

# **HEALTH AND PERSONAL SOCIAL SERVICES ACT (NORTHERN IRELAND) 2001**

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## **EXPLANATORY NOTES**

### **INTRODUCTION**

1. These Explanatory Notes relate to the Health and Personal Social Services Act (Northern Ireland) 2001 (“the Act”). They have been prepared by the Department of Health, Social Services and Public Safety in order to assist the reader in understanding the Act. They do not form part of the Act and have not been endorsed by the Assembly.
2. The notes need to be read in conjunction with the Act. They are not, and are not meant to be, a comprehensive description of the Act. So where a section or part of a section does not seem to require any explanation or comment, none is given.

### **BACKGROUND AND POLICY OBJECTIVES**

3. The Act covers four broad areas. First, it will introduce a body to regulate the social work profession, and other social care workers, in line with the introduction of similar bodies in Great Britain. The outcome of a consultation exercise indicated widespread recognition of the need to introduce a greater degree of regulation of the social care workforce, in order to maintain educational and training standards, standards of conduct and practice, and professional competence.
4. Secondly, the Act will introduce new arrangements to simplify the system for recovery from insurance companies of health services costs of treating road traffic casualties. The existing arrangements for such recovery have proved difficult to administer and have not resulted in an accurate recovery of costs.
5. Thirdly, the Act contains a wide range of amendments to the law on the Health and Personal Social Services. These changes include the repeal of the law relating

to General Practitioner Fund-holding, changes in administration arrangements for family health services, compulsory indemnity cover for family health services practitioners and changes in the arrangements for the remuneration and representation of such practitioners. Provisions on the establishment of HSS Trusts are included, and changes in the administration and financial arrangements of those Trusts. The Act contains measures to reduce evasion of health services charges, such as prescription charges, and to provide for the disqualification of family health services practitioners on grounds of fraud. Other miscellaneous changes will be introduced, on liability of officers of HSS Councils, disclosure of information by the Commissioner of Complaints and public access to the meetings of Health and Personal Social Services bodies.

6. Fourthly, the Act will provide power to regulate the pharmacy profession.

## **CONSULTATION**

### ***Part I - Social care workers (regulation).***

7. In October 1998, the Department issued a consultation paper, *Improving Social Services: A discussion paper*, to seek the views of professionals, employers, trade unions, voluntary bodies, and those who use social services in Northern Ireland, on how social services may be improved. There was an excellent response from all interests and, in addition, many face to face interviews were held on request. Comparable consultation was undertaken in Great Britain. A key proposal in the consultation paper was to set standards of conduct and practice, and to ensure that all staff working in social services in any setting are trained to meet the highest practice standards. Responses to the consultation paper showed overwhelming support for the introduction of regulation of the social care workforce.

### ***Part II - Recovery of charges in connection with the treatment of road traffic casualties.***

8. Health services bodies, consumer interests and organisations representing the motor insurance industry in Northern Ireland have been consulted on the proposals for new arrangements for the recovery from insurance companies of the costs of health services treatment. There was no expression of opposition to the proposals.

### ***Part III - Health and Personal Social Services (miscellaneous changes).***

9. The Department's consultation document "Fit for the Future" contained proposals for ending the arrangements for GP fundholding. A wide range of interests received the consultation document, and responses indicated support for the proposal to abolish fundholding, except from bodies representing fundholders.

Consultation on other miscellaneous changes was undertaken with appropriate interests, principally Health and Personal Social Services bodies, professional representative organisations and other central government departments where appropriate.

***Part IV - Miscellaneous and General (regulation of the profession of pharmaceutical chemist)***

10. The Pharmaceutical Society for Northern Ireland has been consulted.

**OPTIONS CONSIDERED**

***Part I - Northern Ireland Social Care Council.***

11. The decision to introduce the Northern Ireland Social Care Council was taken in the context of decisions taken in Great Britain. The option of retaining existing regulatory arrangements was considered, but rejected in favour of setting up separate councils in England, Scotland and Wales. The proposed Northern Ireland Social Care Council will co-operate with the councils established in Great Britain, to ensure consistency of standards.

***Part II - Recovery from insurance companies of health services costs in respect of road traffic casualties.***

12. The option of retaining existing arrangements for recovery was considered and, in view of its deficiencies, rejected. In considering new arrangements, the decision was taken to centralise recovery rather than place a further administrative burden on HSS Trusts. Options for centralised recovery were considered. Considerations of economy and efficiency indicated that the best option was recovery through the existing Compensation Recovery Unit in the Social Security Agency.

***Parts III and IV - Miscellaneous changes.***

13. It is necessary to place the repeal of the law relating to GP fundholding on the statute book. In relation to other miscellaneous changes, the options in the main were maintaining the status quo or amending the law. Many of the administrative changes to be made will not have a major impact on the delivery of services, but will have administrative advantages or will clarify existing law.

## **OVERVIEW**

14. The Act is divided into four Parts, has 61 sections and 5 Schedules. It makes various amendments to the Health and Personal Social Services (NI) Order 1972, the Registered Homes (NI) Order 1992 and several other enactments.

## **COMMENTARY ON SECTIONS**

### **PART I – SOCIAL CARE WORKERS**

#### *Part I - General*

15. Part I deals with the functions and procedures of the Northern Ireland Social Care Council (“the Council”), and Schedule 1 provides for its constitution. The Council will be established as a non-departmental public body, sponsored by the Department of Health, Social Services and Public Safety. It will operate according to rules, which will be drawn up by the Council and be subject to the approval of the Department. It will register social workers, and other social care workers who have access to vulnerable people. Individuals will have a right of appeal against a decision of the Council not to register them or to remove them from the register. Appeals will be heard by an independent Tribunal, which will be the Tribunal presently constituted under the Registered Homes (Northern Ireland) Order 1992, renamed as the Social Care Tribunal. The panels of persons who may sit on the reconstituted Tribunal will be appropriately expanded. The Council will come within the remit of the Commissioner for Complaints, and the public will have access to its meetings (subject only to where matters confidential to an identifiable person are being discussed).

#### *Section 1 and Schedule 1 – the Northern Ireland Social Care Council*

16. **Section 1 (and Schedule 1)** establish the Northern Ireland Social Care Council, and set out its functions, constitution and procedures, subject to directions and guidance from the Department.
17. The constitution of the Council is set out in **Schedule 1**. The following points in Schedule 1 will be of interest. **Paragraph 2** gives the Council general powers, subject to the direction of the Department. **Paragraph 5** provides a regulation-making power in respect of membership. The power will be exercised to enable the Department to appoint the Chairman and members of the Council. It is intended that the Council will be only as big as is needed to secure the cost-effective discharge of its business, and is unlikely to exceed 25 people. The intention is that the Council will be composed of people representing all the key interests. Members will be appointed so that service users and lay members will

be the majority of the Council. Appointments will be made after consultation with service user interests and by inviting applications from members of the public. **Paragraph 6** provides that remuneration and allowances will be matters for the Department. It is intended to remunerate the Chairman only. All members will be entitled to travel expenses and other costs associated with membership of the Council. **Paragraph 7** provides that the Department will appoint the first chief officer, as this post will be filled ahead of the Council being fully established. This will allow the chief officer to assist his Chairman with preparatory work including appointment of key staff. The Council will make any subsequent appointments of chief officer. **Paragraph 9** gives the Council flexibility to discharge its functions in the most efficient way, through the Council itself, its staff or others brought in for the purpose. Examples of outside assistance the Council might use are contracting with suitable outside bodies, using consultants or temporary staff on fixed term contracts depending on the work to be done. **Paragraph 11** enables the Department to fund the Council from public money. The Council will be funded wholly through this route initially, although in time it is intended that once the registers of social care staff are established fees from registration will contribute to the cost of the registration function, taking into account a registration fee appropriate to a generally low paid workforce.

### ***Section 2 - Social care worker***

18. **Section 2** contains the definitions of "social care worker" and "relevant social work". Social care worker is used as a generic term encompassing the majority of people who are employed in social care work, from unqualified care workers employed in care homes to professional social workers. "Relevant social work" is the term used to describe the work undertaken by professional social workers. Regulations to be made by the Department will specify the descriptions of social care workers, other than those specified in subsection 2, who are to be treated as social care workers.

### ***Sections 3 to 7 - registration***

19. The Council will maintain registers of social care workers, and the procedures for this are set out in sections 3 to 7. **Section 3** provides for the Council to establish and maintain a register of social care workers. Registration with the Council must be designed to meet the needs of a large, diverse and mainly unqualified workforce. This sector has more than 30,000 workers, more than 80% of whom hold no relevant qualifications. Registration with the Council will eventually be based on the satisfactory completion of training in accordance with the Council's requirements, to provide the skills and knowledge necessary for safe, effective and lawful practice in social care. However, in the first place, unqualified workers may be admitted to the appropriate part of the register on the basis of having been signed up to the code of conduct and practice. Applicants will also have to

demonstrate that they are competent and fit to practice social care work. With the low levels of qualifications it is envisaged that registration will be incremental, by occupational group. Professional social workers, virtually all of whom are qualified, will be the first group of staff to be registered. **Section 4** provides for the Council to make rules governing how applications to its register shall be made. The Department will have power to approve all rules made by the Council. **Section 5** lists the conditions an applicant must satisfy in order to be registered with the Council. These conditions are based on approving applicants who are considered competent and safe to practice. The Council must therefore refuse an application for registration if it is not satisfied an applicant meets the conditions. The Council must also be satisfied as to an applicant's good character and that he is physically and mentally fit to perform the whole or part of the work of persons registered in the part of the register to which his application refers. **Section 6** provides for the Council to make rules as to removing or suspending a registered person from any part of the register. The section makes provision for the procedure to be followed and as to rules of evidence in proceedings, which may be in public, by which the matter can be determined. **Section 7** provides a power for the Council to make rules governing registration. It is intended that the rules will cover evidence to be produced in support of an application for registration, the length of the registration period and renewal. (Section 18 provides for a registration fee to be charged, and for the period that any such charge should cover. The intention is that these fees will contribute to the cost to the Council of operating the registration function.)

#### ***Section 8 – Registration: enforcement***

20. **Section 8** provides for protection of the title “social worker”, by making it an offence to describe oneself as a social worker with intent to deceive, if not registered as a social worker in a “relevant register”. A relevant register is a register maintained by the Council, or any comparable register in Great Britain. This section also provides power to prohibit persons from working in certain categories of employment unless they are registered in an appropriate part of a relevant register.

#### ***Section 9 – Codes of practice***

21. **Section 9** concerns the Council's responsibility to develop and promulgate codes of practice for social care work. These codes will set out standards of conduct and practice expected of social care workers, and standards of conduct and practice in relation to those workers, expected by employers of such staff. No such generally agreed codes exist at present. It is intended that drawing up and promulgating these codes will be the first task for the Council. Social care is a fast developing field, and the codes therefore will not remain static. The Council will be obliged to

keep them under review and amend them where it thinks necessary, consulting representatives of social care workers.

***Sections 10 to 13 - Training***

22. **Sections 10 to 13** set out the Council's functions with regard to regulating the education and training of social workers, including requirements in respect of applicants with qualifications gained outside Northern Ireland. **Section 10** provides that the Council will take over the regulation of professional social work training from the Central Council for Education and Training in Social Work (CCETSW). This section gives wide powers to the Council to make rules about the approval of courses with the intention of ensuring the consistency and quality of the education to be provided.
23. **Section 11** provides that the Council will register professional social workers on the basis of their having obtained a recognised qualification. This section will enable the Council to recognise, for the purposes of registration, qualifications gained outside Northern Ireland as being the equivalent of those gained through Council approved training in Northern Ireland. As England, Scotland and Wales will each have their own regulatory body, this section applies to qualifications gained in those countries as well as those gained in other EEA States and in other parts of the world.
24. In common with other professions, **Section 12** provides that continuing registration is to be linked to continuing professional education and development. Continuing education is no less needed in social care, where safe, legal practice depends on an individual's updated knowledge of research advances and developments in best practice. The section provides for the Council to be able to make rules requiring registered persons to take additional training. The council will consult relevant persons before making, or later varying, these rules.
25. **Section 13** is necessary because, as part of its powers to approve and monitor the effectiveness of individual training courses, the Council will need to be able to visit and report on the places delivering this training. The section therefore gives the Council powers to be able to appoint and pay the visitors to undertake this work on its behalf and to visit the place offering the training. Provision is made in respect of visits to both higher education institutes, which deliver the academic element of the training, and social services agencies that provide the practice placements where students can develop their practical skills.

***Section 14 – Functions of the Department***

26. **Section 14** gives certain functions to the Department of Health, Social Services and Public Safety, which it can delegate to the Council. In addition, the

Department may authorise any person to exercise its functions, and will be able to choose an appropriate person to carry out the function efficiently and effectively. Subsections (1), (2) and (3) establish the promotion of social care training as a function of the Department, which it can devolve to the relevant Council.

Promotion of training includes publicising training opportunities, attracting potential students to training and providing information for social care staff and recruits enquiring about training. Subsection (4) gives the Department the power to pay grants and allowances to students and grants to organisations involved in training. It is intended that the Department will devolve the power to pay these grants to the Council.

### ***Section 15 – Appeals to the Social Care Tribunal***

27. **Section 15** gives individuals the right of appeal to an independent Tribunal, which will be the Tribunal presently established under the Registered Homes (Northern Ireland) Order 1992, renamed as the Social Care Tribunal. Individuals will have a right of appeal against decisions of the Council in respect of registration, for example, a decision not to register them, or remove them from the register. Such decisions could affect an individual's ability to secure employment so access to an independent Tribunal is essential.

### ***Section 16 – Publication, etc, of register***

28. **Section 16** requires the Council to make its register public. It is intended that the Council will make the register available on the internet and will also publish it in hard copy annually.

### ***Section 17 – Cesser of functions of CCETSW***

29. **Section 17** provides that CCETSW will cease to exercise its functions in relation to Northern Ireland. This will be from the date that the Council starts to exercise its functions under this Act. The Act does not contain provision to abolish CCETSW, which, as a UK body, is covered in the corresponding Westminster legislation.

### ***Section 18 - Rules***

30. **Section 18** permits the Council to make rules in respect of reasonable charges for its services. In particular, fees may be charged for registration, course approval, training, and the provision of codes of practice or copies from the register.

### ***Section 19 – Default powers of the Department***

31. **Section 19** confers default powers on the Department in respect of the Council. If the Department is satisfied that the Council has failed to discharge any of its



functions, without good reason, or in discharging its functions has failed to comply with any directions or guidance given to it, this section confers a two-fold default power. Subsection (2) details the first stage: the Department may make an order declaring the Council to be in default and issues directions requiring it to take specific action within a specific time scale. If the Council still fails to act, the second stage (subsection (3)) is triggered. This results in the Department either carrying out the functions itself or nominating a person or organisation to discharge the functions on its behalf.

## **PART II – RECOVERY OF CHARGES IN CONNECTION WITH THE TREATMENT OF ROAD TRAFFIC CASUALTIES**

### ***Part II - General***

32. Part II provides for the introduction of a new and simplified procedure for the recovery from insurance companies of the costs of the health services treatment of road traffic casualties, and increases the maximum amounts recoverable.

### ***Section 23 – Payment for hospital treatment of traffic casualties***

33. **Section 23** sets out the circumstances in which health services charges are due. These are similar to those in the Road Traffic (Northern Ireland) Order 1981, although for the first time costs will be recovered in respect of out-patient treatment, bringing the legislation into line with Great Britain, and from the Motor Insurers Bureau (MIB). At present, MIB provides compensation in those cases where the driver is uninsured or untraceable but it is not liable for health services charges. The Act will bring MIB into the scheme, by section 23(3)(d) treating 'payments made in pursuance of a compensation scheme for motor accidents' as compensation payments for the purposes of the Act. However, it is intended that regulations will provide that MIB is not liable to pay the charges in relation to accidents occurring before the scheme comes into force.

### ***Section 24 – Applications for certificates of health services charges***

34. **Section 24** provides for applications for certificates of health services charges. The present scheme gives powers to hospitals to collect charges. The new Act transfers collection to the Department for Social Development which will issue certificates of the charges due. In practice, this work will be undertaken on behalf of the Department of Social Development by the Compensation Recovery Unit (CRU), as part of the Social Security Agency. CRU was established in 1990 to administer the scheme for recovery of certain state benefits paid where both the benefits and compensation are paid in respect of the same accident, injury or disease. The Unit already has extensive links with the insurance industry and

established procedures based on a certificate system. It is intended that the Act and the regulations made under it should reflect, where possible, these established procedures so that the new work of collecting health services charges can be undertaken at minimal additional cost and within a system already established within the insurance industry.

35. Under the provisions of the benefit recovery scheme, a compensator is liable for the full amount of benefit paid up to the date of the compensation payment (subject to a five year maximum). In turn he may reduce the amount of compensation payable to the injured person, but only where benefits and compensation have been paid in the same circumstances. For that reason, in the benefit recovery scheme the compensator must apply for a certificate of charges before making the compensation payment. The amount of that payment can be affected by the benefit recovery. In the health services scheme the amount of compensation is unaffected by the health services charges and the application for a certificate can be made both before and after compensation has been paid. Section 24 therefore contains provisions that will allow compensators to apply for certificates of health services charges before making a payment of compensation. This will mean that in cases where there is both benefit and health services recovery the two recoveries can be managed together by both government and industry for administrative ease and efficiency.
36. According to the circumstances of the case, certificates will be issued with or without an expiry date, or will expire when a particular event occurs. If a health services charges certificate is issued with an expiry date and the certificate has expired by the time the compensation payment is made a further certificate must be obtained. A compensator must also apply for a certificate, after making a compensation payment, if no certificate has been issued to him in respect of the casualty. These obligations do not arise if the compensator has applied for a certificate shortly before making the payment.

***Section 25 – Information contained in certificates***

37. **Section 25** introduces the powers which will enable charges to be calculated according to a tariff. It is intended that the tariff should be as simple as possible. It will be set out in regulations and will consist of a set fee for patients treated in accident and emergency departments or out-patient clinics, regardless of the number of attendances at hospital, and a daily rate for patients who are admitted to hospital for treatment. In addition it is intended that there will be a ceiling for costs in any one case. Initially at least, the tariff will be calculated so that the amounts collected nationally reflect the total cost of the relevant treatment to the health services. Regulations under this section will allow for different limits to apply to health services charges following accidents, which happened before specific dates. The intention is to levy charges which reflect more closely the full

costs of treatment for accidents which happened on or after 2 July 1997, the date of the Chancellor's Budget statement that such changes will be introduced. Claims settled after the legislation comes into effect but which relate to accidents which happened before 2 July 1997 will attract health services charges at a rate set to produce only the maximum chargeable under Article 99 of the Road Traffic (NI) Order 1981. That figure, which was last updated in 1995 by the Road Traffic Accidents (Payments for Treatment) Order (NI) 1995, is £2,949. This retrospective element applies only to charges for in-patient treatment as the 1981 Order does not contain provisions in respect of out-patient charges.

38. Powers are also available in section 25 enabling regulations to be drafted to deal with more complicated cases. For example where a person receives treatment at more than one hospital it is the intention to provide each hospital with a proportion of the health services charge, subject to the overall limit in each case. Regulations will also provide for cases where there is more than one compensator, as can happen in motorway accidents involving many vehicles.

#### ***Section 27 – Recovery of health services charges***

39. **Section 27** enables the Department of Social Development to issue a certificate of health services charges where a claim for compensation has been settled but no application for a certificate has been made as required by section 24. It also enables the Department of Social Development to recover health services charges which are overdue. Where necessary, that Department can enforce payment through the courts.

#### ***Section 28 – Review of certificates***

40. There is no procedure for review under the present health services charges scheme. **Section 28** allows for internal review of any certificate and this can be initiated either by CRU or on application by the compensator. The terms of the new scheme follow closely the provisions for review found in the Social Security (Recovery of Benefits) (NI) Order 1997 as amended by the Social Security (NI) Order 1998.

#### ***Section 29 – Appeals against a certificate***

41. **Section 29** covers appeals. The grounds of appeal set out closely follow those in the benefit recovery scheme. It is intended that procedures to be set out in regulations will also be modelled on that scheme's rules. As in the benefit recovery scheme, a right of appeal will not arise until such time as the liability to repay health services charges has been discharged.

***Section 30 – Appeal tribunals***

42. **Section 30** allows for the same tribunals that hear appeals in compensation recovery cases to hear health services charges appeals. Compensation recovery cases are heard by an appeal tribunal set up as part of the Unified Appeal Tribunal procedure introduced by the Social Security (NI) Order 1998.
43. In the benefit recovery scheme further appeal is made first to the Social Security Commissioners and then to the courts. There will be no appeal to the Social Security Commissioners in the case of health services charges, but **Section 31** allows for appeal to be made to the High Court on a point of law.

***Section 33 – Provision of information***

44. **Section 33** gives powers under regulations for gathering information relevant to the collection of health services charges. In order for the new system of collection to work information will have to be exchanged by the various parties involved in the chain of events from accident to payment of compensation. The mechanism for recovery relies on the compensator being able to supply the CRU with sufficient information for the details of the claim to be verified with the relevant hospital. It is likely that the additional powers to collect information from, for example, the accident casualty or his representative will only be used where the information provided by the compensator is insufficient.
45. It is envisaged that in the normal course of events with the tariff presently planned the only information required about the casualty's health services treatment will be to categorise it as treatment without admission, for example in an accident and emergency department or an out-patient clinic, or treatment given as an in-patient plus the number of days of admission. Where however an appeal against health services charges is subsequently made on the grounds that the treatment given was not as a result of the road accident in question then there may be a need for more detailed information about any treatment the casualty has received.
46. Section 33 also provides a power to define what is meant by a claim and the person against whom a claim is made. It is intended that regulations will require those who might make a compensation payment falling within the scheme to notify CRU, without being asked, that a claim for compensation has been made, and to provide certain information about the claim. Accordingly "claim" and "person against whom the claim is made" will be defined in regulations to make it clear who has the obligation to give the information and when that obligation arises.
47. There are variations in claims handling practice within the insurance industry and it is our intention that these should not affect the stage at which CRU should be

notified of a claim. Since it is also possible that insurance company procedures for dealing with claims will develop it is desirable to be able to change these definitions by regulations (rather than by primary legislation) in order to reflect current practice.

***Section 34 – Use of information held by the Department***

48. **Section 34** allows information obtained for the health services charges scheme to be used for the purposes of the benefit recovery scheme and vice versa. This provision will provide maximum flexibility for both the government and the insurance industry so that, for example, in the cases involving both health services charges and benefit recovery CRU can request and rely on a single set of information for both purposes.

***Section 35 – Payment of health services charges to hospitals***

49. For at least 30 years the receipts generated under Road Traffic legislation have always been recovered by the hospital providing the care. **Section 35** confirms that hospitals will continue to be the direct recipients of the money recovered. It is intended that regulations will provide for the money collected by CRU to be passed directly to the relevant hospitals.

**PART III – HEALTH AND PERSONAL SOCIAL SERVICES**

***Section 39 – Repeal of the law about fund-holding practices***

50. **Section 39** provides for the repeal of Articles 17 to 20 of the Health and Personal Social Services (Northern Ireland) Order 1991, under which fund-holding general practices were established. The section will be subject to a commencement order, and will be brought into operation from a date to be determined, not being earlier than 1 April 2002. Transitional provisions will cover arrangements for the transfer of those assets, rights and liabilities that need to be transferred to a HSS Board.

***Section 40 – Remuneration for Part VI services***

51. **Section 40** provides for new arrangements for determining the remuneration of family health services practitioners. The existing arrangements under Part VI of the Health and Personal Social Services (NI) Order 1972 involve the Department making regulations under Part VI, and making determinations of remuneration under those regulations. Article 7(2) of the Health and Social Security (NI) Order 1984 provides for the validation of the determinations. The Department then publishes statements of remuneration. The new provision will provide power for the Department to determine remuneration and/or appoint other bodies to act as determining authorities. In effect, the Department will continue to exercise the

power to determine remuneration, and the power to appoint other bodies will not be exercised prior to the introduction of new structures for the commissioning of health services. Although other bodies will not initially be appointed as determining authorities, the introduction of this provision will clarify the Department's right to determine remuneration, without reliance on validation under Article 7(2) of the Health and Social Security (NI) Order 1984.

***Section 41 – Indemnity cover for Part VI services***

52. **Section 41** provides that all family health services practitioners should hold professional indemnity insurance. There is at present no requirement for FHS practitioners who provide services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972, or provide personal health services under the Health Services (Primary Care) (Northern Ireland) Order 1997, to hold professional indemnity insurance. Although many such providers do have such insurance (generally through membership of their professional defence organisation) a proportion do not. The requirement will apply to all family health service practitioners providing services under Part VI of the Health and Personal Social Services (Northern Ireland) Order 1972. The same result will be achieved in respect of doctors and dentists providing personal medical services or personal dental services under the Health Services (Primary Care) (Northern Ireland) Order 1997 by the Department directing HSS Boards that such cover should be a condition in the contract for the provision of those services.

***Section 42 – Local Representative Committees***

53. **Section 42** makes technical changes to the law governing Local Representative Committees (LRCs). LRCs may be set up under Article 55 of the Health and Personal Social Services (Northern Ireland) Order 1972 for each HSS Board area to represent the interests of FHS practitioners. LRCs may represent the practitioners who provide general medical, etc, services under Part VI of the 1972 Order.
54. At present, the wording of Article 55 permits any doctor, dentist, etc, to represent general medical practitioners, general dental practitioners, etc, on LRCs. This was never the intention, and the proposed new provisions will correct this anomaly and ensure that only practitioners providing FHS (or their assistants or deputies) will be eligible to represent the profession on LRCs. Persons providing personal medical or dental services under the Health Services (Primary Care) (Northern Ireland) Order 1997 will also be eligible.
55. The Act will also allow a Local Medical or Local Dental Committee to apportion the amount of its administrative expenses between those classes of doctors and dentists represented by the committee.

56. A further change will be that medical practitioners who provide general ophthalmic services will be represented on the Local Medical Committee, rather than on a separate ophthalmic medical committee as at present. Ophthalmic Medical Committees will then cease to exist.

***Section 43 – Establishment orders***

57. **Section 43** makes new arrangements relating to the establishment of HSS Trusts. Trusts are established under Article 10(1) of the Health and Personal Social Services (Northern Ireland) Order 1991. Article 10(1)(a) of that Order limits them to owning and managing property (land and personal property) which had previously been managed or provided by a Board, the Central Services Agency or a special agency. Thus, the estate owned by the Department and managed on its behalf by the Boards, has been transferred (under Article 13 of the 1991 Order) to the Trusts.
58. Trusts are therefore permitted to own, lease, manage, provide and dispose of real and personal property previously provided or managed by a HSS body. There is thus some doubt whether the legislation under which Trusts are established permits Trusts to acquire new hospitals or facilities not previously managed by a HSS body. The Act will contain provision to put it beyond doubt that Trusts are permitted to do this, and will enable the Department to confer, in a Trust establishment order, a duty to provide particular goods or services at or from particular hospitals, establishments or other facilities. The new functions will be conferred on existing Trusts, rather than making provision for each Trust's Establishment Order to be amended.

***Section 44 – Exercise of powers***

59. **Section 44(1)** introduces provisions on the exercise by HSS Trusts of income-generation powers. Trusts' income generation powers may only be exercised to the extent that the exercise will not to any significant extent interfere with the performance by the Trust of its obligations under any Health and Social Services contract or any obligations imposed by its Establishment Order. The Act will extend the current provision to ensure that the restriction it imposes on the exercise of income generation powers applies in respect of all Trust functions, not just those conferred on a Trust in its establishment order. The Act will permit the Department to specify in directions circumstances in which Trusts will also require the Department's consent to exercise their charging and income generation powers. Directions could, for example, specify an amount of income above which Departmental consent is required.
60. **Section 44(2)** gives the Department of Health, Social Services and Public Safety powers to direct HSS Trusts on the exercise of functions. Various functions

concerned with the administration and delivery of the HPSS are conferred on the Department under the Health and Personal Social Services (Northern Ireland) Order 1972, and subsequent legislation. In the case of HSS Boards, the Department has power under Article 17 of the 1972 Order by means of directions to delegate those functions, and by directions to specify how those functions are to be carried out. The practical effect of such delegation is that the function becomes the function of the HSS Board to which it is delegated.

61. The law is not the same in regard to delegation to HSS Trusts. Under the Health and Personal Social Services (Northern Ireland) Order 1991, powers to direct HSS Trusts are intentionally more limited, as those bodies are not agents of the Department. They are autonomous, contract-making entities. The present powers of direction are contained in paragraph 6(1) and (2) of Schedule 3 to the 1991 Order, and relate to specific areas of a Trust's functions. Very broadly, these areas are:-

- (a) entering contracts with other HSS bodies;
- (b) undertaking and commissioning research;
- (c) providing training, and associated functions;
- (d) exercising its functions jointly with another individual or body;
- (e) providing pay beds; and
- (f) income generation.

62. The Department may also direct a Trust in respect of such matters as the qualifications, experience and appointment of its staff, prohibiting or restricting the disposal of assets, compliance with guidance given to Boards and implementing merit awards.

63. These limited powers of direction in relation to Trusts have proved inadequate on some occasions. There are occasions when the Department will wish to direct Trusts on more general matters, an example might be to forbid the transplantation of animals' organs into humans. The only way that this could be done at present would be by directing Boards as to what is required, and then using the power in paragraph 6(2)(e) of Schedule 3 to the 1991 Order to direct Trusts as to compliance with guidance given to Boards. However the power in 6(2)(e) has never been tested in this way and its potential effectiveness is dubious.

64. The Act therefore will substitute a new paragraph 6 in Schedule 3 to the Health and Personal Social Services (Northern Ireland) Order 1991, to widen the Department's power to direct Trusts as to the carrying out of their functions. Examples of how the new power could be used include –

- (a) setting quality targets. The targets might be to achieve certain health outcomes (eg, lower re-infection rate, lower screening failure rate) or achieve particular



service levels or processes (eg, cancer waiting times, ambulance response targets), or put internal systems in place (eg, clinical audit). It is expected that the Department would use existing management levers in the first place, but this power of direction may be an option of last resort.

(b) introducing pay arrangements

(c) controlling borrowing and investment where this involves the private sector land and building issues.

#### ***Section 45 – Public dividend capital***

65. **Section 45** contains provisions on the financial regime of Trusts. Article 14(1) of the Health and Personal Social Services (Northern Ireland) Order 1991 stated that each HSS Trust would have an Originating Capital Debt (OCD) of an amount specified in an order made by the Department. Broadly speaking, this represented the difference between the value of the assets handed over to a Trust, less the value of any liabilities transferred to a Trust. To date, half of a Trust's OCD has consisted of long-term loans, known as Interest Bearing debt (IBD), and half of Public Dividend Capital (PDC), broadly the equivalent of share capital in a public or private company. Hence, a Trust has been required to repay a combination of principal and interest on IBD and dividend on PDC. The intention now is to create a more transparent, less bureaucratic, financial structure than that in place under the internal market. In summary, the OCD of Trusts will be comprised wholly of PDC, and **Section 46** provides for the conversion of all existing IBD to PDC at an agreed future date. By implication therefore, any further advances by the Department to Trusts for capital expenditure will also be in the form of PDC.

#### ***Section 47 – Borrowing, surplus funds and investment***

66. **Section 47** provides that additional borrowing by Trusts, on a short-term basis, will be subject to Departmental direction. Trusts have a duty to obtain value for money when they enter into borrowing arrangements. This usually results in borrowing from the Department. If any borrowing takes place through the private sector it must not be secured borrowing and must offer better value for money than borrowing from the Department.

67. In future, it is intended that, in the main, Trust borrowing will be from the Department. Paragraph 1 of Schedule 4 to the Health and Personal Social Services (Northern Ireland) Order 1991 allows the Department to provide interest-bearing loans to Trusts. Section 47 revises these provisions to allow the Department, with the consent of the Department of Finance and Personnel (DFP), to decide the circumstances and terms and conditions of any loans given to Trusts. The

Department will, with the consent of DFP, be able to decide the interest rate and any charges as appropriate.

***Section 48 – Evasion of charges, etc***

68. **Section 48** introduces new provisions aimed at reducing evasion of health services charges. Exemptions from health services charges are granted for a number of reasons such as age, certain medical conditions, receipt of certain social security benefits, or where a patient is on low income. It is estimated that for 1999/00, some £14m was lost through fraudulent claiming of exemption from Family Health Service (FHS) charges by members of the public. This includes charges in relation to prescriptions, and dental and ophthalmic services.
69. The Act will introduce two deterrent measures. The first will be a civil penalty for wrongfully obtaining exemption from, or refund of, a health services charge. The penalty will be payment of the original charge plus an additional penalty of the lesser of five times the original charge, or £100. These maxima may be increased by an order approved by the Assembly by affirmative resolution. Where penalties are not paid within a prescribed period, a surcharge amounting to 50% of the penalty will be applied.
70. The Act will create a specific criminal offence of knowingly evading or fraudulently gaining an exemption from, or remission of, health services charges. The offence will be a summary offence only and will be heard in a Magistrate's Court. The maximum penalty that a court may impose for such an offence is level 4 on the standard scale of penalties (currently £2,500).

***Section 49 and Schedule 2 – Disqualification of Part VI practitioners***

71. **Section 49 and Schedule 2** provide for the disqualification of family health services practitioners who have committed fraud, or are prejudicing the efficiency of the family health services. Article 65 of, and Schedule 11 to, the Health and Personal Social Services (Northern Ireland) Order 1972 provide for the existence of a Tribunal to enquire into representations that a person's name should be removed from, or not included in, any list of FHS practitioners providing services under that Order. At present, the Tribunal can respond only to representations that a person is unfit to provide services (ie his name should be removed from any list of practitioners maintained by a HSS Board on the grounds of efficiency). The practitioner has a right of appeal to the Appeal Court against removal or non-inclusion.
72. As an anti-fraud measure, the Act will extend the remit of the Tribunal to enquire into representations that a practitioner has been found guilty of serious financial irregularity. Following an inquiry, the Tribunal could order that the practitioner's

name should be removed from, or not included in, a HSS Boards' list. As in "inefficiency" cases, the practitioner will have a right of appeal against removal or non-inclusion.

***Section 50 – Disclosure of information by the Commissioner for Complaints***

73. **Section 50** clarifies existing law on disclosure of information by the Commissioner for Complaints. Since 1997, the Commissioner has the remit of hearing complaints about maladministration in the administrative actions of doctors, dentists, pharmacists, and optometrists providing family health services under arrangements made with a Board, and complaints about the exercise of clinical judgement by doctors and other health professionals employed in the HPSS.
74. The Act will amend the Commissioner for Complaints (Northern Ireland) Order 1996 to remove some of the restrictions in the Order as to the circumstances in which a Commissioner has discretion to pass information he obtains as a result of a complaint made to him. In particular it gives him discretion to disclose such information where it is obtained for the purposes of an investigation and is to the effect that a person is likely to constitute a threat to the health or safety of patients. The Act will place a new requirement on the Commissioner to inform both the provider of the information and the person whom the information is about (where that person's identity is known), that he has disclosed that information, and of the identity of the person to whom he has disclosed it.
75. The Act will also amend those provisions of the Commissioner for Complaints Order which deal with persons to whom the Commissioner may disclose information. Although that provision is worded in terms which implied that it is simply a list of examples of the type of persons to whom information may be disclosed, it could be interpreted as defining the class of such persons and thereby restricting the Commissioner's power to disclose information. The Act will remove those provisions.

***Section 51 – Provision of information as to births and deaths***

76. **Section 51** provides for the provision of information on births and deaths. The General Register Office (GRO) is responsible for registration of births and deaths in Northern Ireland through the Registrars of Births and Deaths in each District Council. Registrars have been forwarding information on deaths to Boards since 1974, following an agreement between the Registrar General and the then Department of Health and Social Services. This information is used to update records, cancel appointments and retrieve equipment. There is already provision, through the Notification of Births Act 1907, for Boards to allow Registrars access to information on all births occurring in their areas but Registrars are also sent

lists, on a weekly basis, to ensure that all births are registered. CSA maintain a central record of patients for HPSS purposes.

77. GRO also passes information on births and deaths to the Department of Health, Social Services and Public Safety for purposes such as the study of epidemic diseases, preventative measures, medical research, etc. Registrars have also been notifying the Central Services Agency (CSA) of births and deaths, to help the CSA maintain a central record of patients for HPSS purposes.
78. This exchange of information has been of great benefit to the Health and Personal Social Services in maintaining records of patients. However, there is a need for unambiguous legal authority permitting exchange of information between GRO and the Department and its agencies. The Act will bring about the legal regularisation of the supply of registration data to the Department and its agencies for health purposes only.

#### ***Section 52 – Liability of officers of Health and Social Services Councils***

79. **Section 52** makes provision as to liability of officers of HSS Councils. Article 97(1) of the Health and Personal Social Services (Northern Ireland) Order 1972 provides indemnity cover for any officer of an HPSS body (Board, special agency, Trust or the CSA) acting reasonably in the execution of the functions of that body, and within the scope of his employment.
80. A recent legal action taken against one Health and Social Services Council and its Chief Officer brought to light the fact that Health and Social Services Council staff and members are not protected by the indemnity provided to officers of other Health and Personal Social Services bodies under Article 97(1). It therefore fell to the Department as the establishing body to provide indemnity in that particular case.
81. Legal advice indicates that Article 97(1) should be amended to cover officers of HSS Councils acting reasonably in the execution of the functions of the Council.

#### ***Section 53 – Regulations under section 11 of the Medical Act 1983***

82. **Section 53** amends the Medical Act 1983, in so far as it extends to Northern Ireland, to enable the Department to make regulations in relation to the training of Pre-registration House Officers (PRHO's). The Medical Act 1983 regulates the medical profession on a UK basis. It provides for the General Medical Council, which through committees governs the standards of training and professional conduct required of the medical profession, and provides as to residence

conditions. Historically the Act and its predecessors applied throughout the UK, although the subject matter is in the transferred field.

83. Section 11(3)(b) and (4) of the Medical Act 1983, as amended by section 35 of the National Health Service (Primary Care) Act 1997, contains power for the Secretary of State to make regulations governing training of Pre-Registration House Officers (PRHOs) in general medical practice. That power has now been exercised by the Health Secretary in respect of England and Wales, and by Scottish Ministers in respect of Scotland. The regulations do not extend to Northern Ireland, as legal advice is to the effect that Department of Health Ministers cannot exercise the power in section 11 of the Medical Act in relation to Northern Ireland.
84. It would be desirable for PRHOs in Northern Ireland to have this additional training opportunity. Bodies with responsibility for medical training have been pressing for the early introduction of comparable legislation to that introduced in the regulations made in GB under section 11, as amended. The Act therefore will further amend section 11(3) and (4) of the Medical Act, in so far as it applies in Northern Ireland, to give the Department of Health, Social Services and Public Safety power to make regulations under that section.

***Section 54 – Public access to meetings of certain bodies***

85. **Section 54** provides for public access to meetings of Health and Social Services bodies. There is no statutory requirement in Northern Ireland for HSS bodies to open their meetings to the public. HSS Boards have in practice held open meetings, but the Act will make it a requirement that this should be the practice for HSS bodies generally. Provision will be made for meetings to be closed to the public where matters confidential to a particular patient or client, or an identifiable group of patients or clients, are being discussed. The Act will also include provision for public notice of meetings, and permit press coverage.

***Section 55 and Schedule 3 – Sale of medical practices: goodwill***

86. **Section 55 and Schedule 3** will replace Schedule 10 to the Health and Personal Social Services (Northern Ireland) Order 1972, which prohibits the sale of the goodwill of a medical practice. Doubts have been cast on the ability to conduct a successful prosecution under the existing wording in Schedule 10, and the new provisions are designed to put it beyond doubt that such sale is illegal.

#### **PART IV – MISCELLANEOUS AND GENERAL**

##### ***Section 56 and Schedule 4 – Regulation of the profession of pharmaceutical chemist***

87. **Section 56 and Schedule 4** provide for regulation of the profession of pharmacist. Each health care profession has a regulatory body with responsibility for setting educational and training standards for the profession, professional registration and standards of conduct. The regulatory bodies are generally established under Acts of the Westminster Parliament and have a UK-wide remit. An example is the Medical Act 1983, which provides for the establishment of the General Medical Council, which through committees regulates education and training, professional registration, and professional standards and conduct.
88. The Acts governing health care and associated professions could, until recently, only be changed by primary legislation, and this had proved cumbersome and incapable of bringing in change with reasonable speed. The Health Act 1999 therefore conferred power on the Secretary of State for Health to bring forward Orders, subject to approval of Parliament, amending those Acts.
89. As mentioned above, the legislation governing professions is generally on a UK basis. One exception is the pharmacy profession, which is regulated in Northern Ireland by the Pharmaceutical Society of Northern Ireland, established under the Pharmacy (Northern Ireland) Order 1976. There will be benefit in having the flexibility to amend the 1976 Order by subordinate legislation, in order to bring in changes intended to improve the services provided to the public or to improve the regulation of the profession by enabling the legislative framework to be kept up to date. The orders will take account of changing public expectations of the pharmacy profession and that professions' own views about the development of their regulation.
90. The order-making power in the Act will provide that any amending order will be laid before the Assembly in draft and be subject to the affirmative resolution of the Assembly.