Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Public Health Bill: Department of Health

2 May 2024

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Liz Kimmins (Chairperson)
Mr Danny Donnelly (Deputy Chairperson)
Mr Alan Chambers
Mrs Linda Dillon
Mrs Diane Dodds
Miss Órlaithí Flynn
Mr Colin McGrath
Mr Alan Robinson

Witnesses:

Dr Jillian Johnston	Department of Health
Mr Chris Matthews	Department of Health
Ms Carol Picton-Lynas	Department of Health

The Chairperson (Ms Kimmins): I welcome Chris Matthews, director of the emergency resilience and protecting health branch; Dr Jillian Johnston, senior medical officer; and Carol Picton-Lynas, head of the health protection legislation branch. Members, we have about 45 minutes for this session, so I ask you to keep that in mind. I invite Mr Matthews to make his opening remarks.

Mr Chris Matthews (Department of Health): Good afternoon, and thank you for the opportunity to provide the Health Committee with an update on the draft public health Bill. The written briefing paper that was submitted last week provides an update on the progress on the draft public health Bill and sets out the key overarching policy proposals that may underpin a new health protection legislative framework for Northern Ireland. At this point, I reiterate that the draft policy proposals are subject to ministerial and Executive approval and that agreement to consult is required, as some of the policy proposals are cross-cutting.

The initial policy scoping work for the new public health Bill was undertaken following the 2016 review of the current Northern Ireland public health legislation, which is the Public Health Act (Northern Ireland) 1967. The review of the 1967 Act identified that the current public health legislative framework needed to be updated in order that Northern Ireland can respond to 21st century public health emergencies and align, where it is appropriate, on a four-nations basis.

The overarching principle of the draft Bill is to protect the population against various forms of infection and contamination, including biological, chemical and radioactive, in addition to infectious diseases, which was the focus of the 1967 Act. It did not cover the first two areas. The draft public health Bill is intended to address the review recommendations and enable Northern Ireland to respond to 21st century public health needs. I will very briefly set out some of the proposals.

The 1967 Act makes provision for the mandatory notification of specific notifiable infectious diseases only by registered medical practitioners to the Public Health Agency (PHA). The draft Bill proposes to extend that to include all infection and contamination that presents or that could present a significant harm to human health. It is an "all hazards" approach, which aligns with the legislative framework in other UK jurisdictions. More importantly, it provides a fuller surveillance picture for the Public Health Agency.

Crucially, any notification process that will be put in place will need to ensure that information on public health interventions is provided on a timely basis in order for it to be effective in controlling the further spread of infections or contaminations. It is proposed that a duty is placed on directors or operators of diagnostic laboratories to notify the Public Health Agency where a specific causative agent that could cause significant harm to public health is identified in a human sample. A causative agent could be a virus or a bacteria, such as the meningococcal bacteria. That surveillance information will enable the Public Health Agency to have a better understanding of testing trends, vaccine programmes and disparities in healthcare access. It will also assist in ascertaining whether guidelines that the PHA has issued are being followed.

A four-nations exercise is under way to review the list of infectious diseases and causative agents in the public health legislation, and we are part of that. When the outcome of that review is completed later this year, we propose to include the agreed list in the new legislative framework for Northern Ireland. Work is also ongoing between the United Kingdom Health Security Agency (HSA) and our colleagues in the Republic of Ireland in order to consider an alignment of those causative agents on a five-nations position.

The draft Bill also seeks to align with the World Health Organization's (WHO) international health regulations (IHR), which were published in 2005 and to which the UK is a signatory. Those regulations provide an overarching legal framework that defines a country's rights and obligations when handling public health events and emergencies that have the potential to cross borders. The IHR are an instrument of international law that is legally binding on 196 countries, including the 194 World Health Organization member states. The international health regulations deal with infections, contamination and infectious diseases, which is our proposal for the public health Bill.

One of the other key areas is the powers of entry and roles of authorised officers, and the draft Bill will provide clarity on those. It will make provision enabling a range of powers following the notification and assessment of a health protection risk. Those include the power to gain entry to premises and investigate, meaning, for example, the power to ask questions, take samples and carry out testing.

It is proposed that the Public Health Agency, as the body with overall responsibility for public health, be given powers to investigate and act in incidents where it is not clear where that responsibility lies in Northern Ireland legislation. The scoping of that policy proposal is ongoing in order to map key responsible bodies and the relevant legislative frameworks that relate to different public health scenarios. For example, if something is food-borne, it is the councils' responsibility to investigate, and water contamination would be for the Drinking Water Inspectorate. What would be the Public Health Agency's role? Emergency powers of entry would be created and a judicial route — in other words, a warrant — may be sought to gain entry to a private dwelling or to secure entry to premises without notice.

The draft Bill may also contain a judicial route to health protection enforcement, enabling the Public Health Agency to make an application to the Magistrates' Court for an order imposing a requirement or restriction on a person, thing or premises. A duty will be placed on the Public Health Agency to have regard to the impact of the order on the welfare of a person or person's dependants, if any, for the duration of the order. Court orders will be required to specify the period for which the order is in force. It is envisaged that that will be a maximum of 28 days, as is already the case in other UK jurisdictions. The draft Bill will also include a provision enabling a person to apply to the court for a variation or revocation of the Magistrates' Court order.

A suite of offences will be in the draft Bill for non-compliance with a requirement or restriction, as will an offence of wilful obstruction. We are liaising with the Department of Justice on the offences and the Magistrates' Court orders. The intention is that, upon summary conviction, a fine would be imposed. Given that the Act dates from 1967, the draft Bill will also ensure that any actions that impact on individuals' freedoms are proportionate to the public health risk and are therefore compatible with the Human Rights Act 1998. The draft Bill will include regulation-making powers for the purpose of preventing, protecting against and controlling or providing a public health response to the incidence or spread of infection or contamination in Northern Ireland, regardless of where that risk originated. In

addition to addressing infection or contamination generally, or with regard to particular forms of infection or contamination that would make provision of a general nature, contingent provision would make specific provision in response to a particular set of circumstances or an emergency.

In the event that infection or contamination measures are required in order to bring forward draft regulations for consideration, the Department will, of course, seek Executive and Assembly approval. Consideration has been given to regulation-making powers for a public health emergency being exercised by any Department at the request of the Minister of Health. That reflects our experience following the initial COVID-19 response period, when regulations required significantly greater sector-specific expertise and understanding of the associated policies; for example, in the hospitality and leisure industries. Safeguards in that would include a restriction on making domestic health protection legislation to the effect that the regulations may not be made unless the appropriate Minister considers, when making the regulations, that the restrictions or requirements are proportionate to what is being sought to be achieved by imposing them.

The draft Bill will also provide us with the ability to be prepared and to respond to 21st century public health challenges, whether those relate to infection or contamination that could present significant harm to human health, as well as infectious diseases. As I said, an all-hazards approach enables us to respond to a broad range of health protection matters generally and, if need be, in an emergency.

Whilst we cannot be sure when the next pandemic will arise or what form public health emergencies will take, a new cross-departmental pandemic resilience programme board, led jointly by the Department of Health and the Executive Office, will deliver a programme of work to build resilience and better prepare Northern Ireland for the challenges of the next pandemic. We have significant stakeholder engagement across various Departments with our colleagues in the Republic of Ireland and the United Kingdom and with other organisations in Northern Ireland, as well as with other environmental health colleagues.

With regard to the timeline on when we might go to consultation, we are waiting on the briefing from the Bingham Centre about the rule of law plans. The centre is finalising its report and will publish on 15 May. The Department will carefully consider those recommendations prior to the consultation on the draft public health Bill. From early indications, it appears that costs that are associated with the Bill will not be significant, and we hope to bring it forward for consultation before the summer.

Thank you for the opportunity to brief you today on the Bill's progress. We will be happy to take any questions.

The Chairperson (Ms Kimmins): Thank you, Chris, and thank you for the briefing that was provided ahead of today's meeting. It was useful for members to have sight of that. I have a couple of questions, and then I will open it up to others. You mentioned the consultation with colleagues in Britain and in the South of Ireland. One thing that really struck me after coming out of the COVID experience was that we focused on working with England, Scotland and Wales when we should really have been working as an all-island epidemiological unit. You alluded in your remarks to the importance of that. If we had thought like that from the very beginning, we could have responded differently. Is the importance of that being taken into account in the discussions? We are on an island, regardless of how we look at it, and, from a common-sense approach, that needs to be front and centre moving forward.

Mr Matthews: We are working on four fronts in our pandemic preparedness and resilience: on a UK basis; on a Northern Ireland plc basis, for want of a better term; in the health sector; and we are beginning to work with our colleagues in the South. They are in the early stages of doing their pandemic preparedness.

As I mentioned, the strategic oversight board is considering the sorts of issues that are involved in a cross-governmental approach and an approach in the health sector, and we are very much tied in with that work. We have been sharing the work that we have been doing thus far with our colleagues in the South, given your comment about the all-Ireland approach and the need to consider the fact that there is a land border. Work is under way on that, and it will continue as we continue to build our resilience.

The Chairperson (Ms Kimmins): You mentioned that your colleagues in the South are in the very early stages of that work. Are they a bit behind where we are?

Mr Matthews: My understanding from my team is that they are slightly behind us in their thinking about the strategic and operational approach, but their thoughts align with the approach that we are taking, so we hope to tie in with that.

The Chairperson (Ms Kimmins): Hopefully, it can be streamlined.

Mr Matthews: A one-health approach has been adopted in responding to the agriculture side, the health side and the environmental side. A committee is in place, which our colleagues in health and agriculture in the South chair. Our deputy chief medical officer (CMO) is part of that one-health approach, which takes into account the North and the South.

The Chairperson (Ms Kimmins): Obviously, the COVID inquiry is under way. Do you think that what comes out of it will have any impact on the legislation and how we then bring it forward?

Mr Matthews: We need to wait for the COVID inquiry's report. The first area that it will report on is module 1. Once that comes out, it will be a consideration for us in our emergency response and the plans that we have in place for pandemic preparedness and resilience. In addition, we will, at the appropriate time, take into consideration any impact that it might have on the Bill and what is in it.

Mrs Dodds: You said that you are going to have powers to make emergency health protection regulations. Will you expand on that a little bit? How will other Departments make health protection regulations? You mentioned agriculture, waterways, infrastructure and so on. I see the relevance of that. You talked about what happened during the pandemic and about how tourism, hospitality and leisure were impacted very badly by closures. How on earth do they fit into those kinds of regulation-making powers? I am not quite sure that I see how that works.

Mr Matthews: The regulation-making powers would be at the request of the Minister of Health, so they would be based on the information at the time about the severity of the issue or whatever it happens to be. The Bill is in only its draft stages, but the proposal is that such regulations would be brought to the Executive for the other Ministers to consider whether other interventions need to happen in the areas that they are responsible for. As I said, the Minister of Health will not ask the Ministers to take that forward; they will need to consider whether there are any issues in or implications for their area, given that they are best placed to make those calls about the impact and implications that it would have for them.

Mrs Dodds: So, rather than having the all-encompassing regulations that we had during COVID, regulations would be much more specific to Departments. Is that what you are saying?

Mr Matthews: Potentially. They could be.

Mr McGrath: Chris, I thought that you were the hardest-working member of the Department of Health until I realised that there are two of you with the same name but in different roles. I am sure that you both work very hard in the Department.

On the back of what Diane said, during COVID, the regulations eventually landed here in the Assembly, and our permission to implement them was sought. Will the Bill follow that same format, or will it give the Minister the ability to take a decision and seek Executive support? Will it come to the House for our support, or will that always be retrospective, after the decision has been taken and implemented? There was a strange scenario throughout COVID where we debated regulations that had been implemented sometimes six weeks previously. Sometimes, we debated regulations that had been implemented and overturned. It felt at times as though the order was wrong for transparency, openness and democracy, frankly. Is that how the process is envisaged in the Bill, or will it be done in a different way?

Mr Matthews: The challenge is the speed with which you need to respond to whatever the issue happens to be. The broad principle in the Bill is that the regulations will be brought to the Executive and Assembly for consideration prior to their being implemented. That is the intention. Whether that due process occurs, which you would expect to happen, depends on the situation or scenario that you are faced with at the time. That is the intention, but, until we are at the foot of it, I cannot say whether that will be the case.

Mr McGrath: What sort of flexibilities do you envisage? Announcements were made about some of the stuff that was being brought to us, and there was suitable time for it to come to the Assembly, but it did not; the process took longer. The announcement could have been, "From Friday night, you will be able to go to a park with only three people". There was an opportunity for the rule to come to the Assembly between the decision's announcement and the rule coming in, but it might have been four weeks before that statutory rule (SR) landed in the Assembly to be debated. Is the same process envisaged under the Bill? Is there scope for that to happen, or will the Bill say, "You need to go to the Assembly, where applicable, first"?

Mr Matthews: The preference would be to go to the Assembly and the Executive first, but I cannot honestly tell you, based on a scenario that we have not encountered yet, whether that will be the case. The scenario that you described would certainly not be the intention, but I cannot put my hand on my heart and say that it may never happen.

Mr McGrath: Will we be able to discuss that as part of the Bill and it is not the case that the Bill will say no?

Mr Matthews: No, that is not the case.

Mr McGrath: So, there is opportunity for that discussion.

Mr Matthews: Yes.

Mr McGrath: That is fine. Good Thank you.

Mr Donnelly: Obviously, the legislation is outdated and well overdue and needs to be looked at again after the pandemic. We have learned a lot since then, and we need to put those lessons into legislation. You said that requirements would be placed on a "person, thing or premises". Can you give an example of how those requirements might be placed on a person? What will that mean?

Ms Carol Picton-Lynas (Department of Health): Placing a requirement on a person would happen, for example, if somebody did not voluntarily comply — this is not just in a pandemic situation; it could be where somebody has an infectious disease that presents a significant risk to human health — if they left their home and attempted to go to work. There is scope to place a legal order, which is a Magistrates' Court order, on a person to require them to not go to work, but, before that can happen, the magistrate must be satisfied that that is the right thing to do. Safeguards are built in, so the PHA would have to present a report to the court to explain the nature of the infection, the ease of transmission, how much of a risk it is to those around the person and why the order needs to be imposed. Having said that, if the court is satisfied with that evidence and makes the order on the person, there is scope for the person who is impacted to ask for a variation or a revocation of the order. There are safeguards for that as well.

Mr Matthews: The intention is that majority of the restrictions would last for a maximum of 28 days. That time could be shorter, but the intention they will last for no more than 28 days, so there could be a review period.

Mr Donnelly: Could that be reapplied?

Mr Matthews: There is a potential for that, depending on the nature of the infection and its impact. Again, the Public Health Agency would have to resubmit and make the case for why the person needed to remain, effectively, at home or in quarantine, depending on the situation. The 28 days is based on the principle in other UK jurisdictions where they believe that 28 days is sufficient for any pathogen to run its course at the very maximum and to allow additional time for that.

Mr Donnelly: How will notification change? How quickly can health interventions be taken in order to prevent further infection or contamination? Will the notification process change?

Ms Picton-Lynas: Under the 1967 Act, registered medical practitioners are required to notify the PHA when they suspect that someone has an infectious disease. The notification process will be expanded to not only deal with infectious notifiable diseases but look at any other infection or contamination that presents a significant risk to human health. Where a doctor, for example, suspects someone has a

particular infection, they will be under a legal duty to notify within seven days of being suspicious. If they consider that the notification should be more urgent, there is scope to notify orally, but they have to have due regard to the time when they do that, and criteria will be set in legislation that will advise when people should pick up the phone and notify the PHA.

Mr Donnelly: Does that mean that the interventions can happen more quickly?

Ms Picton-Lynas: Yes. A duty will be placed on laboratories to notify when they discover a causative agent or notifiable organism that could lead to disease. They will be under a legal duty to tell the PHA, and that will trigger the contact tracing and the other surveillance aspects, with a view to responding quicker.

Mr Matthews: A significant benefit of the Bill is the fact that the PHA will receive more information on a more regular basis to enable it to carry out better surveillance and, as you are saying, take quicker interventions and identify where there may be clusters or issues. It can then either provide specific guidance or take specific actions to deal with those so that they do not escalate to become a more serious public health incident.

Ms Flynn: Thank you very much for your presentation. Where do illegal substances fall in the Bill? The intent of the Bill is to protect the population against disease, but, as you said, it is being broadened to include all infection, all contamination and anything that presents a high risk to public health. When a bad batch of drugs, whether legal, illegal or mixed, circulates in the community, the PHA currently tests the drugs, but it can take up to a week to get the results. That is not quick enough to save people from an overdose. We heard the other week about how spice is ending up in kids' vapes in schools. There is an overarching high-risk public health concern there, and we should consider intervening. Is there a place in the Bill for protecting against such substances ending up on the streets? Should not surveillance and testing kick in?

Mr Matthews: I assume that you mean a surveillance process that is different from what the public health Bill is going to do.

Dr Jillian Johnston (Department of Health): The proposal is that it will be an all-hazards approach. To a degree, some of the things that you mention are likely to be incorporated into the Bill, when they might not have been previously. They may not be included to the full breadth, however.

If an individual were presenting with symptoms caused by some kind of contaminant, and, at that stage, we did not know exactly what it was we were dealing with, the expectation is that a medical practitioner would notify the health protection service in the Public Health Agency. Previously, that would not have happened to the same extent. The PHA would then have a duty to investigate to see whether there had been contact with others and therefore risk. I go back to the power to act on "persons, things or premises", and this might fall under the "thing" aspect. At that point, following investigation, we may, in theory, want to consider that thing, if the investigation were to show that it was linked to an individual presenting with illness and who was potentially a risk to the wider public. We would, however, do that in collaboration with other relevant organisations, such as the police.

Mr Matthews: With the requirement to notify about contaminants, we would hope that additional notifications would come through, which would then serve as a flag for the Public Health Agency to know that there was something there. We would then take forward that work with other partners, identify the contaminant and take appropriate action.

Hopefully, that flow of information, which is the principle behind the proposed Bill, would give the Public Health Agency more information more regularly to enable it to act more quickly. The causative agent would be investigated as well.

Ms Flynn: You said that that might be a surveillance process that is separate from that for an infectious disease. Using it as an example, however, I know that other testing models for lethal drugs are being used in Manchester and Dublin. There is a 24-hour turnaround for results, whereas the current PHA testing system takes a lot longer.

Liz asked a question earlier. Regardless of whom you work with, be they across the water or down South, we must ensure that, when we test locally for disease or contamination, we get the quickest turnaround of results in order to help people and prevent spread.

Mr Chambers: I will expand on a question that Danny asked about somebody who is carrying a bad infection. You say that you can take the case to a magistrate, present evidence and seek a quarantine order — I suppose that it would be called that — for that person to remain at home or enter a hospital setting. Is there any provision in the proposed Bill to enable you to take interim action, prior to going to a magistrate? Think of the timeline: that person could do an awful lot of damage between your knowing about it and your getting the case to a magistrate. Is there a fast-track provision in the legal system that allows you to obtain that type of order in a matter of hours? Hours are really vital in such a case.

It would probably breach human rights, but it would be good if something were to be incorporated into the Bill to give you a temporary power to impose a 24-hour order on such a person, with the proviso that the order would then be brought expeditiously to a magistrate to be confirmed or otherwise.

Ms Picton-Lynas: The intention is what currently happens anyway. It is that the PHA would give notice to the person, suggesting that they do not leave the house and just stay at home. That is the approach to take first before going down a judicial route. Where that person does not comply, there are, as you mentioned, means to get an emergency enforcement order. By way of enforcement, if the person were then to choose to leave the house in contravention of that order, they would be committing an offence, and the order would be enforceable. We will be liaising with DOJ and the Police Service of Northern Ireland on lifting people and taking them back to where they should be. We are still looking at what that might look like, but there is an enforcement provision in the legislation. If people know that it is an offence and a fine is payable, they are more likely to comply.

Mr Chambers: Time is of the essence.

Ms Picton-Lynas: Absolutely, but there is a process for getting a Magistrates' Court order within hours, as you mentioned.

Mrs Dodds: What is the role of the Northern Ireland Health and Safety Executive (HSE)? Is it the case that the PHA takes the lead and the HSE does the investigations?

Mr Matthews: Into?

Mrs Dodds: Into surveillance or whatever. I am thinking, again, of what happened during COVID. The Health and Safety Executive did an enormous amount of work on factories and elsewhere. Is there a role for it, or is that role designated by the Minister?

Ms Picton-Lynas: As part of the policy scoping, we are looking at any public health risk or incident in order to consider what legislative frameworks are currently in place and at existing roles and responsibilities. For example, environmental health officers have a specified role, and that is underpinned by legislation. Similarly, the Health and Safety Executive has a role, and that is underpinned by legislation. From our point of view, any powers that we would be bringing in for the PHA to consider would be for where there are gaps in the legislative framework for undertaking responsibilities. The Health and Safety Executive's current roles and responsibilities therefore should not change.

The Chairperson (Ms Kimmins): I have no further questions, so thank you all for attending today. It has been helpful. I think that we are expecting the legislation to be introduced later this year.

Mr Matthews: Yes.

The Chairperson (Ms Kimmins): As we move through the legislation, we will get into some more of the detail. Thank you for your time.