Conceptualising Delegation of the Hospital Managers' Discharge Power under s.23 of the Mental Health Act 1983.

Abstract

Section 23, Mental Health Act 1983 empowers Hospital Managers to review decisions made by healthcare professionals about whether compulsory mental health care is justified, and to order a person's discharge where they find it is not. Decisions are made by Hospital Manager Panels (HMPs) in a judicial-type process. Section 23 expressly authorises Hospital Managers to delegate this responsibility, and indeed it has been assumed that Hospital Managers pass their HMP function to specially appointed members of the local community; Associate Hospital Managers (AHMs). There is no data about whether, or understanding of the basis on which, delegation occurs. To address this, this paper provides i) data and ii) a framework to justify how delegation decisions should be made by Hospital Managers based on expectations arising from governance arrangements, constitutionality, and democratic community legitimacy. This framework is grounded in the expectation that HMPs serve three functions: as a review mechanism, a safeguard for service user rights, and a democratic legitimacy-generating process. This framework promotes an approach to HMPs which should be incorporated into an amended version of the Draft Mental Health Bill 2022.

Key words

Delegation; Draft Mental Health Bill 2022, Freedom of Information Act 2000; Hospital Managers; s. 23 Mental Health Act 1983; National Health Service

INTRODUCTION

Section 23 of the Mental Health Act 1983 (the Act) grants Hospital Managers, as the detaining authority (eg an NHS Foundation Trust Board), a power to discharge people from compulsory mental health care; detention in hospital, Community Treatment Orders.[1] Although the Act grants the discharge power to those with overall responsibility for the administration of a healthcare organisation (ie the Hospital Managers), this power can be delegated.[2] Where individual healthcare organisations delegate, they may do so by appointing people from their local community to exercise the power; such appointees are referred to as Associate Hospital Managers (AHMs). Hospital Managers, AHMs, or a combination thereof, make decisions about whether to exercise the discharge power through three-person Hospital Manager Panels (HMPs)[3] by a judicial-type process.

In principle, HMPs function not just as a means to review the quality of compulsory care decisions of the healthcare organisation and their staff, but are also a vehicle to safeguard the liberty of service users by providing a route to challenge the legality of that compulsory care,[4] and to bring the democratic consent of the community into the Act's processes through the

[1] In England, see Department of Health, *Mental Health Act 1983 Code of Practice* (HMSO, 2015), 38.1-38.2; and in Wales, Welsh Government, *Mental Health Act 1983 Code of Practice for Wales Review* (HMSO, 2016), 38.1. For simplicity, all subsequent references are to 'The *Code*', with the relevant provisions in the English and Welsh versions displayed as follows: England/Wales, eg 38.1-38.2/38.1.

[2] Mental Health Act 1983, s.23(4)-(6).

[3] Ibid.

[4] See, for example, Joint Committee on the Draft Mental Health Bill, *Volume 2: Oral and Written Evidence*, Session 2004-05, HL 79-II/HC 95-II, Institute of Mental Health Act Practitioners (DMH50), EV101.

appointment of local people to carry out the review process.[5] As a review mechanism HMPs focus on quality assurance and enhancement around professional and bureaucratic decision-making.[6] HMPs allow an organisation to assure itself that the professionals it employs are exercising their powers, and that the organisation as a whole is managing the obligations created by external institutions, such as Hospital Orders made by the Crown Court, appropriately. As a safeguard for service user rights, HMPs staffed by AHMs provide independent oversight of those professionals and bureaucracies.[7] Here the focus is on protecting the rights and dignity of the service user, and by extension the rights of the community at large, by setting up an oversight process and giving service users a means of challenging compulsory care. Finally, and again when they are staffed by AHMs, HMPs are a vehicle for bringing democratic legitimacy to decisions made under the Act.[8] The involvement of AHMs appointed from the local community provides a route by which professional decision-makers must account to the community for their exercise of state power on behalf of healthcare organisations. The extent to which these three functions may be fulfilled by the different combinations of delegation arrangements available is considered below.

[5] T. E. Webb, Local, democratic community justice in the Mental Health Act 1983 (2023) *Legal Studies,* 1-20. doi:10.1017/lst.2023.2.

[6] Implicit, given the power vests in the Board. See below discussion in the "Governance" sub-section, and see the *Code*, 38.3/38.2.

[7] See, for example, Department of Health and Social Security, Home Office, Welsh Office and Lord Chancellors Department, *Review of the Mental Health Act 1959*, Cmnd 7320 (1978), 3.19; HL Deb vol 551 cols 779-780 20 January 1994; n 4 above, Institute of Mental Health Practitioners (DMH 50), EV101.

[8] Above n 5. (Webb).

The position is complicated by the fact that implementation of section 23 invites variation in the efficiency and effectiveness of the review of professional decision-making; inconsistent procedural and substantive treatment of service user rights; and pressure to reduce the effectiveness of HMPs as a democracy-generating mechanism. Such problems arise because the powers of HMPs, and how they should be implemented by individual organisations, have previously received,[9] and continue to receive, no legislative attention;[10] despite calls by those submitting evidence to the 2023 Joint Committee on the Draft Mental Health Bill 2022.[11] More generally, the *Code of Practice* (the *Code*), which advises on the day-to-day implementation of the Act, limits consideration of section 23 to basic procedural matters,[12] and the courts have had little opportunity to supplement this guidance, with only a handful of cases,[13] mostly before the High Court[14] considering HMPs.

The lack of legislative intervention, and a long-standing absence of detailed guidance means that, since each healthcare organisation is a separate detaining authority (Hospital

[9] T. E. Webb, 'Uninformed Reform: The Attempt to Abolish the Hospital Managers' Section 23 Discharge Power Under the Mental Health Act 1983' (2019) 27(1) *Medical Law Review* 79.

[10] See Department of Health and Social Care, Ministry of Justice, *Draft Mental Health Bill*, CP 699 (2022).

[11] See Joint Committee on the Draft Mental Health Bill 2022, Session 2022-23 HC 696/HL 128 (2023), see NAViGO Health and Social Care CIC (MHB0010), p.4; NHS Providers (MHB022); Hywel dda University Health Board (MHB0043), p.7; Mind and Race on the Agenda (MHB0070), p.9.

[12] The *Code*, Ch 38/Ch 38.

[13] The majority of which are cited in the most recent judgment in *South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Dr Whitworth* v *The Hospital Managers of St George's Hospital* v *AU* [2016] EWHC 1196 (Admin), (hereafter '*AU*').

[14] There are no cases before the House of Lords / UKSC, and only one before the Court of Appeal: *R (On the application of T-T)* v *The Hospital Managers of the Park Royal Centre* [2003] EWCA Civ 330.

Manager) under the Act, each has considerable latitude to make local arrangements, creating a fertile environment for inconsistent treatment of like cases across different organisations. The problem is only compounded by the fact that section 23 sits in a data desert, making it difficult for individual organisations to compare their practices.[15] For example, the most recent estimate we have of the number of HMPs convened dates to 2004-05. At that time government estimated that more than 10,000 hearings took place in the preceding year.[16] This figure is likely to have grown with increased use of the Act.[17] Beyond this, there is no national data about even such simple matters as the rate at which HMPs discharge people from compulsory care. The lack of data about how HMPs work, coupled with the absence of legislation, and spartan guidance, means that we have little sense of the rationales underlying the different approaches adopted by said organisations, nor of the variation between organisations this creates.

In thinking about current decisions about delegation of the discharge power, and how we might reconceptualise these in the future, it must be remembered that delegation decisions exist alongside all these challenges. There is no guidance in the legislation or *Code*, save that they permit either Hospital Managers or AHMs to sit on HMPs. There is no data, and so while it is believed most Hospital Managers delegate to AHMs,[18] this assumption lacks an empirical foundation. There is no guiding set of principles underlying how decisions should be

[15] Joint Committee on the Draft Mental Health Bill, *Volume I: Report*, Session 2004-05, HL 79-I/HC 95-I, para 429.

[16] ibid, paras 301, 307; and above n 4 *Volume 2*, Department of Health: Resources and the Regulatory Impact Assessment (DMH404), EV491.

[17] Care Quality Commission, 'Mental Health Act: The rise in the use of the MHA to detain people in England' (2018)

[18] See eg HL Deb vol 551 cols 776-82 20 January 1994; and Explanatory Notes, Mental Health Bill [HL], (as introduced to HL on 7th March 2007) HL Bill 76-EN 54/2, paras 177-180.

made, meaning even patterns of *similar* practice do not necessarily connote *good* practice. In consequence, there is no consistency nationally or locally about delegation. The upshot of which is that, in an area of the law concerning the exercise of severe state powers – ie restrictions on liberty, compulsory care – there is ample opportunity for inconsistent treatment of thousands of cases between healthcare organisations.

Since all three functions of HMPs – as a review mechanism, a rights safeguard, and as a means of generating democratic legitimacy – have, as we shall see, the potential to intersect, this inconsistency can affect all aspects of HMP work. For example, delegation choices, and what the law permits in relation to delegation, can change *who* ends up overseeing uses of the Act by a detaining authority, and by extension *how* that oversight is conceptualised. If Hospital Managers retain the section 23 function, then HMPs lose their independence and democratic community credentials, and are relegated to a form of managerial-executive oversight, of self-regulation. This happens because the Hospital Managers *are* the detaining authority subject to review by HMPs. Conversely, if the function is delegated to AHMs then, as independent members of the local community acting in a judicial-type capacity, there is a greater degree of separation from the detaining organisation, and of democratic oversight within the process.

It is, therefore, essential to address both the data gap and to develop a framework for making delegation decisions. I have resolved the data gap by means of Freedom of Information Act 2000 (FOIA) requests (FOIs), explored below. Any framework for making delegation decisions must reflect on how best to meet the three functions – review, safeguarding rights, democratic legitimacy. In my view, this is best achieved by considering the question of delegation from three perspectives governance, constitutionality, and community justice. For present purposes, governance is concerned with the formal structures and lines of

accountability within healthcare organisations; constitutionality with those principled expectations for separating organisational powers and functions when it comes to the exercise of public power, and its review; and community justice with the need to legitimise restrictions of individual liberty, and the exercise of public power, with democratic legitimacy. It will be seen that, while all three considerations have relevance to each of the three functions, each resonates particularly strongly with one of the functions: review / governance, safeguarding rights / constitutionality, democratic legitimacy / community justice. Against the backdrop of these considerations, the ability of existing delegation decisions to meet their respective functions can be evaluated, and reforms identified which could be implemented within a revised Draft Mental Health Bill.

In short, I will pursue three aims in this paper. First, to assist understanding of current approaches to Section 23 delegation decisions by providing data on delegation practices. In particular, I intend that healthcare organisations will be able to identify whether their own practices align with those of peer organisations. Secondly, through exploration of the three considerations noted above, to establish the appropriateness of existing decisions, and how delegation decisions should be made in the future to best achieve the three functions of HMPs. Finally, and with the wider implications of that discussion in mind, to make a proposal in relation to reform of section 23 as part of an amended Draft Mental Health Bill.

DATA

In June 2021 FOIs were submitted to the 62 NHS Trusts and Health Boards in England and Wales which hold HMP hearings.[19] The requests asked for data on the number of people authorised to sit on HMPs, and the organisations' approach to delegation. Subject to certain limitations, for example concerning time limits,[20] cost,[21] and restrictions on the publication of personal data,[22] the FOIA provides a statutory right of access to information held by public bodies.[23] FOIs cannot be submitted to private organisations, and therefore the practices of independent sector hospitals are not discussed here.

Sixty responses had been received by December 2021, with a further response received by the end of May 2022. Staffing challenges arising from the Covid-19 pandemic likely contributed to the delayed response from many organisations. Of the organisations which responded, one organisation indicated that it did not hold HMPs, of the remainder (n=60), 58 gave permission for the data provided to be reused for research purposes when requested;[24]

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[19] The 62 healthcare organisations were identified from the Care Quality Commission's Care Directory of Active Locations, 1 June 2021 HSCA Active Locations', available via *https://web.archive.org/web/20210618102405/https://www.cqc.org.uk/about-us/transparency/using-cqc-data* accessed 04 August 2023 (filters: Location Type/Sector: NHS Healthcare Organisation; Provider Primary Inspection Category: Mental health – community & residential – NHS; Regulated activity – Assessment or medical treatment for persons detained under the Mental Health Act 1983: Yes).

[20] Freedom of Information Act 2000, s.10(i).

[21] ibid, s.12.

[22] ibid, s.40(2).

[23] See further, Cabinet Office, *Freedom of Information Code of Practice* (July 2018), and ibid s 16.

[24] Normally via an Open Government License, version 3, available at *https://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/*, accessed 04 August 2023.

had made the data publicly available online through their disclosure log; or gave details about how data could be reused on their website or within the response itself (though *all* of the data is public data because it has been released under the FOIA).[25] As will be seen in what follows, the responses received reveal inconsistencies around the implementation of section 23.

QUANTIFYING DELEGATION

The statutory framework is clear about who may not sit on an HMP. The principal exclusions are that, while being a member of the managing body of the healthcare organisation, and therefore a Hospital Manager, one is also either an officer of the organisation, an executive director, or an employee.[26] For English foundation trusts, this means that, of those sitting on the Board, only the Chair and Non-Executive Directors may sit on HMPs. Welsh Health Boards have a different institutional structure, but essentially the same restrictions; only the Chair and Independent Members may sit on HMPs. For simplicity, all references to Hospital Managers in this paper are intended to capture only those managing body members eligible to sit on HMPs.

While the law is clear about who may not sit on an HMP, it has not previously been possible to evaluate the assumption that most managing bodies routinely delegate their section 23 powers to AHMs.[27] Tables 1 and 2, below, address this. Table 1 shows the number of panellists recorded in post across the 58 organisations included in the sample.

[25] See Information Commissioner's Office, *Guide to the Freedom of Information Act* (2017), p.6. The FOI reference numbers included in Appendix 1 of this paper can be used to recompile the dataset.

[26] See the *Code* 38.3-38.6/38.2-38.3, and for independent hospitals, 38.7/38.3.

[27] See above, n 18.

Table 1 – Those authorised to sit on HMPs.

	Total reported in post, England and Wales	Reported in post, England	Reported in post, Wales
AHMs	1,064	969	95
Hospital Managers	60*	54	6
Total	1,124	1,023	101

**One of the 15 organisations in this category reported that Hospital Managers were eligible to sit on HMPs, but did not disclose the number of Hospital Managers so authorised. As such, the true figure is likely to be proportionally larger than indicated. A separate organisation in this category constituted its panels* exclusively *of Hospital Managers*.

Table 2 shows the individual practices of different organisations as regards HMP membership. Most NHS organisations considered constitute HMPs exclusively with AHMs, ie, organisations' managing bodies have entirely delegated their HMP function to community appointees. Within the 14 organisations which permit a combination of AHMs and Hospital Managers to sit, AHMs outnumbered Hospital Managers by approximately 5:1 (AHMs = 271, Hospital Managers = 53, noting the * in Table 1). Only one organisation sat exclusively with Hospital Managers, and no AHMs.

Table 2 – Organisational policy for HMP composition

	Number of organisations with this policy (n=58)	England only (n=51)	Wales only (n=7)
AHMs only	43 (74.13%)	37 (72.55%)	6 (85.71%)
Hospital Managers only	1 (1.72%)	1 (1.96%)	0
A combination of AHMs and Hospital Managers	14 (24.14%)	13 (25.49%)	1 (14.29%)

There are limitations to this data. First, as noted above, only public organisations are subject to FOIs, thus the independent sector is not accounted for. Secondly, it is possible for individuals to sit as AHMs for multiple organisations. The figures in Table 1 reflect individual organisations' local records. There is no way of identifying duplicates between organisations, such as between

neighbouring trusts. Finally, the data in Table 2 does not disclose the rates at which Hospital Managers sit on HMPs in mixed regimes; that is, they are *able* to sit, but it is unclear how frequently they do so.

Even having regard to these limitations, the general pattern is clear. First, most NHS organisations delegate their HMP function entirely to AHMs. Secondly, even in mixed regimes, the ratio of AHMs to Hospital Managers is such that AHMs are almost certainly sitting on HMPs at a higher rate than Hospital Managers. That is, if the number of HMPs sitting each year is in the thousands, it makes sense that the majority of HMP work is undertaken by AHMs since there are simply not enough Hospital Managers in post to conduct a process operating at this scale alongside their many other responsibilities.[28]

CONCEPTUALISING DELEGATION

What the data does not explain is why organisations have chosen to delegate, not delegate, or have opted for a mixed regime. There can be no explanation for why past decisions were made as they were, at least not one that can be applied to the decisions of all organisations, since, absent a common framework, all delegation decisions were ad hoc. In what follows, I will provide a framework for making principled and pragmatic delegation decisions, taking account of the functions of HMPs, by considering the question from the perspective of governance, constitutionality, and community justice.

Governance

The governance tasks of Hospital Managers are wide-ranging. At their core lie two roles "[i] holding the executives [of the organisation] to account while at the same time [ii]

[28] Borne out by past experience – HL Deb vol 551 col 777 20 January 1994; HL Deb vol 687 col 708 26 Nov 2006.

collaboratively engaging in developing strategy."[29] Given the purposes of NHS Boards, there is potential for these roles to conflict. The NHS National Leadership Council (NLC), for example, states that "the purpose of NHS boards is to govern effectively", by "formulating strategy", "ensuring accountability … for the delivery of strategy … seeking assurance that systems of control are robust and reliable", and "shaping a positive culture".[30] By having both ownership of governing, strategy, and culture, while also having responsibility for scrutinising these things, a Hospital Manager may be required to face in two directions at once.

Alongside the potential conflict in terms of the functions themselves, the ethos underpinning the implementation of these objectives may vary, leading to differing Board attitudes, such as the stakeholder or stewardship approaches, which likewise pull Board members in competing directions. Take, for example, NHS Primary Care Trust (PCT) Boards (now Clinical Commissioning Groups, CCGs). In a stakeholder approach, Hospital Managers represent the community, and others with an interest in the work of the organisation, on the Board.[31] There is evidence that PCT Hospital Managers saw their role as being based on this

[29] See further N. Chambers, G. Harvey, R. Mannion, J. Bond, J. Marshall, 'Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development' (2013) 1(6) *Health Services and Delivery Research* 1 (DOI 10.3310/hsdr01060), 50, and further 50-51.

[30] NHS National Leadership Council, *The Healthy NHS Board: Principles of Good Governance* (2013), para 14.

[31] On the 'stakeholder' view of governance, D. Aly, M. Abdelqader, T. K. Darwish and K. Scott, 'The impact of healthcare board characteristics on NHS trust board performance' (2022) *Public Money & Management*, online first, https://doi.org/10.1080/09540962.2021.2022272, 2.

type of local accountability;[32] indeed living in the area was viewed as important.[33] However, this local 'stakeholder' orientation was in tension with system-level concerns, such as the management of limited organisational resources; a 'stewardship view' of board activity.[34] In addition to balancing these concerns, the wider structures within which individual PCTs sat were subject to "strong central reporting lines", creating management pressures from another direction: government.[35] These tendencies persist in new modes of Trust organisation, such as the foundation trust.[36]

Foundation trusts, which are the most common organisational form in the FOI dataset discussed earlier, were intended to have greater autonomy than previous models of administration allowed. In some respects this has proven to be the case,[37] however they still operate in a policy environment where healthcare delivery and organisation is an important political issue.[38] Moreover, while foundation trusts were intended to include greater local

[32] J. Tweed, L. M. Wallace, 'Guardians of the public interest: the expectation and experience of non-executive directors in National Health Service commissioning boards in England' (2021) 35(1) *Journal of Health Organization and Management* 53, 59.

[33] ibid, 60.

[34] ibid, 64, see also 59-60.

[35] ibid, 62.

[36] R. Sheaf, R. Endacott, R. Janes and V. Woodward 'Interaction between non-executive and executive directors in English National Health Service trust boards: an observational study' (2015) 15 *BMC Health Services Research* 470, 479.

[37] P. Allen, J. Keen, J. Wright, P. Dempster, J. Townsend, A. Hutchings, A. Street, R. Verzulli, 'Investigating the governance of autonomous public hospitals in England: multi-site case study of NHS foundation trusts' (2012) 17 *Journal of Health Service Research and Policy* 94, 96.

[38] See eg ibid, 98-99, 100.

representation,[39] at their inception, the ethos underpinning that model strongly inclined towards "a more business-like and efficient approach."[40] It is through this business lens, alongside the "stewardship view",[41] that foundation trust Hospital Managers are said to conceive of local accountability.[42] This approach is primarily concerned with custodianship of an organisation's resources as the measure of good governance, where regulatory compliance and institutional strategy establish the standards to be met, such that any democratic accountability of the organisation to the community is less relevant. As such, the effectiveness of Hospital Managers to hold executive directors, and the wider organisation to account may vary,[43] and in some cases "might require other means of maintaining … public accountability".[44]

This overview of NHS governance structures gives a sense of what accountability means for Hospital Managers: good bureaucratic management of resources and services, achieved through the work of committees and other administrative structures which oversee decisions made by their staff. We now need to consider whether Hospital Managers operate in ways which meet the objectives of HMPs, or whether, viewed from the governance perspective, the HMP process is better served by delegating the power to specially appointed and trained AHMs. From a managerial-bureaucratic point of view there are two benefits to the direct participation of Hospital Managers in the process. First, it may allow Hospital Managers to

[39] ibid, 94.

[40] ibid, 95, see also 96-97; see also n 32 above, 59.

[41] See further n 29 above, 18-19.

[42] ibid, 40.

[43] n 36 above, 3.

[44] ibid, 9; and n 37 above, 100.

meet their accountability function, of which legal compliance is an important aspect.[45] Indeed, Hospital Managers' involvement would seem to be especially pertinent in the context of compulsory mental health care because, not only is inappropriate detention a serious breach of the law, it also comes with attendant principled, public relations, and financial costs.[46] On this view, involvement in the HMP process ensures, at least in the individual HMPs they sit on, that Hospital Managers can personally satisfy themselves of the appropriateness of staff decisions around compulsory care, and the process by which that decision was reached.

Secondly, the personal involvement of Hospital Managers could enhance their accessibility, since they will be in direct contact with AHMs on mixed-regime HMPs, and with clinical staff and service users attending HMPs. Thus, personal involvement can produce opportunities for quality assurance and quality enhancement both systemically, and in individual HMPs. The information gathered can be connected with legal compliance obligations, and may also speak to how the wider policies and processes of the organisation operate, how decisions are made, and how practices are embedded in the organisation. All these possibilities may serve the review purpose of section 23, and may indirectly safeguard service user rights if it enables Hospital Managers to identify systemic issues which could be corrected by addressing organisational policies and practices. In view of this, there does appear to be merit in Hospital Managers retaining a degree of personal involvement in the HMP process, but closer consideration suggests there are better ways of achieving the same, indeed better ends. We can see this by answering two questions. First, is it necessary for Hospital Managers to sit on HMPs to check for legal compliance, and thus contribute to their overall

[45] n 30 above, para 25.

[46] M. Roche, 'Unlawful mental health detention – who is to blame?' (*UK Human Rights Blog*, 20 January 2011).

accountability function? Secondly, is it necessary to sit on some panels to gain an understanding, and to gather information about how the system is working?

To answer the first question, we may start by considering Hospital Managers' wider responsibilities with regards to legal compliance. Not only does the meaning of legal compliance extend far beyond the specific matters reviewed during HMPs, it also covers all the organisation's legal obligations,[47] moreover, legal compliance is only one aspect of the overarching function of securing "accountability". To this concern about the amount of time Hospital Managers can dedicate to HMPs we can add two related points. First, because of these other demands on their time, Hospital Managers are likely to sit infrequently, and so are likely to remain amateurs at this role. Secondly, since HMPs are unlike anything else Hospital Managers do, even in the field of legal compliance, they are unlikely to implement the HMP process as efficiently as those who regularly conduct,[48] and receive training in relation to these hearings (AHMs).[49].

With many competing calls on Hospital Managers' time, taking on the HMP function when others could do so seems unwise. The ability to delegate the HMP function to AHMs creates capacity for the managers of large, complex organisations to undertake other tasks which *only* they can undertake. Delegation to AHMs alleviates the requirement for Hospital

[47] n 30 above, para 34.

[48] This risk has been acknowledged in parliamentary debate and reform consultations, see for example, HL Deb vol 551 col 777 20 January 1994; and Joint Committee on the Draft Mental Health Bill, *Volume 3: Written Evidence*, Session 2004-05, HL 79-III/HC 95-III, Nottinghamshire Healthcare NHS Trust (DMH 286), EV1024.

[49] The *Code* 38.8 / 38.4; see also Joint Committee Written Evidence, above n 11, Sussex Partnership NHS Foundation Trust (MHB0073), 5 (cf 8-9).

Managers to deploy their limited resources towards a judicial-type process which they lack the time, experience and training to carry out effectively themselves.[50] This conclusion is recognised by The *Mental Health Act 1983: Reference Guide* which confirms that the only practical way forward is to delegate. Speaking of the general approach to delegation across their role, the *Guide* says:

> 31.3 For the most part, hospital managers do not have to perform their functions personally, eg by decision of the board of an NHS trust, but may delegate them to officers, ie members of their staff, and, in some cases, to other people.[51]

Much as we do not expect members of the government to personally take all decisions in their departments, so too the general principle that delegation is appropriate applies to Hospital Managers. It is a legitimate approach, since it is authorised by the Act, and accompanying supplementary materials. It is also pragmatic given, as the NLC has recognised, the time commitment required of Hospital Managers in NHS organisations is a "hotly debated topic".[52] It has been suggested that, to alleviate this burden, "some tasks … can be undertaken by other, appropriately selected and trained lay people (for example chairing appeals panels…)";[53] the 1983 Act makes specific provision for this in relation to HMPs.

Turning to the second question, is there value and information to be gained by being involved in making *some* of these decisions? No. Any qualitative experience gained would only

[50] HL Deb vol 551 col 777 20 January 1994.

[51] Department of Health, *Reference Guide to the Mental Health Act 1983* (London HMSO 2015), para 31.3.

[52] n 30 above, para 160.

[53] Ibid.

be anecdotal given the limited time Hospital Managers could spend on this task, and the same insights could be acquired by observing, rather than participating in, HMPs, while also avoiding the attendant constitutional and legitimacy issues, discussed below. Similarly, quantitative data on the rate at which the decisions of professionals (organisation employees) are upheld or overturned by HMPs need not be gathered by Hospital Managers personally. It is true that such data could assist accountability efforts by helping Hospital Managers understand, for example, whether the decisions of their staff around compulsory care are being upheld (a spate of discharges, indicating that HMPs disagree with the professionals employed by the organisation, could trigger further investigation by Hospital Managers). Yet, even more than the qualitative data that might be gained from participation and observation, the direct involvement of Hospital Managers is unnecessary here. The ordinary administrative structures of the organisation can collate this information and provide it to Hospital Managers.

From all this it follows that, while the FOIs did not reveal the extent to which Hospital Managers regularly participated in HMPs (ie institutional policy permitted them to sit, but it is not clear at what frequency this occurs), given the preceding discussion, it is unlikely that they would be able to commit a significant proportion of their time. Indeed, were the Hospital Managers proper *required* to undertake these tasks without assistance by delegation, past experience confirms that either their ability to undertake their other functions would be severely undermined,[54] or their capacity to give effect to the review and appeal safeguards

[54] For example, specifically in relation to their many responsibilities to service users under the Act, see above n 51, 31.4-31.6.

entailed in section 23 would be heavily curtailed.[55] Moreover, as I have suggested, there is no particular need for Hospital Managers to sit on HMPs given that there are structures surrounding the process which can support Hospital Managers to gain a system-level view of concerns and good practice, and which are also procedurally much more familiar to Hospital Managers than HMPs. For example, administrative structures directly associated with the operation of the HMP process, such as any forum- or committee-type meeting where all AHMs appointed by an organisation and one or more Hospital Managers meet; data gathering mechanisms associated with those administrative structures; *ex officio* positions for AHMs on other committees within the organisation; methods for liaison between AHMs and the organisation's legal team; and reporting lines between the legal team and Hospital Managers.[56]

From the governance perspective, it appears that, for reasons of effectiveness, efficiency and convenience, delegation is justified because AHMs are better placed to carry out the HMP process. Moreover, the case against Hospital Managers participating is bolstered by the fact that there are other, more familiar, governance modes through which they can receive information relating to HMPs. It does not make sense for Hospital Managers to be tasked with

[55] For recent comment see, R Jones, 'Response to MHA Review (2): Managers' hearings' (Mental Health Law Online, 10 December 2018), available at *https://www.mentalhealthlaw.co.uk/Richard_Jones,_%27Response_to_MHA_Review_(2):_Managers%27_hearings%27_(10/12/18)* accessed 18 February 2023; and historically, see n 28 above.

[56] See, for example, C. Williamson and C. Vellenoweth, *Directors Guide: Duties of managers for the review of detention under the provisions of the Mental Health Act* (London: National Association of Health Authorities and Trusts, 1996), 16.

an important responsibility alien to their other functions, and for which they do not have the time or training to conduct properly.

The arguments for delegation from a governance perspective are most strongly aligned with enhancing the quality of the review function of HMPs. Safeguarding of rights is not an explicit concern of the governance lens, except inasmuch as it is a facet of legal compliance, but it is implicit that, by enhancing review in pursuit of legal compliance, one is also likely to impact the effectiveness of the safeguards to rights this provides. Furthermore, since the conclusions I have drawn here in relation to governance argue in favour of delegation to AHMs, another secondary effect is the enhancement of the democratic qualities of the HMP process. The Boards of healthcare organisations do not prioritise democratic accountability, but delegation nevertheless brings democracy into an important aspect of the powers entrusted to such organisations by the state. We will see in the following sections that considering the delegation question from constitutional and community justice perspectives more directly supports the second and third functions of HMPs.

Constitutionality

Whereas the arguments made from a governance perspective in favour of delegation are grounded in pragmatic concerns around the effectiveness of review, constitutionality requires delegation on principle to better safeguard service user rights. In this section I show that there are two closely connected constitutional advantages to delegating the HMP function to AHMs, one which follows on from, and lends a principled foundation to the governance perspective; and another which is intrinsically connected with the expectation that HMPs, and by extension

AHMs, should make their decisions independently.[57] That is, delegation is required to appropriately separate out functions, and relatedly, to meet the expectation that no one should be a judge in their own cause. The effect of this is first, to assign the HMP function to a body which is concerned exclusively with review of legality, including rights-compliance, on behalf of the community (AHMs), and secondly, as a mirror of the first, to remove that responsibility from those who are required to balance a range of responsibilities that may conflict with these aims (Hospital Managers).

Separation of Functions

Outside of the mental health context, the division of public power is commonly justified on the basis of one or both of the following: that public power should be divided to avoid it accumulating in one place, and that it should be held in tension with other powers.[58] In addition to avoiding tyranny, or at the very least, creating overmighty centres of power, separation has also been said to have a pragmatic quality, since it allows, as Barber puts it, "the matching of tasks to those bodies best suited to execute them";[59] "efficiency".[60] These justifications can be readily applied within the mental health context. Hospital Managers, and the organisations they run, have extensive public power to administer laws authorising compulsory care. It is accepted, indeed required,[61] that compulsory care must be legally justifiable, and must safeguard rights. It follows that the uses of such power must be capable of independent review,

[57] See *AU*, above n 13.

[58] E Barendt, 'Separation of powers and constitutional government' [1995] PL 599, 600-603.

[59] N. Barber, 'Prelude to the Separation of Powers' (2001) 60(1) *Cambridge Law Journal* 59, 59, see also 71.

[60] ibid, 59; see also n 58 above, 602-603.

[61] *Winterwerp* v *Netherlands* (1979-80) 2 EHRR 387.

ideally by those best placed to conduct it, and therefore that there must be external oversight of the use of the powers contained in the Act. To accomplish this, a separation between the use and review of such power is necessary. In view of this, it is curious that this uncontroversial position is not routinely implemented in the context of Section 23 HMPs, despite straightforward arguments in favour of it. For example, I have already suggested when considering governance that the Hospital Managers are not well-suited to exercising a judicial-type function because of their bureaucratic background. This criticism can be further developed by reflecting on the allocation of functions within the Act.

Barber offers a useful framework for this. When considering how best to allocate, and thereby separate, institutional functions, Barber suggests we examine the "interconnected structural factors that affect the competency of institutions"[62] relating to:

> "… the composition … skills … knowledge and experience of the actors within [the institution] … the scope of the institution's information-gathering powers … the manner of the institution's decision-making processes … [and] the vulnerability of the institution to outside pressures."[63]

By considering these factors, we can reframe concerns about the competency of Hospital managers as being not merely a practical problem, but one of constitutional probity.

First, *composition*, *skills*, *knowledge and experience*. In the earlier section on governance I noted that the work of the Hospital Managers is multi-faceted, covering a range

[62] Above n 59, 72.

[63] Ibid.

of functions connected with strategy, accountability, and culture-building. In terms of the bureaucratic composition of the institution, these functions have an executive flavour, and are normally carried out through committees and other administrative-managerial structures, taking up a good deal of time.[64] The institution is arranged around these structures, and used to making decisions via that framework, and thus has little practice using the skills necessary to carry out judicial-type decisions addressing legality and rights. It follows that the mode by which the HMP function is carried out is likewise alien to the relevant actors, Hospital Managers, within the institution. The institution is incorrectly composed, and the actors within it do not possess the requisite skills, knowledge or experience to fulfil the functions of HMPs themselves.

Secondly, in relation to administering HMPs, the healthcare organisations which Hospital Managers oversee are well-equipped to *gather the information* needed for making individual section 23 decisions; indeed, they must also perform an essentially equivalent function for the Mental Health Tribunal (MHT).[65] In addition to the information needed for individual panels, professional service staff in the mental health law teams within healthcare organisations may gather and analyse system-level data about the HMP process for Hospital Managers, and governance mechanisms within the organisation can facilitate knowledge exchange between the organisation and AHMs. In theory this means Hospital Managers may be well-placed to facilitate rights-protection mechanisms (HMPs, MHTs), and to understand, at a system level, the challenges to these processes. Facilitation and system-level understandings are not, however, what HMPs (or MHTs) are concerned with, they are

[64] n 30 above, para 160.

[65] See eg *Code*, 38.32/38.28.

concerned with what the law, in relation to a given set of facts, means for legality, and the protection of rights.

Third, and to elaborate on the preceding point, though healthcare organisations and their Hospital Managers are well-equipped to gather information, when we consider the effectiveness of this alongside *the mode of decision-making*, a by-now familiar problem arises. In short, Hospital Managers' bureaucratic capabilities do not equip them to use the information gathered for HMPs and the MHT, nor are such reports compiled with the Hospital Managers' governance responsibilities in mind; they are intended to support judicial-type decision-making.[66] We get a better sense of why this poses a problem for Hospital Managers carrying out HMPs by comparing HMPs and the MHT. Although HMPs and the MHT differ in certain ways, both apply the same legal criteria regarding the question of discharging a service user to equivalent written and oral evidence, and do so through similar judicial-type modes of decision-making.[67] In the same way that a specialist tribunal will be more expert in a given area in comparison to an ordinary court, AHMs, whose sole task is to ask whether the criteria for maintaining a compulsory treatment order are still met, will attain a higher degree of competence in making such decisions through experience and training when compared with Hospital Managers who split their time amongst many different functions. Speaking of the MHT on this point, the Upper Tribunal remarked that:

> "I intend in no way to diminish the difficulty or importance of [the MHT's] task when I say that their work involves a limited number of

[66] For context, see P. Davison and A. P. de Albeniz, 'Reports prepared for Mental Health Review Tribunals and Managers' Reviews' (1997) 21(6) *Psychiatric Bulletin* 364-366.

[67] See *Code* 38.15-38.23/38.15-38.20; *Winterwerp* above n 61, 403 para 39.

> questions. My point is that a specialist tribunal applying the same limited range of criteria repeatedly is unlikely to misunderstand the nature of its task."[68]

This observation adds substance to the governance arguments for delegation. It takes those arguments – exercising the power is impractical because of time pressures and a lack of expertise – and gives it a principled foundation: delegation is *constitutionally legitimate* because there is a group who are institutionally better equipped to carry out the requirements of the function in question, providing efficient scrutiny of power to uphold legality and safeguard rights.

More fundamentally, however, allocating to AHMs also connects with the other aspect of the separation of powers noted earlier. The judicial-type nature of HMPs suggests allocating power to the AHMs would avoid the accretion of adjudicative power to a body, the Hospital Managers, which is of an executive / managerial character. The Hospital Managers *are* those administering healthcare institutions and, more pertinently, exercising public power by making orders for,[69] e.g., detention in hospital, and if they do not delegate the HMP power *also* those reviewing such authorisation. By creating distance between the exercise of power and its oversight, a space is established within which independent oversight can take place. As such, allocating the HMP function to those who can conduct it more efficiently, and from a position which does not conflict with their core constitutional character, aligns with the goal of safeguarding rights by preventing inappropriate use of public power, since it separates that

[68] *JLG* v *Managers of Llanarth Court & Secretary of State for Justice* [2011] UKUT 62 (AAC), para 7.

[69] Above n 15, 246.

power from the oversight processes intended to check its exercise. In short, we have efficient scrutiny of power which is separate from those exercising said power.

Independent Review, Natural Justice

Barber's fourth factor, *preventing HMPs from being exposed, or being perceived to be exposed, to outside influence*, builds on this premise, and provides an associated constitutional benefit to delegation: compliance with natural justice. To understand the constitutional advantages for natural justice arising from delegation, it is necessary to explore the concept of independence for NHS Boards in more detail. There is a tension between the role Hospital Managers play as independent representatives of the public interest (as stakeholders in the Welsh,[70] or as business-minded stewards in the English context),[71] and as members of the Board with responsibilities connected with the work of the healthcare organisation. That is, being simultaneously both an independent critic of, and an active participant within the managing body.[72] As I said earlier, Hospital Managers must continuously mediate a conflict between these core functions: "holding the [executive members of the board] to account while at the same time collaboratively engaging … [with them]."[73]

[70] N. Chambers, 'Healthcare board governance' (2012) 26(1) *Journal of Health Organization and Management* 6, 10.

[71] n 37 above, 95.

[72] See further on stakeholder and stewardship theories of boards, n 70 above, 7; in relation to the earlier incarnation of NHS Trust Boards in England see J. Deffenbaugh, 'Understanding the roles of NHS trust board members' (1996) 10(2) *Journal of Management in Medicine* 54, 58.

[73] n 29 above, 50; see also n 70 above, 10, 12; see further n 30 above, 11, quoting the David Walker Review, *A review of corporate governance in UK banks and other financial industry entities* (2009).

The governance structure of public healthcare organisations deliberately creates this tension. While Boards in England and Wales have different structures, in essence they both operate a "unitary board model … with [executive and non-executive] members of the board … taking collective responsibility for decisions".[74] It is true that foundation trusts have an additional layer of governance, the Board of Governors, but the Board of Directors in whom the section 23 power vests retains the characteristics of a unitary board,[75] particularly as regards viewing the work of the board as "a collective endeavour".[76] Thinking of Boards as taking a collective approach to the work of the organisation, a fusion of different responsibilities that are performed collaboratively, helps us to understand why the independence of the Hospital Managers is compromised when it comes to section 23; they are *of* the organisation. When a Hospital Manager sits on an HMP, they are scrutinising the decision-making of the organisation with which they are very closely associated, and indeed may be perceived by those service users subject to the Act, and whose cases are being considered by that HMP, as being an intrinsic part. Even in terms of "the fair-minded and informed observer" test,[77] which prefers professionally informed opinion to that of ordinary members of the public,[78] it is far from certain that Hospital Managers, as Board members, would be seen as sufficiently independent. The adage "that justice should not only be done,

[74] n 70 above, 9; see also n 72 above, Deffenbaugh, 58.

[75] n 70 above, 9; n 29 above, 40.

[76] n 29 above, 53.

[77] *Porter* v *Magill* [2001] UKHL 67, [103].

[78] A. Higgins and I. Levy, 'What the Fair Minded Observer Really Thinks About Judicial Impartiality' (2021) 84(4) *Modern Law Review* 811-841, 840; M. Elliott, 'The appearance of bias, the fair-minded and informed observer, and the "ordinary person in Queen Square market"' (2012) 71(2) *Cambridge Law Journal* 247, 249.

but should manifestly and undoubtedly be seen to be done" is apt.[79] This is especially so given the *context* in which the HMP function is exercised, the restriction of individual rights for compulsory mental health care, and, *per* Barber, should figure in considerations of who is best-placed to carry it out.[80]

The constitutional problems arising from allowing Hospital Managers to sit on HMPs can also be demonstrated by scrutinising the arguments of those who have previously advocated for the involvement of Hospital Managers on HMPs. Take the 1996 Working Group Report which recommended that, because "the final responsibility for their proper undertaking [of the use of compulsory care powers] rests with the … Board … a [Hospital Manager] should be one of the Managers who review detention."[81] From the constitutional perspective we have been discussing, we can see that this argument makes little sense if we apply it in similar contexts. For example, we would not say that, because a Secretary of State is responsible for the work of their department, that they should sit on a panel set up to allow individual citizens to challenge decisions made by that department.[82] Instead, we correctly entrust scrutiny to bodies which are independent of the institution. Fortunately, the recommendation of the 1996

[79] *R v Sussex Justices, ex parte McCarthy* [1924] 1 KB 256, 259.

[80] n 59 above, 59.

[81] Mental Health Act Commission, National Association of Health Authorities and Trusts, NHS Federation, Royal College of Psychiatrists, *Working Group Report on Managers' Review of Detention Under the Mental Health Act 1983* (1996), 4-5 ('Working Group'); and see n 15 above, *Volume 1*, 246; and see also above n 56, p 13 et seq..

[82] Especially not post-Leggatt, *Tribunals for User's – One System, One Service* (2001).

Committee was never implemented.[83] Had it been, it would have offended a foundational maxim of natural justice: that no one should be a judge in their own cause.

Unfortunately, the 1983 Act continues to authorise other arrangements which compromise the independence of HMPs, and thus their effectiveness as *inter alia* a rights-safeguarding mechanism, since on its face it permits Hospital Managers to sit on them. Examining the reasoning in a recent case demonstrates why this is problematic, and why either an alternative interpretation should be applied to this aspect of section 23, or the legislation itself should be amended. In *AU*, a hospital trust sought to bring a judicial review against an HMP it had arranged.[84] The HMP, an all-AHM panel, decided that the criteria for detention were not met, and discharged the service user. The Trust (ie the Hospital Managers and the rest of the delegating Board) disagreed, and sought judicial review of their own HMP's decision. Cranston J was asked to consider, *inter alia*, whether it was possible for the Trust to bring a judicial review against an HMP to which it had delegated power. Cranston J explained that, had the organisation taken the decision itself, the HMP decision would not be reviewable,[85] but because it was taken by "a body which Parliament intends to be an independent decision-making entity",[86] the case was altered. Cranston J drew attention to the fact that the Act prevents employees and executive directors from sitting on HMPs, and concluded that this makes "the Panel … sufficiently separate from and independent of the Trust."[87] Yet, as we have

[83] Although it had some basis in history, see above n 5, 17.

[84] n 13 above.

[85] ibid, 25-26.

[86] ibid, 26.

[87] ibid.

seen, the legislation expressly *includes* Hospital Managers in the list of those who can exercise the power, which poses problems for the perceived independence of HMPs given the governance arrangements already discussed. This point was put more bluntly several years earlier by the Government in its response to the 2004 Joint Committee on an earlier Mental Health Bill: "Hospital managers under the 1983 Act are not formally independent of the detaining authority; legally they *are* the detaining authority".[88] It follows that, as currently worded, since section 23 does not require delegation from Hospital Managers to AHMs, it does not mandate an independent process, it merely facilitates several ways of composing an HMP, only one of which is independent.

If Parliament intends the HMP process to be independent, then complete delegation to AHMs must always be *required*. On Cranston J's analysis, an HMP comprised of Hospital Managers could not be exposed to judicial review by the delegating healthcare organisation, because it would not be sufficiently independent of that organisation. Therefore, only one interpretations of the restrictions on HMP membership to which Cranston J refers are sufficient to secure a constitutionally appropriate level of independence for the HMPs (and, incidentally, allow Hospital Managers to seek judicial review of HMP decisions). To remedy this, the Act requires amendment. That this has not already happened, and is not currently set to happen in the present Draft Mental Health Bill, is part of a wider failure by Parliament to consider section 23.[89]

As has been shown, a consideration of the principles which underpin how Section 23 functions demonstrates that the character of the Hospital Managers' relationship to the

[88] n 15 above, 246, *emphasis added*.

[89] See, above n 9.

healthcare organisation (governance), and how the nature of the HMP process should impact who can conduct it (constitutionality), should close off those elements of section 23 which allow Hospital Managers to sit on HMPs. This is because HMPs cannot be independent in the way Cranston J interprets the intentions of Parliament to require if Hospital Managers sit on them. More than this, an HMP which lacks independence is unlikely to be seen by service users as an effective means of protecting their rights, or by the community as a source of legitimate consent to constrain the rights of those of their peers subject to compulsory care.

While shifting to an all-AHM process would solve a great deal, it would not be a complete solution to the independence problem. The wider context of the relationship between AHMs and healthcare organisations has the potential to undermine AHM independence. Perhaps the most obvious challenge to the independence of AHMs is that they are all appointed by the Hospital Managers.[90] It is an inescapable feature of delegation that the delegator, the Hospital Managers, chooses to whom they delegate power. This is true as regards decisions to appoint people as AHMs, their ongoing retention in post, any remuneration, assigning them from a pool of eligible AHMs to individual HMPs, and so on. If one seeks both justice and the appearance of justice, then plainly this arrangement poses problems. As with the issues identified in the discussion of *AU,* remedying this would require amendment to primary legislation. How one might address these wider operational issues is beyond the scope of the paper, but bluntly severing AHMs from their associated healthcare

[90] Consider n 48 above, *Volume 3*, North East London NHS Foundation Trust Hospital Managers Committee (DMH 124), EV829, para 13; and the sentiments expressed in Secretary of State for Health and Social Care, Lord Chancellor and Secretary of State for Justice, *Reforming the Mental Health Act: The Government's response to the consultation*, CP 501 (2021), 30-31.

organisation would, I think, risk losing some of the relational governance benefits (knowledge exchange through, e.g., interaction on committees), and productive constitutional scrutiny, which AHMs provide, and, as I discuss in the next section, could also undermine their community connection. Careful consideration of how to move forward is required.

Community justice

At this stage, one might suggest that, governance benefits aside, the only important credentials for any oversight process in this space are those of independence and safeguarding service user rights. On such a reading, abolition of HMPs and complete reliance on the MHT provides the obvious antidote to the problems under consideration here. This view has been expressed many times in the course of previous reform discussion around the 1983 Act,[91] and indeed features of it can be seen in the present reform discourse.[92] In brief, advocates of abolishing HMPs and transferring all oversight to the MHT argue that HMPs duplicate the work of the MHT.[93] Why try to address issues arising from the governance obligations of Hospital Managers, or fix constitutional concerns, when the MHT already does the job?[94] This sentiment was evident when the government consulted recently on abolition; it said "that [relative to HMPs] the Tribunal is better placed to assess whether a service user continues to meet the

[91] For example, Department of Health, Improving Mental Health Law: Towards a New Mental Health Act (Cm 6305) (2004), paras 3.54-3.58, 5.1-5.3, 11.15, see further above n 9.

[92] Secretary of State for Health and Social Care, Lord Chancellor and Secretary of State for Justice, *Reforming the Mental Health Act*, CP 355 (2021), 33.

[93] See eg, n 81 above, Working Group, para 10; Report of the Expert Committee, *Review of the Mental Health Act 1983* (1999), paras 5.127-5.128; and n 15 above, *Volume 1*, 194; for a summary see above n 9, section V.

[94] See, for example, the sentiment in Independent Review of the Mental Health Act, *Report* (2018), 150-151.

criteria for detention".[95] However, this position hard to sustain empirically,[96] since it misses an essential point of principle. Even if there were duplication of work, the foundations of HMPs are distinct from those of the MHT. This makes all the difference since it means that the role of the HMPs cannot be conducted by the MHT as currently constituted. Whereas the MHT is grounded in professionalism, on the members of the panel having attained a given level of experience in their chosen fields (eg law, psychiatric medicine), the HMPs, when staffed by local community AHMs,[97] draw their legitimacy *from* that community and encapsulate the "twin principles of 'local justice' and 'justice by one's peers'".[98] This source of legitimacy is inaccessible to the MHT. It is similarly inaccessible for Hospital Managers given the nature of the governance structures surrounding them.

The importance of the community connection is made plain when we reflect on the issues addressed via HMPs. If an individual's liberty is constrained for healthcare purposes, then, as with criminal justice, part of the process for approving this must involve community consent.[99] Indeed, regular community oversight of compulsory mental health care may be more important than in the criminal justice context because constraints upon liberty for mental

[95] Secretary of State for Health and Social Care, Lord Chancellor and Secretary of State for Justice, *Reforming the Mental Health Act*, CP 355 (2021), 33.

[96] Above n 9; and see also proactive mitigations against duplication in The *Code*, 38.13/38.10 and 38.32/38.28.

[97] Above n 5.

[98] House of Commons Justice Committee, *The role of the magistracy: follow-up* Eighteenth Report of Session 2017-19, HC 1654 (2019), para 1; a view supported in, for example, Written Evidence to the recent Joint Committee, above n 11, Mind and Race on the Agenda (MHB0070), 9 and 19; see further above n 5.

[99] J. C. Donoghue, 'Reforming the Role of Magistrates: Implications for Summary Justice in England and Wales' (2014) 77(6) *Modern Law Review* 928, 932.

health care can be repeatedly extended. This is not to detract from the value of familial (Nearest Relative), professional (Responsible Clinician), judicial (MHT), or administrative scrutiny (Healthcare Organisation) of power under the Act,[100] instead, we should recognise that, though they are all legitimate, these constituencies are not capable of speaking for the community.[101] It follows that, recalling the earlier discussion about Barber's allocation of functions, given that no other process under the Act facilitates community involvement, a process which has the capacity to do so should be staffed by those best placed to carry it out. Only AHMs, as members of their, and service users' local community, can connect with this community-based legitimacy.[102] Hospital Managers, by contrast, are principally concerned with administration of the healthcare organisation, and are not required to have ties to that community.

We can examine the legitimacy of the AHMs' claim to represent the community further.[103] The basis of AHMs' legitimacy lies in local democracy; in this context, "democratic" refers to the community connection, rather than an electoral process. The foundations of this date back to the involvement of the local magistracy in the administration of the first public asylums in the early-nineteenth century, and in particular their powers to admit and discharge patients.[104] The discharge power they held, which for much of the nineteenth century, though certainly local, was located in the oligarchic county quarter sessions, became democratic with

[100] See above n 5, fig 1, 5.

[101] J. Bell, 'Lay Judges' (2003) 5 *The Cambridge Yearbook of European Legal Studies* 293; also consider discussion ibid, 933-934 in relation to the magistracy versus professional judges; and see above n 5.

[102] Above n 5.

[103] For detail, ibid.

[104] County Asylums Act 1808, 48 Geo 3 c 96, s XXIII.

the transfer of these powers to the newly created elected county councils in 1888.[105] Later, the power was transferred to the new National Health Service,[106] administered through Hospital Management Committees (HMCs), which themselves retained a strong local and democratic ethos.[107] HMCs were democratic in a similar way to the present-day AHMs, in that the legal framework underpinning their authority encouraged breadth of representation of the local community, though they differed in that they lacked the potential decisional-independence of modern-day AHMs.[108] The principal effect of subsequent developments connected with the Mental Health Acts of 1959,[109] 1983,[110] and 2007,[111] was to facilitate, to an ever-increasing degree, the ability to delegate the HMP function to community appointees, cementing their local-democratic quality, and having a positive impact on their relative independence. There is, therefore, a long-established place for community-oversight of compulsory mental health care, which has been enhanced and consolidated over time.[112]

This arrangement is justified by the capacity of AHMs to represent the community within the Act,[113] and the recognition that the nature of the function of Hospital Managers,

[105] See Local Government Act 1888, ss 44, 86, 111; and Lunacy Act 1890, ss 77, 169-176.

[106] NHS Act 1946, s 78(a) and Sch 9, Part 1.

[107] See R. C. Milward 'Functions and administration of hospital management committees' (1973) 4 *Community Health* 207.

[108] See examples ibid, 207.

[109] ibid, 207-209.

[110] n 7 above, Cmnd 7320, 3.19.

[111] n 18 above, Explanatory Notes, para 177.

[112] For further discussion, see above n 5.

[113] Ibid.

having regard to the governance and constitutional rationalisations already outlined, means they cannot fulfil this role, and nor can the MHT. AHMs are based in their communities, they and service users are fellow members of that community; they are peers. Conversely, "the geographic link …" which a healthcare organisation, and by extension its Hospital Managers, "... [has] with a local area is coincidental".[114] Thus, though Hospital Managers might themselves be local residents, their governance function, and especially in the case of English foundation trusts, their business orientation, aligns their responsibilities not to their locality, but with the organisation's statutory and regulatory framework. Conversely, it would be irregular for an AHM who was not local to an area to sit on an HMP in that area. In short, the claim to community-derived legitimacy is predicated on the assumption that those sitting as AHMs are peers of the service user, and representative of their local community.[115] Thus, the third function of the HMPs – the creation of democratic community justice-based legitimacy within the Act – can only be satisfied by delegation to AHMs. Logically, a decision not to delegate removes community legitimacy from the decision-making processes of the Act.

CONCLUSION

I said earlier that the place and principled underpinning of section 23 in the Act, and in the history of mental health legislation more generally, has been overlooked. In this paper I have focussed on the specific implications of this absence for the question of delegation, but it almost certainly adversely impacts all aspects of the HMP process both conceptually and in practice. In relation to delegation, I have shown that a consequence of this absence is both a)

[114] Ibid, 3.

[115] There are challenges as regards representation, see above n 11, Mind and Race on the Agenda (MHB0070); and above n 5; above n 94, 150.

variability in approach to delegation amongst different healthcare organisations (see Tables 1 and 2), and b), a lack of explanation for, and principled justification of current arrangements. In mapping out what must be considered when making decisions around delegation, I have offered a conceptual foundation for delegation which has the capacity to address both a) and b).

I suggested that, while HMPs provide a species of review, this does not justify the involvement of Hospital Managers in the process. I demonstrated that, though there are governance-based arguments *against* delegation, these are easily undermined when viewed alongside other considerations. For example, the logistical challenges to Hospital Managers taking on the bulk of HMP work, and, by implication, their inevitable lack of experience relative to AHMs in conducting the process effectively. It is pragmatic to delegate the work to a group of people specially intended to conduct HMPs: AHMs. It alleviates workload, and has a much greater chance of ensuring the work is conducted effectively, while supporting Hospital Managers to fulfil their other functions. Viewed in this way, the arguments for delegating on governance grounds are compelling, yet they provide only a thin justification for delegation, offering no principled basis for this arrangement to thicken the quality of rights-protection, and doing little to encourage democratic accountability.

To make the positive case for delegation, I considered constitutional and community justice-based expectations. First, constitutional thinking on the legitimate separation of powers and functions within an organisation, particularly one exercising public power, tells us that delegation is not only desirable for practical purposes, but necessary in principle. This is because the nature of the section 23 power, when it is expressed through an HMP, is judicial, not executive in nature. Recalling Barber, since it is constitutionally efficient to allocate

functions to those bodies best suited to carrying them out to secure the most effective fulfilment of those functions, delegation to AHMs is the appropriate approach. It is, therefore, both constitutionally efficient, as well as constitutionally appropriate, to separate judicial-type HMPs from the otherwise bureaucratic-managerial nature of Hospital Managers. A substantive effect of this is that, rather than trusting the protection of rights to a body which has competing obligations, and which cannot robustly meet the requirement that justice must be seen to be done, rights-protection is instead made the responsibility of a more judicially-orientated body.

Removing a judicial-type power from an executive-administrative arm of the system also enhances the constitutional legitimacy of the system as a whole,[116] since delegation better supports accords with natural justice. The powers of a public organisation to administer compulsory mental health care represents, howsoever necessary and well-intentioned, a severe demonstration of public power. The mode for reviewing this power is broadly judicial in nature, and this establishes certain expectations about how scrutiny will happen. In this context, the need to comply with the adage that justice must both be done, and be seen to be done, is clear. Taking these constitutional matters together, it is inappropriate that the detaining organisation should be directly involved in the review of its authority in particular cases. The only plausible solution to this problem is, as discussed in relation to *AU*, to give the power to an independent body. As I said earlier, whether the AHMs represent the full realisation of independence is open to discussion, but even in their current form they align much more closely to it than do the Hospital Managers.

[116] n 59 above, 59.

Constitutionality, therefore, provides a secure principled basis on which to argue for delegation within the realm of expectations around legal processes, but we can go further. Indeed, we must go further since, while the problems identified in relation to governance and constitutionality could be resolved by transferring the work of HMPs to the MHT, the question of community justice cannot. Examining HMPs from the perspective of community justice- makes the democratic case for delegation through an emphasis on the need to tie oversight of compulsory mental health powers to the community. This is because AHMs are, in principle, representative of the community in a way which is unavailable to either the Hospital Managers or the MHT.

Reflecting on the specific question of delegation, and how future delegation decisions might be rationalised, has wider implications for the ongoing discussion about reform of the 1983 Act, including the 2022 Draft Bill. Reform would afford an opportunity to enhance the independence of HMPs, to protect the role of the community in scrutinising compulsory mental health care powers, and to be more explicit about the conceptual foundations of the HMP process. This would address the inconsistencies in approach identified across England and Wales, target the anomalous provisions which permit Hospital Managers to sit on HMPs, and bring coherence to the role of community in the Act. In the interim, this paper provides clarity on the foundations of section 23 to healthcare organisation Boards, and a framework through which Boards may revisit their decisions around not / delegating section 23 powers to AHMs.