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Case No: CO/2054/2016

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/09/2016

Before :

MR JUSTICE GREEN

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Between :

The Queen on the application of Justice for Health Limited	**Claimant**
- and -	
The Secretary of State for Health	**Defendant**
- and -	
The NHS Confederation (1) **The British Medical Association (2)**	**Interested Parties**

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Jenni Richards QC, David Lock QC, Benjamin Tankel and Saimo Chahal QC (Hon) (instructed by **Bindmans LLP**) for the **Claimant**
Clive Sheldon QC, Joseph Barrett and Ronnie Dennis (instructed by **The Government Legal Department Solicitors**) for the **Defendant**
Jason Coppel QC and Christopher Knight (instructed by **Capsticks Solicitors**) for the **First Interested Party**
Nadia Motraghi (instructed by **Capital Law of Cardiff**) for the **Second Interested Party**

Hearing dates: 19th and 20th September 2016

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Approved Judgment

INDEX

A. Introduction, summary and conclusions		1 – 13
(i)	*The Claimant/junior doctors*	1 – 3
(ii)	*The three issues in the case*	4 – 7
(iii)	*The need for full judicial review*	8
(iv)	*Conclusions on the three grounds*	9 – 12
(v)	*Relief*	13
B. The Parties and affected entities and their respective interests		14 – 28
C. The Facts		29 – 78
(i)	*The early negotiations of terms: The Heads of Terms for negotiation: 2013 – 2015*	30 – 33
(ii)	*The NHS Employers "firm offer": 4th November 2015*	34 – 35
(iii)	*The MOU between the Department of health, NHS Employers, and the BMA signed under the auspices of ACAS: 30th November 2015*	36 – 37
(iv)	*The breakdown in negotiations between NHS Employers and the BMA: January / early February 2016*	38 – 39
(v)	*The position of the Secretary of State: 11th February 2016*	40 – 42
(vi)	*Events subsequent to 11th February 2016*	43 – 45
(vii)	*NHS Employers Webinar: 25th February 2016*	46
(viii)	*The letter from the Government Legal Department: 8th March 2016*	47 – 48
(ix)	*Briefing by Civil Servants to the Secretary of State: 21st March 2016*	49 – 50
(x)	*The Equality Impact Assessment: 31st March 2016*	51 – 53
(xi)	*Pre-action protocol correspondence: 4th April 2016 – 15th April 2016*	54 – 55
(xii)	*Statement made by the Secretary of State to Parliament: 18th April 2016*	56
(xiii)	*The agreement between the BMA, NHS Employers and the Secretary of State: 18th May 2016*	57 – 58
(xiv)	*The BMA junior doctor's referendum*	59
(xv)	*The briefing to the Secretary of State: 6th July 2016*	60 – 63
(xvi)	*The decision under challenge – the Statement of the Secretary of State to Parliament: 6th July 2016*	64 – 65
(xvii)	*The pay and conditions circular issued by NHS Employers: 6th July 2016*	66
(xviii)	*The Public Sector Equality Guidance issued by NHS Employers: 6th July 2016*	67 – 70
(xix)	*The GLD correction to the NHS Employers Circular: 15th July 2016*	71
(xx)	*Communication from NHS Improvements: 28th July 2016*	72
(xxi)	*The position of the Secretary of State in these proceedings*	73 – 75
(xxii)	*The position of NHS employers*	76
(xxiii)	*Position of junior doctors*	77 – 78
D. Legal framework: The scope of the powers and duties of the Secretary of State		79 – 106
(i)	*The structure of the NHSA 2006*	79
(ii)	*The express duties of Secretary of State under the NHSA 2006*	80 – 92
(iii)	*The express powers of the Secretary of State*	93 – 98
(iv)	*The general powers of the Secretary of State under Section 2 NHSA 2006*	99 – 106

E. Ground I: Did the Secretary of State take a decision requiring or compelling NHS employers to implement the new contract and did he act within his statutory powers?	107 – 127
(i) The issue	107 – 110
(ii) Analysis and conclusion	111 – 123
(iii) The compatibility of the actions of the Secretary of State with his statutory powers and duties	124 – 127
F. Ground II: Breach of the common-law duty of transparency and good administration	128 – 166
(i) The issue	128 – 132
(ii) Conclusions on the evidence	133 – 140
(iii) Legal issue I – The scope of the principles of transparency and good administration: Do they apply and if so has there been a violation?	141 – 150
(iv) Legal issue II – does Parliamentary privilege preclude the Court from reviewing the Statement of the Minister?	151 – 165
(v) Conclusions	166
G. Ground III: Irrationality	167 – 191
(i) The issue	167 – 168
(ii) The evidence relied upon by the Claimant	169 – 175
(iii) Analysis and conclusions	176 – 191
H. Conclusion	192

Mr Justice Green:

A. Introduction, summary and conclusions

(i) The Claimant/the junior doctors

1. This case concerns a challenge by a group of junior doctors who object to the manner in which a new set of terms and conditions of employment are to be rolled out across the NHS. The expression “junior doctors” is a misnomer. It includes, in addition to doctors in training, hugely skilled clinicians and practitioners who routinely perform some of the most complex medical procedures, some of whom have many years of experience and are on the cusp of becoming consultants. The actual Claimant to this litigation however is a company which has been formed for the purpose of bringing this claim and representing the interests of the junior doctors who object to the new terms and conditions.

2. The issue of the proposed new contract generates strong feelings. Evidence before the Court demonstrates the level of disenchantment which many junior doctors feel about their working conditions within the NHS. Much of this sentiment is of a general nature and whilst undoubtedly heartfelt is not always of direct relevance to the quite specific legal issues that I have to decide. Nonetheless, it is important context to this case and I have endeavoured in the judgment to summarise the views of all sides to this issue.

3. In recording these views I emphasise that I am not expressing *any* sort of an opinion or conclusion on the competing arguments about the merits or otherwise of the new contract either as a whole package or as to its individual components and nor am I expressing any view as to the merits of the arguments over the “7-day NHS” which includes the issue of weekend mortality rates.

(ii) The three issues in the case

4. In this litigation the Claimant has identified three relatively specific points of law which I can summarise as follows.

5. First (Ground I), it is said that properly analysed the facts demonstrate that on 6th July 2016 the Secretary of State adopted a decision that certain new terms and conditions would be imposed on all NHS employing bodies even though under the governing legislation, the National Health Service Act 2006[1] (“NHSA 2006”), the Minister had no lawful power or jurisdiction to impose such a contract, with the consequence that he exceeded his lawful powers and acted in an unlawful manner. The nub of the issue arises because after a lengthy period of negotiation between representative bodies of employers and employees, the BMA (for the doctors) ostensibly recommended acceptance of a set of terms and conditions to its members which the junior doctors members then rejected in a referendum by a strong majority of 58/42% on a turnout of circa 68%. On 6th July 2016 in the immediate aftermath of being informed of the outcome of the referendum the Secretary of State took a decision that the contract that the doctors had rejected should nonetheless be introduced. He then made a Statement to Parliament in which he set out his reasons for the “decision” he had taken earlier that

[1] As amended by the Health and Social Care Act 2012.

same day to introduce the new terms and conditions without the agreement of the junior doctors. The "issue" here is whether the Secretary of State in his decision taken before he went to Parliament did in fact seek to *impose* new terms on employers (and thereby shut out the possibility for further negotiation) and the nature of his powers in relation to the approval or setting of terms and conditions of employment (bearing in mind that the NHS is in fact not a single body but a collection of different organisations, both public and private, and therefore comprises a variety of different employers).

6. Second (Ground II), it is argued that in any event (ie even if the Minister had the power to do what he did) the manner in which the relevant policy and decision was taken was so opaque and confused that it violated the principles of "*transparency*" and "*good administration*". These are important principles of public law and, in essence, require public bodies to formulate and apply policies in a clear, precise and transparent manner so that those subject to or affected by them know where they stand and can regulate their affairs accordingly. The principles are also important so that those affected by a decision that might be adverse to them can make representations to the decision maker before the decision is taken and/or know the reasons for the decision taken subsequently so that they can decide whether to challenge it in the courts. This issue arises if in fact on analysis the Secretary of State's Statement to Parliament on 6th July 2016 conveyed a false impression and/or is inconsistent with his present position.

7. Third (Ground III), finally, it is argued that, irrespective of all other arguments, the decision adopted by the Secretary of State is unlawful because it is irrational and not based on adequate evidence. It is argued that the basis of the decision to introduce the new contract was the Conservative Manifesto commitment to introduce the "7-Day NHS" and was based upon the premise that the higher mortality rate which occurred across the NHS at weekends could be remedied by the new contracts. As to this it is said that the causal connection said to exist between the introduction of the contract and the prevention of avoidable mortality is not based upon any credible or adequate evidence and the decision of the Secretary of State to introduce the new contract without proper evidence is in consequence illogical, irrational and unlawful.

(iii) The need for full judicial review

8. Because this case has arisen at speed and has been granted expedition, technically, the hearing before me was a "*rolled up*" hearing which was to decide whether I should grant permission to the junior doctors to seek a judicial review and if I decided that permission should be granted then to arrive at a decision on the merits of the grounds of challenge. I indicated at the outset of the oral hearing that I had formed the view that the grounds advanced by the junior doctors were serious and properly arguable, raised important points of principle about the powers of the Secretary of State under the NHSA 2006 and as to the manner in which he should act in exercising those powers, and generally raised an issue of wider public importance. I have therefore proceeded to determine the case on its merits as a full judicial review.

(iv) Conclusions on the three grounds

9. In relation to the three grounds of challenge I have reached the following conclusions.

10. First in relation to Ground I, I have come to the conclusion that the Secretary of State adopted a decision on the 6th July 2016 to approve the terms and conditions which the Minister considered had hitherto been approved by the BMA. The decision of approval did not, however, compel employers to apply the contract to their respective employees. The decision did, nonetheless, contemplate that the contract would be introduced without the collective agreement of the employees. The Secretary of State adopts the strong position that the contract should be introduced and he reserves the right to consider the exercise of powers of compulsion in the event that implementation is inconsistent or fragmentary and thereby threatens the pursuit of the objectives he seeks to achieve, which include the enhancement of a 7-day NHS. In coming to this conclusion I have considered substance over form; I have had regard to the terms of the Ministerial Statement of the 6th July to Parliament read in the context of other documents which precede the Statement, are contemporaneous with it, and post-date the Statement including formal statements and evidence placed before the High Court. Further, I have concluded that the decision adopted by the Secretary of State fell squarely within the scope of his lawful powers under the NHSA 2006.

11. With regard to Ground II, I accept the submission of the Claimant that on the evidence the Statement made to Parliament on 6th July did in fact lead the junior doctors to conclude that contrary to the reality, the Secretary of State intended to "impose" the new contract thereby excluding altogether any daylight for negotiation either with the Secretary of State or with employers. I accept that on the evidence employers understood the Statement as the Minister intended it to be understood but that was not the case for the doctors. However, shortly afterwards and essentially in the course of these expedited proceedings, the Secretary of State has formally provided elaboration and clarification of his decision and confirmed, inter alia, that he is not exercising compulsory powers and therefore, in principle, individual employers retain freedom of contract. This elaboration and clarification means that when <u>all</u> the relevant material is read objectively and in its proper context there is no lack of clarity or transparency. I should add that nothing in this part of the judgment is to be taken as even a hint or suggestion that the Minister misled Parliament.

12. As to Ground III, I also reject this complaint. In my judgment the Secretary of State had a broad margin of discretion under the relevant legislation to introduce the new contract. That contract is said, by the Secretary of State, to serve a multiplicity of purposes only one of which is to assist in addressing problems related to increased mortality at weekends. And in relation to that particular issue, whilst the Secretary of State acknowledges that there is evidence going both ways, he is entitled to accept that the evidence establishes that an increase in the availability and deployment of experienced doctors at the weekend will make some, material, contribution to the problem of increased mortality rates. The evidential basis upon which the Secretary of State relies is cogent and significant. Further, the Secretary of State has acknowledged that he will mandate a review in 2018 and, it follows, make adjustment if necessary. For reasons set out in greater detail in the course of this judgment I conclude that the Secretary of State acted rationally and was within the margins of his legitimate discretion in taking the action that he did.

(v) Relief

13. It follows from the conclusions that I have recorded above that it would not be appropriate to grant any relief to the Claimant. Nonetheless in the present case an important reason leading the junior doctors to embark upon this litigation was their concern that by virtue of the Minister's decision every possible negotiating avenue had been closed off. One significant consequence of this litigation therefore has been that the Secretary of State has, properly and reasonably, taken the opportunity to put his position beyond doubt. Without granting declarations I can nonetheless, formally, record the position of the Secretary of State as articulated in these proceedings. First, the Secretary of State does not purport to exercise any statutory power that he may have to compel employers within the NHS to introduce the proposed terms and conditions. Second, he acknowledges, therefore, that in principle individual employers are free to negotiate different terms with employees. Third, he considers that the scope for individual negotiation may be limited because he has achieved consensus with the employers that the proposed new terms and conditions represent a fair and workable basis upon which to proceed. Fourth, the Secretary of State reserves the right, should problems arise in relation to implementation, to consider the exercise of such statutory powers of compulsion as he has in order to achieve a consistent and uniform introduction of terms across the NHS.

B. The parties and affected entities and their respective interests:

14. In the text below I have set out the identity and interests of the parties to this litigation. In particular I have set out the approach of the parties to the overall issue of review and reform of terms and conditions of employment of junior doctors. I reiterate the point made above that in setting out a summary of the competing views of the affected interests I am not to be taken as expressing any view upon them.

15. **The Claimant – representing junior doctors**: The Claimant is a company formed by five junior doctors who are directly affected by the introduction of the contract in issue in these proceedings. The proceedings are financed by a large number of individuals who have contributed on a crowd-funding basis all of whom it is said oppose the introduction of the new contract. Support has been forthcoming from many sources, including senior members of the medical profession. At an early case management hearing I imposed caps on the recovery of costs to ensure that the party ultimately losing the case did not risk being subject to open ended costs exposure. The principle of cost capping was agreed to by the Secretary of State.

16. It is helpful in order to provide a flavour of the wider underlying dispute to refer to some of the principal objections advanced by the doctors concerned. Evidence has been given by a number of doctors. In the text below I refer in detail to one of the statements since it describes many of the concerns and objections raised by other doctors who have given evidence. In this respect a Witness Statement was served on behalf of the Claimant by Dr Nadia Masood. Dr Masood is 35 years of age and started working as a junior doctor in General Medicine at Kingston Hospital in August 2004. Dr Masood's long term aim is to become a consultant in anaesthesia. In her statement she sets out a number of the problems and difficulties which she experiences in her present work at the Great Ormond Street Hospital. The tenor of her evidence is that the problems she

identifies are typical of those confronting junior doctors generally. She is contracted to work on average 48.25 hours per week over eight weeks and this includes two weekends per month. She presently works in intensive care and in neo-natal and paediatrics. Seventeen persons in total appear on the shift rota but, Dr Masood explains, frequently the seventeen is reduced to only four or five doctors daily. During the night time there may be only three doctors present on the intensive care unit to care for 40 patients. This means that one doctor may care for about 10 patients, notwithstanding that these are the sickest patients in the hospital and each requires intensive care and attention. Dr Masood observes that she and her colleagues find themselves "… *mentally and physically exhausted trying to provide the same safe care to every patient*". She is of the view that this compromises the ability of the doctor to provide care upon a safe basis. She also observes that she is frequently requested to work unfilled shifts over and above her own contracted for duties which means that she has to relinquish rest and free time. She also makes the point that official hours do not necessarily reflect the time taken properly to assess, prepare patients for surgery and to check drugs and equipment prior to the start of surgery. Typically a doctor in her position will arrive at work 30-40 minutes early and at the end of the day that surgeon will have to perform a safe hand-over process for the care of patients to a responsible member of staff and this also takes a considerable period of time. She estimates that on average, she may work up to an hour over her official hours upon a daily basis. The "*net result*" is that there is a "*zero reserve*" i.e. no spare capacity within the system. She also objects that due to the inflexibility of the rota she does not get to choose the days that she must take as annual leave. She is not provided with an up-to-date rota more than a few weeks in advance due to changing shift patterns. Work schedules regularly alter because of staff shortages. Many junior doctors use their "*zero days*" or leave to do audit work, research, to set up meetings, to prepare papers and to update CVs, etc all of which is non-clinical but essential in order successfully to complete training. A "*zero day*" is intended to be a rest day added to a rota after a night shift in order to facilitate recovery.

17. Dr Masood expresses a loss of faith and trust in the "*NHS as a whole*":

> "This has resulted in the complete loss of trust amongst doctors in the government's dedication to the wellbeing of patients, doctors and other staff in the NHS. I do not feel looked after or cared for by the government who oversee my employment. I do not feel like they understand the intensity of my job, enormous responsibility I shoulder as part of it, the sacrifices I have made, and the emotional damage."

18. Dr Masood summarises the position of the junior doctors whom she represents in the following way:

> "There is a lot of anger amongst junior doctors because for a long time there has been a culture of doing what is necessary and not making a fuss because it is a vocation that we have chosen for ourselves. We have been holding the fort for so long that the system is now at collapsing point and maybe we should have spoken up sooner. There are simply not enough people to go round and fulfil the rotas and if it is not possible to increase weekend staffing levels without increasing staff the consequences for the NHS will be dire.

> I have endured. I have felt bullied and undermined by the government throughout the dispute who have refused to constructively engage with any of us, and the announcement of an imposition shows me that they have a total lack of respect for me and my profession. I do not trust that they have the best interests of patients or NHS staff at the core of their proposed and now enforced changes.
>
> The current situation has led to such a decrease in morale amongst all NHS staff that the mood at work has significantly changed. I have heard a Consultant say that they will consider resigning their job if their contracts are changed. I myself have been so affected by the dispute and the way that it has taken away my job satisfaction that I no longer wish to work in the NHS after I complete my training next year."

19. The views of Dr Masood are said to reflect sentiments expressed by many other junior doctors. Other doctors who gave evidence have raised additional points. For instance it was said that the employers and the Secretary of State have combined ("*colluded*") to impose unfair terms and "*subvert*" the NHS and "*push doctors as hard as possible*". A number of doctors raised concerns about safety limits and about the inability of junior doctors to raise concerns (in effect to whistle-blow) about working conditions and safety because of a fear that they would be sanctioned by management. Many of the witnesses raised general concerns about overall staffing levels. A concern was also expressed about the impact of the new contract on working parents and upon childcare. And a concern was articulated that the new contract pay structures could increase gender pay imbalances.

20. **The Secretary of State for Health (the Defendant)**: The Secretary of State has responsibility under the NHSA 2006 for promoting the provision of health services in England. Mr Charles Massey, Director General for Acute Care and Workforce at the Department of Health, has given detailed evidence with the authority and on behalf of the Secretary of State. In a Witness Statement dated 19th August 2016 Mr Massey also set out, for the avoidance of any doubt, the formal position of the Secretary of State as to his statutory powers and whether he has exercised them and as to the extent of the discretion that individual employers within the NHS have to vary the terms presently proposed. In broad terms the position of the Secretary of State can be summarised in the following way. He fully recognises that the contractual position of the junior doctors has not in the past been fit for purpose and was in multiple respects unfair and unsatisfactory. He was not directly involved in the early years of the negotiations between the BMA on behalf of the doctors and the NHS Confederation on behalf of employers, but he became involved latterly when it had become, in his view and that of the employers, plain that negotiations had broken down irrevocably.

21. The Secretary of State accepts that the new contractual terms are not a panacea for all ills. He does not claim that they will, in and of themselves, either bring about the fully functioning 7-day NHS or will resolve all of the outstanding problems that will persist in the way that junior doctors are trained or treated. He acknowledges that he is subject to budgetary constraints and says that he is seeking to introduce cost neutral changes to working conditions. But he, in substance, says that the new terms and conditions

represent a good and fair and balanced start. In his view many of the broader objections raised by the junior doctors are either unrelated to the new terms and conditions (such as *overall* staffing levels, which is an issue that cannot be dealt with in an individual contract between an employer and an employee) or are problems that the new terms and conditions will start to address in a material and sensible manner. The Secretary of State relies upon the fact that the BMA, the body representing the junior doctors in the negotiations, took the view in May and June 2016 (and subject to a referendum on the terms) that the contract that the Secretary of State now wishes to see introduced was fair. He acknowledges that in the referendum the junior doctors rejected the terms.

22. For the Secretary of State a very important point is uniformity of terms and conditions across the NHS. Mr Massey says that implementation of the new contract by NHS employers is important to ensure consistent standards of training provision, patient care and safety. In the end, *if* a lack of uniformity emerged which was in the Minister's view contrary to the public interest he could sponsor legislation to address any major difficulties that arose or use such statutory powers of compulsion as he possessed pursuant to the relevant legislation (see Section D below). Mr Massey explains that about 90% of junior doctors are employed by NHS Trusts and/or NHS Foundations with private GP practices and local authorities also employing a relatively small number of junior doctors.

23. **The NHS Confederation (the First Interested Party)**: The NHS Confederation is a charity and company limited by guarantee that acts as a membership organisation for entities that commission and provide NHS services. Its members include: acute trusts, ambulance trusts, community health service providers, foundation trusts, mental health providers, clinical commissioning groups, and some independent and voluntary healthcare organisations. It is right to observe that there are some employers who are not represented by the NHS Confederation. One component of its membership comprises a network that represents trusts in England on employment and workforce issues. This is known as "NHS Employers". Detailed evidence on behalf of the NHS Confederation was given by Mr Daniel Mortimer, the Chief Executive of NHS Employers. As observed this body is part of the NHS Confederation and has no separate legal personality or status. It is therefore the individual members of NHS Employers that employ junior doctors and who will in due course introduce the new contracts either (i) when doctors join the NHS for the first time, or (ii) transfer to a new post within the NHS as part of their training, with effect from 5th October 2016.

24. Mr Mortimer says that there is almost universal agreement across the NHS that the current contractual framework for junior doctors is not fit for purpose whether from the perspective of employers, junior doctors or patients. He accepts that the BMA started to call for a new contract as early as 2009 with the support of the Doctors and Dentists Review Body ("the DDRB"). In relation to the concerns expressed by the junior doctors which I have summarised above he says: "*I would not suggest that NHS Employers necessarily accepts or endorses all of the criticisms which those statements make, but we certainly do agree with the general theme of those statements that the current contractual scheme is not working well and does not provide sufficient protection for junior doctors in training*".

25. In paragraphs [26] – [28] of his statement Mr Mortimer sets out a summary of the main amendments made to the contract over the course of recent negotiations and he also

identifies those areas of general concern which he says are outside of the remit of the contractual negotiations. These paragraphs obviously reflect the perspective of the employers on the changes (and the junior doctors would not therefore necessarily agree with the categorisation of all of the changes as beneficial) but they are nonetheless a useful summary of the principal areas of negotiations between employers and employees:

> "26. In a number of areas, significant amendments to the March terms and conditions ... were agreed. These included:
>
> (1) Basic pay would be increased between 10 and 11% for all junior doctors.
>
> (2) Rather than a system of enhanced basic pay for all working at weekends, a weekend allowance will be paid for any doctor rostered to work more than six weekends a year. The level of that premium ranges from 10% for one weekend in two to 3% for one weekend in seven or eight.
>
> (3) The nodal pay point structure was further revised. The fifth nodal point was removed, with the money allocated to it being used to recognise trainees who undertake senior decision-making roles. Nodal point values would increase in subsequent years to reflect the need for a national living wage for other lower paid NHS Staff.
>
> (4) A 37% enhancement is paid to (a) all hours between 21.00 and 07.00; (b) all hours between 20.00 and 21.00 where the shift starts between 20.00 and 21.00 and lasts longer than eight hours; and (c) all hours between 07.00 and 10.00 where the shifts starts before midnight and lasts longer than eight hours.
>
> (5) A 46 hour rest period after completion of three or four over night shifts.
>
> (6) No rostering of more weekend working than one in two.
>
> (7) Specific new rules concerning very low intensity on-call duty periods at weekends, allowing for greater flexibility and sensible rostering for doctors working such patterns whilst ensuring proper safeguards against tiredness.
>
> (8) Flexible pay premia were increased to a fixed sum of £20,000, payable in equal annual amounts across the duration of the training period, in oral and maxillofacial surgery, emergency medicine and psychiatry (being pro-rated for less than full time trainees).
>
> (9) Where pay protection applies, there is a qualifying period of six months which is waived for those changing for

caring responsibilities or for reasons linked to a disability.

(10) Pay (or time off in lieu) for additional hours of work can be granted, but must be authorised, in advance or retrospectively. Time off in lieu accrual will depend on whether it arises from rest requirements or hours worked.

(11) A supplementary allowance for on-call availability of 8% of basic pay, over and above any other allowance. Clarification that any actual clinical or non-clinical work done on or offsite during an on-call period would be working time, and that a work schedule would contain an anticipated amount of time for anticipated work on-call.

(12) Additional hours as a locum must be first offered to the NHS via an NHS locum bank.

(13) The Guardian of safe working role was subject to significant strengthening. Those changes included: reporting at least once a quarter to the board; establishing a junior doctors forum to advise the Guardian including on disbursement of money raised through fines; greater specification on the use to which fines are put and the reporting of that use; an additional financial penalty where breaks are missed on 25% or more of occasions in a four week period; a mechanism to ensure a Guardian is appointed for all junior doctors, including those employed by small employers; the right to appeal a Guardian decision as per the local grievance procedure, with a BMA representative on the appeal panel; and for performance management of the Guardian.

(14) Transitional pay protection would be extended by one year.

27. It had become evident to all the parties to the negotiations that many of the issues of concern were not ones which could or should properly be part of the new Contract. In order to address those concerns, a series of steps external but complementary to the Contract were agreed. These included:

(1) Accelerated training support (funding from a different source outside the pay-bill) to enable those returning to work to 'catch up'.

(2) A review of good rostering practice to be carried out by NHS Employers and the BMA by January 2017.

(3) A review of deployment issues such as transfers, deployment and training placements for those with caring responsibilities to be carried out by Health Education England ("HEE") by March 2017.

(4) Comprehensive equalities monitoring mechanisms to be put in place by employers, HEE and the BMA from April 2017, along with additional guidance being developed by NHS Employers and the BMA.

(5) Mandatory regional streamlining processes to be required by HEE and NHS Improvement by April 2017.

(6) HEE committed to provide its share of salary funding for six months after a doctor has completed their specialist training.

(7) A GMC-led review of mutual recognition of competence within the UK, to be completed by March 2017.

(8) Junior doctors would be able to raise whistleblowing concerns about the conduct of HEE without detriment under a separate contractual framework.

(9) The Contract would be the subject of a review in August 2018.

28. As can be seen from the comparison between these terms and those explained in my W/S1, both sides made significant further compromises during those ACAS negotiations to achieve a better, fairer and safer contract for junior doctors which was cost neutral and delivered greater flexibility for employers."

26. I have explained above (cf paragraph [22] above) that the Secretary of State considers that uniformity of contract across the NHS is an important public policy consideration and he agrees with the employers in this respect. A fuller explanation of the rationale for uniformity is given by Mr Mortimer who considers that a single and uniform contract is of real importance in ensuring equality of provision of healthcare to patients:

"**The Desirability of a Single Contract**

65. It is, however, no secret that NHS Employers, as well as other NHS bodies with a national oversight role, have a preference for the adoption of the Contract. As I explained in W/S1, no-one working in the sector has ever been in any doubt that anything other than a uniform contractual approach across the English NHS is desirable. The NHS would cease to function equitably for patients, and indeed for doctors, if individual providers were trying to outbid each other in the recruitment of staff; training must be provided and funded uniformly by HEE; and of course an NHS provider which

adopts a contractual model which costs more money than has been allocated for that purpose by the DoH will quickly face financial difficulties.

66. On 15 February 2016 the Chief Executive of HEE wrote to individual Trusts reminding them that "*A single national approach is essential to safeguard the organisation and delivery of postgraduate medical training to ensure all doctors can secure the professional development they require to complete their training programmes. We are not prepared to see a system where a competition based on a local employer's ability to offer different terms is part of the recruitment process*" ..... NHS Improvement (the umbrella body of NHS regulators such as Monitor) wrote a similar letter on the same day, stressing the need to "*implement the contract consistently across the country*" ... This is not a requirement; it is recognition of a practical reality. No-one, least of all the BMA, has ever suggested in the course of the negotiations that the principle of a single national Contract was a bad idea. Fragmented contracting is not an approach welcomed by any trade union in the NHS, or in my experience by local employees. On the contrary, the process has always been approached on the basis that a single, collectively agreed new contract was highly desirable, which is why so much time and effort was expended on all sides in seeking to agree such a contract.

67. As is the case with most collectively agreed contracts in the employment context, the actual parties to any new contract will be the individual employee doctor and the particular employing provider. In theory, individual providers could adopt different terms and conditions to those set out in the new Contract, and NHS Employers has always recognised and accepted this.

68. Indeed, I am aware that some employing providers have adopted local variations to nationally agreed contracts in the NHS, such as the Agenda for Change contract. However, individual employer approaches on the part of, for example, Foundation Trusts, remain rare across the range of NHS staffing contracts. From my own experience at Trust level, and from my discussions with those in Trusts and Foundation Trusts during the current dispute, I know that the clear preference on the part of employers is for a single, unified, national set of terms and conditions.

69. A certain degree of variation may be necessary to reflect particular local conditions; NHS Employers supports and encourages that in the light of the autonomy individual Trusts have been given. However, inconsistency in training, staffing and service provision is likely to harm patient safety, exposing them to an unacceptable risk of a 'postcode lottery'. Our

> concern is self-explanatory, and echoes that of NHS Improvement and HEE. The autonomy of individual employers is important, but it is not the only factor. NHS Employers has no hesitation in recommending to employers that the Contract be adopted and introduced because it represents a fair and reasonable approach which has been the product of lengthy and detailed negotiations, and a consistent introduction will be most likely to secure essential consistency of training, staffing and service provision.
>
> 70. I re-emphasise, however, that NHS Employers can only recommend the introduction of the Contract, explaining its advantages and improvements. We cannot require any employing NHS provider to adopt the Contract and we have not suggested otherwise. Any attempt to do so would be given very short shrift by my colleagues in individual Trusts and Foundation Trusts."

27. **The British Medical Association (the Second Interested Party)**: The BMA is a professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK. The doctors who are directors of the Claimant are members of the BMA. The BMA commenced judicial review proceedings to challenge the lawfulness of the decisions of the Defendant upon the basis that those decisions infringed section 149 of the Equality Act 2010: the Public Sector Equality Duty. For reasons which it is not relevant to dwell upon the BMA withdrew its challenge at a case management conference convened to lay down directions for the further progress of the present claim.

28. However, the BMA was represented by Counsel in the course of the judicial review and emphasised that at all times it considered that it had cooperated fully and reasonably in the negotiating process. Further it rejected 'imposition' of contractual terms upon junior doctors and believed that the Secretary of State should achieve a negotiated solution. Finally, the BMA was at pains to point out that no endorsement or pronouncement regarding the contract had been made by the Junior Doctors Committee (JDC).

C. The Facts

29. I turn now to set out the principal facts which are relevant to the grounds of judicial review. I do not, by any means, refer to the entirety of the voluminous documentation before the Court which chronicles the way in which the negotiations have proceeded over time, nor to all of those facts and matters which could be said to be relevant to the grounds of challenge. In particular I have concentrated in the text below on facts relevant to Ground I (jurisdiction) and Ground II (transparency/good administration). I have addressed factual matters relevant to the Ground III (rationality) in Section G below which addresses that particular issue.

(i) The early negotiations of terms: The Heads of Terms for negotiation: 2013 - 2015

30. The BMA and others identified the need for reforming the 'New Deal' Doctors' contract (introduced in 2000) as far back as 2008. A case for change and principles for a new national contract were set out in a Scoping Study report by NHS Employers published in 2012. A stake-holder event was held in January 2013 which included doctors, trade unions, employers, other NHS organisations, the Royal Colleges, postgraduate deaneries/educators, the GMC and devolved administrations. A negotiating team agreed Heads of Terms for negotiations in July 2013. These were then ratified by the four UK Health Departments and by the JDC (which was also representing the British Dental Association) as the mandate for UK-wide negotiations. The Heads of Terms provided that the new contract must: "*Be consistent with all aspects of UK law, including working time regulations and the Equalities Act*." Negotiations commenced in October 2013 and were scheduled to continue until the end of October 2014. The negotiations did not however come to an agreed conclusion. The UK Health Departments requested the DDRB to make recommendations on a new contract. NHS Employers, the UK Health Departments, the BMA and a number of other parties submitted evidence to the DDRB.

31. In July 2015 the DDRB made recommendations to the UK Health Departments broadly endorsing NHS Employers' proposals as the basis for further negotiations. The recommendations of relevance to the present case were as follows:

> **"Doctors and dentists in training contract reform: recommendations**
>
> *Recommendation 1*: Pay should be based on stages of training and actual progression to the next level of responsibility, evidenced by taking up a position at that level (paragraphs 4.16 – 4.19).
>
> …
>
> *Recommendation 3*: We support a contract based on work schedules, work reviews and exception reporting, and the end of banding payments (paragraphs 4.27 – 4.28).
>
> …
>
> *Recommendation 6:* We support the use of scenarios C and C+ as the basis for further discussion / negotiation between the parties (paragraphs 4.34 – 4.35).
>
> *Recommendation 7*: A common definition of core time/unsocial hours is required for all NHS groups. If the definition needs to differ between groups, then a commonly understood rationale would be required (paragraph 4.36).
>
> *Recommendation 8*: We support a contract based on basic pay (up to 40 hours per week), rostered hours (up to eight hours per

> week, on average) paid at the same rate as basic pay and an unsocial hours premium (paragraphs 4.34 – 4.36).
>
> *Recommendation 9*: The contract should include an availability allowance to recognise an obligation to be on standby to return to work, with the rate of the allowance varied to reflect the frequency of on-call (paragraph 4.40).
>
> *Recommendation 10*: The contract should include the potential use of RRPs (or flexible pay premia) to incentivise hard-to-fill specialties and that they are paid where required (paragraphs 4.45 – 4.46)."

32. These recommendations formed the basis of subsequent negotiations. An Equality Impact Assessment published by the Defendant on 31st March 2016 (see paragraphs [51] – [53] below) in Annex C sets out the history of negotiations and it includes the following (which it is fair to record reflects the perspective of the Secretary of State) about the position in late 2015:

> "5. … The Secretary of State invited the BMA to return to negotiations, being clear that a negotiated agreement ***was preferred but that a new contract would be introduced if agreement could not be reached***.
>
> 6. The BMA did not return to negotiations. The DDRB offered to explain to the BMA the rationale for its recommendations, but the BMA did not take up this offer. On 4 November 2015, NHSE published an offer that was 'firm, not final' – reflecting that further work and modelling remained to be done, and the continued hope that the BMA would agree to negotiate. The published offer document stated: "*The new pay system and contract will not break any equality laws and will be subject to a full equality impact assessment before implementation*". On 5 November 2015, the BMA balloted its members for industrial action.
>
> 7. Following talks involving ACAS, the parties agreed to re-enter negotiations and a memorandum of understanding was signed by the BMA, NHSE and the Department of Health on 30 November 2015."
>
> (Emphasis in bold added)

33. The Secretary of State made a written statement to Parliament on 16th July 2015 (Hansard, 16 July 2015 Columns 52WS and 53WS). Under the heading " *Next steps"* the following was stated about the negotiations and the intention of the Minister:

> "Given the priority placed on seven-day services by medical leaders and patient groups, I was hugely disappointed that the BMA union walked away from negotiations at such a late stage last October when proposals had been developed. The DDRB has stated that its recommendations and observations, "provide

a roadmap on what could and should be achievable in the interests of everyone with a true stake in the NHS."

We have lost a year in which we could have been moving towards changes that are in the interests of patients, doctors and the NHS. We cannot afford any more delays. That is why I am now asking the British Medical Association (BMA) to engage with us rapidly over the summer and to tell me, by mid-September, whether they will work with us, without delay, to introduce modernised professional contracts for engagement and for training, focused on outcomes, on the basis of the recommendations and observations in DDRB's report.

While we remain prepared to discuss a staged approach to changes for consultants, as recommended by the DDRB, we would be seeking immediate removal of the consultant opt-out, early implementation of new terms for new consultants from April 2016—moving existing consultants across by 2017—and the introduction of a new juniors' contract from the August 2016 intake. We will also introduce a new performance pay scheme, replacing the outdated local clinical excellence awards so that we reward those doctors who are making the greatest contribution to patient care—the DDRB recommends that these be termed "awards for achieving excellence". I will consult on removal of the current local scheme in the autumn, alongside proposals for a reformed national clinical excellence award scheme based on the recommendations previously made by the DDRB. We will be mindful of the importance of recognising those doctors who have national leadership roles in the NHS and the substantial contribution made by clinical academics.

The case for change, in the interests of all, is made. We would prefer to agree changes in partnership, as recommended by the DDRB and acknowledging its observation of the need to build mutual trust and confidence; but we will take forward change, in the absence of a negotiated agreement.

The NHSPRB said that the areas of agreement between the parties, "should provide a positive basis for future discussions and progress on the expansion of seven-day services."

I welcomed the agreement of the NHS trade unions earlier in the year to enter into talks on contract reform. The NHS trade unions have already agreed to a timetable seeing change beginning to be implemented from April 2016. I am now inviting the AfC trade unions to enter into formal negotiations with NHS employers, to that timetable, to agree a balanced package of affordable proposals for reform.

These reforms need to enable trusts to recruit, retain and motivate the staff they need to deliver high-quality safe care

> over seven days. All trusts must make the very best use of their pay bill, making every penny work for patients. I know most trusts prefer to use national pay frameworks provided they are affordable and fit for purpose. I recognise that, if national contracts cannot be reformed, it is likely that employers will feel that they need to use the employment freedoms they already have to take contract change forward."

(ii) The NHS Employers "firm offer": 4th November 2015

34. NHS Employers sent what is described as a "*firm offer*" to the junior doctors' representatives on 4th November 2015. The Secretary of State refers in particular to the following which he considers made it clear that the offer was both "*firm*" but also in a number of respects provisional:

> "Recognising that this offer is firm but not final, the Department of Health has mandated NHS Employers to work on final details, including the continuation of detailed modelling, data gathering, and testing. **It is important to re-iterate that figures in this document are still illustrative at this time**.
>
> It is recognised that the involvement of relevant stakeholders is essential to ensure the final contract is right for both doctors and the NHS. The expert knowledge of relevant stakeholders will continue to be used as the final detail of the new arrangements is worked through. This will include working with Health Education England, the Universities and Colleges Employers Association, the Medical Schools Council, the Medical Royal Colleges, the Care Quality Commission, NHS employing organisations, Skills for Health, Allocate, ESR, and other interested parties.
>
> An Equality Impact Assessment of the new arrangements will also be undertaken.
>
> When all arrangements have been finalised, NHS Employers will publish the new Terms and Conditions of Service for doctors and dentists in training, and a Medical and Dental Pay and Conditions Circular containing new rates of pay."

35. The Secretary of State wrote on the same day to junior doctors inviting them to resume negotiations:

> "The Government was elected on a manifesto commitment to help make the NHS the safest healthcare system in the world by delivering truly 7 day services in hospitals. That pledge included better access to weekend diagnostics, better integration with social care to facilitate weekend discharging, and better staffing across the full range of clinical and support services, so we must press ahead on all of those fronts. But my

strong preference is to get round the table and agree with doctors how we do so in a way that you consider fair, so my door remains open for negotiations.

I know how hard you work, and I know that the pressures on the NHS frontline are intense. We want to make your working lives better, not worse, and I appeal to you to choose talks not strikes, and work with us to get this contract right for you and your patients."

(iii) The MOU between the Department of health, NHS Employers, and the BMA signed under the auspices of ACAS: 30th November 2015

36. The recognition by all parties that there was a need to review doctors' terms and conditions can be seen from the following statement issued by ACAS on 30th November 2015:

> "**Agreement between BMA, DH and NHS Employers**
>
> 30 November 2015
>
> Following productive talks under the auspices of ACAS, the BMA, NHS Employers and the Department of Health are all agreed that a return to direct and meaningful negotiations in relation to a new contract for junior doctors is the right way forward. We intend to reach a collaborative agreement, working in partnership to produce a new contract for junior doctors, recognising their central role in patient care and the future of the NHS.
>
> All parties are committed to reaching an agreement that improves safety for patients and doctors and therefore NHS Employers have agreed to extend the timeframe for the BMA to commence any industrial action by four weeks to 13 January 2016 at 17:00, to allow negotiations to progress. Within that timetable, the BMA agrees to temporarily suspend its proposed strike action and the Department of Health agrees similarly to temporarily suspend implementation of a contract without agreement.
>
> All parties acknowledge that they share responsibility for the safety of patients and junior doctors, which must be paramount. In reaching this agreement to return to negotiations the BMA acknowledge the wish of NHS Employers and the Department of Health to agree and implement a new contract without undue delay. All sides wish to achieve a contractual framework that provides fair reward and a safe working environment for junior doctors throughout the week.

Note: for the purposes of this agreement, NHS Employers is acting on behalf of all employers of junior doctors.

Memorandum of understanding

This memorandum sets out the basis on which the parties will progress the agreement to return to negotiation reached on 30 November 2015.

We acknowledge the commitment of the BMA, NHS Employers and DH to the centrality of junior doctors in the current and future NHS, to recognise their dedication to patients and the NHS, and to provide a safe and supportive environment and fair reward.

The parties support the commitment to patients to ensure that the quality of care and patient outcomes (including appropriately adjusted mortality rates) are the same every day of the week. In that context we recognise the commitment of the government to work with the medical profession and other staff groups in partnership to improve access to seven day services. The parties recognise that junior doctors currently make a significant contribution across seven days, that urgent and emergency care is the priority for such services and that any new contract would support these aims.

All parties acknowledge the crucial role of doctors in training across the NHS in providing safe patient care and the need to properly recognise that contribution not only through terms and conditions but also by reaffirming the commitment to a high-quality training experience, the very best working environment and appropriate work-life balance.

The current cost-neutral November 2015 offer is the basis for further negotiation, and the BMA, NHS Employers and DH have agreed to work collaboratively to develop and oversee new contractual terms and conditions of service for junior doctors.

Contractual safeguards for safety are paramount and we therefore commit to develop a jointly selected and supported guardian role to oversee the hours of work of doctors in training and ensuring appropriate payment for hours worked outside planned work schedules.

A commitment is also made to define propositions on work schedules, including the number of hours designated as plain time ensuring that doctors in training would not be expected to work consecutive weekends, and how time for administrative duties and training should be recognized.

> Our discussions will also address access to flexible training (through joint work between HEE, BMA and NHS Employers), taking into account the changing demographic of the medical workforce, as well as developing further our shared commitment to ensuring that the training and working environment for junior doctors is improved (including addressing issues of fixed leave, study leave, notice of deployment and duty rosters, access to rest and refreshment facilities).
>
> Collaborative work on pay will include an 'open-book' approach to the November 2015 pay calculator and supporting data and models, including cost-neutrality and equality impact, helping ensure clear systems for pay progression and managing transition. This agreement also recognises the need to work in partnership with HEE and where relevant the medical royal colleges to improve the training experience for junior doctors, including improving access to flexible working and enabling the transition to a fully competency-based approach to support junior doctors to progress through their training."

37. Further negotiations began in December 2015 and ended in February 2016. The view of the Secretary of State of these negotiations was that there was "*agreement on approximately 90% of the issues under negotiation between the parties"* (EIA Annex C). However there was disagreement over changes to the number of hours designated as plain time, the rate of pay for those hours and the days on which those hours would be worked. On 4th January 2016 the Secretary of State wrote to the BMA to inform it that henceforward Sir David Dalton had been appointed to lead negotiations on behalf of the Secretary of State and NHS Employers. In his letter to the BMA the Secretary of State expressed the position that he remained willing to negotiate and to show flexibility.

(iv) The breakdown in negotiations between NHS Employers and the BMA: January / early February 2016

38. On 9th February 2016 Sir David Dalton wrote to representatives of the BMA with further proposals to resolve outstanding issues, which centred upon pay for weekend working and plain time working hours. The Claimant describes the letter as containing an "*ultimatum*". The letter sought confirmation in writing from the BMA that it would publicly recommend this "*best and final offer*" to the JDC and recommend its endorsement as the proposition to be put to members. A deadline for confirmation was set at 3pm on the 10th February 2016 "*at the very latest*" and it was made clear that no extension of the deadline would be offered. The letter then stated:

> "If you are not able to give me the assurance, I ask for in this letter, I need to be absolutely clear that I will assume that there is no realistic prospect of a negotiated agreement. In that circumstance I will advise the Secretary of State that we would

> have reached the end of the road in relation to the likelihood reaching a negotiated agreement"

39. The BMA declined the offer to provide the assurance sought and this was made clear in a letter of the 10th February 2016 to the Secretary of State. In the absence of any final agreement on the same date, the 10th February 2016, Sir David Dalton wrote to the Secretary of State explaining that, from the perspective of NHS Employers, a negotiated outcome was no longer possible:

> "Everyone's first preference has always been for a negotiated outcome. Unfortunately this no longer seems possible. Following the consultation with Chief Executives and other leaders in the service, it is clear that the NHS need certainty on this contract and that a continuation of the dispute, with a stalemate and without a clear ending, would be harmful to service continuity with adverse consequences to patients. On this basis I therefore advise the government to do what ever it deems necessary to end uncertainty for the service and to make sure that new contract is in place which is as close as possible to the final position put forward to the BMA yesterday."

(v) The position of the Secretary of State: 11th February 2016

40. The Secretary of State thereafter took the view that further progress by negotiation was unlikely and he announced, on 11th February 2016, that a new contract "*would be introduced without further negotiation*" (EIA Annex C paragraph [9]). On the 11th February 2016 the Secretary of State made a statement in Parliament during which he stated:

> "Along with other senior NHS leaders and supported by NHS Employers, NHS England, NHS Improvement, NHS Confederation and NHS Providers, [Sir David] has asked me to end the uncertainty for the service by proceeding with the introduction of a new contract that he and his colleagues consider both safer for patients and fair and reasonable for junior doctors. I have therefore decided to do that."

41. The Claimant relies upon this Statement, and others made upon the same occasion, to support the submission that the imposition of new contractual terms was a formal decision adopted by the Secretary of State and that this is important context which assists in explaining the position adopted by the Secretary of State on 6th July 2016 and reflected in his formal Statement to Parliament. During the statement to Parliament of 11th February 2016, as recorded in Hansard, the Secretary of State proceeded to describe the terms of the new contract which he had decided would be deployed. He extolled the virtues of the contract explaining, for example, that it reduced the maximum hours that "*tired doctors*" would be required to work in a single week, the maximum hours of consecutive nights that doctors would be asked to work, the maximum number of consecutive long days that a doctor would be required to work, and an elimination of the practice of rostering doctors on consecutive weekends.

42. The Secretary of State also addressed the question of pay and the increase in basic salary and pay premiums. The Secretary of State explained that in view of the BMA's unwillingness to compromise "*… any Government must do what is right for both patients and doctors… Today we are taking one important step necessary to make this possible*" (Hansard, column 1764). He described the Government as "*... taking a decisive step forward to help deliver our manifesto commitment*" (Hansard, column 1765). Later in the same debate (Hansard, column 1770), in response to questions from the Chair of the House of Commons Health Select Committee, the Secretary of State described what the Claimant refers to as a "decision":

> "When, as a Government, we took the decision to proceed with implementing a new contract, we have the choice of many routes, because essentially we can decide exactly what to choose. We have chosen to implement the contract recommended by NHS chief executives as being fair and reasonable."

The Claimant also refers to a number of statements by the Secretary of State to the effect that the decision to impose the new contract is one for him alone or for the "*Government*". This point acquires significance because in later statements to Parliament when the Secretary of State uses the collective pronoun "*we*" it is said by the Claimant that the reference to "*we*" is a reference to the Secretary of State and/or the Government as a whole, but <u>not</u> a reference to the Secretary of State acting in conjunction with individual employers within the NHS.

(vi) Events subsequent to 11th February 2016

43. On 12th February 2016, a summary of certain terms of the proposed draft contract was published, showing the changes that had been made, as a result of negotiations with the BMA, since the November offer, and with a suggested timetable for a phased introduction from August 2016. NHS Employers continued to work on the proposed terms and conditions for the new contract and to prepare associated guidance, including a pay circular with 2016/17 pay rates, and a model contract of employment.

44. On the 12th February 2016 Mr Daniel Mortimer, the Chief Executive of NHS Employers, sent an open letter to every junior doctor employed within the NHS. The Claimant describes this as a "*carefully orchestrated communication exercise*". The letter refers to the position of the Secretary of State in the following way and the Claimant highlights the mandatory terminology used:

> "The Secretary of State decided that the NHS must now introduce a new contract, without the agreement of the BMA, from August 2016."

45. The Claimant says that it was the view of NHS Employers that the Secretary of State had, in substance, issued a decision to them as to the terms of the new contracts and that, upon the taking of the decision, all employers of junior doctors working within the NHS were bound by that decision. They refer also to the fact that the letter laid out an implementation period. The new contract was to be introduced by employers in a

phased manner over 12 months from August 2016 in the expectation that implementation would be completed by August 2017.

(vii) NHS Employers Webinar: 25th February 2016

46. On the 25th February 2016 NHS Employers hosted a webinar with various employers within the NHS. This document is relied upon by the Secretary of State to illustrate the understanding of employers within the NHS as to their freedom to determine their own terms and conditions of employment and, thereby, shed light upon the approach (said to be non-coercive) of the Secretary of State later on, including in his decision of 6th July 2016. In the course of the webinar the presenters addressed the question "*how can terms and conditions of employment be changed?*". As to this the presenters explained that contracts of employment could be changed by reaching agreements through national collective bargaining between representatives of employers and employees. A slide produced for the purpose of the webinar stated: "*where national or local negotiation does not result in agreement, following consultation, employers can introduce new employment contracts by dismissing their staff on due notice and re-engaging them on new employment contracts*". In another slide, under the heading "*can trusts decide not to offer the new national contracts?*", the answer provided was in the following terms:

> "All employers have the freedom to determine their own terms and conditions, including pay for the staff they employ, but the majority use national employment contracts."

(viii) The letter from the Government Legal Department: 8th March 2016

47. On the 23rd February 2016 the BMA sent a Letter before Action under the pre-action protocol to the Secretary of State alleging that the decision adopted by the Minister to approve the terms of the new junior doctors contract was non-compliant with the Public Sector Equality Duty ("PSED") imposed pursuant to section 149 of the Equality Act 2010. The Government Legal Department ("GLD") responded on behalf of the Secretary of State on the 8th March 2016. This letter rejected the suggestion that the Secretary of State had taken any decision or had failed to have proper regard to the PSED:

> "The Secretary of State has had proper regard to the PSED throughout the process thus far. Moreover, a decision as to the final terms and conditions of the new contract has not yet been made. Before making this decision, the Secretary of State will have sight of and will take proper account of a full EIA."

48. The letter refers to *"a decision as to the final terms and conditions*" but it also stated that the Defendant had an "*open mind*" with regards the final terms of the new contract and that he would, if appropriate, amend the final terms in the light and content of the EIA.

(ix) Briefing by Civil Servants to the Secretary of State: 21st March 2016

49. The Secretary of State relies upon an internal briefing provided by civil servants to the Secretary of State as to his requirement to take account of certain statutory duties when exercising his functions in relation to the health service with particular application to the new draft contract. It is submitted that this document establishes that the Minister was advised as to the nature and extent of his powers to compel adherence to a national contract and as to the discretion of NHS employers to determine terms and conditions of employment for staff that they employ. In section 5 of the briefing, in the context of the duty to promote autonomy under section 1D NHSA 2006, the civil servants advised the Minister that he was required to have regard to the desirability (so far as was consistent with the interests of the NHS) of the autonomy and freedom to act of those who provided services within the NHS. However it was pointed out that if the Minister considered that there was a conflict between the duty to preserve autonomy and the discharge of his statutory duties in relation to a comprehensive health service the latter took priority. In this context it was pointed out that local NHS employers already enjoyed the freedom to determine terms and conditions of employment but that "*for decades*" employers had preferred to use the national pay frameworks developed through national collective bargaining. The briefing observes that there is no evidence that local employers wished to negotiate directly with their workforce. So far as the benefits of a consistent national contract were concerned the briefing stated:

> "We know NHS employers want to avoid unnecessary competition in recruiting and retaining doctors which could lead to variability in the quality of training and pay escalation as employers compete for staff. We know this because there has been just one NHS Foundation Trust that chose to develop its own terms and conditions (Southend Foundation Trust) rather than use Agenda for Change when it was introduced in 2004. Southend has, however, continued to use the national pay framework for medical staff."

50. At the end of that same section the advisers state as follows:

> "It is recognised that employers will be encouraged to adopt the new national contract and this could appear to conflict with their autonomy to decide on their own staff's contract terms. However, based on all past evidence, there is nothing to suggest that they would wish to do so. Their representatives led the negotiations, and indeed they are also likely to see the benefit of a national model, and the terms of this new draft contract. Further, this SofS duty is subject to the over-arching duty at section 1, and it is considered that uniform use of the new contract will be beneficial to the comprehensive health service by avoiding competition on contract terms that would be undesirable."

(x) The Equality Impact Assessment: 31st March 2016

51. The Secretary of State accepts that he is subject to the PSED set out in section 149 of the Equality Act 2010. This provides that in the exercise of its functions a public authority must have "*due regard*" to the need to (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Under section 149(2) a person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1). Section 149(3) – (7) lay down the details of the PSED.

52. On 31st March 2016 the Secretary of State published an Equality Impact Assessment ("EIA"). It purports to set out the final analyses for the draft final contract. Its purpose was to "*assist the Secretary of State for health. ... in giving effect to his Public Sector Equality Duty"*. The paper constitutes "*a forward-looking analysis of the expected equalities impact of the new contract informed by, amongst other things: (a) the likely/foreseeable impact of the terms and conditions in the new contract, (b) the available data on the makeup of the current cohort of Doctors by reference to protected characteristics ... and (c) extensive engagement and negotiation between the British Medical Association and NHS Employers regarding the development of the new contract*". The analysis was expressed not necessarily to be final and contemplated the possibility that the Secretary of State would consider further whether the draft terms and conditions of the new contract should be approved and/or should be subject to amendment before introduction.

53. The analysis operated upon the premise that the key objectives of the new contract were as set out in Heads of Terms for negotiation in 2013 which were later recognised in the joint Memorandum of Understanding between the Department of Health, NHS Employers and the BMA signed under the auspices of ACAS on 30th November 2015. These were:

> "a. to enable employers to roster Doctors when needed across seven days including evenings and weekends more affordably to support the delivery of a 7 Day NHS for patients in accordance with the clinical standards developed by the Seven Days a Week Forum;
>
> b. to end time-served automatic annual pay progression ("**AAPP**") and establish a pay model based on the level of responsibility of the role being performed;
>
> c. to provide Doctors with greater certainty and predictability of earnings by: (i) increasing basic pay, and (ii) reducing the proportion of overall pay that is derived from (variable) additional payments;
>
> d. to ensure that Doctors working the most unsocial hours/patterns are paid accordingly;

> e. to provide incentives to encourage entry into hard-to-fill training programmes or clinical academic training programmes and/or undertaking beneficial research work;
>
> f. to provide stronger measures to ensure adherence to safe working hours and patterns;
>
> g. to improve training/support for training; and.
>
> h. to achieve cost-neutrality – whilst not seeking to save money overall and not preventing the total pay bill for junior doctors from rising as trusts recruit more Doctors, the new contract seeks no increase or reduction in pay bill (excluding employer pension contributions and transitional pay protection costs) per whole-time equivalent ("**WTE**")/no change in average earnings for the same average number of hours worked as now."

(xi) Pre-action protocol correspondence: 4th April 2016 – 15th April 2016

54. On the 4th April 2016 solicitors acting for the Claimant sent a detailed letter before action setting out why the Secretary of State had no power pursuant to the NHSA 2006, or otherwise, to adopt a decision setting out the terms and conditions which NHS organisations and others employing junior doctors were to use. With regard to the suggestion that the Secretary of State lacked *vires* to adopt the relevant decision, the following was stated:

> "The Secretary of State acted entirely lawfully in deciding that the appropriate response to Sir David's letter was to announce that he would proceed with the introduction of the new contract without further negotiation with the BMA. Insofar as your letter was intended to assert that the Secretary of State is under some misapprehension as to his legal function, this is incorrect. "

55. In further correspondence between the 12th and 15th April 2016 the GLD stated that the Secretary of State had the power to signify support for a new model contract for junior doctors which NHS bodies were recommended to use.

(xii) Statement made by the Secretary of State to Parliament: 18th April 2016

56. The Claimant refers to a statement made by the Secretary of State in Parliament on the 18th April 2016 in response to a question whether the Secretary of State was "*... absolutely confident that he has the legal power to impose the new contract?*". In response to that question the Minister stated: "*let me answer the Hon. Lady's question very directly. Yes, we are imposing a new contract.*" The Minister proceeded to clarify that it was true that Foundation Trusts had the freedom to introduce their own contracts on pay and conditions and could exercise that freedom but that none had done so. The Claimant relies upon this as evidence to support the contention that the Minister "imposed" the contract. Reliance is placed upon an observation of the Minister later on in the course of the debate as evidence that the decision was taken personally by the

Minister: when using the personal pronoun he says: "*that is why I reluctantly took the decision to proceed with the new contracts*".

(xiii) The agreement between the BMA, NHS Employers and the Secretary of State: 18th May 2016

57. On the 18th May 2016 ACAS confirmed the existence of an agreement between the BMA, NHS Employers and the Secretary of State of negotiated terms which, subject to a referendum of relevant BMA members, were to form the basis for a new contract to be introduced during 2016. ACAS explained that in the course of the previous 10 days discussions between the parties had served to resolve outstanding issues and that further measures had been developed to address the wider concerns of junior doctors. The full contract was to be published at the end of May 2016.

58. The issues which had been resolved, and which were said to have led to the agreement of the BMA, included: an agreement to replace the banding system for rewarding unsocial hours with payment for all work done to support seven day service delivery; a series of new limits upon working hours; and the replacement of an incremental pay system with a series of nodal pay points based on attainment and responsibility rather than time served. The agreement was said to reflect the commitment of all parties: to the safety of patients and junior doctors; to the use of terms and conditions of employment which responded appropriately to the diverse characteristics of the junior doctor community; to the creation of a healthy working environment for junior doctors which valued their contribution throughout the working week; to high-quality training for junior doctors; and to revisions and improvements to terms and conditions to address the ongoing need properly to reward, protect and retain a valued workforce. The ACAS statement then proceeded to set out, in considerable detail, arrangements to cover equality of opportunity, the introduction of a "Guardian" to ensure safe working for doctors in training, incentives for recruitment and retention, terms of service, changes to the working week, and the implementation process. The document also stated that the Secretary of State would publish an equality analysis prior to publication of the contract. Section F(7) under the implementation process analysis included a section on "Joint Contract Review" this stated:

> "It is agreed that the regular review and updating of the contract is vital so that none of the parties find themselves in a protracted dispute. It is agreed therefore that the BMA and NHS Employers jointly commission in August 2018 a review of the efficacy of the contract, to identify any areas for improvement to the contract terms. Priority areas for inclusion in this review have been agreed but there is no wish to restrict the terms of any review at this stage."

(xiv) The BMA junior doctors' referendum

59. The agreement of the BMA was subject to the referendum. This occurred in the course of June 2016 and, as has already been recorded, the junior doctors rejected the contract on a 58/42% basis, upon a 68% turnout. In the light of that vote the JDC stated that the

Secretary of State was compelled to respect the informed decision that the doctors had made and that both sides must, therefore, look again at the proposals. The outgoing Chair of the Junior Doctors Committee, Dr Malawana stated "… *there should be no transition to a new contract until further talks take place*". The position of the Chief Executive of NHS Employers was that it was now a matter for the Secretary of State to determine next steps.

(xv) The briefing to the Secretary of State: 6th July 2016

60. The outcome of the referendum was communicated, by civil servants, to the Secretary of State on the morning of 6th July 2016. There is, before the court, a copy of the 20 page briefing which was placed before the Secretary of State during the morning of the 6th July 2016. It pointed out that the Minister now had to take a "*fresh decision*" and that the options open were either to return to negotiations with the BMA or introduce the new contract without the approval of the BMA based upon the May 2016 proposal agreed by the BMA. If the Minister decided to proceed without agreement from the doctors he then had to decide whether to exercise compulsory powers or proceed upon the basis that employers would voluntarily introduce the contract. The briefing to the Secretary of State considered the options. The conclusion to the briefing was expressed in the following terms:

> "41. You are asked to consider whether you agree to make a new decision to introduce the May contract terms as amended by the further June agreement, working with NHS Employers and NHSI HEE and local employers, so that the new contract is introduced for Junior Doctors as their current contracts expire in line with the timetable in Annex A. That decision should be made having due regard to the equality impacts of the proposals.
>
> 42. This builds on your thorough consideration of the equality implications of both the March contract and the revised May offer. The May contract offer built on the approach taken in the March contract to strengthen the offer particularly to those working less than full time (disproportionately female). You have also considered fully issues across the other protected characteristics and made changes in particular to support those with disabilities. For example, that includes protection of pay should a trainee change speciality for reason of disability, and if they work LTFT then the various proposals outlined above in respect of LTFT JDs.
>
> 43. It is important to note that individual employers will also need to consider equality implications specific to their own workforce as part of implementing the new arrangements."

61. In the course of the submission, and in the context of the Minister working consensually with employers, the Minister was warned that the expressions "imposed" and "imposition" had given rise to difficulties. Paragraph [4] of the briefing stated as follows:

> "4. It is noted that the press has again today referred to the contract potentially being "imposed" by you. As you know, references to "imposition" have been deployed to assert (wrongly) that you are not aware of your legal powers. To avoid further complaints of this sort, we suggest that it is best when addressing this issue to spell out that the new contract will be introduced by you working together with NHS employers. We appreciate that this is long-winded, but think it is worthwhile to try to avoid further unnecessary distraction rising from this point. NHS Employers continue to work with us and are ready to work with us to implement May/June contract, as a fair deal for the NHS should you decide to move forward on that basis. The role of NHS Improvement and Health Education England will also be key as the contract is partly nationally funded through HEE and HEE have been clear that there should be one national training contract. In addition it would be important to emphasise that this contract will only be introduced for those JDs whose contract expires."

62. In paragraph [12] of the briefing it was explained that the current offer did reduce the marginal cost of weekend working and it also addressed the implications of returning to negotiation on the ability of the Minister to further progress other policies:

> "12. The current offer does reduce the marginal cost of weekend working, important for the delivery 7 Day services, whilst recognising the antisocial nature of weekend working (and possible associated costs) by paying an allowance according to the number of weekends worked. Returning to negotiation would delay further contract change and delay implementing this element of your strategy for implementing 7 Day services policy. It would also frustrate the Government's aim of removing AAIP [Automatic Annual Incremental Progression]. The pay bill is a very significant part of the NHS budget, and negotiations have for some time sought to achieve a revised contract that is safe and fair to staff and patients. Not progressing the Junior contract will also delay any changes to the Consultant Contract and Agenda for Change."

63. Finally, in the summary section of the report the advice given to the Minister was that re-entering negotiation would delay implementation of policy, that the concessions already made had been "*significant*", that the offer was a fair offer that had hitherto received support from the BMA leadership, that the NHS now needed certainty and: "*…it is therefore recommended that you decide to work with NHS employers to introduce the May contract (as further revised for LTFT) in its entirety…*". I was informed by counsel for the Minister (in the course of his submissions) that I can proceed in this litigation upon the basis that the Secretary of State adopted the recommendation and the reasons for proceeding in the way proposed as set out in the briefing.

(xvi) The decision under challenge – the Statement of the Secretary of State to Parliament: 6th July 2016

64. Shortly afterwards, on 6th July 2016, the Secretary of State made a formal Statement to Parliament during which the Minister stated that he had decided that the only realistic way to end the "*impasse*" was to proceed with the phased introduction of the exact contract that was negotiated, agreed and supported by the BMA leadership. This is the Statement upon which the Claimant relies for the proposition that the Minister did in fact take a decision the substance of which was to impose the new terms and conditions of employment. The Statement repays close analysis and I therefore set it out in full below. It is not numbered in the original but I have numbered each paragraph for ease of reference. The parts most particularly relied upon by the Claimant as demonstrating that the Secretary of State was proposing to take a mandatory decision are set out in bold below:

> "1. In May, the Government and NHS employers reached an historic agreement with the British Medical Association on the new contract for junior doctors after more than three years of negotiations and several days of damaging strike action. That agreement was strongly endorsed as a good deal for junior doctors by the leader of the BMA's junior doctors committee, Dr Johann Malawana, and was supported publicly by the vast majority of medical royal colleges. However, it was rejected yesterday in a ratification ballot: 58% voted against the contract, so, on the basis of a 68% turnout, around a third of serving junior doctors actively voted against the agreement.
>
> 2. It is worth outlining key elements of the agreement that was voted on. The agreement does indeed help the Government to deliver their seven-day NHS manifesto commitment, but it also does much more. It reduces the maximum hours junior doctors can be asked to work, introduces a new post in every trust to make sure the hours asked of junior doctors are safe, makes rostering more child and family-friendly, and helps women who take maternity leave to catch up with their peers. The president of the Royal College of Physicians, who had opposed our previous proposals, stated publicly:
>
>> "If I were a trainee doctor now, I would vote 'yes' in the junior doctor referendum."
>
> 3. Unfortunately, because of the vote, we are now left in a no-man's land, which, if it continues, can only damage the NHS.
>
> 4. An elected Government whose main aim is to improve the safety and quality of care for patients have come up against a union that has stirred up anger among its own members that it is now unable to pacify. I was not a fan of the tactics used by the BMA, but, to its credit, its leader, Johann Malawana, did, in the end, negotiate a deal and work hard to get support for it. Now that he has resigned, it is not clear whether anyone can

deliver the support of BMA members for any negotiated settlement.

5. Protracted uncertainty precisely when we grapple with the enormous consequences of leaving the EU can only be damaging for those working in the NHS and for the patients who depend on it. Last night, Professor Dame Sue Bailey, president of the Academy of Medical Royal Colleges, said that the NHS and junior doctors needed to move on from this dispute and that if the Government proceed with the new contract it should be implemented in a phased way that allowed time to learn from any teething problems. **After listening to this advice and carefully considering the equalities impact of the new contract, I have this morning decided that the only realistic way to end this impasse is to proceed with the phased introduction of the exact contract that was negotiated, agreed and supported by the BMA leadership.**

6. The contract will be introduced from October this year for more senior obstetrics trainees; then in November and December for foundation year 1 doctors taking up new posts and foundation year 2 doctors on the same rotas as their current contracts expire. **More specialties such as paediatrics, psychiatry and pathology, as well as surgical trainees, will transition in the same way** to the new contract between February and April next year, with remaining trainees by October 2017.

7. This is a difficult decision to make. Many people will call on me to return to negotiations with the BMA, and I say to them: we have been talking, or trying to talk, for well over three years. There is no consensus around a new contract and, after yesterday's vote, it is not clear whether any further discussions could create one. However, the agreement negotiated in May is better for junior doctors and better for the NHS than the original contract that we planned to introduce in March. Rather than try to wind the clock back to the March contract, we will not change any of the new terms agreed with the BMA.

8. It is also important to note that, even though we are proceeding without consensus, this decision is not a rejection of the legitimate concerns of many junior doctors about their working conditions. Junior doctors are some of the hardest working staff in the NHS, working some of the longest and most unsocial hours, including many weekends. They have many concerns, for example, about rota gaps and rostering practices. In the May ACAS agreement, NHS employers agreed to work with the BMA to monitor the implementation of the contract and improve rostering practice for junior doctors. Last month, at the NHS Confederation's

annual conference, I set out my expectation that all hospitals should invest in modern e-rostering systems by the end of next year as part of their efforts to improve the way that they deploy staff. I hope that the BMA will continue to participate in discussions about all these areas.

9. Furthermore, this decision is not a rejection of the concerns of foundation year doctors who often feel most disconnected in that period of their training before they have chosen a specialty. Again, we will continue to make progress in addressing those concerns under the leadership of Sheona MacLeod at Health Education England, and we will continue to invite the BMA to attend those meetings.

10. We will also continue with a separate process to look at how we can improve the working lives of junior doctors more broadly, which will be led by the Under-Secretary of State for Health, my hon. Friend the Member for Ipswich (Ben Gummer). I very much hope that the BMA will continue to participate in that process as well.

11. We will not let up on efforts to eliminate the gender pay gap. Today, I can announce that I will commission an independent report on how to reduce and eliminate that gap in the medical profession. I will announce shortly who will be leading that important piece of work, which I hope to have initial considerations from in September.

12. Most importantly, this is not a decision to stop any further talks. I welcome Dr Ellen McCourt to her position as new interim leader of the junior doctors committee. I had constructive talks with her during the negotiations. **Although we do need to proceed with the implementation of the new contract to end uncertainty, my door remains open to her or whoever takes over her post substantively in September. I am willing to discuss how the new contract is implemented, extra-contractual issues such as training and rostering, and the contents of future contracts.**

13. To me personally and to everyone in this House as well as many others, it is a matter of profound regret that, at a time of so many other challenges, the BMA was unable to secure majority support for the deal that it agreed with the Government and NHS employers, but we are where we are.

14. I believe the course of action outlined in this statement is the best way to help the NHS to move on from this long-running contractual dispute and to focus our efforts on providing the safest, highest-quality care for patients. I commend the statement to the House."

65. In response to a question from Heidi Alexander MP questioning the source of the power to compel hospitals to introduce the contract, the Secretary of State observed:

> "… in reality foundation trusts have the legal right to set their own terms and conditions, but they currently follow a national contract; that is their choice, but because they do that, I use the phrase 'introduction of a new contract' this afternoon. I expect, on the basis of current practice, that the contract will be adopted throughout the NHS."

In the House of Lords, on the same day, the Parliamentary Under-Secretary for State for the Department of Health explained that Secretary of State had decided to proceed with the phased introduction of the new contract and that he "*...does have the power to introduce the new contract along with NHS employees. The Secretary of State is absolutely right to introduce this new contract*".

(xvii) The pay and conditions circular issued by NHS Employers: 6th July 2016

66. As to the response of the NHS employers, shortly after the statement in Parliament, on the same day, 6th July 2016, the Chief Executive of NHS Employers wrote to all NHS trusts informing them that the Secretary of State had just made a statement to Parliament "*outlining his intention to introduce the new contract*". The Claimant refers to the response of one particular Foundation Trust (Royal United Bath NHS Foundation Trust) who referred in correspondence to the fact that the "*SoS has decided to impose the contract*". NHS Employers issued a pay and conditions circular to members notifying employers of the "*instruction of the Secretary of State… to introduce new terms and conditions for all doctors and dentists in national training grades in England*". It proceeded to state that the terms and conditions "*will become effective on 3 August 2016*".

(xviii) The Public Sector Equality Guidance issued by NHS Employers: 6th July 2016

67. On 6th July the NHS Employers issued Published Public Sector Equality Guidance which stated that employers should "… *consider and understand the terms of the national terms and conditions of service (TCS) for NHS doctors in training on the model contract*". It was stated that it was "*expected*" that employers would take the national contract "*as a starting point*" because of the overall benefits of the terms. It is relevant to observe that the tenor of this document is not consistent with employers considering themselves legally bound to adopt the new contract.

68. The first paragraph of the "Summary" stated: "*It is envisaged that NHS trusts and foundation trusts will be considering introducing the new national terms and conditions of service for NHS doctors and dentists in training 2016 from August 2016.*" The document emphasised that employers should not rely upon the national EIA and should therefore conduct their own analysis and in the light of that analysis. The Summary stated:

> "Employers should not simply rely on the national analysis without considering issues locally, as local variations in respect of protected characteristics may not be picked up in the national data that has informed the Department of Health's analysis. For example, your local statistical information may identify that there are higher levels of disabled junior doctors working in some specialities, or indeed across your own junior doctor workforce, than the average across the NHS. Junior doctors and dentists rotate frequently between employers during their training for varying periods of time.
>
> Employers should consult their local policies and procedures when considering the contract alongside their ongoing Public Sector Equality Duty (PSED) obligations. This guidance has been prepared to assist employers in complying with their PSED obligations and in demonstrating that they have had due regard to equalities considerations when implementing the contract. Employers may wish to take, where appropriate, their own legal advice on their equality obligations under the Equality Act.
>
> Consideration should be given locally as to whether any steps should be taken that would reduce any potential impacts on those with protected characteristics. Employers should be able to demonstrate that they have had due regard to their public sector equality duty (PSED) obligations under the Equality Act in the introduction and implementation of the contract and in subsequent monitoring.
>
> There is no one way to discharge obligations in connection with the PSED. There is local flexibility in how this is undertaken. Employers may use their own processes and procedures in considering equalities issues in connection with introducing the contract, provided they comply with the duty. The approach below should provide a strategy that enables employers to have appropriate due regard to equalities issues when working on introducing and implementing the new contract"

69. In relation to implementation of the new national contract at the local level with a view to taking into account local equality issues the Guidance stated:

> "1) Consider and understand the terms of the national terms and conditions of service (TCS) for NHS doctors in training and the model contract. It is expected that employers will take the national contract with its model terms as a starting point, because of the overall benefits of the terms for service delivery, patients, doctors and their employers.
>
> 2) Have regard to the national evidence base and equality analysis and equality statement considered in connection with the nationally developed terms, which are published on the

gov.uk website. Employers may also find it useful to consider issues in the family test, which was published alongside the national equality analysis. Employers should note that there is no obligation to carry out their own local family test.

3) Consider the scope of s.149 Equality Act and the protected characteristics that are covered by its terms and consider what further evidence may be needed to understand any possible equality impacts locally. When doing this, employers are likely to benefit from considering the national equality analysis.

4) Consider data that employers may already have in respect of protected characteristics locally. What further data is needed to consider the issues?

5) Assess the likely impact on staff of the new model terms and whether there are any local issues that may affect either directly or indirectly the impact of the new terms on particular groups of junior doctors.

6) Consider whether or not any potential negative impacts could be minimised or improved, by implementing the contract locally in a particular way but with the aim of still delivering the benefits of the national contract. Regard should be had to the national equality analysis, and the consideration and rationale already given at a national level as to the justification for any potential adverse impacts associated with the contract.

7) Document their analysis. We encourage the use of the template provided at Annex A (page 13 of this document).

8) Monitor the implementation of the contract in case further issues come to light during the introduction and implementation process (as the PSED is an ongoing duty), to include feeding back information to the Department of Health via NHS Employers, as the managers of the new contract.

9) Clearly detail and record all actions taken to minimise any potential equalities impacts and clearly undertake periodic reviews to consider any other activities that can be taken."

70. It is implicit and assumed in the document that local employers can modify the terms and conditions to take account of local equality issues. Thus on page 5 the following is stated: *"**How should employers ensure compliance with their obligations under the PSED?** It is expected that employers will take the proposal to introduce and implement the contract as the starting point. Each employer will have a different makeup of junior doctor staff. This means that there can be no one-size-fits-all approach to considering how the PSED obligations will interact with decisions about implementing the contract. Ultimately, it is for each employer to determine how best to have due regard and the extent to which equalities issues may form, or impact on, other local priorities in deciding to implement the new contract. We emphasise that the*

obligation is yours to comply with, and any decision making is yours in relation to how these issues are addressed locally." However, it is also quite plain that this would not be viewed as the ideal outcome and that there was a strong preference on the part of the NHS Employers for the introduction of a nation-wide and uniform set of terms and conditions.

(xix) The GLD correction of the NHS Employers Circular sent to the Claimant's solicitors: 15th July 2016

71. In a letter dated the 15th July 2016 GLD, on behalf of the Secretary of State, observed that the Secretary of State had never directed or otherwise legally compelled any NHS employers to introduce new terms and conditions for junior doctors nor had the Secretary of State ever purported to issue any direction or otherwise legally compel any NHS Employer to introduce the new contract. The GLD stated that the use of the term "*instruction*" in the document published by NHS Employers (see paragraph [66] above) was inaccurate and would be rectified by NHS Employers. The circular was reissued on 25 July 2016 by Mr Mortimer in an email to approaching 1,000 human resources, workforce and medical directors across the NHS.

(xx) Communication from NHS Improvement: 28th July 2016

72. On 28 July 2016 NHS Improvements wrote to NHS employers to the effect that: *"the government has now confirmed that it will start a phased introduction of the new contract from October 2016 ... Enclosed with this letter is a table which sets out the timescales for implementation by junior doctor grade and speciality ... Your trust boards will need assurance that the new contract will be implemented effectively in your organisation ... From next week, we will also be asking you to provide assurance on progress towards the phased introduction of the contract and rota re-design"*.

(xxi) The position of the Secretary of State in these proceedings

73. In his Summary Grounds of Resistance dated 27th April 2016 (which therefore predated the 6th July 2016 Statement to Parliament) the position of the Secretary of State was set out. It was said that the Secretary of State was well aware when making ministerial statements of his legal powers and he "*does not claim, and never has, that he has a power of legal compulsion in respect of all NHS bodies (still less other, non-NHS, bodies providing healthcare services)*". It is also said that the only decision announced was to "*proceed with the introduction of a new contract*".

74. In a statement served prior to the hearing in this case on 19th August 2016 (which post-dates the 6th July Statement to Parliament) the Secretary of State has endeavoured to elaborate and confirm his position in terms which he submits are clear and unequivocal. Mr Massey, on behalf of the Secretary of State, thus states:

> " ... the 6 July 2016 Decision announced that he: (a) considered that the new contract should be introduced by the NHS without the BMA's approval, and (b) would take such steps as are

> reasonably necessary to ensure that this happens. The SoS does not say, and has never said, that the 6 July 2016 Decision legally compels or obliges any NHS employer to adopt the new contract. NHS employers are not legally bound to adopt the new terms and conditions set out in the new contract. The SoS envisages and expects, however, that NHS employers will voluntarily adopt the new contract. The SoS has encouraged, and will continue to encourage, NHS employers to do so. At present, no relevant NHS employer has indicated that it does not wish to introduce the new contract. If for any reason NHS employers did not introduce the new contract, the SoS would determine at that stage what further action, if any, should be taken."

75. Therefore the Secretary of State's position is that he does not at present purport to compel any NHS employer to adopt the new terms and conditions. He encourages them to do so and he believes that they agree with his view and will introduce the new terms. But he says that the decision he took which is reflected in the Statement to Parliament on 6th July 2016 does not legally oblige employers to adopt the new terms and conditions. He therefore accepts that in principle all employers are free to negotiate with employees. He adds the caveat that in the event that a problem with introduction arises in the future he will then consider his position including the exercise of such powers of compulsion as he possesses under the legislation.

(xxii) The position of NHS employers

76. Do NHS employers themselves consider themselves to be subjected to compulsion by the Secretary of State? As to this Mr Mortimer in his statement on behalf of the employers is at pains to emphasise that his members are fully aware of their legal rights and obligations and his firm position is that no employer is under the apprehension that they are subject to the mandatory fiat of the Secretary of State. He cites relevant evidence to this effect. He tempers this with an acknowledgement that there is a strong public interest benefit in uniformity which would indicate that NHS employers will in practice follow the recommendation of the Secretary of State but he also accepts that, for instance because of the variable application of equality impact assessment results, there could be regional or localised variations. It follows that there is consensus between the Secretary of State and the NHS employers. Both accept that in principle employers have the right to negotiate with employees.

(xxiii) Position of junior doctors

77. It is the submission of the Claimant that the generality of junior doctors construed the statement by the Secretary of State to Parliament on the 6th July 2016 as a statement that the Minister had purported to take a decision which he portrayed as having mandatory effect which the NHS employers were bound to adhere to. As such the effect of the decision was to eradicate all possibilities for further negotiation. In the course of written submissions and in oral argument the parties referred to a considerable number of documents which addressed this proposition. I do not propose to recite these documents in full. The doctors rely upon what they submit is the natural

inference to be drawn from the Parliamentary Statement itself. They rely upon an observation of Professor Sir Bruce Keogh on the 19th July 2016 in evidence to the House of Commons Health Committee: "*the contract has now been imposed…and the implementation of the contract will rest largely with NHS Improvement*". They rely upon the reporting of the decision of the Secretary of State in the media and press. They rely upon earlier statements of the Minister in Parliament (see for instance at paragraph [56] above) which they argue can only sensibly be interpreted as the Minister contemplating unilateral mandatory decisions. And they rely upon various statements from individual doctors who say that they understand the decision to impose the contract having been taken by the Secretary of State. The Secretary of State seeks to refute the proposition by reference to various documents emanating from the BMA itself which it is said reflect an understanding of the true position. For example reference was made to a letter from the Chair of the JDC to all local negotiation committee (the "LNC") chairs, of the 29th February 2016, which refers to the fact that the Chair was "*appalled*": "*…when the Secretary of State took the decision on 11 February to impose new terms and conditions on your colleagues from August this year*". Notwithstanding these words the Secretary of State points out that the Chair urged members to seek to demonstrate to individual employers why they should become involved in discussions about implementation. The letter stated:

> "Our current position is that the BMA and the wider medical profession should not facilitate the government's decision to implement this contract. If your employer asks the LNC to become involved in discussions about implementation, and you feel obliged to take part, I would urge you to take the opportunity to demonstrate why the imposition would be so damaging and to set out the key problems inherent in the contract as proposed".

78. I do not read this letter as an acknowledgement on the part of the BMA that the position of the Secretary of State was that he did not have the power, unilaterally, to impose the contract or was not intending to. To the contrary it suggests just that, as evidenced by the references to the Government imposing the terms. On one view the substance of the letter urges local negotiating committees in effect to persuade local employers to break ranks. Whatever the true meaning of this letter it is in my view unconvincing support for the proposition advanced by the Secretary of State. An additional illustration relied upon by the Secretary of State is a letter from the LNC representatives to Cambridge University Hospitals on the 11th April 2016 in which the following was stated: "*we write to use as the Local Negotiating Committee ("LNC") regarding the risk to CUH posed by the imposition of the 2016 Junior Doctors Contract. We wish to ensure that you fully understand the real and widespread concerns with the contract, and aim to help you reach a balance and considered opinion before deciding on its imposition. Over the past few weeks the government's plan to impose the contract has been denounced…*". This letter is ambiguous. It refers to the Government imposing the contract. As such it reflects a belief in the ability of the Government to impose the contract. However CUH is a NHS Foundation Trust and it has been well publicised and understood that such trusts (unlike NHS Trusts who may set their own terms and conditions absent a direction from the Secretary of State) have the ability to determine their own terms and conditions and, prima facie, cannot be compelled so the context is in any event atypical. As such it is of limited value in establishing, as the Secretary of State seeks to do, that the junior doctors, as a whole, were well aware of the legal

powers of the Secretary of State. In any event these communications pre-date the 6th July 2016 Statement to Parliament.

D. Legal framework: The scope of the powers and duties of the Secretary of State

(i) The structure of the NHSA 2006

79. Before turning to the analysis of the three Grounds of challenge I need to set out the scope of the powers and duties of the Secretary of State. It is convenient to break down the analysis into three components: First, the nature of the statutory duties imposed on the Secretary of State. Second, the express statutory powers granted to the Secretary of State including the power to compel or direct (with particular regard to those powers which could impact upon terms and conditions of employment). Third, the scope and effect of the general power conferred by section 2 NHSA 2006.

(ii) The express duties of the Secretary of State under the NHSA 2006

80. The NHSA 2006 imposes a variety of different types of duty upon the Secretary of State. These are relevant to an assessment of his powers because those powers exist to enable the Secretary of State to attain the statutory duties, and any understanding of his powers must occur within the context of his duties.

81. **The overall duty to promote a comprehensive health service (the target duty):** Section 1(1) imposes a broad duty to continue the promotion in England of a comprehensive health service designed to secure improvement — (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness. The key words and phrases are: "*promotion*", "*comprehensive*" and "*designed to secure improvement*". It is difficult to contemplate a broader target duty.

82. Section 1(2) is of some significance because it relates the duty to "*functions*": "*For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act.*" The "*purpose*" referred to is that in section 1(1) ie the promotion in England of a comprehensive health service. The term "*Functions*" is defined in section 275: "*Functions includes powers and duties*".

83. **Specific duties in Section 1A-1G relevant to terms and conditions of employment**: Section 1A - 1G NHSA 2006 lay down further duties of a somewhat more specific nature though even these are also cast in broad terms. Each duty is expressly related to the "*functions*" of the Secretary of State under the Act. Of these target duties a number are of relevance to the issue of terms and conditions of employment.

84. *Section 1A*: Section 1A imposes a duty to exercise functions *"with a view to securing continuous improvement in the quality of services provided to individuals*". This does not refer expressly to terms and conditions of service of doctors because, by its nature, it is a duty directed at a broad objective encompassing a potentially vast range of different sub-topics. But if and insofar as the Secretary of State concluded that the introduction of the new terms was necessary as part of this duty there is no reason why

in principle at least it should not be sufficiently broad to encompass that course of action.

85. *Section 1B*: Section 1B imposes a duty on the Secretary of State to "*have regard to*" the NHS Constitution. The Constitution itself describes its relevance:

> This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution. Section 1E concerns the duty of the Minister to promote research.

86. Section 4a of the Constitution spells out the employment related matters to which section 1B applies and it hence follows that the Secretary of State is to have regard to employment matters when seeking to achieve his target duties and exercise his statutory powers and functions:

> "Staff have extensive legal rights, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.
>
> The rights are there to help ensure that staff: • have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives; • have a fair pay and contract framework; • can be involved and represented in the workplace; • have healthy and safe working conditions and an environment free from harassment, bullying or violence; • are treated fairly, equally and free from discrimination; • can in certain circumstances take a complaint about their employer to an Employment Tribunal; and • can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest."

87. *Section 1F*: Section 1F imposes a duty on the Minister so "*as to secure*" an *"effective*" system of planning and delivery of education and training to persons who are employed in the provision of health services in England. Again, these are matters which may be covered by terms and conditions of employment.

88. *Section 1G*: Section 1G imposes a duty on the Minister to report to Parliament on, and then keep under review, the treatment of NHS health care providers as respects any matter *"... which might affect their ability to provide health care services for the purposes of the NHS or the reward available to them for doing so*". The concept of "*reward"* is broad enough to include terms and conditions of employment of junior doctors.

89. The duties referred to above are loosely termed "*target duties*" because although cast in mandatory terms they lay down broad objectives to be achieved and impose upon the Minister the obligation to act in a way which is eg "*designed to achieve*" or "*secure*" the objective (section 1(1)) or to act "*with a view to securing*" the objective (section 1A(1)) or to "*have regard to*" the objective (section 1B(1)). They are target duties in the sense that (a) they do not specify a particular or precisely defined end result as opposed to a broad aim or object and (b) their mandatory nature is diluted by the fact that they do not compel the achievement of that end result instead requiring the Secretary of State only to factor those objectives into consideration.

90. *Section 1D (The duty of autonomy)*: There are other duties of relevance to the issues arising. With regard to the relationship between the Secretary of State and other providers of services section 1D reflects an important principle (introduced by the Health and Social Care Act 2012 ("HSCA 2012")), namely that of <u>autonomy</u>. It is relevant context because, at base, this case concerns the autonomy of individual NHS employers to impose their own, freely chosen, terms and conditions of employment and the right of the Secretary of State to set or disprove those terms and in some degree thereby fetter the "*autonomy*" of employers. The Section requires the Minister to *"have regard to the desirability*" of securing so far as consistent with the best interests of the health service that other persons with responsibility under the legislation should be free to exercise those function as they see fit. One of the principal aims of the amendments to the NHSA 2006 brought about in the HSCA 2012 was the delegation of greater responsibility <u>to</u> the NHS itself and <u>away</u> from politicians. However the statutory concept of "autonomy" is by no means absolute. The nature of the duty is mitigated by three considerations: (a) it is only a factor the Minister must have regard to, (b) it applies only "*so far as consistent with the interests of the health service"* and (c) if the Secretary of State considers that there is a conflict between respecting autonomy and the broad duty imposed upon him in section 1 (see paragraphs [80 ff] above) then this latter duty takes precedence.

91. *Section 1(3) – relationship of the Secretary of State with Parliament*: The Secretary of State's role at the apex of the NHS structure is reflected in section 1(3) pursuant to which it is the Secretary of State who has ministerial responsibility to Parliament for the provision of health service in England. This ties in with section 1G on the duty to report to Parliament including on "*rewards*" (see paragraph [88] above).

92. *Section 2A - The duty to protect the public*: Section 2A NHSA 2006 also sets out duties on the Secretary of State. The section defines the duty as a duty *" as to protection of public health"* and in section 2A(1) it is cast in the following terms: "*The Secretary of State must take such steps as the Secretary of State considers appropriate for the purpose of protecting the public in England from disease or other dangers to health".* The duty is framed in terms of a broad objective of "*protecting public health*" and is a duty only to take such of the "*steps*" (analysed below) which he considers are appropriate. It leaves a considerable leeway to the Minister as to ways and means.

(iii) The express powers of the Secretary of State

93. I turn now to the powers of the Secretary of State. These are set out in a variety of different places in the Act where they tend to be referred to as "*functions*" or "*steps*" that may be taken.

94. *Express powers or "steps" or "functions" open to the Secretary of State to take – Section 1(1) and 1A – 1G*: There is no express list of powers or "*steps*" that may be taken *within* section 1 (in relation to improving health) to secure the achievement of the objectives in section 1(1) and 1A – 1G. However, section 2A(2) NHSA 2006 sets out the "*steps*" that "*may be taken*" by the Secretary of State to achieve the broad object in section 2A(1) and this concerns protecting the public from disease or other dangers. In section 2B(2) the Secretary State has power to take such steps as are considered appropriate to improve health . There is obvious overlap between sections 1 and 2A and 2B. The list of steps that "*may*" be taken in sections 2A(2) and 2B(3) are non-exhaustive (cf the word "*include" in both*). Thus for instance in section 2A(2) the steps are expressed as follows:

> "(2) The steps that may be taken under subsection (1) include—
>
> (a) the conduct of research or such other steps as the Secretary of State considers appropriate for advancing knowledge and understanding;
>
> (b) providing microbiological or other technical services (whether in laboratories or otherwise);
>
> (c) providing vaccination, immunisation or screening services;
>
> (d) providing other services or facilities for the prevention, diagnosis or treatment of illness;
>
> (e) providing training;
>
> (f) providing information and advice;
>
> (g) making available the services of any person or any facilities."

95. These various powers or "*steps*" are broad. It is hard to imagine a "*step*" that the Secretary of State might wish to take which was not within the compass of those listed. In my judgment by their very nature they include matters relating to terms and conditions of employment. For instance subsections (b) – (g) above all entail the Secretary of State providing or making available services. He can only do this through third parties (be they organisations or individuals cf the phrase "*any person or any facilities*" in section 2A(2)(g)) and to achieve this the Secretary of State must, *inter alia*, become involved to some degree in setting the terms and conditions of employment or "*reward*" (to use the term in Section 1G NHSA 2006). But even if a step that the Secretary of State wished to take fell outwith this particular list it is apparent from section 2A(1) (protecting the public from disease and other dangers to health) and from the list of steps that he may take in section 2A(2) to secure that objective that wide powers are conferred on the Secretary of State under the banner of

protection which would also entitle the Secretary of State to adopt measures relating to terms and conditions of employment. For instance these powers include "*making available the services of any person or any facilities*".

96. The Secretary of State's general functions in relation to staffing in the NHS are expressly provided for in section 254A(i)(b) alone and/or in conjunction with subsections (d)/(e):

> "(1) The Secretary of State may, for the purpose of assisting any person exercising functions in relation to the health service or providing services for its purposes—
>
> (a) ...
>
> (b) facilitate the recruitment and management of the person's staff;
>
> (c) ...
>
> (d) do such other things to facilitate or support the carrying out of the person's functions or other activities as the Secretary of State considers appropriate;
>
> (e) arrange for any other person to do anything mentioned in paragraphs (a) to (d) or to assist the Secretary of State in doing any such thing.*"*

97. **Express powers of compulsion**: The NHSA 2006 in addition confers upon the Secretary of State certain powers of compulsion in relation to particular bodies and entities (not all of which are, I would emphasise, necessarily relevant to the issues arising in this case). Thus for instance:

(a) Under section 3B NHSA 2006 the Secretary of State can "*require*" NHS England to commission services which power has been exercised in the shape of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations").

(b) Under section 6C the Secretary of State has exercised powers to *require* local authorities to provide specified services in the shape of the Local Authorities (Public Health Functions etc.) Regulations 2013 ("the 2013 Regulations"). The making of these regulations does not strip from the Secretary of State any powers he otherwise has: See section 6C(4) in relation to local authorities.

(c) Under section 6E the Secretary may impose "*requirements*" on NHS England or clinical commissioning groups ("CCGs") (to be known as "*standing rules"*) in relation to the commissioning function of NHS England or CCGs.

(d) Under section 7 the Secretary of State may "*direct"* Special Health Authorities to exercise any functions of the Secretary of State.

(e) Under section 8 the Secretary of State has a power to "direct" NHS Trusts "*about its exercise of any functions*"

(f) Under Schedule 4 NHSA 2006 NHS Trusts are constituted as "*bodies corporate*" (cf paragraph 1). They acquire considerable autonomy under these provisions though some of their powers are circumscribed. So for instance the Secretary of State can under paragraph 4 by regulation provide for the qualifications of the chairman and directors of such trusts. And the Secretary of State has the power to dissolve a Trust in certain circumstances which include where the Secretary of State "*considers it appropriate in the interests of the health service*" (paragraph 28). Although NHS Trusts have their own free standing power to set terms and conditions of employment (cf paragraph 25) they must do so in accordance with regulations and/or directions given by the Secretary of State under paragraph 25(3). This states:

> "Staff
>
> 25
>
> (1) An NHS trust may employ such staff as it considers appropriate.
>
> (2) An NHS trust may--
>
> (a) pay its staff such remuneration and allowances, and
>
> (b) employ them on such other terms and conditions,
>
> as it considers appropriate.
>
> (3) An NHS trust must--
>
> (a) in exercising its powers under sub-paragraph (2), and
>
> (b) otherwise in connection with the employment of its staff,
>
> act in accordance with regulations and any directions given by the Secretary of State.
>
> (4) Before making any regulations under sub-paragraph (3), the Secretary of State must consult such bodies as he may recognise as representing persons who, in his opinion, are likely to be affected by the regulations."

(g) The Secretary of State has the power to approve the rates and conditions of employment of GP Speciality Regulars under Regulation 50 of the National Health Service (General Medical Service Contracts) Regulations 2015; and Regulation 42 of the National Health Service (Personal Medical Services Agreements) Regulations 2015.

98. There are no analogous provisions in relation to NHS Foundation Trusts which are governed by Chapter 5 NHSA 2006, or in relation to local authorities or private employers. Most hospitals in England are now managed by NHS Foundation Trusts. They were first introduced in April 2004 and they differ from other existing NHS Trusts. They are independent legal entities with a high degree of accountability to their local area and they also enjoy a high degree of independence from central government. They provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. They have a substantial degree of financial independence and can raise capital from both the public and private sectors within borrowing limits, determined by projected cash flows. They may retain financial surpluses to invest in the delivery of new NHS services. Foundation Trusts are overseen by NHS Improvement (the operational name for Monitor and the Trust Development Authority).

(iv) The general powers of the Secretary of State under Section 2 NHSA 2006

99. The third possible source of the powers of the Secretary of State lies within section 2 NHSA 2006 which empowers the Secretary of State to do *"anything*" which is calculated to facilitate or is conducive to or incidental to the discharge of any of his functions. Accordingly it has the effect of extending the express *prima facie* powers referred to above. The general power applies to each of the Secretary of State, NHS England and Clinical Commissioning Groups. It can bring within the scope of the relevant person or body's powers certain activities which, otherwise, would be beyond the jurisdiction of that person. Section 2 provides:

> "General power
>
> The Secretary of State the Board or a clinical commissioning group may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on that person by this Act".

100. The scope of this section (though in the context of a very different factual situation and on that occasion involving NHS England) was considered by the High Court in *National Aids Trust v National Health Service Commissioning Board (NHS England)* [2016] EWHC 2005 (Admin) ("NAT"). It was stated there (at paragraph [92]) that the power was relatively wide ("*quite generous*") and was to be construed by reference to its express language:

> "92. In the present case there are various indications from within Section 2 that the incidental power is quite generous. In particular it may be exercised when it is "*calculated to facilitate"* the discharge of any function conferred upon NHS England and/or when it is "*conducive*" to the discharge of that function and/or when it is "*incidental*" to such discharge. By using three expressions to enlarge the scope of the power all of which require NHS England to use its judgment Parliament is deliberately seeking to avoid the argument that the provision of

> a particular treatment that might otherwise be on the margins of NHS England's powers is outside of its jurisdiction."

101. Section 2 has been briefly considered in two further cases. It was considered, but only in passing, by Burnett LJ in *R (Whapples) v Birmingham Crosscity Clinical Commissioning Group* [2015] EWCA Civ 435 at paragraph [25]. It was also referred to in *R (W) v Secretary of State for Health* [2015] EWCA Civ 1034 at paragraphs [68] – [70]. It was made clear there that section 2 did not limit any power the Minister otherwise enjoyed at common law. In broad terms neither authority is inconsistent with the analysis I have set out above.

102. Section 2 is not of course an open ended liberty on the part of the Secretary of State to take any decision he considers is conducive or facilitative or convenient. There are in my view three (interrelated) limitations inherent in section 2.

103. First, Section 2 is an ancillary power; it comes into play to plug gaps and lacunas. Therefore if there is an express power to do something then that express power should be used rather than the fall-back power in section 2. This is in accordance with the standard principle of statutory interpretation ("*generalibus specialia derogant*") that where the literal or express meaning of an enactment covers a situation for which specific provision is made then it is presumed that the situation was intended to be dealt with by the specific provision (see generally Bennion on Statutory Interpretation, 6th edition, page [1038] section [355]). Whenever section 2 is prayed in aid the first question should therefore be: Does the Secretary of State have an express power which he has chosen not to exercise? If he does (and he has not) then he cannot use section 2. If however the answer to this question is negative (there is no express power) then the second inherent limitation comes into play.

104. The second limitation is that there should be nothing in the legislation which expressly or impliedly precludes the exercise by the Secretary of State of a power to act. For instance if (hypothetically) there was a provision which conferred upon a body or person an "*exclusive*" right to do something or if it were said that "*only*" a certain person could perform a particular action or exercise a particular power then this would necessarily preclude the Secretary of State from using section 2 to act in relation to the subject matter in question.

105. The third limitation is that any resort to section 2 must in any event be grounded in the discharge of one of the *functions* of the Secretary of State under the NHSA 2006. That which the Secretary of State seeks to do must be "*calculated to facilitate"* the discharge of that function and/or be "*conducive*" to the discharge of that function and/or be "*incidental*" to such discharge. The power must thus be referable to a function of the Secretary of State identified under the Act. The concept of "*functions*" is defined to include all of the powers and duties of the Secretary of State (cf section 275 NHSA 2006). The "*functions*" of the Secretary of State for the purpose of section 2 include in relation to the setting of terms and conditions of employment.

106. I turn now to consider each of the three grounds of challenge.

E. Ground 1: Did the Secretary of State take a decision requiring or compelling NHS employers to implement the new contract and did he act within his statutory powers?

(i) The issue

107. The Claimant originally argued that the Secretary of State took decisions on 11th February, 31St March and 6th July 2016 as to the terms and conditions that NHS employers were required to adopt in relation to the employment of the junior doctors. Prior to the hearing the position was modified such that the focus lay solely with the statement of the Minister of 6th July 2016 which is said to represent the final decision and that which should be the subject of the challenge. The earlier "decisions" were said to be relevant only as context. I have in this judgment focused *only* upon the decision taken on 6th July 2016 and reflected subsequently in the Statement to Parliament on the same day as representing the act under challenge. I have taken these earlier acts into account only as capable of throwing light upon the events that have occurred and their proper analysis.

108. The Claimant argues that the decision reflected by the Statement to Parliament of 6th July 2016 was *ultra vires* since the Secretary of State therein purported to impose a decision upon all concerned, including employers and employees, in circumstances where he had no power in law to compel adherence and/or even if he had such power he had not purported to exercise it. It is said that although the Secretary of State could have directed NHS Trusts to accept the new terms he has not done this and that in relation to other employers, such as NHS Foundation Trusts, there is no statutory power. Though it is accepted that, in principle, the Secretary of State does have the power to make a recommendation to employers as to the terms and conditions of employment to be adopted. The practical gravamen of the objection is that the Secretary of State has scuffed out all vestiges of hope for further negotiation. It is said that the doctors can now neither negotiate with the Secretary of State or employers.

109. The Claimant has formulated its case, in its written submissions, in the following way:

> "The clear inference … is that *only* NHS Foundation Trusts have the right to choose the form of contract for junior doctors they employ, and that for others the decision is being made for them by the Secretary of State. That is incorrect and the distinction drawn by the Secretary of State is false. Absent the issuing of directions to NHS Trusts (which the Secretary of State has not done and has never suggested he would do) there is no legal structure in the NHS for imposing national terms of employment for junior doctors. The NHS is made up of a large number of provider organisations, all of which have the legal right to enter into contacts of employment on the terms and conditions the employer and employee have agreed between them. These terms cannot be mandated or determined at the centre by the Secretary of State. Employers of junior doctors which are NHS Foundation Trusts, local authorities or primary care organisations cannot be subject to compulsion by the Secretary of State. In relation to NHS Trusts which are not NHS Foundation Trusts, section 8 confers a power upon the Secretary of State to issue directions. Whether directions could

> lawfully be issued under section 8 in relation to the contract for junior doctors is not an issue which this Court needs to consider, as the Secretary of State has not used this mechanism. Accordingly, all employers of junior doctors working in the NHS are in the same position as NHS Foundation Trusts."

110. The Secretary of State rejects this analysis and submits: (a) that he was well aware of his powers of formal compulsion; (b) that he neither purported to make, nor announced (to Parliament or otherwise) that he would make any compulsory decision; (c) that he did take a decision "approving" the proposed terms and conditions but this, in principle, did not deprive employers of their freedom of contract.

(ii) Analysis and conclusion

111. The first issue is to identify the substance of the decision actually taken; the second issue is then to consider whether the Secretary of State had the power to adopt that decision.

112. There are a number of points and conclusions I have arrived at on the evidence as to the first issue.

113. First, there is no doubt, and indeed it is common ground, that "a" decision was taken and that it was taken by the Minister on the morning of 6th July 2016, before the Statement to Parliament. The decision was taken unilaterally by the Secretary of State. It may be obvious but this was not a decision <u>of</u> Parliament or taken pursuant to any Parliamentary process or procedure. It was a decision taken unilaterally by the Secretary of State in accordance with his powers and duties under the NHSA 2006 following advice.

114. Second, the decision was one of "approval". This is not the actual phrase used in the Statement itself. It is however an apt description of the substance of the decision taken. The Minister has statutory powers and duties which are germane to issues of employment (see paragraphs [93] – [105] above). He also has a clear budgetary responsibility and he has taken the position that the new contractual reforms should be cost-neutral. As I explain below in relation to statutory competence he has the power to "approve" model contracts and the evidence shows convincingly that the practical reality was that the Secretary of State became closely involved because the employers and employees had failed by themselves to reach agreement (see e.g. paragraphs [39ff] above). That same body of evidence also shows that the "approval" or sign-off of the Minister was considered to be central to progress. In this respect there is also the fact that the Minister does have certain powers of compulsion such that, even if he was loathe to use such powers, they remained in his armoury should he ever need to deploy them. His position is that he would consider compulsory powers <u>if</u> implementation became fragmented in a way that in his view was inconsistent with his duties under the Act. The expression "approval" is hence apt. Some debate in Court occurred as to whether this was tantamount to a weak or strong recommendation. In so far as this debate is informative, on the facts, and if one is to use that phrase, it is a very strong recommendation.

115. Third, the approval decision was in effect only a framework decision. It did not lay down the details of how the phased introduction or implementation of the contract would occur. It has left these details to the employers and/or further decisions of a more nuts and bolts nature. Nonetheless the decision has both short-term and long-term ramifications. Thus in the short term the decision triggers the process of phased introduction by employers of the new contracts and this is how it has been understood by employers. But it also has longer term implications in that the Secretary of State has made clear that he will engage in a range of further discussions and negotiations on issues which are of concern to the junior doctors and which affect their working lives. He has accepted (see the evidence referred to at paragraphs [58] and [188] of this judgment) that the contract will be reviewed in a process commencing in August 2018. In the Statement to Parliament itself the Secretary of State says that he is conscious of the concerns of "*foundation year doctors*" and that these would be addressed in the future (see Ministerial Statement paragraph [9] set out at paragraph [64] above) and that there would be an ongoing process to improve the lives of junior doctors "*more broadly*" (Statement paragraph [10]) and that efforts would be made to address the "*gender pay gap*" and that there was no bar to further discussions on implementation, teething problems and extra-contractual issues such as training and rostering and the content of future contracts (Statement paragraph [12]).

116. Fourth, whilst decision was taken by the Secretary of State unilaterally it was as a matter of practical reality based upon a consensus with the NHS employers (and regulators) and it endorsed the objective of a single, consistent, nationwide contract. There is no evidence before the Court which suggests that employers wish to see individualised or fragmented contractual terms and conditions applying across the NHS (see paragraph [26] above). The upshot is that although the decision was taken unilaterally by the Minister its implementation was a joint and consensual exercise with employers. This helps in understanding why the Minister uses both the personal and the collective pronoun in relation to his decision. So, in the Statement when referring to the adoption of the decision the Minister uses "I" but when he refers to implementation he uses "we". For instance:

> "After listening to this advice and carefully considering the equalities impact of the new contract, ***I have this morning decided*** that the only realistic way to end this impasse is to proceed with the phased introduction of the exact contract that was negotiated, agreed and supported by the BMA leadership."

And**,**

> "It is also important to note that, even though ***we are proceeding*** without consensus, this decision is not a rejection of the legitimate concerns of many junior doctors about their working conditions".
>
> (Emphasis added)

117. Fifth, a corollary to this is that there was no need for the Secretary of State to have resort to powers of compulsion; he was *ad idem* with the employers. It is for this reason that the Secretary of State in clarificatory evidence before this Court has made clear that he would only consider exercising such powers of compulsion as he has in the

event that in the future he considered that the introduction of the contract in practice was, in his view, threatening objectives he lawfully sought to achieve under the legislation.

118. Sixth, a further corollary of this is that in principle it remains open to employers to engage in negotiations with employees. Whether there is in practice much scope for this is certainly not for me to speculate about. But it remains an important point in this case that this is a lawful option open to both employers and employees. This is not spelled out in the Statement to Parliament but was nonetheless accepted as a correct inference to be drawn by Mr Sheldon QC, for the Secretary of State, in the course of his submissions in response to a question from me on the topic and it is evident from the formal Witness Statement tendered in this case on behalf of the Minister (see paragraph [74] above).

119. Seventh, a consequence of the rejection of the contract by the junior doctors in the referendum is that the decision of the Secretary of State necessarily involves proceeding to implementation without the collective agreement of the employees. Evidence in the case (for instance the webinar – see paragraph [46] above) shows that from a relatively early stage employers had contemplated how, from the perspective of contract law, they would address the alternative scenarios of with/without collective agreement.

120. Eighth, the Statement to Parliament reflected a "*fresh*" decision taken by the Secretary of State in the light of the rejection of the terms in the referendum and it is a reason why what had gone before provides only limited guidance as to how the Minister's Statement was to be interpreted and understood. Until the rejection there were some grounds at least for supposing that the contract could be introduced with consensus across the board. That is the evidence of the Secretary of State and is reflected in the documents: see e.g. paragraphs [57] – [58] above. Indeed, this was a point expressly made by the Minister to Parliament. The rejection of the contract thus altered the landscape. The contract, henceforward, would have to be introduced without (the hoped for) consensus and in the face of objections from the junior doctors. This was a material change in circumstances. As set out in paragraphs [60] and [61] above this meant that the Minister had to address and form conclusions about a number of options and it also meant that the way in which the Minister had decided to exercise those options had to be gleaned from the Statement.

121. I have come to the above conclusions based upon the Statement made by the Minister to Parliament read in the context of other relevant documents. I have given greatest weight to those documents which are contemporaneous (such as the briefing submission to the Minister on 6th July 2016) and todocuments in these proceedings tendered by way of elaboration and clarification of the Statement where I am satisfied (as I am) that these are not simply attempts to rewrite history. Documents preceding the Statement of 6th July are of some relevance as context but, because the decision taken on 6th July 2016 was a "fresh" decision taken in the light of an altered landscape, these documents are of lesser probative value. There are undoubtedly some vagaries and inconsistencies in the documents and in the language used. These are more relevant to the issues surrounding Ground II. However, I generally have well in mind the following points about the probative weight to be attached to different pieces of evidence:

(i) It is necessary to consider substance and not form.

(ii) I should not attach undue weight to infelicities of language and should not be quick to draw adverse inferences from ambiguous words or phrases used by the Minister or others.

(iii) Not every statement by the Minister should attract equal weight. The Court must remember that in the refined, *ex post*, environment of a court room counsel use finely honed forensic skills to pick over the traces of odd sentences here or there, and off the cuff remarks or unguarded observations made without the benefit of the advice of civil servants and without forethought. Unless a healthy dose of circumspection is applied there is a real risk that the true pith and substance of the reasons may be lost.

(iv) Far greater weight therefore needs to be given to formal, considered and deliberate statements. And even then, as in the present case, a deliberate and prepared statement might still have its inherent limitations. There are limits as to the technical and legal detail that would normally be included in a statement to Parliament, which quite obviously also has a "political" element to it. In the present case the Statement was made literally hours after the announcement of the referendum result of the junior doctors. It is also evident that the Minister considered he had to make a speedy statement to Parliament given the high level of public and Parliamentary interest in the issue.

(v) All of the above are reasons why, as the case law shows, context is important.

122. So far as the law relating to the interpretation of Ministerial Statements is concerned is involved there was not much significant dispute about this. The interpretation of the statement is a matter for the Court and is to be construed (i) objectively; (ii) in accordance with the language used; and, (iii) having regard to its proper context: See e.g. *R(Parratt) v Secretary of State for Justice* [2010] 1 WLR 1848 at paragraph [32]; *R(Sainsbury's Supermarket Ltd) v First Secretary of State* [2005] EWCA Civ 520 at paragraph [16]; *R(Raissi) v Secretary of State for the Home Department* [2008] QB 836 at pages [122] – [123]; and *Tesco Stores Ltd v Dundee City Council* [2012] PTSR 983 at paragraph [18]. It is not the task of the Court to ask whether the meaning that the Minister has himself attributed to the statement is a reasonable one: see e.g. *R(O) v Secretary of State for the Home Department* [2016] 1 WLR 1717 at paragraph [28]. Equally, it is not the task of the Court to ask what the man on the "Clapham Omnibus" (or his modern equivalent) would say: see the colourful observations of Lord Reed JSC (with whom the remainder of the Supreme Court agreed) in *Healthcare at Home Ltd v Common Services Agency* [2014] UKSC 49 at paragraphs [1] – [3]. These are the principles that I have applied in arriving at the conclusions above.

123. By way of example of the difficulties arising considerable debate focused upon the use, by the Minister, of the phrases "we", "impose" and "introduce". It is correct that on occasion the Minister has used the collective pronoun "we" (as in "we" are imposing/introducing the contract) to refer to Government as a whole; but elsewhere the expression has been used in a more nuanced fashion to refer to the Minister and NHS employers working collectively in the introduction of the new contract. The same

goes for "impose" and "introduce". These could indicate that it is the Minister acting unilaterally that intends to "impose" the contract upon employers or require employers to "introduce" it; or they could simply refer to the employers deciding for themselves to impose or introduce the contract upon employees without agreement having been reached with the employees through collective negotiation. These expressions, and in particular "impose", become more even difficult to construe because on the Secretary of State's own case he did "approve" the new contract and it was submitted that; in practice, there may be only limited scope for NHS employers to depart from the approved terms (albeit that they have the right to do so); that the Secretary of State did not wish employers to depart from the contract; and, that he would consider using his statutory powers of compulsion to ensure consistency. In this sense it could be said that there is a degree of *de facto* (if not *de jure*) compulsion. In short on occasion the Minister has used key phrases somewhat loosely and he has been picked up on this by the press, by other MPs and indeed he was warned of the risks of use of the particular word "impose" by his civil servants (see paragraph [61] above) when it was suggested that the phrase "*introduce*" might be more neutral and less problematic. These examples serve only to highlight the dangers of an over-precious interpretative exercise and why substance must prevail over form.

(iii) The compatibility of the actions of the Secretary of State with his statutory powers and duties

124. In my judgment the decision that the Secretary of State took was well within his powers. I have set out the relevant statutory provisions in Section D above. Taking the matter shortly my conclusions are as follows.

125. First, all of the conduct engaged in was within his powers. These include participating in negotiations for a national NHS contract and seeking to facilitate agreement between employers and employees; providing a mandate to another body or person (such as NHS Employers or to Sir David Dalton) to engage in negotiating on behalf of employers or broker a deal; concluding that negotiations have failed; concluding that a national NHS staffing contract should nonetheless be introduced; and expressing approval as to the terms of such a contract. This list is not intended to be exhaustive. The Secretary of State has ample powers to do these things under section 254A NHSA 2006 (see paragraph [96] above). He also has broad powers under section 1(1) and 1A – 1G NHSA 2006 (see paragraphs [93ff] above). These powers are in furtherance of the duties imposed upon him in section 1(1) and 1(2) NHSA 2006 (see paragraph [81] – [82] above) and Section 1A-1G and 2A NHSA 2006 (see paragraphs [83] – [92] above).

126. The Secretary of State has now made it plain that he holds his powers of compulsion in reserve. There was some debate in Court as to the extent of these powers. At present the issue of the scope of these compulsory powers is academic. It suffices to record that the Minister has certain explicit express powers, for instance in relation to NHS Trusts (see paragraph [97(f)] above). In relation to those in respect of whom there is no explicit power (such as NHS Foundations or local authorities etc) *whether* a power of compulsion exists depends upon the application of section 2 NHSA 2006 (see paragraphs [99] – [105] above) and in particular whether the conditions for the engagement of the general power (set out in paragraphs [103]- [105] above) are met. I

did not hear detailed argument on this issue and it is neither necessary nor appropriate for me to express any view at all on how this would apply in practice.

127. For these reasons the first ground of challenge does not succeed. The Secretary of State has not acted *ultra vires.*

F. Ground II: Breach of the common-law duty of transparency and good administration

(i) The issue

128. I turn now to the second ground which is said to be freestanding and applies even if, *prima facie*, the Secretary of State acted within his powers under the NHSA 2006.

129. The Claimant argues that it is a fundamental tenet of public law that policies relating to the exercise of statutory powers be transparent and clear. In this way arbitrary and unlawful results are avoided. It follows, *a fortiori*, that not only must the policy itself be clear and transparent but that decisions taken by public officials in the exercise of those powers must equally be clear and transparent. These principles have variously been said to form component parts of the "*rule of law*" and the "*principle of legality*". They may also be said to be part of the principle of "*good administration*".

130. The gist of the argument is that over a period of months the Secretary of State in public conveyed the clear message that the action he was taking amounted to a binding decision which he had power to adopt. However (as the case is now put for the Secretary of State) all along the truth was that the Secretary of State was doing no more than making a recommendation or proffering guidance to NHS employers. The mismatch between the words used and the intention (now) said to have existed at the time reveals a high level of confusion, ambiguity and lack of transparency. The Statement to Parliament of 6th July 2016 represented a critical opportunity for the Secretary of State to make plain the non-binding nature of the decision that he had been taken, but he failed to do so. This is not merely a semantic quibble: the decisional, mandatory, language used occurred shortly after the result of the referendum and was in the context of highly sensitive national negotiations. It was directly capable of affecting the behaviour of all parties in their respective bargaining positions. It will have conveyed to the employers the clear message that they, in effect, had no real choice but to succumb and to accept the terms and conditions approved by the Secretary of State and to introduce them. The use of the phrase "*instruction*" in the NHS Confederation communication (see paragraph [66] above) reflects the fact that in truth the Ministerial Statement to Parliament of 6th July 2016 could only sensibly be read as a clear and binding direction to employers. And as for employees the tenor of the Ministerial Statement had the effect of deterring any attempt to restart negotiations. In the circumstances it was unlawful for the Secretary of State to use words that appear to amount to the giving of an instruction or the adoption of a formal decision with legal effects if in truth the Secretary of State accepts that the "decision" amounts only to a non-binding recommendation.

131. The Secretary of State rejects this contention and argues that it is untenable because: (a) the Statement to Parliament was perfectly clear; (b) there is in any event no public law *"duty of clarity"* applicable to decisions or policies of this nature and the authorities

cited by the Claimant relate to quite different types of issue; and (c), in any event, it is not (and could not be) any part of the Court's judicial review function to act as a referee of Parliamentary debates regarding on-going, politically controversial, strikes and wage disputes. Such an approach would, amongst other things, be contrary to Article 9 of the Bill of Rights and/or Parliamentary privilege.

132. In this part of the Judgment I shall (i) set out my conclusions on the evidence; (ii) consider whether there has been a breach of the principles of transparency and good administration and then (iii) consider whether my conclusion in any way collides with Parliamentary privilege and/or Article 9 of the Bill of Rights.

(ii) Conclusions on the evidence

133. I start with some general observations and conclusions about the evidence.

134. First, I consider who the addressees of the decision were. In my view the most directly relevant addressees were (i) employers and (ii) employees. The decision was taken on the morning of 6th July 2016 as the dust of the referendum result was still settling and it directly affected those two categories of person because it governed their future professional private law relationship. The decision also, albeit less directly, affected members of the public in their capacity as consumers of health services. And it also affected Parliament to whom the Minister was accountable both as to the use of public funds but also as to the pursuit and achievement of the statutory objectives under the NHSA 2006. In the course of argument counsel for the Secretary of State argued that the addressees of the decision were essentially the employers since it was they who had the responsibility for taking decisions on employment matters at the local level and that was what the decision was really about. However, Mr Sheldon QC, for the Minister did (somewhat reluctantly) acknowledge that employees were also affected. In my view employees were manifestly a critical category of addressee of the decision. Through the BMA they had endeavored to negotiate a collective agreement with the employers and everyone has agreed that the preferred outcome would have been a collective agreement. Sadly such an agreement could not be reached. But more importantly the decision will have substantial short and long term implications for doctors. In the short term it entails the introduction of a new contract which affects the professional lives of circa 50,000 junior doctors and others and it impacts upon their private law contractual (employment) rights. In the longer term the decision set out some of the more important parameters which govern future discussions and negotiations over both contractual and extra-contractual matters. In real terms the decision impacts profoundly upon junior doctors and they were obvious addressees.

135. Second, for understandable reasons the Statement to Parliament is relatively brief and does not set out any sort of detailed excursus into the legal niceties of the powers of the Secretary of State or his target duties or as to the detailed components of the contract or the contractual rights of employers and employees. Significantly it did not explain that (i) the Minister was not exercising any power of compulsion and that therefore (ii) in principle employers could negotiate with employees. Given that employers were on the same side of the bargaining table as the Secretary of State they would understand the ramifications of the Statement. Indeed that is the clear and unequivocal evidence of the NHS Confederation and NHS Employers in these proceedings on behalf of the

employers. I have no hesitation in accepting this evidence. The same cannot be said of the junior doctors. They were not "inside the tent" and would have therefore been outside of the lines of communication which routinely would have existed between the Secretary of State and the employers. It was argued by the Secretary of State that the BMA and the LNC (the local negotiating committees of the BMA) are highly sophisticated and would have well understood the full implications of this Statement. Having read the evidence, including that which the Secretary of State argues is the high water mark of his argument that the junior doctors did understand the position, I accept the junior doctors' evidence. I accept the evidence of the junior doctors that they were in genuine doubt as to whether or not there was any negotiating daylight left following the Minister's statement and, further, construed the Statement as entailing the Secretary of State compelling introduction or implementation of the contract and thereby eradicating further negotiating options. I do not think it can fairly be argued that the existence of even a right in principle to negotiate (had it been spelled out) would not have been of great interest and importance to the doctors. At this juncture the Minister could opt to exercise statutory powers of compulsion <u>or</u> simply work cooperatively with employers to introduce the new contact. If he adopted the latter course (which was his selected option) then in principle negotiating daylight remains; but if he adopts the former it does not. The Ministerial Statement did not expressly address which option was being exercised.

136. Third, the misapprehension was as to an important, material, consideration viz., whether there was any scope *at all* for further negotiation with the Minister and/or employers. The Statement self-evidently, and on its face, was intended to convey important information to the junior doctors since: it rejected the invitation or exhortation (see paragraph [59] above) by the doctors that the parties return to negotiations following the referendum result; it informed the junior doctors that the pre-referendum contract would now be introduced without their collective agreement; but it also told them that, post-introduction, the Minister (and employers) was ready and willing to negotiate and discuss a range of other related matters. However, the Statement did not say that, *even in principle*, the doctors could negotiate with their employers.

137. Fourth, the next point is that, for reasons I have set out in relation to Ground I, I accept that the Secretary of State did not compel employers. He now accepts that there is in principle negotiating daylight which exists. But I have accepted the Secretary of State's analysis by looking, with the obvious benefit of hindsight, at the full range of relevant documents, the most important of which would not have been available to the junior doctors prior to this litigation.

138. Fifth, and importantly, I accept that in the aftermath of the Statement of 6th July 2016 the Secretary of State, through his legal advisers and in evidence on his behalf in this Court, has taken steps to elaborate upon his position and to clarify any ambiguity that arose and he has set out his position in formal, clear and unequivocal terms. I also accept that these later statements are consistent in their substance, with the Ministerial Statement of 6th July. In other words there has been <u>no</u> revisionist tendency to rewrite history. Thus on 15th July 2016 the GLD, on behalf of the Secretary of State, answered a specific question from the solicitors acting for the Claimant which was whether the Secretary of State asserted that as from August 2016 or October 2016 any NHS employers will come under a legal obligation to employ doctors in training on the new

contract. To this the answer was: "*No, as previously explained… the Secretary of State has never purported to issue any direction or otherwise legally compel any NHS employer to introduce the new contract. The Secretary of State has decided and announced that he considers that the new contract should be introduced.*" The position was repeated in a formal witness statement served on behalf of the Secretary of State on 19th August 2016 in these proceedings (see paragraph [74] above). The availability of the right to negotiate was reiterated in written and oral legal submissions in Court. Thus, as from a point in time which is well before the start date for formal implementation of the contract (5th October 2016) the Minister has clarified the accurate position.

139. Sixth, I should address one specific point made by Mr Coppel QC, for the NHS Confederation (i.e. for the employers) about the briefing given to the Minister by his advisers on the morning of 6th July 2016. He argued that the briefing (see paragraphs [60] – [63] above) was clear and unequivocal and represented the best evidence of the relevant reasons and was, indeed, superior (because it was not summary reasons) to the actual statement of the Minister in Parliament. I disagree and I am sure that Parliament would also disagree. I accept that the briefing is admissible and relevant but *only* because I have accepted that it accurately reflects the reasons of the Minister and because Mr Sheldon QC confirmed (on instructions) that this was so. Because of this it can stand as a fair statement of the reasons that the Minister actually accepted. Absent such unequivocal confirmation the document is no more than the unpublished submission of a civil servant to his Minister which would carry little if any weight at all. It was not in any event communicated to the junior doctors until this litigation as part of disclosure. I therefore do not accept that it is relevant in assessing how the Ministerial Statement to Parliament would have been understood *at the time*. I accept that it has *some* probative value in interpreting the Minister's Statement. But, by its nature it is a discursive document which sets out a wide variety of different matters and whilst it is possible to filter "reasons" from the general analysis contained within the document it does not readily stand as a crisp self- contained statement of those reasons. I therefore attach greater weight to the formal statement of the Minister to this Court elaborating upon his position and clarifying and removing any ambiguity.

140. Seventh, the upshot of this is that I accept that at the time of the Ministerial Statement, as a matter of evidence, the junior doctors did consider that compulsion was in play and that there was no negotiating daylight left. I also accept however that subsequently the Secretary of State has properly provided elaboration and clarification and that as from the date of that clarification there has been no ambiguity.

(iii) Legal issue I - The scope of the principles of transparency and good administration: Do they apply and if so has there been a violation?

141. I turn now to the law. The principle of transparency has evolved out of Strasbourg jurisprudence but it is now well established as a common law principle. It is said to amount to a component of the "rule of law" and the principle of "legal certainty". In *Nadarajah v Secretary of State for the Home Department* [2005] EWCA Civ 363 at [68] Lord Justice Laws stated that it was a *"requirement of good administration"* (to which the courts would give effect) that *"public bodies ought to deal straightforwardly and consistently with the public"*. The principle serves a number of important purposes. A law or policy should

be sufficiently clear to enable those affected by it to regulate their conduct i.e. to avoid being misled. Such a law or policy should also be sufficiently clear so as to obviate the risk that a public authority can act in an arbitrary way which interferes with fundamental rights of an individual. Clear notice of a policy or decision is also required so that the individual knows the criteria that are being applied and is able to both make meaningful representations to the decision maker before the decision is taken and subsequently to challenge an adverse decision (for instance by showing that the reasons include irrelevant matters). Where the principle applies it might require the publication of the policy that a decision maker is exercising; it might require that the policy be spelled out in greater detail so that the limits of a discretion may be demarcated; it might require the decision-maker to be more specific as to when he/she will or will not act.

142. In *Al-Nashif v. Bulgaria* 36 EHRR 37 the Strasbourg Court was concerned with a submission that an interference with private life was not "*in accordance with the law*". It was common ground in that case that the impugned orders had a basis in the relevant domestic law but the applicants alleged, however, that the applicable law lacked the clarity and foreseeability required by the concept of lawfulness as enshrined in the Convention. This was because it authorised the Ministry of the Interior to deport persons who had never been convicted or investigated upon the basis of orders issued without examination of evidence, without the possibility of adversarial proceedings, and without giving reasons. In this connection the Court stated:

> "119. The Court reiterates that the phrase "in accordance with the law" implies that the legal basis must be "accessible" and "foreseeable". A rule's effects are "foreseeable" if it is formulated with sufficient precision to enable any individual – if need be with appropriate advice – to regulate his conduct. In addition, there must be a measure of legal protection in domestic law against arbitrary interferences by public authorities with the rights safeguarded by the Convention. It would be contrary to the rule of law for the legal discretion granted to the executive in areas affecting fundamental rights to be expressed in terms of an unfettered power. Consequently, the law must indicate the scope of any such discretion conferred on the competent authorities and the manner of its exercise with sufficient clarity, having regard to the legitimate aim of the measure in question, to give the individual adequate protection against arbitrary interference (see *Amann v. Switzerland* [GC], no. 27798/95, ECHR 2000-II, §§ 55 and 56, *Rotaru v. Romania* [GC], no. 28341/95, ECHR 2000-V, §§ 55-63, *Hasan and Chaush v. Bulgaria* [GC], no. 30985/96, ECHR 2000-XI, and the Klass and Others v. Germany judgment of 6 September 1978, Series A no. 28).
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> 120. The Government's position was that although the Aliens Act did not circumscribe the cases in which a person might be considered a threat to national security so as to warrant his deportation, the term "national security" was clarified in the

> Framework National Security Concept (see paragraph 83 above).
>
> 121. The Court reiterates that as regards the quality of law criterion, what is required by way of safeguards will depend, to some extent at least, on the nature and extent of the interference in question (see *P.G. and J.H. v. the United Kingdom*, no. 44787/98, ECHR 2001-IX, § 46).
>
> It considers that the requirement of "foreseeability" of the law does not go so far as to compel States to enact legal provisions listing in detail all conduct that may prompt a decision to deport an individual on national security grounds. By the nature of things, threats to national security may vary in character and may be unanticipated or difficult to define in advance.
>
> 122. There must, however, be safeguards to ensure that the discretion left to the executive is exercised in accordance with the law and without abuse."

143. In *Limbu et ors v SSHD* [2008] EWHC 2261 (Admin) Blake J citing *Al-Nashif* with approval described the principle as a component of the principle of legality which is applied by the courts in judicial review proceedings. He did not confine it to cases involving exclusively the ECHR. He stated at paragraph [65]:

> 65. Transparency, clarity, and the avoidance of results that are contrary to common sense or are arbitrary are aspects of the principle of legality to be applied by the courts in judicial review. They are well exemplified by the jurisprudence of the European Court on Human Rights on the term "in accordance with the law". Thus in Al Nashif (loc cit) the Court at [139] repeated its consistent case law that the phrase implies:
>
> > "the legal basis must be accessible and foreseeable. A rule's effects are foreseeable if it is formulated with sufficient precision to enable any individual– if need be with appropriate advice- to regulate his conduct…..the law must indicate the scope of any such discretion with sufficient clarity to give the individual adequate protection against arbitrary interference".

144. He proceeded (at paragraph [69]) to condemn a policy under challenge on the basis that it either irrationally excluded material and potentially decisive considerations that the context and the stated purpose of the policy indicated should have been included *"... alternatively, it was so ambiguous as to the expression of its scope as to mislead applicants, entry clearance officers and immigration judges alike as to what was a sufficient reason to substantiate a discretionary claim to settlement here*" He reiterated: "*Transparency and clarity are significant requirements of instructions to immigration and entry clearance officers that are published to the world at large, generate expectations of fair treatment and bind appellate bodies in the performance of their statutory functions*". More generally he accepted that there was a "*delicate*

balance between rigidity and flexibility to be applied in the formation of such sensitive polices…".

145. In *R(Lumba) v SSHD* [2012] 1 AC 245 at paragraphs [34] – [38] in issue was the duty on the Minister to publish immigration detention policies. Lord Dyson MR stated that transparency was a component of the rule of law, again using language which resonates in the common law:

> "34. The rule of law calls for a transparent statement by the executive of the circumstances in which the broad statutory criteria will be exercised. Just as arrest and surveillance powers need to be transparently identified through codes of practice and immigration powers need to be transparently identified through the immigration rules, so too the immigration detention powers need to be transparently identified through formulated policy statements.
>
> 35. The individual has a basic public law right to have his or her case considered under whatever policy the executive sees fit to adopt provided that the adopted policy is a lawful exercise of the discretion conferred by the statute: see *In re Findlay* [1985] AC 318, 338E. There is a correlative right to know what that currently existing policy is, so that the individual can make relevant representations in relation to it. In *R (Anufrijeva) v Secretary of State for the Home Department* [2003] UKHL 36, [2004] 1 AC 604, para 26 Lord Steyn said:
>
> > "Notice of a decision is required before it can have the character of a determination with legal effect because the individual concerned must be in a position to challenge the decision in the courts if he or she wishes to do so. This is not a technical rule. It is simply an application of the right of access to justice."
>
> 36. Precisely the same is true of a detention policy. Notice is required so that the individual knows the criteria that are being applied and is able to challenge an adverse decision. I would endorse the statement made by Stanley Burnton J in *R (Salih) v Secretary of State for the Home Department* [2003] EWHC 2273 (Admin) at para 52 that "it is in general inconsistent with the constitutional imperative that statute law be made known for the government to withhold information about its policy relating to the exercise of a power conferred by statute." At para 72 of the judgment of the Court of Appeal in the present case, this statement was distinguished on the basis that it was made "in the quite different context of the Secretary of State's decision to withhold from the individuals concerned an internal policy relating to a statutory scheme designed for their benefit". This is not a satisfactory ground of distinction. The terms of a scheme which imposes penalties or other detriments are at least as important as one which confers benefits. As Mr Fordham

> puts it: why should it be impermissible to keep secret a policy of compensating those who have been unlawfully detained, but permissible to keep secret a policy which prescribes the criteria for their detention in the first place?
>
> 37. There was a real need to publish the detention policies in the present context. As Mr Husain points out, the Cullen policies provided that certain non-serious offenders could be considered for release. The failure to publish these policies meant that individuals who may have been wrongly assessed as having committed a crime that rendered them ineligible for release would remain detained, when in fact, had the policy been published, representations could have been made that they had a case for release.
>
> 38. The precise extent of how much detail of a policy is required to be disclosed was the subject of some debate before us. It is not practicable to attempt an exhaustive definition. It is common ground that there is no obligation to publish drafts when a policy is evolving and that there might be compelling reasons not to publish some policies, for example, where national security issues are in play. Nor is it necessary to publish details which are irrelevant to the substance of decisions made pursuant to the policy. What must, however, be published is that which a person who is affected by the operation of the policy needs to know in order to make informed and meaningful representations to the decision-maker before a decision is made."

146. In *R(Oboh) v SSHD* [2015] EWCA Civ 514 Richards LJ at paragraphs [28]-[29] approved of these principles when addressing a passage in a Home Office guidance document, "*Requests for removal decisions*", as it applied prior to its withdrawal on 13 April 2015. The context was that overstayers or illegal entrants whose applications for leave to remain had been refused without a right of appeal could request the Secretary of State to make a removal decision which, under the law as it stood at the material time, would generate a right of appeal. The guidance informed immigration officers how to respond to such requests. One of the challenges before the Court was as to the alleged lack of certainty or transparency in the guidance. The Court cited *Limbu* (ibid) and *Lumba* (ibid) with approval but cursorily rejected the argument on the facts of the case.

147. In *R(Richmond Pharmacology Ltd) v Health Research Authority* [2015] EWHC 2238 (Admin) Jay J applied the principle of transparency to guidance given in public statements by the Health Research Authority in relation to the latter's characterisation of the duties of those sponsoring and carrying out clinical trials: specifically, the Claimant argued that the Authority wrongly asserted that those in its position were under *legal* duties to register their trials on publicly available websites and to publish data about the outcome of such trials. The thrust of the judgment can be seen from the following paragraphs:

> "85. The question arises whether the combined effect of paragraphs 1.8 to 2.22 of the *"Key messages"* document negatives or cancels-out the misleading, confusing and unclear purport of the passages I have highlighted. In my judgment, it does not, for at least three reasons. First, there are too many passages which are defective. Secondly, the informed reader is entitled to reach the end of these public documents without being left in a state of confusion and dubiety. Thirdly, during the course of this judgment I have identified certain passages which are not so unclear or confusing that their revision is in my view mandated, but which are far from ideal. In my judgment, this is a factor which weighs in the balance against the Defendant. In any event, given the specific faults I have identified, I would now expect the Defendant as a responsible public body to cast a self-critical eye over the whole of its website material in this domain.
>
> 86. I should make explicit the legal criteria I have been applying, and the basis for my decision having applied those criteria. I am not holding that the Defendant has expressly stated that there is a legal obligation in relation to the pre-September 2013 approvals, or that this is clearly to be inferred from what the Defendant has said. I am holding that the Defendant's public utterances fail the public law test of certainty and transparency as explained in the jurisprudence mentioned under paragraph 48 above. Specifically, I am content to hold that these are (to the extent I have specified) *"so ambiguous as to the expression of its scope as to mislead"* the informed reader (see Blake J in Limbu, paragraph 69). I question whether the test is or ought be quite that stringent, but it is unnecessary for me to decide that point."

148. In my judgment the principle of transparency applies. First, the present decision was not a "one-off" as was submitted. On the contrary the decision has short, medium and long terms effects and sets out what the Minister expects of himself, of employers, of regulators and of the junior doctors over a protracted period of time. Second, the decision was, in part, addressed to the junior doctors since it was the sole vehicle through which the Minister communicated that he would not negotiate further with them and would introduce the contract without their collective agreement. Third, the decision affected important private law contractual (employment) rights of the doctors. Fourth, the decision set out the Minister's future negotiating stance vis-à-vis the junior doctors in relation to such issues as non-contractual matters, teething problems with the contract itself and the 2018 joint contractual review with the BMA. The principle of transparency is a component of the broad principle of "*good administration*", the *"rule of law*" and "*legal certainty*". In my judgment it would take a powerful legal and policy argument for these to be disengaged from a decision such as that in dispute; and I can discern none.

149. Assuming therefore that the principle applies has there been a violation?

150. In my judgment there has not. In my view it is important to look at the facts in the round. The Ministerial Statement is the starting point and, as I have found on the facts, did lead to a degree of misapprehension. However, I accept that the Minister has speedily removed that ambiguity or confusion and made his position clear. When one stands back and asks whether the principle of "good administration" has been infringed the answer is no. There is no longer legal uncertainty. The position of the Secretary of State became clear shortly after the Statement to Parliament and significantly in advance of the formal date for implementation of the new contract. Where a decision maker formulates a policy or issues a decision which contains within it the seeds of confusion then it is in fact the very epitome of good administration for elaboration and clarification to take place as soon as reasonably possible and before the Statement exerts any adverse or prejudicial effects. This is what occurred in this case.

(iv) Legal issue II – does Parliamentary privilege preclude the Court from reviewing the Statement of the Minister?

151. Mr Sheldon QC for the Secretary of State (supported by Mr Coppel QC) argued that to engage in an analysis which could involve criticising the Minister for his conduct in Parliament, including in relation to the accuracy of his statements, violated Parliamentary privilege. It was said that this Ground involved a direct criticism of the Minister's words in Parliament and was hence inadmissible as involving a violation of Parliamentary privilege. To put the point into context it was however accepted that the Court *was* entitled, on the basis of the present authorities, to examine the Statement to Parliament for the purpose of Ground I (jurisdiction) <u>and</u> Ground III (rationality) but <u>not</u> Ground II. So, on this basis I am entitled in principle, and without violating Parliamentary privilege, to hold that the Minister acted irrationally, perversely and unlawfully, but I cannot find that, even inadvertently and having acted in good faith, he promulgated a statement in Parliament which some of its intended addressees were confused by because of ambiguities in the language used.

152. I find this to be a difficult proposition to sustain in relation to the decision which is being challenged which, by common accord, is <u>not</u> the process of any Parliamentary procedure or process.

153. Article 9 of the Bill of Rights 1689 states: *"the freedome of speech and debates or proceedings in Parlyament ought not to be impeached or questioned in any court or place out of Parlyament*".

154. The basis of Parliamentary privilege was set out by Stanley Burnton J in *Office of Government Commerce v Information Commissioner* [2010] QB 98. In that case the Judge stated:

> "46. These authorities demonstrate that the law of Parliamentary privilege is essentially based on two principles. The first is the need to avoid any risk of interference with free speech in Parliament. The second is the principle of the separation of powers, which in our Constitution is restricted to the judicial function of government, and requires the executive and the legislature to abstain from interference with the judicial function, and conversely requires the judiciary not to interfere

> with or to criticise the proceedings of the legislature. These basic principles lead to the requirement of mutual respect by the Courts for the proceedings and decisions of the legislature and by the legislature (and the executive) for the proceedings and decisions of the Courts.
>
> 47. Conflicts between Parliament and the Courts are to be avoided. The above principles lead to the conclusion that the Courts cannot consider allegations of impropriety or inadequacy or lack of accuracy in the proceedings of Parliament. Such allegations are for Parliament to address, if it thinks fit, and if an allegation is well-founded any sanction is for Parliament to determine. The proceedings of Parliament include Parliamentary questions and answers to. These are not matters for the Courts to consider.
>
> 48. In my judgment, the irrelevance of an opinion expressed by a Parliamentary Select Committee to an issue that falls to be determined by the Courts arises from the nature of the judicial process, the independence of the judiciary and of its decisions, and the respect that the legislative and judicial branches of government owe to each other."

155. He went onto clarify the limits of the doctrine. Evidence of proceedings in Parliament were admissible evidence as "*relevant historical facts or events*" (ibid paragraph [49]) and legislation could be struck down where, for instance incompatible with EU law or it could be declared incompatible under the Human Rights Act 1998.

156. I will deal with this issue even though I have found in favour of the Minister on this Ground. It could, one supposes, be argued that in finding as a fact that there *was* some ambiguity in the Ministerial Statement which did lead to an incorrect conclusion being drawn there is some criticism of the Minister. There is no doubt but that the principle of Parliamentary privilege, which characterises the mutual trust that must exist between the Courts and Parliament, is of high importance. I should hence start by making very clear that my conclusion is not based upon even a hint that the Minister deliberately misled Parliament, or that he failed to act in good faith, or even that the Statement did not properly serve the broader purpose of keeping Parliament and the public properly informed. The difficulty in the present case is that in a relatively brief statement of reasons an issue of significance to one category of relevant addressee was not spelled out (viz., the scope for negotiations with employers) and did thereby lead to misapprehension.

157. Ms Richards QC for the Claimant contends in response that no issue of privilege arises. There is a well-established distinction between (i) impermissibly calling into question or seeking to establish liability based on Parliamentary proceedings; and (ii) permissibly adducing Parliamentary proceedings as objective evidence of something which took place outside Parliament. The issue was considered by the Privy Council in *Toussaint v Attorney General of St Vincent and the Grenadines* [2007] 1 WLR 2825. It is helpful to consider that case in some detail. The facts are important. There the Government had sold a piece of land to the Police Commissioner which was later alleged to have been improperly sold at a substantial undervalue. Subsequently the

Government sought to re-acquire the land. The Prime Minister made a statement in Parliament seeking to give reasons for this decision which were premised upon some specific policy reasons relating to the creation of a "learning centre". No mention was made of any compensatory payment having been made to the Police Commissioner. It later transpired that a payment had in fact been made. The Police Commissioner brought proceedings under the Constitution for unlawful expropriation of his property. In evidence he referred to the statement of the Prime Minister in Parliament. He doubted the explanation given and said that the true reason for the expropriation was "*political*". The respondent Government sought to strike out the allegation upon the basis that it was based upon words spoken in Parliament which attracted Parliamentary Privilege. Reliance was placed not only on the privilege provision of the domestic Constitution but also Article 9 of the Bill of Rights and the wider common law principle of freedom of speech and parliamentary privilege as referred to in *Prebble v Television New Zealnd Ltd* [1995] 1 AC 321. The Court of Appeal of Saint Vincent and the Grenadines, applying these principles, held that the Prime Minister's statement was inadmissible. The Privy Council, applying Article 9 and the common law, overturned that decision holding that the statement was admissible and did not attract Parliamentary privilege. Lord Mance, for the Board, endorsed the following propositions as describing a situation falling <u>outside</u> the scope of Parliamentary privilege (see paragraphs [19] and [34]).

> "The present case is concerned with executive action outside the House of which the Prime Minister gave prior notice to the House in his budget speech. Mr Clayton submits that the Prime Minister's statement in the House of Assembly is relied upon simply for its explanation of the motivation of the executive's action outside the House. The only allegation of impropriety relates to that action. It is not alleged that the Prime Minister misled the House or acted improperly within the House. The Prime Minister's statement in the House is relied on for what it says, rather than questioned or challenged."

158. The Privy Council held that there was no objection to a Court relying upon a Statement by a Minister to Parliament in judicial review proceedings in particular which related to conduct outside of Parliament. The Privy Council summarised the position in case law in the following way in paragraphs [16] and [17]:

> "16. … the House of Lords has on a number of occasions stated that use may be made of ministerial statements in Parliament in judicial review proceedings. <u>*R v Secretary of State for the Home Department, Ex p Brind*</u> *[1991] 1 AC 696* is an example noted by Lord Browne-Wilkinson in <u>*Pepper v Hart*</u> *[1993] AC 593*, 639f. Similar recognition of this "established practice" is found in the speeches in <u>*Wilson v First County Trust Ltd (No 2)*</u> *[2004] 1 AC 816* of Lord Nicholls of Birkenhead (para 60), Lord Hope of Craighead (para 113) and Lord Hobhouse of Woodborough: para 142. Further examples were noted in the Report of the Joint Committee on Parliament Privilege quoted by Lord Bingham of Cornhill, giving the opinion of the Board

> in *Buchanan v Jennings (Attorney General of New Zealand intervening) [2005] 1 AC 115*, para 16.
>
> 17. In such cases, the minister's statement is relied upon to explain the conduct occurring outside Parliament, and the policy and motivation leading to it. This is unobjectionable although the aim and effect is to show that such conduct involved the improper exercise of a power "for an alien purpose or in a wholly unreasonable manner": *Pepper v Hart,* per Lord Browne-Wilkinson at p 639a. The Joint Committee expressed the view that Parliament should welcome this development, on the basis that *"Both parliamentary scrutiny and judicial review have important roles, separate and distinct, in a modern democratic society"* (para 50) and on the basis that "*The contrary view would have bizarre consequences"*, hampering challenges to the *"legality of executive decisions ... by ring-fencing what ministers said in Parliament"*, and making *"ministerial decisions announced in Parliament ... less readily open to examination than other ministerial decisions"*: para 51. The Joint Committee observed, pertinently, that: *"That would be an ironic consequence of article 9. Intended to protect the integrity of the legislature from the executive and the courts, article 9 would become a source of protection of the executive from the courts*".

159. The Privy Council held at paragraph [23]:

> "…the Board observes that the meaning of the Prime Minister's statements to the House is an objective matter. Mr Clayton accepts that Mr Toussaint can only rely on the statements for their actual meaning, whatever the judge may rule that to be. While no suggestion may be made that the Prime Minister misled the House by his statement, Mr Toussaint also remains free to deploy any evidence available to him on the issue whether the public purpose recited in the declaration was a sham-for example, evidence as to the nature and location of the land and the likelihood or otherwise of its being required for a learning resource centre. The Prime Minister's statement to the House is potentially relevant to Mr Toussaint's claim as an admission or explanation of the executive's motivation. If the Prime Minister were to suggest that he expressed himself incorrectly, and did not intend to say what he said, then it would not be Mr Toussaint who was questioning or challenging what was said to the House."

160. In *Trust Special Administrator Appointed to South London Healthcare NHS Trust & Anor v London Borough of Lewisham & Anor* [2013] EWCA Civ 1409 it was held by the Court of Appeal that an *ultra vires* decision by the Secretary of State did not cease to be *ultra vires* only by the fact that the decision was announced in the House of Commons.

161. In my judgment no issue of Parliamentary privilege arises. The case is analogous to that arising in *Toussaint*. The principles set out in that judgment can be taken to reflect the common law: See on the precedent value of a judgment of the Privy Council, *Willers v Joyce (Re Gubay (deceased) No 1)* [2016] UKSC 43. In this present case the subject of the judicial review is a decision taken by the Minister *outside* of Parliament. Had I found for the Claimant the relief sought would have been in relation to that decision. The decision is not the progeny of a proceeding in Parliament. This is not a case for instance where the opinion of a Committee of Parliament is being impugned.

162. Equally this is not a case where it is alleged that the Minister misled Parliament. The worst that can be said is that in a short summary statement there were various matters not expressly addressed that caused some addressees to form an incomplete and inaccurate view. If a Court is not entitled to arrive at even this limited conclusion then as the Privy Council observed in *Toussaint* (cf paragraph [17] set out above when citing from the Report of the Joint Committee on Parliamentary Privilege) *"bizarre consequences"* would arise which would hamper challenges to the *"legality of executive decisions ... by ring-fencing what ministers said in Parliament"*, and making *"ministerial decisions announced in Parliament ... less readily open to examination than other ministerial decisions"*. The Joint Committee observed, pertinently, that: *"That would be an ironic consequence of article 9. Intended to protect the integrity of the legislature from the executive and the courts, article 9 would become a source of protection of the executive from the courts"*.

163. There are two final points that I would make.

164. First, if my conclusion on this is wrong then it would lead to some extraordinary and unjust results. I put the following hypothetical proposition to Mr Sheldon QC, for the Secretary of State, to test how far his argument on privilege went. Assume that a Minister takes an ordinary decision (outside of any Parliamentary procedure) but instead of stating his reasons in the ordinary way in a decision letter or document, he seeks to avoid challenge by (a) announcing the existence of the decision and (b) his reasons, in Parliament. However, when placed under pressure to give reasons outside of Parliament, the Minister does so but this time in terms which are flatly contradictory to the reasons given in Parliament. Mr Sheldon's submission was that the Court could not perform a compare and contrast exercise to see what the true reasons were. The Court had to ignore the reasons given in Parliament. The upshot of this is that the Court would have to pretend that when the decision was taken there were no reasons given at all. Ms Richards QC for the junior doctors likened this to the Minister donning a Harry Potter "*invisibility cloak*".

165. Second, the Secretary of State made a further point, to the effect that the junior doctors were not prejudiced by a limitation upon the ability of the Court to review the Statement in Parliament because they could have issued a Freedom of Information Act request or written to the Minister for clarification. Mr Sheldon QC cited the observation to this effect by Stanley Burnton J in *Office of Government Commerce* (ibid paragraph [52]). I do not, certainly on facts such as the present, accept this analysis. First, Stanley Burnton J was referring to opinions generated as a consequence of Parliamentary proceedings unlike in the present case which concerns a decision taken outside of Parliament. He also referred to the possibility of MPs making such a request, not other private persons. Second, the present decision was, in part, directed at private law, contractual relations between employers and employees operating outside

of Parliament. Third, the Secretary of State could have but did not promulgate his reasons in an appropriate form, such as a letter to the BMA, outside of Parliament. Fourth, time was of the essence given that implementation of the decision was due to commence in just short of 3 months, and unquestionably as from the moment of the Minister's statement employers would begin planning implementation in earnest. Fifth, given that litigation was contemplated almost immediately following the Ministerial Statement any response to a FOIA request could well have been delayed. In such circumstances to require the doctors to issue formal FOIA requests in order to enable them to be able to formulate legal and industrial action strategies in a fast moving situation is unreal.

(v) Conclusions

166. The principle of transparency/good administration applies to the decision in issue taken on 6th July 2016. The decision was not taken pursuant to Parliamentary process or procedure. The Court can examine the reasons given, even if set out only in a Parliamentary statement. On the facts the junior doctors did conclude that the decision compelled employers and eradicated all room for negotiations. The Secretary of State has elaborated upon and clarified his reasons in the course of these proceedings. When viewed in the round the Secretary of State has made his position clear and unequivocal in a timely manner. There has been no breach of the principles of transparency or good administration.

G. Ground III: Irrationality

(i) The issue

167. I turn now to the final ground of challenge. The Claimant argues that the decision was based upon a false assumption that there is a causal nexus between the proposed contract and the alleviation of higher mortality rates at the weekend in the NHS and it was irrational for the Secretary of State to introduce the new terms and conditions by reference to this objective when what was required was a far more rigorous and detailed analysis of mortality rates and the contribution that the new terms could make, if any, to a reduction in those rates, before the new contract was introduced. It is also said that it has all along been acknowledged by the Secretary of State that he had no adequate evidential or modelling underpinning for this objective. The gravamen of the challenge is a classic rationality challenge: the reasons do not "*add up*" and the Secretary of State failed to take sufficient steps to acquaint himself with and take due account of relevant information. The Claimant cites *De Smith's Judicial Review* (7th edition) at paragraph [11-052] as an accurate summary of the principles which govern the requirement in law for a decision maker to have an adequate evidential basis for a particular decision:

> **"Decisions unsupported by substantial evidence** This encompasses situations where there is "no evidence" for a finding upon which a decision depends or where the evidence, taken as a whole, is not reasonably capable of supporting a

> finding of fact. Such decisions may be impugned as "irrational" or "perverse", providing that this was a finding as to a material matter."

168. For his part the Secretary of State disputes this analysis. He contends that there was a proper basis for his position but that in any event the decision he took was one which was squarely within the wide margin of appreciation that he has when taking a "*polycentric, high level, political decision that must fall to the judgment of the elected, democratically accountable Minister…"* The bar to any successful challenge is very high. He also takes issue with the way in which the Claimant characterises his "decision". He says that the rationality challenge can only be to his recommending the adoption of the new contract, and not to any decision compelling its adoption (see the analysis in relation to Ground 1).

(ii) The evidence relied upon by the Claimant

169. In this section I have set out some of the principal pieces of evidence upon which the Claimant relies in support of its objection. I have not however by any means set out all of the evidence relied upon.

170. As to the *"central rationale*" of the contract namely that there should be a "*7-day NHS*" the Claimants refers (*inter alia*) to the Conservative Party Manifesto 2015[2] and a Report of the DDRB (July 2015) where at paragraph [2.8] it is stated:

> "Expanding seven-day NHS services is one of the key drivers behind the contract reform proposals put to us."

171. The central reason that has been advanced in public by the Secretary of State for taking the decision to impose or implement this contract is the so-called *"weekend effect"* in terms of patient mortality. A letter from the Secretary of State dated 19 January 2016 is cited as one illustration: *"this Government was elected on a mandate to deliver a seven-day NHS ... independent research published in the BMJ found that there are 11,000 excess deaths in our hospitals every year because of the weekend effect ... We are determined to ensure that employers can staff their hospitals properly seven days a week so that patients get the care they need whenever they fall ill"*. Various statements of the Secretary of State over time to Parliament are also cited:

> "In such a situation, any Government must do what is right for both patients and doctors. We have now had eight independent studies in the last five years identifying higher mortality rates at weekends as a key challenge to be addressed. Six of these say staffing levels are a factor that needs to be investigated.

[2] The Conservative Party Manifesto 2015 stated (page [37]): "*… our NHS faces major challenges. An ageing population will place more pressure on health and social care, and life-saving but expensive new drugs will push up costs. And for years it's been too hard to access the NHS out of hours, even though sudden illness and events which you and your family cannot plan for do not respect normal working hours. We will rise to these challenges. By building a strong economy, we will be able to increase spending in real terms every year. With a future Conservative Government, you will have a truly 7-dayNHS, at the frontier of science, offering you new drugs and treatments, safeguarded for years to come*".

> Professor Sir Bruce Keogh describes the status quo as "an avoidable weekend effect which if addressed could save lives" and has set out the 10 clinical standards necessary to remedy this. Today we are taking one important step necessary to make this possible… No Government or Health Secretary could responsibly ignore the evidence that hospital mortality rates are higher at the weekend or the overwhelming consensus that the standard of weekend services is too low, with insufficient senior clinical decision makers."
>
> "The choice I had to make was to do something about mortality rates at weekends or to duck the issue."
>
> "… we have had eight studies in the past six years, six of which have said that staffing levels at weekends are one of the things that need to be investigated"
>
> "a person admitted at the weekend has an 11% to `5% higher chance of death than if they were admitted in the week – that is proven in a very comprehensive study"
>
> "… what we want to do is reduce the difference between mortality rates for people admitted in the week and at weekends".

172. In relation to particular studies relied upon by the Secretary of State the Claimant contends that even if they do show a higher mortality rate at weekends they do not establish any causal connection between the availability of more junior doctors at weekend and mortality rates.

173. As to the proposition that there is an adverse effect on mortality of weekend admissions the Claimant cites various pieces of peer reviewed literature which cast doubt upon the proposition. I set out some of the conclusions in the more trenchant of these analyses:

   a. Mortality in out-of-hours emergency medical admissions – more than just a weekend effect (Maggs et al, JR Coll Physicians Edinb 2010): *Overall mortality for emergency general admissions in this UK district hospital is not significantly increased at weekends, but appears to be greater on Mondays, at night and when all out-of-hours periods are taken together ... Further work is also needed to clarify the cause of these outcomes and in particular to distinguish the patient and pre-hospital factors from the in-hospital factors".*

   b. The increased mortality associated with a weekend emergency admission is due to increased illness severity and altered case-mix (Mikulich et al, Acute Medicine, January 2011) *"It is clear that the case-mix of patients may later at the weekend, with implications for the resultant outcome ... It is possible that patients admitted at weekends may have a higher co-morbidity and therefore a worse outcome ... Thus while concerns have been raised about reduced hospital staffing during weekends and the availability of important intensive medical treatments, our data implications patient factors ... Our data clearly*

suggests that the weekend effect is largely attributable to an increase in illness severity and an altered case-mix".

c. Mortality from Acute Upper Gastrointestinal Bleeding in the UK: Does it display a "Weekend Effect? (Jairath et al, American Journal of Gastroenterology, 24th May 2011)) *"In conclusion, patients presenting at weekends are more critically ill and have greater delays to the performance of endoscopy. Despite this, we found no difference in the risk adjusted mortality for patients presenting at weekends compared with weekdays, regardless of whether or not a hospital had a formal OOH endoscopy service."*

d. Mortality outcome of out-of-hours primary percutaneous coronary intervention in the current era (Noman et al, European Heart Journal (2012)) *"This large observational study demonstrates that there are no differences in mortality following PPCI whether it is performed during or outside routine-working hours".*

e. *Mortality from meningococcal disease by day of the week: English national linked database study* (Goldacre et al, Journal of Medical Health (2013): *"There was no evidence of excess deaths from meningococcal disease associated with weekend care".*

f. Effects of Out-of-Hours and Winter Admissions and Number of Patients per Unit on Mortality in Pediatric Intensive Care (McShane et al, The Journal of Pediatrics, 2013): *"We found that out-of-hours emergency admissions to pediatric intensive care showed no increase in risk adjusted mortality in England and Wales suggesting that units are able to provide a consistent quality of care throughout the day and night every day of the week. The increased mortality in planned out-of-hours admissions is likely to reflect admission following complex operative procedures where the risk adjustment models may underestimate the true expected probability of mortality".*

g. Out-of-hours primary percutaneous coronary intervention for ST-elevation myocardial infarction is not associated with excess mortality (Rathod et al, BMJ Open, 2013): "*In our study, despite the reduced staffing levels and support services at weekends, there was no excess in adverse outcomes, suggesting that suitable seniority and experience of the medical care on site is a crucial rather than an exact replication of weekday service provision".*

h. Emergency medical admissions, deaths at weekends and the public holiday effect (Smith et al, group.bmj.com, 2012): "*Our study has shown that patients admitted as emergencies to medicine at weekends have a slightly but not significantly higher mortality at 7 and 30 days compared with patients admitted during the week ... The belief that a lack of consultants at weekends is responsible for the 'weekend effect' has been the subject of much recent media interest and has also contributed to an RCPL recommendation that consultants should spend more time on the AMU at weekends. It remains uncertain, however, to what extent this would reduce variations in mortality ... While there is little here to suggest that a lack of services or lack of medical*

staff at normal weekends is in any way harmful, the same reassurance cannot be given to patients admitted as emergencies on public holidays".

i. Higher mortality rates amongst emergency patients admitted to hospital at weekends reflect a lower probability of admission (Meacock et al, J Heaoth Serv Res Policy OnlineFirst, May 2016):

> *"Previous studies have compared mortality risk, adjusted for patient characteristics, between those admitted to hospital during the week and their counterparts admitted on weekends. These studies have consistently found higher mortality rates for patients admitted at weekends, both before and after risk adjustment. Whilst we have also found higher mortality rates amongst patients admitted at weekends, our study differs in two important respects. First, we widened our focus to include all patients attending A&E departments, including those not admitted, in order to avoid possible selection effects in the admitted population. Second, we assessed direct admissions and admissions via A&E separately, in order to gain a better understanding of variations in patient flows throughout the week. Using this approach we found there were fewer patients admitted to hospital in an emergency on weekends, attributable to a 61% lower volume of direct admission and a 5% lower risk-adjusted probability of admission following an A&E attendance. These increased thresholds for admission at weekends are likely to have biased previous studies on weekend mortality.*
>
> *Current initiatives to move towards seven day hospital services are only likely to be successful if reduced availability of services in hospitals on the day of admission is the major cause of the weekend effect. Our findings cast significant doubt over whether this is the case. Patients who attend A&E on weekends are at no higher mortality risk than patients who attend A&E on weekdays. However, a smaller proportion of attending patients are admitted at the weekend and this higher threshold for admission is likely to mean that patients who are admitted via A&E at the weekend are, on average, sicker than patients admitted ruing the week. Reduced availability of primary care services at weekends means that few patients are admitted to hospital via this route and these patients are also likely to be sicker than their counterparts admitted during the week.*
>
> *Our results add to the increasing body of evidence questioning the use of standardized morality rates as an indicator of the quality of care in hospitals. The weekend effect identified in previous studies may be a statistical artefact driven by the selection bias introduced by restricting the focus to the admitted population. Extending services in hospitals and in the community at weekends may increase the number of emergency admissions, particularly for patients with less severe illness, and this could have the desired effect of achieving lower hospital morality rates. However, this would be a statistical phenomenon rather than a clinically meaningful improvement as it*

> *would be achieved by admitting less sick patients rather than by reducing the absolute number of deaths."*

174. As to the proposition that the Secretary of State has no evidence to support his position the Claimant relies upon evidence given by Mr Massey (who has given evidence in this litigation) to the House of Commons Public Accounts Committee on 23rd February 2016 on behalf of the Permanent Secretary to the Department of Health (and said to reflect the position of the Secretary of State). The Claimant relies upon the following questions and answers:

> "Q136 David Mowat: I have one observational question, Mr Massey, on your answers to Mr Pugh on the seven-day NHS issue. We got to the fact that it is all included somehow in the £10 billion that was approved by the Chancellor. Ballpark, how much of that £10 billion is needed for the seven-day NHS?
>
> Charlie Massey: We have not separated out in that way. Part of what we are trying to achieve through a seven-day service is very much at the heart of what we are trying to do in terms of new models of care and the way in which we are looking at different—
>
> Q137 David Mowat: So, for example, if you did not do the seven-day contracts that are potentially being imposed, how much do you think you would save by not doing it? You must have an idea of what the number would be.
>
> Charlie Massey: Can I be clear? In terms of the junior doctors' contracts that you are talking about—
>
> Q138 David Mowat: It is not just junior doctors, is it?
>
> Charlie Massey: For the junior doctors' contracts, we are not changing the overall envelope of pay—the amount we pay—for junior doctors.
>
> Q139 David Mowat: No, but if they are working more weekends, presumably somebody else is having to provide cover, if you have the same number of doctors, shifts, rotas and rosters that they are not doing in the week.
>
> Charlie Massey: It is important to look at the whole of the contractual environment in thinking about that. Clearly, there has been an awful lot of attention over the last few months around junior doctors.
>
> Q140 David Mowat: I don't want to spend too long on this; I just wanted to understand. You said the £10 billion covers the seven-day NHS. I think you have told me the answer.

Charlie Massey: Yes. There is no separate pot set aside for something with the specific label of seven-day services.

Q141 David Mowat: It does not give a great feeling of warmth that you understand the implications of the policy in terms of manpower. Another way of asking the question is what is the delta in manpower—or man and woman power—that you need to meet the seven-day NHS? There must be an implication.

Charlie Massey: I wish it was a question that could be answered in a simple and mechanical way that applied to every single trust and local health economy—

Q142 David Mowat: Right, but if you don't know the answer approximately—I understand you might have to work it through in detail, but if you don't know in broad terms what the answer is, how can you be doing the policy?

Charlie Massey: It differs so substantially from one local health economy to another. When we have looked at some of the eight adoptor trusts, some of those have talked about that driving cost savings. A lot were talking about the reduction in bed days that happened as a result of that, without leading to additional cost in terms of the deployment of their senior clinical disciplines.

Q143 David Mowat: Yes, but you are the guys sitting above all of these trusts. You have already given evidence that if all the trusts were as good as the best trust, the world would be a better place, and everything like that. I am surprised that you can put this policy in place without having some idea of the implication for staffing levels at the headcount planning level—that is what today's hearing is about—or, indeed, for cost and budget.

Charlie Massey: That is a big part of the reason why the planning guidance in December asked local footprints to create their own sustainable transformation plans that bring together all of those issues.

David Mowat: What if the answer comes back as being more than £10 billion?

Q144 Karin Smyth: If we look at appendix 3 on your data and what you know about the workforce, there is no "readily accessible" data on vacancy rates, there is limited data on course completion rates, there is limited data on leaver rates and there is no inclusion of information on temporary staff employed by agencies. So you don't know, do you?

Charlie Massey: The Report rightly identifies that there are some data gaps within our workforce planning.

> Q145 Karin Smyth: That's generous.
>
> Charlie Massey: I wouldn't disagree with that, but that isn't to say that we aren't taking action across the system to fill those data gaps. We have a workforce information architecture process where we are essentially coming to plan specifically for how we are going to plug those gaps. That feeds into the workforce advisory board that Professor Cumming chairs, which looks at workforce planning across the system to deliver seven-day services and the five-year forward view. We have work in train, but we don't yet have that data, which I agree is something that we need. I hope that next time we have this conversation, we will be looking at it from a very different perspective.
>
> Chair: I have to say that the lack of data, as Karin Smyth has rightly highlighted, worried us before the hearing, and I am not sure that we are convinced by the answers that you can do your job without that data. I am going to bring Chris Evans in for a quick-fire, and then I have a few more."

175. The Claimant argues that it is manifest from this that the Secretary of State did not have sufficient data or modelling to underpin the "7-Day NHS" policy.

(iii) Analysis and conclusions

176. I start by considering the evidence on the issues of causality and weekend mortality rates; then I consider factors which are relevant to determining the scope of the margin of appreciation or discretion attributable to the Secretary of State in a case such as the present.

177. I do not accept the Claimant's argument that the evidence base upon which the Minister acted was inadequate.

178. First, it is accepted by counsel on all sides, and certainly reflects my reading of the literature, that in actual fact the evidence goes both. Further there was no suggestion by the Claimant that the evidence relied upon by the Minister was not from authoritative sources, or otherwise failed to meet up to proper research or professional standards (see *British American Tobacco et ors v Secretary of State for Health* [2016] EWHC 1169 (Admin) (*British American Tobacco*) at paragraphs [276] – [404], on the weight that Courts should attach to evidence that fails to adhere to internationally accepted research standards). In such circumstances, in law, it is very difficult to criticise the Secretary of State if he chooses to adopt one of the "sides" to the argument. In the text below I set out a selection of the principal pieces of evidence relied upon by the Minister to explain his position. I do this simply to show that there is a cogent body of evidence from authoritative sources which supports both the existence of a weekend effect and a causal connection between that adverse effect and a shortage of skilled staff. I would observe that when various authors refer to the need for more "*consultants*" at weekends most sources accept that in practice what is needed

is more "*senior decision makers*" or "*skilled staff*", which is a concept includes a significant number of experienced "junior" doctors (in addition to consultants). For example, the Academy of Medical Royal Colleges in "*Seven Day Consultant Present Care*" (December 2012) stated:

> "There is a growing body of evidence that case mix-adjusted mortality rates are higher for patients admitted electively or as emergencies to hospital 'out-of- hours', with most research focussing on weekends [Freemantle 2012, Mohammed 2012, Cram 2004, Cavallazzi 2010, Aylin 2010, Kruse 2011, Buckley 2012, MaGaughey 2007, James 2010, Worni 2012, De Cordova 2012, Deshmukh 2012]. The size of the weekend effect lies between 0.2% and 1% absolute increase in crude mortality over all admissions, detectable with large populations but not large enough to use mortality as an end-point in interventional studies.
>
> Not all studies report a positive association however [Byun 2012; Kazley 2010; Kevin 2010; Myers 2009]. One recent publication has demonstrated that the 'weekend effect' is more marked for elective admissions than for emergency admissions [Mohammed 2012]; a potential explanation requiring further investigation is incomplete adjustment for case mix of weekend elective admissions, with patients with complex and comorbid disease being more likely to be admitted well in advance of surgery for investigation and stabilisation.
>
> **The rational for seven day working: Unreliable care and poor process control contribute to the 'weekend effect'.**
>
> Factors contributing to increased mortality may include inadequate numbers of skilled staff [Kane 2007, Cho 2008, Kane 2007, Needleman 2002, Pronovost 2002, Wallace 2012, Kim 2010, Aiken 2002, Penoyer 2010], healthcare error and adverse events [Hogan, Vlayen, Buckley], lack of organisation and structure for care delivery [Anderson], and reduced access to specific interventions [Kostis, Deshmukh]…
>
> …
>
> Summary
>
> The weekend effect is very likely attributable to deficiencies in care processes linked to the absence of skilled and empowered senior staff in a system which is not configured to provide full diagnostic and support services seven days a week. The inexorable increase in emergency admissions creates additional tensions in delivering elective care. Diseases with well-defined diagnostic and treatment pathways are less susceptible to the weekend effect, probably because of better process control. The most effective way to improve outcomes for patients admitted

to hospital at weekends is to ensure that care is delivered by adequately supported consultants and monitored using care pathways."

179. NHS England in *"NHS Services, Seven Days a Week Forum – evidence base and clinical standard for the care and onwards transfer of acute in patients"* (2013) stated:

"2.1 Variation in outcomes

Significant variation in patient outcomes for those admitted as an emergency exists across England. This variation is seen in patient experience, mortality rates, length of hospital stay and re-admission rates. Evidence suggests that the workforce, systems and processes in place at hospitals to manage emergency admissions can have an influence on these patient outcomes.

This evidence base draws on the significant amount of research carried out in this area along with a national survey of acute hospital services. It aims to highlight the associations between both poorer outcomes and the variation in outcomes for patients, and the systems and processes in place which influence them.

2.1.1 Mortality rates

Evidence drawn from national research by influential professional bodies, such as the Royal Colleges and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), have highlighted deficiencies of care for many areas and demonstrated that patients admitted as a medical emergency at the weekend have a significantly greater risk of dying in hospital than those admitted on a weekday.

Further evidence of this "weekend effect" was reported in an analysis of NHS inpatient data from 2009/10 by Freemantle et al. The analysis concluded that being admitted at the weekend is associated with an increased risk of mortality within 30 days of admission compared to weekdays. This ranged from an 11% increase on Saturday to a 16% increase on Sunday when compared to patients admitted on a Wednesday.

Most recently a further study by Bell et al found that patients admitted to hospital as an acute medical emergency at the weekend had a 14% increased chance of mortality than those admitted on a weekday.

The explanation for this higher mortality rate outside of normal working hours is multifactorial and as such there is little evidence to establish a cause and effect relationship. However, a great deal of analysis has been undertaken in the area and

> some widely accepted associations made, which are discussed further in section 5 and summarised as follows:
>
> • Variable staffing levels in hospitals at weekends;
>
> • A lack of consistent specialist services, such as diagnostics, at weekends; and
>
> • A lack of availability of specialist community and primary care services, resulting in more patients on an end of life care pathway dying in hospital."

180. The nexus between the "*weekend effect*" and changes to junior doctors and consultants' contracts was acknowledged by the DDRB. As stated in the independent, expert, DDRB's report:

> "Seven-day services
>
> 17. We find the case for expanded seven-day services in the NHS, in order to address the 'weekend effect' on patient outcomes, where studies show that mortality rates, the patient experience, length of patient stay and re-admission rates are all poorer for those patients admitted at weekends, to be compelling. We note that this is the area of common ground between the parties and our response to the proposals has been influenced by this broad agreement, although we realise that this is not the only driver for change to junior doctors' and consultants' contracts."

181. As part of the process of collecting evidence to submit to the DDRB, NHS providers posed questions to members (November – December 2014). One question posed was as to the extent to which the junior doctor contract amounted to a source of barriers to the delivery of more 7-day services within the existing budgetary spend. As to this 6% considered it to be the "*main*" source of barriers; 50% considered it to be "*a source of some barriers*"; 21% considered it to be a source of "*a few*" barriers and only 6% said it was not a source. In terms of the way forward the overwhelming preference was for a collective, nationally negotiated, contract reform which was viewed as a "*key reform*".

182. The Secretary of State cites the 2015 Freemantle study, published in September 2015[3] which concluded that *"patients admitted on Saturday and Sunday are sicker and face an increased likelihood of death within 30 days even when severity of illness is taken into account*". This study updated an earlier study which found that during the financial year 2009 – 2010 weekend admissions were associated with a significantly higher risk of in-hospital death compared with mid-week admissions. These findings were consistent with an analysis of 254 leading hospitals in the US. The 2015 study updated that research and was based upon 14.8 million admissions and 280,000 deaths for the year 2013-2014. The Claimant argues that the study did not provide "*a sound or*

[3] Nick Freemantle, Increased mortality associated with weekend admission: a case for expanded seven day services? BMJ 2015:351:h4596 doi (5th September 2015)

rational evidential foundation for the Secretary of State's decision to impose (or introduce) the junior doctors' contract. The study did not establish any causal link between, on the one hand, its statistical conclusions and, on the other hand, the availability of junior doctors at weekends. Indeed, the study itself explained that "it is not possible to ascertain the extent to which these excess deaths may be preventable; to assume that they are avoidable would be rash and misleading". The Claimant did however acknowledge that in the study the following was stated: *"... from an epidemiological perspective, however, this statistic is "not otherwise ignorable" as a source of information on risk of death and it raises challenging questions about reduced service provision at weekends"* and that *"our analysis shows that we need to determine exactly which services need to be improved at the weekend to take the increased risk of mortality".*

183. As to where the balance of the evidence lies, Mr Massey, who has given evidence on behalf of the Secretary of State, adopts a comment by Professor Paul Aylin (Professor of Epidemiology and Public Health, Imperial College London), a leading authority in the field, who stated in an article *"Making sense of the evidence for the weekend effect*"(BMJ 2015:351 doi: 10.1136, September 2015):

> "… At first glance, there is conflicting evidence about whether the weekend effect exists at all. However, closer scrutiny shows that apparently "contradictory" studies tend to be smaller, carried out in single hospitals, and lack statistical power. Death after hospital admission, particularly for a planned surgical procedure, is relatively rare, and small studies simply don't have the numbers…"

In the Freemantle paper the authors adjusted for whether patients admitted at the weekend were sicker than those admitted on a weekday and they concluded that even after these adjustments there was a "weekend effect":

> "Our analyses show that, although fewer hospital admissions occur at the weekend, patients admitted on Saturday and Sunday are sicker and face an increased likelihood of death within 30 days even when severity of illness is taken into account. This finding is similar to that of our previous analysis."

In his commentary on this article, Professor Aylin, whilst adopting a cautious tone, reiterated that the weekend effect remained even after adjusting for case mix:

> "An obvious criticism of some of these observational studies is that patients admitted at the weekend are simply sicker. Freemantle and colleagues do indeed find a higher proportion of sicker patients at the weekend but attempt to account for this by adjusting for case mix using a wide range of variables included in administrative data. They are not the first group to adjust for this, yet the weekend effect seems to persist. No attempt to account for sicker patients in an analysis is perfect, but risk adjustment models based on administrative data have been shown to be as good, if not better, than models based on

> clinical data. The possibility, however, of residual confounding can never be entirely ruled out."

184. Professor Aylin goes on to detail further studies that have used diverse ways of addressing this issue of case mix and concludes:

> "This combination of both process and outcome measures strengthens the case for poorer quality of care at the weekend."

185. In my judgment in an area of policy where there is a genuine conflict of views between reputable professionals the Secretary of State is perfectly entitled to take one side of the argument and the fact that there is a respectable body of expert opinion on the other side of the argument is not sufficient to result in the conclusion that the Minister acted irrationally. On no basis can it be said that the position taken by the Minister was irrational or lacking a proper evidential basis. Put shortly it was within his margin of appreciation to conclude (i) that there was a discernible weekend effect and (ii) that in some measure the new contract which sought to adjust working patterns of junior doctors (which included experienced practitioners), could contribute in a material way to alleviating that adverse effect.

186. In determining whether a decision maker has acted irrationally the intensity of the scrutiny to be applied by a Court is context sensitive. Case law tends to suggest that the following considerations will tend to broaden the scope of the margin of appreciation: where the decision maker is taking a decision in the health field with the objective of improving patient care; where the decision adopted is prospective and precautionary (ie based upon a prediction of future benefit and where there is perceived to be a benefit in acting sooner rather than later notwithstanding uncertainties); where the decision maker has indicated a willingness and intention to review the policy as it unfolds to ensure that it is in fact working adequately and to review and modify it to address emerging problems. These sorts of considerations apply in the present case. My *prima facie* conclusion however is that on the basis of the evidence (of causal connection between senior staffing levels and mortality rates) there is a sufficient evidential basis upon which the Minister could rationally act. That conclusion stands alone but it is also reinforced by these other considerations, all of which apply in some measure in this case.

187. I would refer to the following additional factors which are relevant to the margin of appreciation or discretion that must in law to attributed to the Secretary of State.

188. First it is relevant to consider the intrinsic nature of the "*decision*" that the Secretary of State actually took. As to this, as I have already pointed out, even the Statement to Parliament of 6th July 2016 did not indicate that the Secretary of State considered that the new terms were the end of the line. He accepted that there might be teething problems to be sorted out and that certain other important matters such as rostering could be the subject of further discussions either with him or which would require the intervention of the regulator. In other words the "decision" was not an end point but a staging point, albeit an important and substantial starting point. The evidence before the Court included a recent statement of the Secretary of State to Parliament dated 5th September 2016 in which the Secretary of State identifies a range of issues which could be considered outside the scope of the introduction of the new contract. He also identified issues which the new contract was intended to address but which could also

trigger intervention by regulators. An illustration is "*rota gaps*". The new terms and conditions include specific provisions to address the issue of rota gaps. The independent Guardian of Safe Working Hours will report to Trust and Foundation Trust Boards on the issue of any rota gaps within junior doctor rotas. The Secretary of State accepted that the new contract would "*shine a light on rota gaps where they exist*". The Secretary of State made specific reference to rota gaps in his statement to the House of Commons on 5th September 2016, where he said that:

> Many junior doctors have expressed concern about rota gaps, and the new contract acknowledges and tackles this concern. The guardians of safe working hours will report to trust and foundation trust boards on the issue of rota gaps within junior doctor rotas. This will shine a light on the issue and it will be escalated, potentially to the Care Quality Commission and the General Medical Council, when serious issues are not addressed.

It is in this context also relevant that the Minister has committed to a review of the contract by NHS Employers in conjunction with the BMA in August 2018 (see paragraph [58] above). At that point the two sides will jointly commission a review of the efficacy of the contract, to identify any areas fro improvement. The contract is not writ in stone; it can be changed and improved. This is one factor broadening the margin of appreciation: see for an analogous case *British American Tobacco (ibid)* at paragraphs [455] – [460].

189. Second, the reasons for introducing the contract are not limited to the contribution they will make to the alleviation of higher weekend mortality rates. A number of different justifications have been advanced some of which relate to the 7-day NHS and others which do not. As set out in the March 2016 Equality Impact Analysis (see paragraphs [51] – [53] above) on the contract at paragraph [7], the 'seven-day NHS' is only one aspect of the rationale for the new terms and conditions. The Minister has treated the contract as an intertwined bundle or package of terms and conditions. Even if, therefore, criticism could properly be levelled at one (albeit important) perceived benefit this does not mean that the package should not still be introduced in its entirety. As was pointed out to the Minister in the briefing paper of 6th July 2016 a return to negotiation would risk putting back a series of other reforms, all of which were considered to be beneficial (see for example paragraph [62] above). This seems to me to be a further factor which broadens the scope of the relevant margin of appreciation.

190. Third, it is also important to calibrate the actual claim made by the Secretary of State for the new terms and conditions. On occasion the tenor of the Claimant's argument was that the new contract being advanced was said by the Secretary of State to be a cure for higher weekend mortality rates. However, the Secretary of State does not say any more than that the new contract will, in his view, *contribute* to addressing the problems of weekend adverse effects. He makes no claim that they will amount to "*a*" or "*the*" cure. The rationality challenge must hence be focused upon whether, in accordance with his legitimate margin of appreciation or discretion, the Secretary of State acted irrationally in concluding that the new terms would make some (possibly modest albeit material) contribution to the issue of weekend mortality. And as to this a criticism will therefore go wide of the mark if all it says is that there are other important considerations which need to taken account of, aside from new terms and

conditions. The same applies where the Claimant makes what is, ostensibly, a perfectly rational criticism that the new terms are not perfect and will not fully obviate the risk arising. This will miss the mark because on the evidence before the Court the Secretary of State does not disagree. He would retort only that in his view the new terms will make *some* contribution to addressing the problem but that much else needs to be done in addition.

191. For all of these reasons Ground III does not succeed.

H. Conclusion

192. For all of the reasons set out in this judgment the application for judicial review does not succeed.