Eagle Star House
5-7 Upper Queen Street
Belfast BT1 6FB

BMA

Northern Ireland

Health Protection Legislation Branch
C/O PHD Admin Team
Room C4.22
Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ
[via email: phbt@health-ni.gov.uk]

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Policy Proposals to inform the development of a new Public Health Bill for Northern Ireland
Response from BMA Northern Ireland

Introduction

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

BMA Northern Ireland is grateful for the opportunity to provide views on the initial policy proposals to inform the development of a new Public Health Bill for Northern Ireland

BMA Northern Ireland welcomes the progress towards developing a new Public Health Bill for Northern Ireland, acknowledging the key recommendations from the Review of the Public Health Act (NI) 1967[1] final report that a new Public Health Bill was needed. Since publication of this report in 2016, public health systems in Northern Ireland, and indeed across the whole world, have been severely tested by the Covid pandemic. The extent to which the failure to act accordingly on these recommendations impacted the pandemic response in Northern Ireland is to be determined by the ongoing Covid Inquiry. However, in its initial report, the Inquiry noted

[1] DoH (2016) *Review of the Public Health Act (NI) 1967 Final report*: https://www.health-ni.gov.uk/sites/default/files/consultations/dhssps/review-public-health-act-ni-1967.pdf

National director (Northern Ireland): Claire Armstrong
Co-chief executive officers: Neeta Major & Rachel Podolak

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British Medical Association
bma.org.uk/northernireland

that, at least in relation to pandemic planning, 'the system in Northern Ireland had become unduly complex'[2].

Given new public health challenges continue to emerge, this work is even more pressing.

Overarching comments

There are a number of overarching comments on the proposals BMA Northern Ireland would wish to note, before responding to some of the specific questions raised in the consultation document.

- Protecting the workforce

Very few of the provisions within the proposals outlined can be delivered without sufficient consideration of the workforce requirements, including protecting doctors from the impact of dealing closely with potentially dangerous public health incidents.

Some of the questions in the consultation deal with specific proposed duties on registered medical practitioners (RMPs), including widening the scope of their current duties to report cases of notifiable disease to the Public Health Agency (PHA). However, we would first note that generally, the proposals don't sufficiently recognise the role played by the workforce in supporting an effective public health system, nor does it provide adequate protections for those involved in responding to a public health incident.

To put this in context, the Faculty of Public Health (FPH) recommends a workforce equivalent to 30 public health specialists per million of the population working in all parts of the health and social care system[3]. This means that Northern Ireland requires more than 57 public health specialists, based on its current population[4]. Yet, in 2021 the FPH estimated that, across Northern Ireland, there were just 15.3 per million – almost half of the recommended numbers.

The proposals increase duties on registered medical practitioners and gives PHA more powers to mandate certain examinations, investigations and treatments. Yet the consultation document doesn't outline which professionals may be mandated to undertake such work, whether consent of the registered medical practitioner is required, or whether there are any obligations to provide them with appropriate personal protective equipment (PPE). Likewise, the legal basis for any PHA mandates must be clear and there must be adequate legal protections for healthcare workers where necessary.

With such a low number of public health specialists, we would be concerned that the additional workload that stems from these proposals would be borne by those already under significant pressure, including the depleted public health workforce and other doctors. GPs, for example, are often the front door to the health service for those presenting with potential infectious disease. It would not be acceptable for the wider medical workforce, including those working in

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[2] UK Covid-19 Inquiry (2024) *Module 1: The resilience and preparedness of the United Kingdom - A report by The Rt Hon the Baroness Hallett DBE, Chair of the UK Covid-19 Inquiry*: https://covid19.public-inquiry.uk/wp-content/uploads/2024/07/18095012/UK-Covid-19-Inquiry-Module-1-Full-Report.pdf
[3] Faculty of Public Health (2021) *Faculty of Public Health submission to the Comprehensive Spending Review, September 2021*: https://www.fph.org.uk/media/3323/fph-submission-to-csr-2021-final.pdf
[4] NISRA (2024) Mid Year Population Estimates: https://www.nisra.gov.uk/statistics/population/mid-year-population-estimates#:~:text=The%20census%20population%20of%20Northern,to%20March%202021%20(1%2C898%2C600).

primary care, to be under additional duties on top of already crippling HSC pressures, event more so without adequate support and protections.

Enforcement of the proposed regime also raises concerns where doctors may have legitimate concerns about following a PHA directive, for example, if they aren't themselves sufficiently protected or have other justifiable professional or personal objections. Similarly, current pressures on the system may contribute to issues or delays in compliance or making formal notifications. It would seem disproportionate for practitioners to face any potentially significant consequences for issues beyond their control. Doctors must be supported to comply with any new duties, rather than punished for being unable to do so.

- Scope of proposals

BMA Northern Ireland responded to the 2015 review of the Public Health Act (NI) 1967, raising a number of issues for consideration. Of these, one recommendation was the introduction of health impact assessments, for which we continue to advocate. Public bodies should be equally seeking to avoid or minimise any negative impacts on the health and well-being of the population, as well as promoting positive impacts. This is something that would sit alongside existing statutory processes, such as Section 75 of the Northern Ireland Act, and so relatively easy to implement. It's therefore disappointing that the scope of this consultation has been narrowed so as only to focus on health protection, which whilst crucial and welcome, is just one strand of the wider public health system.

The narrow scope of this legislation also means that wider public health measures, including those addressing health inequalities, aren't proposed. The health inequalities experienced by different population groups remain stark in Northern Ireland. For example, preventable mortality in 2018-22 in the most deprived areas was three times the rate in the least deprived areas with the gap widening slightly over the last five years[5]. Of course, even the relatively narrow health protection proposals must be fully consistent with equality protections and human rights. However, this new public health legislation is a missed opportunity to begin addressing long-standing inequalities and ensure that all population groups are afforded the best opportunity to live a healthy life.

We understand the concern outlined in the consultation document that a wider scope could cause delay in development and passage of a new Bill, however, this must also be weighed up against the 2015 review, which recognised that the 1967 Act was too narrow. The review noted the need to consider expansion of the proposed Bill to cover ill health prevention more broadly and health improvement. Whilst we welcome the necessary focus on health protection, we would also want to see urgent progress on these other priorities.

A further consideration, given the focus on health protection, is how the regime will operate alongside the measures in place in the Republic of Ireland. The proposals don't appear to anticipate the need for cross border working, for example, in relation to infectious diseases, outbreak investigations or other hazardous events and situations which will likely require a coordinated response.

- BMA Covid review

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[5] Department of Health (2024) *Annual Health Inequalities Report 2024* https://www.health-ni.gov.uk/publications/health-inequalities-annual-report-2024

It's vital that the proposed Bill is developed with adequate learning from the public health response to the Covid pandemic. The BMA undertook a review of different aspects of the pandemic, including government responses, delivery of health care and the impact on the medical profession and patients[6].

In relation to the public health response[7], the review recommends that UK public health structures ensure they enable the best possible development, distribution, and implementation of independent expert public health advice which is fully considered and given appropriate weight in government decision making – particularly at times of national crisis.

As well as ensuring adequate funding and resourcing, the review also recommends that governments should take steps to ensure that the staffing, tools, and facilities needed to address any future pandemic can be scaled up quickly if necessary. It also calls for governments to review their approach to localised restrictions in the event of a future pandemic, to ensure that, if used again, these processes are clear, inspire confidence, and are enforceable. These recommendations are relevant to the scope of the proposed Bill and require due consideration.

Outside of the direct public health response to the pandemic, the BMA review made further recommendations requiring consideration which support adequate protection for health care staff and patients. These include ensuring that systems for deciding and issuing IPC guidance: a) issue updated guidance rapidly in response to fast-changing situations and evidence; b) communicate guidance effectively, and; c) highlight existing rights and responsibilities under health and safety law[8].

We would welcome all efforts to ensure that lessons are learned from the Covid pandemic and that the BMA review and its recommendations are adequately considered in the development of the Bill. The voice of the medical profession is vital to the effective response to any future public health emergency.

- HSC estates

The legislative framework for delivering an effective public health system is just one element of what is required. We have noted already the importance of the workforce in achieving the stated ambitions, however, a further crucial consideration is the role of the HSC estate and its ability to adequately manage a notifiable event let alone a larger scale public health emergency.

The BMA referenced concerns with the health service estate in its Covid review, recommending improvements in capital investment to modernise physical infrastructure and improve ventilation of the estate to cope better in any future pandemic. However, BMA's recent *Brick by*

[6] BMA (2022) BMA COVID-19 review: https://www.bma.org.uk/advice-and-support/covid-19/what-the-bma-is-doing/bma-covid-19-review

[7] BMA (2022) *BMA Covid review 4 The public health response by UK governments to COVID-19:* https://www.bma.org.uk/media/5980/bma-covid-review-report-4-28-july-2022.pdf

[8] BMA (2022) *BMA Covid review 1 How well protected was the medical profession from COVID-19?:* https://www.bma.org.uk/media/5644/bma-covid-review-1st-report-19-may-2022.pdf

brick report[9] provides further evidence of the need to address the inadequacy of the HSC estate.

Clearly the degradation of the estate is an issue impacting the everyday operation of the health service - crumbling buildings and infrastructure often force wards and beds to close, compounding a wider lack of space across healthcare estates and contributing to ever-expanding waiting lists. Insufficient space in hospitals and GP practices is hindering doctors' training and is preventing the recruitment of additional staff.

However, in the context of health protection, a significant number of our members report that the condition and configuration of their workplaces would not allow for appropriate ventilation and IPC (infection prevention control) measures in the event of a further wave of COVID-19 or a future pandemic.

Without addressing the HSC estate, requirements contained in any new Public Health Bill may not be practically deliverable on the ground.

BMA Northern Ireland response to consultation questions

Alongside the general issues BMA Northern Ireland has noted above, which are applicable to the many of the provisions outlined in the consultation, we also have a number of specific responses detailed below:

- Question 5: Do you agree or disagree with the proposed "all hazards" approach to notification? Please give reasons for your answer.

BMA Northern Ireland is broadly supportive of an 'all hazards' approach to notification, in line with the approach adopted in other UK jurisdictions, and in furtherance of the WHO recognition[10] that this is key to strengthening emergency preparedness. However, more clarity is needed on what this entails in relation to notifiable events and duties on medical practitioners. For example, terms such a 'causative agent' will require a clear definition. We understand that this is intended expand the current range of notifiable events from just clinically manifested disease, to include an identified source or causes of such disease. This is potentially open to broad interpretation and will require clarity. We therefore welcome the ongoing work at a UK level to provide this and await its conclusion.

- Question 6 (a): Do you agree or disagree with the duties to be placed on registered medical practitioners?
  (b): Do you agree or disagree with the types of information that registered medical practitioners must notify?

BMA Northern Ireland notes the proposals include widening the scope of current duties on registered medical practitioners to report cases of notifiable disease to the Public Health

[9] BMA (2022) *Building the Future - Brick by brick: The case for urgent investment in safe, modern, and sustainable healthcare estates*: https://www.bma.org.uk/media/6579/bma-infrastructure-1-report-brick-by-brick-estates-dec-2022.pdf

[10] WHO (accessed 2024) *Key approaches to strengthening emergency preparedness and response:* https://www.who.int/europe/emergencies/our-work-in-emergencies/key-approaches#:~:text=The%20all%2Dhazard%20approach%20acknowledges,and%20demand%20a%20multisectoral%20response.

Agency, with the potential to additionally require notification of significant presentations of infection and contamination, as well as application of duties to incidents involving deceased persons.

Current duties already exist on medical professionals, and BMA Northern Ireland does not object in principle to revising and updating these duties to be more responsive to potential public health incidents now and in the future.

Alongside any duties, there will need to be a clear process through which notifications can be made that is appropriate, accessible and proportionate.

Registered Medical Practitioners are likely to require specialist advice and support, including provision of PPE. There must be a clearly articulated responsibility on the Department of Health, PHA and HSC bodies to ensure such an infrastructure is in place.

Clarity will be needed on the correct interpretation of terms within the proposed legislation. We have referred already to use of the term causative agents. The proposals also refer to circumstances where notification is deemed 'urgent'. Again, this will require clear explanation that articulates the type of incidents that sit both inside and outside of this classification.

Likewise, the proposals refer to duties on registered medical practitioners (RMPs) 'to notify in relation to other infections, not listed in the Schedule of notifiable diseases, which they believe present or could present, a significant risk to human health'. This poses the risk of exceptionally broad interpretation, and it's unclear how this would practically operate.

- Question 9: Do you agree or disagree with the proposed enhanced powers of entry for "authorised officers" of the PHA? Please give reasons for your answer.
- Question 10 – Please give reasons for your answers. (a): Do you agree or disagree with the definition of "authorised officer"?
  (b): Do you agree or disagree that the Department should specify who the "authorised officers" should be in legislation?

BMA Northern Ireland notes the enhanced PHA powers, including power of entry of 'authorised officers'. We would request assurance that such authorised officers are not compelled to undertake PHA directives, especially in instances where the person is not an existing officer of the agency. We would be opposed, for example, to medical practitioners being compelled to attend an incident, or undertake an exam or investigation, that they feel poses too great a risk to their wellbeing.

- Question 13-19: Enhancements of PHA powers

In addition to PHAs current advisory role, the proposals seek to it new powers to authorise other bodies to act to investigate and mitigate an incident within their remits. This is a significant increase in authority that warrants further details as to how this would work operationally, for example, outlining which bodies would be within scope, what the process would be for authorisation and what actions would be the body be permitted to take. It's also vital that additional powers are sufficiently resourced so as to be utilised safely and effectively.

The proposals would also provide PHA the power to 'serve a notice on any person or groups of people requesting them to do, or refrain from doing, anything for the purpose of preventing,

protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents or could present significant harm to human health'. Clear criteria for such an order will be important to ensure these are reasonable and proportionate, and we would urge that due consideration is given to the impact of stigma, for example related to certain health conditions, across different groups and communities. This will be important to ensure that there is openness about any health risks and can help to improve trust and compliance with any public health measures.

It is proposed that restrictions or requirements that may be imposed on a person include mandated submission to medical exams and/or treatments. The legal basis for this must be clearly outlined, considering existing precedent and case law. We must also draw on the experiences of dealing with the Covid pandemic, for example, discussions around vaccinations[11] which can present complex practical and ethical questions.

It's vital that the public are given the information they need to make informed decisions about the care they receive, and that doctors are provided with the support and guidance to provide safe and effective care. For example, much more clarity is needed on the extent of examinations and treatment permissible under the proposals and certainty is required over the practical and legal protections available to medical practitioners who undertake them. There must be a clear process around patient consent and any obligations on doctors must be within the scope of professional standards[12].

As with orders in relation to people, PHA will have power to issue directions over premises, including closure if deemed necessary. We recognise that this may indeed be appropriate in responses to an emerging public health concern or in an emergency, however, further detail will be required as to exactly what process would be undertaken to determine whether closure is required and how this will work operationally. We have particular concerns about potential orders for closure of medical settings, including hospitals and GP surgeries, and the subsequent impact on doctors and other healthcare workers.

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[11] BMA (2021) *Covid vaccinations: Forced to choose:* https://www.bma.org.uk/news-and-opinion/covid-vaccinations-forced-to-choose

[12] GMC (2024) *Good Medical Practice:* https://www.gmc-uk.org/-/media/documents/good-medical-practice-2024---english-102607294.pdf