patients who move from the South to the North. Ways must be found to regulate that so that patients are not inconvenienced. That daily movement of prescriptions is not as important a consideration for England, Scotland and Wales who do not have a land border with another EU country.

292. Mr Blaney: Our society is not regarded as a supportive professional regulatory body, because the sanctions available to it only allow the polar-opposite positions of either removing pharmacists from the register or allowing them to remain on it. Pharmacists will not turn to the regulator to ask for help if the only options open to them are to be struck off or reprimanded. The society's role must change from one of negative regulation to one of positive regulation. It is important to consider how the range of sanctions is constructed, but we must also introduce a supporting framework to advance the profession.

293. Mr Gallagher: Raymond Anderson made the point about the problems that pharmacists who work close to the border face. I come from a border area, so I understand that regulations are needed that better reflect the fact that pharmacists work in areas close to the border and that their customers can come from either side of that border. Will you tell us again about your particular concerns about that?

294. Mr Anderson: An out-of-hours centre has been established in Castleblaney. That centre covers part of south Armagh. Prescriptions written in that area cannot be dispensed in the North of Ireland, because a general practitioner who is registered in the United Kingdom has not written them. The Cabinet Office is considering changes to the legislation, but if that legislative change goes through, prescriptions could be taken across the border and dispensed in pharmacies in the other jurisdiction. A pharmacist would then have to determine whether it was a legitimate prescription and, if the prescription was for schedule 2, 3 and 4 controlled drugs under the Misuse of Drugs Act 1971 and associated regulations, it would increase the chances of a pharmacist's deciding not to dispense the prescription because he or she was not sure whether the prescription was legal. Handwriting on prescriptions can easily be forged, and computers can also be used to forge prescriptions.

295. It can be hard to verify whether a prescription has been written by a GP or whether it is fraudulent. If we allow prescriptions to move across the border and be dispensed in both jurisdictions, pharmacists will have to be very vigilant about whether they are legitimate. That is one concern, although the movement of controlled drugs and the potential for controlled drug prescriptions to be dispensed across the border could pose a problem too.

296. Mr Gallagher: I hope that there will be a development of the out-of-hours GP services in border areas, although, as you are probably aware, a pilot scheme has been set up. Are you satisfied that those concerns will arise from the pilot studies that are under way?

297. Dr McClelland: The UK delegation is trying to get the Pharmaceutical Group of the European Union (PGEU) to change its name to the pharmacy group of the European Union, which would be so much easier; unfortunately, however, the German and French translations just do not go there. I am a member of the UK delegation, which, more often than not, forgets that the UK has a land border with another European country. The pilot schemes will show the way, one hopes, but let us start with pilot schemes. Let us take it slowly across the border.

298. The Pharmaceutical Society of Ireland and the Royal Pharmaceutical Society of Great Britain work closely together in Europe. The Pharmaceutical Society of Ireland has gone through huge regulatory changes, and it is now allowed all the derogations. All the problems with opening pharmacies and ownership have been swept away by the Southern Government, and the Pharmaceutical Society of Northern Ireland is waiting to see what happens there. Article 63 of the Health and Personal Social Services (Northern Ireland) Order 1972 and proposed new article 63AA of the Health (Miscellaneous Provisions) Bill refer to an application being "necessary and desirable". Europe could sweep that away. The UK delegation would like to keep it in, but our Southern Irish friends have let it go.

299. However, because we are a group of small islands off Europe, we must learn to work across the border to provide for patients; healthcare in Malta, Luxemburg and other small countries crosses borders, and they have full patient mobility where their Governments fund it. Does that help?

300. Mr Gallagher: Yes. Thank you.

301. Mrs Hanna: You mentioned community pharmacies and told us that the breadth of services is a plus. Does the proposed legislation puts that at risk? You also said that you do not like the pharmacy supervision proposals. Why is that? You said that one size does not fit all, which I accept. I am not saying that the proposals are good or otherwise, but could they be balanced in a way that would be acceptable? Should pharmaceutical professionals be included? Is the present system sufficiently independent?

302. Mr Anderson: I will address the first part of the question, which related to the risk to pharmacies and remote supervision. Regarding the latter, we are aware that some larger organisations are undertaking trials in which a pharmacist sits in a remote office and looks at a bank of screens. Therefore when patients go into a pharmacy, the pharmacist may not be there; instead, patients would use touch screens to take part in videoconferences with a pharmacist.

303. Mrs Hanna: Is that remote supervision?

304. Mr Anderson: Yes. Such a system could jeopardise the sustainability of pharmacies. It could downscale a pharmacy or remove the skills of the pharmacist from the pharmacy. If patients did not like remote supervision, they could go to a pharmacy where that service is not provided. However, patients might find that there is no longer a facility for them to go to a pharmacy with a minor ailment, or to discuss issues with the pharmacist relating to medicines or their side effects, or with matters that affect the family. Remote supervision risks losing personal contact.

305. Mr Blaney: If a patient has been taking the same medication for several months or has been given a repeat prescription, a pharmacist may intervene and ask why a treatment has not been successful; with remote supervision, that personal intervention may be lost.

306. Our fundamental questions about pharmacy supervision are whether the miscellaneous provisions realise the corporate goal of reducing costs for organisations, whether they upset existing one-to-one care, and whether they will improve patient care. That is a good example of our society not looking at professional ambition but at patient safety and treatment.

307. We are eager to ensure that a proper support network is in place and that expectations do not become so great that they dilute the community aspect of pharmacists' services.

308. Pharmacists welcome the clinical aspects of pharmacy — getting out into the community and working in GPs' surgeries. They welcome the minor ailment scheme, independent prescribing and opportunities to utilise the professional skills that they have been trained to provide.

309. We do not want to see a replication of the situation as regards GPs and nurses where, having been starved of an opportunity for so long, any opportunity would be grasped without ensuring that changes will not undermine quality of service. Consideration must be given to how the introduction of additional services and requirements can be supported.

310. As regards the White Paper, we have been fortunate. The Foster report recommended that the Pharmaceutical Society of Northern Ireland merge with the Royal Pharmaceutical Society of Great Britain (RPSGB). However, at that time, we were assured by Minister Burnham and Minister Goggins that no London-centric decision would be made and that Northern Ireland would have the opportunity to consider the future of its pharmacy regulation.

311. We set up working parties, but we have not taken a position on the matter yet because we wish to look at the opportunities that a UK-wide college for pharmacy could provide. However, we are concerned about the dilution of the regulatory function in Northern Ireland. At present, we have sovereignty and legislative responsibility and, considering the matter from the perspective of the Northern Ireland patient, we must think long and hard before we cede that responsibility.

312. The society could be made more open, transparent and inclusive to patients, perhaps through lay representation. However, the legislation does not provide for that. The legislation has been in operation for more than 30 years, so we would push for a re-

examination of the fundamental legislative framework that the regulatory body, which is empowered to provide sanctions and to regulate the profession, works to. If that could be changed, the Bill would enable the boards to reflect the requirements of the professional regulatory body.

313. Dr McClelland: The Council for Health Care Regulatory Excellence in London oversees all the regulators. However, at its inception in 2004–05, it saw no place for the Pharmaceutical Society of Northern Ireland.

314. That attitude softened following Dame Janet Smith's report. The view then was that, because of Northern Ireland's small population, its land border with another country and because it worked in a different way from the rest of the UK, pharmacy in Northern Ireland was one of the best regulated of the healthcare professions. However, the system was thought too resource-intensive to be duplicated. The chairperson of the Council for Health Care Regulatory Excellence asked me whether I thought that our local system for pharmacy regulation and inspection could be applied across the United Kingdom. I had to answer in the negative, because I thought it too resource-intensive.

315. If the present system is considered too resource-intensive, we must ask ourselves whether the Bill, with its provisions to set up another register and inspection regime in the health boards and the duplication that that would involve, would not be even more resource-intensive.

316. Mr Anderson: We have a high-quality system in which the inspectorate is separate from the organisation, and that is why it received acclaim from Dame Janet Smith. Dame Janet also considered the possibility of rolling out that system across the UK but felt that it was too resource-intensive. We must ask ourselves whether that is a good reason to throw away our system and change to one that might not be as effective or efficient.

317. The Chairperson: Thank you for your fine presentation; you have given the Committee food for thought. You will receive a copy of the report of our proceedings. The Committee would appreciate copies of any speaking notes that were used.

318. I welcome Ms Maggie Reilly, the Chief Officer of the Western Health and Social Services Council and Ms Stella Cunningham, the Chief Officer of the Southern Health and Social Services Council. Please address specific provisions in the Bill and tell the Committee which clauses, if any, you would like to see amended.

319. Your presentation should last 10 minutes, and then it will be open to Committee members to ask questions. You are most welcome, and I look forward to hearing your presentation.

320. Ms Maggie Reilly (Western Health and Social Services Council): Thank you very much. Good afternoon, everyone. Many of you will be aware of the existence of the four health councils — one in each health board area — which were established in 1991. They are often called watchdog bodies for patients as they serve as a voice for them. Therefore the four health councils welcome the opportunity that the Committee for Health, Social Services and Public Safety has given us to present our views on the provisions of the Health (Miscellaneous Provisions) Bill.

321. Our presentation is based on the views of council members across Northern Ireland and on our analysis of the concerns of the public and service users about the Bill. In particular, we will mention some of the issues that were raised directly with us as we supported people who were making complaints in the Health Service.

322. The Committee's invitation gives recognition to the health councils' role and we thank you for that. We intend to provide a much fuller response to all the Bill's provisions and amendments later. Ms Stella Cunningham will provide you with our views on general

dental services, and I will follow that with our comments on the provisions regarding disqualification by the tribunal, after which you will want to ask questions.

323. Ms Stella Cunningham (Southern Health and Social Services Council): The four health councils are pleased to offer comments on the clauses in the Bill that deal with dental services. Dental services are a core part of National Health Service provision and are fundamental to the general health of our population. This is a matter that the health councils have inquired into regularly since our establishment in 1991. You have been provided with recent research by the southern council into patient experiences of general dental services, and you have also been supplied with a joint statement from the four councils highlighting what we believe to be the crucial issues from the patient's perspective.

324. I want to make three points this afternoon. Patients' aspirations are changing and dental work is increasingly seen as a fashion accessory; however, Northern Ireland still has the worst dental health record in the UK, and we live with the political decision not to fluoridate the water supply.

325. First, we support the provisions of clause 2 for proposed new article 60A: access to NHS dentistry is at a critical point in Northern Ireland. If the new dental contract is not speedily resolved, the NHS will continue to leak dentists until the only option will be private treatment, and that could disadvantage vulnerable groups. In the southern area we conducted a survey of 68 dental practices in October 2006. At that time, 43% of practices in the southern area were registering NHS patients. When we updated the survey in May 2007, only 12 practices, or 21%, were still registering NHS patients. This means that it is virtually impossible to register with a dentist as an NHS patient in Newry and South Down, while in an area such as Dungannon there is extremely limited choice. That situation is replicated throughout Northern Ireland.

326. In the northern area only 27 practices, or 32%, now accept new NHS patients. There are no practices open in Carrickfergus, Cookstown or Magherafelt. Alongside the situation in Dungannon, we see that there is practically no capacity in the whole of the mid-Ulster area. In the western area there is no statutory out-of-hours dental provision; it has been left to dentists to provide that service. There is now no access to NHS dentists in Fermanagh or Omagh.

327. The health councils believe that there is a moral issue at stake: the public purse contributes to the training of dentists but does not gain full advantage from that contribution. Access to services also depends on where a patient lives.

328. Secondly, the health and social services councils welcome proposed new article 61, which the Bill will insert into the Health and Personal Social Services (Northern Ireland) Order 1972, as it will allow health and social services boards to make such arrangements as they see fit to provide dental services, whether by employing salaried dentists or by making local arrangements with primary dental care practitioners. Such arrangements should be based on local need and should aim at ensuring maximum choice for service users in a way that does not lead to NHS provision being perceived as a second-class service.

329. There will not be a one-size-fits-all solution. The Northern Health and Social Services Board has sought to employ salaried dentists; the Southern Health and Social Services Board's preferred option is to enter into contracts with high-street dentists for specific NHS slots. Whatever local arrangements may be made, they must be sustainable in the long term and provide boards with the ability to influence the location of practices to ensure equity of provision.

330. Finally, on proposed new article 61A and proposed new schedule 15A that clause 2(2) and clause 4(3) respectively will insert into the 1972 Order, the health and social services councils believe that the new contract should review dental charges. The

present system is cumbersome for dentists, confusing for patients and does not reward health promotion activity. A simpler tariff of charges limited to basic dental care, including health promotion, could separate services that are required for good general dental health from cosmetic treatments. A charging system that allowed patients to retain their NHS entitlement, while paying for enhanced treatments that are not available on the NHS, would retain the principle behind an NHS dental service and meet the expectations of today's service users. We also suggest that a further group — people aged 65 and over — be added to the list at paragraph 1(1) of proposed new schedule 15A.

331. We welcome the fact that the Bill allows a new dental contract to be negotiated. We urge that the opportunity to secure quality accessible dental services for all sections of our community should not be lost.

332. Ms Reilly: On the issue of disqualification by tribunal, the four health and social services councils welcome and strongly endorse schedule 1(5)

"After paragraph 1 (7), insert—

'(7A) The third condition for disqualification is that the person concerned is unsuitable (by virtue of professional or personal conduct) to be included, or to continue to be included in the list.'."

333. That ground is well recognised by the professional regulatory bodies and is in keeping with the principles of good clinical and social-care governance and of public accountability. We fully concur with the extension of the category of professions to include all practitioners who are on, or have applied to be included on, the board's list so that all such practitioners will be subject to the tribunal's jurisdiction.

334. It is self-evident that if a disqualification judgement is made against a practitioner, the sanction should be upheld in all board areas of Northern Ireland. Arrangements should be put in place to ensure that any sanctions that a tribunal in Northern Ireland, England, Scotland or Wales makes are appropriately communicated across the system to ensure that a disqualified practitioner may not practise in any of those regions. Therefore there is merit in having a UK-wide list that is open to all boards and Health Service commissioners. With the move towards greater co-operation and shared care for patients using the health service in the Republic of Ireland, and given some of the border-area arrangements, we hope that further arrangements will be put in place to ensure that such sanctions are communicated, recognised and enacted in both jurisdictions.

335. There should be a formal interface and integration between the function of the tribunal and that of the professional regulatory bodies on matters of alleged serious misconduct. That seems to have been missed in the Bill. We fully support the provision to allow boards to suspend temporarily a practitioner on referral to a tribunal, as that will create greater safety for patients.

336. In our experience, when a matter of conduct is referred to a body such as the General Medical Council and the case is judged to warrant a full investigation, boards do not have the power to suspend the practitioner temporarily. We want reassurance that the Bill will reflect the need for boards to be able to use temporary suspension for matters of serious misconduct, whether such cases are referred to the professional regulatory body or to the tribunal. The Bill makes no reference to referrals to the professional regulatory body. In cases of potentially serious misconduct, it seems logical to offer the same level of safety when a practitioner is referred to the regulatory body as when the matter is referred to the tribunal.

337. However, we caution against prolonged precautionary suspension as the practitioner has a right to have his case heard in a timely manner.

338. There may also be issues about a board's ability to fund and find temporary replacements for suspended practitioners, and that may affect patients. However, neither of those considerations should influence a decision to make a precautionary suspension.

339. Finally, we want to ensure that provisions to extend the powers and functions of the tribunal are open and transparent so that the public and patients can have full confidence in its workings and decisions.

340. The Chairperson: Thank you for your submission. Will the arrangements under the Bill be sustainable in the longer term?

341. Ms Reilly: Do you mean sustainable in general or in specific areas?

342. The Chairperson: In general terms.

343. Ms Reilly: Ensuring that all the provisions of the Bill are enacted will involve a cost. The Bill has been prepared with the present model of four health and social services boards in mind. However, a single health and social services authority, under the RPA, will presumably replace those boards. Therefore to ensure sustainability, account must be taken of imminent changes.

344. As regards patient safety, it depends what is meant by sustainability. Patient safety is most important, and the Bill reinforces it. The other issue for us is access to services. Therefore sustainability will ultimately depend on how much is invested.

345. Ms Cunningham: Since we do not have a sustainable dental service, we need the Bill to drive forward and build one.

346. Mrs Hanna: As regards driving forward dental services and improving access to them, we accept the points that you make. Will the Bill achieve those aims?

347. Ms Cunningham: It will enable the development of a new general dental services contract. The other important point is the role of the boards, which, as Ms Reilly said, will be replaced at some stage. The boards control the development of doctors' practices and pharmacies; however, dental surgeries are outside that control. Dental provision is a cornerstone of healthcare, and it should be treated in the same way as the provision of GP services. It is essential that boards have some control over the development of dental practices.

348. Mrs Hanna: Therefore a broad spread of services should be covered.

349. Ms Cunningham: Yes.

350. Mrs Hanna: Will dental provision be covered or is an act of faith involved?

351. Ms Cunningham: It is increasingly the case that more dental practitioners operate in the private sector than in the NHS sector, so there will always be some tension. However, giving boards a clearer role in deciding on the location of practices can only strengthen their hand.

352. Ms Reilly: To reinforce that point, it is important to note that this is the start of a process that will enable a contract to be hammered out between dentists and a board that will have some responsibility for commissioning dental services.

353. Mrs Hanna: Therefore it is the detail that is needed.

354. Ms Reilly: Yes, but the Bill is necessary to start the ball rolling and to give it some impetus.

355. Mr Buchanan: Why are dental practices closing or no longer taking on NHS patients? Dentists say that the NHS does not pay enough to cover a patient's treatment

and so they cannot carry out the necessary work to the required standards. That is why they are opting out of the NHS.

356. Ms Cunningham: We agree with that absolutely. There can only be sustainable NHS dental services if dentists feel valued and are recompensed as part of that. The current funding system is complex and is administratively heavy on dentists. They are not being rewarded for their health-promotion work, which most dentists do as a matter of course, even though they cannot charge for it. Anomalies in the charging system must be sorted out.

357. Another factor is the change in the way in which dentistry is viewed — affluent sections of society increasingly use the service as a kind of cosmetic-enhancement process. As people who speak from the patient's point of view in the context of the NHS, we believe that what is required is a dental service that can meet all sections of our community's health needs. We must ensure, through the Health (Miscellaneous Provisions) Bill, that dentists are rewarded for operating in the less affluent and more peripheral areas. Everyone needs access to good, general-health dentistry.

358. Dr Deeny: I agree. Maggie, you said that different areas have limited access to health services and dental services. As a GP, I am aware that there have been access problems in the south-west of Northern Ireland at weekends.

359. We have just learnt that Mr Shaun Woodward is to be the new Secretary of State for Northern Ireland. He said previously that the review of public administration (RPA) could result in the four health and social services councils being amalgamated into one body, which is to be called the patient client council (PCC). I do not like the word "client"; I prefer "patient".

360. As this is the first time that the health and social services councils have given evidence to the Committee for Health, Social Services and Public Safety, for my benefit and that of the Committee, will you clarify the role that they play? How much clout do the councils have? I know that they are supposed to be the patients' representative or spokesperson. There are many issues and problems across Northern Ireland; I hear about them every day. Do the public know enough about the councils, or about the proposed PCC?

361. Yesterday, in Omagh, a mother gave birth to twins in a hospital that has no maternity backup whatsoever. That is totally unacceptable, yet that sort of problem occurs all the time. What can be done if patients approach the councils with concerns about services that are completely inadequate and unacceptable? Could the public be made more aware of the councils' role?

362. It is good that the councils can lobby a Committee such as this, but will they, in future, be able to address patients' serious concerns about healthcare and health provision across Northern Ireland? Will a new single body have more power and clout?

363. Ms Reilly: The health and social services councils were established in 1990. When they started, they were only ever meant to be a committee of local people nominated to a council to debate and discuss healthcare issues, to raise them through their committee, to write letters to the appropriate bodies, and to lobby in that form.

364. As they developed, they did not have the appropriate funding to match that development. Furthermore, as the public became more aware that there was an independent body, speaking on their behalf, they began to go to the health and social services councils to ask them to intervene on their behalf, whether that was to support them in making complaints, to lobby on their behalf, or to advocate on behalf of individuals. Therefore part of our remit is to monitor the quality of the services that are provided and the general public's access to those services.

365. Our role is not to be a proxy patient, because we think that it is incumbent on the Health Service to speak directly to patients about services or changes to services. However, we will speak in the public interest, in the more general interest of patients or clients, or on behalf of any service users.

366. One of the most important functions that we perform is to support the public when they want to make complaints. Every health body has a complaints system, but sometimes it is inaccessible to members of the public. We support and help the public to understand their rights, and what they should reasonably expect from the system. The councils are available to ensure that the public have full access and receive full answers, and to monitor their progress right through to independent review.

367. We agree that it was a problem that we have never had the resources to make the public aware of the complaints system. It is a catch-22: when we make the public aware of the system, we do not have the capacity to deal with the resulting influx of enquiries.

368. Therefore we welcome Shaun Woodward's vision of a new PCC, which he outlined when he was Minister with responsibility for health. He said that a new council would have better resources and be much more powerful. However, the power will probably lie in the new council's level of influence — to whom it has the right to speak directly; whom it can pressure to make changes; its right to be listened to; and how its recommendations are acted on — as opposed to having statutory powers to act there and then. Such power rightly belongs to the regulatory bodies, such as the Regulation and Quality Improvement Authority (RQIA).

369. The Chairperson: I see that there are no further questions. That was a short session. I thank you, Maggie and Stella, for your interesting presentation.

Thursday 5 July 2007

Members present for all or part of the proceedings:
Mrs Iris Robinson (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Thomas Buchanan
Rev Dr Robert Coulter
Mr Tommy Gallagher
Mrs Carmel Hanna
Mr John McCallister
Ms Carál Ní Chuilín
Ms Sue Ramsey

Witnesses:

Mr John Botteley	(Theatrical Management Association)
Mr Nick Livingston	(Arts Council of Northern Ireland)
Mr Robert Kirkwood	(Department of Health, Social Services and Public Safety)
Dr Brian Gaffney Mr Gerry McElwee Mr Seán Martin	Smokefree Northern Ireland Coalition

370. The Chairperson (Mrs I Robinson): We now come to the Health (Miscellaneous Provisions) Bill. I refer members to the folder circulated at the Committee meeting of 21 June 2007, which contains the papers relating to the Bill. Members are reminded to bring the folder to each meeting of the Committee Stage of the Bill.

371. I refer members to the following correspondence on the smoking issue: from the Chartered Institute of Environmental Health; from Northern Ireland Cancer Registry; a letter from the Roy Castle Lung Cancer Foundation; and, finally, a letter dated 28 June 2007 from the Northern Ireland Chief Environmental Health Officers Group. Copies of the letters are in members' packs. An information pack from the Health Promotion Agency has also been tabled for members' information.

372. During the Committee Stage of the Bill, officials from the Department of Health, Social Services and Public Safety, Mr John Farrell and Mr Robert Kirkwood, will be present to provide clarification or to answer questions. Today's evidence session will consider the provision in the Bill to allow performers to smoke if the artistic merit of a performance requires it. During the Second Stage of the Bill, the Minister signalled his intention to withdraw that exemption to the smoking ban at the Consideration Stage of the Bill.

373. At present, however, clause 15 remains part of the Bill.

374. The two sets of witnesses in attendance today wish to put the cases for and against the exemption. The sessions will be short, with each organisation allocated about half an hour. The first set of witnesses is from the Theatrical Management Association (TMA) and the Arts Council of Northern Ireland. The Health Committee welcomes Mr John Botteley, who is the Theatre Director at the Grand Opera House and a member of the TMA; and Mr Nick Livingston from the Arts Council of Northern Ireland. Witnesses, you can decide whether one or both of you will give the presentation, for which you will have 10 minutes. After that, there will be about 20 minutes of questions.

375. Mr John Botteley (Theatrical Management Association): Thank you, Chairperson. I will begin the presentation; Mr Livingston will speak on behalf of the Arts Council. I am a member of the council of the Theatrical Management Association.

376. The TMA represents a large proportion of the theatres and theatrical production companies in the UK. In Northern Ireland, the Grand Opera House and the Lyric Theatre in Belfast; McNaughton Productions Ltd in County Antrim; the Market Place and Arts Centre in Armagh; the Millennium Forum in Derry; and the Riverside Theatre in Coleraine are all members of the TMA. It also represents the National Operatic and Dramatic Association (NODA), which has 22 affiliate groups in Northern Ireland and which represents 4,000 amateur participants.

377. Mr Nick Livingston (Arts Council of Northern Ireland): In February 2007, the Arts Council responded to the consultation on smoke-free premises and vehicles and to proposed regulations to be made under powers in the Health (Miscellaneous Provisions) Bill. The Arts Council welcomed the proposed exemption for actors who participate in a performance when the artistic integrity of the piece determines that smoking should be part of a performance.

378. The council supports the position taken by Equity and the Society of London Theatre. The exemption should be applied not only in England, but also in Northern Ireland when sections of the work to be performed require it. The Arts Council wants to persuade the Government of its view and notes that the regulations apply only to performers and not to the place of performance or premises, and only when justified by the plot. Exemptions are in place in England and in the Irish Republic, where actors have the option to use herbal cigarettes.

379. The Arts Council is not opposed to the introduction of the smoking ban in workplaces and enclosed spaces, nor does it dispute the evidence that has been provided to the Committee by the Chief Medical Officer that smoking claims the lives of about 2,300 people each year in Northern Ireland — a truly shocking statistic. The Arts Council does, however, consider the exemption to be about more than merely trying to achieve a

lifelike effect on stage when an author has written a stage direction that a character should smoke in a scene.

380. Smoking during scenes of certain plays, such as the modern classic 'Saturday Night and Sunday Morning', assists the author to establish the character. The character's smoking is part of the play and the characterisation and contributes to the quality of the experience that the audience enjoys. Smoking is, therefore, an integral part of that play. Can we imagine, for example, Winston Churchill without his trademark cigar or Joanna Lumley as her character Patsy in 'Absolutely Fabulous' without her cigarettes? It is difficult to imagine how that effect would be achieved convincingly in any other way.

381. The Arts Council is not opposed to the greater freedom of the general public to enjoy smoke-free areas. The general smoking ban is not the issue; the issues is the unique circumstances of theatre, film and television, where smoking is required to establish character, period, historical accuracy or setting when there is no alternative. Interpreting smoking as using "any lit substance" would also rule out the use of herbal cigarettes. Scenes would, therefore, lose the power to convince. Smoking happens in real life, and if the stage is to reflect real life in all its diversity, theatre practitioners must be able to use the tools of their craft to make effective use of props and to sustain the power of the scene.

382. If a blanket ban on smoking in all public places were imposed, smoking would be one of the few human behaviours that could not be portrayed on stage, film or television, and that would be extraordinary. We accept, for example, that an actor can take a drink on stage; however, he is not consuming alcohol but a substitute, such as apple juice, Ribena or burnt sugar. Real blood is not shed on stage in a production that contains violent scenes; a substitute is used. Therefore smoking would become one of the few human behaviours that could not be simulated on stage.

383. In his evidence to the Committee on 14 June, the Chief Medical Officer referred to the dangerous effect that an exemption would have on actors and performers; but that is difficult, if not impossible, to establish. The risk to theatregoers from short-term exposure to smoke in brief scenes is incalculably small.

384. Is there any real evidence that attending a theatrical performance at which a few plumes of smoke drift forward from the stage amounts to passive smoking? Is there a material health risk to the audience? Is there any known evidence of risk from smoking herbal cigarettes? Theatres are huge spaces, and smoke quickly dissipates into the fly tower and backstage. The inconvenience and disruption to the public who are sitting in the auditorium is small.

385. We are concerned about the intrusion on artists' liberty. Furthermore, an issue of artistic quality arises. Northern Ireland is renowned throughout the world for the quality of its contemporary theatre, with playwrights such as Graham Reid and Brian Friel having brought great distinction to Northern Ireland. The public has a right to know that what it witnesses on stage is being represented as the author wrote it. Were we to compromise that, our reputation as a centre of theatrical excellence and distinction might be short-lived. To ban smoking on stage would be a cruel judgement on those who care about and work in theatre, and whose endeavours have succeeded in creating artistic integrity of a calibre that is valued and acknowledged internationally.

386. The TMA believes that a blanket ban on smoking in public places will reduce the choice available to audiences in Northern Ireland. Northern Ireland depends on touring product from the rest of the United Kingdom, and it is difficult to see how scenes could be adapted or rewritten to accommodate our audiences. Our argument that herbal cigarettes — for which there are no known health risks — proposes a reasonable alternative. Theatres are wide-open spaces in which the smoke quickly dissipates, causing little inconvenience to the public.

387. Mr Botteley: The public areas in the Grand Opera House have been virtually smoke-free for the past 10 years. Since it reopened in October last year, the theatre — front of house and backstage — has had a total smoking ban in place, with the exception of a couple of occasions when actors smoked on stage.

388. I support the legislation. An artist friend of mine died of lung cancer as a result of exposure to smoky venues. The entertainer Roy Castle, whom the Chairperson mentioned, died of a smoking-related disease, which he attributed to working in arts venues. Therefore I am aware of the situation.

389. The TMA does not want to return to those times. However, we do seek an exemption for the very occasional occurrence when smoking is important to a production. Theatre portrays society warts and all; it portrays fiction, fact and fantasy. We are concerned that, without the exemption, we would have to censor productions, without there being any resultant health benefit.

390. Theatre portrays the best and the worst of people. The longest-running play in the history of theatre, 'The Mousetrap', by Agatha Christie, is still performing in London after 55 years. Its central theme is murder, but, of course, no actual murder takes place. In the theatre, we use artifice. At Second Stage, the Minister cited 'Julius Caesar'. He is right to say that no real blood is shed in productions; however, as an alternative, actors can use what resembles real blood in order to convince audiences.

391. The problem is that although there are realistic alternatives to blood and shootings, we cannot find a realistic alternative to smoking. The Grand Opera House production of 'Chicago', which was staged last week, featured a dance sequence that is a stylised portrayal of 1920s America — a time when many men smoked. In order to comply with the new legislation, all the dancers in that scene had unlit cigarettes. It looked completely unconvincing and, frankly, ludicrous.

392. There is an argument that smoking on stage encourages others to smoke. However, a recent production of 'Trainspotting' at the Grand Opera House was described by one customer as the best argument against drug taking that he had ever seen. Smoking was integral to the plot, and had a smoking ban been in place, that play could not have been staged in Northern Ireland.

393. In addition, the law can restrict what is seen on television or on film. On the first day of the ban in England, Dot Cotton of 'EastEnders' was portrayed lighting up as usual in the Queen Vic pub, only to be told to put out her cigarette. That is an example of how drama can reflect what happens in people's lives. It is interesting to note that that scene could not have been filmed in Northern Ireland.

394. In the portrayal of historical characters, smoking partly defines who those characters are — Mr Livingstone referred to Winston Churchill. In 'The Rat Pack – Live from Las Vegas', Dean Martin always has a characteristic cigarette in one hand and a glass of bourbon in the other. The Grand Opera House had two sell-out weeks of that production in January 2007; had the smoking ban been in place, that show could not have been produced in Northern Ireland because the characterisation could not have been made without the bourbon and the cigarette.

395. It can be argued that alcohol is just as damaging to health as smoking. As Mr Livingstone said, alcohol can be simulated on stage whereas smoking cannot. The fact that the legislation differs in various jurisdictions poses a serious problem for productions staged in the Grand Opera House. An actor can smoke a cigarette on stage in England or a herbal alternative in the South of Ireland, but they cannot do so in Northern Ireland. Most of the productions staged in the Grand Opera House come from England or the South of Ireland; we would either have to change those well-rehearsed productions — which is inconceivable —or do without them.

396. A couple of weeks ago, I attended a West End production of 'The Hound of the Baskervilles', which I was considering bringing to Northern Ireland. The production features Sherlock Holmes lighting his pipe. That is an important part of the show, but the ban means that I cannot bring that production to Northern Ireland. Surely some herbal tobacco smoke from Sherlock Holmes's pipe would not affect anyone's health.

397. In conclusion, the Theatrical Management Association and the National Operatic and Dramatic Association ask for an exemption from the ban on smoking on stage where it is essential to the plot or to historical accuracy, and in associated rehearsals. At the very least, as a compromise we ask that the law allow the use of non-tobacco products. In that way, tobacco smoke could be simulated in the same way that murder is simulated without the use of real blood. We believe that there is no risk to health in allowing the very occasional portrayal of smoking in the wide-open space of a theatre stage or, for that matter, a film studio.

398. The Chairperson: Thank you very much, Mr Livingstone and Mr Botteley. I shall now open up the discussion so that members can ask questions. I visited Disney-MGM Studios in America with my grandchildren where we enjoyed seeing simulations of battles scenes from the 'Star Wars' trilogy and the magnificent props from the film studios. I find it difficult to accept that no one in the theatrical world, which you are representing today, can find a realistic alternative to smoking on stage.

399. Mr Botteley, you said that the legislation in the Republic of Ireland allowed some flexibility in these matters. What did you mean by that?

400. Mr Botteley: Actors can smoke herbal cigarettes on theatre stages in the Republic of Ireland. The legislative definition of smoking in the South refers to tobacco; herbal cigarettes can, therefore, be smoked on stage in that jurisdiction. It is my understanding that no health risks are associated with the smoking of herbal cigarettes or the passive smoking of such products.

401. That is the alternative that we seek. I agree that Disney-MGM Studios use alternatives. However, Dean Martin's having a cigarette in his hand is central to the way in which his character is defined, but a burning cigarette is not permitted in Northern Ireland. It is permitted in England, and in the Republic herbal cigarettes can be smoked on stage.

402. The Chairperson: What happens when touring productions go to Wales and Scotland?

403. Mr Livingston: No exemption was granted in Wales and Scotland, so those productions would be in the same position as in Northern Ireland. The difference is that Northern Ireland has an established reputation for excellence in the theatre, and it would be unfortunate if that reputation were diminished because of the general ban on smoking. Touring productions may not come to Northern Ireland because rehearsals would be expensive; scenes would have to be prepared differently and different stage directions given.

404. Mr Botteley: Wales and Scotland have the same limited choice that we in Northern Ireland argue against. Certain productions would not be seen because producers would not want to re-rehearse a scene for one visit to Northern Ireland. Productions in Scotland and Wales are similarly limited.

405. The Chairperson: You did not address the issue of the use of convincing props.

406. Mr Botteley: It is against the law to use a lit cigarette, and no convincing alternative has been found. In certain scenes, it is important that actors bring a burning cigarette to their lips. In 'Chicago', unlit cigarettes were used, and they looked ridiculous. In the Lyric Theatre's production of 'Dancing at Lughnasa', Brian Friel had to rewrite a scene because of the smoking ban, which is fine, provided the author is available to do

that. That play is about a young girl in the 1920s and 1930s, whose rebelliousness and emancipation are characterised by the fact that she smokes. That is a powerful image. When I saw the play last week, the actor had to open a packet of Woodbines, take out a cigarette, put it to her lips and then put it back on the table without smoking the cigarette. Most of the audience were preoccupied by her not smoking the cigarette because of the smoking ban rather than engaging with the plot of the play.

407. Rev Dr Robert Coulter: You said that you believed that herbal cigarettes would not be harmful to audiences because of the wide-open space in a theatre. What scientific evidence do you have for that?

408. Mr Botteley: I cannot cite any scientific evidence to support that. The area above the stage in the Grand Opera House is twice the size of the stage, and the auditorium is massive. However, there is no scientific evidence that our proposed substitute — herbal cigarettes — damages health. I cannot believe that one cigarette in a huge space — 50 to 60 times the size of the Senate Chamber — would cause any health-related disease. The smoke would go up into the ether, and it would be difficult for anyone to inhale it.

409. Rev Dr Robert Coulter: Can I take it that that part of your evidence is purely an assumption?

410. Mr Botteley: Yes, it is an assumption.

411. Mrs Hanna: I fondly support the arts, including the Grand Opera House, the Lyric Theatre and other venues; however, I do not believe that the absence of a lit cigarette will affect acting ability. You have referred to the excellent standards of acting in Northern Ireland. Do you not think that good actors can simulate smoking with an unlit cigarette? I have seen 'Dancing at Lughnasa' at the Abbey Theatre and at other venues, and I would not have been distracted if the cigarette had not been lit.

412. Mr Botteley: I understand where you are coming from. The problem is that there is no ban in England; therefore plays, as rehearsed there, will not be able to come here. If there were a blanket ban throughout the United Kingdom, however much we disliked it, we would have to cope. With few exceptions, the productions that come to the Opera House are generated in the West End or in other parts of England, where no such ban exists. It is a question of providing theatre-going choice for the people of Northern Ireland.

413. The 'Hound of the Baskervilles' and 'Trainspotting', which are great productions and award-winning shows, cannot come to Northern Ireland because their management would not change their structures to suit one venue. If actors could smoke herbal cigarettes on stage, such productions would come to Northern Ireland.

414. Mrs Hanna: I cannot understand why that should be. The only difference is that our legislation would require cigarettes to remain unlit. I am not an actor, but I could pretend to smoke a cigarette on stage — I could pretend to puff and inhale; I do not believe that it would make much of a difference. Is the problem that actors would not be allowed to come on stage here unless they performed plays in exactly the same way as in England or is it because they would not wish to do so?

415. Mr Botteley: Last week, unlit cigarettes were used in a production of 'Chicago' at the Opera House — they were completely unconvincing. Although that is a personal view, it is shared by the Theatrical Management Association, which represents every theatre director in the UK.

416. Mr Livingston: When the Minister of Health, Social Services and Public Safety made his remarks to this Committee on 17 June, I was surprised by the unprecedented outcry from actors in Northern Ireland. Articles and blogs on the Internet appeared almost immediately, and there was an in-depth article in 'The Stage'. There is a general feeling that to implement this ban would be to chip away at an important artistic liberty.

It seems extraordinary that the stage, which can so accurately portray every other aspect of our lives, will be silenced in this area. From the perspective of theatre technicians and actors, it seems incomprehensible.

417. Mrs O'Neill: What do the groups that are lobbying against artists being allowed to smoke on stage feel about herbal cigarettes? Have you been in contact with such groups?

418. Mr Botteley: I have not been in contact with any such groups. I am aware that, as with everything, there is a suitable alternative, and the only realistic alternative to smoking tobacco is smoking herbal cigarettes.

419. Ms S Ramsey: I thank the guys for their presentation. It was said that some actors perceive the proposed introduction of this ban as chipping away at their profession. I disagree. Things change every day — we live in a changing world. I do not wish to be flippant, but, not so long ago, it was thought OK to send children up chimneys. People realised that that was wrong and changed their attitudes.

420. Roy Castle was mentioned in the presentation, and hope was expressed that if smoking were allowed to continue in auditoriums, no harm would come to audiences in those wide-open spaces. For health and safety reasons, a duty of care exists for staff and workers. The concerns apply not only to audiences but to those who work in those environments every day.

421. Is there any evidence that plays have not been taken to Scotland and Wales? Dean Martin and 'The Rat Pack' were mentioned. Has that show not been staged in Scotland or Wales?

422. Mr Botteley: The ban has been in force for too short a time. I arrange the programme for the Opera House 18 months in advance, as do my colleagues, so it is too early to gather evidence. I spoke to a colleague who runs the Festival Theatre in Edinburgh, and the problem has yet to arise there — it is too early to say whether the ban will affect shows in Scotland.

423. I made a direct programming decision not to bring 'The Hound of the Baskervilles' to Northern Ireland because smoking a pipe is integral to the plot. Therefore, I made that direct decision.

424. To answer the question about sending kids up chimneys; the difference is that the theatre portrays history, whereas life moves on. In all other circumstance, the ban is utterly justified. However, we still need to portray historical events. For example, 'Mary Poppins', which is currently playing in the West End, portrays chimney sweeps going up chimneys. That is a portrayal; it does not actually happen — that is the difference.

425. Ms S Ramsey: I am well aware of that. However, Mr Botteley has said that there is evidence that we will lose out on the theatre productions that could be shown here. The Chairperson asked about the situation in Scotland and Wales because the same legislation operates in those regions also. Can it be said — 18 months in advance — that there is no way that 'The Rat Pack: Live from Las Vegas' will be shown in Scotland or Wales because of the smoking ban?

426. Mr Botteley: I cannot speak for what will happen in Scotland and Wales; I can only mention the discussion I would need to have with the producer about bringing the show here. The fact is that it would be a lesser production if Dean Martin were not shown in the way in which he is characterised in the current form of the show. I can confirm that 'The Hound of the Baskervilles' will not be coming to Northern Ireland.

427. Mr Livingston: Essentially, substitute stage directions would have to be written. Reflecting on the points that have been made, the view of most actors is that they respect the author's integrity and would wish to see his intentions carried out. They

would want to present a piece so that Northern Ireland audiences could see it in the manner in which the author originally intended.

428. We will arrive quite quickly at a situation where it will not be possible to approach authors and ask them to write new stage directions for plays because in some cases they will be dead. In those circumstances, that part of the repertoire would be seen less frequently, and that would deny choice to audiences in Northern Ireland.

429. Mr Botteley: The other issue is that 'The Rat Pack: Live from Las Vegas' is an accurate reconstruction of an concert that actually took place. It has been recreated as accurately as possible from film footage and, therefore, the smoking that featured in the concert must be portrayed in the show. I am not saying that it would be impossible to change that, but it would be against the artistic integrity of the piece to do so. I have not spoken to the producer, but if he said that he did not want to change that aspect, the only option would be not to show it here.

430. Mr Buchanan: I apologise for my late arrival.

431. I, too, am a great lover of the arts. However, I find it difficult to believe that those involved in the arts and the theatre cannot come up with something that is akin to a cigarette. If tobacco or cigarettes were allowed to be used during theatrical performances, would that not create the potential for licensed premises across Northern Ireland to be afforded the same right?

432. Cigarette smoke causes many deaths, and we need to provide a healthier society for young people, many of who see performers as role models. Would it not defeat the purpose of introducing a smoking ban across Northern Ireland if we were to allow performers to smoke cigarettes during performances such as those described by Mr Botteley? Exempting theatres would defeat the purpose of the ban and provide a bad example to young people in society.

433. The detrimental effect that the smoking ban will have on theatres across the Province and on the various plays and performances that will not be staged has been mentioned. How much will theatres lose financially because they are unable to present such plays during the first 12 months of the ban?

434. Mr Botteley: The member has asked several questions. First, herbal cigarettes would be a suitable substitute for tobacco; however, they are also covered by the legislation. Secondly, as regards the effects that smoking on stage might have on young people, theatre drama shows life as it is, not as we would like it to be. I do not believe that an Agatha Christie play showing a murder on stage will encourage people to commit murder. Smoking on stage will not encourage anyone to smoke. People smoke; therefore drama should be able to show that.

435. The example of Dot Cotton in 'EastEnders' was very clear. The message in that instance was the opposite of the encouragement that Mr Buchanan suggested. Dot lit a cigarette in a pub and was told that, for a very good reason, she could not do that. That was a very positive anti-smoking message.

436. 'Trainspotting' is a very powerful play about people with drug addictions. However, its message is exactly the opposite; it is about not taking drugs. It would not have been possible to stage that play if the actors had not been able to light up, because it was about the fact that lighting up — in this case, rolling joints and injecting heroin — was bad. The piece demonstrated that that was bad, and if the actors could not portray the drugs being taken, they could not demonstrate the message.

437. There would be no loss of revenue to theatres. The ban will have no financial impact, but it will have an impact on art. That is why we are here.

438. The Chairperson: Does that answer all your questions, Tom?

439. Mr Buchanan: Yes.

440. Mr McCallister: Tom asked most of the questions that I was interested in. I agree with Tom and Carmel: it is incredible that, given the ingenuity of theatre producers, there is no better alternative than herbal cigarettes. I worry about the effects of smoking on young people, and I worry about the message that would be given if smoking on stage were to be permitted. As Tom also said, that might open the legislation to challenges from pubs. If pub takings were being affected by the smoking ban, then why should representatives of the licensed trade not ask for exemptions also? I feel strongly that the Committee must take a stand on this matter.

441. I am involved in amateur dramatics, so I — [Interruption.]

442. Ms S Ramsey: It is called the Assembly.

443. The Chairperson: Order.

444. Mr McCallister: I am interested in the arts and in theatrical productions. However, the fact that Northern Ireland's legislation is in line with that in Scotland and Wales leaves our English colleagues as the odd ones out. The sooner they join us, the sooner the problem will be solved.

445. Mr Livingston: We do not dispute the need for smoke-free workplace regulations in Northern Ireland. However, theatre is a special case. Points that might be made, for example, by the licensed trade, are not necessarily those that we would embrace. Our point is that, if a stage direction — which is a very specific instruction by an author — requires actors to smoke, we are going to be faced with a dilemma. Should we ignore the author's direction, and the characterisation it implies, and would we lose the value of the social or historical setting of the piece? Would the scenes portrayed on stage still be convincing? Would the lack of smoking erode the quality of the experience that the public currently enjoys? Fundamentally, would it affect the choice of plays that will be offered to the public on Northern Ireland's stages?

446. Mr McCallister: Actors do not have to get drunk to portray drunkenness convincingly. Therefore, they do not have to smoke to make a role convincing.

447. Mr Livingston: We covered the point about alcohol. Alcohol is not consumed on stage because a substitute can be used. We are suggesting that a substitute for tobacco be considered.

448. The Chairperson: Carmel, do you want to ask a supplementary question?

449. Mrs Hanna: As someone who encourages and supports the arts, I hope that actors will not lose out on jobs because of artistic integrity.

450. We all feel strongly that the ban should apply to all workplaces, including the theatre. However, I hope that actors will still visit here regularly and will not stay away simply because they cannot light up on stage.

451. Mr Botteley: Let me make one supplementary point. It does not take a great deal of intelligence to realise that we are batting on a fairly sticky wicket here but, pending more research on herbal cigarettes, would it be possible for us to put warning signs outside theatres or reach another compromise?

452. Although many of my colleagues feel that there should be no compromise on artistic integrity, the people of Northern Ireland will lose out by being given an inferior choice in comparison with that which is available in England. I am a theatre director, not a scientific expert. If herbal cigarettes do not constitute a risk to health, as I am assured is the case, could an exemption be given for smoking those instead of tobacco? Such an exemption would seem to satisfy all the genuine objections that members raised while providing the alternative for which they have rightly asked. We are not set on having an

exemption for cigarettes; we are just asking that the ban should be realistic in the context of the piece.

453. The Chairperson: We take that point on board.

454. Ms S Ramsey: I want to make two quick points. First, as Carmel Hanna pointed out, if the Bill were to be introduced, as worded, it could offer individual actors opportunities for smoking that they would not otherwise have. Secondly, if a compromise were to be included in the Bill — which I would not support — who would be responsible for policing such legislation?

455. Mr Botteley: As the person responsible for the Grand Opera House, I would be facing a substantial fine were the law to be broken. Members can be absolutely sure that I would police it.

456. Ms S Ramsey: I am conscious of the fact — and I am just trying to think this through — that if Belfast City Council's smoke wardens entered the Grand Opera House and smelled smoke there, performers could claim to be smoking as part of a rehearsal. That suggestion needs to be thought out more.

457. Mr Botteley: We would have no objection to policing the legislation or to welcoming wardens from Belfast City Council as we do as regards all the other licensing legislation to which we are subject.

458. The Chairperson: Unfortunately, smoking was made glamorous by film stars and stage actors. The whole thing probably emanated from American movies and from the advertising of cigarette brands such as Camel and Marlboro. Tobacco advertising was then banned. In Northern Ireland, we have a big problem of very young teenage girls taking up smoking as a habit. If we were to slacken the legislation by providing exemptions, where would we stop? We would simply be opening a can of worms.

459. I hope that the Committee has given you a fair hearing but, as you may have gauged, many of us feel that the interests and welfare of the people of Northern Ireland are best served by protecting them from secondary inhalation and from being in smoky environments. Having said that, I sincerely thank you both, Mr Botteley and Mr Livingston, for attending.

460. Obviously, the Committee will need to address issues such as what constitutes herbal cigarettes and other minutiae when it considers the Bill line by line. Thank you for attending. No doubt we will hear from you again.

461. Mr Botteley: I thank the Committee for listening.

462. The Chairperson: Mr Kirkwood, does the Republic of Ireland legislation contain an exemption that allows thespians to smoke herbal cigarettes on stage?

463. Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): Yes. During the drafting of the Health (Miscellaneous Provisions) Bill, a conscious decision was taken to adopt a definition of "smoking" that was similar to that applied in England, Wales and Scotland. The definition in article 2(2)(b) of the Smoking (Northern Ireland) Order 2006 states: "smoking includes being in possession of lit tobacco or of anything lit which contains tobacco, or being in possession of any other lit substance in a form in which it could be smoked."

464. That definition was chosen largely because it was designed to aid enforcement in cases in which those caught in breach of the ban would claim that their cigarette did not contain tobacco.

465. It was considered that amending the legislation in order to permit the smoking of herbal cigarettes on stage would make enforcement more difficult. Any amendment to

the Bill allowing for the smoking of herbal cigarettes would mean further defining what herbal cigarettes are. For example, would cannabis qualify?

466. The Chairperson: As well as acting, the performers would all be merry. Thank you very much.

467. I welcome the representatives of the Smokefree Northern Ireland Coalition: Dr Brian Gaffney, chief executive of the Health Promotion Agency for Northern Ireland; Mr Gerry McElwee, head of cancer prevention at the Ulster Cancer Foundation; and Seán Martin from the Chief Environmental Health Officers Group.

468. Dr Brian Gaffney (Smokefree Northern Ireland Coalition): I thank the Chairperson and the Committee for allowing the Smokefree Northern Ireland Coalition to state its case for opposing the proposed exemption.

469. I am here in my capacity as chairperson of the Smokefree Northern Ireland Coalition, which is a coalition of partners from the public sector, statutory bodies, the community and voluntary sectors, and the private sector. Established in the run-up to the introduction of the Smoking (Northern Ireland) Order 2006, the Smokefree Northern Ireland Coalition acted as advocates of the legislation and lobbied for its passage. The coalition remains together in order to provide a voice for partners across Northern Irish society in the implementation of smoke-free legislation. We are also trying to improve public health by preventing smoking in general. Accompanying me today are colleagues who each represent their particular sectors on the coalition.

470. The coalition obviously opposes the proposed exemption. The reasons why the legislation was originally passed must be recalled. We regard “performers”, as clause 15 of the Bill refers to them, as another workforce, who must be protected from the effects of passive smoking. Why is one person’s smoking harmful to others? Tobacco smoke contains about 4,000 chemicals, 60 of which are known or suspected to cause cancer.

471. It is well known that people who do not smoke, and who are exposed to second-hand smoke, have a higher risk of suffering from lung cancer, heart disease and strokes, than those who are not exposed. It can also induce asthma attacks, cause pregnancy complications, and put children at risk.

472. A recent review of international research on the immediate health impact of smoke-free workplace legislation found rapid and dramatic improvements. Therefore, as a result of this legislation, we are seeking to achieve rapid and dramatic improvements for every workforce — including the acting profession.

473. The director general of the World Health Organization (WHO) summed up the evidence by saying:

“The evidence is clear, there is no safe level of exposure to second-hand tobacco smoke”.

474. That is true whether it involves a few puffs in a theatre, or a large amount of smoke in the theatre because tobacco smoke is a class A carcinogen — that has been accepted.

475. The proposed exemption is not limited to performances in theatre productions and other mainstream dramatic arts. It is a loose definition and covers any performance in any venue. It could include a performance in a public house, a hall or even a school. It would be ludicrous for smoking to be allowed at a school play, perhaps performed by an outside theatre company, just because of the belief that it is important to artistic integrity. What does “artistic integrity” mean? It has not been defined. We are opposed to the exemption because of the lack of a safe level of exposure to second-hand smoke, and because there are other implications in allowing people to smoke tobacco on stage or to use a substitute.

476. The influence of the tobacco industry in film and television is well documented. The 'British Medical Journal' has clearly highlighted that influence amongst teenagers. The five-year tobacco action plan for Northern Ireland, which we all work to — including, to my knowledge, the Arts Council of Northern Ireland, as a statutory body that is seeking to reduce inequalities in health — emphasises the fact that young people, who are affected by those performances, should be protected from tobacco smoke, and should be prevented from smoking.

477. To include the exemption would weaken legislation that has already been shown to be well supported across industry. It is important to remember that all workforces in Northern Ireland have had to make changes. Why should the performing workforce not have to do so too? The rate of compliance, as members will hear from my colleague, has been 99% or more. There is no doubt that this piece of legislation is well supported.

478. Some of the points that were raised previously surprised me. Recently, in Edinburgh, Mel Smith gave a successful depiction of Winston Churchill and was able to do so without smoking. Evidence presented on the basis of one's opinion, or on the basis of one person attending a production, should not be treated seriously.

479. We are also concerned about the lack of definition of the word "herbal". I am not sure what that means. By introducing herbal cigarettes, we could be exposing people to damaging substances. I certainly do not know whether or not smoking herbal cigarettes in the presence of someone who has asthma could induce an asthmatic attack. Therefore, we do not support any move to allow the use of herbal cigarettes.

480. When people go the theatre or go to a performance, their choice is to go to the theatre — not to have their health damaged. We ask the Committee to take that into consideration.

481. As a Sherlock Holmes fan, I am surprised and disappointed that one person can make an arbitrary decision to refuse to allow the Northern Ireland public to see a play that we have seen reviewed in London on the basis that it cannot be performed because of a lack of lighting up a pipe. I do not recall that ever affecting my appreciation of Sherlock Holmes.

482. Mr Seán Martin (Smokefree Northern Ireland Coalition): Environmental Health Officers have been charged with enforcing the new legislation. All sectors of industry have embraced it, and we have had practically no difficulties whatsoever. The law is currently being enforced with regard to theatre productions. Permitting an exemption would be a backward, not a forward step, and we would like to move forward.

483. In less than a year, smoking will also be banned in mental-health units in Northern Ireland. It would be a step in the wrong direction to grant an exemption that would permit actors to smoke as part of a theatrical production. The legislation gives the Minister powers to add to smoke-free premises, and we feel that that is the way forward, rather than going backwards and permitting smoking to be part of stage productions.

484. I reiterate Dr Gaffney's point that the word "performers" and not "actors" is being used in the legislation. It means that the exemption would not apply solely to theatres. The ridiculous situation could arise in which, even though smoking is banned in pubs, a theatrical production could be staged in a pub, and it could then be argued that actors should be allowed to smoke there for the sake of artistic integrity. That could lead to double standards being applied. At the moment, we are clear on the law, and people accept it. They supported the legislation before it was introduced, and they have shown that they support it wholeheartedly now. We have had few problems with enforcing the legislation.

485. Mr Gerry McElwee (Smokefree Northern Ireland Coalition): I reiterate the point that second-hand smoke is a killer. Tobacco smoke is a lethal cocktail of 4,000 chemicals

including ammonia, arsenic and cyanide. We have heard from Dr Gaffney that there is an increased risk of stroke — up to 80% for non-smokers — not to mention lung cancer and heart disease.

486. The legislation was introduced after a long battle to protect the health of our population. The legislation is popular, and, hopefully, our research will soon prove that it is beneficial in improving the health of the population and, particularly, that of our workforce.

487. It is worth remembering that the legislation was introduced following many consultations. There were 71,000 responses from the public consultation in 2005, and 92% of the public informed us that they wanted comprehensive legislation. It would be strange if we were to go back on such popular and effective legislation only two months after its introduction. If our colleagues from the theatre discovered asbestos in a theatre tonight, I assume that they would close it and there would be no performance. However, we do not need to close the theatre to keep out cigarettes — all that we need to do is maintain the current legislation. The question is whether we wish to introduce carcinogens into the workplace and public places — to do so would defy all logic.

488. The Theatrical Management Association spoke about portraying real life accurately. However, if a play were being staged about the shipyard in the 1940s and 1950s, would real asbestos have to be introduced — I think not.

489. The association also spoke about herbal cigarettes. However, as Dr Gaffney said, the association did not provide a definition for such a cigarette. As far as I can see, they could be described as cigarettes minus nicotine and, therefore, could give us 3,999 chemicals but not 4,000. The association also stated that it has been assured that herbal cigarettes pose no health risk, but I do not know how it could have been given such an assurance. It defies logic. The Smokefree Northern Ireland Coalition believes that when substances such as herbal cigarettes are burned, similar cocktails of lethal chemicals are produced. There is no safe level, and we should not be exposing ourselves to them.

490. Smoking in the movies was mentioned. In the 1950s, three times as many people smoked as do now, yet several recent studies have found that there is now more smoking in Hollywood movies than there was in the 1950s. Perhaps it is due to product placement from big industry, but it could also be due to lazy scriptwriters who cannot think of another way to portray tension, rebellion — or whatever other emotion — other than by putting a cigarette into the scene.

491. I do not believe that there is a case for going back on our legislation. We have heard arguments about actors being unable to portray reality. I do not want to place any more tobacco products on the public stage. However, I will demonstrate an exception. Without needing to do much research, a colleague of mine went to a joke shop and bought this cigarette that I have brought with me. I assure the Committee that talcum powder and not a burning substance is coming out of it. We believe that the Theatrical Management Association has scored an own goal by stating that everything else — cleaning chimneys, producing blood, taking heroin and shooting bullets — can be portrayed on stage except smoking.

492. It is called acting, and it is time that that option was considered. In any scripts that need to be rewritten, the actor should simply be directed to hold, but not light, a cigarette.

493. The Chairperson: Thank you. I liked your props, which were most convincing. Indeed, I was going to ask whether you would mind stubbing out your cigarette.

494. Before I open the floor to members' questions, can I ask why the exemption was successfully included in the legislation in England? I assume that the Health Development

Agency made similarly rigorous demands to yours that the Government should not go down that route.

495. Dr Gaffney: I must emphasise that there was no smoke-free coalition in England. In looking back on how the legislation on smoking was introduced, I refer to New York, which was one of the first cities to introduce a ban. The New York Coalition for a Smoke Free City guided us on our approach. It emphasised the need for a lobby, or advocate body, comprising as many of the public, statutory, community/voluntary and private sectors as possible, to send a consistent message. By following that advice, we succeeded in a way that those in England did not. We were able to push through what we consider to be successful, well-supported legislation, with which there is a high level of compliance.

496. Mr McCallister: Is there any rock-solid evidence that would make you accept the use of herbal cigarettes?

497. Dr Gaffney: No one really knows what herbal cigarettes contain. There is no consensus on that and no definition. Therefore to ensure that a dangerous substance was not being introduced into public areas, rigorous trials would have to be carried out to define what is meant by a “herbal” cigarette.

498. Even allowing herbal cigarettes would create role models who smoke for those young people who see actors doing it on stage. It would also allow owners of other businesses, such as licensed premises, to argue that if smoking on stage does not harm anyone’s health, it should be permitted in their pubs.

499. How to police the smoking of herbal cigarettes would cause confusion. An exemption to allow smoking on stage would introduce a negative element into what the Chief Medical Officer referred to as probably the most important piece of public-health legislation for many decades. When the ban was introduced in England, Sir Liam Donaldson described it as “a footprint” in public health. Rather than seeking to weaken the legislation, the ban should be supported and additional measures sought to prevent further smoking.

500. The Chairperson: Are you happy with that answer, Mr McCallister?

501. Mr McCallister: I am more than happy.

502. Rev Dr Robert Coulter: I thank the witnesses from the coalition for coming today. I am impressed by your arguments, particularly the powerful and valid one about school plays. Is it an insult to the intelligence of the people in the audience that, although they have no problem with accepting actors in a play portraying drug taking, they cannot make a similar leap of imagination on the portrayal of smoking without it actually happening? If the exemption is agreed, how would it be policed? How would we know that the cigarettes being smoked did not contain tobacco?

503. Dr Gaffney: I have nothing but admiration for professional actors. However, almost every other workforce in Northern Ireland has had to amend its behaviour to comply with legislation that protects its safety. Any building that contains asbestos, which is another class-A carcinogen, must have it removed.

504. We have legislation on smoking because tobacco smoke is a class-A carcinogen, and the workforce must comply. I expect professional actors to come up with a creative solution by amending or interpreting stage directions to make clear what they are trying to portray. I cannot tell them how to do that, but I am sure that they can come up with an answer.

505. Mr Martin: The definition of smoking is good and all-encompassing and is written in a way with which the Smokefree Coalition is happy, because it prevents expenditure on analysing products to determine what they are.

506. The difficulty that we would face if herbal cigarettes were introduced as an option for performers is that smoking is defined in the legislation as using “any lit substance”, including tobacco and herbal cigarettes. That is primarily to make enforcement easier.

507. If an actor were seen smoking a lit substance, we would not have to take a sample or approach the smoker because there is no funding to send a sample for analysis — he or she would be considered to be smoking. From the perspective of the agency that is charged with enforcement, allowing the use of herbal cigarettes would be a retrograde step.

508. Rev Dr Robert Coulter: In those circumstances would policing the legislation be impossible?

509. Mr Martin: It would be expensive and difficult for the enforcement agencies. It would also be a backward step, because the legislation makes enforcement easy: everyone understands that smoking cannot be done in public spaces and workplaces.

510. Rev Dr Robert Coulter: Would it insult the intelligence of the audience to expect it to accept a portrayal of drugs, but not of cigarettes?

511. Mr Gaffney: Any reports that I have heard about current plays have been very positive. I have not heard of anyone saying that they did not enjoy a production because the cigarettes were not lit. I would find it hard to believe if they did.

512. Mr McCallister: How would you portray Winston Churchill now? [Laughter.]

513. The Chairperson: There we shall end. Cut.

514. I watch ‘Bones’, which is so realistic that I sometimes hide behind the cushion. If that programme can have such realistic props, surely a convincing cigarette or pipe can also be created.

515. I thank you, Brian, Seán and Gerry, for your presentation.

Thursday 6 September 2007

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mrs Michelle O’Neill (Deputy Chairperson)
Rev Dr Robert Coulter
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mrs Carmel Hanna
Ms Carál Ní Chuilín

Witnesses:

Mr John Farrell	(Department of Health, Social Services and Public Safety
Ms Christine Jendoubi	Acting
Mr Robert Kirkwood	Chief Dental Officer
Mr Donncha O’Carolan	

516. The Chairperson (Mrs I Robinson): I welcome Ms Christine Jendoubi, Mr John Farrell, Mr Robert Kirkwood and Mr Donncha O’Carolan, who are here to provide clarification and answer questions as the Committee commences its clause-by-clause

scrutiny of the Health (Miscellaneous Provisions) Bill. Members have been provided with much written material, including a copy of the Bill, a detailed commentary and a copy of extracts from the legislation that the Bill seeks to amend. Members will recall that oral evidence was taken from groups before recess and that further written submissions were received over the summer.

517. Members should use the notes on the clauses that were prepared by the Department and which were circulated last week and the document provided by Committee staff at tab 4. The Committee will have several options on each clause. Before inviting the Committee to choose an option, I will ask the officials to outline briefly the purpose and meaning of each clause. Members may then seek clarification.

518. Following discussion with officials on each clause and the potential for amendment, the options available to the Committee will be: first, to declare itself content with the clause as drafted; secondly, to agree the potential for amendment and request that the Department consider the matter and report its position to the Committee — and by doing so defer consideration of the clause. If an amendment is considered appropriate, the Committee can invite the Department to say whether it would be willing to undertake the drafting of such an amendment.

519. Clause-by-clause scrutiny of the Bill will now commence. At tab 4 of the papers there is a list of suggested questions on each clause that have arisen from the written submissions. Members may wish to use those during discussions.

Clause 1 (Persons performing primary medical services: listing subject to conditions)

520. Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): The Bill amends The Health and Personal Social Services (Northern Ireland) Order 1972, which is Northern Ireland's main primary health legislation. The amendments relate to primary care arrangements and specifically to family practitioner services. The Bill also amends The Smoking (Northern Ireland) Order 2006, as Kevin Shiels described earlier.

521. Clause 1 relates to primary medical services. It provides for a person's inclusion — or continued inclusion — on the list of persons performing primary medical services to be subject to conditions. That is a new provision. It also provides for there to be one list for Northern Ireland, instead of the current four. That means that if a person is removed from the list, he or she will be unable to practise anywhere in Northern Ireland. At the moment, if someone is removed from one of the lists, he or she can still practise in the other three board areas.

522. That concludes my remarks on clause 1. I am happy to take questions.

523. The Chairperson: If you do not mind, I will kick off. Clause 1 provides for a change from separate board lists to a regional list of primary medical services performers. By and large, that is generally welcomed. However, clause 1 also deals with the conditions for inclusion or continued inclusion on the list. The British Medical Association (BMA) has called for a suspension framework and a right of appeal against suspension. Is a right of appeal provided for in the Bill?

524. Ms Jendoubi: We will discuss how the tribunal deals with these matters later, but, in general, the Bill does not provide for a right of appeal against suspension. It provides for a right of appeal against removal from the performers' list, but that already exists, as far as general practitioners (GPs) are concerned. Other provisions in the Bill extend the performers' list regulations to pharmacists, dentists and opticians, and a right of appeal will extend to them, too. However, at the moment, it does not provide a right of appeal against suspension.

525. That raises an interesting issue: the assertion that suspension is a neutral act has been challenged. The matter was put to bed by the Appeal Court ruling in the Mezey

case, which found that it was not a neutral act. It is neutral in so far as it does not prejudice the outcome of a disciplinary investigation, but it has an effect on the individual concerned and their capacity to work.

526. The Chairperson: The BMA is very keen on the right to appeal, and Kieran, as a GP, may want to comment on that.

527. Dr Deeny: As a primary care professional, I believe that the Bill should make some allowance for a right of appeal. If I were suspended tomorrow, it would leave me in a dreadful situation professionally. It is very wrong that medical professionals do not have the basic right of appeal that every member of the public is entitled to in law. It leaves the profession very hard done by. I back the BMA completely on this: provision for a right of appeal should be built into the Bill.

528. Mr John Farrell (Department of Health, Social Services and Public Safety): The health board would have to have reasonable grounds for suspending a GP. There would have to be clear criteria: suspension would not occur willy-nilly. The legislation does not contain the detail of the conditions that could apply when a suspension takes place; that detail will emerge in the regulations. However, the Department proposes to provide clear guidance on cases in which a suspension could be made. We will refer to the Appeal Court ruling on the Mezey case, which sets out the types of conditions that could apply.

529. Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): May I clarify the point? Clause 1 is specific to general practitioners — it applies to no other profession. Clause 1 amends article 57G of the Order, and nowhere in the clause is provision made for suspension. As Christine said, clause 1 simply amends a paragraph of article 57G to allow for subordinate legislation that would provide for one list, rather than requiring GPs to be on the list of the board in whose area they perform services. It also proposes new paragraphs (3A) and (3B), which allow for regulations to set out conditions for inclusion or continued inclusion on the list — the board can include somebody on a list, subject to conditions.

530. For example, a health and social services board that considers a GP who is returning from maternity leave to be falling short in some areas of her practice must ask that GP to undertake training to compensate for those deficiencies. When the practitioner had done so, she may apply to be included on a list so that she can provide services in the board's area. It is a relaxation of the present provisions because it allows a board to put a practitioner on its list, subject to conditions.

531. The Bill also introduces an alternative to suspension. For example, if a board feels that a practitioner who is already on its list is falling short in one of his her competencies, it does not automatically have to suspend the practitioner. It will allow the board to discuss any problems that the GP may have so that a solution can be worked out amicably between them. The GP will remain on the list, but subject to conditions. That is what the clause does — no more and no less. Suspension —

532. Dr Deeny: Is the word "suspension" used?

533. Mr Kirkwood: No. The provision for suspension is already included in The Primary Medical Services (Northern Ireland) Order 2004, which inserted article 57G into the 1972 Order. The primary provision for suspension of GPs already exists — but only for GPs. The Bill has clauses that make provision for other practitioners such as dentists, pharmacists and opticians. The enabling power that clause 1 introduces is to draft regulations to amend The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004 list regulations, to move away from four lists to one list, and to introduce the conditions of conditional inclusion and contingent removal.

534. Dr Deeny: Suspension without the right of appeal sounds like guilty until proven innocent.

535. Mr Kirkwood: Clause 1 does not mention suspension of a GP. The primary power to suspend a GP already exists. The performers' list regulations will be amended to include suspension of a GP. The regulations will set out in detail how that is to be done, the involvement of the National Clinical Assessment Service (NCAS) in such a suspension, and the period of suspension. That will be set out in regulations that will come before the Committee before consultation. You may say that there must be a right of appeal against suspension; however, there is no such right in England, Wales and Scotland.

536. The BMA has debated the matter at length. Northern Ireland is not going any further than England, Scotland and Wales; why should Northern Ireland be different from the established arrangements in England, Scotland and Wales?

537. Ms Jendoubi: As Robert says, the Committee can discuss that matter when the regulations have been introduced.

538. Mr Kirkwood: The regulations will cover the issue, but clause 1 relates only to GPs. It amends article 57G of The Health and Personal Social Services (Northern Ireland) Order 1972 concerning primary medical services and relates solely to GPs. Similar provisions are made in subsequent clauses of the Bill for ophthalmic, pharmaceutical and dental services. However, clause 1 will enable boards to move from a four-list system to one regional list, and it introduces powers of conditional inclusion and contingent removal, which, I feel, is beneficial, as it will give boards the power to put someone on their list. It will also allow them to introduce conditions rather than simply take the ultimate decision to suspend. The situations in which that option would apply will be set out in amendments to the performers' list regulations. The legislation will appear as an SL1 letter to the Committee, setting out the policy decisions that will be implemented in the amending regulations.

539. The Chairperson: There will be opportunity to discuss that matter later; however, I want to move on.

540. Dr Deeny: These matters are of extreme interest to me. I agree entirely that four boards give the impression that there are four different health systems here. I believe that my practice is the only one that takes patients from three different health boards, and for many years I have seen the problems that that creates, so changing the system is a good idea. However, I am suspicious about using the word "suspension" to someone who might lose his livelihood without the right to appeal; it is irrelevant that there is no such right in England, Wales or Scotland.

541. Mr Kirkwood: That is a debate for another day. Clause 1 is not concerned with those matters, and to debate them would be outwith its provisions. I know that because it is a miscellaneous provisions Bill; it jumps from here to there and is very hard to follow; but that is what it does.

542. Ms Ní Chuilín: Perhaps this is a question for Kevin Shiels, but in order to include the point that Kieran Deeny made, will there be an opportunity to amend the clause rather than add to it? Can we amend what is already there?

543. Ms Jendoubi: That would require an amendment to The Primary Medical Services (Northern Ireland) Order 2004.

544. Mr Kirkwood: What sort of amendment do you want to make?

545. Ms Ní Chuilín: One that would address the point that Kieran raised. What happens here matters to him.

546. Mr Kirkwood: Yes, but Dr Deeny was talking about suspension; clause 1 does not cover suspension. An amendment could not be tabled to something that is not in the clause.

547. Ms Ní Chuilín: That is fair enough.

548. Mr Kirkwood: I hope that I have clarified the effect of the provisions of the clause.

549. Ms Ní Chuilín: The point that I want to make, and which the BMA raised with us, is about how the costs of suspension would be covered.

550. Mr Kirkwood: There are provisions —

551. Ms Ní Chuilín: Are there detailed provisions for costs and how they will be contained?

552. Mr Kirkwood: There is already provision for the payment of suspended practitioners in The Primary Medical Services (Northern Ireland) Order 2004, so there is no need for new primary legislation to cover that. There is already subordinate legislation that makes provision to pay a GP suspended by the tribunal or by the Interim Orders Committee. Once we introduce provision for health boards to use powers of suspension, we will amend the subordinate legislation to include that provision. We do not need new primary legislation to introduce that, so we do not need to include references to such payments in the Bill.

553. The Chairperson: The health and social services councils of Northern Ireland have called for the amendment: "preventing unsuitable inclusion by virtue of professional or personal conduct" to be added to the conditions provided for in regulations. Is that already covered, and should it be added if it is not covered?

554. Mr Kirkwood: It is not covered. The BMA picked that up with regard to the new condition that will be introduced for the jurisdiction of the tribunal on grounds of unsuitability by professional or personal conduct. The conditions that are being imposed relate to people who are to be included on a list or who are already included on a list. The reason that the unsuitability provision is not included is that there are no degrees of unsuitability: if a practitioner is unsuitable, he or she cannot be on a list and must be removed or suspended. If a board says that someone is unsuitable to be on a list for a professional or personal reason, it cannot impose conditions on the practitioner, because that person will already have been taken off the list. That is similar to the situation in England, Scotland and Wales.

Question, That the Committee is content with the clause, put and agreed to.

Clause 1 agreed to.

Clause 2 (Provision of dental services)

555. Ms Jendoubi: Clause 2 introduces new arrangements for the provision of general dental services. It places a duty on each health and social services board to provide or to secure the provision of primary dental services in its area, to the extent that the board considers necessary to meet the needs of its area. Clause 2 also enables boards to enter into contracts with general dental practitioners to provide dental services for their areas.

556. The provisions in question introduce a range of regulation-making powers. Some respondents to the consultation complained about the lack of specificity of many of the provisions of the Bill. The reason for the lack of specificity is that they are regulation-making powers: the detail and underpinning measures that will allow for the

implementation of the provisions of the 1972 Order will come before the Committee as regulations in due course.

557. Ms Ní Chuilín: That makes no sense to me. There is nothing specific in the Bill, yet we are being asked to regulate something that is not specific.

558. Mr Kirkwood: What Christine is saying is that the Bill introduces enabling powers to make regulations to enter into dental contracts. Many of the comments from the consultation referred to the lack of specific detail and wanted to know what would go into the contracts. Christine is saying that that issue will be dealt with further down the line.

559. The detail will be set out in the contract regulations that will come before the Committee; many of the new provisions are technical. Proposed new articles 60A to 61F will replace article 61 of the 1972 Order. That is it in a nutshell. Clause 2 introduces enabling powers to make regulations for entry into a general dental services contract. The terms of that contract are still being negotiated by the British Dental Association (BDA).

560. Ms Ní Chuilín: Will the regulations come before the Committee?

561. Mr Kirkwood: Yes. The enabling powers that have been drafted are more or less identical to the primary powers for the general medical services contract: "Each Health and Social Services Board shall, to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary dental services within its area, or secure their provision within its area."

562. Regulations will be written around that idea. Performers' lists regulations will be written for dentists. There will be contract regulations. The regulations for the general medical services contract are like a book. The contract, its contents and how it will operate still need to be negotiated. Clause 2 introduces an enabling power to facilitate the writing of regulations that will surround the contract and the boards' entry into contracts with dentists.

563. Mrs Hanna: The matter is daunting for the Committee because it has concerns; it is, however, unsure of the stage at which it should talk about those concerns. Everyone wants the new services to have a positive effect. I hear a great deal from my constituents about the lack of National Health Service (NHS) doctors. There are concerns about the fact that what happens in England and Wales is being more or less copied here. The situation seems similar. I want to be sure that I know when I must intervene and express my concern about how targets will be set and measured and, indeed, about the availability of pilot schemes. I presume that now is not the stage to raise those concerns. However, I want to know when the Committee will have the opportunity to do so.

564. The Chairperson: I have concerns that so many NHS dentists are removing themselves from the system and into private dental care and about the lack of dental practices.

565. Ms Jendoubi: We hope that when a contract has been agreed by the BDA it will be piloted across Northern Ireland before it is rolled out. The contract must be underpinned by regulations that will prescribe with whom health boards can enter into a contract, what the contract needs to cover, and dental practitioners' and boards' responsibilities under the contract.

566. Services that can be contracted separately outwith the general dental services contract, such as those of individual, high-street dentists — orthodontists, for example — might be covered by a separate personal dental services contract under primary dental services. The underpinning legislation needs the primary powers of the Bill to enable the Department to make regulations that will bring the contract into being.

567. The Chairperson: If I am reading you correctly, you are suggesting is that if the ‘i’s are dotted and the ‘t’s crossed, we may see more dentists wanting to operate in the National Health Service.

568. Ms Jendoubi: Donncha would be happy to explain, at some length, the benefits that the new contract will bring.

569. The Chairperson: Can we touch briefly on that? I am concerned; because many of my constituents tell me — as I am sure other members’ constituents tell them — that there are queues to get into a dental practice. The number of NHS dental practices that have gone over to private dental work means that services are reducing, especially in disadvantaged areas. We are all concerned about the dental health of young children, but if parents cannot afford to pay the private sector, we need more NHS dentists.

570. Mr Donncha O’Carolan (Acting Chief Dental Officer): May I respond to the point that Carál made? Although it is very hard to comment on something so vague, the key is proposed new article 60A, which will place a duty on the boards to provide services in their areas. The 1972 Order allows dentists to choose where they set up and whom they treat. Significantly, proposed new article 60A will transfer the balance of power. The boards will have the power to decide where practices locate and to ensure that there is access in their areas. That is the fundamental provision of clause 2; the regulations will cover the detail on how that is done. The boards will hold the budget and they will decide how it is allocated. At the moment, services are completely demand-driven. The boards cannot compel a dentist to set up in a particular area or to see particular patients, so in many ways their hands are tied. The Bill will reverse that.

571. Ms Ní Chuilín: On 2 July the Assembly debated the lack of availability of NHS dental treatment, although that might have been a premature debate. My understanding was that boards would be compelled to provide dental services in areas of high deprivation. Apart from being compelled to provide services, I thought that they might consider doing preventative work, improving education and health awareness and promoting healthy eating. It alarms me that aspects of dentistry could be streamlined or that professions could be categorised or sectioned off. I cannot relate that to the Bill. Market forces have determined whether there are dental services in our communities.

572. Mr O’Carolan: That is correct. Dentists make all the decisions at the moment, but the Bill will give the boards power, and as they hold the budget they will be able to decide where they will target their money.

573. Ms Ní Chuilín: If the long-term use of antibiotics rots a child’s teeth, the parents have to take out a bank loan to pay for treatment, because such treatment is deemed cosmetic. Rather than having to wait months for an appointment, parents should be able to avail of the service in their health centre or healthy-living centre. Access is the key, and at present many people do not have access.

574. Rev Dr Robert Coulter: Will the new legislation interfere with the ability to sell a dental practice?

575. Ms Jendoubi: No. A dentist will still be an independent practitioner working under a contract with the health board.

576. Mr Kirkwood: It will depend on the negotiations on the contract. However, proposed new article 61B allows a health and social services board to enter into a contract with those specified in the sub-paragraphs. The contents of the contract have not been decided, so we cannot answer that today.

577. Ms Jendoubi: This legislation will not affect that one way or the other.

578. Mr O’Carolan: At present, dentists cannot sell their Health Service contract to anyone, so there will be no change.

579. Rev Dr Robert Coulter: Therefore, it would not be in the contract at all?

580. Mr O'Carolan: That matter would not be dealt with in this legislation. Dentists are independent practitioners and businesspeople. Their premises and equipment belong to them, so they are free to sell them.

581. Rev Dr Robert Coulter: In proposed new article 60A(1) in the 1972 Order, each of the four health and social services boards would provide dental services. Is that really in the public interest, especially in the interest of those people who live on the periphery of a board area?

582. Ms Jendoubi: Proposed new article 60A(1) places a duty on each health and social services board to provide for its area's needs. That may mean a difference in emphasis but not in the service that is available. The Department of Health, Social Services and Public Safety is negotiating a Northern Ireland-wide contract with the BDA, under which everyone will work to the same terms and conditions. Therefore, as Ms Ní Chuilín pointed out, boards will have the flexibility to decide, for example, whether to set up a practice in a disadvantaged area. Moreover, it is not compulsory for dentists to enter into a contract. They will still be free to make that decision.

583. If a board cannot get an independent practitioner to set up in a particular area, it becomes the board's duty to secure dental services in some other way; for example, by employing a salaried dentist or by temporarily appointing the Community Dental Service (CDS) to provide dental services where they are needed. Proposed new article 60A(1) merely places a duty on a board to ensure that dental services are available where necessary.

584. Mrs O'Neill: The BDA suggests that proposed new article 60A(2)(b), which states that a board

"may in particular make contractual arrangements with any person",

585. contradicts proposed new article 61B(1), which states that a board

"may, subject to such conditions as may be prescribed, enter into a general dental services contract".

586. Mr Kirkwood: It is not contradictory. Proposed new article 60A(2)(b) refers to primary dental services. Proposed new article 61B(1) deals with a general dental services contract.

587. Ms Jendoubi: That is the difference. Proposed new article 61B relates to the contract.

588. Mr Kirkwood: Proposed new article 60A relates to primary dental services, which is the generic term for general dental services and personal dental services; therefore, proposed new article 60A(2)(b) does not contradict proposed new article 61B(1).

589. Mrs O'Neill: May I have clarification on the categories of dental personnel who will be subject to the Health Service tribunals? For example, will hygienists, dental nurses, and so on, fall into the same category? Will that be covered by regulations?

590. Mr Kirkwood: Yes, that will be set out in regulations. The tribunal services will cover healthcare professionals, so, when it has been negotiated and is in place, the contract will clarify what personnel, other than dentists, will be covered by the tribunal regulations. However, the overall provision for healthcare professionals will allow regulations to stipulate who will be covered.

591. Mrs O'Neill: The BDA has also called for provision for piloting the new dental contract. The Northern Health and Social Services Board has interpreted clause 6 as meaning that pilot schemes will not be possible until the Bill has been passed. Is that correct?

592. Ms Jendoubi: We can deal with clause 6 now if the Committee wishes.

593. Mrs O'Neill: Shall we come back to clause 6?

594. Ms Jendoubi: We are happy to deal with it now.

595. Clause 6 will remove the power to make pilot schemes for provision of personal dental services. However, it will not obviate boards' power of the boards to pilot general dental services. We can do that without the need for primary legislation. We have agreed with the BDA that the new contract — when we get one that we all agree looks as if it is a runner — will be piloted before it is rolled out formally.

596. Mr Gallagher: I have concerns about a couple of points. We have heard about the current problems with dental services. As has been said, the Committee wants an outcome that delivers a service for the public and that results in a profession that is worthwhile and rewarding for its practitioners. It is to be hoped that our dentists will enter into contracts because those contracts will be rewarding.

597. I am concerned about what is happening, for example, in England. I am not sure what you mean when you talk about British dental services. I presume that you mean dentists in Northern Ireland who are members of the BDA, and that you are in discussions with those dentists. I see that you are nodding by way of confirmation. That is encouraging. However, the contracts are not working well in England; they have not produced the desired outcome. There are still huge problems with dental services in England. After going to all this bother, we do not want to end up with bigger problems here.

598. Although I have heard that there is no contradiction between, under proposed new article 60A(2)(b) of the 1972 Order, entering into contractual arrangements with any person and, under proposed new article 61B(1), entering into general dental services contracts, it appears that there is one. Is it necessary to include proposed new paragraph (2)(b) of the 1972 Order? We are trying to solve a problem by removing any doubt or suspicion about the way forward.

599. Another point concerns the piloting of general dental services, which Christine mentioned. Will the boards pilot those new services before or after the new contracts are agreed? Will the Bill become law before the contracts are piloted, or will it be done the other way around? Will everyone be confused?

600. Ms Jendoubi: Technically, the Department does not need either primary or subordinate legislation in order to run pilot schemes. However, for practical reasons, the Department will need to know the contents of the subordinate legislation in order to ensure that it is consistent with the content of the pilot schemes. The Department hopes to develop subordinate legislation at roughly the same time as the contract is implemented, so that we can ensure that the contract and the subordinate legislation are consistent.

601. The Committee will play its role by scrutinising the subordinate legislation that underpins the contract. The detail of the contract will be a matter for negotiation. Tommy Gallagher is absolutely right to say that the new contract that was established in England found no favour with the profession, largely because of the way in which remuneration was handled. Dentists' activity is still measured in units of dental activity (UDAs), and that keeps dentists on what they refer to as the treadmill of "drill and fill". Dentists are paid for the amount of treatment that they carry out rather than for their professional time spent on preventive measures and the promotion of oral health.

602. We will try to take full account of the English contract and learn what we can from it, such as what to do and what to avoid. Together with the BDA, we will produce a dental contract that suits Northern Ireland and its dentists, that acknowledges their professionalism and that rewards them for the use of their time rather than for the number of root canals that they fill.

603. Mr O'Carolan: We have never indicated that the English contract will be introduced in Northern Ireland. The Minister told the Assembly that on 2 July 2007. We hope that a joint communiqué with the BDA will be issued this month to all dentists. It will indicate how our contract will be different from the English one.

604. Mr Gallagher feels that there is a contradiction in the Bill. Proposed new article 60A(2)(b) deals with all dental services, which means primary care as performed by our independent practitioners as general dental services, and personal dental services, which we do not have in Northern Ireland at present. Regulations must be written for that provision to be introduced. Proposed new article 61B(1) deals specifically with the general dental services contract. It is necessary that that distinction be included in the legislation.

605. Mrs Hanna: We want a better service; we do not want "drill and fill". We want to ensure that people are attracted to the dental profession, that they receive sufficient remuneration for their work and that they are not on that treadmill to which Christine referred.

606. The Committee has been given the impression that the content of the Health (Miscellaneous Provisions) Bill will change little. However, as Tommy said, if all contracts were to be signed before the pilot schemes were in place, it would be hard to undo the legislation if it were found not to be right. Surely it would better to find out first whether the pilot schemes work, before the contract is set in stone. It is important that that be done.

607. Ms Jendoubi: The contract will not be set out in regulations, but its underpinning framework will be. The contract will be piloted. It will not be set in stone until after the pilots have been rolled out and it becomes clear what has worked and what needs to be tweaked. Only when we reach the point at which everyone is content will the boards enter into a contract with individual dentists. I agree that the full contract cannot be set out in legislation.

608. Dr Deeny: I hope that the answer to both of my questions will be yes.

609. I have been approached in the past fortnight by a constituent and patient, who told me that she could not get an NHS dentist in either Omagh or Dungannon. She had tried to register with every one of them. Is what you are saying that, in future, clause 2 will ensure that the boards will bring that situation to an end?

610. Ms Jendoubi: Yes.

611. Dr Deeny: That answer is important, because if patients cannot get an NHS dentist, a serious deficiency in dental care exists.

612. Last week, I was appointed to the West Local Commissioning Group (LCG), having had to take the Department to the High Court, so I have an interest to declare. The health and social services boards will, at some point; come to the end of their lives — we know that. It is now too late to legislate for their replacement by LCGs, as was to have happened by 1 April 2008. Will the term "local commissioning groups" replace "boards" in the legislation?

613. Mr Farrell: As Christine has already indicated, the answer to your first question is yes. As for your second question, when it comes to the use of the term "boards", the Bill must use terminology that applies to the structures currently in place. We currently have

health and social services boards; however, if, after the review of public administration (RPA) is implemented, they are to be replaced by a new health and social care authority, any reference to "boards" in the existing legislation will have to be amended in the legislation that establishes the health and social care authority.

614. Ms Ní Chuilín: The BDA has called for an independent adjudication of any disputes that may arise as a result of clause 2. Its concern extends to clause 3. To achieve that outcome, the BDA recommends that proposed new article 61E(2)(b) be changed from

"for the Department, or a person appointed by it"

to

"for the Department to appoint an independent person or panel".

615. Ms Jendoubi: Again, that issue will be set out in regulations, so the Committee will have another chance to examine the details.

616. Mr Kirkwood: The same dispute-resolution procedure that the general medical services (GMS) contract uses will probably be followed, whereby the Department appoints someone and a tribunal is established.

617. The Chairperson: The BMA has queried the proposed change to the cross-heading after article 60 of the 1972 Order from "General Dental Services, General Ophthalmic Services and Pharmaceutical Services" to "Primary dental services". Moreover, in clause 5, Roe Valley Dental Practice has queried the change to the cross-heading and heading that precede article 15B of the 1972 Order from "personal dental services" to "primary dental services". What is behind the decision to use those different titles?

618. Mr O'Carolan: "Primary dental services" is a generic term for general dental services and personal dental services, which is an alternative way in which to deliver general dental services. No personal dental services operate in Northern Ireland at present, but that proposed change to the 1972 Order gives the option of having those services in the future. Rather than include "general dental services" and "personal dental services" in every sentence, "primary dental services" is used as a catch-all term.

619. The Chairperson: Therefore, "primary dental services" is used as an umbrella term.

620. Mr Kirkwood: I want to raise a further point so that the Committee is aware of the full provision of clause 2. Although we have covered the contract issues, clause 2 will introduce proposed new article 61F to the 1972 Order. That provision sets out the enabling power for how dentists will be listed in future. We discussed that issue when we considered clause 1. The proposed new article sets out similar powers to those that are currently in place for GPs for conditional inclusion on a list and for contingent removal and suspension.

Question, That the Committee is content with the clause, put and agreed to.

Clause 2 agreed to.

521. The Chairperson: If members agree, we will call a halt to our scrutiny of the Bill, because we are now due to hear evidence from the Northern Ireland Fire and Rescue Service. We will scrutinise the Bill further next Thursday. Clause 3, from where we will begin, is fairly short. I hope that it will be full steam ahead. Thank you very much.

522. Ms Jendoubi: We look forward to it.

Thursday 13 September 2007

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mrs Carmel Hanna
Ms Carál Ní Chuilín
Ms Sue Ramsey

Witnesses:

Mr John Farrell	
Ms Christine Jendoubi	Department of Health, Social Services and Public Safety
Mr Robert Kirkwood	
Mr Donncha O'Carolan	Acting Chief Dental Officer

623. The Chairperson (Mrs I Robinson): I welcome the departmental officials, Christine, John, Robert and Donncha — I have found out how to pronounce that name. Members will recall that clauses 1 and 2 have been agreed. Members have been provided with much written material, including a copy of the Bill, a detailed commentary and a copy of extracts from any legislation that the Bill amends. Members will also recall that we took oral evidence from a number of groups before the summer recess, and further written submissions have been received over the summer.

624. I suggest that, in the main, Members should use the notes on clauses that the Department has prepared, which were circulated to Members last week, as well as the paper provided by the Committee staff.

625. The Committee will have a number of options when considering each of the clauses. Before choosing an option, I will invite the officials to outline briefly the purpose and meaning of the clause. Members can then, if they wish, seek clarification. Following discussions with officials on each clause and the potential that there might be for amendment, the Committee can consider the options available to it.

626. The first option is to decide whether it is content with the clause as drafted. The second is to agree the potential for an amendment and request that the Department consider the matter and report its position back to the Committee: by doing so, we effectively refer the clause for further consideration. In cases where an amendment is considered appropriate, we can invite the Department to indicate whether it would be willing to undertake the drafting of such an amendment. We will now begin the clause-by-clause scrutiny at clause 3.

Clause 3 (General dental services: transitional)

627. The Chairperson: I invite officials to outline the meaning of this clause. Thereafter, questions will be taken.

628. Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): This clause deals with general transitional provisions and provides for the transition

between the existing contract for dentists and the new contract. It also provides that all practices will have the right to enter into a new contract. At the point of transition, the boards will not have, for example, the right to decide to which existing dental practices they will offer the new contract. All existing practices must be offered the contract. The clause ensures continuity of provision for patients so that they will not notice the transition between the old and new contracts.

629. We must organise matters so that the new contract will come into effect on the same day as the transitional arrangements that are provided for in the legislation. There must be no gap: the legislation must be ready for the new contract to come into effect. When the legislation comes into effect, the old contract will fall, so the new contract has to be ready on the same day. This clause provides for that transition.

630. The Chairperson: The British Dental Association (BDA) has called for an Order made under clause 3(7) to be subject to an affirmative, rather than a negative, resolution procedure. What is your view on that?

631. Ms Jendoubi: The draftsmen, rather than the Department, usually decide whether a clause will be subject to affirmative or negative resolution. In my experience, the affirmative resolution procedure is usually reserved for clauses that include a power to set fees, charges or financial penalties. We have no strong views on that matter, and we are happy to take a recommendation from the Committee.

632. The Chairperson: If members are agreed, can I ask the panel about the relationship between negative resolution and affirmative resolution?

633. Ms Jendoubi: “Affirmative resolution” means that the clause cannot go forward unless the Assembly votes in favour of it. “Negative resolution” means that the clause is put before the Assembly for a period of days, I think of 40 days, during which time the Assembly can pray against it. If no-one prays against it during that period, then it is carried.

634. The Chairperson: We are covered. We do not lose out, we have a period of grace, then.

635. Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): The transitional arrangements would require that at a stage before drafting, the Committee would be involved in the policy that was being set out. As Ms Jendoubi said, the difference between affirmative and negative resolution is that, with affirmative resolution, the legislation has to be approved by the Assembly and it is necessary to go before the Executive for approval to make the legislation. Although it is an Order, it is still subordinate legislation. With negative resolution, the policy intention included in it would come before the Committee, so you would have an opportunity then. Once the legislation had been made and was laid, the Committee would have another chance. Any Member could pray against it, and the legislation could be annulled at that stage, if that was what the Committee wanted.

636. The Chairperson: Therefore, there is a window of opportunity.

637. Ms Ní Chuilín: If we go for affirmative resolution, on the other hand, we give the prerogative to the Executive, and we have no recall. Is that correct?

638. Mr Kirkwood: No. We would be going to the Executive first, in the affirmative —

639. Ms Ní Chuilín: And then come back to us?

640. Mr Kirkwood: Yes.

641. The Chairperson: Am I correct in thinking that the Committee has a period after the Executive give their —

642. Mr Kirkwood: Yes, but with negative resolution it would not need to go to the Executive. We would come to the Committee setting out the policy that was intended to be taken forward in the legislation.

643. The Chairperson: Are members content?

644. Mrs Hanna: We should go with whatever leaves us with most opportunity to come back. I find that it becomes very complicated when we ask a question. Sometimes the answers make it almost more complicated, because we get a lot of information back. Really, we want to leave it as open as possible so that we can come back if we feel it is necessary to do so. The Committee should choose whichever is most favourable to it and affords it the most opportunity to return to the issue.

645. The Chairperson: If the clause provided for affirmative resolution an order for transitional provision would go to the Executive first and then we would have the opportunity to come back to it for a second time.

Question, that the Committee is content with the clause, put and agreed to.

Clause 3 agreed to.

Clause 4 (Charges for dental services)

646. The Chairperson: I invite the officials to explain the meaning of the clause, and we will invite questions thereafter.

647. Ms Jendoubi: Clause 4 provides for a change from the existing item-of-service payments to dentists to a new regime of charges. It removes paragraph 1A of schedule 15 to the Health and Personal Social Services (Northern Ireland) Order 1972 — which provides for item-of-service payments — and inserts a new paragraph 1A that allows regulations to set out a new system of charging. It also inserts a new schedule 15A, which deals with exemptions, into the 1972 Order. Schedule 15A replaces article 26 of the Health and Social Services (Primary Care) (Northern Ireland) Order 1997. Therefore, the exemptions in the primary legislation are all now contained in one Order. It does not add any new exemptions, and it does not change any of the exemptions that are already in force. That was the basis on which we consulted.

648. Ms Ní Chuilín: Does it mean that people of 65 years of age and over will be exempt from charges?

649. Ms Jendoubi: No, because they are not exempt at present. The basis that we consulted on —

650. Ms Ní Chuilín: Was that the primary dental care strategy?

651. Ms Jendoubi: Yes.

652. The Chairperson: Do you want to expand on that, Carál?

653. Ms Ní Chuilín: I believe that there should be exemptions for people aged 65 and over.

654. This may not be the time to discuss that; maybe we can do that when we go into the nitty-gritty of the dental contract.

655. Mr Donncha O'Carolan (Acting Chief Dental Officer): Recommendation 5 of the primary dental care strategy, which the Department consulted on, was that the existing exempt groups should continue to receive free dental treatment. None of the groups that were consulted wanted the current exempt groups to be changed. No one wanted the

over 65s to be exempt from dental charges. The Department drafted the legislation on that basis.

656. Ms S Ramsey: That does not make it right. It is my birthday today and, although I am not 65 yet, I would like free dental treatment when I reach that age.

657. Mr Kirkwood: There would be an expense attached to that. If a policy decision were made or an amendment tabled that over 65s should be included among exempt groups, the Minister would have to consider whether it was affordable and whether it was a priority compared to other priorities in the Health Service.

658. Dr Deeny: What groups did you consult with prior to drafting the legislation?

659. Mr O'Carolan: An extensive list of consultation groups is held in the Department. I do not know exactly how many groups are on it, but there are around 70 names.

660. Dr Deeny: Did any of them say that over 65s should receive free dental care?

661. Mr O'Carolan: None of them came back with that view. Free treatment for over 65s is not available anywhere else in the UK.

662. The Chairperson: Are you saying that it is offered nowhere, not even in Scotland?

663. Mr O'Carolan: Some areas offer free dental examinations. The Department costed free dental examinations at a total of £600,000. [This sentence could not be picked up properly due to mobile phone interference.] That is just for examinations; the cost of the treatment would run to millions.

664. Ms Ní Chuilín: People have paid their stamps for most of their adult lives. At the age of 65, people would imagine that they would be able to get their dentures without paying. [This sentence could not be picked up properly due to mobile phone interference.]

665. The Chairperson: Do you want it to be called?

666. Ms S Ramsey: Free dental care for the over 65s needs to be explored. I understand that there are cost implications. However, elderly people receive free transport, free eyecare and free prescriptions. The fact that no other regions have taken action on free dental care for over the 65s should not stop us from leading the way. I do not mean to be flippant, but the fact that none of the consultation groups requested the measure should not stop us from introducing it either.

667. The Chairperson: Can you give me an idea of how many in the population are over 65?

668. Ms Jendoubi: I cannot answer that off the top of my head.

669. The Chairperson: Do members agree that before the Committee takes any decision, we defer and come back to it, deo volente, next week? I suggest that a rough calculation is made to find out what the cost might be and the number of people that it would affect.

670. Dr Deeny: Did you say that 70 groups were listed for consultation on the issue of dental charging?

671. Mr O'Carolan: I do not know exactly how many are listed. The Department has a distribution list that all consultation documents have to go out to.

672. Dr Deeny: Is Age Concern on that list?

673. Mr O'Carolan: Yes, as far as I am aware, Age Concern is on the list.

674. The Chairperson: Help the Aged is also on the list.

675. Mr O'Carolan: It is a comprehensive list.

676. The Chairperson: We shall set clause 4 aside and invite the witnesses to return and provide a report with further information.

677. Mr John Farrell (Department of Health, Social Services and Public Safety): Our population is ageing, and the number of people who are over 65 today may not reflect what the number will be in five or 10 years' time. We should look forward a couple of years, if possible, and forecast what the future cost may be.

678. The Chairperson: It would be appropriate to consider more than one year.

679. Ms S Ramsey: Money can be saved by investing in health.

680. The Chairperson: I am sure that that view is not just a personal crusade.

Clause 4 referred for further consideration.

Clause 5 (Provision of dental services: Article 15B arrangements)

681. The Chairperson: Could you please talk us through clause 5, Ms Jendoubi?

682. Ms Jendoubi: Clause 5 looks very daunting. It seems very complicated, but all it does is make minor technical amendments to existing articles 15B, 15C, 15D and 15F, under which boards can enter into arrangements for "personal dental services": the clause changes that to "primary dental services". As was mentioned during last week's Committee meeting, primary dental services embraces both general dental services (GDS) and personal dental services — those being services for which boards can enter into contracts, except for general dental services that will be contracted for with each individual dentist. For example —

683. Mr O'Carolan: Are you looking for examples of when personal dental services might be used?

684. Ms Jendoubi: Yes.

685. Mr O'Carolan: Under the new contract in England, all orthodontic treatment is carried out under the banner of personal dental services. However, other areas, such as out-of-hours care or when a preventative scheme is needed in a deprived area, are not covered under the heading of GDS. A specific tailor-made scheme could be set up to target such areas. That would offer a degree of flexibility for the future; GDS is a bit more rigid. This would allow other providers such as dental hygienists and dental therapists to deliver services alongside dentists.

686. The Chairperson: The purpose is to protect the public.

687. Ms Jendoubi: We do not currently have personal dental services in Northern Ireland, nor do we have a vision for them in primary legislation. We have never brought the provisions that already exist into force. Clause 6, which was also mentioned at last week's meeting of the Committee, deals with piloting personal dental services. Clauses 5 and 6 together will remove the provision to pilot personal dental services, because we cannot foresee circumstances in which we would want to pilot that type of separate contract. That might be a fixed-term contract dealing with specific areas, and it is not the sort of arrangement that a health and social services board would want to pilot. A board would simply want to let the contract. Articles 15B, 15C, 15D and 15F will provide for personal dental services to be made permanent.

Question, That the Committee is content with the clause, put and agreed to.

Clause 5 agreed to.

Clause 6 (Revocation of power to make pilot schemes for provision of personal dental services)

688. Ms Jendoubi: That is the clause that I have just mentioned.

Question, That the Committee is content with the clause, put and agreed to.

Clause 6 agreed to.

Clause 7 (Assistance and support for persons providing primary dental services)

689. Ms Jendoubi: The boards currently have such powers in respect of general practitioners, but not dentists. Clause 7 gives boards the power, when a dentist is injured, off sick, or when there has been a fire at a dentist's surgery, for example, to step in and appoint a locum to ensure that continuity of service is maintained.

690. The Chairperson: The clause simply protects the continuation of services.

Question, That the Committee is content with the clause, put and agreed to.

Clause 7 agreed to.

Clause 8 (Ophthalmic services)

691. Ms Jendoubi: Clause 8 provides for ophthalmic services what preceding clauses provide for general medical and dental services, in so far as it provides for them to be on a performers' list for Northern Ireland.

692. It provides for the conditional inclusion, and contingent removal, of practitioners from the performers' list, and it provides for suspension by boards in the same way as other family practitioners.

693. The Chairperson: As in malpractices?

694. Ms Jendoubi: Yes. It is on exactly the same grounds.

695. Dr Deeny: Does that apply solely to optometrists? They used to be called opticians, but they are optometrists now.

696. The Chairperson: They all have fancy names now.

697. Dr Deeny: There can be confusion with ophthalmologists when we refer to "ophthalmic services", but we are talking about optometrists.

698. Ms Jendoubi: It is "persons providing general ophthalmic services".

699. Dr Deeny: But it is referring to optometrists?

700. Ms S Ramsey: I am being blinded by science.

701. Ms Jendoubi: To be honest, so am I. I understand that opticians did not like to be called opticians, but preferred to be called optometrists in the same way that chemists prefer to be called pharmacists.

702. The Chairperson: They just like big words. That is what it boils down to.

703. Ms Ní Chuilín: Perhaps the Chairperson is right. People say that they are going to the chemist's, not to the pharmacist's —

704. The Chairperson: Or to their pharmaceutical adviser.

705. Ms Ní Chuilín: You normally use the name of the shop that you get your glasses from, but we will not give anyone free advertising.

Question, That the Committee is content with the clause, put and agreed to.

Clause 8 agreed to.

Clause 9 (Local optical committees)

706. Ms Jendoubi: There are local optical committees in the same way that there are local medical committees in Northern Ireland. At the moment ophthalmic medical practitioners are not included in local optical committees, and clause 9 provides for them to be included.

707. Ms Ní Chuilín: Dispensing opticians are not included — we have just had this conversation.

708. Ms Jendoubi: As I understand it, dispensing opticians are people who sell glasses. They do not actually examine your eyes.

709. Dr Deeny: Therefore, a dispensing optician is not an optometrist?

710. Mrs Hanna: Nor an optician.

711. Ms S Ramsey: Yes, because you get your eyes tested there.

712. Dr Deeny: The optician only sells the glasses.

713. Ms S Ramsey: Most of them do eye tests as well.

714. Ms Ní Chuilín: At the place where I get my glasses — which I will not name — I just walk in, get my eyes tested, get my glasses and walk out.

715. Mr Farrell: An optometrist carries out the eye examination.

716. Ms Ní Chuilín: And then a salesperson will sell the glasses?

717. Mr Farrell: It would not be a salesperson. The dispensing optician will be responsible for ensuring that the lenses that you are prescribed have been done up in the correct way and are put into the glasses. Dispensing opticians do not actually carry out eye tests. They have their own separate role to play in the optician's practice, but they cannot examine eyes.

718. Ms Ní Chuilín: A bit like the hygienist in the dentist's, really?

719. Mr O'Carolan: My understanding is they can fit the glasses and dispense them, but they cannot examine your eyes.

720. The Chairperson: Why are dispensing opticians not included, and is it appropriate for them to be included, in local optical committees?

721. Ms Jendoubi: We can look at that and come back to the Committee.

722. The Chairperson: Optometry Northern Ireland argues that it is anomalous that dispensing opticians do not have a statutory right to membership of local optical committees and has proposed an amendment to clause 9 to provide for that. The Committee wants to explore why dispensing opticians are not included and whether it is appropriate that they should be.

723. Can the Department examine that?

724. Mr Farrell: The Department will examine that and come back to the Committee. Local medical and dental committees comprise either doctors or dentists. The Department wants optometrists — the people who carry out eye examinations — to sit on the local optical committees. Dental hygienists, for example, do not sit on dental committees. One must read across to specify what professions should have places on committees.

725. Mrs Hanna: I think that there is a difference. An optometrist examines eyes. However, a dispensing optician fills out prescriptions and measures it all up. I do not wish to denigrate what dental hygienists do, but I think that dispensing opticians have a much more technical role.

726. Ms Jendoubi: Optometrists are on the local optical committees.

727. Mrs Hanna: Surely dispensing opticians are arguing to be on the committees.

728. Ms Jendoubi: You have described optometrists, who are already on the committees.

729. Mrs Hanna: So dispensing opticians do not fill out prescriptions; they do not measure?

730. Ms Jendoubi: Exactly.

731. Mrs Hanna: When I get my eyes checked, one person examines them and another person works out what the prescription should be. Certainly, at the practice that I go to, it seems very much like teamwork: one person examines my eyes and the other does somewhat more than simply choose the frames.

732. Dr Deeny: Clarity on that is needed. GPs get referrals from optometrists. They are synonymous with opticians of the past. However, the Committee is hearing the term "dispensing optician", which is confusing. My understanding is that a dispensing optician is not qualified to examine the back of someone's eyes. That must be made clear, because, until now, people have understood opticians and optometrists to be synonymous. That is not the case. A dispensing optician is not a qualified optometrist. Can the Department provide clarity on that? Indeed, is the term "optician" a proper description of someone who is just selling glasses?

733. Mr Farrell: I believe that opticians do more than simply sell glasses.

734. Mrs Hanna: That is the point that I have tried to make.

735. Mr Farrell: Dispensing opticians ensure that a prescription is made up correctly and that the fitment is correct. They do not carry out eye examinations or assess whether a person's eyesight is strengthening or weakening. They do not determine what prescription lens a patient needs. The optometrist does that. Optometrists are also able to refer their patients to secondary care, whereas dispensing opticians cannot do that because they are not able to examine the eyes.

736. The Chairperson: Members agree that the Department will provide more information on that.

Clause 9 referred for further consideration.

Clause 10 (Pharmaceutical services)

737. Ms Jendoubi: Clause 10 largely consolidates the provisions for pharmaceutical services that are already in the Health and Personal Social Services (Northern Ireland) Order 1972. However, over and above that, it makes the same provisions for pharmacists that the previous clause made for optometrists and ophthalmic services: the performers' list; conditional inclusion and contingent removal; and suspension. We want provisions to be consistent throughout family practitioners services.

738. The Chairperson: The Pharmaceutical Society of Northern Ireland argues that the provision adds further confusion to the regulation of pharmacists and feels that it will cause duplication. Can you respond to that?

739. Ms Jendoubi: It depends what it means by “duplication”. If it means duplication of the role of the regulatory body and the role of the tribunal, the Department argues that there is none. That was discussed last week. I do not know what else the society might mean by duplication.

740. The Chairperson: Could we defer that? A delegation from the Pharmaceutical Society will address the Committee later.

Clause 10 referred for further consideration.

Clause 11 (Disqualification by the Tribunal)

741. Ms Jendoubi: This clause covers schedule 1 of the Bill, which amends schedule 11 to the 1972 Order in relation to the provisions for the tribunal. We will come to that in a moment.

742. The Chairperson: Is the Committee content with the clause as drafted?

743. Ms Ní Chuilín: I know that we discussed that before; however, the issue of suspension and neutrality seems to be a neutral act.

744. Ms Jendoubi: We will get to that when we discuss the amendments to that schedule. This is just the covering clause.

Question, That the Committee is content with the clause, put and agreed to.-

Clause 11 agreed to.

Clause 12 (Charges for services provided to persons not ordinarily resident in Northern Ireland)

745. Ms Jendoubi: This is a humanitarian provisions clause. It is extant already in other parts of the United Kingdom and is a parity measure. It provides that, when someone has been allowed to come into the country for a course of treatment, the Secretary of State or, in our case, the Department of Health, Social Services and Public Safety, can determine that, on humanitarian grounds, that person should not be charged. The reasons for being brought in for treatment must include the fact that the treatment is not available in the person’s own country. For example, specialist services, or some cutting-edge technology, might be provided by the Royal Victoria Hospital.

746. The Chairperson: Someone may be classed as a “bleeder” and may not be able to have a tooth extracted unless senior consultants are on hand.

747. Mr Kirkwood: It will be only for treatment that is not available in the person’s home country.

748. The Chairperson: I use that as an example of a specialist treatment that may not be available in other countries.

749. Mr Kirkwood: The provision allows for that person to come over here to be treated and for the Department to consider if he or she should be charged.

750. The Chairperson: On the other hand, does it open the floodgates? You must prove that it cannot be —

751. Mr Kirkwood: Specific criteria will be set down in regulations. As Christine said, the first requirement is that the treatment is not available in the person’s home country.

752. Mrs Hanna: My query may be covered in some other part of the legislation. Will that provision cover emergency treatment for toothache for someone visiting the country? Is that covered anywhere?

753. Mr Kirkwood: That is covered in “persons not ordinarily resident”.

754. Mrs Hanna: It is covered?

755. Mr Kirkwood: A person can receive emergency treatments during a temporary stay in Northern Ireland. Legislation already covers that.

756. Ms S Ramsey: Christine, did you say that this is not available in other parts of England, Scotland and Wales?

757. Ms Jendoubi: I said that it is.

758. The Chairperson: We are coming into line.

759. Ms S Ramsey: Sorry. Such a provision is a good idea, on the basis that we should have top-of-the-range, merged services, as long as it is not abused.

760. Mr Easton: Will this “humanitarian grounds” provision apply only to serious cases or could it be used for simple things?

761. Ms Jendoubi: Ordinarily, simple things are available in the person’s own country. An example might be a youngster who has been caught in a bomb blast in Iraq and who is then brought to Northern Ireland because surgeons here have specialist skills, or a child born with a severe abnormality that specialist plastic surgeons here have skills to treat.

762. The Chairperson: Is that like the dental surgery that is required to correct a cleft palate?

763. Dr Deeny: On that costing, I know that the charge is waived for someone coming in from another country where the treatment is not available, but is the country not charged? For example, if someone from Canada — a wealthy country — came for neurosurgery in the Royal Victoria Hospital, will that country not be charged for the treatment?

764. Ms Jendoubi: This clause deals with exceptional humanitarian grounds, and “exceptional” means just that. Someone coming to Northern Ireland for treatment that is not available in another country would not necessarily attract the use of that clause. There would have to be something particular about the treatment that would move the Department to regard it as exceptional in that way.

765. The Chairperson: The member picked a bad example. Canada would be able to cope with all kinds of dental work.

766. Dr Deeny: Is it for people from poor countries? Is that what you are saying?

767. Ms Jendoubi: Treatment would have to be examined on a case-by-case basis.

768. The Chairperson: Do you feel that the wording ties down what it actually means?

769. Mr Kirkwood: The clause more or less brings Northern Ireland into line with the rest of the UK, where it has currently fallen behind. The provision would probably be used more in London, for example, where there are specialist hospitals. It would be used more there than for patients transferring to Northern Ireland for specialist treatment.

770. Dr Deeny: Does a similar arrangement exist in America, for example?

771. Mr Kirkwood: There is reciprocity among various countries in relation to the Health Service.

772. Dr Deeny: Last week, the Committee met one patient who is now in Chicago having treatment that is not available here. I wonder whether we can draw a comparison, when there is no available treatment here.

773. Ms Jendoubi: I am afraid that I cannot comment on whether the Americans should charge that patient.

774. Ms S Ramsey: Why the NHS?

775. The Chairperson: That is a fair point; the family are paying half the cost of treatment, and we are asking the Department to pay the other half. However, that is another issue that we have not sorted out.

Question, That the Committee is content with the clause, put and agreed to.

Clause 12 agreed to.

Clause 13 (Retirement of practitioners)

776. Ms Jendoubi: The Committee may be familiar with this clause and its import already. The Department came to the Committee before the summer recess with the underpinning regulations for this clause. It will remove from the primary legislation the requirement for age restrictions for dental practitioners and GPs. The GP age restriction is no longer in effect, and the restriction on dental practitioners is the only one left. Dental practitioners were required to retire at 70 years of age, which is against the European directive that deals with discrimination on the grounds of age. Therefore, the Department is asking for it to be removed.

777. Dr Deeny: GPs will be able to work forever or until we drop?

778. Ms S Ramsey: Dr Deeny will be OK; he can work for another 40 years.

Question, That the Committee is content with the clause, put and agreed to.

Clause 13 agreed to.

Clause 14 (Minor and consequential amendments)

779. Ms Jendoubi: This clause deals with small technical amendments that are necessary for the interpretation of the 1972 Order. For example, “Article 17C” should be replaced with “section 17C”, because that was a mistake in the original Order. There is nothing of import.

780. Ms Ní Chuilín: I do not understand what this clause is about.

781. Mr Kirkwood: It is a clause that can be included in any primary legislation. It is a standard type of clause, similar to Clause 16, which deals with interpretation. They are clauses that pick up on any minor or consequential amendment that is needed because articles are being changed.

Question, That the Committee is content with the clause, put and agreed to.

Clause 14 agreed to.

782. The Chairperson: If I may, we will finish there, because we have other deputations from which to hear. Next Thursday, we hope to consider the remainder of the clauses, as well as the two schedules and the long title, thereby completing the Committee Stage of the Bill. I thank you for your attendance.

783. Ms Jendoubi: Thank you very much.

Thursday 20 September 2007

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mrs Carmel Hanna
Ms Carál Ní Chuilín
Ms Sue Ramsey

Witnesses:

Mr John Farrell Ms Christine Jendoubi Mr Robert Kirkwood	Department of Health, Social Services and Public Safety
Mr Kevin Shiels	Northern Ireland Assembly Bill Office

784. The Chairperson (Mrs I Robinson): I welcome Christine Jendoubi, John Farrell and Robert Kirkwood, who are here to provide clarification and answer questions as the Committee for Health, Social Services and Public Safety continues its clause-by-clause scrutiny of the Health (Miscellaneous Provisions) Bill. This is becoming a habit; I feel that we have adopted you.

785. Members of the Committee will use notes on the clauses that have been prepared and circulated by the Department of Health, Social Services and Public Safety.

786. At our meeting on 13 September, clauses 4, 9 and 10 were referred for further consideration. I intend to commence by scrutinising those clauses and, thereafter, resume from clause 15.

Clause 4 (Charges for dental services)

787. The Chairperson: At our previous meeting it was noted that the Western Health and Social Services Board and the health and social services councils had called for people over the age of 65 and other categories to be exempt from charges for dental services. The issue was raised with officials, who agreed to consider it further and report back to the Committee. I invite comments from officials and further questions from members on the issue of charging for dental services.

788. Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): We have prepared some figures for the Committee to consider. Those figures outline the estimated costs of providing free dental treatment for those over the age of 65.

789. The Chairperson: Yes, we asked how many people over the age of 65 the proposal would affect. Christine, will you talk us through the figures?

790. Ms Jendoubi: Estimated population increases between 2004-05 and 2013-14 are based on assumptions by the Northern Ireland Statistical Research Agency (NISRA). We have assumed that there will be a 3% uplift per annum because that is what normally happens.

791. The estimated cost of treatment for people aged over 65 is based on actual figures and incorporates fee payers and those who are exempt from charges. Adding the figures for fee payers and those who are exempt from charges gives the total spend on dental treatment.

792. All figures given are based on the number of people who are registered with a dentist, which is 31% of people over the age of 65. The total number of people over the age of 65 in each year is also shown.

793. The proposal is that those who pay fees be given free dental treatment so that everyone will be exempt from charges. In 2007-08, it would cost £3·8 million to provide free dental treatment for those who pay fees. Fee payers are included in the 31% of those over the age of 65 who are registered with a dentist. If dental treatment were free for everybody over the age of 65, a significant increase in cost could be expected, because many of the 69% of people who are not registered would register. However, a proportion of older people in the over-65s category does not have any teeth. Therefore, dental treatment would not be an issue for them, unless they wanted to get dentures. The fee-payers column shows the estimated cost of giving free dental treatment to those over the age of 65 who are currently registered with a dentist; however, the figure could be anything up to three times the statistics listed in that column.

794. Moreover, the exempt column shows the estimated cost for those over the age of 65 who are exempt from paying dental charges because they are on low incomes. The fee payers are those who have already been deemed able to pay. They, therefore, would be the beneficiaries of free dental treatment.

795. The Chairperson: Can we distinguish between those fee payers? The way in which many people have been raised means that, like those on a better income, they will pay their way regardless of whether they can afford to. Is there a way in which to dissect the information in the fee-payers column to identify those who are in the low-income bracket?

796. Ms Jendoubi: No.

797. The Chairperson: Does anybody wish to comment or ask a question?

798. Ms Ní Chuilín: For only 31% of people over the age of 65 to be registered with a dentist is quite a low percentage.

799. Ms Jendoubi: It is. Less than 50% of adults, and about 60% of children, are registered with a dentist in Northern Ireland. That percentage is clearly lower for the older population.

800. Ms Ní Chuilín: That is quite a low percentage. If people over the age of 65 were exempt, would you anticipate an increase in the registration rate?

801. Ms Jendoubi: Yes.

802. Ms Ní Chuilín: Is a projected percentage available?

803. Ms Jendoubi: No, and I could not guess what the percentage increase would be.

804. Mr Easton: The figure of 35% is very low. Theoretically, if those over the age of 65 were exempt from paying dental charges, and if all those who were eligible to register with a dentist did so, the cost of providing free dental care for them could rise to about £10 million.

805. Ms S Ramsey: Do the figures mean that, are you saying that, out of the 31% of people over the age of 65 who are registered with a dentist, roughly half are already exempt from paying?

806. Ms Jendoubi: Yes, slightly less than half are exempt.

807. Mr Buchanan: Is the exemption based on means testing?

808. Ms Jendoubi: It is based on the benefits that a person is entitled to, such as income support.

809. Ms Ní Chuilín: People who get pensions are also exempt.

810. Mr Buchanan: It seems that, of the 31% who are registered with a dentist, more than half already receive free dental treatment.

811. Ms Jendoubi: It is less than half. Approximately 35% of people over the age of 65 who are registered receive free dental treatment.

Question, That the Committee is content with the clause, put and agreed to.

Clause 4 agreed to.

Clause 9 (Local optical committees)

812. The Chairperson: Members will recall that Optometry Northern Ireland argued that it was anomalous for dispensing opticians not to have a statutory right to membership of local optical committees, and it proposed an amendment to clause 9 to rectify that anomaly. Officials agreed last Thursday to consider the proposed amendment and to provide further clarification of the role of a dispensing optician. Christine, may we have your comments?

813. Ms Jendoubi: I have another piece of paper to distribute.

814. The Chairperson: Why am I not surprised? That is another rainforest gone.

815. Ms Jendoubi: The piece of paper explains the difference between an optometrist and a dispensing optician.

816. The Chairperson: We are all on a learning curve.

817. Ms Jendoubi: Committee members can take away the information to read.

818. The Department was almost surprised to learn that the definitions are almost exactly the same as those that we gave the Committee last week.

819. An optometrist conducts eye tests and examinations and prescribes eye drugs. A dispensing optician makes up the prescription that the optometrist has prescribed, fits the lenses and frames, or contact lenses, and dispenses them. Clause 9 is designed to reflect the fact that ophthalmic opticians, who are now called optometrists, are listed and can have a contract with the board to provide ophthalmic services. They appear in the Central Services Agency (CSA) list, which makes them contractors.

820. Clause 9 now incorporates ophthalmic medical practitioners. They are doctors who are also qualified to conduct eye tests and prescribe glasses and contact lenses. Article 55(3)(a) of The Health and Personal Social Services (Northern Ireland) Order 1972 did not originally include dispensing opticians because they cannot hold contracts, conduct eye tests or prescribe. Therefore, dispensing opticians cannot enter into the same kind of relationship with the board.

821. In the past week, we have discovered that dispensing opticians can hold a contract with a health and social services board if they own a practice in which they employ an optometrist to conduct eye tests and prescribe. There are few, if any, dispensing opticians who do that in Northern Ireland; they could be counted on the fingers of one hand. If it is accepted that the role of a local optical committee is to reflect the interests of those who are on the list and hold contracts, it is up for consideration

whether the clause needs to be extended to include provision for those dispensing opticians who can enter into contracts because they employ an optometrist.

822. Mrs Hanna: Would those dispensing opticians who employ optometrists and can be counted on the fingers of one hand go out of business were they not to be included in the provisions?

823. Ms Jendoubi: No.

824. Mrs Hanna: What effect does it have on them not to be included?

825. Ms Jendoubi: The optometrists who they employ are already on the CSA list, because they must be listed in order to practise. The clause as it stands will have no effect on them at all, nor will it have any effect on dispensing opticians; it simply allows ophthalmic medical practitioners to sit on the local optical committee.

826. The Chairperson: Are you satisfied with that answer, Carmel?

827. Mrs Hanna: Yes.

Question, That the Committee is content with the clause, put and agreed to.

Clause 9 agreed to.

Clause 10 (Pharmaceutical services)

828. The Chairperson: The Committee will recall that the Pharmaceutical Society of Northern Ireland (PSNI) argued in Committee on 28 June 2007 that clause 10 adds further confusion to the regulation of pharmacists in Northern Ireland. A transcript of that meeting can be found in the members' pack. The clause was referred for further consideration last Thursday. Christine will now talk us through the clause.

829. Ms Jendoubi: Clause 10 makes the same provision for pharmacists as previous clauses make for dentists and as clause 1 makes for general medical practitioners. It allows for the existence of one performers' list for pharmacists instead of four — one in each board area — and includes provisions for the conditional inclusion, and contingent removal and suspension, of pharmacists from the list.

830. Ms Ní Chuilín: You mentioned suspension of pharmacists from the list. I apologise for not having a copy of the Bill in front of me, but I recall the notes on the clause.

831. When a pharmacist is deemed unfit to practise, does suspension follow directly? No intermediate stage, during which problems might be discussed, is implied in the clause. Is removal mandatory until a suspended person is considered fit to practise again?

832. Ms Jendoubi: The situation is the same for all practitioners. A board will contemplate suspending a pharmacist only in exceptional circumstances; suspensions must be considered case by case. Boards do not suspend pharmacists lightly. If there is a problem with a pharmacist, a board will want a pharmacy to continue operating, as it provides a service to an area. It will work through the problem with a pharmacist as far as it considers that appropriate in the interests of patient safety. That is one of the key considerations for a board in deciding whether a pharmacist should be suspended.

833. Mr Easton: I am unsure as to how relevant this question is, but if a pharmacist who owns a practice is suspended, is he or she allowed to employ another pharmacist who meets all the criteria to run the business?

834. Ms Jendoubi: Yes.

Question, That the Committee is content with the clause, put and agreed to.

Clause 10 agreed to.

Clause 15 (Smoking: exemption for performers)

835. The Chairperson: I remind members that the Minister has indicated that he will not support clause 15 at Consideration Stage. The Committee heard the arguments for and against the exemption at our meeting on 5 July, a transcript of which is in the members' pack. I invite officials to outline the meaning of the clause, and I will invite questions from members afterwards.

836. Ms Jendoubi: Clause 15 provides for an exemption from The Smoking (Northern Ireland) Order 2006 to allow for smoking by an actor in a theatrical performance, where the integrity of the performance requires it. That includes in rehearsal.

837. The Committee received representations from the Theatrical Management Association about the possibility of using herbal cigarettes as a substitute. That is something that the Committee will want to take into account; however, the Minister is not impressed by the argument.

838. The Chairperson: If memory serves, members were sympathetic to the Minister's stance that there should be no exemption.

839. Mr Easton: I want this clause removed.

840. Ms Jendoubi: That is also the Minister's wish.

841. Mrs Hanna: We are unanimous.

842. The Chairperson: Ms Jendoubi, will you explain how a clause is removed from a Bill?

843. Ms Jendoubi: Kevin Shiels explained the process for doing so a couple of weeks ago.

844. Mrs Hanna: He is behind you.

845. Ms Jendoubi: He will explain it again if the Committee so wishes.

846. Mr Kevin Shiels (Northern Ireland Assembly Bill Office): Technically, to remove a clause at Consideration Stage does not require the tabling of an amendment. The Bill, including clause 15, is will become the property of the Assembly, not just of the Minister. The Minister will remain the Bill's sponsor of, but it will be in the hands of the Assembly. Only the Assembly, in a plenary sitting at Consideration Stage, can vote to include or exclude a clause from the Bill.

847. If the Minister is still minded to have the clause removed, he will get the draftsman to put to the Bill Office his intention to oppose clause 15 when the Speaker puts the Question that it stand part of the Bill.

848. Likewise, if the Committee, having taken evidence, is of the same mind, it can, through your name, Chairperson, convey the same decision to the Bill Office, and it would appear on the Marshalled List thus:

"The following Members have indicated their intention to oppose the Question that clause 15 stand part of the Bill."

The Marshalled List would then probably show the Minister's name, and, below that, the Committee's name would appear.

849. Clause 15 of the Bill would then be treated as if it were an amendment. The Minister would be asked to speak to his intention to oppose the clause. You, Chairperson, and any other Members who so wished would then have an opportunity to speak. The Speaker would then put the Question that clause 15 stand part of the Bill. At that stage, Members need to be very careful that they vote against the Question that the clause stand part of the Bill.

850. The Chairperson: Of course, but closer to the time, if that is the route that we choose to take, we will obtain further assistance on establishing the correct procedure for the passage of the Bill.

Question, That the Committee is content with the clause, put and negatived.

Clause 15 disagreed to.

Clause 16 (Interpretation)

851. Ms Jendoubi: This is a standard clause that will be found in any Bill. In some Bills, and certainly in regulations, it will appear as the first provision. In this Bill, the definition of some terms used appears in clause 16 because that is where the draftsman inserted it.

852. The Chairperson: This is a fairly simple and non-contentious issue.

Question, That the Committee is content with the clause, put and agreed to.

Clause 16 agreed to.

Clause 17 (Supplementary provision)

853. Ms Jendoubi: Again, this is a standard clause that will be found in any Bill. It is a catch-all clause, designed to cover unforeseen circumstances.

Question, That the Committee is content with the clause, put and agreed to.

Clause 17 agreed to.

Clause 18 (Repeals)

854. Ms Jendoubi: This is a covering clause. Every schedule to a Bill or an Order in Council must contain a clause in the body of the Bill that introduces the schedule. Clause 18 introduces schedule 2.

Question, That the Committee is content with the clause, put and agreed to.

Clause 18 agreed to.

Clause 19 (Commencement)

855. Ms Jendoubi: This clause provides for the times at which the sections of the new Act, and the schedules to it, will come into operation.

Question, That the Committee is content with the clause, put and agreed to.

Clause 19 agreed to.

Clause 20 agreed to.

Schedule 1 (Amendments of Schedule 11 to the 1972 Order)

856. Ms Jendoubi: Schedule 1 provides for changes to the operation of the tribunal, on foot of amendments to the 1972 Order that appear earlier in the Bill that pertain to opticians, pharmacists, dentists and GPs. Specifically, the main changes are that schedule 11 to the 1972 Order will now include applicants to a performers' list as well as those who are already on that list. It will include locums, deputies and employees as well as principal practitioners. It will extend the grounds on which a tribunal can consider a case that has been referred to it to include unsuitability by reason of professional or personal conduct.

Question, That the Committee is content with the schedule, put and agreed to.

Schedule 1 agreed to.

Schedule 2 (Repeals)

857. Ms Jendoubi: Schedule 2 contains consequential repeals made on the foot of provisions that the Bill will introduce.

Question, That the Committee is content with the schedule, put and agreed to.

Schedule 2 agreed to.

858. The Chairperson: The clause-by-clause consideration of the Health (Miscellaneous Provisions) Bill has been completed. No clauses remain referred for further consideration. I advise members that a draft Committee report to the Assembly will be prepared for consideration and agreement at a future meeting.

859. I thank Christine, Robert and John for all the time and energy that they have put into briefing us. The Bill's Committee Stage was completed very quickly, and I am sure that you are even happier than I am that it was so quick. Thank you very much for your attendance.

Appendix 3

Written Submissions

Royal College of Nursing Northern Ireland

The Health (Miscellaneous Provisions) Bill

Introduction

1. RCN Northern Ireland welcomes this opportunity to submit views on the Health (Miscellaneous Provisions) Bill and conveys its gratitude to the Committee for the opportunity to do so. We hope that our comments will prove helpful to the Committee in

its scrutiny of the draft legislation. As requested, we have linked our comments to the appropriate section(s) of the draft legislation.

Primary medical services (clause 1)

2. RCN Northern Ireland responded to the DHSSPS consultation on this issue in October 2005 and this response is attached for the information of the Committee. We reiterate our view that the legislative powers prescribed by this Bill should complement, rather than compete with, those of the appropriate statutory professional regulatory bodies. Our only concern in relation to the current drafting of the legislation relates to the efficacy of ascribing the defined powers to organisations (Health and Social Services Boards) that, notwithstanding the Minister's recent announcement in relation to the HSCA, are currently planned to cease to exist in April of next year. Other than this, we have no comments to make upon the wording of the draft legislation.

Dental services (clauses 2-7)

3. The Committee will recognise that issues related to the dental profession fall, in general terms, outside the scope of practice of the majority of RCN members in Northern Ireland. Nevertheless, we believe that this section of the draft legislation deals with a number of significant issues in relation to the provision of a comprehensive, equitable and accessible health service for the people of Northern Ireland.
4. Committee members are already aware of the shortfalls in the provision of dental services in Northern Ireland and the consequences that this has for the oral health of our population. For these reasons, RCN Northern Ireland welcomes the requirements at 60A (2). As the Minister has acknowledged recently on the floor of the Assembly, the new commissioning powers set out at 61 will improve access to health service dentistry, allow a greater focus on oral health promotion and enable an enhanced degree of responsiveness to local needs within the broader framework of a regional contract.
5. RCN Northern Ireland also welcomes the intention to negotiate a separate dental service contract for Northern Ireland and, particularly, the provision allowing health and social organisations directly to employ dental practitioners.
6. Once again, we note that the current drafting of the legislation refers to Health and Social Services Boards and reiterate the comment made at paragraph 2 above.
7. RCN Northern Ireland has no specific comments to make in relation to clauses 8-11 other than, in general terms, to indicate our support for these measures.

Charges for service provided to persons not ordinarily resident in Northern Ireland (clause 12)

8. RCN Northern Ireland supports the intention underlying this clause, based upon the principle of exemptions on exceptional humanitarian grounds.
9. We have no comments to offer on clauses 13 and 14.

Smoking: exemption for performers (clause 15)

10. RCN Northern Ireland, in partnership with a range of other health care organisations, played a significant role in helping to make the case for the workplace smoking ban that has now been enacted in Northern Ireland. We have consistently raised our concerns to the DHSSPS about the number of exemptions to the legislation and feel that this particular proposal is entirely devoid of merit. The RCN Northern Ireland response to the

initial DHSSPS consultation on this matter is appended for the information of the Committee. “Artistic integrity” does not, in our judgement, provide any kind of justification for subjecting performers, theatre staff and members of an audience to the potentially lethal effects of second-hand smoke. We were pleased to note that the Minister has recently indicated that he is mindful of the benefits of not enacting this particular clause and the RCN urges the Committee to be similarly robust in rejecting what we believe is an unacceptable dilution of the scope and intent of Northern Ireland’s smoke-free legislation.

11. We have no comments to make on clauses 16-20 of the draft legislation.

Conclusion and further information

12. RCN Northern Ireland reiterates our gratitude to the Committee for inviting this submission and we hope that our comments will prove helpful to the Committee in its scrutiny of the draft legislation.
13. For further information about the work of the RCN in support of nurses and patient services in Northern Ireland, please contact Dr John Knape, RCN Northern Ireland Head of Communications and Policy, at john.knape@rcn.org.uk or by telephone on 028 90 384 600.

July 2007

Response of the Royal College of Nursing Northern Ireland to a DHSSPS consultation on Further measures to improve the provision of primary care services

Background

1. The Royal College of Nursing [RCN] represents nurses and nursing, promotes excellence in practice and shapes health policy. The RCN in Northern Ireland represents almost 13,000 registered nurses, health care assistants and nursing students. Across the United Kingdom, we have around 380,000 members.

Introduction and general observations

2. RCN Northern Ireland welcomes the opportunity to respond to this important consultation by the Department of Health, Social Services and Public Safety [DHSSPS]. Our response is based upon the expert professional views of RCN Northern Ireland members and officers.
3. We were disappointed to be excluded from the list of consulted organisations. Whilst we accept that the proposals as set out do not explicitly relate to nursing, the general principles under-pinning them are of concern to all health care professionals and the organisations that represent their interests. Moreover, the document refers at various points to extending the scope of the Tribunal and presumably any such extension would potentially encompass nurses.
4. Whilst RCN Northern Ireland welcomes, in general terms, the underlying public protection objectives that are outlined in this paper, we are concerned that no reference is made to the role of professional regulatory bodies and that the list of organisations being consulted does not include all such relevant bodies. The omission of the General Medical Council is particularly noteworthy in this respect. Whilst we understand that the role of the Tribunal and the Boards is in lieu of that of an employer for practitioners who

are effectively self-employed, local procedures for handling concerns about the conduct or practice of a member of a regulated profession are likely to be most effective when they complement those of the appropriate professional regulatory body.

Specific comments

5. At paragraph 2.8, first bullet point, employers are entitled to make appropriate judgements about whether or not to employ a particular individual based upon the professional expertise and experience of that individual. In respect of the groups that fall within the remit of the Tribunal and Board, this principle extends to those bodies. They are not, however, entitled to seek to determine "unsuitability by reason of professional or personal conduct". This is the domain of the appropriate statutory regulatory body. At the third bullet point, the DHSSPS should specify precisely which professional groups it envisages falling within the Tribunal's expanded jurisdiction. This consideration applies equally to the third sentence of the third bullet point of paragraph 2.9.
6. At paragraph 2.9, the proposal not to permit a right of appeal against a decision to suspend is, in the context of human rights and employment legislation, potentially contentious. Suspending a practitioner from the right to practise their profession is rarely a "neutral" act and it is somewhat disingenuous of the Department to claim that it is.
7. If a practitioner is to be considered innocent until proven guilty in relation to alleged professional misconduct, which they must, payment should continue until the point at which guilt is proven beyond reasonable doubt. This principle must apply equally to all health professionals at all times.

Conclusion

8. Whilst RCN Northern Ireland is, in general terms, supportive of the principles set out in the consultation document and their underlying purpose of protecting the public, we believe that they could be made more robust and command wider support through engagement with the relevant statutory regulatory bodies. We urge the DHSSPS to initiate such engagement before finalising its proposals.

Further information

9. For further information about the work of the RCN in support of nurses and patient services in Northern Ireland, please contact Dr John Knape (Public Affairs Adviser) at john.knape@rcn.org.uk.or by telephone on 028 90 668 236.

October 2005

Western Health and Social Services Board

Health (Miscellaneous Provisions) Bill

Thank you for the opportunity to comment on the above draft Legislation.

The comments offered in this letter build on those submitted in response to the following documents:

- Further Measures to Improve the Provision of Primary Care Services (August 2005)

- Proposal for a Draft Order in Council – The Health Services Primary Care (Amendment) (NI) Order 2006. A Consultation Document August 2006

The measures outlined in the draft Legislation are welcomed by the Western Health and Social Services Board.

We would make the following specific comments in relation to the provisions set out in the draft Legislation.

Dental Services

- 6.1 – (1) The proposals set out in the section dealing with General Dental Services would provide a framework within which the negotiation of the new Dental Contract will take place
- 61E (5) Is it the case that all disputes in relation to dental contracts would need to be referred to a County Court, or would there also be provision for dealing with dispute resolution under a HPSS contract? In the case of the General Medical Services Contract, contractors elected to sign a contract at law or a HPSS (NHS) contract. The provisions of the contract where the same but the routes for dispute resolution differed
- Schedule 15A. 1-(1) We would suggest that the proposals relating to dental charging exemptions should include free services for persons over 65 years of age

Ophthalmic Services

- 9 We support the proposal to enable Local Optical Medical Practitioners (OMPs) to become lay members of the Local Optical Committee

Pharmaceutical Services

We would make the following comments in respect of pharmaceutical services:

- The Power of Suspension in relation to community pharmacies needs particular consideration. Thought needs to be given as to how suspension of individual pharmacies would deliver the intended result, given that it is often companies which are on the pharmaceutical list
- We support the concept of local pharmaceutical services (LPS), but more detail would be needed on how the development of LPS would be consistent with the proposed new contract for pharmacists which is currently under negotiation
- We support the 'remote' provision of additional pharmaceutical services, provided adequate safeguards relating to confidentiality and governance are in place

Tribunal

We would make the following general comments:

- We support the proposed changes in terms of tribunals. Boards, and their successors, need the power to suspend practitioners where such a move is deemed to be in the interest of patient safety, welfare or where suspension is in the public interest (eg probity issues)

- We support the proposal to allow payments to continue to practitioners suspended by Boards or the Interim Orders Committee of the GMC. Parameters would need to be set on the level and duration of payments

Smoking

The Western Health and Social Services Board strongly opposes the proposal to permit performers to smoke during a performance. Furthermore we do not accept that any circumstances exist where the artistic integrity of a performance makes it appropriate for a person, who is taking part in that performance to smoke.

Permitting performers to smoke during performances implies that artistic integrity is more important than the health of performers, stagehands and other staff, as well as the public. There is no safe exposure level to tobacco smoke, which is a known Class 'A' carcinogen.

We do not agree that the artistic integrity of a performance could ever rely on performers smoking tobacco and thereby exposing others and themselves to the dangers of tobacco smoke. Clearly there are other appropriate options if the performer is required to mimic the use of any tobacco product. The theatrical and performance industry clearly relies heavily on the use of numerous props during performances.

The purpose of the overall legislation is to protect people from exposure to tobacco smoke, not to require an individual to smoke against their wishes in order to secure a place in a performance. This proposed amendment could result in the coercion of artistes and performers whether willing or not, to smoke in order to secure a part.

This proposed exemption is not in keeping with the current legislation in Scotland our closest United Kingdom neighbour. Furthermore, it our understanding that the Welsh Assembly has rejected a similar exemption.

The British Medical Journal has clearly highlighted the influence of the film and television industry on the uptake of smoking amongst teenagers. The documented research shows that there is evidence that the more smoking teenagers see in films the more likely they are to smoke (BMJ. Vol. 323 (7326); Dec 15, 2001). The definition of performance in the proposed amendment regulations seems to include television, film and theatre and in addition may include fashion shows etc. all of which influence the smoking habits of the young.

We note the Department's provision that this legislation would be self-regulating. It is our opinion that this would be completely ineffectual. There is no reasonable expectation that this provision could be enforced, in any circumstance. We do not envisage that the industry would self-regulate. Moreover, it is entirely unreasonable for enforcement officers to determine 'artistic integrity'.

It is unfortunate that this amendment is proposed in what is otherwise the most significant single public health measure in modern times.

General

We would offer the following comments to other general provisions of the draft Legislation and related matters.

- There is a need to strengthen the process relating to application by practitioners to join lists. Arrangements should include PECS checks, references and medicals. PECS checks should also apply to practitioners already on lists
- We support the proposal to extend to N Ireland the provision which allows overseas visitors to be exempt from financial charges on humanatarian grounds.
- There is a need to harmonise the types of information to be supplied by practitioners seeking entry to Boards lists.
- We support the retention of the requirement for practitioners to be included on the list of any Board in whose area they perform services
- The complaints procedure relating to family practitioners services would need to be reviewed. In particular, clarity is needed on how the complaints procedure fits with other action open to Boards, for example, referral to tribunals and power of suspension

We trust the comments set out in this letter are useful.

Dominic Burke

Chief Executive

Health & Social Services Councils of Northern Ireland

Health (Miscellaneous Provisions) Bill

1. The Health & Social Services Councils (HSSCs) were set up by the Government in1991 to represent the views and opinions of the public on matters relating to health and social care. They are independent from those who plan, manage and provide health and social care.
2. We wish to comment on a number of specific areas of the Bill which are set out below.

3. Primary Medical Services

3B – We believe that an additional point should be included:

(c) preventing unsuitable inclusion by virtue of professional or personal conduct.

4. Primary Dental Services – Clause 60. We believe this to be an important aspect of the Bill and make the following comments:
5. Clause 60A (1) (2). The HSSCs support these clauses, believing that access to NHS dentistry is currently at a critical point and that the HSSBs have a key role in ensuring sustainable services and equity of access.
6. Clause 60A (3). The requirement for patients to re-register with their dentists every 15months is confusing for patients. There is very little awareness of this requirement. HSSBs should be required to publicise this fact to maximise current dental registration of their population.
7. Clause 60A (5). The HSSCs believe that evolving public attitudes to cosmetic dental treatment requires a clear demarcation as to what dental treatment relates to general healthcare rather than cosmetic treatment. We believe that this should be reflected in

the prescribed description of primary dental care services. Health promotion activity should be specifically included within this description.

8. General Dental Services Contracts – Clause 61. The HSSCs have been greatly concerned by the delay in negotiating the new contract and welcome the Bill as part of the progress this.
9. Clause 61A. The HSSCs welcome the provision to allow HSSBs to enter into contracts regarding primary care dental services.
10. Clause 61C. The HSSCs trust that payments under the new contract will be simplified to ease the administrative burden on dentists. We feel that oral health promotion work should also be acknowledged in the payment scheme. We would also support a payment system that allowed patients to retain their NHS entitlement while paying an additional cost for enhanced treatments not available on the NHS.
11. Clause 61F (3) Include as for persons providing pharmaceutical services i.e.

'.....shall be granted only if the Health and Social Services Board is satisfied, in accordance with the regulations, that it is necessary or desirable to secure in the neighbourhood in which the premises are located the adequate provision by persons included in the list of the dentistry services or some of the dentistry services, specified in the application....'

This inclusion would have the similar effect of making the Board responsible for commissioning sufficient dental health service for its population (if this premise is accepted then it will have a further impact on the wording of the rest of this part of the regulations).

We would also expect the same standards of proficiency in English as outlined in 3c of the proposals for persons providing pharmaceutical services.

12. Schedule 15A 1. We believe that additional groups should be added at (1) (e) (f) (g).

(e) was over the age of 65 years

(f) was in receipt of Income Support Job Seekers Allowance, or whose partner is receiving one of these.

(g) People who are on low income and who do not qualify for these benefits should be eligible for help with payments using certificate and application forms.

13. Disqualification by the Tribunal

Schedule 1 amends Schedule 11 to the Order of 1972 (disqualification of persons providing Part 6 services).

The four HSS Councils strongly endorse the inclusion for referral to the Tribunal on the ground of 'unsuitability by reason of professional or personal conduct'. This ground, recognised by professional regulatory bodies such as the General Medical Council, is key to assuring clinical governance as well as maintaining public confidence in services commissioned by the Boards.

All categories of primary health practitioners who are on or applying to be on the Boards list should be subject to the Tribunals jurisdiction.

Where a disqualification judgement is made, then such a sanction should be upheld and enforced across all Board areas. Knowledge of and enforcement of such sanctions should also be

upheld right across the UK. The Boards list and any judgements should be open to all Health and Social Services employers across all of the regions.

The increasing move towards greater cooperation between N.I. and the R.O.I. in health service provision, shared care arrangements and service level agreements, suggests a similar requirement for sharing Tribunal decisions between the jurisdictions.

We are fully supportive of the Board being able to temporarily suspend a practitioner on referral to a Tribunal as this provides a greater measure of safety for patients.

It is our experience that where a case has been referred to e.g. the GMC on matters of personal or professional conduct and has been judged to warrant a full investigation that the Board currently does not have the power to temporarily suspend the Practitioner.

We believe that the Board should be able to invoke temporary suspension, on matters of professional or personal conduct, whether the practitioner is referred to either their professional regulatory body or the Tribunal.

There should be no anomaly between the regulatory bodies and the Board regarding the level of sanction or the use of precautionary measures to safeguard patients.

We would caution against a prolonged period of precautionary suspension on two grounds:

There may be issues about the ability of Boards to recruit temporary replacements for the suspended practitioner and thus running the risk of providing a lesser service to patients.

The need to safeguard the right of practitioners to have their case heard in a timely manner.

However neither of these considerations should in any way influence the decision to make a precautionary suspension.

We believe there should be a formal interface between the function of the Tribunal and that of the professional regulatory bodies on matters of professional or personal conduct.

Consideration will have to be given to the resources which will be required by the Tribunal in order that it may take on the expanded role of considering matters related to professional or personal conduct.

We would want to ensure that whatever regulations, policies and procedures are put in place to extend the powers and function of the Tribunal are open and transparent so that the public and patients can have full confidence in its workings and the decisions made by it.

Stella Cunningham

Chief Officer, SHSSC
On behalf of the 4 HSS Councils

Northern Ireland
Orthodontic Specialist Group

Health (Miscellaneous Provisions) Bill

Introduction

The Northern Ireland Specialist Orthodontic Group (NISOG) is a representative body for Specialist Orthodontists working in practice in Northern Ireland. It represents 32 high street specialist orthodontists who carry out the vast majority of orthodontic treatment in the region. Orthodontics is a specialist branch of dentistry which deals with and treats irregularities in the growth and development of teeth and jaws using braces. NISOG is in talks with hospital based orthodontists, community orthodontists, general dentists with an interest in orthodontics and purchasers about setting up a Local Orthodontic Committee (LOC) as an umbrella group to address future primary and secondary care issues.

We welcome the opportunity to give written advice to the Northern Ireland Assembly Committee on Health, Social Services and Public Safety. To help inform members on issues in dentistry and orthodontics in particular further information is appended:

- BDA issues for information to the Health, Social Services and Public safety Committee (Jun 2007).
- The Northern Ireland Specialist Orthodontic Group (NISOG) information for purchasers framework document (2007). (This document is in the process of being amended and will be forwarded in the near future).

Orthodontics is in many ways a unique branch of dentistry in the primary care setting due to the length of time and cost to train orthodontists, the long length of treatment times, the nature of the treatment involved and high need and demand for treatment among the population.

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) about the proposed Health Bill. There are however further areas of concern in the proposed bill that may give rise to problems that are specific to orthodontic practice as compared to general dental practice.

Changes to the Powers of the Health Service Tribunal and Health and Social Services Boards.

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this at Section 2.9 it is proposed that local suspension of a practitioner can be imposed once a Board has decided there is a case to answer. This act is a very serious matter both for the orthodontist and the patients undergoing treatment. The number of patients undergoing treatment with an orthodontist is around 450 patients, all of whom need to be seen every 6-8 weeks for regular adjustment of their braces, otherwise damage can occur to the patients teeth and gums. Once an orthodontist reaches their maximum workload they can only take on a patient for treatment when they have finished another patients treatment (average treatment time is 18 months). If an orthodontist is suspended then several hundred of their patients will be unable to have their braces regularly adjusted. It would be the Boards responsibility to ensure their treatment is continued and it may not be possible for other orthodontists to absorb such a number of patients. NIOSG believe there should be a right of appeal and review mechanism attached to “local suspension” and that before or at the time any such act of suspension is carried out NISOG or LOC should be consulted about the continued care of patients who would be affected.

Payment to suspended practitioners

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Primary Dental Services

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this, Section 61B (1) If, after current contracts are honoured/ transition arrangements are completed , the Board enters into an agreement for a practitioner to provide specialist orthodontic services in the future, the Board should ensure as far as possible that the practitioner is a qualified orthodontist on the GDC specialist list. Where this is not possible due to a lack of local specialist cover then NISOG or LOC could offer advice . For patient safety reasons the Board should try and ensure that whether treatment is carried out by non-specialists or specialists , the treatment methods employed should be evidence based, widely accepted and of the type taught in Dental Schools and Hospitals across the UK .

General Dental Services : payment

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this 61C 3(a) any standards or measure of level of performance should be agreed in consultation with NISOG or LOC. The level of remuneration for each course of treatment or measure of clinical activity should be the same for every orthodontist across the whole of N. Ireland . Reducing remuneration while keeping the amount of activity the same would undermine efforts to produce high quality results and may encourage more treatments in the private sector.

General Dental Services contracts: other required terms

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this, 61D (2) “the manner in which and standards to which services are to be provided”, NIOSG or LOC should be consulted on any patient selection criteria such as IOTN or any standards for treatment outcome proposed. Any outcome standards which must be met should be the same for non-specialists and specialists.

61D (2) contract termination and 61D (3) “provision as to the circumstances in which a Health … Board may impose a variation in a contract.”

The prolonged nature of orthodontic treatment, 1.5-3 years active treatment and 1-2 years follow up, necessitates appropriately designed contracts. Short term contracts or rapid cessation of contracts can have devastating effects on patient care and may have medico-legal consequences. Contracts should be rolling to accommodate the long term nature of orthodontic treatments and if possible be open ended.

61D (4) “shall make provision as to the right of patients to choose the persons from whom they are to receive services”. This clause may have the effect of lengthening waiting lists for orthodontic treatment. Patients already have a choice as to which orthodontic practice they are referred to . If patients reach the top of a practice waiting list, are assessed and then specify a particular orthodontist to carry out any treatment they may have to wait again depending on that practitioners workload. This clause would also hinder the workings of specialist practice as patients are usually assigned in practice to a particular orthodontist/ clinical assistant depending on the presenting complaint, complexity of orthodontic treatment to be carried out and the interests/ expertise of the practitioner. NISOG would recommend an opt out of this clause for specialist orthodontic practitioners.

General Dental Services: transitional

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Financial Implication

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Points for inclusion

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this any new orthodontic contract arrangements should:

- Create a contract that allows equitable access to orthodontic treatment for all patients who need and want treatment.
- Target treatment to those in greatest need for treatment and to those that would benefit most from having treatment eg growing children.
- Develop a payment structure that rewards orthodontists for the care and treatment they provide to their patients and adequately reflects the long time spent in post graduate training and attainment of post graduate specialist qualifications.
- Adequately compensates orthodontists for the long term investment in practice staff, buildings and equipment and provide a stable financial atmosphere so that long term investment in practices can continue.

Additional Information

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Mistakes made in England and Wales

NISOG agrees with all the issues raised and recommendations made by the BDA (outlined in the BDA issues for information to the Health, Social Services and Public safety Committee 21st Jun 2007 publication) in regards to this section of the proposed bill.

Further to this if past performance is to be used as an indicator of future contract values then they should take into account atypical test years (eg maternity leave, sickness) and start up/growing practices where the annual gross payment was abnormally reduced. This would avoid the unnecessary orthodontic crisis that has developed in some parts of England and Wales with the new contract where some contract values were very low, orthodontists withdrew from the NHS and patients were unable to access or continue NHS orthodontic treatment.

Adequate levels of funding are required to continue to meet the need for treatment in the population and improve access to orthodontic treatment for patients, whatever their socio-economical background, across the region. A permanent increase in specialist manpower is required to help reduce waiting lists and improve geographical access.

It is generally accepted that up to a third of all 12 year olds need and want orthodontic treatment, although it should be noted orthodontic treatment is generally started between 12years and 16 years of age. The Northern Ireland Census 2001 suggests that there are approx 26532 children of 12 years of age. This means at any one time there are at the very least 8755 children in this age group in need and want of orthodontic treatment. The average treatment cost per course of complex orthodontic treatment is £1200 although this would be higher in a secondary care setting. National funding of approximately £10,506,000 would be required just to treat those patients who are 12 years of age and in need and demand of treatment. The total current spend on orthodontic treatment 06/07 according to the Central Services Agency is £6,424,412 . Further funding is therefore required to maintain and increase the advances in orthodontic access and quality of treatment the profession has made over the last decade and a half.

Orthodontists want the population of N. Ireland to have equitable access to care which, due to their efforts, is now nearly equal to that in the rest of the U.K.

Northern Ireland Specialist Orthodontic Group
June 2007

Northern Health and Social Services Board

Comments on Dental Section of Health (Miscellaneous Provisions) Bill

Clause 60A.2(a)

This could cause difficulties if the same organisation was both commissioning and providing a service.

Clause 61C.3(a)

Does this wording permit payments to be made which take account of BOTH compliance with standards AND performance levels?

Clause 61D.2

Will there be specific dental Regulations to cover complaints and disciplinary procedures?

Clause 61D. 2(e)

In relation to rights of entry, under the current contract Boards must give a period of notice. This allows practices to address alleged short comings prior to inspection reducing the effectiveness of the exercise and the validity of inspection information.

General Dental Services: transitional

Clause 3.(2)

Care needs to be taken to ensure that history of care quality and patient safety issues are considered before any existing contract holder transfers over to the new GDS contract.

Revocation of power to make pilot schemes for provision of personal dental services

Clause 6

This will mean that until the Health (Miscellaneous Provisions) Bill is passed and the Regulations drawn up, pilots will not be possible. This may slow down the development of a new GDS contract.

16 July 2007

Roevalley Dental Practice

Health (Miscellaneous Provisions) Bill

Following your invitation to make a written submission re the Health Bill introduced on 05/06/2007.I have read and perused the Bill and understand this is to partly help facilitate the changes within the Health and Social Services Boards.

I find that there are some matters that are confusing and may need clarifying in terminology. In the Dental services Section Part 2(1)this clause is substituting the term primary dental services for general dental services.The actual definition of this should be clearly defined.Primary dental Services usually refers to and at the moment is provided by both general and community dental services. The rest of the document continues to refer to general dental services repeatedly and it would need to be clearly defined at some point that that now refers to a contract within the primary dental services.This really is a matter of wording.After deleting one term and then repeatedly reusing it without defining the difference could be mis construed.

In Part5(Article 15B)the mention of personal dental services adds further to the problem.It should be made more succinct from the outset that both personal and general dental services are to be called primary dental services.

This needs to be clearly and concisely defined.As a general dental practitioner who understands the workings of GDS,PDS and CDS I have found it ,if not confusing at least requiring a lot of concentration and attention to be clear on the matter to fully understand the document.I would think that other people reading this with no background of primary services would be at a total loss to grasp the ideology and thinking behind this.

Dr Winifred P McLaughlin

Principal dental surgeon

British Dental Association

Health (Miscellaneous Provisions) Bill [as Introduced]

Introduction

Changes to the legislative framework for Primary Dental Services will have important and far reaching impacts for dental services to the population of Northern Ireland.

The text of the draft Bill is the similar to that in England and Wales contained in the Health and Social Care (Community Health and Standards) Act 2003. Therefore it would appear from the text of Bill that Northern Ireland is following the example of local commissioning for dental services, as in the April 2006 arrangements for dental contracting in England and Wales. The dental profession has many concerns with the new dental contracting arrangements for England and Wales, such as the lack of a required improvement in access to NHS dentistry, lack of necessary improvements in oral health or the quality of care. These shortcomings must be learned from and avoided in Northern Ireland. It is therefore imperative that Northern Ireland has a tailored dental contract which is locally sensitive and avoids the concerns, highlighted below, now apparent in England and Wales.

Overview of new Dental Contract arrangements in England and Wales

On 1 April, 2006 the Government introduced a new general dental services contract and patient dental charges which have fundamentally changed the way in which NHS dentistry is provided in England and Wales.

The England and Wales dental contract is between primary care trusts (PCTs) or local health boards (LHBs), who are now responsible for commissioning general dental services, and high street dentists who deliver the care to patients as either general dental practitioners or specialists, eg orthodontists. The new arrangements also affect the salaried primary dental care service in England and Wales, which comprises dentists who are employed directly by NHS trusts to provide dental care to some of the most vulnerable groups in society.

The contract has introduced a new system for measuring the treatment output, or performance of NHS dentists. Between 1 October 2004 and 30 September 2005, PCTs and LHBs measured the number and type of courses of treatment delivered by all NHS dentists in its area. Based on this information, PCTs and LHBs wrote into each new contract a target for the number of units of dental activity (UDAs) each dentist or practice should perform. UDAs are the measure used to count number of weighted courses of treatment. The weighting arises from a simplistic measure of treatment complexity, which corresponds with the accompanying new system of dental charges. For simple procedures, such as a check-up, dentists are awarded one UDA, work that involves intervention, such as fillings and root canal treatment is worth 3 UDAs and dentists are awarded 12 UDAs for work that necessitates laboratory involvement such as crowns or fitting dentures. Dentists must meet 96 per cent of their contractual UDA target in order to receive full payment. The BDA believes that the calculation and target-setting were flawed, making it very difficult for dentists to manage and meet their commitments.

The stated aim of the new contract was to improve access to NHS dentistry, improve oral health and raise the quality of care. However, the BDA has initial evidence that the new contract does not fulfil these goals, and that it could compromise care to the most vulnerable in society.

Suggested amendments

BDA Northern Ireland suggests the following amendments to the text of the Health (Miscellaneous Provisions) Bill [as introduced].

1. At 60A (2) (b) delete '...and may in particular make contractual arrangements with any person.'

Explanatory note: This phrase is superfluous and contradicts 61B (1)

2. At 61E (2) (b) proposed wording amendment - delete

'(b) for the Department, or a person appointed by it, to determine the terms on which a contract may be entered into.'

and replace it with the wording

'for the Department to appoint an independent person or panel, to determine the terms on which the contract may be entered into.'

Explanatory note: it is essential that in entering into contracts, Health Boards are required not simply to implement rules, but to ensure that contracts are fair and reasonable, taking into account all of the information and circumstances. There must be independent adjudication of any disputes that may arise.

3. At 61E, proposed insertion of an additional paragraph on Piloting arrangements, whereby

'Regulations shall make provision for the piloting of arrangements for new contracting arrangements for General Dental Services Contracts.'

4. General Dental Services: Transitional

Comment: It is essential that transitional arrangements are not detrimental to existing providers. Dentists in England and Wales noted numerous errors in the calculations of their contractual UDA requirements. In addition, funding dedicated to provision of dental services must be ring-fenced and reserved for that purpose over the transitional period and subsequently. There must be adequate funding available to provide for those dentists whose test period was not typical of their normal service provision.

3 (4) Proposed amendment – Delete '...disputes by the Department or a person appointed by it'

and replace with

'...disputes by an independent panel or person appointed by the Department.'

Comment: It is vital, where disputes on contracts arise, whether in the initial contracting stage or at a later date, that they are adjudicated in a manner which is genuinely independent and takes into consideration criteria and information which are both reasonable and appropriate as well as having due regard for procedure.

3 (7) Proposed amendment – Delete 'An order made under this section shall be subject to negative resolution'

and replace it with

'An order made under this section shall be subject to the affirmative resolution procedure.'

Comment: The Draft Order provides a fundamental change to the availability of the dental service to the public and therefore should be subject to affirmative resolution.

Other comments

5. BDA recognises that changes to the powers and duties of the Health Services Tribunal are necessary.

Currently there are Tribunal arrangements in place, but they are rarely, if ever, utilised.

Changes to the Health Services Tribunal must have the confidence of the professions involved and to attain this will require input from the relevant professional bodies.

6. Section 2.8 - BDA requires clarification on the categories of dental personnel subject to the jurisdiction of the Health Services Tribunal.

7. Section 2.9 proposes that local suspension of a practitioner can be imposed, without a right of appeal, once a Board has decided there is a case to answer.

Local suspension of a practitioner is a very serious matter, which BDA believes should carry a right of appeal and review mechanism.

8. BDA is concerned by the length of time during which dentists may be suspended and the provisions which will be made for practices, patients and themselves during this time. It is imperative that clarity is provided around the payments made to dentists under suspension in order to avoid penalising either the practice or the service delivery.

9. There is a failure to recognise the role of the UK Regulatory Body for dentists, the General Dental Council on issues of dentists' fitness to practise.

British Dental Association

18 July 2006

Optometry Northern Ireland

Health (Miscellaneous Provisions) Bill 2007

Optometry Northern Ireland is the umbrella professional organisation which represents optometrists, dispensing opticians and optical businesses in Northern Ireland. We welcome this opportunity to comment on the Health Bill 2007 and have focused our response on the ophthalmic clauses - clauses 8 and 9. We would be happy to provide further assistance and background information, on any of the points we have raised, to the committee if required.

This Bill aims to introduced measures which have been instigated in Scotland, England and Wales. We support this move to align healthcare measures to the rest of the UK and hope that Northern Ireland will go even further to ensure patients receive the best possible care through a range of eye care services and a wide choice of provider. We believe the proposals we have set out in this document provide an extremely effective approach to providing high quality, easily accessible eye care services with enhanced choice for all patients in Northern Ireland.

Clause 8 - Ophthalmic services

Entitlement to a GOS contract

We welcome clause 8 which provides regulation making powers to prescribe ways in which persons including companies performing general ophthalmic services (GOS) are to be listed. When this is enacted by Regulations, it is important that nothing limits patient choice by artificially limiting the number of performers of general ophthalmic services. Anyone, subject to the nationally-set criteria, who wishes to provide general ophthalmic services, should be able to do so. This is what drives the competitive market and secures access, choice and value for patients. We are keen to ensure that every optometrist who meets national criteria and wishes to provide general ophthalmic services continues to do so. This will also ensure patients' choice is not restricted and that all patients are able to see the provider of their choice. If Health and Social Services Boards were allowed to limit the number of GOS practices this could have a detrimental effect on patients with waiting lists, restricted access and limited choice.

We therefore suggest the following amendment to clause 8;

Amendment 1

Insert new paragraph:

Article 62A (4)

"Regulations shall direct that any healthcare professional who meets the prescribed description shall be included on a list maintained under the regulations by a Health and Social Services Board to provide general ophthalmic services."

New NHS eye examination

As we have stated above we hope the Northern Ireland Executive will lead the UK in the way eye care services are delivered, drawing on the best practices from other parts of the UK, which will ensure patients in Northern Ireland have the best possible eye care system and best possible eye health in the UK. We hope the committee will consider introducing further measures to extend the categories of patients eligible for a GOS sight test and to extend the services provided under the sight test into a full eye examination. In Scotland since 1st April 2006 everybody is entitled to a GOS eye examination and if clinically necessary, to more extensive tests. These services by optical practices (defined and funded by the Scottish Executive) have improved access and quality of care for patients and have reduced the pressure on GPs, hospitals eye departments and casualty departments. This is not the old sight test for more money but a completely new contract, with everyone in Scotland being entitled to the new and extended NHS eye examination.

We therefore propose the following amendments to Clause 8;

Amendment 2

In Article 62 paragraph (1) substitute the words “securing the testing by them of the sight” for the words “the carrying out of eye examinations including where clinically necessary testing of sight.”

Amendment 3

In Article 62 of the Order of 1972 paragraph 1 remove from “(a) of a child; up to “as may be prescribed.” and insert - “of all persons.

Paragraphs 4, 5 and 6 of Article 62 cease to have effect.”

Three tier system

We propose the introduction of a three-tiered system for primary ophthalmic services, covering:

- essential services, which all Health and Social Services Boards must commission and which any eligible contractor may provide, i.e. the provision of NHS eye examinations and supplementary tests.
- additional services, covering any other services that all Health and Social Services Boards must commission such as domiciliary eye care services and which are prescribed in regulations.
- enhanced services, which Health and Social Services Boards may choose to commission.

As we have mentioned above we believe Level 1 services should include a new NHS eye examination and supplementary eye examination as is currently in operation in Scotland. We would propose including domiciliary eye examinations under Level II and shared care services under Level III. We are keen to work with the Northern Ireland Executive to draft regulations setting out this three tier system to ensure it is specific to the needs of patients in Northern Ireland.

Amendment 4

Insert after Article 62

Article 62B – Provision of primary ophthalmic services.

Health and Social Services Boards must exercise their powers so as to provide or secure the provision, within its area, of the following services-

(a) the carrying out of eye examinations mentioned in Article 62 (1);

(b) such other primary ophthalmic services as may be prescribed; and

(c) to the extent that it considers necessary to meet all reasonable requirements, any further primary ophthalmic services.

Clause 9 – Local optical committees (LOCs)

We believe dispensing opticians should have the statutory right to membership of local optical committees. Since the 1980’s dispensing opticians have not been permitted to be represented by local optical committees or to be members themselves. Although in practice many are co-opted, we do not feel this is adequate representation given the key role of dispensing opticians in

delivering eye care services. Dispensing opticians fit glasses and contact lenses for which NHS optical vouchers are used, yet they are not listed by Health and Social Services Boards nor are they represented on LOCs. Although dispensing opticians, like optometrists, maintain high professional standards it is anomalous in light of the Shipman inquiry that these professionals, who work closely with children and vulnerable groups, are not listed in the same way as other healthcare professionals. We hope that the Northern Ireland Executive will follow the lead of the Welsh Executive who are currently examining how to achieve DO listing. It is imperative that the public and Health and Social Care Boards know which professionals in their area are providing care directly to patients and supervising others to do so.

We therefore suggest amending clause 9 to include dispensing opticians as well as optometrists and ophthalmic medical practitioners.

Amendment 5

We propose that clause 9 should read as follows:

9. In Article 55 of the Order of 1972 (recognition of local representative committees), in paragraph (3) (a) after the word "the" insert "ophthalmic medical practitioners and" and after the word "services" insert "and dispensing opticians."

17 July 2007

Northern Health and Social Services Board (Pharmaceutical Services)

Health (Miscellaneous Provisions) Bill

I refer to your letter of 20 June 2007 to Dr J Watson regarding the above.

The pharmacy aspects of this Bill have been discussed with the Department's Chief Pharmacist. The proposed amendments will clarify certain aspects of the arrangements for considering requests for inclusion in the Pharmaceutical List, particularly in respect of appliance suppliers.

A more fundamental review of these arrangements is overdue. This has been the subject of discussion and correspondence between the Board Pharmacy Directors and relevant Departmental officers. It is hoped that such a review will be taken forward and the outcomes incorporated into legislation at the next available opportunity.

Denis J Morrison

Director of Pharmaceutical Services
16 July 2007

National Patient Safety Agency

Health (Miscellaneous Provisions) Bill

We thank you for the opportunity to comment on the above Bill, which is being considered by the Committee for Health, Social Services and Public Safety.

Having conferred with colleagues we have no specific suggestions for amending the wording of the Bill.

We welcome the Bill as it offers the Health and Social Service Boards the potential mechanisms to enable them to manage General Medical Services Performers, where their performance or behaviour is a cause for concern. In particular we welcome the following:

- The power of a Board to suspend a Performer pending referral to a Tribunal etc
- The power of a Board to impose conditions on a Performer
- The removal of local disqualification in favour of disqualification across all the Boards
- The inclusion of additional grounds for removal of a Performer by the Tribunal.

We believe these additional measures will enable Boards to act appropriately, and in similar fashion as elsewhere in the UK.

NCAS remains committed to providing advice and support to NHS organisations to achieve effective and timely resolution of issues associated with concerns about medical and/or dental practitioners' performance.

Professor Tim van Zwanenberg EdD FRCGP

Associate Director (Devolved Administrations)
National Clinical Assessment Service (NCAS)
National Patient Safety Agency

General Medical Council

Health (Miscellaneous Provisions) Bill

Introduction

1. The General Medical Council welcomes the opportunity to provide a written submission to the Committee on the Health (Miscellaneous Provisions) Bill 2007 (the Bill).
2. The General Medical Council (GMC) believes that one element (Schedule 1 Paragraph 1 (5)) of the Bill, in relation to the extension of powers of the Health Service Tribunal, has the potential to cause confusion and a lack of clarity in the respective roles of organisations within the regulatory framework for doctors.
3. We believe that this can be addressed through minor amendments to the proposed Bill that would require Health and Social Services Boards, and Tribunals, to have regard for other remedy or regulatory process. Such amendments could help mitigate against any such confusion or risk in the primary legislation both now and in the future.

Background

4. The General Medical Council (GMC) regulates doctors in the UK under the provisions of the Medical Act 1983 (as amended). This includes over 6,000 doctors in Northern Ireland.
5. Our objective, as defined in the Medical Act 1983 and the Charities Act, is to "protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine". Our four main functions are:

a. to control entry to the medical register;

b. to determine the principles and values that underpin good medical practice ;

c. to set the educational standards for medical school; and

d. to deal firmly and fairly with doctors whose fitness to practise is in doubt.

6. The concept of independent, publicly accountable regulation with patient safety at its heart enables the GMC to set a framework of principles and values which can command the confidence and support of all those who receive and provide healthcare in the UK. These principles and values are embodied in the publication Good Medical Practice, which underpins all the GMC's work.
7. Our governing body, the Council, is made up of both medical and lay members.
8. In November 2006, the GMC published a package of proposals (http://www. gmc-uk. org/about/reform/index. asp) for the further reform of medical regulation which we believe is necessary. A great many of the proposals have been reflected in the White Paper Trust, Assurance and Safety – the Regulation of Healthcare Professionals in the 21st Century published by the Department of Health (England) in February 2007. The UK Government's intention to take this forward in a Health and Social Care Bill in the 2007-08 Westminster Parliamentary term was included in the UK Government's Draft Legislative Programme announced on 11 July 2007.

GMC's interest in the Health (Miscellaneous Provisions) Bill

9. The great majority of doctors in the UK are good doctors, delivering safe and effective healthcare, often under difficult and demanding conditions. We must work with others to ensure that standards remain high and that prompt and effective action is taken to deal with actual or emerging impairment. Regulation is too important to be left to regulators alone. The GMC therefore believes in a four-layer model emphasising the complementary roles of personal regulation, team based regulation, workplace regulation and national regulation:

i. Personal regulation, which reflects the way in which individual doctors regulate themselves, based upon their commitment to a common set of ethics, values and principles, which puts patients first.

ii. Team based regulation, which reflects the increasing importance of team working and requires health professionals to take responsibility for the performance of the team and to act if a colleague's conduct, performance or health is placing patients at risk.

iii. Workplace regulation, which reflects the responsibility that the Health Service and other healthcare providers have for ensuring that their staff, and those who use their facilities, are fit for their roles. Workplace regulation is expressed through clinical governance and performance management systems.

iv. Professional regulation, which is undertaken by the GMC and other statutory health regulators and, for example, by medical Royal Colleges where appropriate. Professional regulation is expressed through work on standards, education, registration and licensing, including revalidation, and fitness to practise procedures.

10. The GMC supports the principle of ensuring that professional regulation and workplace regulation connect in a coherent manner that reflects their distinct but complementary roles. Workplace regulation reflects the responsibility that the Health service and other healthcare providers have for ensuring that their staff are 'fit for purpose' in their roles. This is expressed through clinical governance and performance management systems and enables many matters to be resolved at a local level. It also provides an important role in identifying doctors, whose 'fitness to practise' may be impaired, for referral to the GMC. The GMC can consider whether a serious or persistent failure to abide by Good Medical Practice has occurred, and consider appropriate sanctions.

11. The regulatory framework is most effective where each layer fulfils its distinct, but complementary role. It is important not to conflate those responsibilities in a way that risks duplication of activity, confusion over roles or loss of clear regulatory accountability.

12. At present, Schedule 1 Paragraph 1 (5) of the Bill proposes that Schedule 11 of the Health and Personal Social Services (Northern Ireland) Order 1972 (1972 Order) be extended. This would allow matters of unsuitability 'by virtue of professional or personal conduct' to be considered by the Tribunal as a grounds for disqualification from the Performers List.

13. We believe that the legislation as drafted could conflict, or cause confusion, with the provisions for 'Fitness to Practise' matters to be dealt with by the GMC in accordance with Part V of Medical Act 1983 (as amended).

14. If, at any stage of investigation, a Health and Social Services Board or an Independent Tribunal believes that a doctor's fitness to practise may be impaired, it should be referred to the GMC for consideration.

15. It is important that the legislation supports the framework of existing regulatory structures and encourages appropriate use of individual regulatory bodies. There is an opportunity to clarify the legislation to ensure that any potential for confusion about these roles is avoided and that no regulatory gap appears.

16. A number of minor changes could help remove any possible risk of confusion and ensure that where patient safety may be at risk, an immediate referral is made to the GMC. Clarification in the legislation would help to reduce any chance of duplication and additional regulatory burden for all concerned.

17. At present to be on a Medical Performers List, doctors must be registered with the GMC. Therefore, any doctor who is removed from the register would no longer qualify to remain on any NHS performers list in the UK.

18. In certain cases, a GMC Interim Order Panel can make an early decision on whether to suspend a doctor's registration or restrict a doctor's practice if it is necessary to protect the public or is deemed to be in either the public interest, or the interests of the doctor.

19. The Bill proposes to allow for suspension of individuals while investigatory processes take place. We support this principle in the interest of patient and public safety. However, the appropriate regulatory layer and investigatory process may also be required.

Moving Forward

20. The legislation as it stands could be open to misinterpretation. One option would be to amend the legislation to ensure that the Health and Social Services Board has regard for other remedy or regulatory process. Equally, the duty should also be on the Tribunal to have regard for other remedies. This would mean that any concern arising regarding a doctor's fitness to practise during an investigation is forwarded to the GMC for investigation in the interests of patient safety and wider public interest.

21. The GMC believes that minor amendments to the Bill to ensure consideration of other regulatory bodies would complement existing regulatory processes across all of the healthcare professions referred to in the Bill. It would also provide the scope for further clarity to be provided in expanded form through relevant regulations which the Minister referred to in the Second Reading of the Bill in the Assembly on 19 June 2007.
22. We trust that the information contained in our submission is of assistance to the Committee in its deliberations. Please let us know if we can be of any further help to the Committee on this matter and if you would like any further information or clarification on our submission.

Alan Walker

Northern Health and Social Services Trust

Health (Miscellaneous Provisions) Bill

Thank you for your letter of 20 June 2007 and the opportunity to comment on the above Bill which has been referred to the Committee for Health, Social Services and Public Safety. I would comment as follows on the three main provisions:

1. The provisions within the Bill significantly enhance the safety of patients receiving primary care services and should increase public confidence. The removal of the Health Service Tribunal's sanction of "local disqualification" is significant and welcome. The provision for the Health and Social Services Board to suspend a practitioner while professional, tribunal or indeed criminal proceedings take place, will enable Commissioners to more robustly manage situations where patients could be put at risk. Extending the list system to all primary care practitioners including locums, deputies and employees provides for good governance in primary care. I welcome all of these provisions.
2. I also welcome the provisions relevant to dental services and, in particular, the opportunity for the Health and Social Services Boards to directly employ dentists. Given that RPA provisions will replace the four Board areas, with effect from 1 April 2008, it might be more appropriate if the new Bill were to empower Trusts to undertake this provision.
3. I have no comments to make on the amendment to the Smoking Order, which affects artistic performances.

I trust these comments are helpful.

Norma Evans

Chief Executive

Queen's University of Belfast (Northern Ireland Cancer Registry)

Health (Miscellaneous Provisions) Bill

Thank you for the opportunity to make a written submission to the committee for Health, Social Services and Public Safety on Health (Miscellaneous Provisions) Bill.

I wish to address my comments mainly on the proposed amendment to the Smoking (NI) Order 2006 to permit smoking by those taking part in performances if artistic integrity so requires.

As Director of the N. Ireland Cancer Registry where we collect details of all cancers diagnosed in Northern Ireland, several thousand of which related directly to tobacco with an increased hazard to workers exposed to environmental tobacco smoke. We have welcomed the Smoking NI 2006 Order as it protects workers from known Class A carcinogens.

In relation to smoking during performances, I wish to make the following points;

- Actors and stage crew etc. are workers and this is their workplace, this legislation was enacted to protect workers and we must ensure equality of enforcement.
- If smoking is an essential part of the plot there are suitable alternatives which are very realistic but which do not contain nicotine. Good artisans will improvise – some of the best performances I have seen have been with minimal props.
- If real cigarettes are used for the final performance then it is very likely they will also be required during rehearsals and so the amount of exposure is larger than just during a performance.
- There are many non smoking artists who may be forced to adopt the habit for the part they intend to play. Nicotine is a very addictive drug and unfortunately several performers have reported that as a result of playing a smoking role they have started to smoke with obvious health hazards.
- Consideration needs to be taken of the wide variety of artistic performances and vast range of possible venues. Artistic performances could be concerts/school performances etc. and could take place in many locations including pubs where bar staff work. The difficulties defining what constitutes an artistic performance could be difficult and represent the thin edge of the wedge in relation to the smoking ban.

I feel it is important that the Health Committee acts in the best interests of performers and continues to support the implementation of this legislation which has proved very popular among the population where 99% compliance has been reported.

In relation to dental health, there is a documented social inequality in N. Ireland in terms of dental health with higher levels of filled/missing teeth in areas of social deprivation. In dental health, prevention is better than cure and yet for financial reasons many people can only visit the dentist when they have pain and are in need of treatment. I would favour a system which encourages a focus on prevention of dental disease and increased equality of care.

Dr Anna Gavin

Director
3rd July 2007

Ulster Cancer Foundation

Health (Miscellaneous Provisions) Bill

We write to you to express our deep concern following the first stage of the Health (Miscellaneous Provisions) Bill. We in the Ulster Cancer Foundation believe that this move provides a loophole in the Smoking (Order) 2006, and such a development would create public confusion and put lives at risk.

The smokefree workplace and public places legislation in Northern Ireland has been very effective and very popular. It has been widely accepted, with 99% compliance reported, and will save lives of local employees. One of the reasons it has been a success is the consistency of its approach. People know what to expect when they go to work or out for a night.

It is, therefore, deeply disappointing that we have this attempt to row back on such landmark public health legislation. Tobacco smoke is a lethal cocktail of four thousand chemicals including arsenic, ammonia, and cyanide. Second hand smoke is a class A carcinogen in the same category as asbestos. Non smokers exposed to second hand smoke have an 80% increased risk of stroke and a 30% increased risk of lung cancer and heart disease.

If this amendment is passed, it will mean stage hands, actors and audiences will be exposed to carcinogens and noxious fumes in a confined space. It will also lead to confusion among the public about where smoking is allowed.

It is ridiculous to argue that smoking on stage is essential to the performance. An extension of that argument would be that actors should be allowed to shoot up heroin on stage if they are playing heroin addicts. Surely any competent actor can use props and their own acting skills to portray smoking. We demonstrated examples of props which are widely available at your meeting on 5th July.

It is important to note that such loopholes have not been allowed in Scotland, Wales or the Republic of Ireland. This issue was the subject of a local consultation in the Spring of 2007. We understand that 25 out of 29 responses were against the introduction of smoking on stage. The 2005 consultation received 71,000 replies with 92% calling for comprehensive legislation. Surely a local assembly will not introduce legislation which so blatantly ignores the strongly held views of local people and would damage the health of local employees and theatre goers.

I would draw your attention to the incident this month when “Happy Mondays” front man Shaun Ryder is said to have smoked several cigarettes during the band’s concert in Manchester. It is alleged he lit “cigarette after cigarette” throughout the event at The Ritz on Whitworth Street recently. Performers in England are exempt from the smoking ban if the “artistic integrity” of their act requires it. It is believed members of the audience started smoking as a result of Ryder’s actions.

Do we want this to happen here in Northern Ireland? We should remember that rock bands often perform in licensed premises, universities and indeed schools.

The proposal that herbal cigarettes be used in performances should also be resisted. There is no definition of a herbal cigarette and whilst many do not contain nicotine, when burned do produce many other carcinogens. This proposal could also undermine the entire smokefree legislation by giving the impression that herbal cigarettes might safely be used in other workplaces and enclosed public places.

We in the Ulster Cancer Foundation strongly urge you to personally oppose this amendment and continue to work towards a totally smokefree Northern Ireland.

Arlene Spiers, Chief Executive (17 June 2007)

Western Investing for Health Partnership

Health (Miscellaneous Provisions) Bill

I refer to your letter of 20th June in respect of Health (Miscellaneous Provisions) Bill.

I'd like to take this opportunity to respond on behalf of the Western Investing for Health Partnership in respect of the document. Regarding the first two provisions, in relation to patient safety issues around regulatory powers of Boards and the Health Service Tribunal and changes to way dental services are organised, I would wish to make no formal submission as they would be outside the direct remit of the health improvement agenda, which IFH covers. However I would like to make some specific comments in relation to item 15 'Smoking Exemption for Performers', with particular reference to (2 – 4a & 4b), which should have subsequent impact in the remaining items in this specific section.

It is the view of the Western Investing for Health Partnership that when performers smoke during a performance, it implies that artistic integrity is more important than the health of the performers, stagehands and other staff, as well as the public attending the performance. It is our view that there is no safe exposure level to tobacco smoke, which is known as Class A Carcinogen.

We do not agree that the artistic integrity of a performer could ever rely on the performer smoking tobacco and thereby exposing others and themselves to the dangers of tobacco smoke. Clearly there are other more appropriate options if the performer is required to mimic the use of tobacco products. The theatrical and performance industry clearly relies heavily on the use of numerous props during performances and the same view should be taken in respect of the use of tobacco on stage or in a performance.

When the new legislation was brought in, in respect of exposure to tobacco smoke, the purpose was to protect people, this also means not requiring an individual to smoke against their wishes in order to secure a place in a performance. The proposed amendment could result in the coercion of an artist and performers, whether willing or not, to smoke in order to secure a part and therefore put their health at serious risk, or creating an inequality in that performers may not be able to go forward for a role.

To move forward with the proposed exemption is not in keeping with the current legislation in Scotland and Wales. The British Medical Journal has clearly highlighted the influence of film and television industry and the uptake of smoking amongst teenagers. The documented research showed that evidence that the more teenagers see films, the more likely they are to smoke. The definition of performance and the proposed amendment regulation seems to include television, film and theatre and in addition could include fashion shows etc., all of which influence the smoking habits of the young.

Western Investing for Health feel it is unfortunate that this amendment has been proposed, given the significant progress that has been made in addressing the single biggest issue that affects public health in our modern times and we would strongly oppose the inclusion of the exemption in the Health (Miscellaneous Provisions) Bill.

If you have any further queries in respect of this, please do not hesitate to contact me.

Brendan Bonner

Investing for Health Manager

28th June 2007

Southern Health and Social Care Trust

Health (Miscellaneous Provisions) Bill

I write on behalf of the Southern Health and Social Care Trust in relation to the proposed amendment to the Smoking [NI] Order 2006 to permit smoking by those taking part in performances if artistic integrity so requires.

The Trust would not support this amendment on the basis that it challenges the absolute ban on smoking in enclosed public spaces and therefore reduces the strength of the message regarding the harm from passive smoking.

Additionally, it would be difficult to agree criteria to govern all situations of artistic integrity; for example, if this included school drama productions, there would be a mixed message going out to young people.

I trust these views will be considered.

Dr. Gillian Rankin

Director of Older People and Primary Care

Northern Health and Social Services Board
Director of Public Health

Health (Miscellaneous Provisions) Bill

Thank you for your letter of 20 June 2007 regarding the above subject.

I must strongly object to any possible proposal to allow performers to smoke during a performance. I feel that there are no circumstances where the artistic integrity of a performance justifies smoking and the exposure of persons to a “Class A” cancer causing agent.

According to the World Health Organisation (WHO) Director General, Dr Margaret Chan “The evidence is clear there is no safe level of exposure to second-hand tobacco smoke”. I believe that all workers are entitled to be protected from exposure to second-hand tobacco smoke with persons working in the performance industry being given the same level of protection.

This proposed exemption for Northern Ireland is not in keeping with current smoke-free legislation in Scotland and Wales. If this exemption is passed it will lead to confusion among the public about where smoking is allowed. Taking into account that the smoke-free workplace and public places legislation in NI has been very effective and popular with 99% compliance reported this could only be viewed as a significant backward step.

If this sought after exemption for performers was allowed, this would permit exposure to second-hand smoke in performance settings at a time when smoke-free legislation progresses to protecting some of these currently exempt, such as persons in mental health settings from 30 April 2008.

The British Medical Journal has clearly highlighted the influence of the film and television industry on the uptake of smoking amongst teenagers. The documented research shows evidence that the more smoking teenagers see in films the more likely they are to smoke {BMJ. Vol. 323 {7326}; Dec 15, 2001}. The definition of performance in the proposed amendment

regulations includes television, film and theatre and other shows etc, all of which evidence would suggest influence the smoking habits of young people.

There are obvious props available to create the illusion of smoking as there are props available to create other illusions on stage. This industry relies heavily on the use of props with performances and can do likewise in relation to tobacco use in order to protect staff and the public from the unacceptable exposure to a Class A cancer causing agent from tobacco smoke.

I previously objected to such an amendment in February 2007 and I note that the overwhelming majority of responses to that consultation were against any possible relaxation on current smoke-free legislation. The public in NI in previous consultations have shown their overwhelming support to comprehensive smoke-free legislation.

I see the NI Smoke-free legislation as one of the most significant public health developments during my 30 years in public health and look forward to its future development in obtaining a smoke-free society.

Dr J D Watson

Director of Public Health

16 July 2007

Eastern Group Environmental Health Committee

Health (Miscellaneous Provisions) (NI) Order 2007 Smoke-Free Legislation – Performance Exemption

I am writing to you to express my concern about the proposed exemption to the smoke-free legislation for performances.

I wrote to the Department on 28 February 2007 outlining my views on this matter. It is my understanding that an overwhelming number of responses to the consultation on the Draft Smoke-free (Exemptions, Vehicles, Penalties and Discounted Amounts) (Amendment) Regulations (NI) 2007 favoured a rejection of this proposal.

According to the World Health Organisation (WHO) Director-General, Dr Margaret Chan, "The evidence is clear, there is no safe level of exposure to second-hand tobacco smoke." Second-hand tobacco smoke is a Class A carcinogen. Workers employed in theatres and in other parts of the performance industry are absolutely entitled to the same protection afforded to others. I strongly believe there is no rational or sustainable argument to grant this exemption. It is abundantly clear that there are many credible alternatives available to simulate smoking during a performance.

This exemption will have the effect of forcing actors who may not smoke to do so to secure a part, if the director feels the "artistic integrity" of the piece requires it. It is wholly unreasonable to place a worker in such an invidious position.

It is very likely that there would be problems with the interpretation of the terms "performance" and "artistic integrity" (which will create great difficulties for enforcement officers).

The proposal does not in any way limit “performance” to theatre productions and other mainstream dramatic arts; The definition of the term ‘performance would cover events including any performance in a public house for example, tribute bands where the ‘guitar hero’ or another band member is a smoker. The influence that the fashion industry has on young people is considerable and a director might decide to introduce a theme for an event which could, under this proposal, include smoking as part of an image to be cultivated. Merely tightening the definition of ‘performance’ would not, in our view, provide an acceptable solution as there is no safe level for a class A carcinogen as second hand tobacco smoke.

The influence of the tobacco industry in film and television is well documented. Similarly the British Medical Journal has clearly highlighted the influence of the film and television industry on the uptake of smoking amongst teenagers. The documented research shows that there is evidence that the more smoking teenagers see in films, the more likely they are to smoke (BMJ. Vol. 323 (7326); Dec 15, 2001). The Tobacco Action Plan includes: “preventing people from smoking” and “protecting non-smokers from tobacco smoke” amongst its key objectives and also highlights children and young people as one of the priority groups. This piece of draft legislation is not in accord with the plan.

Northern Ireland has secured a huge level of compliance with the smoke-free legislation, the highest of any UK region to date. It would be a shame if, having made a huge effort to secure this, we took such a backward step. In addition on 27 May 2007 the WHO signalled the urgent need to make all indoor public places and workplaces 100% smoke-free.

I urge you to reject this proposal.

David F J Knox, Senior Environmental Health Officer (29 June 2007)

Chief Environmental Health Officers Group N.I.

Health (Miscellaneous Provisions) Bill

I am writing to you to express our concern about the proposed exemption to the smoke-free legislation for performances.

The Chief Environmental Health Officers’ Group (CEHOG) wrote to the Department on 16 February 2007 outlining our views on this matter. It is our understanding that an overwhelming number of responses to the consultation on the Draft Smoke-free (Exemptions, Vehicles, Penalties and Discounted Amounts) (Amendment) Regulations (NI) 2007 favoured a rejection of this proposal.

According to the World Health Organisation (WHO) Director-General, Dr Margaret Chan, “The evidence is clear, there is no safe level of exposure to second-hand tobacco smoke.” Second-hand tobacco smoke is a Class A carcinogen. Workers employed in theatres and in other parts of the performance industry are absolutely entitled to the same protection afforded to others. CEHOG strongly believe there is no rational or sustainable argument to grant this exemption. It is abundantly clear that there are many credible alternatives available to simulate smoking during a performance.

This exemption will have the effect of forcing actors who may not smoke to do so to secure a part, if the director feels the “artistic integrity” of the piece requires it. It is wholly unreasonable to place a worker in such an invidious position.

It is very likely that there would be problems with the interpretation of the terms “performance” and “artistic integrity” (which will create great difficulties for enforcement officers).

The proposal does not in any way limit “performance” to theatre productions and other mainstream dramatic arts; The definition of the term ‘performance would cover events including any performance in a public house for example, tribute bands where the ‘guitar hero’ or another band member is a smoker. The influence that the fashion industry has on young people is considerable and a director might decide to introduce

a theme for an event which could, under this proposal, include smoking as part of an image to be cultivated. Merely tightening the definition of ‘performance’ would not, in our view, provide an acceptable solution as there is no safe level for a class A carcinogen as second hand tobacco smoke.

The influence of the tobacco industry in film and television is well documented. Similarly the British Medical Journal has clearly highlighted the influence of the film and television industry on the uptake of smoking amongst teenagers. The documented research shows that there is evidence that the more smoking teenagers see in films, the more likely they are to smoke (BMJ. Vol. 323 (7326); Dec 15, 2001). The Tobacco Action Plan includes: “preventing people from smoking” and “protecting non-smokers from tobacco smoke” amongst its key objectives and also highlights children and young people as one of the priority groups. This piece of draft legislation is not in accord with the plan.

Northern Ireland has secured a huge level of compliance with the smoke-free legislation, the highest of any UK region to date. It would be a shame if, having made a huge effort to secure this, we took such a backward step. In addition on 27 May 2007 the WHO signalled the urgent need to make all indoor public places and workplaces 100% smoke-free.

I urge you to reject this proposal.

Barny Heywood

Secretary

28 June 2007

Northern Group Systems

Health (Miscellaneous Provisions) Bill

Northern Group Systems strongly object to the proposal to allow performers to smoke during a performance. We feel that there are no circumstances where the artistic integrity of a performance justifies smoking and the exposure of persons to a “Class A” carcinogen.

According to the World Health Organisation {WHO} Director General, Dr Margaret Chan “The evidence is clear there is no safe level of exposure to second-hand tobacco smoke”. We believe that all workers are entitled to be protected from exposure to second-hand tobacco smoke with persons working in the performance industry being given the same level of protection as workers in other sectors. We also believe that should such an exemption be granted then non smokers would be forced to smoke to obtain parts.

This proposed exemption for Northern Ireland is not in keeping with current smoke-free legislation in Scotland and Wales. If this exemption is passed it will lead to confusion among the

public about where smoking is allowed. Problems have already been encountered in England where the smoke free law permits such an exemption. Problems have already been encountered in England where smoke free law permits such an exemption. Taking into account that smoke-free legislation in NI has been very effective and popular with compliance levels in excess of 99% this could only be viewed as a significant backward step. Smoke-free legislation was introduced on the 30th April 2007 and since then performers have been complying with the current controls on smoking. Indeed in Scotland where such restrictions have been in place for over a year there have been no difficulties and no negative affects from not permitting smoking as part of performances

Currently smoke-free legislation permits a small number of exemptions, which allow persons to smoke primarily in areas regarded as their home. This proposed exemption does not fit within that category. Indeed some of the exemptions available from smoke-free requirements will be removed on the 30th April 2008. From that date people will not be permitted to smoke in mental health units and detention cells in police stations yet if this exemption was allowed performers would be permitted to smoke during performances.

The British Medical Journal has clearly highlighted the influence of the film and television industry on the uptake of smoking amongst teenagers. The documented research shows evidence that the more smoking teenagers see in films the more likely they are to smoke {BMJ. Vol. 323 {7326}; Dec 15, 2001}. The definition of performance in the proposed amendment regulations includes for example television, film and theatre and other shows etc, all of which evidence would suggest influence the smoking habits of young people. If Northern are to continue to reduce smoking prevalence then we need to take steps to reduce the update of smoking by young people. Reducing the number of images of influential people smoking will help in this regard.

There are obvious props available to create the illusion of smoking as there are props available to create other illusions on stage. This industry relies heavily on the use of props with performances and can do likewise in relation to tobacco use in order to protect staff and the public from the unacceptable exposure to a Class A carciogen.

Northern Group Systems responded to the consultation on the proposed smoke-free amendment regulations in February, indicating that we were strongly opposed to such an amendment. I note that the overwhelming majority of responses to that consultation were against any possible relaxation on current smoke-free legislation. The public in NI in previous consultations have shown their overwhelming support to comprehensive smoke-free legislation. We believe that the Minister should use the powers available in the Smoking (NI) Order to add additional smoke-free places and not to relax the current situation.

A member of my staff attended the health committee on 5th July. During that session the Theatrical Management Association suggested that herbal cigarettes were a reasonable alternative which should be permitted. We strongly disagree for two reasons. Firstly herbal cigarettes are not safe, they contain a cocktail of hazardous chemicals like tobacco based cigarettes but do not contain nicotine. Secondly the use of herbal cigarettes of which there is no definition would lead to great enforcement difficulties and would not prevent the problems highlighted above. We strongly resist the idea that herbal cigarettes should be allowed to be used.

We see the NI Smoke-free legislation as an important piece of public health legislation and look forward to the day when Northern Ireland becomes a smoke-free society.

Alistair Morgan

Director

17 July 2007

Pharmaceutical Contractors Committee (NI) Ltd

Health (Miscellaneous Provisions) Bill

I am writing to ask you to make available to the Committee for their consideration of the Health (Miscellaneous Provisions) Bill the following submission on behalf of the Pharmaceutical Contractors Committee (NI) Ltd. The Pharmaceutical Contractors Committee (PCC) represents all pharmacists who have contracts with local HPSS Boards in Northern Ireland.

In the main, we welcome the thrust of this draft legislation which aims to provide further safeguards and protection for users of primary care health services in Northern Ireland. However, there are some issues we wish to raise at this point.

Health Service Tribunal

In general terms the Committee supports the future role envisaged for the Tribunal and we welcome the composition of the Tribunal, which will include professional and lay members. However, we also believe that there should not be a majority of members on the Tribunal from the statutory sector, to ensure balance and a range of knowledge and experience.

It is hoped that persons chosen to act on Tribunals should be persons of experience, integrity and sound judgement. PCC believes that there should be arrangements in place to allow for appeal procedures against all final decisions. Tribunals should be accountable for their decisions and be prepared to provide full explanations for their decisions and procedures. The explanation should always cover

- the factual basis for their decision;
- the legal jurisdiction being used;
- confirmation or otherwise, that they have accepted any legal advice which may have been sought;
- the reason for any sanction applied.

The Tribunal should also seek to

- protect a healthcare professional's patients and colleagues;
- safeguard public confidence in healthcare practitioners generally;
- contribute to upholding high standards amongst healthcare professionals and, most importantly, recognise that the protection of the general public is the most significant responsibility.

In areas concerning the health, either physical or mental of the healthcare professional where hard evidence is difficult to come by, the aims of the Tribunal might also be achieved by involving an intervention from a representative of the healthcare professions. The intention would be to address the issue by way of an offer of help and support for the individual

concerned, for example via an agreed rehabilitation process carried out with the active co-operation of the affected practitioner.

A further cause for concern is the proposition that the suspension of a practitioner while a tribunal is pending is a neutral act. We do not believe that suspension is a neutral act nor that it will be perceived as such by patients and the general public. We have significant concerns that a practitioner who is suspended is likely to suffer damage to their professional reputation due to that act, regardless of the eventual outcome of any tribunal.

We would also welcome further clarification on the issue of continuity of service while a practitioner is suspended. The suspension of a local pharmacist has implications for the service available to patients, particularly in rural areas and has implications for colleagues. PCC would like to see this matter addressed and responded to in the Bill.

I hope this is of help.

T G Hannawin

Chief Executive

18 July 2007

Pharmaceutical Society of Northern Ireland

Health (Miscellaneous Provisions) Bill

Many thanks for the opportunity to respond to your query in relation to the Health (Miscellaneous Provisions) Bill. I must offer our apologies for the delay in our response to your initial query. The request was received during the preparation for the Society's Extraordinary General Meeting.

I note that the Society did respond to the initial consultation of 2005, and that within this response we highlighted a number of points for clarification.

The Pharmaceutical Society of Northern Ireland is the regulatory and professional representative body, established in legislation under the more recent Pharmacy (Northern Ireland) Order 1976.

We are the body responsible for maintaining the register of practising pharmacists and pharmacies operating throughout Northern Ireland. Each Pharmacist is bound by the regulations of the Society and the Professional Code of Ethics and Practise.

The Society is itself undergoing a period of accelerated change, primarily due to the recommendations contained within the White Paper – Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century. This paper will have a significant impact upon the future structures and work of the Society.

The Health (Miscellaneous Provisions) Bill, could appear to add a further degree of confusion to the regulation of Pharmacists in Northern Ireland.

Whilst we would be supportive of any steps which will add further concentration upon improving patient safety, we would question the viability and whether this is the best approach to improving patient care.

There are legislative anomalies between Northern Ireland and Great Britain, which would pose a greater concern for the Society. The Pharmacy and Pharmacy Technicians Act, 2006, which has introduced a range of sanctions available to the Royal Pharmaceutical Society which we would wish to similar legislation introduced in Northern Ireland. We would wish to see our Continuing Professional Development process legislated, and an update to the 1976 Order which would enable the Society to review lay representation, our registers, and the structure and purpose of the Society and its governance.

We continue to work with the DHSSPSNI to have these legislative measures introduced as soon as is practicable, which would have a more direct impact upon improving patient safety and for the profession of Pharmacy than perhaps this Bill would do. I have attached as appendix 1, part of the work that the Society is continuing to address, and we would be grateful if these elements could be considered overall in relation to Pharmacy regulation.

The involvement and support of employers is essential in ensuring that standards are maintained and supported. The regulatory body however, must ultimately be the body responsible for the determination of these professional standards and whether the individual has been in breach and can deal with the matter efficiently.

The Bill would seem to be providing duplication to the registration function which is currently established for Pharmacists and Pharmacies, and would also seem to be recommending that a regulatory function would reside within the Board structure. We do not consider that this would be a sensible or appropriate measure as the Society exists to perform this function.

As an employer we would anticipate that the Boards would have disciplinary powers, but that they would not have regulatory or statutory powers over the Profession.

We would be willing to attend the Statutory Health Committee Hearing in order to offer whatever assistance we can to this process, and assure you of our best intentions at all stages to deliver the most appropriate regulatory framework to best serve patients within Northern Ireland.

Raymond G A Blaney

Director

British Medical Association

Health (Miscellaneous Provisions) Bill

Introduction

1. The British Medical Association

1.1. The British Medical Association, or BMA, is the professional organisation and trade union for doctors in the UK. Across the UK more than three out of four practising doctors, and the majority of medical students, are members.

1.2. The BMA is the voice of the medical profession - putting across to politicians, the public and the press the profession's collective views on a wide range of subjects including public health, medical ethics and the state of the NHS.

1.3. The BMA in Northern Ireland, or BMA(NI), supports over 4,000 members from every branch of the medical profession in Northern Ireland.

1.4. The BMA represents consultants, general practitioners, staff and associate specialists, junior doctors, public health doctors and medical academics, and medical students. The BMA has a committee to work on behalf of the interests of each of these branches of practice with a Council to represent all the branches of practice in a single entity.

1.5. The BMA is the only recognised trade union for doctors able to negotiate on their behalf with government in relation to contracts and terms and conditions. As well as this function the BMA produces a wide range of policies from public health issues to medical ethics, and from the state of the health service to doctors' contracts. Its policies are decided by elected members, mainly practising doctors and is supported by a professional staff

1.6. The BMA also produces a wide range of publications on health issues including the British Medical Journal.

1.7. The BMA believes in a Health Service that is free at the point of delivery; is centrally planned; is adequately funded; provides equality of access regardless of locality or income; is exclusively based on clinical priority; provides an equal standard of care; ensures equality of health outcome; does not discriminate in terms of race, age, disability or religion

1.8. The BMA is a voluntary professional association of doctors, speaks for doctors at home and abroad, provides services for its members, is an independent trade union, is a scientific and educational body, is a publisher, and is a limited company, funded largely by its members.

The Health (Miscellaneous Provisions) Bill

2. Clause 1, 2 (1), 8 (2) & 10 (2)

2.1. The BMA(NI) agrees with the inclusion of all practitioners (general practitioners, dentists, opticians, pharmacists and ophthalmic and pharmaceutical bodies corporate) onto a single performer list in each Health and Social Services (HSS) Board.

2.2. This makes practical sense and will make it easier for the eventual amalgamation of all the Health and Social Services Boards into the new Health and Social Care Authority.

3. Schedule 1 Clause 3 (3) (2)

3.1. The BMA(NI) agrees with the removal of the sanction of "local disqualification" from the Tribunal's powers.

3.2. If a practitioner is deemed unfit to be included in one HSS Board list, it would be inappropriate for them to be included in any other list.

4. Clause 13

4.1. The BMA(NI) welcomes the repeal of the Article 4 of the Health and Medicines (NI) Order 1988.

4.2. Article 4 empowers the Department of Health Social Services and Public Safety to specify the age at which a general practitioner (GP) must retire. It is right this power should be repealed in order to reduce the age discrimination directed at the medical profession where retirement ages are imposed.

5. Schedule 1 Clause 8 (4)

5.1. The BMA(NI) does not support the extension of powers to a Health and Social Services Board to suspend a practitioner before referral to the Health Services Tribunal, as described in the Bill.

5.2. Suspension is a rare occurrence and there are already many safeguards in place to ensure patient safety is maintained. The BMA(NI) and the Northern Ireland General Practitioner Committee, a BMA branch of practice committee, has worked with HSS Boards to persuade GPs, where necessary, to opt for voluntary suspension. This has worked well as all stakeholders are working in the interests of patient safety and high standards of service provision.

5.3. Where a GP underperforms there is often an issue regarding the GPss ability to cope with circumstances in their life. This underperformance may be due to illness, alcoholism, drug addiction, or depression. In these cases the GP requires help, not punishment. Each case is individual, requiring everyone involved to work for a satisfactory resolution.

5.4. The problem with an HSS Board having the power to suspend without recourse to appeal is that it would not have to put the allegations to the Tribunal before suspension, but could do it before the Tribunal sees the evidence of the allegation. This may lead to many of the good relationships built up over the years to be undermined by a predisposition to suspend first and ask questions later.

5.5. The BMA(NI) is very concerned about the possible impact such a suspension would have on a general practitioner before the Tribunal is able to make a full investigation of the issue. The BMA(NI) firmly believes that suspension is not a 'neutral act' and that in the recent case of Mezey v South West London and St George's Mental Health NHS Trust[1] the judgment by Lord Justice Sedley was that, in relation to the employment of a qualified professional in a function which is as much a vocation as a job,

"Suspension changes the status quo from work to no work, and it inevitably casts a shadow over the employee's competence. Of course this does not mean that it cannot be done, but it is not a neutral act."

5.6. The BMA(NI) is very concerned about patient safety and recognises the need to give patients confidence that the service they are receiving is of the utmost standard and delivered by GPs working to a consistently high standard. Under this clause the safety of patients, the delivery of consistent high standard service and the continuity of care could be under threat, due to the finality of a total suspension.

5.7. The BMA(NI) is mindful of the power of the HSS Board to impose specific restrictions on a practitioner if they are to be retained on a performer list. This alternative of placing conditions on practitioners may be a way to avoid total breakdown of practitioner/patient trust. This may also be of some help in rural areas where there are many single handed GP practices.

5.8. It is suggested that clause 8(4) could be amended to read:

“(8) Regulations may provide that where a Health and Social Services Board, in accordance with regulations made under Article 57G, 61F, 62A or 63AA, wishes to suspend a person from a list prepared under regulations made under the provision in question and the Board applies to the Tribunal for a direction to be made under sub-paragraph (2) in relation to the person to whom the proposed suspension applies, the board shall have regard to the guidance on suspensions as set out under 57G 3(l), until the Tribunal determines the application.”.

5.9. It is suggested that a clause be added to Clause 1 of the Bill to read:

(4) After paragraph 3(k) insert:-

(l) the implementation of a suspensions framework as formulated by the Department.

5.10. Any process regarding suspension would need to be negotiated to create a suspensions framework, which can be co-ordinated at Departmental level in close negotiation with the respective professional and trade union bodies. For the medical profession to have confidence in any possible suspension process there would need to be real engagement to assess what would be practical and reasonable.

5.11. Any type of suspension, be it full partial or even voluntary, must have all costs fully covered.

5.12. Should the clause go through without any amendment there is a major concern about the non-existence of the right to appeal an HSS Board suspension and the impact on delivery of the health service at Primary Care level.

5.13. In the end this would detrimentally affect the provision of service to patients, leaving them without care or continuity of care.

6. Clause 1

6.1. The BMA(NI) cautiously welcomes the extension of powers to HSS Boards to allow payment to suspended practitioners by amending the Primary Medical Services (NI) Order 2004 57G

6.2. The extension of the ability of payment to suspended practitioners is welcome as a matter of course, however clarification is required on the framework for this process and to what extent it covers the costs of the suspended practitioner.

6.3. The impact of the redistribution of service provision to other partners in a GP practice to cover for the suspended GP, or the costs of a locum to replace the suspended GP for the duration of suspension requires a closer examination, so that any suspension does not penalise the practice or adversely impact on the provision of primary health care services to patients.

6.4. Any suspension must be cost neutral to the general practitioner and/or practice and to the delivery of health services to the patient.

7. Schedule 1 Clause 1(5)

7.1. The BMA(NI) does not support the introduction of an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely “unsuitability by reason of professional or personal conduct”.

7.2. There is a complete lack of clarity on the definition of this additional ground for disqualification, in addition to fraud and prejudice to the efficiency of service.

7.3. Clarity is also required on how this new condition would impinge upon investigations by professional regulatory bodies, such as the General Medical Council, into fitness to practice as defined in the Medical Act 1983. Such bodies have clear definitions and sanctions for such conduct.

7.4. More detail on how this power differs significantly from the issue of fitness to practice is required. The BMA(NI) would also suggest that the Committee call for evidence from the General Medical Council (GMC) and the Medical Defence Organisations (MDO), as they may also be involved any case where a general practitioner has been suspended.

7.5. It is suggested that any reference to this condition be removed from this Bill, until a full consultation on the implications of this condition has been carried out. Once clarified, and if agreed, an amendment to Schedule 11 of the HPSS (NI) Order 1972 can be made to reflect responses to the consultation.

8. Clause 15

8.1. The amendment of the Smoking (NI) Order 2006 is to permit those participating as performers in a performance to be allowed to smoke if the artistic integrity of the performance makes it appropriate.

8.2. The BMA, along with many other organisations, campaigned successfully to have the smoking ban introduced. The BMA(NI) sees this cosmetic change as an attempt to dilute the public health principles of the smoking ban.

8.3. Passive smoking has been proved to kill and therefore this amendment should be scrapped immediately.

9. General

9.1. There is no recognition within the Bill, or explanatory notes, of the role of professional regulatory bodies such as the GMC.

9.2. The BMA continues to work closely with the GMC to create efficient, safe and fair disciplinary procedures for the profession and we would urge the Health Committee to seek assurances that any changes to Tribunal as a result of this Bill will be consistent and compatible with existing regulatory procedures.

[1] Mezey v South West London and St George's Mental Health NHS Trust [2007] EWCA Civ 106

Appendix 4

Written Evidence and other Correspondence considered by the Committee

Research and Library Services

Northern Ireland Assembly

Research Paper

19 June 2007

Health (Miscellaneous Provisions) Bill

The Health Miscellaneous Bill was introduced by the Executive into the Assembly on 5th June 2007. The provisions contained within the Bill implement proposals contained in the consultation paper 'Further Measures to Improve the Provision of Primary Care Services' and a number of recommendations contained in the Primary Dental Care Strategy.

Research Papers are compiled for the benefit of Members of The Assembly and their personal staff. Authors are available to discuss the contents of these papers with Members and their staff but cannot advise members of the general public.

Summary of key points

Primary Medical Services and The Tribunal

The Bill introduces provisions to change the powers and duties of the Health Service Tribunal (Tribunal) and the four Health and Social Services Boards (Boards) in order to strengthen quality assurance and improve the protection of patients and health and social services resources. These measures include:

- introduction of a provision for regulations to allow a Board directly to suspend a listed practitioner and extends the power of the Boards to allow payment to suspended practitoners;
- extension of the functions of the Tribunal by introducing an additional ground, namely unsuitability by "virtue of professional or personal misconduct", under which it may deal with a practitioner referred to it; and
- removal of the sanction of local disqualification, so that if a practitioner is not fit to deliver services in one Board's area he can not do so in an other

In relation to medical services, the Bill also: removes of the retirement age restriction on general medical and general dental practitioners; and provides for the exemption of charges provisions for health service treatment to overseas visitors.

Ophthalmic and Pharmaceutical Services

The Bill provides regulating powers to prescribe the way in which persons performing any general ophthalmic or pharmaceutical services are to be listed and the criteria an individual will have to meet in order to be listed. The Bill also allows Ophthalmic Medical Practitioners to be members of Local Optical Committees.

Dental Services

The Bill introduce changes to the way dental services are organised in an attempt to address difficulties in terms of access to health service dental care in some areas and of targeting resources at areas of greatest need. Provisions contained within the Bill also enable a Health and Social Services Board to enter into a contract under which primary dental services are provided. It also contains provisions to 'Govern the terms and content of the new general dental services contract and who may provide or perform primary dental services under such a contract'. In addition it provides '...regulation making powers which will be used to set out the detail of the rights and obligations under the new contract and also to prescribe the ways in which persons performing primary dental services are to be listed'

Smoking

The Bill provides for an exemption from the Smoking (Northern Ireland) Order 2006 for those participating as performers in a performance, if the artistic integrity of the performance makes it appropriate for them to smoke

Contents

Health (Miscellaneous Provisions) Bill

Introduction

The Health Miscellaneous Provisions Bill was introduced into the Assembly by the Executive on the 5th June 2005. The second stage debate was held on 19th June 2007. The Bill amends the Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order) in relation to the provision of health care and amends the Smoking (Northern Ireland) Order 2006 (the 2006 Order) to provide that in certain circumstances premises may not be smoke-free only in relation to performers; and for connected purposes.

Clause 1
Primary Medical Services

Clause 1 deals with changes to the powers of Health and Social Services Boards in relation to maintenance of lists of family health service practitioners (FHSPs). The purpose of the provisions is to address "deficiencies" in the current procedures and "improve on these arrangements in the interests of patients".[1]

Under current procedures FHSPs must register on appropriate Board lists in order to be able to provide services. Boards currently maintain for their areas lists of:

- dentists undertaking to provide general dental services;
- optometrists and ophthalmic medical practitioners undertaking to provide
- general ophthalmic services;
- pharmacists undertaking to provide pharmaceutical services;
- GPs undertaking to provide or assisting with the provision of primary medical services.

Practitioners in Northern Ireland must be registered on the list of any Board in whose area they perform services. This means that a practitioner may be registered on more than one Board list.

Boards can refuse a practitioner entry to its list or remove him or her from its list on certain mandatory grounds, for example, where the practitioner's name is not included in the register of his or her professional body or the practitioner is subject to general disqualification by the Tribunal. Currently, Boards have no powers to suspend practitioners and must apply to the Tribunal.

Clause 1 is designed to harmonise requirements placed on practitioners who wish to join Boards 'lists of persons providing primary medical services and extends the power of Boards in relation to inclusion or continued inclusion on such lists. The rationale for the measures implemented by Clause 1 is set out in the 'Further Measures to Improve Primary Care Services' consultation document in the following terms:[2]

Our proposals are that the information which all practitioners must supply to the appropriate Board should:

- be harmonised as far as possible; and
- cover additional types of information which would help demonstrate their fitness to be listed and to treat patients.

The information supplied would include written declarations/undertakings. For example, all listed practitioners would have to inform the appropriate Board of gifts received from patients and any financial interests as prescribed in regulations. All applicants wishing to join a list and all those already listed would have to report all adverse or current proceedings in a court or by professional regulatory bodies and provide confirmation that they have no criminal convictions by means of an Enhanced Criminal Records Disclosure when required to do so. (para 2.7)

It is proposed that the Boards' powers should be are extended as follows:

- give Boards powers to suspend practitioners from their own lists i.e. local suspension. This sanction should only be imposed once a Board has decided that there is a case to be answered and referral to the Tribunal is appropriate. It is not proposed to allow a right of

appeal against a Board's decision to suspend locally. Suspension in these circumstances is classed as a neutral act; it is not a disciplinary sanction. This power is intended to protect the interests of patients, staff and the practitioner who is suspended. It is intended that Regulations will provide that if the practitioner is included in another Board's list that Board must also consider suspension.

- give Boards powers to "conditionally include" practitioners on a list and to "contingently remove" practitioners from a list in cases where aspects of a practitioner's performance give cause for concern but are not serious enough to warrant local suspension. "Conditional inclusion" means that the Board is prepared to admit a practitioner to its list so long as he agrees to be bound by specific conditions e.g. undertaking training. "Contingent removal" is the same as "conditional inclusion" but applies when a practitioner is already included on a Board's list, i.e. a practitioner must agree to be bound by specific conditions in order to remain on a list. (para 2.9)

In summary, it is proposed to extend Boards powers to include the following:

(a) Mandatory refusal/removal from lists for all practitioners

(b) Local suspension from lists

(c) Conditional inclusion on lists

(d) Contingent removal from lists

There is already a right of appeal to the Department for GPs in the circumstances described at (a) above. This would be extended to include the other practitioners. There would be no right of appeal in cases described at (b) as suspension in these cases will be a neutral act. There will be a right of appeal to the Tribunal in the circumstances described at (c) and (d). As these new powers are not to be used lightly, guidance will be issued to Boards explaining the circumstances in which the sanctions may apply. (paras 2.10 – 2.11)

The Court of Appeal has recently concluded,[3] however, that suspension is not a neutral act, as it changes the status quo from work to no work and inevitably cases a shadow over the employee's competence.

Clauses 2-7
Dental Services

Clauses 2-7, of the Bill introduce changes to the way dental services are organised in an attempt to address difficulties in terms of access to health service dental care in some areas and of the ability to target resources at areas of greatest need.

These provisions contained in these clauses largely mirror those contained in legislation introduced in England and Wales[4] in 2003. They also take forward a number of recommendations contained in the Primary Dental Care Strategy (the PDC Strategy), which was launched by the then Minister Paul Googins in November 2006.[5] This PDC Strategy contains the following description of the current primary dental care system in Northern Ireland.

In Northern Ireland, primary dental care is provided by both the CDS and the GDS.

The Community Dental Service

The CDS is a Trust based salaried service and employs 64 WTE dentists, 117 WTE DCPs and 8 WTE clerical staff. Its remit covers school screening, oral health promotion and dental services for those individuals who are unable to receive dental care from the GDS. This patient group includes:

- Children and adults with learning disabilities, physical disabilities and sensory disabilities;
- Children requiring dental extractions under general anaesthesia
- The elderly, particularly those resident in nursing homes;
- Individuals suffering from dental phobias or disproportional anxiety of dental treatment;
- People suffering from social exclusion;
- Individuals with such complicating medical or social issues that for a variety of reasons they are unable to access dental care in the GDS.

The General Dental Services

The current GDS delivery system is made up of 752 independent contractors (557 WTEs) working from 376 practices spread across the four Health and Social Services Boards. The overall GDS expenditure for 2005-2006 was £62m (net of patient charges). This is held centrally and the Statement of Dental Remuneration (revised annually) sets out how dentists' fees and allowances are to be paid. There are three main payment streams:

Item of Service (IoS). The Statement of Dental Remuneration contains over 400 detailed treatment items with the corresponding fee that the dentist will be paid for providing that treatment. Most adults will pay 80% of the cost of their treatment with the Health Service paying the balance through the CSA. Treatment is free for children, adults receiving certain low-income benefits, pregnant women and nursing mothers. IoS accounts for the majority of health service funding to GDS dentists.

Capitation payments: When patients register with a GDP the dentist receives a monthly payment to maintain their oral health. Unlike GMS arrangements patients only remain registered for 15 months. If the patient does not re-attend the dentist within this time their registration lapses and the dentist stops receiving capitation payments.

Allowances: GDPs are able to claim a series of allowances to help offset practice running costs or the time spent on Continuing Professional Development. (paras 5.1-5.6)

The PDC Strategy, however, also highlighted the following 'shortcomings' of this existing system.

The current primary dental care system is dominated by the General Dental Service (GDS). However, when the GDS was set up in 1948 dental disease levels were very high and distributed reasonably evenly among a population whose main concerns were pain relief and the restoration of function. Nowadays disease levels among children and particularly adults (always the main users of the GDS) are much lower on average and are concentrated in socially deprived groups. Patient expectations have also changed with more people looking for treatment that not only relieves pain and restores function but also improves appearance.

In the development of the strategy it was also found that under the current system: -

- quantity not quality is rewarded;

- treatment rather than prevention is rewarded;
- the service provided is demand led rather than needs led;
- the SDR, with over 400 items, is administratively complex;
- associated patient charges are difficult for the public to understand and for practice staff to calculate;
- dentists incomes are directly related to the volume of treatment provided thus leading to the remuneration treadmill;
- Boards have no control over targeting services at areas and patients with greatest need. (paras 5.7 to 5.8)

Given these shortcomings, the PDC Strategy concluded that a system which was set up 50 years ago no longer met the needs of patients, oral health care professionals or society at large. The Bill seeks to introduce measures to deliver an improved system which includes new commissioning, contractual and charging arrangements relating to dental services.

Provision of Dental Services

Amongst other things, Clause 2 introduces a new specific duty on each Health and Social Services Board to provide or secure the provision of primary dental services within its area to the extent that it considers necessary to meet all reasonable requirements. The rationale for these provisions is contained in the PDC Strategy, which states that:

Current GDS arrangements mean there is no scope for commissioners to tailor GDS provision to the needs of the local community. Under the proposed system, commissioners would take greater responsibility for securing the provision of primary care dental services to meet the needs of patients in their areas. At present primary care dental budgets are either held centrally by the Department for GDS or by Trusts for CDS. Giving commissioners greater responsibility to deliver primary care dental services will require them having control of and responsibility for budgets if the objectives of improving oral health care are to be achieved. In the future commissioners will hold funding for primary dental care. Whilst ensuring universal access to appropriate dental care, commissioners will decide how best to commission dental services based on the oral healthcare needs of the local population but overall policy direction will remain with the Department. In order to increase the efficiency of primary dental care there will be greater integration of the GDS and the CDS. There will be a shift in emphasis from repairing the effects of dental disease to disease prevention. DCPs will have a greater role under the new system than they do currently. (paras 6.15-6.16)

In it's response to consultation on the PDC Strategy, the British Dental Association (the BDA) did not oppose the recommendation that 'Commissioners should hold funding for primary and dental care and decide how best to commission dental services based on the oral health needs of the local population' (Recommendation 6) but did highlight a number of issues relating to the operational difficulties which might arise and underline the need to ensure that safeguards were in place for existing providers.

One of the recommendations contained in the PDC Strategy was that 'A new NI wide GDS primary dental care contract framework be developed to provide the basis to Commission services to meet local need' (Recommendation 10). Responding this recommendation, the BDA stated:

Development of new contractual arrangements will require negotiation, shaping and a 'mission' for primary care dentistry to work within. When surveyed in January 2006, General Dental

Practitioners are clear that they wished to see a single contractual arrangement in place for dentists...BDA continues to have reservations about the knowledge and expertise of commissioning bodies to contract for dental services in a structure where local commissioning of dental services is new to all stakeholders. Experience from England in 2006 demonstrates that commissioners are tackling a range of unknown issues. In so doing, they are gambling with the ongoing dental health of the population and with the viability of existing practices...Piloting and evaluation of new ideas and concepts in working and using the workforce to best advantage will be essential to underpin the successful introduction of new arrangements. BDA calls for involvement in piloting, with clear evaluations of pilots before further development.[6]

General Dental Services Contracts

Clause 2 contains provisions which would enable a Health and Social Services Board to enter into a contract under which primary dental services are provided. It also contains provisions to 'Govern the terms and content of the new general dental services contract and who may provide or perform primary dental services under such a contract'. In addition is provides '...regulation making powers which will be used to set out the detail of the rights and obligations under the new contract and also to prescribe the ways in which persons performing primary dental services are to be listed'.

In relation to the development of new contractual arrangements, the Chief Dental Officer's winter update published in January 2007 noted that:[7]

The Department has now commenced negotiations with the BDA in order to develop new contractual arrangements and a series of meetings have been scheduled up to summer 2007 to progress the negotiations. It is important to stress that it is not the intention of either the Department or BDA to simply introduce the English contract. Northern Ireland has specific problems, such as our poor levels of oral health, which need to be addressed in any new contract. At this stage there is no specified date for introducing the new contract but it is hoped to be able to pilot the new arrangements across agreed sites in 2008. Following evaluation of these pilots, a new contract could be rolled out Northern Ireland, most likely some time in 2009. We feel that it is better to spend time now developing an acceptable contract for patients, the profession and government, rather than set tight deadlines which may not deliver the result we all need. In the interim, the Department will continue to look at ways of rewarding dentists for their commitment to the Health Service and ensure patients have access to health service dentistry.

Many dentists will want to know how the Northern Ireland contract will differ to the contract which was introduced in England and Wales in April 2006. While the negotiating team is not in a position to specify detail, there are some significant areas where we differ from England and Wales:

- The strategy allows us to define the range of treatments which will be available under the contract
- We are not compelled to use Units of Dental Activity (UDA's) as performance measures and the
- negotiating team will be looking at the various output measures available with a view to determining the most appropriate measure.
- There is a commitment to piloting the new contract before rolling out across the region in order
- that any problems may be addressed and allow dentists to be familiar with the operational aspects of the contract.

- There is a strong desire to factor prevention into the new arrangements
- There is a commitment to reward quality and not just output.
- There will be one body, the Health & Social Services Authority, dealing with implementing and administering the new contract across Northern Ireland.

Charges for Dental Services

Clause 4 sets out new arrangements to prescribe the way in which patient charges can be made and recovered for dental services and set out dental charging exemptions. Again, the need for change in relation to charges for dental services was highlighted in the PDC Strategy.

Up to now Northern Ireland has followed the rest of the UK in relation to policy on patient charges and currently charges are linked to the amount dentists are paid for providing individual items of treatment. The patient, unless exempt, pays 80% of the cost of treatment, up to a maximum of £384. There are currently more than 400 different items of service with associated charges and it has been viewed by patients, their representatives and others that the current system is bureaucratic, not easy to understand, and also often makes it difficult to distinguish between private and HS care.

The Strategy has proposed new arrangements under which contracts will exist between commissioners and GDS practitioners for the delivery of agreed services. Individual fees are likely to become obsolete and this means that the present patient charging system will no longer be appropriate.

A new system of patient charges based on three bands, related to the complexity of the treatment provided was introduced in England in April

2006. The new system is intended to be:

- Simpler, for both patients and dentists, moving from 400 individual charges to three price bands, reducing the maximum cost of NHS dental treatment and maintaining the existing exempt groups; and
- Clearer, so that patients know how much they are being charged and what treatment they will receive for their money on the NHS.

It is proposed to monitor the new patient charging system in England with a view to introducing similar arrangements in Northern Ireland when the new delivery system takes effect. (paras 8.1-8.4)

The PDC recommended, therefore that new patient charging arrangements in England should be monitored with a view to introducing a similar system in Northern Ireland. (Recommendation 17)

From 1 April 2006 new contractual arrangements for high street dentists were introduced in England. This involved a move away from the item of service remuneration to an annual payment which was no longer directly related to the dentists activity. The intention being that this would enable dentists to spend more time with their patients and adopt a more preventive approach to oral health care. Breaking the link between remuneration and items of treatment provided requires a new system of dental charging no longer based on the dentists' remuneration. Regulations, therefore, introduced a new system of charging for dental services based on a 3 banded system, where treatment provided or appliances supplied will attract one of the 3 set charges depending on the complexity of the treatment provided.[8] From April 2007, the charges for each band have been:

Band 1 – Diagnosis, treatment planning and maintenance £15.90
Band 2 – Treatment £43.60
Band 3 – Provision of appliances £194.00
Urgent treatment £15.90

In responses to consultation on the introduction of the new charging regime, the BDA noted that further public consultation would be required before it was introduced but also recognised that patients require more clarity with regard to charges levied for dental treatment.[9]

Clause 4 also sets out a number of groups of people and types of treatment for which there are exemptions from charges. In effect this means that the following groups are exempt from charges if at the time of treatment they are:

- under the age of 18;
- under the age of 19 and receiving qualifying full-time education;
- pregnant; or
- have given birth to a child within the previous 12 months.

In addition to these groups, no charge is to be made:

- in respect of the repair or replacement of any appliance;
- in respect of any appliance supplied to a patient for the time being resident in a hospital; and
- in respect of the arrest of bleeding.

Clauses 8-9
Ophthalmic Services

Clause 8 inserts a new Article[10] into the 1972 Order providing regulation making powers to prescribe the ways in which persons performing any general ophthalmic services are to be listed and the criteria an individual will have to meet in order to be listed. It also provides regulation making powers in respect of suspension from a list by a Board and for a practitioner's inclusion or continued inclusion on a list to be subject to conditions determined by a Board.

At present, Ophthalmic Medical Practitioners (OMPs), i.e. doctors who perform ophthalmic services, are permitted to be members only of Local Medical Committees. In order to rectify this anomaly, Clause 9 amends Article 55 of the HPSS Order 1972 to allow OMPs to be members of Local Optical Committees.

Clause 10
Pharmaceutical Services

Clause 10 inserts a new Article[11] into the 1972 Order making similar provisions for persons providing pharmaceutical services as Clause 8 does for ophthalmic services.

Clause 11
The Tribunal

Clause 11 relates to the Tribunal, which is the principle disciplinary body for FHSPs. It is an independent body comprising a Chair and deputy Chair appointed by the Lord Chief Justice, a member of the relevant profession and a lay member both appointed by the Department.

The Tribunal undertakes investigation of any case referred to it by a Board for the suspension or removal of a practitioner's name from a Board's list. The Tribunal may inquire into cases where:

- The continued inclusion of a FHSP on a list held by a NHS Board would prejudice the efficiency of the service to which the relevant list relates
- List applicants or those already on lists have committed or attempted to commit fraud against any publicly funded health service

Currently, however, the Tribunal has no power to inquire into cases of list applicants whose inclusion on a NHS Board list would prejudice the efficiency of the service to which the list relates. Where, following investigation, the Tribunal finds against a FHSP it can impose the following sanctions:

- Interim suspension from all lists in which the practitioners name is included
- Local disqualification – disqualification from the list on which the practitioner appears
- General disqualification – disqualification from all lists
- Conditional disqualification from lists - a disqualification which comes into effect only if the Tribunal determines the practitioner has failed to comply with any conditions imposed by it.
- Declaration of unfit to practice - Where a general disqualification has been made against a FSHP the Tribunal may additionally declare that a FHSP is unfit to practice in any capacity.

Clause 11 amends Schedule 11 of the Health and Personal Social Services (Northern Ireland) Order 1972 in a number of ways including:

- New Ground for Disqualification by the Tribunal

The Bill proposes to introduce an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely unsuitability by virtue of professional or personal conduct.

- Extending the Categories of Person Subject to Tribunal's Jurisdiction

The categories of person subject to the Tribunal's jurisdiction is extended to include all practitioners including those practitioners assisting with the provision of services and those practitioners wishing to join a Board's list.

- Removal of the Local Disqualification Sanction

The Bill will remove the sanction of local disqualification, thus if a practitioner is not fit to deliver services in one Board's area he or she should not be able to do so in another.

The Bill's proposals are similar to those enacted in the rest of the UK. Experience there has suggested that the proposals have been largely uncontroversial. Essentially they are updating an existing framework to ensure that necessary action can be taken to address any failings in the system, for example those identified by the case of Dr Harold Shipman, more effectively.

According to the Explanatory and Financial Memorandum to the Bill, referrals to the Tribunal are currently very rare and should only involve the most serious cases. The Department believes this will continue to be the case.[12]

Clauses 12-14
Other Amendments Relating to Health Services

In relation to England, the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004[13] provide for the making and recovery of charges in respect of certain services provided under the National Health Service Act 1977 to certain persons not ordinarily resident in the United Kingdom ("overseas visitors"). Regulation 7 enables the Secretary of State to make a determination in certain circumstances to exempt specified overseas visitors from charges for specified services for exceptional humanitarian reasons and regulation 6 exempts from charges for treatment, the need of which arose during the course of a visit, specified persons who accompany a person to whom an exemption for exceptional humanitarian reasons applies.[14]Clause 12 provides regulation making powers in relation to health service charges and exemption from charges for persons not ordinarily resident in Northern Ireland. This will, amongst other things, allow the Department to consider exemption from charges to overseas visitors on humanitarian grounds.

Legislation currently provides for the removal from any list maintained for the provision of General Medical Services or General Dental Services, the name of any person who has attained age 70. Clause 13 repeals Article 4 of the Health and Medicines (Northern Ireland) Order 1998 which empowered the Department to make regulations specifying the age at which general practitioners and dentists must retire from practice. The decision to so is a consequence of the EC Employment Framework Directive 2000/78/EC, (the Directive) which prohibited discrimination on grounds of age in the field of employment and vocational training from December 2006.

Clause 14 makes minor and consequential amendments to the Health and Personal Social Services (Northern Ireland) Order 1972

Clause 15
Smoking

Clause 15 provides for an exemption from Articles 4, 7, 8, and 9 of the Smoking (Northern Ireland) Order 2006[15] for the purpose of making provision for those participating as performers in a performance, or in a performance of a specified description, not to be prevented from smoking if the artistic integrity of the performance makes it appropriate for them to smoke. The reference to a performance may 'include, for example, the performance of a play, or a performance given in connection with the making of a film or television programme; and if the regulations so provide, include a rehearsal.

In England, similar provision for an exemption from the smoking ban is contained in Section 3 (Smoke-free premises exemptions) of the Health Act 2006.[16]

In Scotland, under the Smoking, Health and Social care (Scotland) Act 2005 enacted on 29 March 2006 (introducing a smoking ban in public places), there is currently no provision to permit smoking in theatres or other enclosed environments where theatrical performances are taking place. The Scottish Executive has taken the view that, while there may be some performances in which smoking is an essential element of the storyline, alternatives are available to allow the realistic portrayal of smoking.

The Health Act 2006 devolves powers to the National Assembly for Wales to make regulations for a ban on smoking in enclosed public places in Wales. The new law came into force on 2nd April 2007. Assembly Members voted in favour of the regulations on 30th January 2007 but decided not to include the exemption contained within the 2006 Act to permit performers in theatres (or similar artistic performances i.e. film or television production) to be excluded from the ban. Legislative provision for the application of the smoking ban in Wales is provided by The Smoke-free Premises etc. (Wales) Regulations 2007 Statutory Instrument.

Within the legislation (Public Health (Tobacco) Act, 2002 and the Public Health (Tobacco) (Amendment) Act 2004) underpinning the Republic of Ireland's ban on smoking in public places, which came into effect on 29th March 2004, there is no exemption which permits smoking in theatres or other enclosed public placed where a performance is occurring in connection with the making of a film or television programme.

Clauses 16-20
Supplementary

The following information on these supplementary clauses is contained in Explanatory and Financial Memorandum to the Bill. Clause 16 defines some of the terms used in the Bill. Clauses 17 and 18 contain supplementary provisions. Clauses 19 and 20 set out the arrangements for commencement of the provisions and the short title of the Bill.

Schedules

Schedule 1 makes a number of changes to Schedule 11 to the 1972 Order and these are considered above in relation to the Tribunal. Schedule 2 sets out the provisions that are repealed by the Bill.

Equality and Human Rights

The Explanatory Note and Financial Memorandum which accompanies the Bill states that 'the provisions of the Bill are compatible with the Convention on Human Rights. This note also states that the Department has conducted a Preliminary Equality Impact Assessment (PEQIA) on the proposals but that this did not identify any potential for adverse impact on any to the nine categories listed in Section 75 of the Northern Ireland Act 1998.[17]

[1] DHSSPS (2005) Further Measures to Improve the Provision of Primary Care Services. www.dhsspsni.gov.uk/primary-care-services3.pdf

[2] DHSSPS Further Measures to Improve Primary Care Services (2005) http://www.dhsspsni.gov.uk/primary-care-services3.pdf (June 2007)

[3] Mezey v South West London & St George's Mental Health NHS Trust [2007], EWHC 62

[4] Part 4 of Health and Social Care (Community Health and Standards) Act 2003 2003 Chapter 43 http://www.opsi.gov.uk/ACTS/acts2003/20030043.htm (June 2007)

[5] DHSSPS Primary Dental Care Strategy (2006) http://www.dhsspsni.gov.uk/dental_strategy_2006.pdf (June 2007)

[6] Response from BDA to Primary Dental Care Strategy Consultation by DHSSPS (2006) http://www.bda.org/about/docs/BDA%20Primary%20Dental%20Care%20Strategy%20NI.pdf (June 2007)

[7] http://www.dhsspsni.gov.uk/cdo-winter-2007.pdf

[8] The National Health Service (Dental Charges) Regulations 2005 2005 No. 3477 http://www.opsi.gov.uk/SI/si2005/20053477.htm (June 2007)

[9] Response from BDA to Primary Dental Care Strategy Consultation by DHSSPS (2006) http://www.bda.org/about/docs/BDA%20Primary%20Dental%20Care%20Strategy%20NI.pdf (June 2007) p14

[10] 62A

[11] 63AA

[12] Health (Miscellaneous Provisions) Bill Explanatory and Financial Memorandum http://archive.niassembly.gov.uk/legislation/primary/2007/niabill2_07_efm.htm Para 31

[13] Statutory Instrument 2004 No. 614 http://www.opsi.gov.uk/si/si2004/20040614.htm (June 2007)

[14] Explanatory Note Statutory Instrument 2004 No. 614 http://www.opsi.gov.uk/si/si2004/20040614.htm (June 2007)

[15] Statutory Instrument 2006 No. 2957 (N.I.20) The Smoking (Northern Ireland) Order 2006 http://www.opsi.gov.uk/si/si2006/20062957.htm

[16] Health Act 2006 (c. 28) http://www.opsi.gov.uk/acts/acts2006/ukpga_20060028_en.pdf

[17] http://www.opsi.gov.uk/acts/acts1998/80047--j.htm#75

Letter Dated 8 June to the Chairperson from The Northern Ireland Cancer Registry, Queen's University of Belfast

Health (Miscellaneous Provisions) Bill

Congratulations on your election. It is great to have local representation again. I understand that the Health Committee will, in the next week, debate the issue of smoking during art performances, as a possible opt-out of the legislation enacted under the Smoking NI Order 2006. I am writing to you as Director of the N. Ireland Cancer Registry where we collect details of all cancers diagnosed in Northern Ireland, several thousand of which related directly to tobacco with an increased hazard to workers exposed to environmental tobacco smoke. We have welcomed the Smoking NI 2006 Order as it protects workers from known carcinogens. In relation to smoking during performances, I wish to make the following points;

Actors and stage crew etc. are workers and this is their workplace, this legislation was enacted to protect workers and we must ensure equality of enforcement.

If smoking is an essential part of the plot there are suitable alternatives which are very realistic but which do not contain nicotine.

If real cigarettes are used for the final performance then it is very likely they will also be required during rehearsals and so the amount of exposure is larger than just during a performance.

There are many non smoking artists who may be forced to adopt the habit for the part they intend to play. Nicotine is a very addictive drug and unfortunately several performers have reported that as a result of playing a smoking role they have started to smoke with obvious health hazards.

I feel it is important that the Health Committee acts in the best interests of performers and continues to support the implementation of this legislation which has proved very popular among the population where 99% compliance has been reported.

Dr Anna Gavin

Director

8 June 2007

Letter Dated 12 June 2007 from the Roy Castle Lung Cancer Foundation

Health (Miscellaneous Provisions) Bill

I am writing to you to you to express the concern of the Roy Castle Lung Cancer Foundation following the first stage of the Health (Miscellaneous Provisions) Bill. We at the Foundation believe that this move provides a loophole in the Smoking (Order) 2006, and such a development would create public confusion and put lives at risk.

The smokefree workplace and public places legislation in Northern Ireland has been very effective and very popular. It has been widely accepted, with 99% compliance reported, and will save many lives. One of the reasons it has been a success is the consistency of its approach. People know what to expect when they go to work or out for a night.

It is, therefore, most disappointing to have this attempt to move backwards on such landmark public health legislation. Tobacco smoke contains four thousand chemicals including arsenic, ammonia, and cyanide. Second hand smoke is a class A carcinogen in the same category as asbestos. Non smokers exposed to second hand smoke have an 80% increased risk of stroke and a 30% increased risk of lung cancer and heart disease.

If this amendment is passed, it will mean stage hands, actors and audiences will be exposed to carcinogens and noxious fumes in a confined space. It will also lead to confusion among the public about where smoking is actually allowed.

The largest area of theatres in the world – Broadway, New York, is smokefree, yet this has not had any effect on audiences or performances. It is ridiculous to argue that smoking on stage is essential to the performance. An extension of that argument would be that actors should be allowed to shoot up heroin on stage if they are playing heroin addicts. Surely any competent actor can use props and their own acting skills to portray smoking.

It is important to note that such loopholes have not been allowed in Scotland, Wales or the Republic of Ireland. This issue was the subject of a local consultation in the Spring of 2007. We understand that 25 out of 29 responses were against any move to allow smoking on stage. The 2005 consultation received 71,000 replies with 92% calling for comprehensive legislation. Surely a local assembly will not introduce legislation which so blatantly ignores the strongly held views of local people and would damage the health of local employees and theatre goers.

The Roy Castle Lung Cancer Foundation strongly urge you to personally oppose this amendment and continue to work towards a totally smokefree Northern Ireland.

Mike Unger

Chief Executive

Letter Dated 21 June 2007 from The Northern Ireland Ambulance Service

Re: Health (Miscellaneous Provisions) Bill

21 June 2007

I write to thank you for your correspondence dated 20 June 2007 and would advise that the northern Ireland ambulance Service (NIAS) has no response to make to the above Bill.

Liam McIvor

Chief Executive

Briefing Paper Dated 18 June 2007 Received from The British Dental Association

Health (Miscellaneous Provisions) Bill

BDA issues for information to the Health, Social Services and Public Safety Committee 21 June 2007

Introduction

The British Dental Association (BDA) is the professional association for dentists in the UK. It represents over 20,000 dentists working in general practice, in community and hospital settings, in academia and research.

The BDA welcomes the opportunity to give evidence to the Northern Ireland Assembly Committee on Health, Social Services and Public Safety.

To assist Committee members in assimilating information on dentistry, further information is appended:

- The BDA Northern Ireland Election Manifesto for Dentistry
- The BDA Northern Ireland response to the DHSSPS Primary Dental Care Strategy document of December 2005
- The BDA Northern Ireland response to 'Further measures to improve the Provision of Primary Care Services'

BDA Northern Ireland continues to lobby politicians into giving recognition to the problems facing health service dentistry in Northern Ireland.

Northern Ireland requires recognition of the issues, development of policy and funding initiatives and implementation to bring about change.

Northern Ireland needs development of a properly resourced dental service, which provides high quality care and prevention, which meets the needs of patients and ultimately improves our appalling oral health.

Changes to the Powers of the Health Service Tribunal and Health and Social Services Boards

1. BDA recognises that changes to the powers and duties of the Health Services Tribunal are necessary.
   The introduction of an additional ground of 'unsuitability by reason of professional or personal conduct', under which the Tribunal may deal with a practitioner referral requires clarification.
2. There is a failure to recognise the role of the UK Regulatory Body for dentists, the General Dental Council on issues of dentists' fitness to practise.
3. At Section 2.8 there is a proposal to extend the categories of persons subject to the jurisdiction of the Tribunal. BDA also seeks clarification of whether this will extend to all dentists, dental hygienists, dental therapists and the four additional groups of dental care professionals of dental nurses, dental technicians, clinical dental technicians, and orthodontic therapists. The four additional groups of dental care professionals must be registered by 30 July 2008.
4. At Section 2.9 it is proposed that local suspension of a practitioner can be imposed, without a right of appeal, once a Board has decided there is a case to answer. In the draft Order, this is classed as a 'neutral act', which is not a disciplinary sanction.

Local suspension of a practitioner is a very serious matter and is clearly not a neutral act Therefore, BDA believes there should be a right of appeal and review mechanism attached to 'local suspension'.

5. Payment to suspended practitioners

The BDA is concerned by the length of time during which dentists may be suspended and the provisions which will be made for them and their patients and practices during this time. It is imperative that clarity is provided around the payments made to dentists under suspension.

Primary Dental Services

6. General dental services contracts: disputes and enforcement

61E makes provision for the resolution of disputes as to the terms of a proposed general dental services contract.

BDA Northern Ireland requests that there is full and proper consultation with BDA in agreeing the regulations so as to agree a meaningful disputes resolution process on contracts.

General dental services: transitional

7. For dentists who are already providing general dental services at the time when new contracting arrangements come into place, it is imperative that the new arrangements are not detrimental to existing providers. Funding dedicated to provision of dental services must be ring fenced and reserved for that purpose over the transitional period.

Proper consultation with BDA on the regulations will be required to ensure that there are proper safeguards in place with no detriment to existing practitioners.

8. At (4) the draft Bill proposes 'An order under this section may make provision for the resolution of disputes in relation to any contract entered into, or proposed to be entered into, under subsection (2) or (3), including provision for the determination of disputes by the Department or a person appointed by it.'
   The English model, where the Litigation Authority during the transitional period was able only to review whether primary care organisations had applied the rules, and not whether their application of the rules was reasonable, is unacceptable and severely undermined confidence in the new arrangements in England. BDA Northern Ireland suggest that there is professional involvement in disputes resolution. On a related point, if there is to be a 'test year' which determines practice funding, it is essential that there is adequate funding to ensure that dentists whose year was atypical are not disadvantaged.
9. At (7) the draft Bill proposes that 'An order made under this section shall be subject to negative resolution'

BDA believes that the implications of this Bill are far reaching and have a significant impact on future dental services provision. The Bill should therefore be subject to the affirmative resolution procedure, involving a full debate in the Assembly Chamber. There should also be consultation with the BDA on the regulations which arise from the Bill.

Financial implications

10. To secure dental services to the public, which meet current and future legislative and regulatory requirements and provide contractual arrangements with appropriate reimbursement mechanisms for dentists and dental practices, will require an investment framework. It is imperative that the Northern Ireland Assembly gives early recognition to the poor state of our dental health in Northern Ireland and the amount of investment which will be required to secure future dental services to the public.
    Additionally, the cost of change, of itself, requires resource allocation to ensure minimal disruption and no detriment to existing providers of dental services.

11. Smoking: exemption for performers

Smoking is detrimental to oral health and BDA Northern Ireland is therefore opposed to the amendments under this heading.

Point for inclusion

12. The England and Wales Health and Social Care Act 2001 and/or the Health and Social Care (Community Health and Standards) Act 2003 include measures to secure Dental Public health input. Dental Public Health input is necessary to secure a dental contract which meets the needs of the population of Northern Ireland and BDA requires clarification on the status of dental public health input with respect to this draft bill.

Additional Information

13. BDA Northern Ireland welcomes the acting Chief Dental Officer's statement of 24 May in Minutes of Evidence to the Health, Social Services and Public Safety Committee that the new dental contract in Northern Ireland will 'pay dentists for their time and insert appropriate performance measures'.

BDA seeks confirmation that the discredited English and Welsh Unit of Dental Activity will not be applied in Northern Ireland, and recognition that the mistakes of the new dental contract in England can be avoided for Northern Ireland through proper consultation and negotiation with the British Dental Association.

14. Piloting of new arrangements for dental contracting is essential. There must be a commitment on the part of DHSSPS to pilot and evaluate any new arrangements.
15. Health service dentistry is caught in a funding system that doesn't allow dentists to provide preventative based holistic care for patients. The Audit Commission described dentists working in the health services as working on a treadmill, where patients are conveyed through the surgery as fast as possible. Health Service Dentistry is focused on treatment, with no emphasis on prevention. Fees set by government are earned by dentists in respect of treatment; the dentist pays all of the expenses of the practice from these fees. Fees have not kept pace with the increased burden of practice expenses, the need to modernise and remain abreast of regulatory and legislative changes.

Hence the enforced move by dentists away from the health service.

Mistakes made in England and Wales:

- Timing of the regulations and lack of consultation made business preparations and planning for dental practices difficult if not impossible
- There was lack of clarity on the way the Unit of Dental Activity was calculated
- Lack of financing information for commissioners to take account of atypical practice years, to fund new practices and take account of patient charge revenue
- Inadequate safeguards to allow practices to change ownership
- Lack of advance information to commissioners on the contracting arrangements.
- Insufficient resource within the commissioning body to be able to take on this new commissioning role
- The system in England and Wales was not properly piloted
- Dentistry has both primary and secondary care elements. Changes in one area of service provision have an impact on the remaining aspects and this needs to be taken into consideration.

British Dental Association

Northern Ireland
18 June 2007

Briefing Paper Received from the Health and Social Services Council

Health (Miscellaneous Provisions) Bill

NHS Dentistry:
Health & Social Services Councils' Perspective

A joint Councils event on 23 May 2007 focused on NHS Dentistry in Northern Ireland. This paper highlights some of the issues raised together with suggested action to be agreed by the four Health and Social Services Councils.

Oral Health

Northern Ireland has the worst oral health in the UK and Ireland. Children here have up to three times the amount of dental disease in England.

While some measure have been put in place to improve our oral health the dental professions view is that fluoridation of the water supplies would produce the most benefit.

Water Fluoridation

A consultation on water fluoridation was rejected in 1995.

HSSCs are of the opinion that a public debate on this issue is now timely again.

GDS Contract

The General Dental Service contract has been in existence since 1948. A new contract was introduced in 1990. Negotiations are underway for a further new NI contract. It is unlikely to be introduced here before 2009 at the earliest. England and Wales introduced a new contract in 2006.

Access to an NHS Dentist

In the meantime an increasing number of dentists are closing their practice lists to NHS patients. The position is quite serious in some areas where at present patients can no longer register for NHS dentistry and the number of dental practices offering NHS Dentistry is reducing on a weekly basis. The options are to pay for private dental services or join an insurance scheme such as Denplan.

Boards are trying to resolve this immediate pressure by, for example, in some areas appointing 'salaried dental staff' to provide NHS dentistry at specific locations. In this example the issue of accessibility will remain.

HSSCs feel that progress in the new Northern Ireland Dental contract negotiations need to remain focused. The method of financial reimbursement for NHS dentistry appears to be a large factor in this. HSSCs are of the opinion that timescales need to be set and adhered to.

Location of Dental Practices

There appears to be little that the Department can do to influence dental practice location or structure (single handed or multi-practitioner). As a consequence the physical location of dental practices across Northern Ireland is governed by market forces. This results in areas of deprivation which can be without a locally based practice. Deprivation is also linked with high rates of dental disease in children.

HSSCs feel that the Department and Boards need a greater say in determining where NHS dental practices will be based.

Registration with a Dentist

The percentage of the population registering with a dentist is fairly static and currently stands at around 53%. Registration lapses if a person does not attend their dentist in a period of 15 months.

HSSCs are of the opinion that the public needs to be encouraged to register and attend regularly. However, the issue of getting access to an NHS dentist needs resolving first.

Private Dentistry

An increasing number of practices are opting only to provide private treatment. There is an obvious demand for such work particularly where it is largely cosmetic and outside NHS dentistry.

There is a need for clarity for the public on what can and cannot be provided on the NHS.

There is also a need to ensure that people are aware that private treatments are not regulated or monitored to the same extent as NHS dentistry.

It is also important that NHS dentistry is not promoted in any way as inferior or of poorer quality to encourage people to pay for private work.

The four Health and Social Services Councils would wish to raise these issues with the Minister.

Briefing Paper from the Department for Health, Social Services and Public Safety: Dated 17 May 2007

Draft Health (Miscellaneous Provisions) Bill

Background

1. The main purpose of the draft Bill is to introduce policy changes which will strengthen further the quality of primary care services in Northern Ireland.

2. The Bill has been left over from the Westminster Northern Ireland Order in Council programme. The main proposals are explained below:

(i) Patient Safety:

From time to time it is necessary to consider the suspension of a GP, dentist, pharmacist or optician because their practice may compromise the safety of patients. Under existing legislation, the procedures for this are extremely cumbersome. The proposed legislation will bring us broadly into line with the rest of the UK, following the Shipman Inquiry, by giving powers to local health authorities (Health and Social Services Boards) to suspend practitioners with immediate effect pending further investigations or to allow them to practise only under certain conditions. These

powers are deemed essential to ensure that the care of patients is not compromised by errant practitioners.

(ii) Dental Services

The legislation will introduce changes to the way dental services are organised. Under current arrangements in some areas it can be difficult to access health service dental care and also difficult to target resources at areas of greatest need. To alleviate these problems the proposed policy change is to allow local commissioning of dental services by Health and Social Services Boards either through contracts with individual practices or to directly employ dentists to provide dental services.

(iii) Smoking

The legislation also amends the Smoking (Northern Ireland) Order 2006 to make provision for those taking part in performances, so as to permit smoking by such performers if artistic integrity so requires. This amendment mirrors the English position regarding exemptions for theatrical performances where smoking is an integral part of the performance.

(iv) Other Issues

Within the spirit of the EC Directive regarding discrimination on grounds of age in the field of employment, the power to make regulations as to the retirement age of general practitioners and dentists would be repealed. The legislation also makes provision for exemption from health service charges for overseas visitors on exceptional humanitarian grounds. This exemption would be considered if an overseas visitor, who had been granted leave to enter Northern Ireland for a course of treatment, applied for exemption of charges.

3. A copy of the draft Bill and Explanatory and Financial Memorandum are attached as Annex 1 and Annex 2. The Explanatory and Financial Memorandum explains in detail the policy changes being introduced by the Bill. It also covers the financial effects of the Bill (which are de minimis) and the outcome of consultation on the proposals.

Michael McGimpsey

Minister of Health, Social Services and Public Safety

Pharmaceutical Society of Northern Ireland

22nd June 2007

Our Ref: RB/DP

Hugh Farren,
Committee Clerk
HSSPS Committee
Room 412
Parliament Buildings
BELFAST BT4 3XX

Dear Hugh,

Many thanks for the opportunity to respond to your query in relation to the Health (Miscellaneous Provisions) Bill. I must offer our apologies for the delay in our response to your initial query. The request was received during the preparation for the Society's Extraordinary General Meeting.

I note that the Society did respond to the initial consultation of 2005, and that within this response we highlighted a number of points for clarification.

The Pharmaceutical Society of Northern Ireland is the regulatory and professional representative body, established in legislation under the more recent Pharmacy (Northern Ireland) Order 1976.

We are the body responsible for maintaining the register of practising pharmacists and pharmacies operating throughout Northern Ireland. Each Pharmacist is bound by the regulations of the Society and the Professional Code of Ethics and Practise.

The Society is itself undergoing a period of accelerated change, primarily due to the recommendations contained within the White Paper – Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century. This paper will have a significant impact upon the future structures and work of the Society.

The Health (Miscellaneous Provisions) Bill, could appear to add a further degree of confusion to the regulation of Pharmacists in Northern Ireland.

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Whilst we would be supportive of any steps which will add further concentration upon improving patient safety, we would question the viability and whether this is the best approach to improving patient care.

There are legislative anomalies between Northern Ireland and Great Britain, which would pose a greater concern for the Society. The Pharmacy and Pharmacy Technicians Act, 2006, which has introduced a range of sanctions available to the Royal Pharmaceutical Society which we would wish to similar legislation introduced in Northern Ireland. We would wish to see our Continuing Professional Development process legislated, and an update to the 1976 Order which would enable the Society to review lay representation, our registers, and the structure and purpose of the Society and its governance.

We continue to work with the DHSSPSNI to have these legislative measures introduced as soon as is practicable, which would have a more direct impact upon improving patient safety and for the profession of Pharmacy than perhaps this Bill would do. I have attached as appendix 1, part of the work that the Society is continuing to address, and we would be grateful if these elements could be considered overall in relation to Pharmacy regulation.

The involvement and support of employers is essential in ensuring that standards are maintained and supported. The regulatory body however, must ultimately be the body responsible for the determination of these professional standards and whether the individual has been in breach and can deal with the matter efficiently.

The Bill would seem to be providing duplication to the registration function which is currently established for Pharmacists and Pharmacies, and would also seem to be recommending that a regulatory function would reside within the Board structure. We do not consider that this would be a sensible or appropriate measure as the Society exists to perform this function.

As an employer we would anticipate that the Boards would have disciplinary powers, but that they would not have regulatory or statutory powers over the Profession.

We would be willing to attend the Statutory Health Committee Hearing in order to offer whatever assistance we can to this process, and assure you of our best intentions at all stages to deliver the most appropriate regulatory framework to best serve patients within Northern Ireland.

Yours sincerely,

Raymond G A Blaney
Director

cc Raymond Anderson – President
Brendan Kerr – Registrar and Head of Professional Services

:urther Measures to Improve the Provision of Primary Care Services

The Pharmaceutical Society of Northern Ireland welcomes the opportunity to comment on this consultation document and apologies for the slightly late response, which was as a result of the timings of the Society's Committee and Council meetings.

The Society welcomes any changes, which protect patients, the wider public and professionals. This response makes comment primarily in respect of two major areas ie the changes to powers and duties of the Health Services Tribunal and the four Health and Social Services Boards and Local Pharmaceutical Services, including remote supervision.

The Society would be in general agreement with the proposals in respect of :-
Enhanced Criminal Record Disclosures
Retirement Age of General Medical and General Dental Practitioners
Local Representative Committees
Payment to Suspended Practitioners
Provision of Health Services to Persons Not Ordinarily Resident in Northern Ireland
Financial Implications
Equality Impact Assessment

In terms of changes to powers and duties of the Tribunal and Boards, it is reasonable that Boards' powers should be extended in relation to practitioners who are in contract with them and there would be general concurrence with the proposals.

However, in terms of pharmacists, it is difficult to envisage how this would work in practice to protect patients, the Board's local population and the individual concerned. Boards are in contract with those on the Pharmaceutical List and these contractors practically all have pharmacists employed by them. These proposed provisions would appear to allow the Board to suspend the contractor from the Pharmaceutical List held by the Board, but not have give any ability to suspend an employee or locum pharmacist. All pharmacists are required to be registered by the

armaceutical Society of Northern Ireland in order to work as a pharmacist or to carry on the business of a pharmacy from premises also registered by the Society. In order to suspend a pharmacist, other then a contractor who is on a Board List, this would then require suspension from the Pharmaceutical Register, which is outwith the Boards and the responsibility of the Society.

The Society therefore is of the view that this model may not provide the protection envisaged and these specific points in relation to pharmacists need to be taken into consideration.

In terms of Local Pharmaceutical Services, the Society welcomes any changes which bring pharmaceutical services closer to the local population in a way which most meets local need and allows pharmacist to use the skills and knowledge they have in respect of medicines and their management. The Society understands that there have been many local initiatives in Northern Ireland which could be considered as LPS and, where these have been successful, they have been rolled out across the Province.

The Society is concerned about the lack of clarity in the proposals in respect of LPS and how these services will integrate with the new community pharmacy contract, which is currently being negotiated. The Society is also unsure as to how LPS will be taken into account in new pharmacy applications and the other matters the proposed new regulations are to provide for.

In terms of remote provision of pharmaceutical services, there is again a lack of clarity as to what this means. Whilst flexibility in terms of patients' access to medicines is desirable, this must be balanced by the ability to provide clear, specific information to patients and their carers, which can be provided by a pharmacist and in most cases is best provided 'face to face'. The essential role of the pharmacist in medicines management in its widest sense must not be lost, otherwise patient and public safety cannot be ensured. Any arrangements put in place must be robust in the sense of not allowing remote access to medicines to promote abuse or misuse.

The Society hopes that these comments are helpful.

Briefing Paper from the British Medical Association

Health (Miscellaneous Provisions) Bill

Contents

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Summary

The BMA(NI) has examined the Health (Miscellaneous Provisions) Bill and wishes to state the following

1. The inclusion of all practitioners (general practitioners, dentists, opticians, pharmacists and ophthalmic and pharmaceutical bodies corporate) onto a single performer list in each HSS Board area is welcome.

2. The removal of the sanction of “local disqualification” from the Tribunal’s powers is welcome. The BMA(NI) agrees that if a practitioner is deemed unfit to be included in one HSS Board list, it would be inappropriate for them to be included in any other list

3. The extension of powers to a Health and Social Services Board to suspend a practitioner before referral to the Health Services Tribunal is very worrying. The statement that this suspension is a ‘neutral act’ is disputed by the BMA(NI) and recently in law[1] suspension as a ‘neutral act’ was found not to be case.

4. The BMA(NI) understands the argument for HSS Boards to have the power for local suspension on the grounds of patient protection, but there must not be an abuse of this power and must be clearly shown that when this power is used there was no other alternative. Alternatives such as the proposed power to place conditions on practitioners may be a way to avoid total breakdown of practitioner/patient trust, especially in small rural practices.

5. The extension of the ability of payment to suspended practitioners is welcome as a matter of course, however clarification is required on the framework for this process and to what extent it covers the costs of the suspended practitioner.

6. The introduction of an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely “unsuitability by reason of professional or personal conduct” is of concern to the BMA(NI). There is a complete lack of clarity on the definition of this additional ground for disqualification, in addition to fraud and prejudice to the efficiency of service. The BMA(NI) would like to closely examine this third ground with a view to how this would impinge upon investigations by professional regulatory bodies, such as the General Medical Council, into fitness to practice. Such bodies have clear definitions and sanctions for such conduct.

7. The repeal of the Article 4 of the Health and Medicines (NI) Order 1988 empowering the DHSSPS to specify the age at which general practitioners must retire is very welcome.

8. The amendment to the Smoking (NI) Order 2006 is wholly inappropriate and unacceptable. It should be scrapped as soon as possible.

9. The BMA(NI) is concerned that there is no recognition within the Bill, or explanatory notes, of the role of professional regulatory bodies such as the General Medical Council. The BMA continues to work closely with the GMC to create efficient, safe and fair disciplinary procedures for the profession and we would urge the Health Committee to seek assurances that any changes to Tribunal as a result of this Bill will be consistent and compatible with existing regulatory procedures

These are initial views and after further detailed analysis of the Bill the BMA(NI) will, if necessary, forward any supplementary evidence to the Health Committee for its consideration.

Introduction

The British Medical Association is the professional organisation and trade union for doctors in the UK. Across the UK more than three out of four practising doctors, and the majority of medical students, are members. The BMA office in Northern Ireland (BMA(NI)) is based in the Old Gasworks in Belfast and supports over 4,000 members from every branch of the medical profession in Northern Ireland.

The BMA is the voice of the medical profession - putting across to politicians, the public and the press the profession's collective views on a wide range of subjects including public health, medical ethics and the state of the NHS.

The BMA(NI) welcomes the opportunity to give evidence to the Assembly Health Committee on the Health (Miscellaneous Provisions) Bill.

Getting to The Health (Miscellaneous Provisions) Bill

The Health (Miscellaneous Provisions) Bill is mostly derived from the DHSSPS consultation "Further Measures to Improve the Provision of Primary Care Services"[2] which concluded late 2006. It also includes an amendment to the Smoke-free (Exemptions, Vehicles, Penalties and Discounted Amounts) Regulations (Northern Ireland) 2007[3] which concluded in early 2007. The bill is trying to reflect legislation currently in force in the rest of the United Kingdom.

Further Measures to Improve the Provision of Primary Care Services

The General Practitioners Committee of the BMA(NI) responded to the DHSSPS consultation "Further Measures to Improve the Provision of Primary Care Services". The response can be found in Appendix A.

(a) Most of the consultation was acceptable in the changes that were proposed.

(b) There were serious concerns about the Boards having the power to suspend practitioners from their own list before referral to the tribunal and as this power was normally reserved for the tribunal and it appears that Boards wish to be able to have more control over local suspension which includes powers to conditionally include or "contingently remove" practitioners from a list

(c) There were also concerns in respect of the enhanced criminal records disclosures which have created problems for GPs in England who have "soft intelligence" on unsubstantiated cases and which is being revealed to PCTs and PCOs on CRB checks. The BMA(NI) wanted to know what the implications were regarding this soft intelligence in Northern Ireland and whether this will preclude a GP from admission onto a Performers List.

Draft Smoke-Free (Exemptions, Vehicles, Penalties and Discounted Amounts) (Amendment) Regulations (NI) 2007

BMA(NI) Council responded to the consultation on the Draft Smoke-Free (Exemptions, Vehicles, Penalties and Discounted Amounts) (Amendment) Regulations (NI) 2007. The response can be found in Appendix B

(a) This draft amendment is to provide a personal exemption for anyone taking part in a performance where the artistic integrity of the performance requires them to smoke

(b) In its response, the BMA(NI) strongly objected to the amendment and stated that artistic integrity was not a valid argument to allow smoking when the whole basis of the Smoking (NI) Order 2006 was to protect public health from the dangers of passive smoking.

Background to The Health (Miscellaneous Provisions) Bill

Primary Medical Services Performers Lists

Each Health and Social Services (HSS) Board (Northern, Southern, Eastern and Western) maintains a number of performer lists. These lists contain information on providers of primary medical services allowed to work in the HSS Board area.

A General Practitioner (GP) must register on the appropriate HSS Board list in order to be able to provide primary care services. A GP can not provide primary medical services unless they are on the list of the HSS Board in whose area the GP wishes to perform those services. This also means a GP may be registered with more than one HSS Board if they work in more than one area, for instance a Non-Principal GP, or Locum, could obtain work in all of the HSS Board areas.

For an HSS Board to register a GP on its list criteria for suitability is applied in accordance with the Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (NI) 2004.[4]The DHSSPS sent a circular explaining the 2004 Order to the Chief Executive of each Health and Social Services Board, the Chief Executive of the Central Services Agency, GMS Contractor Practices and the Chief Executive of each HSS Trust.[5]

At the moment there are four general practitioner performers lists, one for each HSS Board. This is in addition to performers lists the HSS Board must maintain for general dental services, general ophthalmic services and pharmaceutical services.

The Tribunal and the HSS Boards Functions

The HSS Boards have an obligation to commission general medical services, maintain lists, as discussed under 'Primary Medical Services Performers Lists', and to protect patients from underperforming practitioners.

Boards have no powers to suspend practitioners and must apply to the Tribunal to carry out this action. Boards can refuse a practitioner entry to its list or remove him or her from its list on certain mandatory grounds, for example, where the practitioner's name is not included in the register of his or her professional body or the practitioner is subject to general disqualification by the Tribunal.

The Tribunal is constituted under the Health and Personal Social Services (Northern Ireland) Order 1972 and consists of a chair, appointed by the Lord Chief Justice, a deputy chair, 2 lay members, and 8 professional members. Its remit is to inquire into cases where representations are made by a HSS Board or other persons on the continued inclusion of persons on a performers list. The Tribunal has only met on 2 occasions since 1978.

The Tribunal undertakes independent investigation of any case referred to it by a Board for the suspension or removal of a practitioner's name from a Board's list. Removal from a Board's list is the ultimate sanction as it effectively prevents practitioners from providing family health services. The Tribunal may inquire into cases where the continued inclusion of a practitioner on a list held by a Board would prejudice the efficiency of the service to which the relevant list relates (does not apply to those practitioners applying to join a list); or those practitioners applying to join a list or those already on lists have committed or attempted to commit fraud against any publicly funded health and social service.

The following sanctions are available to the Tribunal:-

- interim suspension from all lists in which the practitioners name is included;
- disqualification from the list on which the practitioner appears (known as 'local disqualification');

- disqualification from all lists (known as 'general disqualification' which is the same as national disqualification in England, Wales and Scotland) ;
- a declaration of unfitness to practice in any capacity (may only be considered when a general disqualification has been made);
- conditional disqualification from lists, i.e. a disqualification which comes into effect only if the Tribunal determines the practitioner has failed to comply with any conditions imposed by it.

The Smoking Ban

The Smoking (Northern Ireland) Order 2006 came into effect on Monday 30 April 2007.

This legislation was introduced to protect workers and the public from the risks of passive smoking and will be enforced by environmental health officers from local councils

Unless there is an exemption it is against the law to smoke in most 'enclosed' and 'substantially enclosed' workplaces and public places, including work vehicles and public transport.

The law requires those responsible for smoke-free premises and/or vehicles to prevent or stop a person smoking there and are required to display no-smoking signs so that they are clearly visible to all employees, customers and visitors.

Failure to comply with the requirement to display no-smoking signage may result in the issue of a £200 fixed penalty notice or lead to a prosecution, for which the maximum penalty on summary conviction will be £1,000.

Individuals may receive a £50 fixed penalty notice if they smoke in smoke-free premises or smoke-free vehicles. The maximum penalty on summary conviction will be £1,000. Those responsible for smoke-free premises and/or vehicles who fail to prevent or stop someone smoking in the smoke-free areas may be prosecuted for which the maximum penalty on summary conviction will be £2,500.

There is also the offence of obstructing an authorised officer of a local council for which the maximum penalty on summary conviction will be £1,000.

The Smoking (NI) Order 2006 has a number of regulations attached to it in order to implement the ban, and these are the

- Smoke-free (Exemptions, Vehicles, Penalties and Discounted Amounts) Regulations (Northern Ireland) 2007
- Smoke-Free (Signs) Regulations (Northern Ireland) 2007
- Smoke-free (Premises, Vehicle Operators and Penalty Notices) Regulations (Northern Ireland) 2007
- Smoking (2006 Order) (Commencement) Order (Northern Ireland) 2007

The Department for Health, Social Services and Public Safety produced a consultation on the Draft Smoke-Free (Exemptions, Vehicles, Penalties, and Discounted Amounts) (Amendment) Regulations (NI) 2007 which started 17th January 2007 ended on 28 February 2007.

The amendment proposed in the consultation proposed to make provision for those participating as performers in a performance to be allowed to smoke if the artistic integrity of the performance makes it appropriate for them to smoke.

The Health (Miscellaneous Provisions) Bill Proposals

The Health (Miscellaneous Provisions) Bill is an attempt to replicate measures that have been introduced in Scotland by means of the Smoking, Health and Social Care (Scotland) Act 2005 and in England and Wales through the Health and Social Care Act 2001 and the Health and Social Care (Community Health and Standards) Act 2003. To replicate provisions contained in the Health Act 2006 the Bill also amends the Smoking (Northern Ireland) Order 2006 to provide that premises may not be smoke-free in relation only to performers, if the artistic integrity of the performance makes it appropriate for them to smoke.

The Bill proposes changes to allow local commissioning of dental services by Health and Social Services Boards.

The Bill will introduce an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely "unsuitability by reason of professional or personal conduct". It will also extend the categories of person subject to the Tribunal's jurisdiction to include all practitioners including those practitioners assisting with the provision of services and those practitioners wishing to join a Board's list. At present the Tribunal may direct that a practitioner's name should be removed from the list of a Board (local disqualification) or should be excluded from all Board Lists (general disqualification). The Bill will remove the sanction of local disqualification, thus if a practitioner is not fit to deliver services in one Board's area he or she should not be able to do so in another.

The powers of the four Health and Social Services Boards will be extended. Currently where it is necessary to protect patients, a Board can refer a case to the Tribunal to suspend a practitioner, while the full case is considered. The Bill introduces the provision for regulations to allow suspension of a listed practitioner directly by a Board. Suspension could take place pending, for instance, referral to the Tribunal or the outcome of a court case or a hearing by a professional regulatory or licensing body. The Bill also extends the powers of the Boards to allow payment to suspended practitioners.

The Bill will introduce the power for regulations to provide and set out the criteria for refusal or removal of a practitioner from a Board's list. It will also insert provisions to provide for a Board to admit or retain a practitioner on its lists as long as he or she agrees to be bound by specific conditions and extends the existing list system to embrace all practitioners including locums, deputies and employees.

The Bill also amends the Smoking (Northern Ireland) Order 2006 to make provision for those taking part in performances, (for example on stage or in the making of a film or a TV programme), so as to permit smoking by such performers if artistic integrity so requires.

BMA(NI) Response to The Bill

In response to the Health (Miscellaneous Provisions) Bill the BMA(NI) is happy with a number of changes as proposed and would commend them to the Health Committee. These are,

1. The inclusion of all practitioners (general practitioners, dentists, opticians, pharmacists and ophthalmic and pharmaceutical bodies corporate) onto a single performer list in each HSS Board.

This makes practical sense and will make it easier for the eventual amalgamation of all the HS Boards into the new Health and Social Care Authority.

2. The removal of the sanction of "local disqualification" from the Tribunal's powers.

The BMA(NI) agrees that if a practitioner is deemed unfit to be included in one HSS Board list, it would be inappropriate for them to be included in any other list.

3. The repeal of the Article 4 of the Health and Medicines (NI) Order 1988.

This article empowers the Department of Health Social Services and Public Safety to specify the age at which general practitioners must retire. The current age that GPs must retire is 70 and to reflect European legislation on age discrimination it is right this power should be repealed.

Other parts of the Bill raise a number of concerns and require closer examination on the effects they will have. These areas of concern are,

1. The extension of powers to a Health and Social Services Board to suspend a practitioner before referral to the Health Services Tribunal.

Suspension is a rare occurrence and there are many safeguards in place to ensure patient safety is maintained. In employment law, suspension pending investigation of an allegation is normally viewed as a 'neutral act'. This is where the allegation is very serious and, in the interests of all parties, the person under investigation is temporarily suspended or excluded from their employment with pay and benefits but is not deemed guilty or innocent until judgement.

The problem with an HSS Board having this power is that it would not have to put the allegations before the Tribunal to suspend but can do it before the Tribunal sees the evidence of the allegation. There would need to be a negotiated guidance framework on how this would work.

The BMA(NI) is very concerned about patient safety and recognises the need to give patients confidence that the service they are receiving is of the utmost standard and delivered by general practitioners working to a consistently high standard.

The BMA(NI) is also very concerned about the possible impact a suspension would have on a general practitioner before the Tribunal is able to make a full investigation of the issue. The BMA(NI) would also contend that the statement that suspension is a 'neutral act' is incorrect and that in the recent case of Mezey v South West London and St George's Mental Health NHS Trust[6] (also see Appendix C) the judgment by Lord Justice Sedley was that, in relation to the employment of a qualified professional in a function which is as much a vocation as a job,

"Suspension changes the status quo from work to no work, and it inevitably casts a shadow over the employee's competence. Of course this does not mean that it cannot be done, but it is not a neutral act."

The BMA(NI) is mindful of the power of the HSS Board to be able to impose specific restrictions on a practitioner if they are to be retained on a performer list. This alternative of placing conditions on practitioners may be a way to avoid total breakdown of practitioner/patient trust. This may also be of some help in rural areas where there are many single handed GP practices. The process for this would need to be negotiated to create a guidance framework on how this would work.

2. The extension of powers to HSS Boards to allow payment to suspended practitioners

The extension of the ability of payment to suspended practitioners is welcome as a matter of course, however clarification is required on the framework for this process and to what extent it covers the costs of the suspended practitioner.

The impact of the redistribution of service provision to other partners in a GP practice to cover for the suspended GP, or the costs of a locum to replace the suspended GP for the duration of suspension requires a closer examination so that any suspension does not penalise the practice or adversely impact on the provision of primary health care services to patients

3. The introduction of an additional ground under which the Tribunal may deal with a practitioner who has been referred to it, namely "unsuitability by reason of professional or personal conduct".

There is a complete lack of clarity on the definition of this additional ground for disqualification, in addition to fraud and prejudice to the efficiency of service.

The BMA(NI) would like to closely examine this third ground with a view as to how this would impinge upon investigations by professional regulatory bodies, such as the General Medical Council, into fitness to practice as defined in the Medical Act 1983. Such bodies have clear definitions and sanctions for such conduct.

More detail on how this power differs significantly from the issue of fitness to practice would be required.

4. The amendment of the Smoking (NI) Order 2006 to permit those participating as performers in a performance to be allowed to smoke if the artistic integrity of the performance makes it appropriate.

The BMA, along with many other organisations, campaigned successfully to have the smoking ban introduced. The BMA(NI) sees this cosmetic change as an attempt to dilute the public health principles of the smoking ban.

Passive smoking has been proved to kill and therefore this amendment should be scrapped immediately.

The BMA(NI) is also concerned that there is no recognition within the Bill, or explanatory notes, of the role of professional regulatory bodies such as the General Medical Council. The BMA continues to work closely with the GMC to create efficient, safe and fair disciplinary procedures for the profession and we would urge the Health Committee to seek assurances that any changes to Tribunal as a result of this Bill will be consistent and compatible with existing regulatory procedure.

Appendix A

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Mr R Kirkwood
Department of Health, Social Services & Public Safety

Primary Care Directorate
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Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ

Our Ref: NIGPC/BD/zc 3 November 2005
Your Ref: BP 1029/03

Dear Mr Kirkwood

CONSULTATION "Further Measures to Improve the Provision of Primary Care Services"

NIGPC has reviewed the above consultation and would like to make the following response.

The GPC lawyer has commented on the fact that the Boards extension of powers will allow them under paragraph 2.9 to suspend practitioners from their own list before referral to the tribunal.

NIGPC has serious concerns about this as this power was normally reserved for the tribunal and it appears that Boards wish to be able to have more control over local suspension which includes powers to conditionally include or "contingently remove" practitioners from a list.

NIGPC has also concerns in respect of the enhanced criminal records disclosures which we understand are creating problems for GPs in England who have "soft intelligence" on unsubstantiated cases and which is being revealed to PCTs and PCOs on CRB checks. We would need to know what the implications are regarding this soft intelligence in Northern Ireland and whether this will preclude a GP from admission onto a Performers List.

NIGPC has no other comments to make on the other proposed changes which appear to be acceptable.

Yours sincerely

DR BRIAN DUNN

Chairman

NI General Practitioners Committee

Appendix B

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Ms Melissa Maguire
Investing for Health Team (Tobacco Control)
DHSSPS
Room C4.22
Castle Buildings
Stormont

BELFAST
BT4 3SQ

Our Ref: 070228/SMO/01 28 February 2007

Dear Ms Maguire,

Draft Smoke-Free (Exemptions, Vehicles, Penalties and Discounted Amounts) (Amendment) Regulations (NI) 2007

Thank you for the opportunity to respond to the above consultation.

This latest consultation proposes an amendment to the principal smoke-free public enclosed places regulations for the sole purpose of ensuring the artistic integrity of a performance.

The British Medical Association, Northern Ireland (BMA(NI)) strongly objects to the inclusion of this amendment and is disappointed that such a proposal should be consulted upon at such a late stage.

Artistic integrity is not a valid argument to allow smoking when the whole basis of the legislation is to protect public health from the dangers of passive smoking.

If you require any further clarification on this response do not hesitate to contact the BMA(NI) office at your earliest convenience.

Yours sincerely,

Dr Brian Patterson

Chairman, Northern Ireland Council

Appendix C

Case No: A2/2007/0062

Neutral Citation Number: [2007] EWCA Civ 106
IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM QUEEN'S BENCH DIVISION
(MR JUSTICE UNDERHILL)

Royal Courts of Justice
Strand, London, WC2A 2LL
Date: Thursday, 8th February 2007

Before:

LORD JUSTICE SEDLEY
LORD JUSTICE DYSON

and
SIR PETER GIBSON

Between:

MEZEY
(Claimant / Respondent)

- and -

SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST
(Defendant / Appellant)

(DAR Transcript of
WordWave International Limited
A Merrill Communications Company
190 Fleet Street, London EC4A 2AG
Tel No: 020 7404 1400 Fax No: 020 7831 8838
Official Shorthand Writers to the Court)

MR M SUPPERSTONE QC AND MS L MILLIN

(Instructed by Messrs Capsticks) appeared on behalf of the Appellant.

MR J HENDY QC

(instructed by Messrs Radcliffes le Brasseur) appeared on behalf of the Respondent.

Judgment
Lord Justice Sedley:

1. The claimant is a consultant psychiatrist, one of whose patients, a paranoid schizophrenic, killed another man in circumstances which led to a series of internal inquiries into the incidents on the part of the defendant Trust, which is either her employer or, it matters not at present, one of her two employers. Following the third of these reports, a decision was taken by the defendant to initiate disciplinary proceedings against her and meanwhile to suspend her from clinical work, but not from either the library or her office or, provided she came there for good reason and on informal notice, the Trust premises generally. The disciplinary hearing will probably take place early this summer.

2. A much fuller account can be found in the judgment of Underhill J [2006] EWHC 3473 (QB) and [2007] EWHC 62 (QB). Its accuracy is disputed in one respect by Mr Supperstone QC for the Trust, but the dispute does not require resolution at this juncture. Nor on the other hand is it disputed that the Trust has a contractual power of suspension.

3. The claimant, however, on advice disputes the contractual lawfulness of her suspension; hence these proceedings, for which a speedy trial has been set in the week beginning 19 February. But on 20 December 2006, Underhill J, following full argument, granted an injunction restraining the Trust, pending the trial, from implementing the suspension in so far as it affected the claimant's non-clinical duties. It was so limited because the claimant agreed that it was appropriate for her to abstain pending the hearing from the diagnosis and treatment of individual patients. The Trust, for its part was and (as I understand it) remains willing for her to continue to use her office and the library. This has left in dispute whether the claimant might also continue to attend audit and case conferences and to organise the academic programme.

4. Underhill J was not asked directly to adjudicate on the detail of this. He was asked to hold, and he did hold, that it was cogently arguable that the contractual power of suspension had not been validly exercised in the first place, so that the preservation of the status quo became the resumption of the claimant's employment, subject only to her own voluntary undertaking not to resume direct clinical work.

5. Having made his order, which is a matter of record and which I will not read out, the judge refused the Trust permission to appeal. What he also did, however, was stay the operation of his injunction upon the Trust's undertaking expeditiously to renew its application before this court. Given that full trial of the action is to take place less than two weeks from now, I venture to doubt whether but for its undertaking to proceed in this way, the Trust would have considered it an apt use of resources to seek to appeal rather than proceed directly to the trial which is imminent. But for better or for worse the application is now before us.

6. Mr Supperstone puts it on two alternative bases. First, that it is wrong in legal principle for a court, at least pending trial, to restrain a suspension as opposed to a dismissal. Secondly, that if the judge had such power, his exercise of it was so faulty as to justify the intervention of this court. It is convenient to follow Mr Supperstone's course this morning and to deal with the second limb first.

7. It seems to me that the judge's decision to grant an injunction, assuming for the present that he had the power to make it, was properly and tenably reasoned. I do not propose to explain in detail why: a reading of it will show what the judge took into account and how he weighed up the legal arguments and factual evidence before reaching his conclusion. Under this head, however, the amended grounds of appeal take issue with the judge's provisional appraisal of the content of the parties' contractual relationship.

8. This is a judgment, especially when made by a judge with extensive knowledge and experience of employment law, which the court will interfere with only if it is clearly unsound. Mr Supperstone contends that it is, but for the reasons spelt out by the judge at paragraphs 12 to 18 of his judgment I do not think that this can be viably asserted. It is at trial later this month that a fresh look will be taken at the contractual material and a final decision be reached as to what the contract included. For present purposes I consider that the judge's appraisal of what the contract arguably contained is entirely tenable.

9. Having so decided, the judge found it arguable that the Trust had failed to apply the contract properly, not in relation to clinical work, from which the claimant had voluntarily withdrawn, but in relation to the entirety of her non-clinical activity. He did so avowedly against the background of a long period since the initial disaster, including two previous inquiries during which

suspension had not been deemed necessary, but decided simply upon the footing that this had given the claimant two years' grace during which she had not done anything further to call her own clinical competence in question.

10. It seems to me that if the judge had power to grant an injunction, his decision to do so, and the terms in which following further argument he eventually did so, are not vulnerable to challenge in this court. Did he then have power to grant an interlocutory injunction restraining a suspension from employment?

11. Mr Supperstone accepts that it is perfectly permissible to restrain a dismissal, but he contends that a suspension is a qualitatively different affair. It is, he submits in the skeleton argument:

"a neutral act preserving the employment relationship".

12. I venture to disagree, at least in relation to the employment of a qualified professional in a function which is as much a vocation as a job. Suspension changes the status quo from work to no work, and it inevitably casts a shadow over the employee's competence. Of course this does not mean that it cannot be done, but it is not a neutral act. Indeed, Mr Supperstone goes on in his skeleton argument to justify the suspension on the grounds that the criticisms of the claimant in the most recent report were serious and that she had -- I use his word -- "failed" to accept the criticism of her in the two previous reports.

13. The justification of all this awaits the judgment of the disciplinary tribunal, but it seems to me inescapable that the Trust's decision to suspend the claimant meanwhile was not and could not be expected to be a neutral act. Like the court in its turn, the Trust was trying to do the best thing for the time being, but in the judge's considered view it had arguably mistaken its legal powers in so doing.

14. Mr Supperstone has sought to distinguish a stay of suspension as not having the same purpose as a stay of dismissal, namely to preserve the contractual relationship. He says that here there is a breakdown of trust and confidence, not at base but pending the disciplinary inquiry and affecting, meanwhile, the claimant's clinical judgment. This, he submits, no injunction can repair or should purport to repair.

15. It might be thought that the preservation of employment pending suspension is a less drastic step than the preservation of employment against a threat of dismissal. The latter used to be regarded as an insuperable barrier to an injunction (see Ali v Southwark [1988] ICR 567(582)), but the courts in recent years have recognised that it is sometimes an artificial one. The same, it seems to me, is true of the present suspension.

16. A reading of the documentation makes it clear that the Trust has sought throughout to act responsibly, not precipitately, and to confide the decision on the claimant's competence to an independent tribunal. It shows that the claimant for her part has tried to meet the Trust halfway by agreeing not to undertake direct clinical work, leaving only the disputed areas that I have mentioned. Indeed, it seems a great pity that the relationship has had to be litigated at all.

17. I cannot accept Mr Supperstone's reliance on the residual or secondary clinical duties, which are all that stand between the parties, as capable of establishing a relationship of trust so damaged that no injunction should have been granted. This aspect of the case, it seems to me, goes simply to the content of the judge's order, something which is not the subject of the present application. Nor am I able to accept that, absent a threatened repudiation by dismissal, there is nothing in law on which the court's power of restraint can bite.

18. There seems to me to be no reason of principle why the court should be without power, if in all the other circumstances it judges it right to do so, to stay a suspension just as it may stay a dismissal. Each is capable of being a breach of contract, the one no doubt more fundamental than the other, and each is capable of not being fully compensable in damages.

19. I would therefore for my part refuse this application for permission to appeal. The effect of the refusal, if my Lords agree, will be that the judge's order now takes effect, but only pending the trial which will take place later this month. It is limited by the claimant's undertaking "not directly or personally to assess, treat or care for patients" but not otherwise.

20. LORD JUSTICE DYSON: I agree.

21. SIR PETER GIBSON: I also agree.

Order: Application refused.

Mezey v South West London and St George's Mental Health NHS Trust [2007] EWCA Civ 106 (08 February 2007) URL: http://www.bailii.org/ew/cases/EWCA/Civ/2007/106.html Cite as: [2007] EWCA Civ 106

[1] Mezey v South West London and St George's Mental Health NHS Trust [2007] EWCA Civ 106

[2] DHSSPS, Further Measures to Improve the Provision of Primary Care Services, 2006. This can be accessed at http://www.dhsspsni.gov.uk/primary-care-services3.pdf

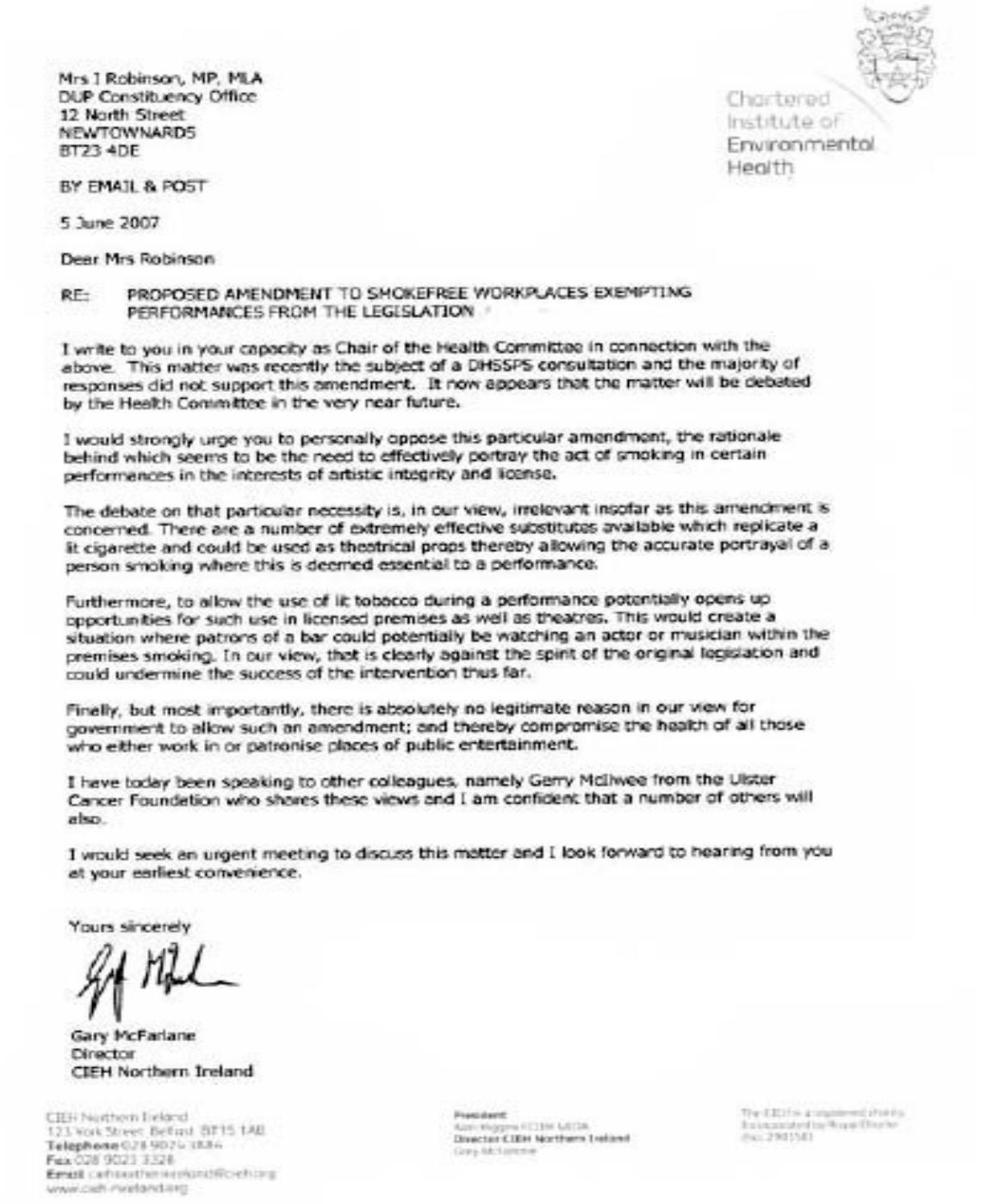
[3] DHSSPS, Draft Smoke-Free (Exemptions, Vehicles, Penalties, and Discounted Amounts) (Amendment) Regulations (NI) 2007, 2007. this can be accessed at http://www.dhsspsni.gov.uk/showconsultations?txtid=21869

[4] Statutory Rule 2004 No. 149, The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004, OPSI, 2004. The legislation can be accessed at http://www.opsi.gov.uk/sr/sr2004/20040149.htm

[5] Dr Jim Livingstone, Director of Primary Care, CIRCULAR NO. HSS(PCD) 7/2004, Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (NI) 2004 (S.R. 2004 NO. 149), DHSSPS, 02 JUNE 2004.
The Circular can be accessed at http://www.dhsspsni.gov.uk/publications/2004/hsspcd7-2004.pdf

[6] Mezey v South West London and St George's Mental Health NHS Trust [2007] EWCA Civ 106

Correspondence from
Chartered Institute of Environmental Health



Mrs I Robinson, MP, MLA
DUP Constituency Office
12 North Street
NEWTOWNARDS
BT23 4DE

Chartered Institute of Environmental Health

BY EMAIL & POST

5 June 2007

Dear Mrs Robinson

RE: PROPOSED AMENDMENT TO SMOKEFREE WORKPLACES EXEMPTING PERFORMANCES FROM THE LEGISLATION

I write to you in your capacity as Chair of the Health Committee in connection with the above. This matter was recently the subject of a DHSSPS consultation and the majority of responses did not support this amendment. It now appears that the matter will be debated by the Health Committee in the very near future.

I would strongly urge you to personally oppose this particular amendment, the rationale behind which seems to be the need to effectively portray the act of smoking in certain performances in the interests of artistic integrity and license.

The debate on that particular necessity is, in our view, irrelevant insofar as this amendment is concerned. There are a number of extremely effective substitutes available which replicate a lit cigarette and could be used as theatrical props thereby allowing the accurate portrayal of a person smoking where this is deemed essential to a performance.

Furthermore, to allow the use of lit tobacco during a performance potentially opens up opportunities for such use in licensed premises as well as theatres. This would create a situation where patrons of a bar could potentially be watching an actor or musician within the premises smoking. In our view, that is clearly against the spirit of the original legislation and could undermine the success of the intervention thus far.

Finally, but most importantly, there is absolutely no legitimate reason in our view for government to allow such an amendment; and thereby compromise the health of all those who either work in or patronise places of public entertainment.

I have today been speaking to other colleagues, namely Gerry McIlwee from the Ulster Cancer Foundation who shares these views and I am confident that a number of others will also.

I would seek an urgent meeting to discuss this matter and I look forward to hearing from you at your earliest convenience.

Yours sincerely

Gary McFarlane
Director
CIEH Northern Ireland

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President
Director CIEH Northern Ireland

The CIEH is a registered charity

Appendix 5

List of Witnesses

List of Witnesses who Gave Evidence to the Committee

Mr John Farrell Department of Health, Social Services and Public Safety
Ms Christine Jendoubi Department of Health, Social Services and Public Safety
Mr Robert Kirkwood Department of Health, Social Services and Public Safety

Mr Bryan Bailie Department of Health, Social Services and Public Safety
Mr Donncha O'Carolan Department of Health, Social Services and Public Safety

Mr Brian Best British Medical Association Northern Ireland
Dr Brian Dunn British Medical Association Northern Ireland
Dr Brian Patterson British Medical Association Northern Ireland
Mr Ivor Whitten British Medical Association Northern Ireland

Ms Claudette Christie British Dental Association Northern Ireland
Mr Seamus Killough British Dental Association Northern Ireland

Mr Raymond Anderson Pharmaceutical Society of Northern Ireland
Mr Raymond Blaney Pharmaceutical Society of Northern Ireland
Dr Kate McClelland Pharmaceutical Society of Northern Ireland

Ms Stella Cunningham Southern Health and Social Services Council

Ms Maggie Reilly Western Health and Social Services Council

Mr John Botteley Theatrical Management Association

Mr Nick Livingston Arts Council of Northern Ireland

Dr Brian Gaffney Smokefree Northern Ireland Coalition
Mr Gerry McElwee Smokefree Northern Ireland Coalition
Mr Seán Martin Smokefree Northern Ireland Coalition