Public Law & Judicial Review North 2012

HEALTH AND HEALTHCARE PUBLIC LAW: NOTES

(1) The Health and Social Care Act 2012

Changes include (amongst many others):

- The establishment of an NHS Health Service Commissioning Board.[1]
- The establishment of clinical commissioning groups.[2] Most NHS services will now be commissioned by GPs.
- Fairly woolly duties upon the Secretary of State, including in relation to the NHS Constitution, the reduction of inequalities, the promotion of providers' autonomy, and the protection and improvement of public health.[3]
- The abolition of Strategic Health Authorities, Primary Care Trusts and the Health Protection Agency (amongst many other bodies).[4] But Local Area Teams of the Commissioning Board…
- The establishment of Monitor (from the Independent Regulator of NHS Foundation Trusts). Monitor's job is to protect and promote the interests of health care service users. It is meant to prevent anti-competitive behaviour, promote integration, secure public involvement in its decisions, and carry out impact assessments.[5]

New duties that may found useful challenges?

- Duty to have regard to the need to reduce inequalities: the Secretary of State; the NHS Commissioning Board, clinical commissioning groups, Monitor.[6]

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[1] Health and Social Care Act 2012, section 9, inserting section 1H into the National Health Service Act 2006. See also sections 23 and 25 of, and Schedule 1 to, the 2012 Act.

[2] Health and Social Care Act 2012, section 10, inserting section 1I into the National Health Service Act 2006. See also sections 25-28 of, and Schedule 2 to, the 2012 Act.

[3] Health and Social Care Act 2012, sections 3-5, 11 and 12.

[4] Health and Social Care Act 2012, sections 33, 34 and 56. See also sections 278-283.

[5] Health and Social Care Act 2012, sections 61-71.

[6] National Health Service Act 2006, section 1B, 13G, 13N, 14T and 14Z1; Health and Social Care Act 2012, section 62 and 96.

- ‘Effectively, efficiently and economically’: the NHS Commissioning Board, clinical commissioning groups, Monitor, the National Institute for Health and Care Excellence (NICE) .[7]

- Duties to obtain appropriate advice: the Secretary of State, the NHS Commissioning Board, clinical commissioning groups, Monitor.[8] And duties for health or social care bodies to have regard to certain NICE guidance.[9]

(2) The NHS Constitution[10]

A comprehensive service, available to all … reflecting the needs and preferences of patients … working across organisational boundaries … You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you … You have the right to privacy and confidentiality … (NB Other ‘pledges’ are ‘not legally binding’.)

The rights (and their sources) are expanded upon in a handbook.

NHS bodies and service providers, including GPs, must have regard to the NHS Constitution.[11] So, shortly, must the Secretary of State.[12]

No case-law, apparently.

(3) Co-operation

NHS bodies are required to co-operate with each other in exercising their functions.[13] And they and local authorities are also required to co-operate with each other.[14]

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[7] National Health Service Act 2006, sections 13D and 14Q; Health and Social Care Act 2012, sections 62 and 233; Schedule 8, paragraph 11, etc.

[8] National Health Service Act 2006, section 3B(4)(a), 13J, 14W; Health and Social Care Act 2012, section 62(8),

[9] Health and Social Care Act 2012, section 237(7) to (9) and section 265(5) amd (6).

[10] bit.ly/cMLvma

[11] Health Act 2009, section 2. See also National Health Service Act 2006, section 14P (once in force).

[12] National Health Service Act 2006, section 1A (to be inserted by section 3 of the Health and Social Care Act 2012).

[13] National Health Service Act 2006, section 72.

[14] National Health Service Act 2006, section 82.

Consider also:

- The local authority duty to work with health services during community care assessments.[15]
- The co-operation duty relating to after-care following a Mental Health Act admission.[16]
- The co-operation duties relating to children's services.[17]
- Duties arising when patients are being discharged from hospitals in England.[18]
- Principle 5 of the NHS Constitution ('working across organisational boundaries').
- The new co-operation duties created as a result of the Health and Social Care Act 2012.[19]

(4) Equality law

Under-used protected characteristics under the Equality Act 2010? Disability (section 6, Schedule 1); age (section 5).

Don't forget:

- That cancer, HIV and multiple sclerosis are *automatically* disabilities.[20] Also automatically disabled is anyone who has been certified as blind, severely sight impaired, sight impaired or partially sighted by a consultant ophthalmologist.[21]
- The duty to make reasonable adjustments (sections 20 and 21).
- Combined discrimination/dual characteristics (section 14).

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[15] National Health Service and Community Care Act 1990, section 47(3).

[16] Mental Health Act 1983, section 117(2), read with *R v Mental Health Review Tribunal, ex parte Hall* [2000] 1 WLR 1323.

[17] Children Act 1989, section 27; Children Act 2004, sections 10 (England) and 25 (Wales).

[18] Community Care (Delayed Discharges etc) Act 2003, sections 2 to 5.

[19] See sections 288-291.

[20] Equality Act 2010, Schedule 1, paragraph 6.

[21] Equality Act 2010 (Disability) Regulations 2010 (SI 2010/2128), regulation 7.

- That the public sector equality duty (section 149) isn't just about equality impact assessments. Nor is it just about eliminating prohibited conduct. It's also progressive: *advance* equality of opportunity; foster good relations.

- The statutory codes of practice (bit.ly/d3BWN5).

- The new NHS duties to have regard to the need to reduce inequalities with respect to (1) access to services and (2) the benefits of those services.

(5) Policies

Increasingly important sources of rights in healthcare (and elsewhere). Two recent, contrasting developments:

1. Consolidation of the administrative law requirement that public authorities must generally follow their own policies, absent good reason. Failure to do so, where the failure bears upon the decision made, may render that decision unlawful.[22]

   (Contrast with old-fashioned fetter,[23] which is important in the face of the growth in the mindless application of health-related policies.)

2. An emerging line of authorities suggesting a new ground for judicial review of a policy: that it gives rise to an *unacceptable risk of unlawfulness*, even if it can in principle be operated lawfully.[24]

(6) Using health professionals in judicial review claims

Do we underestimate the importance of medical evidence?

- It's often possible to get great evidence, for free, from treating clinicians. If you don't ask, you won't get.

- Those without training may not understand the difference between evidence and advocacy, and the weight afforded to apparent impartiality. Help them out.

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[22] See, in particular, *R (Kambadzi) v Home Secretary* [2011] 1 WLR 1299 at [36], [41], [51].

[23] For which, see *R v Home Secretary, ex parte Venables* [1998] AC 407, 496G to 497C.

[24] See Armstrong and Sandell 'Unlawful systems: the concept of unacceptable risk' [2011] JR 248 and *R (Suppiah) v Home Secretary* [2011] EWHC 2 (Admin) at [137].

- Charm, deference and ego-massaging go a long way.
- Ask simple, open, numbered questions.
- Ask about qualifications and relevant background, knowledge of their patient (including length of time), access to records.
- Let them know what happened afterwards.

Note the GMC guidance for experts (bit.ly/GDSP2U) and *draft consultation* guidance for all doctor witnesses (bit.ly/KVXpgz).

Also Part 35 (bit.ly/L35dln), Practice Direction 35 (bit.ly/L35dln), and the Protocol for the Instruction of Experts to Give Evidence in Civil Claims (bit.ly/LRsypy).

(7) Whether doctors are fooled by their patients/clients

A growing trend for courts to disregard medical evidence on the assumption that the doctor didn't question the validity of her patient's account. Your ammunition includes:

> "… But to say that it is not the duty of a doctor to disbelieve the account given by a patient may be correct but takes one absolutely nowhere. It is plain that a psychiatrist does exercise his critical facilities and experience in deciding whether he is being spun a yarn or not, and all of us sitting in these courts in different jurisdictions from time to time have heard psychiatrists saying that they do believe an account or that they do not believe an account. It is, therefore, wrong to suggest, as part of support for his conclusion, that doctors do not look into anything critically; nor would it be fair to Dr Eastgate to say that he accepted uncritically the claimant's account. One does not know, because the doctor does not say, but it certainly should not be assumed against the doctor that he did."[25]
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> "… a fundamental aspect of [medical experts'] expertise is the evaluation of patients' accounts of their symptoms …"[26]
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> "… as must inevitably happen, to some extent the expert starts with an account from her client and patient …"[27]

But make sure you provide your expert with all relevant documents, or her evidence may be rejected and you may be publicly bollocked.[28]

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[25] *R (Minani) v Immigration Appeal Tribunal* [2004] EWHC 582 (Admin) per Moses J at [26]. *Cf AE and FE (PTSD – internal relocation) Sri Lanka** [2002] UKIAT 05237 per Collins J at [10], [11].

[26] *Y (Sri Lanka) v Home Secretary* [2009] EWCA Civ 362 per Sedley LJ at [12].

[27] *R (AM) v Home Secretary* [2012] EWCA Civ 521 at [30].

[28] *SS (Sri Lanka) v Home Secretary* [2012] EWCA Civ 155 at [30]-[31].

(8) Checking out the other side's healthcare professionals

In the last year I have picked up a prison doctor witness who had an adverse fitness-to-practise determination made against him relating to honesty, a prison doctor witness who was not on the GMC's register at the material time, and (I think) a psychiatrist upon whose evidence the UKBA was relying who had been struck off the medical register for having had a sexual relationship with a patient.

- General Medical Council's register: www.gmc-uk.org
- GMC's fitness to practise determinations: bit.ly/L0FGnH
- The medical colleges' membership databases: e.g. psychiatrists (bit.ly/Npw8W0), GPs (bit.ly/NDr7H5)
- Nursing and Midwifery Council's register: bit.ly/aVCLEQ
- NMC's fitness to practise determinations (difficult to search): bit.ly/rAP6iq
- In fields of public law where the same people come up often (e.g. immigration, prison) case-law and Google search searches are often fruitful.

(9) An underused authority when in need of medical evidence about ECHR rights?

RV v Sweden (Application no 41827/07), judgment 9 March 2010, paragraph 53. An Article 3 ECHR case: an asylum-seeker had produced non-specialist evidence suggesting that scarring might have been caused by ill-treatment. The state ought to have arranged for an expert opinion because he had made out a *prima facie* case. The burden of proof 'in principle' rests with the applicant but the *state* has a duty to ascertain all relevant facts.

(10) Support for destitute asylum-seekers (and others) – developing law

Expect a Supreme Court case on the local authority duty to provide accommodation to ill or disabled people who are in need of care and attention not otherwise available to them.[29]

'Care and attention' means 'looking after', which means doing something can't or shouldn't do for herself.[30] It does not envisage any particular intensity of support and is not limited to acts done by local authority employees or agents; but it must not be reasonably practicable and efficacious to supply it without the provision of

[29] The duty is in the National Assistance Act 1948, section 21(1)(a).

[30] *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808.

accommodation: *SL*.[31] The Defendant has been granted leave to appeal to the Supreme Court.

(11) Restraint during medical treatment

Recent development in the law. Collins J, finding a breach of Article 3, in *FGP v Serco PLC* [2012] EWHC 1804 (Admin) at [54]:

> [I]t seems to me that there is a presumption that restraints should not be applied during treatment and there should be no attendance within earshot during consultations unless it is decided on proper grounds that such restraints or presence are needed. I do not think it is correct to approach the matter on the basis that restraints and presence will continue unless medical staff request otherwise.

(12) Immigration detention and health

'Rule 35' requires reports by doctors on those detained whose health is likely to be injuriously affected by detention, or who may have been the victim of torture.[32]

The relevant Home Office policy requires that:

- Rule 35 reports trigger prompt reviews.[33]
- Those suffering from serious medical conditions and/or serious mental illness, where (in both cases) their condition cannot be satisfactorily managed within detention, be detained only in very exceptional circumstances.[34]

The qualifications of *serious* mental illness *that cannot be satisfactorily managed within detention* were added on 26 August 2010 and were found to be unlawful, because of failures to comply with public sector equality duties, by Singh J on 17 April 2012.[35]

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[31] *R (SL) v Westminster City Council* [2011] EWCA Civ 954, reported as *R (S) v Westminster City Council* [2012] 1 All ER 935.

[32] Detention Centre Rules 2001 (SI 2001/238), paragraph 35.

[33] Enforcement Instructions and Guidance (bit.ly/uRubkQ), chapter 55, paragraph 55.8A.

[34] Enforcement Instructions and Guidance (bit.ly/uRubkQ), chapter 55, paragraph 55.10.

[35] *R (HA (Nigeria)) v Home Secretary* [2012] EWHC 979 (Admin).

(13) NHS charges and overseas visitors[36]

'Overseas visitor' means not ordinarily resident.[37]

GP services are available at a GP's discretion irrespective of immigration status. *GPs generally don't know this and routinely get it wrong.* Note, also, the requirements of administrative law, Equality Act 2010, etc.

The making and recovery of hospital charges is mandatory.

Class of service exemptions include:

- accident and emergency services – but not in-patient services (so emergency in-patient services are excluded)
- certain infectious or sexually-transmitted diseases (but not HIV)
- family planning services
- services to people who are liable to be detained under the Mental Health Act 1983

Class of person exemptions include:

- twelve months' lawful residence
- employment, self-employment, volunteers, students, taking up permanent residence
- asylum-seekers, including failed asylum seekers still receiving support
- children in care
- exceptional humanitarian reasons (very, very narrow).

Hospitals often get this wrong.

Leave to enter or remain will normally be refused to people with NHS debts of £1,000 or more.[38] The Department of Health publishes guidance telling NHS trusts that they can share non-medical information about patients with the UK Border Agency for the purpose of collecting such debts.[39]

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[36] National Health Service Act 2006, section 175; National Health Service (Charges to Overseas Visitors) Regulations 2011 (SI 2011/1556).

[37] On which, see *R (YA) v Health Secretary* [2009] EWCA Civ 225.

[38] Immigration Rules, paragraphs 320(22) and 322(12).

[39] *Implementing the Overseas Visitors Hospital Charging Regulations 2011*, paragraphs 5.55 and 5.56 and Appendix 7. All at bit.ly/jlGHEn.

(14) Right to die – changes on the horizon?

The current law is that:

- Deliberately accelerating a death is murder. But doctors can take steps to relieve symptoms when their intention is to relieve suffering, even when they know that those steps may accelerate death.[40] This happens all the time.

- Withdrawing or withholding life-prolonging treatment, where the prolongation of life is not in the patient's best interests, is also lawful and quite common.[41]

- Assisting a suicide is unlawful.[42] But this is only prosecuted with the Director of Public Prosecutions' consent.[43] The DPP has a policy setting out the considerations governing the exercise of his discretion.[44] In practice he hasn't prosecuted anyone for compassionate assistance with travel to Dignitas' facilities in Switzerland.

Recent developments:

- The (independent) Commission on Assisted Dying reported in January 2012 and recommended changes to the currently 'incoherent' law.[45]

- The All-Party Parliamentary Group on Choice at the End of Life is now consulting on a draft bill that would permit assisted suicide for terminally-ill people.[46]

- The General Medical Council has recently finished consulting on draft guidance about doctors who assist with suicide.[47]

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[40] *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

[41] See, again, *Bland*.

[42] Suicide Act 1961, section 2(1).

[43] Suicide Act 1961 section 2(4).

[44] bit.ly/azBOdz. This was required by the House of Lords in *R (Purdy) v DPP* [2009] UKHL 45, [2010] 1 AC 345, to make the 'law' (here, the exercise of the DPP's discretion) compliant with the Article 8 requirement of foreseeability. Article 8 encompasses individuals' choices about the way in which they pass the closing moments of their lives: see also *Pretty v United Kingdom* (2002) 25 EHRR 1 at [67].

[45] bit.ly/xFHSHm

[46] bit.ly/LNcO76

[47] bit.ly/AxGiW5

- In June 2012 a three-judge Divisional Court heard linked judicial review applications by two men with locked-in syndrome. *Nicklinson* seeks (amongst other things) that a defence of necessity be recognised to the offence of murder. *AM* seeks a development of the DPP's policy to make clear the position of helpers who do not have emotional ties to the person who wishes to end her/his life. Judgment expected in the autumn.

(15) A few (amongst many) important areas of law not covered in this note

General access to NHS treatment.

Access to NHS-funded healthcare in other European Economic Area member states.

Consultation and public involvement in decisions about NHS services.

Removal of patients from GPs' lists.

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