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IN HIS MAJESTY'S COURT OF APPEAL IN NORTHERN IRELAND

ON APPEAL FROM THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND KING'S BENCH DIVISION (JUDICIAL REVIEW)

BETWEEN:

EILEEN WILSON AND MAY KITCHEN

Appellants;

v

DEPARTMENT OF HEALTH FOR NORTHERN IRELAND, SOUTH EASTERN HEALTH AND SOCIAL CARE TRUST AND BELFAST HEALTH AND SOCIAL CARE TRUST

Respondents.

Before: McCloskey LJ, Horner LJ and Rooney J

Mr Ronan Lavery KC and Mr Conor Fegan, of counsel (instructed by McIvor Farrell solicitors) for the Appellants
Mr Ian Skelt KC and Ms Laura McMahon, of counsel (instructed by the Departmental Solicitors Office) for the first Respondent
Mr McGleenan KC and Mr Gordon Anthony, of counsel (instructed by the Directorate of Legal Services) for the second and third Respondents
Ms Bobbie-Leigh Herdman (instructed by Aisling Gallagher LLM) on behalf of the Commissioner for Older People for Northern Ireland, by written intervention

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McCLOSKEY LJ (*delivering the judgment of the court*)

INDEX

Subject	**Paragraph No**
Introduction	1-2
The Material Facts	3-4
The Issues	5

Statutory Framework	6-12
Other Important Evidence	13-17
Justiciability	18-25
"Macro/Target" Statutory Duties	26-35
The Statutory Duty Asserted	36-48
The Questions for the Court	49-64
The Family Planning Case Argument	65-67
The Art 98 Ground	68-69
The Article 8 ECHR Ground	70-74
Some Concluding Reflections	75-79
Disposal	80

Introduction

[1] Eileen Wilson and May Kitchen, (the "appellants") have something of significance in common. Each was the subject of a hospital referral by their respective General Medical Practitioners ("GPs") some years ago, in June 2017 (Mrs Wilson) and July 2019 (Mrs Kitchen). The purpose of the referrals was to have their cases considered by an appropriate medical consultant. Each of them has been the subject of certain hospital services subsequently. Both complain of protracted delay in the provision of medical treatment and services to them. In the language of counsels' skeleton argument, in both cases the complaint is of a "failure to provide …. medical treatment within a reasonable time."

[2] The appellants challenged the failures of which they complain by applications for judicial review. The cases were, sensibly, conjoined. Colton J dismissed their applications. These combined appeals follow.

The Material Facts

[3] The parties responded positively to the court's invitation to agree the material facts. Their joint stance was that these are rehearsed accurately in paras 4-6 of the judgment of Colton J. Thus, in the case of *Mrs Wilson*, per [2023] NIKB 2, para [4]:

> "The applicant, Eileen Wilson, is a 47-year-old lady who lives alone. She was referred to the South Eastern Health and Social Care Trust's ("the Trust") neurology service in June 2017 by her general practitioner because of suspected multiple sclerosis. The initial referral for assessment was classified as "urgent." She was initially advised that the current waiting list for neurology appointments is 163 weeks. Her case was later assessed by the attending consultant to be "routine." She was placed on a waiting list and has been advised to contact her GP in the event of any deterioration in her condition. She was due to have an

> appointment on 16 March 2020 but this was cancelled due to restrictions arising from the Covid-19 pandemic. A consultant neurologist conducted a virtual appointment with her on 11 March 2022. MRI scans were conducted on the applicant on 11 May 2022. She has not been diagnosed with having multiple sclerosis as a result of that scan and it is suggested that her symptoms should continue to be treated as fibromyalgia."

It is appropriate to add the following. The hospital consultant's initial evaluation of this appellant's referral, resulting in the re-categorisation from "urgent" to "routine", was undertaken within a period of approximately 30 weeks. It is evident that the stimulus for the GP's referral was a concern that the appellant might have been afflicted with multiple sclerosis. This concern was assuaged at an early stage of the hospital's involvement.

[4] In the case of *Mrs Kitchen*, per paras 5 and 6 of the judgment of Colton J:

> "[5] The applicant, May Kitchen, is a 75-year lady who also lives alone. She was diagnosed with cataracts approximately five years ago. She was referred to the Belfast Health and Social Care Trust's ("the Belfast Trust") ophthalmology service on 7 July 2019 by her general practitioner and optician. She was advised that the necessary operation for treatment of her cataracts would not take place for three to four years due to the length of waiting lists. After the pre-action protocol letter was issued on her behalf on 13 December 2019 although the waiting list for a routine out-patient appointment was 42 months she was provided with an appointment by the Belfast Trust for examination and testing of her eyes on 5 February 2020.
>
> [6] Although she was offered this out-patient appointment she was advised that the current waiting time for surgery was likely to be 15-17 months. Despite attending the out-patient's appointment she did not receive a date for surgery. She was fearful of losing her sight completely and therefore felt compelled to pay for private surgery through Benenden Health Care. Following an appointment on 14 September 2020, she was offered an appointment for private surgery within approximately six weeks."

This court, having reviewed further the affidavit evidence and having raised this issue with the appellants' counsel, established that this appellant did not in fact pay for the private cataracts operation which she ultimately received. Rather, following her

hospital appointment and testing (February 2020) she was able to procure a private health insurance policy which indemnified her against the cost of the operation performed some nine months later. Thus the operation was cost free for her. The amount of her policy premium is not specified.

The Issues

[5] As recorded at para 9 of the first instance judgment, both appellants contend that the failures in question are unlawful on account of

(a) breach of statutory duty and

(b) a breach of section 6 of the Human Rights Act 1998, specifically an interference with their right to respect for private life protected by article 8 ECHR.

Statutory Framework

[6] It is appropriate to deal with certain issues of nomenclature at this juncture. As will become apparent, the statutory provisions upon which the appellants initially based their respective challenges were extensive in number and span a period of some five decades, dating from 1972. The first respondent is the Department of Health for Northern Ireland ("DOH"). The second and third respondents are two of the Northern Ireland Health and Social Care Trusts ("the Trusts"). In order to properly understand the relevant statutory provisions a brief outline of the lineage of the three respondents is appropriate.

[7] DOH has had more than one statutory predecessor during the 50 year period in question. Its original predecessor was the Ministry of Health and Personal Social Services for Northern Ireland ("the Ministry"). The original predecessors of the Respondent Trusts were the Health and Social Services Boards ("the Boards"). The Ministry and the Boards were the bedrock of the structures and arrangements established by the Health and Personal Social Services (NI) Order 1972 ("the 1972 Order").

[8] Since 1972 there have been several notable statutory developments relating to the provision of State funded health and social care in Northern Ireland. These can be traced through, in chronological sequence, the Departments (NI) Order 1982; the Health and Personal Social Services (NI) Order 1991; the Health and Personal Social Services (NI) Order 1994; the Departments (NI) Order 1999; the Health and Personal Social Services Act (NI) 2001; and, ultimately, the Health and Social Care (Reform) Act (NI) 2009 (the "2009 Act").

[9] The parties helpfully co-operated with the court in exploring what appeared to the court to be one particular incongruity. In the available website versions of the 1972 Order there are continuing references to the Ministry in certain key provisions: see para 10 ff. This is plainly erroneous, given that the Ministry ceased to exist in 1982,

having been in existence under various guises since the enactment of the Ministries Act (NI) 1944. In 1982 the Ministry was effectively replaced by a new agency, the Department of Health and Social Services. The Boards, which were first established under the 1972 Order, ceased to exist upon the advent of the two Northern Ireland Orders and Council already noted, introduced in 1991 and 1994. Finally, DOH was established under the aegis of the 2009 Act. Its immediate statutory predecessor was the Department of Health, Social Services and Public Safety. The court is satisfied that all remaining references to the Ministry in the 1972 Order should be construed as referring to DOH. This analysis was not contentious among the parties to the appeals.

[10] From the initiation of these proceedings until a late stage of the appeals, the appellants' breach of statutory duty case had multiple statutory components. Ultimately, a substantial refinement materialised. However, in order to properly understand the evolution of the proceedings and the judgment of Colton J, it is appropriate to rehearse these several statutory provisions. The learned judge undertook this exercise at paras 11-17 of his judgment at [2023] NIKB 2, which we hereby reproduce (with some minor corrections):

> "[11] The general statutory duties of the Department in relation to the provision of healthcare are set out in section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the 2009 Act"). Section 2 provides as follows:
>
> "**Department's general duty**
>
> 2-(1) The Department shall promote in Northern Ireland an integrated system of—
>
> (a) health care designed to secure improvement—
>
> (i) in the physical and mental health of people in Northern Ireland, and
>
> (ii) in the prevention, diagnosis and treatment of illness; and
>
> (b) social care designed to secure improvement in the social well-being of people in Northern Ireland.
>
> (2) For the purposes of subsection (1) the Department shall provide, or secure the provision of, health and social care in accordance with this Act and any other statutory provision, whenever passed or made, which relates to health and social care.

(3) In particular, the Department must –

(a) develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland;

(b) determine priorities and objectives in accordance with section 4;

(c) allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

(d) set standards for the provision of health and social care;

(e) prepare a framework document in accordance with section 5;

(f) formulate the general policy and principles by reference to which particular functions are to be exercised;

(g) secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland;

(h) monitor and hold to account [...] the Regional Agency, RBSO and HSC trusts in the discharge of their functions;

(i) make and maintain effective arrangements to secure the monitoring and holding to account of the other health and social care bodies in the discharge of their functions;

(j) facilitate the discharge by bodies to which Article 67 of the Order of 1972 applies of the duty to co-operate with one another for the purposes mentioned in that Article.

(4) The Department shall discharge its duty under this section so as to secure the effective co-ordination of health and social care."

[12] The predecessor to the section 2 general obligation was Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972 ("the 1972 Order") which is relevant for the court's analysis. It provided:

"**General duty of Department**

4. It shall be the duty of the Department–

(a) to provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

(b) to provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland and the Department shall so discharge its duty as to secure the effective co-ordination of health and personal social services."

[13] Further to Article 4, Articles 5-6 of the 1972 Order provide:

"**Provision of accommodation and medical services, etc**

5.-(1) The Department shall provide throughout Northern Ireland, to such extent as it considers necessary, accommodation and services of the following descriptions–

(a) hospital accommodation, including accommodation within the meaning of Article 110 of the Mental Health Order;

(b) premises, other than hospitals, at which facilities are available for all or any of the services provided under this Order or the 2009 Act;

(c) medical, nursing and other services whether in such accommodation or premises, in the home of the patient or elsewhere.

Provision of general health care

6.-(1) The Department shall secure the provision of primary medical services, of general dental and ophthalmic services and of pharmaceutical services in accordance with Part VI."

[14] The general duties set out in section 2 and Article 6 above are supplemented by Articles 5 and 15 of the 1972 Order which provide the more detailed outworkings of the general, unparticularised duties enshrined in section 2 and Article 6. They provide as follows:

"**Provision of accommodation and medical services, etc**

5.-(1) The Department shall provide throughout Northern Ireland, to such extent as it considers necessary, accommodation and services of the following descriptions—

(a) hospital accommodation, including accommodation within the meaning of Article 110 of the Mental Health Order;

(b) premises, other than hospitals, at which facilities are available for all or any of the services provided under this Order or the 2009 Act;

(c) medical, nursing and other services whether in such accommodation or premises, in the home of the patient or elsewhere.

(2) In addition to its functions under paragraph (1), the Department may provide such other accommodation and services not otherwise specifically provided for by this Order or the 2009 Act as it considers conducive to efficient and sympathetic working of any hospital or service under its control, and, in relation to any person and notwithstanding anything contained in section 2(1)(a) of the 2009 Act, to provide or arrange for the provision of such accommodation or services, and in connection therewith,

to incur such expenditure as is necessary or expedient on medical grounds.

(3) Where accommodation or premises provided under this Article afford facilities for the provision of primary medical services, of general dental or ophthalmic services or of pharmaceutical services, they shall be made available for those services on such terms and conditions as the Department may determine.

(4) The Department may permit any person to whom this paragraph applies to use for the purpose of private practice, on such terms and conditions as the Department may determine, the facilities available at accommodation or premises provided under this Article.

(5) The persons to whom paragraph (4) applies, being persons who provide services under this Order or the 2009 Act, are as follows:—

(a) medical practitioners;

(aa) persons providing primary medical services under a general medical services contract or in accordance with Article 15B arrangements;

(b) dental practitioners;

(c) ophthalmic ... opticians;

(d) pharmacists; and

(e) such other persons as the Department may determine."

[15] Article 15(1) of the 1972 Order (as amended) which is to be considered in conjunction with section 2(1)(b) of the 2009 Act (social care), provides:

> 'An authorised HSC trust shall make available advice, guidance and assistance, to such extent as it considers necessary and for that purpose shall make such arrangements and provide or secure the provision of such facilities (including the provision or arranging for the provision of residential or other accommodation, home help

and laundry facilities) as it considers suitable and adequate.'

[16] Article 15B provides as follows:

"**Primary medical services or personal dental services**

15B.-(1) The Department may make one or more agreements with respect to its area, in accordance with the provisions of regulations under Article 15D, under which—

(a) primary medical services are provided (otherwise than by the Department); or

(b) personal dental services are provided (otherwise than by the Department).

(2) An agreement made under this Article—

(a) may not combine arrangements for the provision of primary medical services with arrangements for the provision of personal dental services; but

(b) may include arrangements for the provision of health care -

(i) which are not primary medical services or personal dental services; but

(ii) which may be provided under this Part."

[17] In respect of statutory duties imposed on the Trust and the Health and Social Services Board Article 56(1) of the 1972 Order provides:

"**Primary medical services**

56.-(1) The Department shall, to the extent that it considers necessary to meet all reasonable requirements, provide primary medical services or secure their provision.

(2) The Department may (in addition to any other power conferred on it)—

(a) provide primary medical services itself;

(b) make such arrangements for their provision as it thinks fit, and may in particular make contractual arrangements with any person.

(3) The Department shall publish information about such matters as may be prescribed in relation to the primary medical services provided under this Part."

And finally:

"**98. Services free of charge**

(1) The services provided under this Order or the 1991 Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 shall be free of charge, except where any provision contained in or made under this Order or the Health Services (Primary Care) (Northern Ireland) Order 1997 or the 2009 Act expressly provides for the making and recovery of charges."

[11] The Judge, to his credit, dealt with each of these provisions seriatim. At the appeal stage, the contours of the appellants' breach of statutory case evolved by reduction, as shall become apparent infra.

[12] The appeal phase of these proceedings was marked by quite intensive judicial case management and the generation of several revisions of the authorities and statutes bundles, followed by the hearing itself. As the hearing progressed the court tentatively enquired whether the appellants' reliance on the multiplicity of statutory provisions rehearsed above reflected a combination of the unnecessarily complicated and the excessively optimistic. The court suggested to Mr Lavery that, on the premise that Article 5(1) of the 1972 Order establishes a statutory duty owed individually to members of the population, the following elements of Article 5(1)(c) were in play:

"**The Ministry shall provide** throughout Northern Ireland, to such extent as it considers necessary, ………

(c) **Medical** … services…."
[Our emphasis.]

Following reflection Mr Lavery was disposed to endorse this approach. We consider that he was correct to do so. In this way Article 5(1)(c) of the 1972 Order became the centre piece of the appeals.

Other Important Evidence

[13] As appears from paras 18-37 of his judgment, the judge paid particular attention to certain aspects of the evidence, in particular, a report dated 3 January 2022 prepared by Professor Deirdre Heenan of Ulster University. The following passage encapsulates the author's detailed critique of what is commonly described as "waiting lists" in the realm of publicly funded health care in Northern Ireland:

> "Prior to the pandemic the health and social care system in Northern Ireland (NI) was in a state of turmoil. It was stretched to its limits, struggling to cope with record levels of demand, soaring costs and ongoing staffing issues. Ministerial targets for waiting times in elective care, Emergency Departments (EDs), and cancer care being missed by more and more each month. Over the last two decades, all regions of the United Kingdom (UK) have struggled to contain waiting lists, but NI was by far the worst performer. NI was the only region of the UK where waits of over a year for treatment were commonplace. The number of people waiting for elective care in NI has risen exponentially since the mid-1990s. It is difficult to overstate the gulf between waiting lists in NI and other regions of the UK. In 2019 the number of people on a waiting list in NI was 105,486 (population 1.9 m) compared to 1,089 in England, (population 56m) (Heenan and Dayan, 2019). These long delays in treatment have eroded the principle which underpins the NHS, healthcare based on need, free at the point of delivery."

[14] Elaborating, Professor Heenan highlights that over 50% of patients have been on hospital waiting lists following GP referral for periods exceeding the "official target" of 12 months. This gives rise to "increased distress, worsening of the disease and the potential increase in preventable deaths." The Professor states:

> "Behind these shocking statistics are real people languishing in pain in an unresponsive system which is delivering care to a much lower standard than other UK regions. Yet waiting lists continue to rise and more people are consigned to wait years for diagnosis and treatment. The DOH have repeated stated that the issue is largely financial, and more money is required …
>
> NI spends more per head of population on healthcare than any other UK region, with by far the worst outcomes. This raises a number of questions about the efficiency and effectiveness of the healthcare system and the extent to which it is fit for purpose. NI does not have a credible and realistic strategy to address waiting lists. Policy

> development in this crucial area of healthcare has been woefully inadequate with multiple NI Audit Office reports highlighting weak decision making and poor value for money. The backdrop to these issues is a context of long delayed structural reform and transformation. Seven major reviews have pointed to the same direction of travel. Services must be rationalised into regional specialist centres and fewer hospitals, with a focus on community care and prevention. Every political party in NI agrees with this prognosis but are unwilling or incapable of delivering fundamental changes."

As the report further explains, the main focus of the author's critique is waiting lists for elective care, i.e., care planned in advance for those whose medical condition requires "a procedure of treatment that can be managed by being placed on the waiting list …. [and] … diagnostic services – medical tests to assist in the diagnosis of disease and can assist in the management of patient care."

[15] Professor Heenan next criticises the outcome of multiple successive reviews of the public healthcare system in Northern Ireland dating from 2001. She opines that DOH has failed to formulate an appropriate comprehensive strategy addressing the issue of waiting lists. She suggests that nothing novel has emerged from more recent reviews and criticises proposed reforms as being merely aspirational. The Professor is emphatic that lack of funding is <u>not</u> the basic mischief.

[16] There is affidavit evidence on behalf of the Respondent Trusts and DOH. The Trusts' affidavits explain how the system for elective surgical procedures operates in the sphere of ophthalmology services (Mrs Kitchen's case). The guiding principle is that of treating patients with the same clinical need on the basis of clinical priority, as assessed, and then in chronological sequence. There are corresponding acknowledgements in the case of Ms Wilson. The following averments draw together several relevant strands:

> "… The Trust does not dispute that there has been a delay in Mrs Wilson's treatment or that delay in treatment is unacceptable. However, …. the delay is presently unavoidable. The unfortunate reality for the Trust is that it must work within a framework of finite resources where demand for hospital services continues to grow and put pressure on all specialities …. [and] … the pressure on the Health Service has intensified greatly since [the] pandemic began."

The material averments on behalf of the other respondent Trust in the case of Mrs Kitchen are, in essence, the same.

[17] There is also affidavit evidence on behalf of DOH. The court has considered this in full. This contains extensive information, including statistics, bearing on the three main themes of an ever-increasing gap between demand and capacity, a funding deficit and the constraints caused by short term funding cycles. There are notable averments such as:

> "The Health Minister has repeatedly stated that a significant increase in recurrent funding will be required to place budgets and secure provision on a sustainable footing and to return waiting lists to acceptable levels."

And:

> "The Department has been faced with single year budgets since 2015/16. This has impeded long term financial planning and resulted in a focus on the short term. All funding received by the Department in recent years has been used to fund the costs associated with maintaining existing models of service and associated cost pressures. During this time, there has been limited budgetary cover to also fund service improvements ….
>
> The Department has been increasingly reliant on securing non-recurrent additional funding during in-year monitoring rounds to support the ongoing running costs to maintain existing services ….[which] … cannot be used to invest in staff or services …
>
> Since 2015 the annual budget allocated to the Department has not been sufficient to keep waiting times to an acceptable level. There has been an acknowledgement that there is an imbalance between patient demand for many elective specialities in NI and the available recurrently funded capacity …
>
> The Department routinely and persistently makes the case for significant additional funding as part of the budget process, but ultimately the decision on how much funding to allocate, and how to deploy the funding that is allocated, rests with the Executive and the Minister. The reactive nature of many other health services and the need to be in a position to respond to immediate need will often lead to resources being deployed away from elective care ….
>
> Whilst NI spends more on health per capita than other parts of the UK … there is a need for healthcare funding in

Northern Ireland of between 7% and 16% greater than that of England …

Northern Ireland's spending in 2019/20 was only some 7.8% above that of England …

Whilst doctors, nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow to a level where many believe that they are now out of control, will take years to stabilise and even longer to return to their pre-2015 levels. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround …

A multi-year budget approach is needed to secure a recurrent funding source to increase the capacity of our elective care system, whether in-house or through increased use of the independent sector, and to enable us to invest in the staff and infrastructure required …

There are limitations to relying on short term funding models for these services. Reducing waiting times and keeping them at acceptable levels will require long term investment …

The way in which services are organised in Northern Ireland has also contributed to issues with efficiency …

Maintaining 24/7 emergency surgery at multiple acute hospital sites has led to a service that is overly reliable on locum doctors and agency nurses in order to fill rotas …

Ultimately, even if all of the reforms set out in the 2017 Elective Care Plan are introduced successfully, the scale of the backlog is so great that this is beyond the capacity of the HSC to resolve. The HSC will need to access additional capacity through partners in the private and charitable sectors for the foreseeable future in order to bring waiting times down to acceptable levels."

Justiciability

[18] It is necessary to consider the issue of justiciability at this juncture. Both at first instance and on appeal DOH has contended that the subject matter of the appellants' challenges is not justiciable. This entails the argument that the subject matter concerned lies beyond the purview of the supervisory jurisdiction of the High Court and, on appeal, this court. Appreciation of the basic legal doctrine in play is essential. If the subject matter of any given legal challenge is considered by the court to be non-justiciable, the role of the court is thereby exhausted. There is no adjudication of the merits of the challenge – unless the court chooses to do conduct an obiter or 'in the alternative' exercise – because the issues raised lie outwith its competence.

[19] One of the clearest illustrations of the application of the non-justiciability principle is provided by a purported challenge to primary legislation. Prior to the withdrawal of the United Kingdom from the European Union primary legislation was susceptible to challenge on the ground that it was incompatible with supreme EU law: see, for example, *Fleming v Revenue and Customs Commissioners* [2008] UKHL 2 at 24, per Lord Walker. Post-withdrawal, primary legislation is vulnerable to challenge only on the ground that it is incompatible with one of the protected Convention rights in pursuit of a declaration of incompatibility under section 4 of the Human Rights Act. By virtue of the Pickin principle, primary legislation is otherwise non-justiciable: *Pickin v British Railways Board* [1974] AC 765, 7987. This is subject to further development of the common law, in particular under the aegis of the principle of legality discussed in, particularly *R (Jackson) v Attorney General* [2005] UKHL 56 at 102, per Lord Steyn.

[20] As the primary legislation illustration demonstrates, a judicial assessment of non-justiciability will not infrequently be based upon constitutional principles. Equally, as demonstrated by the review in Chapter 3 of De Smith's Judicial Review (9th ed), the gradual erosion of outdated, rigid distinctions in the incremental development of the common law has brought about a corresponding enlargement of the supervisory competence of the High Court exercisable in judicial review proceedings. This is illustrated by the progressive vulnerability to challenge of the exercise of prerogative powers. Thus, for example, the Supreme Court has held that where primary legislation is made in the exercise of prerogative powers the supervisory jurisdiction of the High Court is not excluded by the principle of parliamentary sovereignty: *R (Bancoult) v Secretary of State for Foreign and Commonwealth Affairs (No 2)* [2008] UKHL 61.

[21] In *Bahamas District of the Methodist Church v Symonette* [2000] UKPC 31, the test framed by the Privy Council was whether the courts "… have power to enquire into such a claim and consider whether any relief is called for", at para 32. As the terms of this test indicate and as elaborated in the analysis in *De Smith* (op. cit) at para 3-014ff the issue is properly viewed as one of <u>jurisdiction</u>. If the subject matter of the challenge is non-justiciable, the High Court has no jurisdiction to act. Thus, by way of illustration, the decisions of the Privy Council that issues relating to the internal procedures of the United Kingdom Parliament (*Prebble v Television Museum* [1995] 1 AC 321 at 332) and decisions of the senior courts of England and Wales (in *Re A*

Company [1981] AC 374 at 392) are non-justiciable may be viewed through the prism of jurisdiction. So too decisions relating to the non-justiciability of the exercise of certain functions of the Attorney General (*Attorney General v Gouriet* [1978] AC 435).

[22] In contrast to justiciability, the term reviewability also forms part of the legal lexicon in this sphere. In this context Colton J noted the observations of Kerr LCJ in *Re Shuker's Application* [2004] NIQB 20 at para 7:

> "In the course of the hearing a good deal of debate was engaged on whether this issue was properly to be regarded as one of justiciability; it was suggested that it might better be seen as an issue involving the reviewability of the Attorney's decision. It is possible (at least at a theoretical level) to distinguish the question of justiciability (which might be defined for present purposes as 'whether the decision of the Attorney General is subject to the jurisdiction of the court') from the notion of reviewability (i.e. whether the specific type of challenge made can, in the particular circumstances of the case, be permitted) although the application of the correct principles from either concept may provide the same answer, and in any event, the concepts tend to blend into one another. Mr Morgan accepted that whether the Attorney's decision was subject to judicial review would depend on a case-by-case analysis, which might suggest that this partakes of a reviewability rather than a justiciability approach to the question. But it is clear that justiciability issues must also be judged on an individual basis – see, for instance, R (on the application of Abbasi and another) v Secretary of State for Foreign and Commonwealth Affairs and another, paragraph 85. For reasons that we shall give, we consider that this species of decision is justiciable but there are significant constraints on the extent of review that may be undertaken."

This passage, considered as a whole, defines reviewability in terms of the extent, or intensity, of the review which the High Court may permissibly undertake. This we consider to be orthodox dogma.

[23] We consider that in every case where reviewability is the focus of debate there is no issue as to justiciability: the court, by definition, has accepted (or, where required, ruled) that it is competent to review the act or decision under challenge and progresses to consider the quite different question of how intense such review should be where the challenge is based on the Wednesbury irrationality ground. Where the challenge is founded on any of the other established public law grounds, no issue of intensity of review arises. The decision in *R (A and Others) v Secretary of State for the Home*

Department [2022] EWHC 360 (Admin), which features in the judgment of Colton J and was raised in argument before this court, belongs to the non-justiciable category. So too the recent decision of this court in *Re Burns and McGready's Application* [2022] NICA 20.

[24] It is argued on behalf of DOH that the subject matter of the appellants' challenges are (per counsels' skeleton argument):

> "… not justiciable as they are concerned with political decision making for the provision of public care."

The decided cases invoked in support of this contention are *Re Burns (supra), Re A and Others, Re Napier's Application* [2021] NIQB 120, *Re Shuker* and *R v Secretary of State for Trade and Industry, ex parte Lonrho* [1989] 1 WLR 525 (at 536 especially per Lord Keith). In addition Mr Skelt KC, in oral argument, prayed in aid the passage in *R v Secretary of State for the Environment, ex parte Hammersmith and Fulham London Borough Council* [1991] 1 AC 521 at p 563c/h, per Lord Donaldson MR.

[25] We consider that none of these cases supports the argument advanced. The key distinguishing feature is that these combined appeals concern the exercise by public authorities of statutory functions in the sphere of public law, which are <u>not</u> confined to the narrow constraints of matters "of political judgment" (per Lord Keith, supra). The guiding principle is well settled:

> "If the source of power is a statute, or subordinate legislation under a statute, then clearly the body in question will be subject to judicial review."

See *R v Panel on Takeovers and Mergers, ex parte Datafin* [1987] QB 815, at 847 (per Lloyd LJ). As appears from the decision of the Privy Council in *Mohit v Director of Public Prosecutions of Mauritius* [2006] UKPC 20, paras 20-21, this principle operates as a <u>presumption</u>, one which will be rebutted only where there is "compelling reason" to do so (per Lord Bingham). This presumption clearly applies here and no compelling reason for disapplying it is evident. We further consider that the exacting test in the *Hammersmith* case is not satisfied, by some measure. Furthermore, and in any event, *Hammersmith* must be considered in light of the clear and consistent line of authority just rehearsed. Thus, in agreement with Colton J, we consider the real issue in these challenges to be that of the extent of the court's review – in shorthand, reviewability.

"Macro/Target" Statutory Duties

[26] Section 2 of the 2009 Act is a provision described in the legislation itself as "Department's General Duty." Colton J adopted and applied the analysis in *Re JR47* [2013] NIQB 7 relating to section 2(3) – specifically paras (c), (h) and (j) – of the 2009 Act, at paras 34-36:

"The next and final limb of Mr. E's breach of statutory duty challenge focuses on Section 2 (3)(c), (h) and (j) of the 2009 Act. My first conclusion is that Section 2(3)(c) is couched in heavily qualified terms and confers on the Department a discretion of manifest breadth. On the evidence, I find no infringement by the Department of this discrete statutory provision. Secondly, I find that the Department has taken positive steps in fulfilment of the requirement enshrined in Section 2(1)(h) and no infringement thereof is established. Thirdly, I find no evidence that the Department has infringed Section 2(1)(j). In making these conclusions, I have intentionally employed the neutral language of "infringe" and "infringement." Applying this tool of assessment, none of the asserted infringements (or contraventions) is established. In short, I find that no illegality in the Department's exercise of these discretionary statutory powers has been established. More specifically, having regard to the contours of this discrete ground of challenge, I find that no crystallised duty owed by the Department to Mr. E has arisen. I elaborate on this finding in the following paragraph. This suffices to defeat this discrete aspect of Mr. E's challenge…

The specific question is whether Mr. E can establish a rights/duties axis on the facts of his case. Where statutory provisions of this kind are concerned, the debate which is frequently stimulated focuses on whether these are so-called "target" duties. This nomenclature and that of target setting legislation (which is not the same: see, for example, Section 1(1) of the Climate Change Act 2008 and Section 1 of the Child Poverty Act 2010) have become established features of the legal lexicon during recent years. In R (G) –v- Barnett LBC [2004] 2 AC 208, the statutory provision under consideration was Section 17 of the Children Act 1989. Lord Hope observed that one of the central features of target duties is that they are "… concerned with general principles and not designed to confer absolute rights on individuals": see paragraphs [76] – [88] of his opinion and that of Lord Millett. This expansion of the legal lexicon can be traced to the judgment of Woolf LJ in R –v- Inner London Education Authority, ex parte Ali [1990] 2 ALR 822 and its evolution can be traced through decisions such as R –v- Radio Authority, ex parte Bull [1998] QB 294 (at p. 209 especially) …

> The three statutory provisions under scrutiny here are couched in manifestly broad, elastic and non-prescriptive terms. I consider that they confer a significant measure of discretion on the Department. In my view, the general principle in play is that statutory provisions of this kind do not create enforceable duties on the part of the public authority concerned. This accommodates the proposition that, in a certain factual matrix, an enforceable statutory duty owed to an individual could conceivably crystallise – an issue which I do not determine here. Insofar as this analysis is doctrinally sound, I find that the Department at no time owed any such duty to Mr. E. This finding is made swiftly in the wake of formulating the duty asserted. It seems to me that Mr. E is asserting that these statutory provisions imposed on the Department a duty to provide him with suitable accommodation in the community, of his liking and acceptable to him, within a reasonable period following his first ventilation of a wish to this effect. In my view, a duty in these terms simply cannot be spelled out of the statutory, factual and policy matrix before the court."

Colton J considered this analysis to be "beyond doubt": see para 60 and the analysis which follows. This court endorses this conclusion.

[27] The subject of so-called "macro/target" statutory duties has featured in the jurisprudence of the House of Lords. In *R (G) v Barnet LBC* [2003] UKHL 57 Lord Hope stated, at 80, that one of the central features of such duties is that they are:

> "… concerned with general principles and not designed to confer absolute rights on individuals."

The House held, by a majority, that section 17(1) of the Children Act 1989 is a "general duty", not owed to – and hence not justiciable at the suit of by – any child individually: see especially per Lord Hope at paras 83, 85 and 91. In thus concluding their Lordships contrasted the terms in which certain other provisions of the statute were framed: see for example per Lord Hope at para [80]. The majority was also influenced by the label of "General Duty" (which is of course a feature of section 2 of the 2009 Act): see para 83. The legislative background further reinforced this assessment: see paras 83-85. Lord Hope added at 85:

> "It is an overriding duty, a statement of general principle. It provides the broad aims which the local authority is to bear in mind when it is performing the 'other duties' set out in Part III … and the 'specific duties' for facilitating the discharge of those general duties which are set out in Part I of Schedule 2 …"

Lord Hope continued, at para 91:

> "I think that the correct analysis of section 17(1) is that it sets out duties of a general character which are intended to be for the benefit of children in need in the local social services authorities' area in general. The other duties and the specific duties which then follow must be performed in each individual case by reference to the general duties which section 17(1) sets out. what the subsection does is to set out the duties owed to a section of the public in general, by which the authority must be guided in the performance of those other duties …"

Furthermore, as Lord Hope emphasised, the other duties in the statute are couched in terms conferring a discretion as to performance. This was clearly irreconcilable with the suggestion that section 17(1) conferred a duty on the authority actionable at the suit of individual children.

[28] The issue of "macro/target" duties was further considered by the House of Lords in *R (Ahmad) v Newham LBC* [2009] UKHL 14. Baroness Hale, at para 13 offered the following observations:

> "…Thirdly, there is a fundamental difference in public law between a duty to provide benefits or services for a particular individual and a general or target duty which is owed to a whole population. One example of the former is in Part VII of the 1996 Act, which deals with the housing authority's duties towards individual homeless people. If certain conditions are fulfilled, section 193(2) requires that the authority "shall secure that accommodation is available for occupation by the applicant." The individual applicant has the right to challenge a decision that the duty is not owed in the county court. Another example is in section 20 of the Children Act 1989, which requires a local children's services authority to provide accommodation for "any child in need" because, in effect, he has no-one who can look after him properly. An example of a target duty is in section 17 of the 1989 Act, which provides that "it shall be the general duty" of local children's services authorities to provide a range of services to safeguard and promote the welfare of children in need within their area. This does not give any particular child a right to be provided with a particular service: see *R (G) v Barnet London Borough Council* [2003] UKHL 57, [2004] 2 AC 208. In the case of social housing, there is not even a duty to provide it, although

> there is a duty to have and to operate a lawful allocation policy."

[29] As the speeches of the majority in *Barnet* make clear, the question of whether a statutory provision couched in the terms of duty is of the "macro/target" variety is, fundamentally, one of statutory construction. The exercise to be undertaken by the court requires the full statutory context to be considered. As the outline in paras 5-11 above makes clear, section 2 of the 2009 Act does not exist in isolation. Rather it is but one element of a collection of statutory provisions which must be considered together and as a whole. One particular feature of the statutory arrangements in Northern Ireland is that Health and Social Services Trusts (formerly Health and Social Services Boards), in the performance of their functions, act as the statutory agent of DOH (formerly the Ministry, later the Department, of Health and Social Services).

[30] The statutory matrix under scrutiny in these proceedings has several features which resemble closely that considered in *Barnet*. These include in particular the title "General Duty" in section 2 of the 2009 Act, the broad and elastic terms in which this is couched, and the series of more specific statutory duty provisions couched in the language of duty laced with discretion which follow. In our view these features, considered in combination, confound the suggestion that section 2 imposes on DOH a mandatory obligation owed to individual members of the population actionable at the suit of an aggrieved individual. As we shall explain infra, the same analysis must logically apply to the relevant provisions of the 1972 Order.

[31] The judge next considered Article 5 of the 1972 Order. It is convenient to deal with a minor issue first. The appellants contend that Colton J held that Article 5 of the 1972 Order is (per counsels' skeleton argument) to be characterised "a target duty … an unenforceable statutory duty." This court considers that the judge did not so hold. Paras 58-66 of the judgment, considered as a whole, yield the analysis that the judge, having concluded that section 2 of the 2009 Act and Article 5 of the 1972 Order have the character of "target duties", then turned to consider Article 5 of the 1972 Order and, in doing so, applied an analysis which this court endorses viz Article 5 imposes a duty in notably qualified terms. In the same passage the judge, unassailably, highlighted the importance of considering these statutory provisions together. Thus, we reject this discrete argument on behalf of the appellants.

[32] It follows that the appellants' original quest to establish that by virtue of section 2 of the 2009 Act DOH has been guilty of a breach of statutory duty owed to them individually by reason of the acts and/or omissions in the matter of the waiting list delays of which they complain was doomed to fail. Before this court, Mr Lavery KC, ultimately, did not contest this analysis.

[33] The appellants rested their respective cases, as pleaded, on Article 6 of the 1972 Order. This requires DOH to "… secure the provision of primary medical services, of general, dental and ophthalmic services and of pharmaceutical services in accordance with Part VI." Colton J considered this to be a "general/target duty": see para 64 of

his judgment. Giving effect to our analysis of section 2 of the 2009 Act (above) we concur with this assessment.

[34] The court's suggestion to Mr Lavery that the appellants' breach of statutory duty case must be composed of two key elements, each formulated with the maximum clarity, was not contested. We have addressed the first of these elements already, namely the confirmation that it comprises the relevant parts of Article 5(1)(c) of the 1972 Order set forth in para 12 above. The second key element of the appellants' case, as Mr Lavery ultimately accepted, must be that following the two GP referrals DOH and/or the respondent Trusts was/were guilty of an unreasonable delay in providing them with further "medical services."

[35] The refinement in the appellants' cases at the appeal stage outlined in para 12 above, while altering the contours of these proceedings, had no impact on the central contention advanced by Mr Lavery and Mr Fegan (of counsel), at both the first instance and appeal stages. This contention had the following three specific ingredients: an assessment of need having been made a duty of provision arose; the duty was to provide the requisite service within a reasonable time; and at the "provision" stage the availability of resources was not a permissible consideration.

The Statutory Duty Asserted

[36] In JR 47, at para 20, the High Court considered Article 5 to form part of "the more detailed out workings of the general, unparticularised duty enshrined …." in section 2(1) of the 2009 Act and Article 6 of the 1972 Order. As we shall make clear infra, we consider that the High Court did not intend in this assessment to suggest that this provision establishes a duty owed to individuals. Moreover, this duty is to be performed in accordance with the evaluative judgements and discretionary assessments of DOH. This follows irresistibly from the statutory language – "… to such extent as it considers necessary ..." and "… as it considers conducive to efficient and sympathetic working of any hospital or service under its control." Stated succinctly, DOH is endowed with a substantial measure of discretion as to how this discrete duty is to be performed.

[37] At para 58 of his judgment Colton J recorded the following argument on behalf of the appellants, which is maintained before this court:

(i) Once an assessment of need has been made ("stage 1"), a duty of provision arises ("stage 2").

(ii) The stage 2 duty is to provide the assessed benefit within a reasonable time.

(iii) The availability of resources is not a permissible consideration at stage 2.

The judge, for the reasons given in the paragraphs which follow, rejected this contention, which was maintained before this court by Mr Lavery KC on behalf of the appellants.

[38] The starting point must be that this argument cannot be advanced in some kind of vacuum. Rather it must necessarily belong to the framework of a specific statutory provision or provisions. In their skeleton argument counsel on behalf of the appellants highlight, correctly, that in both cases, an assessment was made by the Trusts that the appellants should ascertain more specialised publicly funded services in hospital. The next step in the argument is that DOH and the respondent Trusts thereby became subject to a duty to provide such services in each case. Applying elementary principles, this duty could arise only under the auspices of a specific statutory provision or provisions (subject to the article 8 ECHR ground – infra).

[39] As appears from para 67ff of the judgment of Colton J, the appellants seek to establish "an enforceable statutory duty" on the part of DOH and the respondent Trusts. Self-evidently the precise terms of this duty are of fundamental importance. Having reviewed the skeleton arguments at first instance it is clear that section 2 of the 2009 Act has at all times been to the forefront of the appellant's breach of statutory duty challenge. The next statutory provision invoked is Article 6 of the 1972 Order, which is said to impose a "general statutory duty" on the Department. Next, Articles 5 and 15B of the 1972 Order are invoked. These (borrowing the language of JR 47, supra) are said to "… impose the more detailed out workings of the general, unparticularised duty enshrined …." in section 2(1) of the 2009 Act and Article 6 of the 1972 Order.

[40] Having identified the core statutory provision upon which the appellant's first ground of challenge rests, the submission formulated in both cases is that an assessment of need having been made a duty of provision was triggered. Specifically, the "assessment of need" was the GP's assessment that each appellant required the assessment/services of a hospital consultant. These were embraced by the "duty of provision." The "duty" it is contended, is to provide the services of a hospital consultant within a reasonable time. The final ingredient in the argument is that in the performance of this duty resources are not a permissible consideration.

[41] The appellants' case is founded on two first instance decisions of the Northern Ireland High Court. The first of these is *Re LW's Application* [2010] NI 217. This case concerned an accident victim who, sadly, had highly complex personal needs requiring the provision of specialised care by scarce, highly trained carers. Contending that these services had not been adequately provided the applicant brought proceedings against the relevant Trust. The assessment of the court was that the Trust was acting as statutory agent of DOH. This was based on the statutory language – "on behalf of" – of Article15 of the 1972 Order. The applicant's breach of statutory duty case was based on section 2 of the Chronically Sick and Disabled Persons (NI) Act 1978 (the "1978 Act") and the <u>social care</u> limb of Article 15 of the 1972 Order. Unsurprisingly, the detailed provisions of the 1978 Act feature prominently in

the judgment of the court. The court held that a breach of this statutory duty had been established: see paras 33-38. The court stated at para 38:

> "This conclusion applies equally, whether one views the Trust's legal obligation to the Applicant through the prism of an absolute (viz unqualified) duty <u>or</u> a duty to act reasonably in supplying the assessed provision."

The judgment then notes that in another first instance decision in this jurisdiction, *Re Judge's Application* [2001] NIQB 14 the <u>second</u> of these two approaches was adopted.

[42] The critical feature of the litigation framework in *Re LW* was that the applicant was able to invoke a statutory provision which the court adjudged to impose a specific duty owed to her and, therefore, actionable by her in judicial review proceedings. Neither of the present appellants can rely on section 2 of the 1978 Act in this way. For the reasons explained in paras 24-25 above we have held that section 2 of the 2009 Act is a species of "macro" or "target" statutory duty which does not subject DOH to an obligation owed to the appellants or any other member of the population. Thus, subject to one further discrete issue regarding section 2 to be addressed infra, the appellants are unable to make good their respective challenges relying on this statutory provision. Pausing, it is appropriate to acknowledge Mr Lavery's acceptance of the court's suggestion that *LW* can scarcely avail either of the appellants having regard to its very different statutory context.

[43] The second of the High Court decisions on which the appellants rely, *Re JR47's Application* (noted above), is another social care provision case. The challenge to DOH was based on section 2 of the 2009 Act, while the challenge to the relevant Trust was based on Article 15 of the 1972 Order. The judicial review application was dismissed. The <u>assessment</u> in that case was that the applicant, a hospital voluntary patient, should be resettled in the community. As the court observed at para 4, some 11 years after his community re-settlement first became theoretically possible, the applicant continued to reside in a hospital setting. The court, while accepting that a duty of provision could arise under Article 15, concluded that in the specific factual matrix prevailing no such duty had crystallised: see paras 32-33. Turning to section 2 of the 2009 Act, the court held that this statutory provision enshrines a "target" duty, noting further that by virtue of the decision of the House of Lords in *G (supra)*, it does not therefore confer rights on individuals. The court stated at para 36:

> "The general principle in play is that statutory provisions of this kind do not create enforceable duties on the part of the public authority concerned."

[44] At para 79ff the court examined the specific issue of <u>when</u> a Trust is obliged to provide a service which it has assessed as appropriate for the person concerned. The court rejected the submission that there is a duty of <u>immediate</u> provision. It concluded that:

> "… the post-assessment duty imposed on the relevant authority is to provide the assessed benefit **within a reasonable time**. It is trite to add that the measurement of this period will inevitably vary, tailored to its particular context."

The judgment elaborates, at para 81:

> "In principle, in some cases, the need which is assessed as requiring satisfaction by the provision of one of the available social care benefits or facilities may be so pressing as to demand immediate provision. In other cases swift, but not immediate, provision may be appropriate. In still others, somewhat more delayed provision could be harmonious with the legislative intention. Each case will be unavoidably fact sensitive, governed by the omnipresent shadow of the policy and objectives of the statute."

On the facts of the case, the delay in making the community resettlement provision was one of five years. The court concluded that this was "so excessive as to be unlawful" under Article 15: see para 82. There was no appeal.

[45] Throughout the relevant passages of its judgment – in para 81 in particular – the court made clear its view that at stage 2 (provision) resources are not an admissible consideration. However, resources are a legitimate consideration at the logically anterior assessment stage. This both chimes with common sense and reality and, further, is harmonious with the presumed legislative intention. The legislature cannot have intended that a Trust would assess that a person requires a specified benefit, service or facility which it cannot afford to provide. Thus, at the first stage, it is implicit in every completed assessment that the Trust has decided that it has the resources to provide the assessed benefit, service or facility. This analysis confirms the correctness of Mr Lavery's argument on this discrete issue.

[46] The content of the initial medical assessment made in every case is obviously a matter of central importance. In the situations under scrutiny in these appeals, the stage 1 assessments were made by GPs. In both cases these entailed a referral to hospital for the purpose of the provision of such further medical services as might be considered appropriate. As to timing, the categorisation was "immediate" in the case of Mrs Wilson (later revised to "routine") and "routine" in that of Mrs Kitchen. It formed no part of the assessment in either case that this assessment must – or even should – follow within a particular timescale. Pausing, it cannot be gainsaid that GP assessments/referrals of this kind can, where the author considers it appropriate, incorporate this kind of element.

[47] In our view, the GP assessment/referral in both cases is to be analysed in the following way. Each of the appellants was referred by their respective GPs to hospital for the purpose of further consideration of their individual cases, which entailed the provision of further medical services, in accordance with the arrangements and circumstances prevailing at the time of referral. For the GP making the referral and the patient in receipt of same – the appellants – the stand-out aspect of those prevailing arrangements and circumstances must surely have been the state of the hospital "elective" waiting lists and the consequences flowing therefrom. In short – a cocktail of limited resources, overburdening demand and delay. Furthermore, neither referral guaranteed an appointment with a consultant, either within a specified timescale or at all, or indeed any particular form of medical service (the statutory language). All decisions and assessments at stage 2 were a matter for the relevant hospital, in accordance with its then prevailing arrangements and procedures.

[48] It follows that if the appellants are able to establish that when their GP referrals to hospital were made either DOH or the Respondent Trusts thereby became subject to a duty to provide them with an appointment with, or other services from, a hospital consultant within a reasonable time, the measurement of the reasonable time period must be made by reference to the prevailing context. Alternatively phrased, the measurement of a reasonable time in every case cannot be made in an abstract vacuum but is rather context driven.

The Questions for the Court

[49] We propose to address the full breadth of the appellants' combined challenges notwithstanding the contraction noted in para 12 above, as this will maximise the guidance to be provided by this court.

[50] The questions to be addressed, tabulated in the next paragraph, must be formulated in the light of the primary declaratory relief sought. This, following amendment at first instance, is formulated thus.

> "A declaration that the Respondents have failed to provide or secure the provision of adequate and/or effective medical services within Northern Ireland and/or the jurisdiction of the [two Trusts] pursuant to section 2 of the [2009 Act] and/or Articles 6, 15, 15B and 56 of the [1972 Order]."

While there was no reformulation of the first declaration sought, the wording in effect became "a declaration that DOH has failed to provide throughout Northern Ireland, to such extent as it considers necessary, medical services, contrary to Article 5(1)c of the 1972 Order": see para 12 above.

[51] A dichotomy must be recognised at this juncture. That aspect of the primary declaration pursued relating to DOH concerns section 2 of the 2009 Act and Article 6

of the 1972 Order. As regards the two respondent Trusts, the relevant statutory provisions are Articles 15B and 56 of the 1972 Order. One significant consequence of the appellants' ultimate refinement of their challenges to Article 5(1) of the 1972 Order was, as Mr McGleenan correctly submitted, that there was no enduring case against either of the Trusts.

[52] Having regard to the terms of the primary declaration pursued in the Order 53 pleading as amended, it is necessary to formulate with precision the questions which this court must address, adhering strictly to the statutory language. The court must determine whether either of the appellants has, on the facts of their individual cases, established that:

(i) DOH has failed to promote in Northern Ireland an integrated system of health care designed to secure improvement in the physical and mental health of people in Northern Ireland and in the prevention, diagnosis and treatment of illness (the section 2(1) question).

(ii) DOH has failed to provide, or secure the provision of, health and social care in accordance with the 2009 Act and any other statutory provision relating to health and social care (the section 2(2) question).

(iii) That DOH has failed to perform any of the ten specific duties listed in section 2(3) of the 2009 Act (the section 2(3) question).

(iv) DOH has failed to secure the provision of primary medical services (the Article 6 question).

(v) DOH has failed to provide throughout Northern Ireland, to such extent as it considers necessary, any of the specified accommodation and services (the Article 5 question).

(vi) The Respondent Trusts have unlawfully failed to exercise their discretionary power to make one or more agreements under which primary medical services are provided (the Article 15B question).

(vii) The Respondent Trusts have failed, to the extent that they consider necessary to meet all reasonable requirements, to exercise their powers so as to provide primary medical services or secure their provision (the Article 56(1) question).

(viii) The Respondent Trusts have failed to exercise their power to provide primary medical services or make such arrangements for their provision as they think fit or make contractual arrangements with any person (the Article 56(2) question).

We shall address Article 98 of the 1972 Order separately. See paras [68]-[69] infra.

[53] The preceding exercise is instructive for three reasons in particular. First, it demonstrates the scale of the hurdles which the appellants must overcome in order to succeed. Second, it highlights the limited material before this court and the corresponding limitations on the exercise of a jurisdiction which is one of supervisory superintendence. Third, it facilitates the task of correctly identifying which of the statutory provisions in question is of the "macro/target" species.

[54] This court is satisfied that in cases where the DOH or a Trust is under a duty to provide an assessed service, this must be provided within a reasonable time. To hold otherwise would be to dilute and diminish the relevant statutory provisions to a level which the legislative cannot conceivably have intended. This court considers, therefore, that JR47 [2013] NIQB was correctly decided on this issue. No contrary argument was advanced. Thus, the starting point in each appellant's case is a valid one.

[55] We turn to examine the core facts of the two cases. First, Mrs Wilson. During the period June 2017-May 2022 this lady was in receipt of the various medical services summarised in para 3 above. The beginning of this period was marked by a referral of this appellant to hospital by her General Medical Practitioner ("GP"). The GP labelled her case "urgent." This was modified to "routine" by the hospital consultant who initially considered it. Subsequently the consultant remained satisfied with the initial assessment. During the later stages of the period under scrutiny it was suggested on this appellant's behalf that her condition had deteriorated. The response of the respondent Trust was to indicate that she should seek a further referral by her GP. This has not materialised.

[56] There is no suggestion that the medical services provided to this appellant were other than in accordance with the arrangements and circumstances prevailing at the time of the GP referral; the hospital consultant's assessment was manifestly prompt; the GP referral having been made in the context of waiting list delays of 163 weeks for hospital neurology appointments, an appointment was allocated well within the aforementioned time scale (circa 30 weeks); this was cancelled due to the pandemic; some two years later a "remote" consultation with a consultant neurologist was conducted; and unremarkable MRI scans followed within the ensuing two months.

[57] Following the initial variation of her GP's "urgent" categorisation, this appellant was not considered to require any kind of urgent hospital attention or service subsequently. At the outset of the period under scrutiny, a diagnosis of fibromyalgia was being debated and at the conclusion of the period under scrutiny this diagnosis was confirmed. It is appropriate to add that no detriment to this appellant's health in consequence of the timeline under consideration has been established. All of these considerations combine to point firmly to the conclusion that no breach of any duty to provide this appellant was any material health service or benefit, whether within a reasonable time or at all, has been established.

[58] Ms Kitchen. In the case of this appellant the core facts are: in July 2019 she was referred to the respondent Trust by her GP, following a diagnosis of cataracts; the Trust informed her that by reason of its waiting lists there would be a three to four year delay prior to performing the requisite medical intervention; for a routine outpatient appointment the average waiting time was 42 months; (nonetheless) in February 2020 (ie within seven months) this appellant was given and attended a hospital appointment for examination and testing of her eyes; the need for surgery was evidently confirmed; she was informed that this would entail a delay of some 15 to 17 months; thereafter, by choice she received this treatment via the private medical sector; and the surgical procedure was completed by November 2020.

[59] In the case of Mrs Kitchen, the factual matrix is different on account of the hospital consultant's assessment that she did require operative intervention. There was, however, no corresponding assessment that this intervention should be carried out either urgently or within any particular timescale. The evidence before the court indicates that by virtue of the operation of the "queue" system the difficulties presented by lengthy hospital waiting lists and associated delays would not have precluded the making of any such assessment either then or subsequently and, hence, a more expeditious operation. Clinical priority is the dominant criterion: see the affidavit of Ms Hanrahan and the Protocol exhibited thereto. A further material feature of the case of Mrs Kitchen is that the surgical intervention which was assessed as appropriate for her was of the elective, planned variety. This stands in obvious contrast to emergency/life saving surgery arising in other contexts.

[60] There is one further consideration of significance in this appellant's case. Bearing in mind that the main focus of this appellant's challenge is the period postdating her initial hospital assessment (following the GP referral) her case is largely speculative. In substance, this appellant invites the court to speculate that the pre-operation period would have been 15 to 17 months had she elected to wait. The evidence establishes clearly that this period would have been substantially shorter if clinical need had thus indicated subsequent to the initial assessment. In the event, in consequence of this appellant's chosen recourse to the private medical sector this period is incalculable. The factual vacuum which in consequence characterises the main element of this appellant's case is inescapable.

[61] For the purposes of this exercise, the court will assume that it is possible to spell out of any or all of the eight statutory provisions concerned – section 2(1), (2) and (3) of the 2009 Act and Articles 5, 6, 15B, 56(1) and (2) of the 1972 Order – a duty on the part of either DOH or the Respondent Trusts concerned to provide either appellant with appropriate medical services within a reasonable time of the GP referral. On this assumption, giving effect to the preceding examination of the core facts in each case, we consider that both appellants fall manifestly short of establishing a breach of statutory duty in the terms of any of the alternatives rehearsed in para [52] above. Each of their cases received appropriate further medical services within a reasonable time of the GP referrals. In short, on the assumption that an identifiable statutory duty exists, each case fails on its particular facts.

[62] There are, however, more fundamental, and logically anterior, reasons why the appellants' challenges must be dismissed. First, the primary declaration which they pursue is remote from their core submission, namely that the respondents have failed in their statutory duty to provide them with appropriate medical services within a reasonable time of the referrals to hospital by their respective GPs. There is a manifest mismatch.

[63] In addition to the foregoing the formulation of the primary declaration sought is in the most general terms imaginable. It expresses an assessment, and a condemnation, by the court of the provision of medical services in the jurisdiction of Northern Ireland as a whole to the population as a whole. Firstly, this is irreconcilable with the inescapable and basic reality that these combined challenges are strictly confined to the individual facts of the cases of Mrs Wilson and Mrs Kitchen. The contours of the supervisory review function of this court are shaped accordingly. The fact of a single, highly critical expert opinion does not alter this reality. This species of judicial superintendence differs markedly from, for example, a public inquiry or an investigation and report by a panel of independent experts, something which has been a recuring feature in the sphere of public health for many years. Secondly, the evidential foundation for the declaration pursued is manifestly lacking.

[64] The final reason why the appellants' breach of statutory challenge must fail is the following. With reference to para [52] above, we consider it abundantly clear that Questions 1 to 4 and 6 relate to "macro/target" statutory duties which do not confer individual rights on either appellant – or, for that matter, any member of the population. Questions 5, 7 and 8 relate to the exercise of discretionary powers couched in manifestly elastic terms. The appellants have failed to identify any unlawful failure on the part of any of the respondents to exercise any of these discretionary powers. They have, rather, pitched their respective cases at a general, unparticularised and purely theoretical level. No public law misdemeanour has been established.

The Family Planning Case Argument

[65] The appellants developed a discrete argument relating to remedy. Relying on *Re Family Planning Association of Northern Ireland* [2005] NI 188 paras 40-44 and 92, Mr Lavery KC submitted that a judicial review challenge to a "macro/target" duty by a person with sufficient interest (or standing) does not preclude the court from granting appropriate declaratory relief. Alternatively phrased, the consideration that a statutory duty is of this species does not insulate the authority concerned against the possibility of the court granting discretionary declaratory relief.

[66] Certain pertinent questions at once arise. If the court were to make either of the declarations pursued, would this effectively entail the recognition of a duty/individual rights axis as regards Article 5 of the 1972 Order and, by logical extension, the other target statutory duties considered in this judgment? How can satisfaction of the standing requirement pave the way to the grant of discretionary

public law relief to persons whose challenges are based on so – called "target" statutory duties? And finally, is the Family Planning case correctly decided in this respect?

[67] These questions were not examined in the Family Planning case. Nor did the court in that case give any consideration to the juridical DNA of the discretionary public law remedy of a declaration. Only one of the three judgments delivered considered the declaration issue and the relevant passages therein are couched in conclusionary terms. These questions, and perhaps others, may foreseeably arise in some future case when they will benefit from more detailed consideration. It is both unnecessary and inappropriate to attempt to determine them in this judgment. In passing, we would draw attention to the principles enunciated in *Re Rice's Application* [1998] NI 265 highlighting the limited grounds upon which this court may depart from one of its earlier decisions.

The Art 98 Ground

[68] Article 98(1) of the 1972 Order, under the rubric "Services free of Charge", provides:

> "The services provided under this Order or the 1991 Order or the Health Service (Primary Care) (NI) Order 1997 or the 2009 Act shall be free of charge, except for any provision contained in or made under this Order or the (1997 Order) or the 2009 Act expressly provides for the making and recovery of charges."

We consider the meaning of these words to be crystal clear. Absent a clear enabling provision to the contrary, all of the agencies concerned are subject to the prohibition against charging for any service provided under any of the statutory measures concerned. As Colton J stated at para 1 of his judgment:

> "When the National Health Service was founded in 1948 by Aneurin Bevin, it had three core principles at its heart; that it would meet the needs of everyone, that it would be free at the point of delivery and that it would be based on clinical need, not ability to pay."

[69] As our preceding analysis of the facts demonstrates, each of the appellants was in receipt of publicly funded services provided within the framework of the statutory regime under scrutiny. All of these services were provided free of charge. The appellant, Mrs Kitchen, opted to pay an insurance premium which entitled her to receive certain medical services provided by the private health sector. These services were not provided "under" any of the relevant statutory measures. This ground of appeal collapses accordingly.

The Article 8 ECHR Ground

[70] Both appellants involve the private life dimension of article 8(1) ECHR. The single Strasbourg decision on which this aspect of the appellants' cases is promoted is *Passannante v Italy* [1998] 26 EHRR CD 153. This is an admissibility decision of the European Commission. It related to a complaint entailing the contention that the applicant's rights under article 8(1) ECHR had been infringed in consequence of a delay of five months in securing a neurological appointment in the state system. A chamber of the Commission held that the application was inadmissible. The terms of this dismissal must be considered:

> "… The Commission considers that the circumstances of the present case are not such as to warrant the conclusion that the delay of the public authorities raises a serious issue under Article 8 of the Convention and that the present application is manifestly ill founded within the meaning of Article 27(1) of the Convention."

Close attention must be paid to another passage:

> "… The Commission considers that ………… where the State has an obligation to provide medical care, an excessive delay of the public health service in providing a medical service to which the patient is entitled **and the fact that such delay has, or is likely to have, a serious impact on the patient's health could** raise an issue under Article 8(1) of the Convention."
> [Emphasis added.]

[71] This court will make three assumptions favourable to the appellants, namely:

(a) that theirs are "physical integrity" article 8(1) cases

(b) positive obligations on the part of the respondents within the compass of article 8(1) could be in play and

(c) the test formulated by the Commission is correct. Given our analysis of the factual matrix of each case above, the conclusion that each appellant's case falls demonstrably short of satisfying the Commission's test follows inexorably.

[72] The appellants have raised an issue about how their article 8 challenge was formulated before the judge at first instance. Before this court they suggest that at first instance the argument canvassed was "… that the waiting lists were so excessive that provision of medical treatment had become ineffective and a breach of article 8 pursuant to Passannante …." (appeal skeleton, para 19). It is not clear to this court that this was the formulation of the appellants' case at first instance (cf High Court

skeleton, paras 29-31). Moreover, the coherence of the passage in the appeal skeleton argument is somewhat opaque. Subject to these qualifications, the self-imposed hurdle of establishing that the provision of post-referral treatment to each of them was "ineffective" is manifestly not overcome. We refer again to our analysis of the facts above.

[73] Thus, both appellants fall manifestly short of establishing a breach of their rights under article 8(1). It follows that no issue under article 8(2) ECHR arises for determination.

[74] Furthermore, the secondary declaration pursued by the appellants is based upon their article 8 ECHR challenge:

> "A declaration pursuant to section 8(1) of the Human Rights Act 1998 that the Respondents' acts or omissions are incompatible with the Applicant's rights pursuant to Article 8 of the European Convention on Human Rights ('ECHR') in breach of their duties pursuant to section 6(1) of the Human Rights Act 1998."

The effect of the manifest lack of specificity in this formulation defeats the quest to secure this declaratory relief at the notional first base.

Some Concluding Reflections

[75] As Colton J emphasised, there is no coherent legal standard or criterion to be applied in the measurement of a reasonable time in any given case. This in turn highlights the limitations on the competence of a court seized of isolated legal challenges of this kind. That said, as we consider this to be the correct legal test the court will apply it, however challenging in every case.

[76] The considerations rehearsed in *Re JR 47* at para 31 resonate with some force in these appeals:

> "The subject matter of this challenge belongs par excellence to the so-called "macro-economic/macro-political" field. The notorious fact of progressively diminishing state resources surfaces and resurfaces repeatedly in the publications under scrutiny. These disclose that delicate, borderline, contentious and difficult decisions about the determination of priorities in the allocation of finite resources have had to be made. The merits of Mr. E and the other members of his group are undoubtedly strong. The court genuinely sympathises with them. However, regrettably, there exists within society a multiplicity of meritorious individuals and classes – the infirm, the

elderly, neglected children and the unemployed, to name but a few. Properly analysed, I consider that the present challenge resolves to a complaint – a genuine one – about how Government has chosen to allocate its limited budget. The difficulties inherent in challenging resource allocation decisions are graphically illustrated in **R v Cambridge Health Authority, ex parte B** [1995] 1 WLR 898, which involved an unsuccessful challenge to a health authority's decision that it would not provide expensive and speculative medical treatment to a girl aged eleven years suffering from acute leukaemia. Sir Thomas Bingham MR stated:

> 'Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients …
>
> It would be totally unrealistic to require the authority to come to the court with its accounts and seek to demonstrate that if this treatment were provided for B there would be a patient C who would have to go without treatment.'

This passage continues:

> 'In Administrative Law (Wade and Forsyth, 10th Edition), the authors observe (p. 327):
>
> 'In these discretionary situations it is more likely to be unlawful to disregard financial considerations than to take account of them.'

While a complaint of this kind does not per se lie beyond the purview of this court's supervisory jurisdiction, bearing in mind the doctrines and principles in play its nature makes judicial intervention inherently improbable. Given my primary findings and conclusions, no issue of public interest justification arises. However, if it did, I would have concluded that ample public interest justification has been demonstrated. Unfairness amounting to an abuse of power – the applicable legal touchstone – would not have been established."

[77] The limitations on the judicial role in these cases are underscored by the report of Professor Heenan, which constitutes the main evidential plank of the appellants'

cases. In summary, one person of admitted expertise has presented the court with an elaborate critique of the subject of hospital waiting lists and related issues in Northern Ireland. However, this is but a single expert opinion. Moreover, consideration of all the evidence demonstrates beyond peradventure the multi-faceted and polycentric nature of the issues in play.

[78] The forum for debate, inquiry, investigation and proposals for improvement and resolution of the issues raised in these proceedings – fundamentally, the single issue of hospital waiting lists in Northern Ireland and its offshoots – belongs to government Ministers, politicians, economists, sociologists, doctors, academics and doubtless other experts and many interested persons and agencies. The subject is one of much controversy and obviously broad and substantial dimensions. It is manifestly inappropriate for judicial intervention.

[79] This court of supervisory superintendence does not possess the traits or credentials, expert or otherwise, of the members of the aforementioned forum. Furthermore, it is evident that the evidence assembled before this court provides but a snapshot of the subject concerned, while the DOH affidavit evidence demonstrates that it is a divisive and contentious one. This subject is, par excellence, unsuitable for assessment in a judicial forum.

Disposal

[80] For the reasons given, which are broader than those elaborated by Colton J, the appeals are dismissed, and the order of the judge affirmed.