Northern Ireland Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Justice Bill: Regulation and Quality Improvement Authority

14 January 2015

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Alastair Ross (Chairperson)
Mr Stewart Dickson
Mr Sammy Douglas
Mr Tom Elliott
Mr Paul Frew
Mr Chris Hazzard
Mr Seán Lynch
Mr Alban Maginness
Mr Patsy McGlone
Mr Edwin Poots

Witnesses:

Mrs Kathy Fodey	Regulation and Quality Improvement Authority
Mr Glenn Houston	Regulation and Quality Improvement Authority

The Chairperson (Mr Ross): From the Regulation and Quality Improvement Authority (RQIA), I welcome Glenn Houston, the chief executive, and Kathy Fodey, the director of regulation and nursing. The session is being reported by Hansard, and the transcript will be published on the Committee website in due course. When you are ready, do you want to brief us on your thoughts? We will then open the meeting up to questions from members.

Mr Glenn Houston (Regulation and Quality Improvement Authority): Thank you very much, Mr Chairman. I have prepared an opening statement, which I am happy to share with you.

Thank you for the opportunity to attend the Committee for Justice this afternoon. On 15 September 2014, the Regulation and Quality Improvement Authority made a written submission in response to the consultation on the Justice Bill. The RQIA wishes to acknowledge that this is a complex and highly sensitive issue on which members of the public and elected representatives hold strong views. The RQIA's area of expertise is health and social care, so we are not here to make alternative proposals in respect of amendments to the criminal law that is currently under consideration. While we acknowledge the complexities of the ethics of termination of pregnancy and abortion, we are here to identify and consider the potential impact of the legislation on our specific area of work. We believe that the proposed new clause 11A raises issues for regulation, which we have identified and highlighted in our response to the consultation. These issues centre on the potential impact of clause 11A for the interpretation and application of the Independent Health Care Regulations (Northern Ireland) 2005 as they currently stand.

The RQIA's written submission to the Committee was informed by legal opinion, as we considered it necessary to obtain legal advice on the potential implications of the proposed amendment for the RQIA's role and responsibilities under our principal Order, which is the Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 and, of course, the Independent Health Care Regulations (Northern Ireland) 2005. We intend, Chairman, to confine our remarks to the impact of the proposed amendment and the implications that it may have for our role as a regulator.

The RQIA was established under the provisions of the Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003. Article 35 of that Order states that the RQIA has:

> *"the function of carrying out inspections of statutory bodies and service providers, and persons who provide or are to provide services for which such bodies or providers have responsibility, and making reports on the inspections".*

Currently, almost 1,500 independent care services are registered with the RQIA. The largest categories are private dental care, nursing homes and residential care homes. Since the establishment of the RQIA in 2005, there has been a steady increase in the number of registered agencies and establishments every year. Each registered service is subject to annual inspection by the RQIA, and the frequency of those inspections is determined by another regulation, the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005. So services are regulated in accordance with the relevant specific regulations and the associated minimum standards developed by the Department of Health, Social Services and Public Safety (DHSSPS).

The Independent Health Care Regulations (Northern Ireland) 2005 place a statutory duty on the RQIA to register and inspect independent hospitals and clinics that meet the stated requirement for registration. Currently, there are two conditions that would require an independent clinic to be registered with the RQIA. These conditions are identified at regulations 4 and 5. To summarise, these conditions for registration are, first, that an independent clinic must register if it intends to carry out a prescribed technique or make use of prescribed technology and, secondly, that a medical practitioner working in the clinic is not otherwise engaged in providing services to Health and Social Care (HSC) in Northern Ireland. In this context, the key reference in the regulations is:

> *"a medical practitioner who provides no services in pursuance of the 1972 Order".*

Therefore, if a medical practitioner does not provide services under the Health and Personal Social Services (Northern Ireland) Order 1972, any surgery or consulting room where that medical practitioner is working must be registered with the RQIA as it meets the definition of an independent clinic that is specified in the regulations.

When a medical practitioner does provide services under the 1972 Order, the surgery or consulting room is not required to be registered as it does not meet the legal definition of an independent clinic. This gives rise to a legal paradox. Two clinics in the same town may provide the same range of services. One will require to be registered due to the fact that a doctor working in that clinic does so on a wholly private basis. The neighbouring clinic does not fall to be registered if the doctor is also employed on either a full-time or part-time basis providing services in the NHS in Northern Ireland. The RQIA has raised this matter with the Department, along with a request that it be considered as part of any planned review of the Independent Health Care Regulations (Northern Ireland) 2005.

It is also important to consider the range of prescribed techniques and technologies as referenced in the Independent Health Care Regulations (Northern Ireland) 2005, which are listed under regulation 4. They include, for example, use of lasers, endoscopy and in vitro fertilisation. Termination of pregnancy is not listed as a prescribed technique. Under the current legislation, therefore, there is not a requirement for an independent clinic providing such a service to register with the RQIA on that basis alone. That is an important point, Chairman. This means that an independent clinic that provides termination of pregnancy within the law as it currently stands does not need to be registered with the RQIA, provided the doctors working there are also contracted to work in the NHS in Northern Ireland.

The legislation does not provide for the RQIA to offer voluntary registration. The RQIA will register only services that are required by law to be registered. When an independent clinic falls to be registered under the regulatory framework, we are required to inspect that clinic annually. That is a minimum of one inspection per annum.

The requirements for registration with health and social care regulators differ across the United Kingdom. In Wales, for example, a clinic would be excluded from the requirement to register only if doctors were providing NHS services in that clinic. Therefore, any clinic employing doctors who provide services on a wholly private capacity would be required to register with its regulator, the Healthcare Inspectorate Wales.

In England, there are specific and detailed statutory provisions and regulatory standards against which the quality and legality of the services of the termination of pregnancy in an independent clinic can be measured and assessed by the Care Quality Commission (CQC). This provides a specific regulatory framework against which the CQC may inspect those services. To summarise that point: under the current legislation in Northern Ireland, an independent clinic will fall to be registered and inspected by the RQIA only on the basis of the type of services provided and whether it employs a doctor on a wholly private basis. Currently, there is one independent clinic in Northern Ireland, which, under its statement of purpose, provides a range of family planning and sexual health services, and termination of pregnancy up to nine weeks' gestation. Its statement of purpose includes reference to medical abortion within the limited and strict legal criteria of Northern Ireland for clients aged 16 and above up to nine weeks' gestation. Marie Stopes International's Belfast clinic is registered with the RQIA under the provisions of the Independent Health Care Regulations (Northern Ireland) 2005. It falls to be registered solely as it employs a doctor on a wholly private basis.

In the event that the criminal law is amended to include new clause 11A, an independent clinic, such as Marie Stopes, would be prohibited from providing terminations in Northern Ireland under any circumstances. In that regard, Marie Stopes would be required to amend its statement of purpose specifically to exclude medical abortion being undertaken on the premises. The clinic, however, would still fall to be registered with the RQIA if it continued to provide other medical services and employed a doctor on a wholly private basis. Should Marie Stopes cease to employ a doctor on a wholly private basis, the service would no longer need to be registered with the RQIA. In that scenario, the RQIA would have no mandate to enter and inspect the clinic.

It is unlikely that clause 11A, of itself, would prohibit the clinic from providing information to patients about termination of pregnancy or in signposting patients to registered clinics outside Northern Ireland.

If enacted, clause 11A would make it illegal for any independent health-care provider to carry out an abortion, as that procedure could be performed only on premises operated by an HSC trust, with the notable exception of the circumstances outlined in proposed clause 11A(2)(b).

The RQIA has received legal advice that has confirmed that, under the current legislation, the RQIA has no authority to question or challenge the decisions of a medical practitioner in respect of his or her treatment of an individual patient in any setting. Therefore, the RQIA cannot question a medical practitioner's assessment of the basis on which a decision to offer a termination of pregnancy is made. In the event that the RQIA became aware of circumstances that suggested that a medical practitioner had acted other than in accordance with his or her professional code of practice, the RQIA would be obliged to refer that matter to the General Medical Council (GMC) for further investigation. Should the RQIA become aware of information that suggested that any employee of a registered service had engaged in a criminal act, the RQIA would immediately refer that matter to the relevant authority — the PSNI. The RQIA is not empowered to carry out criminal investigations. However, we would, and we do, liaise closely with the PSNI in circumstances where we believe that it is necessary and appropriate to do so.

Our engagement with regulated services is based solely on providing fair and unbiased regulation to drive improvement in the quality of services for those who rely on them. The RQIA would caution against any proposal that would fundamentally alter the nature and purpose of that responsibility.

To conclude: any changes to the criminal law that would have implications for the existing legislation that governs the regulation of independent providers and Health and Social Care trusts must be given due consideration. Any resultant amendments required to the regulations and minimum standards for health and social care would require to be taken forward either in tandem or shortly after in sequence. Chairman and members, thank you very much for the opportunity to present this information.

The Chairperson (Mr Ross): Thank you very much. From your written submission and your opening statement, you seem to be particularly concerned about two areas. First is the change in the RQIA's role, in that you would move from assessing quality to enforcement. If the amendment were made, are you suggesting that you would need to work with the police on all those issues and on any role that you would have in that area?

Mr Houston: Chairman, as I said, we currently register approximately 1,500 services. There are times when we are obliged to work collaboratively with the PSNI — for example, on investigations into allegations of the abuse of vulnerable adults, which we do routinely. In any circumstance in which any of our officers are privy to information that ought to be shared with the PSNI, we share that information. As you rightly said, our organisation is neither mandated nor has the capacity or resource to conduct criminal investigations. Our written submission indicates that, if that were to change, we would want to employ people with particular skills and possibly work in tandem with the PSNI when it was necessary to do so. We view that as fundamentally not within the current ethos of the regulation of health and social care services in Northern Ireland.

Mr A Maginness: Thank you very much for your very helpful submission. I will start by asking about your role. Is it correct that you do not have a clinical capacity?

Mr Houston: I will hand over to my colleague Kathy Fodey, who is our director of regulation. She will explain what we do.

Mrs Kathy Fodey (Regulation and Quality Improvement Authority): If you mean clinical capacity in the assessment of clinical decision-making, the short answer is no. It is the same as if we were inspecting an independent hospital that undertook a hip surgery. We would not question the clinical decision-making that led to that surgical procedure being undertaken. We do not second-guess the actions of medical practitioners.

Mr A Maginness: You referred to the Marie Stopes clinic. My understanding is that the clinic is registered with you. Is that correct?

Mrs Fodey: It is, yes.

Mr A Maginness: Will you describe your role in relation to Marie Stopes? I am not quite sure what impact that would have on the clinic and your inspection role.

Mr Houston: I will make a couple of points in response to your question and will ask Mrs Fodey to elaborate. The 2005 regulations currently govern the activities of independent health-care providers. As I said, when a clinic falls to be registered, our requirement under the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005 is to undertake an inspection of that service once a year as a minimum. If the service falls to be registered on the basis that it employs a doctor on a wholly private basis, the focus of our inspection will be on the activities of the individual clinician. I will ask Mrs Fodey to say a little more about that.

Mrs Fodey: The Independent Health Care Regulations (Northern Ireland) 2005 dictate that the Marie Stopes clinic falls to be registered by the fact that it employs a doctor on a wholly private basis. That doctor does not work in the NHS or Health and Social Care in Northern Ireland in any other capacity. Therefore, that doctor falls to be regulated by us as a private doctor, in the capacity of an independent clinic private doctor.

The independent health-care standards were finalised and launched by the DHSSPS in 2014, and we specifically register and inspect against a number of standards. Those include informed decision-making and what information is available to patients who come to be seen by a private doctor. They also include patient-client partnerships: how they are managed; how complaints against a private doctor are dealt with; how records are maintained and whether they are stored appropriately in accordance with data protection and confidentiality; and whether they are protected. There are clinical governance issues about the operation of a private doctor's practice, the staff indemnity insurance and the practising privileges of that doctor. Is there a policy, a protocol and a contract for that private doctor to operate on those premises?

Management control of operations covers a range of things, like the operating hours of a clinic, governance and management. If a doctor administers medications, for example, it might cover the safe disposal of sharps. Those are the type of governance and management operation issues. It also deals with medical emergencies. If a medical emergency were to occur, are there sufficient facilities and the wherewithal in that clinic to deal with it?

Mr A Maginness: I will be more specific: you do not inspect any clinical decisions that are made by a doctor.

Mrs Fodey: No, we do not.

Mr A Maginness: If a doctor, for example, were to carry out a procedure in relation to abortion, would you be aware of that?

Mrs Fodey: Our focus is to ensure that a doctor is qualified and trained to undertake the procedure that he has been employed to do. If that doctor is employed in that capacity to provide abortion, the expectation is that he or she is trained to administer medications to a woman, in the same way, with a doctor who is employed to provide hip surgery, we expect him or her to be registered with the relevant royal college and to have the appropriate qualifications. I am not sure whether that answers your question.

Mr A Maginness: It does and it doesn't. What I am trying to get at is this. Let us leave Marie Stopes aside. Can you go into a clinic that, from time to time, carries out abortion procedures and invite it to detail those procedures? Can you inspect the records for that sort of activity?

Mrs Fodey: Are you talking specifically about Marie Stopes as it operates in Northern Ireland?

Mr A Maginness: I wanted to make it a general point, so clinics that are similar to Marie Stopes. You may not want to comment directly on Marie Stopes, so I want to see whether you can advise the Committee as to what might happen in your inspection of abortion procedures.

Mr Houston: There are probably three broad areas, Mr Maginness. First, when a clinic is registered, it must abide by its statement of purpose. If a clinic strayed beyond its statement of purpose, we would be concerned with that and would endeavour to address it. Secondly, a clinic must abide by the regulations, and, as I explained in my opening statement, the regulations in Northern Ireland are different from regulations in other countries, including England and Wales. One of our current challenges in Northern Ireland with those regulations is that they do not specifically address or prescribe the techniques by which a termination of pregnancy may take place. Thirdly, in working within the regulatory framework, we must look at what that framework requires of a clinic, which is specified in the regulations. You mentioned one area: record-keeping. A clinic must keep good records. Our ability to access records is governed by the 2003 Order. There are certain circumstances, which are clearly laid out in the Order, whereby we can access records without consent. Generally, if we access records, we must do so with the consent of the patient. The exception in the 2003 Order is when a concern is identified to us that the life of a patient may be immediately at risk. That provides an exception, but, even in those exceptional circumstances, we must justify the basis on which we take that decision. That would inevitably require us to seek legal opinion and be sure of our grounds.

Mr A Maginness: From what you say, it seems to me that your powers to inspect any clinic that may be involved in abortion outside the National Health Service are limited.

Mr Houston: They are.

Mr A Maginness: Whereas, in England and Wales, there are different powers, so the situation is different.

Mr Houston: The regulations are different, and they are more extensive in relation to the procedure for the termination of pregnancy or abortion.

Mr A Maginness: Your written submission states that you had some problems with proposed clause 11A — I do not know whether you still have them — and treatments carried out beyond NHS facilities — for example, treatments that are borderline abortion or something of that nature carried out by a private clinician. You felt that, in such circumstances, what is legitimate within the present law may not be lawful. I think that that is the gist of what you were saying.

Mr Houston: I preface my answer by saying that neither of us is a trained barrister or solicitor and neither of us is an expert in the law. However, what we were attempting to do in our written submission was to identify areas that might arise as unintended consequences of clause 11A. One of the questions we posed in our submission was: how might an ectopic pregnancy be treated under clause 11A if it were identified outside an NHS service?

It is worth making the general point that many clinicians are in private practice. Those clinicians, if they also work in the NHS, do not fall to be registered as an independent clinic under the regulations. The issue is how clause 11A might extend to circumstances of that kind. Obviously, clinicians have a choice to refer people on and to refer them into the NHS, which many do, including general practitioners.

The second question we raised was: if an individual sought medical advice and, on the basis of that consultation, opted to have a medical abortion within the law as it stands, and clinicians in private practice were administering that medication outside NHS premises, how would clause 11A cover that circumstance? We do not have an answer to that; we raise it as a question.

Mr A Maginness: You raise that question quite rightly, and you have come here independently to speak to the Committee.

Have you looked at section 1(3) of the Abortion Act 1967? I will give you a copy, because it may be helpful to have a wee look at it. It reads:

> *"Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Secretary of State for the purposes of his functions under the National Health Service Act 2006 or the National Health Service (Scotland) Act 1978".*

It continues:

> *"or in a place approved for the purposes of this section by the Secretary of State."*

Section 1(4) states:

> *"Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman."*

The point I make to you is this: Mr Wells's amendment, in my opinion, reflects this subsection. I cannot see much difference between that and Mr Wells's amendment. This is the substantive law under which — I believe, anyway — British abortion law is carried out. If Mr Wells's amendment is reflective of that, and it does not cause legal problems in England and Wales of the type to which you have quite properly adverted — I am not in any way critical of that — why would it cause a problem here?

You may not have an answer to that question, and I respect that, but I raise the issue because I think there is very little difference between Mr Wells's amendment and the substance of subsection (3).

Mr Houston: I bow to your knowledge on that, Mr Maginness. I do not wish to challenge that in any stated shape or form, but —

Mr A Maginness: I am not expressing a legal opinion here.

Mr Houston: Whether it is a legal opinion or a personal opinion, I still would not wish to challenge it.

Mr A Maginness: It is a personal opinion.

Mr Houston: You asked, quite rightly, whether we had looked at the Abortion Act 1967. Having referred to the situation in England in my oral statement, I can share with the Committee two things: the Care Quality Commission (Registration) Regulations 2009 and the Department of Health's 'Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion)', which are described as interim procedures. The opening statement in that document says that the Secretary of State for Health has a responsibility under section 1(3) of the 1967 Act, as amended by section 37 of the Human Fertilisation and Embryology Act 1990, to approve places other than places exempted by this section for the purpose of treatment for termination of pregnancy (abortion) and that all places operated by non-NHS bodies must be approved.

Mr A Maginness: Yes.

Mr Houston: Those documents may be useful to the Committee.

Mr A Maginness: My final point is that, in present circumstances, outside the NHS, is there an approved place here where an abortion procedure could take place lawfully?

Mr Houston: The only place outside the NHS that offers that service is Marie Stopes International. It is currently registered under the independent health care regulations.

Mrs Fodey: We would point out, however, that England has actually written the requirements into its regulations and standards for termination of pregnancy and abortion. There is no equivalent in Northern Ireland, so there is no requirement to register a place to undertake the termination of a pregnancy. The place is registered by virtue of employing a doctor on a wholly private basis.

Mr A Maginness: Thank you very much; that is very helpful.

Mr Elliott: I apologise for missing the start of your presentation. I have a query about a point on page 4 of your written submission, which begins:

> *"If it is the intention of the promoters of this Clause to impose a blanket ban on private healthcare entities providing pharmaceutical early pregnancy termination services".*

Do you know that paragraph?

Mr Houston: Yes, I have it here.

Mr Elliott: Can you expand on that slightly more? You have given an example in the preceding paragraph. Are there any wider difficulties around that, or is it limited to what you have put in the preceding paragraph?

Mr Houston: The reference we made, Mr Elliott, in the preceding paragraph was to the example of a situation arising inadvertently as the result of a road traffic accident. How does the law apply in that circumstance? That is an extension of the purpose and nature of the law as opposed to the literal interpretation of the law. For us, the most significant issue is what becomes of an individual who is acting under medical supervision and guidance, but perhaps is administering an abortifacient at home as opposed to on NHS premises or in a clinic. Would clause 11A as it currently stands criminalise that activity, and is that an intended or an unintended consequence? I deliberately pose it as a question, because I am not clear what the intention was.

Mr Elliott: If it was not intended as part of the proposal, I assume there is a mechanism for — I will not say "getting round it" — dealing with that situation.

Mr Houston: There may well be appropriate means of setting out exemptions. In every piece of legislation, exemptions are normally prescribed. The independent health care regulations prescribe certain exemptions; for example, an occupational health service offered by an employer does not need to register as an independent clinic. It may employ a doctor who is working on a wholly private basis for that company providing occupational health advice, but that is a prescribed exemption.

Mr Elliott: Maybe this is an unfair question, but do you see it as a practice that could increase the numbers administering such medication at home?

Mr Houston: I look to my colleague, Kathy, to add to my answer. When the Abortion Act 1967 came onto the statute book, we did not have the Internet. The Internet opens up opportunities to individuals that were not around maybe even five years ago. A concern that any health care provider would have would be that, as an unintended consequence, women will be driven underground and put themselves at greater risk out of fear of seeking service, help, and support through a registered clinic or the NHS.

Mrs Fodey: The only thing I would add is, following Glenn's point on access through the Internet, we have a difficulty with some web-based doctor services. They do not know where you live, so the doctor at the other end may not know that he is supplying drugs to someone who is resident in

Northern Ireland against the law. Does that in itself make it against the law? I cannot answer those questions, but these are the types of scenarios that may be subject to this.

Mr Elliott: I assume that could be happening at present, as well.

Mr Houston: It could be. We do not know.

Mrs Fodey: Individuals could be sourcing medication on the Internet for such purposes without it being known to any of us.

Mr Elliott: Thank you very much.

Mr Poots: How many abortions have been carried out in the Marie Stopes clinic?

Mr Houston: We do not know the answer to that question, Mr Poots.

Mr Poots: And therefore you do not know if any have been carried out outside the law.

Mr Houston: One follows from the other. We do not know the number that have taken place.

Mr Poots: Who does know? Does the PSNI know?

Mr Houston: I doubt that the PSNI knows, but I cannot answer for them. Marie Stopes should know. They should be keeping a record.

Mr Poots: Do you accept that it is an unacceptable position that people could be operating outside the law?

Mr Houston: It raises an important question about the kind of information that an independent health clinic should be recording, what it should be doing with that information and what permissions there ought to be around the sharing of that information with the consent of patients. This is certainly a matter that has been of concern to this Committee previously.

Mr Poots: Euthanasia is illegal in Northern Ireland and, indeed, across the UK. If someone was offering that facility, that would also be against the law.

Mr Houston: I am sure you are correct in that.

Mr Poots: It would therefore be unacceptable for an organisation to do so and hold those records without sharing them. Do you accept that it is inappropriate that any organisation could be acting outside the law? You are suggesting that records should be shared with the patient's permission. I am sorry, but when it comes to the law, that overcomes that particular issue. If someone is engaging in an act which is breaking the law, then you do not have the right to hold on to that information.

Mr Houston: Again, this is perhaps something that is a very important interplay between the criminal justice legislation and health and social care regulations in terms of how information should be held and captured and under what circumstances, and with whom that information should be shared. For example, should it be shared with the Department of Health, Social Services, and Public Safety? Should it be shared with the Health and Social Care Board or the Public Health Agency? Should it be shared with the Regulation and Quality Improvement Authority? Those are all, I think, very valid questions and should be part of a debate.

Mr Poots: Fair enough.

Mrs Fodey: The only thing I would add to that is that our expectation is that any medical practitioner registered with the General Medical Council would not only adhere to their code of conduct but fulfil their responsibilities under the law.

Mr Poots: Everybody, including the PSNI for that matter, is subject to scrutiny. Everybody has the ability to break the law. That is why we have scrutiny mechanisms in place. We have a Police

Ombudsman, for example. As an organisation, you carry out many different inspections of people working in the health and social care sector. This group, however, perhaps because of weaknesses in the law or things which have not previously been thought about, have found a gap in the law allowing them to carry out work that does not come under scrutiny. That is basically what the issue is. I am not suggesting that they are breaking the law, but there is no mechanism for scrutinising that. That is, therefore, a deficiency that we need to address. I think this is what Mr Wells was trying to address. You raised quite a few issues about the legal context to clause 11A. Did that come from you or did you get legal advice?

Mr Houston: As I said in my oral statement, we felt it was appropriate to seek a legal view because we are not ourselves experts in the law. We sought and received opinion about proposed amendments, and our written submission reflects that opinion.

Mr Poots: Thank you.

Mr Lynch: You state that the draft clause is ill thought out. On what key grounds do you take this view?

Mr Houston: There were two reasons for our queries. One was whether there are unintended consequences. The second issue — it is more a criminal justice than a health and social care issue — is how we make good law that can be policed and against which individuals can properly be held to account. We wanted to point out that, whereas we as a regulator have a very specific and well-defined regulatory role within the health and social care order and its associated standards, we are not a criminal justice agency and are not, therefore, well placed to police the law.

Mr Lynch: Thank you.

Mr McGlone: We are coming to the nub of the issue. Can you talk me through what you check in a facility that you regulate?

Mrs Fodey: It very much depends on the premise under which the facility is registered with us. If it is a nursing home, we inspect against the nursing home regulations and DHSSPS minimum standards for nursing homes. By the same token, if it is an independent clinic, we inspect against the independent health care standards. Because they are silent on the issue of termination of pregnancy, if we are there to inspect a private doctor service, we focus our inspection on the private doctor service, including how that private doctor came to be registered in that clinic, what services are provided, how records are maintained and what qualifications they have.

Mr McGlone: So the question is whether a person is qualified to administer or serve within that practice or building or facility. Let me take you to a hypothetical — or probably non-hypothetical situation, as I would be surprised if you have not been there as an organisation. What if you find something untoward in terms of the level of professionalism or practice of a suitably qualified individual or individuals? What is the trigger mechanism then?

Mrs Fodey: That does happen; it is not a hypothetical situation. It happens across a range of services, and there are a number of mechanisms that we use. The very first thing is to assess the impact on patients and relatives — people who are in receipt of services. If for example, it immediately triggered safeguarding vulnerable adults or child protection issues, we would refer those on to the relevant authorities immediately. If we felt that there was an issue — whether we felt that the law was being breached and a crime was being committed — we would refer that on to the PSNI, and we have protocols for joint working with the PSNI that provide us with an easy mechanism to do that.

Mr Houston: I would add another dimension, Mr McGlone. The registered provider — the registered person, as it is known in the regulations — has a duty and a responsibility, if they have a concern about the practice of anyone employed in that clinic, to address that. That might involve also making a referral to the professional regulator: if it is a doctor, that is to the General Medical Council and, if it is a nurse, that is to the Nursing and Midwifery Council. We have had conversations in the past with registered persons about that very issue.

Mr McGlone: We will presume that that is the public sector. Can we move over into, say, an independent or private sector? You alluded to that earlier. Is it the independent health care regulations?

Mrs Fodey: Yes.

Mr McGlone: If you are in premises, what does your remit cover there? Is it different to the public sector, or is it the exact same remit? What is the trigger mechanism or the process to be followed if you find something untoward, improper or illegal regarding a professionally qualified individual? What happens in the independent or private sector?

Mrs Fodey: There would be no difference whatsoever. We still protect the people in the first instance. We make referrals to the PSNI, if that is appropriate; we refer it to the professional regulator; and we, as the regulator, would take enforcement action if we felt that it was a breach in regulations.

Mr McGlone: I will tease that out a wee bit further for you. Say, for example, an illegal abortion was taking place — you would certainly hope not in the public sector — in the private sector or in an independent clinic, as we will call them, what level of evidence or information are you privy to, to make the call that that was illegally taking place? In other words, unless somebody discovers it and passes it on to you, the police or whatever, what are your powers of investigation to establish whether that may or may not be happening? It could be that or it could be something else — for example, the illegal prescription of drugs.

Mr Houston: In any circumstance where a concern is brought to our attention, regardless of where it came from, the first thing that we have to consider is the appropriate authority to investigate that concern. If the appropriate authority is, for example, the PSNI, then we could actually be compromising a police investigation if we stepped into that space and, somehow or other, prevented a robust investigation being led by the PSNI.

Mr McGlone: I think that you are maybe picking me up slightly wrong. I am not talking about where someone has reported it to you; I am talking about your level or your capacity to discover whether something untoward or illegal is happening.

Mrs Fodey: During our inspection, we may discover something, but that would be coming across something. If you are asking whether we go in deliberately and search to see whether there has been a breach in the criminal law, the answer is no.

Mr McGlone: Right. Say that people's medical files are kept in there: do you have access to those medical files?

Mr Houston: First, we need to make sure that proper records are kept, and that is referenced in the independent health care regulations. The regulations are quite specific about the records that an independent clinic should keep. They are also very specific about the range of events that an independent clinic should report to the regulator. For example, the death of a patient is the very first thing that would be reported. Also prescribed is:

> *"any serious injury to a patient ... any infectious disease ... any event in the establishment or agency which adversely affects the well-being or safety of any patient ... any allegation of misconduct resulting in actual or potential harm .. any theft, burglary or accident in the establishment or agency."*

Those are the kind of things that the responsible individual is required to report to the Regulation and Quality Improvement Authority. Those would be triggers to the RQIA to ask a number of questions and, depending on how those are dealt with, they might also be triggers to refer the matter on to the GMC or the police.

Mr McGlone: That is the guidance. Finally, then, have there been occasions where, whether public or private, abortions have been listed among those?

Mr Houston: No. Abortion is not specifically listed, Mr McGlone.

Mr McGlone: I know it is not listed; I heard your list there. Has the actual act of an abortion been listed under any of those headings?

Mr Houston: I am not aware of that at any stage since my time in RQIA, which goes back to 2009.

Mr McGlone: That has been very helpful. Thank you.

Mr Dickson: I appreciate the presentation that you made. Have you actually received any complaints about the Marie Stopes clinic and the services that it provides?

Mrs Fodey: No.

Mr Dickson: You have conducted an inspection there, is that correct?

Mrs Fodey: We have, yes.

Mr Dickson: Were any adverse comments made in the inspection that you conducted about any of the services that it provides?

Mrs Fodey: By staff?

Mr Dickson: No, in your report.

Mrs Fodey: Adverse comments about —

Mr Dickson: About the quality of record-keeping or whatever.

Mrs Fodey: No. We assessed the clinic, and it was fully compliant with the standards that we went out to inspect against.

Mr Houston: In the last inspection, if I am not mistaken, there were no requirements or recommendations made.

Mr Dickson: That is very helpful, thank you.

The Chairperson (Mr Ross): Thank you very much. We appreciate your time.