

BETWEEN:

THE QUEEN

On the application of

JUSTICE FOR HEALTH LTD

Claimant

- and -

THE SECRETARY OF STATE FOR HEALTH

Defendant

- and -

THE BRITISH MEDICAL ASSOCIATION (1)
THE NHS CONFEDERATION (2)

Interested Parties

CLAIMANT'S SKELETON ARGUMENT

Hearing: 19 and 20 September 2016

Time estimate: 1.5 -2 days

Pre-reading estimate: 1 day

INTRODUCTION

Summary of the claim

1. The Claimant¹ seeks judicial review of the decision of the Secretary of State for Health on 6 July 2016 to “introduce” (or “implement” or “impose”) a new contract pursuant to which NHS and other bodies employ doctors in training below consultant grade (“junior doctors”).
2. The Claimant’s case, in summary, is as follows:

¹ A company formed by five junior doctors: Dr Nadia Masood, Dr Ben White, Dr Marie McVeigh, Dr Amar Mashru and Dr Francesca Silman.

Ground 1 (see paragraphs 66-75 below):

- a. The Secretary of State has purported to have and to exercise a power to determine the terms and conditions on which junior doctors will be employed.
- b. Whether the Secretary of State's decisions are characterised as "*introducing*" or "*implementing*" or "*imposing*" the new contract, the reality is that the Secretary of State has no power to act as a decision-maker in this regard (whether solely or jointly with others) and/or to take a decision as to the terms and conditions on which NHS bodies and other employers should employ junior doctors.
- c. Whilst the Secretary of State would be entitled to *recommend* a new contract, he has plainly attempted or purported to go significantly further than a mere recommendation or the expression of opinion or approval for the new contract.

Ground 2 (see paragraphs 76-7 below):

- d. The Secretary of State has failed to make the true nature of his decision clear and has acted in breach of the requirements of transparency, certainty and clarity.

Ground 3 (see paragraphs 84-102 below):

- e. The Secretary of State has acted irrationally.
3. Although the focus of the claim is now the Secretary of State's most recent decision on 6 July 2016, his actions, and the nature and effect of the decision, can only properly be understood in the context of the Secretary of State's earlier decisions and announcements, not least because the Secretary of State claims to have taken a consistent position throughout.

Chronology in overview

4. A very brief chronology is set out below. A more detailed (and hopefully agreed) chronology will be available to the court in advance of the hearing. References to [B/T/p] are to the relevant Bundle, Tab and Page of the Court's bundles.

30 Nov 2015	Agreement of BMA, NHS Employers and Department of Health to resume contract negotiations
9 Feb 2016	Letter from Sir David Dalton to the BMA requiring acceptance of final offer [B7/T107]
10 Feb 2016	Letter from Sir David Dalton to the Secretary of State [B7/T109]
11 Feb 2016	Statements by the Secretary of State for Health in the House of Commons [B9/T7/p63-77]
12 Feb 2016	Letter from NHS Employers to all junior doctors saying that the Secretary of State has decided that the NHS must now introduce a new contract [B8/p304-5]
23 Feb 2016	Public Accounts Committee sitting
23 Feb 2016	Pre-action letter from the BMA to the Secretary of State [B9/T/2, p11-27]
8 March 2016	Response from the Government Legal Service (GLS) to the BMA [B9/T2/p28-34]
31 March 2016	Publication of the full terms of the new contract
4 April 2016	Pre-action letter from the Claimant to the Secretary of State [B3/T3/p1-41]
11 April 2016	Response from the GLS to the Claimant [B3/T3/p46-52]
18 April 2016	Claim issued
18 April 2016	Further statements by the Secretary of State in the House of Commons [B4/T15/90-108]
27 April 2016	Secretary of State's summary grounds of resistance filed
5 May 2016	Direction by Cranston J of a rolled-up permission and substantive hearing of the claim, to be heard together with the claim that was then being brought by the BMA (on equality duty grounds only) on 8-10 June 2016 [B3/T7/p7]
9 May 2016	Secretary of State paused the introduction of the new contract whilst further talks take place
18 May 2016	ACAS agreement
25 May 2016	Consent order adjourning June hearing [B3/T7/p8-9]
27 May 2016	Revised terms of new contract published
29 June 2016	Result of referendum of junior doctors – new contract rejected
6 July 2016	Statements by Secretary of State in the House of Commons [B5/T31/p334-342]
21 July 2016	Case management hearing before Green J [B3/T7/p10-12].

Recommended pre-reading

5. The following documents are recommended by way of pre-reading:

Parties' skeleton arguments

1 st statement of Dr Nadia Masood	B1/T2/p1-11
Statement of Dr Marie-Estella McVeigh	B1/T2/p42-51
Statement of Dr Amar Mashru	B1/T2/p58-68
Statement of Dr Francesca Silman	B1/T2/p85-98
Statement of Dr Benjamin White	B1/T2/p177-198
Statement of Dr Clare Gerada	B1/T2/p286-305
Statement of Dr Benjamin Dean	B1/T2/p391-6
2 nd witness statement of Dr Nadia Masood	B1/T2/p426-430
Witness statement of various doctors	B2/p519-525
2 nd statement of Charles Massey	B3/T4/p87-163
3 rd witness statement of Charles Massey	B3/T4/p167
Secretary of State's public statements on 11 Feb 2016	B9/T7/p63-77
Secretary of State's public statements on 18 April 2016	B4/T15/90-108
Secretary of State's public statements on 6 July 2016	B5/T31/p334-342.

6. This skeleton argument is structured as follows:

Legal framework	Paragraphs 7-26
Factual background	Paragraphs 27-65
Ground 1	Paragraphs 66-75
Ground 2	Paragraphs 76-7
Parliamentary privilege	Paragraphs 78-83
Ground 3	Paragraphs 84-102
Response to Judge's note	Paragraph 103
Remedies	Paragraphs 104-8.

THE LEGAL FRAMEWORK

The structure of the National Health Service

7. The NHS is seen by the public as a single entity but whilst there are times when it seeks to operate as a single public service, the NHS in fact operates within a complex legal structure with a clear definition between the roles and responsibilities of multiple different public bodies including the Secretary of State. A significant proportion of services for NHS patients is also provided under contract by healthcare professionals and others who are employees of private businesses which contract with NHS commissioning bodies to deliver services to NHS patients, especially in primary care.
8. Junior doctors who deliver services to NHS patients are thus employed by NHS bodies, local authorities and private businesses.
9. The primary statute defining the many roles of public bodies within the NHS is the National Health Service Act 2006 (“the NHS Act”) which is a consolidating Act which repealed the National Health Service Act 1977². The NHS Act has been subsequently amended by a number of statutes including the Health and Social Care Act 2012 (“the 2012 Act”). The 2012 Act made substantial changes to the role of the Secretary of State as detailed below. Following the changes made by the 2012 Act, there are broadly 4 types of public bodies involved in the NHS:
 - a. **The Secretary of State** whose role is defined by the 2012 Act and, in summary, is now limited to setting the broad strategic direction for the NHS and being accountable to Parliament for the provision of NHS services to patients³.
 - b. **Commissioners of NHS services:** In England, the National Health Service Commissioning Board (known as “NHS England”) and local clinical commissioning groups (“CCGs”)⁴ perform these functions. NHS commissioners place contracts with providers of NHS services but do not employ staff to deliver services directly to patients.
 - c. **Providers of NHS services:** These are primarily NHS Trusts, NHS Foundation Trusts, local authorities (which deliver public health services) and private sector businesses (including GP practices).

² Which was itself a consolidating act.

³ The Secretary of State also has wide emergency powers under section 253 of the NHS Act to intervene at any level of the NHS although these powers do not appear to be relevant to the present dispute.

⁴ Clinical commissioning groups are public bodies which commission the majority of NHS acute services for a local population. They function as a membership organisation.

- d. **Regulators of NHS bodies and others delivering services to NHS patients:** The primary regulators are the Care Quality Commission and NHS Improvement (incorporating Monitor and the NHS Trust Development Authority).
10. Junior doctors are employed by a variety of NHS provider bodies and others which fall into the “provider” category set out above including the following:
- a. **NHS Trusts:** These are public bodies created under Chapter 3 of Part 2 of the NHS Act. NHS Trusts are contracted by clinical commissioning groups (“CCGs”) using NHS contracts to provide a wide range of community, mental health and hospital services to NHS patients. The original plan of the government in the 2012 Act was that all NHS Trusts should become NHS Foundation Trusts by 1 April 2016 at the latest but this has not happened. The Secretary of State has the power to issue directions to an NHS Trust under various powers, principally section 8 of the NHS Act. If a direction is made by the Secretary of State it imposes specific legal obligations on an NHS Trust to do things or provide services, or to cease to do something or cease to provide a service as specified in the direction. It is common ground that no directions have been issued to NHS Trusts concerning the terms of employment contracts for junior doctors.
- b. **NHS Foundation Trusts:** These are public benefit corporations under Chapter 5 of Part 2 of the NHS Act⁵. NHS Foundation Trusts have Members and Governors, as well as a Board of Directors. NHS Foundation Trusts are primarily accountable to their members as opposed to being accountable upwards to the Secretary of State or any other NHS national body. Save when exercising emergency powers (which are not relevant for present purposes), the Secretary of State has no power to issue directions to an NHS Foundation Trust.
- c. **Local Authorities:** Local authorities provide public health services. Junior doctors training in public health can be employees of a local authority or can be employees of an NHS Trust (or NHS Foundation Trust) and work for a local authority under an NHS arrangement known as an “honorary contract” which provides for an employee of one NHS body to work at and be treated as an employee of another body.
- d. **GP practices:** Almost all GP practices are private businesses that contract with NHS England to deliver primary care services to patients on their list. GP practices and

⁵ Originally created by the Health and Social Care (Community Health and Standards) Act 2003.

NHS Trusts employ junior doctors as part of a training rotation whilst they are working at the relevant GP practice. GPs can operate as sole practitioners, in partnerships or within medical companies.

The role and powers of the Secretary of State

11. The Secretary of State has a duty under section 1(1) of the NHS Act to continue the promotion of a comprehensive healthcare system. Section 1(2) of the NHS Act provides:

“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.”

12. The interrelationship between the duties set out in sections 1(1) and 1(2) has been explained by a Memorandum issued by the Department of Health in August 2011⁶ at §4 as follows:

“This duty is not and has never been a stand-alone duty to provide or secure the provision of services. The phrase “in accordance with this act” means that the actual functions of providing and securing the provision of services are set out elsewhere in the 2006 Act. The duty to provide services is primarily conferred by section 3 of the 2006 Act, and section 12 allows services to be commissioned, rather than provided directly.”

13. Accordingly, the powers of the Secretary of State which he is entitled to use to deliver on his target duty to promote a comprehensive health service must be found elsewhere within the NHS Act or within another statute. Sub-sections 1(1) and 1(2) cannot be relied upon directly to give the Secretary of State vires to give legally binding instructions to a third party, including any NHS body.

14. Prior to the implementation of the 2012 Act in April 2013:

- a. The primary routes by which the Secretary of State delivered on his duty to promote a comprehensive health service were through his direct duty under section 3(1) of the NHS Act to provide a range of secondary care and other services to NHS patients; through his ability to issue directions to primary care trusts which were, in turn, required to commission primary care services, community dental services, community pharmaceutical services and a variety of other services; and by reason of his emergency powers to make directions under section 253 of the NHS Act.

⁶ See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215474/dh_129483.pdf

- b. The Secretary of State was entitled to and did delegate the discharge of his duties to provide services to NHS patients under section 3(1) to primary care trusts but the primary legal responsibility for the provision of services rested on the Secretary of State.
15. Substantial changes to the legal architecture of the NHS, and in particular to the role of the Secretary of State, were made by Parliament when it passed the 2012 Act. For present purposes the main changes were as follows:
- a. Primary Care Trusts were abolished as the local commissioning bodies for acute and other services, and were replaced by clinical commissioning groups and the Secretary of State was not given any power (save in emergency) to issue directions to a clinical commissioning group.
 - b. NHS England was created as a corporate body separate from the Secretary of State in order to discharge many of the functions previously discharged directly by the Secretary of State, and the Secretary of State was given no general power to give directions to NHS England.
 - c. The Secretary of State's duty to provide a range of acute and other services to NHS patients under section 3 of the NHS Act was repealed and a like duty was imposed in its place on a combination of NHS England and clinical commissioning groups.
 - d. The primary method by which the Secretary of State is entitled to set the strategic priorities for the NHS is through the publication of a "mandate" provided by the Secretary of State to NHS England (see section 13A of the NHS Act imposed by section 23 of the 2012 Act)⁷. Section 13A(2) provides:

"The Secretary of State must specify in the mandate-

- i. The objectives that the Secretary of State considers the Board should seek to achieve in the exercise of its functions during the financial year and subsequent financial years as the Secretary of State considers appropriate, and*
- ii. any requirements that the Secretary of State considers necessary to impose on the Board for the purpose of ensuring that it achieves those objectives."*

⁷ The formal mandate was the successor of the more informal "NHS Operating Plan" which was issued annually by the Department of Health up to 2013.

- e. The Secretary of State is only entitled to give directions to NHS England if the Secretary of State considers that it is guilty of significant failure in the discharge of its functions: see section 13Z2.
16. The 2012 Act retained the duty on the Secretary of State to promote a comprehensive health service. A new section 1(3) of the 2006 Act provided:
- “The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.”*
17. Section 5 of the 2012 Act introduced a new section 1D to the NHS Act which imposed the following duty on the Secretary of State:
- “(1) in exercising functions in relation to the health service, the Secretary of State must have regard to the desirability of securing, so far as is consistent with interests of the health service-*
- (a) That any other person exercising functions in relation to the health service or providing services for its purposes is free to exercise those functions or provide those services in the manner that it considers most appropriate,*
- and*
- (b) That unnecessary burdens are not imposed on any such person.”*
18. One purpose of the duty of autonomy in section 1D was to place limitations on the ability of the Secretary of State, acting outside of the mandate, to become or attempt to become the decision-maker for any public body delivering functions under the NHS Act, and to enable NHS bodies to be free to act in the way that they thought best and to develop new and innovative ways of carrying out their functions.
19. The Secretary of State has made reference (in correspondence and/or in Parliament) to other provisions of the NHS Act, which are summarised below:
- a. Section 1A (1) provides that the Secretary of State must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with (a) the prevention, diagnosis or treatment of illness, or (b) the protection or improvement of public health. Section 1A (2) provides that in discharging this duty the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.

- b. Section 1B requires the Secretary of State, in exercising functions in relation to the health service, to have regard to the NHS Constitution.
 - c. Under section 1F(1) the Secretary of State must exercise his functions under specified enactments so as to secure that there is an effective system for the planning and delivery of education and training to persons who are employed in an activity which involves or is connected with the provision of services as part of the health service.
 - d. Section 2 confers a power on the Secretary of State, the Board or a CCG to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on that person by the Act.
20. Section 8 of the NHS Act provides that the Secretary of State may give directions to NHS Trusts (and Special Health Authorities) about the exercise of any of their functions. The Secretary of State has not sought to exercise this power in the present context.

The legislative purposes behind the changes in the 2012 Act

21. Ministers explained the purposes of the changes to the powers of the Secretary of State during the passage of the Bill which became the 2012 Act. For present purposes, it is only necessary to refer to the following quotations which explain the legislative purposes behind the restrictions of the powers of the Secretary of State and the imposition of the duty to respect the autonomy of providers of NHS services to act as they consider appropriate when discharging their functions.
22. The then Secretary of State said on 31 January 2011 as follows in Parliament⁸ (emphasis added):

*“The Bill explicitly defines roles and responsibilities that were previously at the discretion of Ministers. Until now, legislation on the NHS has more or less said, “The NHS is whatever the Secretary of State chooses to make it at any given moment.” That was why, in the past, reorganisations took place on a practically annual basis under the Labour Government, without there ever being any consistency or coherence to them. **I intend to be the first Secretary of State in the history of the NHS who, rather than grabbing more power or holding on to it, will give it away.**”*

⁸ See <http://www.publications.parliament.uk/pa/cm201012/cmhansrd/cm110131/debtext/110131-0002.htm>

23. On 7 September 2011 the junior Minister, Mr Paul Bairstow MP, explained that the purpose of the Bill was to ensure that the Secretary of State only intervened in an emergency as follows⁹ (emphasis added):

“I want it to be clear that we do not envisage the Secretary of State having to intervene other than in exceptional circumstances. Nevertheless, the measures are the legislative back-stops in the Bill and it is right that they are there to protect the comprehensive nature of our NHS and to provide reassurance. To answer my right hon. Friend the Member for Bermondsey and Old Southwark (Simon Hughes) directly, there are a number of ways in which the Secretary of State could secure the provision of services. In particular, he could impose requirements on the NHS commissioning board and clinical commissioning groups using both the mandate and the standing rules. He could establish, and has the powers to do so, a special health authority, and could direct it to carry out any NHS function. That power has been used in the past to establish NHS Direct—a service-providing organisation. Also, he could intervene, including by replacing the management and directing them in the event of a significant failure. Those measures are the belt and braces in the Bill to make absolutely sure that the NHS and the public are protected from all eventualities. We have ensured that the Secretary of State’s powers are sufficient to ensure that a comprehensive NHS is provided, including through the public sector, rather than simply relying on existing providers and the market.

The position is clear: we are giving the NHS more freedoms and autonomy—something that many of us in the House have for many years argued should take place—and we are increasing its accountability. We are making watertight the obligations to provide a comprehensive health service that is free to all, based on need and not ability to pay.”

24. Further, the Department of Health issued a document in August 2011¹⁰ which purported to explain the future role and functions of the Secretary of State. This explained the limitations on the role of the Secretary of State as follows:

“14. Under the Bill, the Secretary of State retains a responsibility for securing the provision of services for the purposes of the health service, but in relation to the NHS services he will carry out this responsibility by exercising the powers conferred by the Bill: for example, his powers to issue a mandate (new section 13A), make standing rules (new section 6E) and intervene in the case of Board failure (new section 13Z1). The Board will have a concurrent duty to promote the health service and a duty as to securing the provision of services, combined with various powers including the power to intervene in cases of clinical commissioning group failure (new sections 1E and 14Z19).

15. In addition, the Government’s policy is that neither the Secretary of State, nor the NHS bodies responsible for securing local services, should be providing NHS services – i.e. the Department, the Board and clinical commissioning groups should not be directly managing NHS hospitals or other facilities, nor employing the staff providing NHS services”.

⁹ See <http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110907/debtext/110907-0002.htm>

¹⁰ See

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215474/dh_129483.pdf

25. The Claimant submits that the structure of the NHS Act, following the amendments created by the 2012 Act, provides strict limitations on the power of the Secretary of State to act as a decision-maker on behalf of NHS bodies and others and/or to take decisions which attempt or purport to bind NHS bodies and others exercising functions under the NHS Act.
26. If the Secretary of State purports to take a decision where he has not got the power to do so, the court will intervene to quash that decision: see *Trust Special Administrator Appointed to South London Healthcare NHS Trust & Anor v London Borough of Lewisham & Anor* [2013] EWCA Civ 1409¹¹.

FACTUAL BACKGROUND

The decision made by the Secretary of State on 11 February 2016

27. Prior to 11 February 2016 there were protracted negotiations between NHS Employers and the BMA¹² about the terms of a replacement contract for the employment of junior doctors. The Claimant does not propose to set out the detail of those negotiations. What is set out below focuses upon the statements and actions of the Secretary of State insofar as material to the issues in this case. All underlining in these extracts has been added for emphasis.
28. The Claimant notes that during the course of those negotiations the Secretary of State said on 16 July 2015 [B4/T6/p61] in a speech to the King's Fund:

“There will now be 6 weeks to work with BMA union negotiators before a September decision point. But be in no doubt: if we can't negotiate, we are ready to impose a new contract.”

29. On 17 November 2015 the Secretary of State wrote to the BMA [B6/T81], stating that:

“You have talked repeatedly about the government holding numerous ‘preconditions’ which prevent the British Medical Association from returning to negotiations. As I have made clear, including in our meeting following your election to lead the Junior Doctors’ Committee in September, and in public statements, there are no preconditions to talks

¹¹ The Claimant notes that this was a case in which the Secretary of State for Health's decision had been made/communicated by way of a statement in Parliament: see *R (London Borough of Lewisham) v Secretary of State for Health* [2013] EWHC 2381 (Silber J).

¹² At times the negotiations have also involved the Secretary of State/Department of Health – see, e.g. the ACAS document dated 18 May 2016 [B8/p2] - although it is unclear what his role has been.

whatsoever. We are prepared to negotiate about anything within the current pay envelope – but I am sure you understand that we have to reserve the right to make changes to contracts if there is no progress on one of the issues preventing a truly 7 day NHS, as promised in our manifesto ...” (underlining added)

30. On 30 November 2015 the Secretary of State made a statement in the House of Commons [B9/T5/p44], in which he referred to a:

“potential agreement ... between the BMA leadership and the Government. This agreement would allow a time-limited period during which negotiations can take place, and during which the BMA agrees to suspend strike action and the Government agree not to proceed unilaterally with implementing a new contract.”

He added [B9/T5/p47]:

“The hon. Lady [Heidi Alexander MP] has repeatedly called for the Government to remove the threat of contract imposition. Let me tell her why we cannot do that. It would give the BMA a veto over a manifesto commitment that has been endorsed by the British people ... We will suspend proceeding to the new contracts during the period in which negotiations happen – a short, time-limited period – and in return the BMA will suspend the threat of strikes for that time-limited period. Removing the threat of imposition permanently has not been agreed in any other part of the NHS or any other part of the public sector. The Government must balance the needs of patients, doctors and taxpayers and giving one of those groups a veto over any new contract would make it impossible to make that judgment.”

“... Governments of any party must have the right to set the terms and conditions of an employment contract. That is a right that no part of the public sector has moved away from, and it is a vital right for all employers. I have simply said that I will not move towards any new contract while negotiations are happening during this time-limited period.” [B9/T5/p48]

31. On 9 February 2016 Sir David Dalton, who was leading the negotiations on behalf of NHS Employers, wrote to the BMA summarising an offer on the substantive outstanding issues [B7/T107]. The letter contained the following ultimatum:

“I ask you to confirm to me in writing that you would publicly recommend this best and final offer with respect to these substantive issues, to the JDC¹³ and recommend that they endorse it as the proposition to be put to your members.

I therefore ask you to let me know by 3pm tomorrow at the very latest, whether you are both prepared to back the proposals and recommend their acceptance to your JDC. It is not possible to offer an extension to this deadline.

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

¹³ A reference to the BMA Junior Doctors Committee.

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 of reaching a negotiated agreement.”

32. The same day the Secretary of State, during questions in the House of Commons, referred to the possibility of imposing the contract [B9/T/6/p61]

“The Labour party is saying that if a negotiated settlement cannot be reached, we should not impose a new contract – in other words, we should give up on seven-day care for the most vulnerable patients.”

33. The BMA declined to provide Sir David Dalton with the assurance that he had requested (as set out in a letter from the BMA dated 10 February 2016 to the Secretary of State¹⁴).

34. In the absence of a final agreement between the negotiating parties, on 10 February 2016 Sir David Dalton wrote to the Secretary of State referring to this “final offer” and saying as follows [B7/T109]:

“Everyone’s first preference has always been for a negotiated outcome. Unfortunately this no longer seems possible. Following 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 a 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 whatever it deems necessary to end uncertainty for the service and to make sure that a new contract is in place which is as close as possible to the final position put forward to the BMA yesterday.”

35. On the following day, 11 February 2016, the Secretary of State made a Parliamentary statement in which he explained the decision he had reached in response to Sir David’s request [B9/T7/p63]. The Secretary of State stated:

“Along with other senior NHS leaders and supported by NHS Employers, NHS England, NHS Improvement, the 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 today decided to do that.”

36. The Secretary of State described the terms of the new contract which he had decided was to be used to employ junior doctors in the NHS. He explained that *“In such a situation [referring to*

¹⁴ The BMA repeated in its letter its suggested pay model, reiterating that it would provide the cost neutrality sought by NHS Employers whilst providing junior doctors appropriate recognition for evening, night and weekend work.

what he described as 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" and described the government as "taking a decisive step forward to help deliver our manifesto commitment" [B9/T7/p64-5].

37. The Secretary of State stated that there was "*support for imposition*" [B9/T7/p67] and referred to "*the contract that we are going to implement*" [B9/T7/p75]. The natural meaning of the words used by the Secretary of State was that the Secretary of State took the view that *he* had, on behalf of the government, made the decision to implement a new contract for junior doctors saying [B9/T7/p69]:

"When, as a Government, we took the decision to proceed with implementing 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 invites the Court to accept that, whatever later gloss or reinterpretation may have been attempted, this was the objective meaning of the words at the time they were used.

Events following the Secretary of State's decision on 11 February 2016

38. On 12 February 2016 Mr Daniel Mortimer, the Chief Executive of NHS Employers, sent an open letter to every junior doctor then working in the NHS [B8/p304-5]. The letter referred to the history of negotiations concerning a proposed replacement contract for junior doctors working in the NHS and then stated:

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

The letter concluded:

"... the new contract will be introduced by employers in a phased manner over 12 months from August 2016 and it is expected that implementation would be completed by August 2017. The new Guardian role will however be introduced in every trust in England from August 2016."

39. On 8 March 2016 the Government Legal Service ("GLS"), on behalf of the Secretary of State, responded to a letter before claim from the BMA [B9/T2/p28-9]. This letter suggested that no final decision had been made by the Secretary of State about the terms of the proposed contract:

“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”

“The Secretary of State has an open mind regarding the final terms of the new contract and if he considers it appropriate, would amend the final terms in the light and content of the EIA.”

40. It is apparent that the Secretary of State’s position, as set out in that letter, was that he was entitled to, and he intended to, make the decision about what would be the final terms and conditions of the new junior doctors’ contract.
41. On 31 March 2016, following the publication of the terms and conditions of the contract [B7/T121], NHS Improvement wrote to NHS Foundation Trusts and NHS Trusts advising, inter alia [B9/T19/p233],

“As you are aware, the government has announced its intention to introduce a new contract for junior doctors, with a phased introduction beginning in August 2016... The contract will be implemented in phases, starting in August 2016. Enclosed is a table which sets out the timescales for implementation by junior doctor grade and specialty ... Trust boards will need assurance that the new contract will be implemented effectively in your organisation ...”

42. NHS Employers published FAQs on 31 March 2016 which contain, in the Claimant’s submission, no suggestion that it was now up to NHS Trusts and other employers of junior doctors to choose what course to take or what contract to adopt: see, e.g., “*from 3 August 2016, the 2016 contract will start to be introduced*”, the government has “*no option but to introduce the contract*”; “*the government asked NHS Employers to prepare the full range of terms and conditions, guidance and materials to help both doctors and dentists in training and their employers understand and implement the 2016 contract from 3 August 2016*” [B1/T2/p401-2]¹⁵.

The pre-action protocol correspondence

43. On 4 April 2016 the Claimant, by its solicitor, sent a detailed letter before claim [B3/T3/p1-41]. The GLS responded by way of a letter dated 11 April 2016 [B3/T3/p46-5]. This letter confirmed that the Secretary of State had not issued any directions under the NHS Act and asserted that:

¹⁵ See also the letter from NHS Employers dated 1 April 2016 [B9/T16/202].

“24. 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. In so far as your letter is intended to assert that the Secretary of State is under some misapprehension as to his legal functions, this is incorrect.”

44. The Claimant notes that this letter averred a positive case that the Secretary of State had the power to make the decision to proceed with the introduction of a new contract for junior doctors and had exercised that power. However the letter did not explain the source of that power. The letter contained an express denial that the Secretary of State was under any misapprehension concerning his legal powers which, in the context of the letter, must be taken as an affirmation of his powers to take the decisions set out in the letter.
45. There was a further exchange of letters between solicitors on 12 and 15 April 2016 [B3/T3/p53-7, 66-70]. The GLS claimed that the Secretary of State was exercising a wide range of powers under the NHS Act and referred to sections 1, 1A, 1B, 1G and 2, which, it was said, enabled the Secretary of State to “*take a leading role in negotiations*”, “*approve the terms of model national contracts*” and “*take steps leading to the introduction of model national contracts*” by the various employers of junior doctors. It characterised the Secretary of State’s decision on 11 February as an announcement “*that a new model contract should proceed to be introduced*”. Thus the case put forward in these letters changed from the position taken in letter of 11 April. The new case was, essentially, that the Secretary of State had the power to signify his support for a new model contract for junior doctors which NHS bodies were recommended to use. The Claimant submits that the words used by the Secretary of State (before, on and after 11 February) could not reasonably be understood to mean (and were not in fact understood to mean) that the Secretary of State was merely signifying his support for a new model contract for junior doctors. That was not the decision that the Secretary of State had either made or announced.

Events on and after 18 April 2016

46. The present claim was issued on 18 April 2016.
47. On 18 April 2016 the Secretary of State made a further statement in Parliament [B4/T/ p90-91], explaining that:

“there has been no change whatsoever in the Government’s position since my statement to the House in February.... [Sir David Dalton] asked me to end the uncertainty for the service by proceeding with the introduction of a new contract without further delay. That is what I

agreed to, and what we will be doing. It will start with those in foundation year 1 from this August, and proceed with a phased implementation for other trainees as their current contracts expire ...”

48. In answer to a question (from Heidi Alexander MP) requesting a straightforward answer to a simple question (“*is the Health Secretary imposing a new contract – yes or no?*”) the Secretary of State responded as follows [B4/T15/p92-3]:

“Yes, we are imposing a new contract”.

He then drew a distinction between foundation and non-foundation trusts, explaining that:

“it is true that foundation trusts have the freedom to introduce new contracts on pay and conditions. They can choose to exercise that freedom, but none of them has done so. She asked about non-foundation trusts. They do not have that freedom, and that is why we will be introducing a new contract for everyone.”

The Secretary of State continued as follows:

“Leadership is not just about talking and negotiating; it is also about acting. That is what Ministers have to do, and in this situation we have a very simple decision to make after three years of talks: do we proceed with the measures necessary to deliver a seven-day NHS and better care for patients, or do we duck those decisions? This Government chose to act.” [B4/T15/p94]

49. The Secretary of State was asked to clarify his position¹⁶ and explained [B4/T15/p97]:

“We are introducing a new contract from this August, and it will be for all junior doctors. It will go progressively through the different ranks of junior doctors and, over the course of the new year, the vast majority of new doctors will move on to the new contracts. The reason that we did not use the word “impose” in the original statement was not a matter of semantics. We are proceeding with this new contract and everyone will move on to it, which is the gist of what most people mean by this.”

50. The Secretary of State had the following exchange with John Cryer MP [B4/T15/p99-100]:

*“Q On the basis of the Secretary of State’s previous comments, and particularly his opening comments, is he absolutely confident that he has the legal power to impose the new contract?
A Yes.”¹⁷*

¹⁶ See the question from Stella Creasey MP: “*The Secretary of State will be aware that, when it comes to a medical diagnosis, words and clarity matter. The same applies to us as politicians. He has said today that he is imposing a contract, in contrast with what his legal team are saying to the doctors. For the avoidance of doubt, will he set out explicitly what legal powers he thinks he has to do that?*”

¹⁷ See also the Secretary of State’s further reply (to the following question from Jo Stevens MP: “*If the Secretary of State is correct that he has the legal power to impose contracts, can he tell the House from where that power derives?*”) - “*... let me make it clear that the Secretary of State does have that power and that we are using it correctly and we will argue that case very strongly in the High Court.*” [B4/T15/p109]

51. He confirmed, further, that the decision had been taken by him (“*I reluctantly took the decision to proceed with the new contracts*” [B4/T15/p101]) and that its effect was as follows: “*Just to be absolutely clear, the new contract is legally binding and it will apply to all junior doctors in the NHS.*” [B4/T15/p108]
52. In the House of Lords on the same day, the Parliamentary-Under Secretary of State for the Department of Health, Lord Prior, repeated the Secretary of State’s statement explaining the decision that had been taken and added as follows:

“... the noble Lord [Lord Hunt] has raised two substantial points. The first is the difference between introduction and imposition. The fact is that, in the context of the NHS, where there is really only one offer, the difference between introduction and imposition is very small. Technically, it is true that individual employers are responsible for its imposition, but in reality ... the Secretary of State has considerable powers in this matter. I do not think the noble Lord would want all trusts to cut their own deals locally – there has to be an actual contract. It is true that when the legislation for foundation trusts was brought forward by the noble Lord’s Government a few years ago, they were given the power to negotiate their terms and conditions locally but, with the exceptions of, I think, Southend and possibly Guy’s and St Thomas’, they have chosen to stick with the national contract.”

In response to a further question¹⁸ the Parliamentary Under-Secretary of State replied:

“I do not think that the Secretary of State has been under any misapprehension about his powers in this matter. The BMA, on behalf of the junior doctors, is judicially reviewing his powers, but those powers are clearly set out in Section 1 of the 2006 Act. It is our position that he has always had those powers ...”

53. The Secretary of State wrote to Heidi Alexander MP on 22 April 2016 [B4/T17/p117] stating that:

“the new contract is being introduced without the agreement of the BMA. This is what you describe as ‘impose’ although I generally prefer to use the term ‘introduce’... This is being done by me, working together with NHS employers. In doing so, I am exercising my powers under the NHS Act 2006 (in particular sections 1, 1A, 1B, 1F, 1G and 2). NHS employers are using their employment powers, as they are the employers of junior doctors, not me. This is well established as a precedent in the NHS ...”

¹⁸ “Is not the reality of the situation that for many months the Secretary of State has used the language of coercion rather than compromise? It is abundantly clear that he never had the statutory authority to impose such a contract of service on the doctors. At what point was he first advised that he had no such authority?”

He asserted that he had made the scope of his powers clear at the outset of the debate (*“I said that while NHS Foundation Trusts can determine pay and conditions for the staff they employ, in practice, trusts opt to use national contracts”*) and claimed that he was not saying that he had the power to “impose” working alone, but *“working with NHS employers”*.

54. Further statements from the Secretary of State included the following:

- a. In a letter to the BMA dated 19 April 2016 [B4/T16/p115] the Secretary of State wrote that it was *“not now possible to change or delay the introduction of this contract without creating unacceptable disruption for the NHS”*
- b. In a further letter sent by the Secretary of State to the BMA on 23 April 2016 he asserted that *“the new contract for juniors is now being introduced following the failure of negotiations ... we will now be proceeding with the new contract”* [B4/T18, p119].
- c. The Secretary of State told Parliament on 25 April 2016 that:

“the Health Act 2006 makes very clear where my powers are to introduce a new contract, either directly or indirectly, when foundation trusts choose to follow the national contract” [B4/T19/p128]

“... it is a total tragedy when the Health Secretary ends up with no other choice but to impose. Had we sensible negotiations that would not have been necessary.” [B4/T19/p130]

“We proposed a sensible compromise ... but, as Sir David Dalton, the chief executive at Salford Royal, said, we had to decide quickly what we were going to do because the contracts are coming in this August and there is a process we have to go through.” [B4/T19/p131]

“What we have is a very intransigent and difficult junior doctors committee of the BMA, which has refused to negotiate sensibly. In that situation, the Health Secretary has a simple choice: to move forward or to give up. When it comes to patient safety, we are moving forward.” [B4/T19/p141]

55. On 5 May 2016 the Chief Executive of NHS Employers wrote that *“the Secretary of State has indicated his willingness to pause the unilateral implementation of the junior doctors contract to enable talks with the BMA”* [B9/T17/p208] – the implication being that the implementation of the contract was a matter for the discretion and judgment of the Secretary of State.

56. In May 2016 further talks between the BMA and NHS Employers took place. On 18 May 2016 it was announced that an agreement had been reached between the BMA, NHS Employers and the Secretary of State, subject to a referendum of the BMA's junior doctor members. On 27 May 2016 the proposed terms and conditions of the new contract were published by NHS Employers.
57. The referendum in relation to the new terms and conditions took place in late June. On 5 July 2016 it was announced that junior doctors had rejected the contract offer, with 58% of junior doctors voting against it. Following the announcement, Dr Malawana, the outgoing Chair of the BMA's Junior Doctors Committee (JDC), said that: *"The result of the vote is clear, and the government must respect the informed decision junior doctors have made. Any new contract will affect a generation of doctors working for the HNS in England, so it is vital that it has the confidence of the profession. Given the result, both sides must look again at the proposals and there should be no transition to a new contract until further talks take place"*.

On and after 6 July 2016

58. On 6 July 2016 the Secretary of State made a statement to Parliament on the junior doctors' contract [B5/T31/p334] explaining the decision he had taken. He announced that:

"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.

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."

Repeated reference was made by the Secretary of State to the "decision" which he had made. In response to a question from Heidi Alexander MP, asking for the source of the power to force hospitals to introduce the contract, the Secretary of State's response was that *"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 used 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"* [B5/T31/341-2]. The Secretary of State was clearly drawing a distinction (as he had previously) between NHS Foundation Trusts – which he seemed to accept had an entitlement to set their own terms and conditions (and therefore a choice in relation to any new contract) and NHS Trusts/other employers of junior doctors which, inferentially, had no such right.

59. In the House of Lords on the same date the Parliamentary Under-Secretary of State for the Department of Health explained the Secretary of State's decision in the following terms [B9/T38/p298-304]:

"The Government has decided that to help deliver their manifesto commitment for a seven-day NHS, they will now proceed with the phased introduction of the new, safer contract."

"The Secretary of State plans to introduce the new contract with NHS employers in a phased way beginning in November."

"The Secretary of State does have the power to introduce the new contract along with NHS employers."

"The Secretary of State is absolutely right to introduce this new contract".

60. Following the announcement by the Secretary of State on 6 July 2016, the Chief Executive of NHS Employers wrote to all Trusts [B9/T42/p336-7], informing them that *"the Secretary of State has just made a statement to the House of Commons outlining his intention to introduce the new contract"* (and see the response from the Royal United Bath NHS Foundation Trust on the same date - *"the SoS has decided to impose the contract"*).

61. At the same time NHS Employers issued a Circular (Pay and Conditions Circular (M & D) 2/2016) to its members [B8/p264]¹⁹, stating that²⁰:

"1. This Circular notifies employers of the instruction of the Secretary of State for Health to introduce new terms and conditions for all doctors and dentists in national training grades in England. The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 will become effective on 3 August 2016.
2 Doctors and dentists in training in England will begin or transition to new arrangements in line with the timetable published by NHS Employers.
3 The new pay arrangements and pay codes contained herein will become effective from 3 August 2016."

The reference to the *instruction* of the Secretary of State was amended²¹ - only after the matter had been raised by the Claimant's solicitors - on 25 July 2016 to refer to notifying employers *"of the introduction of a new model contract ..."* [B5/T33/p460].

¹⁹ The circular, with the same reference to "instruction", was also appended to the terms and conditions published on 6 July 2016 [B5/T33/p454].

²⁰ Underlining added for emphasis, as with all the extracts set out in this skeleton.

²¹ See the email from the Department of Health dated 19 July 2016 referring to the proposed amendment - *"the Pay Circular is, unintentionally, a little unclear in that respect."* [B8/p270].

62. NHS Employers published, at or about the same time,
- a. An “Implementation timeline”, which set out the dates on which different categories of doctors in training “*will*” transition to the new terms and conditions of service [B8/p209-211];
 - b. FAQs which stated that:
 - *“the 2016 contract for doctors and dentists in training will apply in England for trainees in hospital and community posts and public health posts approved for postgraduate medical/dental education. These will replace the current new deal arrangements ... The new contractual arrangements will also apply in England to general practice trainees”*
 - *“Most doctors and dentists in training will be moved onto the 2016 contract from October 2016, with the majority moving from their next available rotation date or in August 2017” ;*
 - *“on the 6 July the Secretary of State announced in the House that further talks were unlikely to bring resolution and that the new terms would therefore be introduced in England from August 2016”.*
63. Only one document published by NHS Employers at this time had a slightly different flavour: the *Public Sector Equality Guidance* which suggests that employers should “*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*” [B8/T198D].
64. On 28 July 2016 NHS Improvements wrote to Trusts 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.*” [B9/T22/p239].

How the Secretary of State’s decision has been understood

65. It is apparent that – unsurprisingly - the Secretary of State’s statements have been understood to constitute a firm decision by the Secretary of State to impose the contract, and not (as the

Secretary of State now contends) merely a decision to cease negotiations and to recommend the contract. See by way of example:

- a. the BMA's understanding as set out (for example) in its letter dated 29 February 2016 to all LNC chairs in England: "*the Secretary of State took the decision on 11 February to impose new terms and conditions on your colleagues*", "*the government's decision to implement this contract*" [B4/T5];
- b. the response of a number of the Chief Executives of NHS Trusts who were said to have supported Sir David Dalton's letter of 10 February 2016 – and who publicly confirmed following the Secretary of State's statement that they did not support contract imposition [B9/T25/p245] [B9/T31/p254];
- c. the understanding of the Royal College of Surgeons [B4/T8/67];
- d. the letter from NHS Employers to all junior doctors in England dated 12 February 2016, informing them that "*The Secretary of State has decided that the NHS must now introduce a new contract, without the agreement of the BMA, from August 2016*" (see above);
- e. the material published by NHS Employers, which paints overall a picture of a contract that will be implemented nationally, with a detailed implementation timetable set by the Secretary of State, rather than a mere recommendation or encouragement with employers being free to make their own choices;
- f. the correspondence from NHS Improvement, e.g. at [B9/T19/p233, B9/T22/p239];
- g. the reported observation of Professor Sir Bruce Keogh (medical director of NHS England) in March 2016 that "*the imposition of the contract was one of the saddest days I have seen in the NHS*" [B9/T33/p268];
- h. the clear understanding of a number of the Royal Colleges, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists, that the Secretary of State had decided upon contract imposition [B9/T26/p247; B9/T27-28/p248-250];
- i. the debates in Parliament that have followed the Secretary of State's statements;

- j. the understanding of NHS Trusts such as Royal Wolverhampton NHS Trust that it has no option but to impose the junior doctors' contract [B9/T30/p253] – see also Barking, Havering and Redbridge University Hospitals NHS Trust [B9/T34/p279];
- k. the observations of Professor Sir Bruce Keogh on 19 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”* [B9/T43];
- l. the reporting of the Secretary of State's decision in the media – see, e.g., B9/T29/p251;
- m. the understanding of junior doctors themselves – see, e.g., the statement of Dr Francesca Silman [B1/T2/p94]:

“Due to the imposition of the contract, many junior doctors now feel demoralised to the point that they do not wish to continue with their medical careers. Not a week goes by without me hearing of yet another doctor considering quitting medicine or going abroad to work. Furthermore, my friends that have gone abroad to work temporarily, have now told me that they will not return. Whilst this evidence is anecdotal, it is deeply concerning that we could lose a whole generation of doctors due to the imposition of a contract considered by most junior doctors to be unsafe and unfair. The strength of feeling is so great that I do not believe that the government has properly considered the impact on retention and recruitment of doctors following contract imposition. There could be a disastrous lack of doctors, and this in turn will increase rota gaps and perpetuate the problem further in a snowball effect, given how rota gaps are covered. Whilst the government has acknowledged that morale is a problem among junior doctors, and commissioned an independent review by Prof Dame Sue Bailey on this issue, it is ridiculous that they have excluded aspects of contract imposition from this study. All the junior doctors that I speak to, consider contract imposition as the most demoralising thing that could possibly happen to our profession, and I believe will drive doctors away from the profession. This could break a profession already stretched to its limits.”

- n. the current position of the JDC, as set out in a recent statement from its Chair, Dr McCourt:

“[The Secretary of State] continues to ignore our request to stop the imposition ... the BMA has repeatedly said that it will call off further action if the Secretary of State stops his imposition of the contract ...”.

SUBMISSIONS

Ground 1 – No power to take the decision which the Secretary of State purported to take

66. The Claimant advances the following core submissions in support of its first ground of challenge.

- a. The Secretary of State's statements are a matter for interpretation objectively by the court: see, e.g., *R (Parratt) v Secretary of State for Justice* [2010] 1 WLR 1848 at [32]; *R (Sainsbury's Supermarkets Ltd v First Secretary of State* [2005] EWCA Civ 520 at [16]; *R (Raissi) v Secretary of State for the Home Department* [2008] QB 836 at [122-123]; *Tesco Stores Ltd v Dundee City Council* [2012] UKSC 278 at [18] (“*in this area of public administration as in others ..., policy statements should be interpreted objectively in accordance with the language used, read as always in its proper context*”); *R (O) v Secretary of State for the Home Department* [2016] UKSC 19 at [28] (“*there is no dispute that the court's approach to the meaning of the policy is to determine it for itself and not to ask whether the meaning which the Home Secretary has attributed to it is reasonable*”).
- b. In seeking to establish the nature and meaning of the Secretary of State's decision - a decision of considerable public interest, with the potential to affect huge numbers of people both directly (junior doctors) and indirectly (all those involved in the NHS and the public at large) - the Court's focus should be on the Secretary of State's public statements, rather than confidential briefings by civil servants.
- c. It is abundantly clear from the material set out above that the Secretary of State communicated to both the members of the House of Commons and others that he had the power to make the decision as to the contract which would be used for the employment of junior doctors after the date when his decision took effect and that he was purporting to make such a decision and to announce it publicly in Parliament. In effect, he assumed the power to make a decision that NHS bodies would use a new form of contract for junior doctors. In fact, he has no such power.
- d. It is equally clear, construing the material objectively, that the Secretary of State did not express the view that he was merely making a *recommendation* to NHS employers about the type of contract that NHS bodies and others who were employing junior hospital doctors were *advised* to use after August 2016. The Secretary of State's statements made it clear that the Secretary of State was acting under the (mistaken) impression that he had *the power to make a final decision* about the terms of the proposed contracts and was exercising that power to make a decision or, at the very least, that the Secretary of State was acting as a joint decision maker. Everything that

the Secretary of State has said and done since is consistent with (and only consistent with) this position.

- e. Any suggestion that the decision announced by the Secretary of State on 6 July 2016 amounted to no more than a non-binding recommendation made to NHS employers is not a proper or reasonable interpretation of the words used by the Secretary of State, particularly when viewed against the background of the Secretary of State's earlier decisions and statements. The Parliamentary statement is not an expression of a recommendation on the part of the Secretary of State that the new contract *ought to* be introduced, but a statement of the Secretary of State's *decision* that the new contract *will* be introduced (see, e.g., "*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, 'the contract will be introduced from October this year', 'this is a difficult decision to make'*").
 - f. Whether one uses the term *impose*, *instruct*, *implement* or *introduce* (all of which are terms which the Secretary of State and/or NHS Employers have used during the course of this dispute) is immaterial. There is no relevant difference (as the Parliamentary Under-Secretary of State for Health explicitly acknowledged) between deciding to impose the contract and deciding that the contract will be introduced and it is clear that in July, as in February and April 2016, the Secretary of State has purported to take, and has publicly communicated, and was understood to have taken, a decision on behalf of the NHS that the new contract will be implemented.
67. It is instructive to consider the attempts have been made, by or on behalf of the Secretary of State, to draw a distinction between NHS Foundation Trusts and NHS Trusts. See, e.g.:
- a. the reference in *The Guardian* [B4/T8/p66] to a Department of Health spokesman confirming that: "*Foundation trusts are not mandated to bring in the new contract. They can negotiate locally. However, [non-foundation] trusts are [obliged to use Hunt's contract]*";
 - b. the response from Lord Prior (Parliamentary Under Secretary of State for Health) to a written question on 22 February 2016 [B4/T12/p73] "*The Secretary of State is not imposing the junior doctors' contract on National Health Service foundation trusts which are free to determine the terms and conditions, including pay, for the staff they employ*";

- c. the distinction drawn by the Secretary of State on 18 April 2016 between Foundation Trusts (“*they can choose to exercise that freedom [to introduce new contracts]*”) and non-Foundation Trusts (“*They do not have that freedom, and that is why we will be introducing a new contract for everyone*”);
 - d. the similar distinction drawn by Lord Prior on 18 April 2016 (see para 52 above);
 - e. the Secretary of State’s letter on 22 April 2016 to Heidi Alexander MP (see para 53 above);
 - f. the Secretary of State’s statement to Parliament on 25 April 2016 (in which he referred to Foundation Trusts being able to choose to follow the national contract); and
 - g. the Secretary of State’s reference on 6 July 2016 to Foundation Trusts having “*the legal right to set their own terms and conditions*”.
68. The clear inference (and in the case of the Secretary of State’s statements on 18 April, the express assertion) 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.
69. The Secretary of State’s line in these proceedings is that he has decided to “*introduce a contract without the agreement of the BMA, working together with NHS Employers*”. This formulation is question-begging. It fails to make clear what is meant by “*deciding to introduce*” or to “*deciding to proceed with the introduction of a new contract*”.

70. The Secretary of State's decision was, in the Claimant's submission, plainly imperative in nature. He has sought to make a decision and not just make a recommendation. The fact that he was invited to make this decision by NHS Employers and/or that he has made the decision together, in some unspecified way, with NHS Employers, does not prevent it being the Secretary of State's decision as opposed to making a recommendation where others will be the decision makers. However the Secretary of State has no such decision making power. In substance, it is just the "imposition" that he accepts he does not have the *vires* to carry out.
71. It does not assist the Secretary of State's case to say that he is "*working together with NHS Employers*". The NHS Act does not confer any greater or additional powers if he works together with NHS Employers than if he works without them.
72. Further,
- a. In relation to NHS Trusts, the Secretary of State is not entitled to use his general powers in section 2 of the NHS Act imperatively in relation to the use of a particular contract where he has relevant specific powers later in the Act to give directions – see the principle of *generalibus specialia derogant* i.e. "*Where the literal meaning of a general enactment covers a situation for which specific provision is made by some other enactment within the Act, it is presumed that the situation was intended to be dealt with by the specific provision.*" (*Bennion on Statutory Interpretation*, 6th edition, section 355, p1038).
 - b. In relation to other types of employers, the Secretary of State has no such power at all. If section 2 is not apt to include a power to decide that trusts will adopt a particular form of contract, then *a fortiori* it cannot include a power to decide that other types of employer will do so.
73. The statement made by the Secretary of State on 6 July (whether viewed in isolation from, or against the background of, his earlier statements) was decisive in character. It was not a statement that merely endorses a contract with a non-binding recommendation that employers should consider, and expressing the hope that they will fall into line. It is the Secretary of State who is deciding that negotiations should come to an end and that a contract should go ahead without the agreement of the BMA. The statement repeats the consistent assumption that other employers do not have the freedom to choose their own terms and conditions that Foundation Trusts do. It is the Secretary of State who is deciding the timetable for implementation, with no hint of "I have made this decision today, but we must wait to see what individual trusts decide". The message is

that this will happen on the timetable that he is setting out (and on the very same day NHS Employers sent out its payment circular which notifies employers - erroneously, it is now said - of “*the instruction of the Secretary of State for Health to introduce new terms and conditions of service for all doctors and dentists in national training grades in England*”).

74. None of the statutory provisions referred to by the Secretary of State empowered him to take a decision of this character, which is precisely why the Secretary of State has sought within these proceedings to characterise the decision he took as something other than what it was.
75. The Secretary of State has thus purported to take decisions that he had no legal power to take and has not acted in accordance with the limits of his statutory authority.

Ground 2: Breach of the common law duty of clarity

76. The Claimant submits that:
 - a. It is a “*requirement of good administration*” (to which the courts will give effect) that “*public bodies ought to deal straightforwardly and consistently with the public*”: see, e.g. *Nadarajah v Secretary of State for the Home Department* [2005] EWCA Civ 363 at [68] (per Lord Justice Laws)²².
 - b. It is a fundamental requirement of the rule of law that policies on the exercise of statutory criteria be transparent and clear, in order to avoid arbitrary and unlawful results, and that decisions taken by public officials in the exercise of their duties are also required to be transparent and clear. See, e.g., *R (Lumba) v. Secretary of State for the Home Department* [2011] UKSC 12, [2012] 1 AC 245, at [34] (per Lord Dyson): “*The rule of law calls for a transparent statement by the executive of the circumstances in which the broad statutory criteria will be exercised.*”
 - c. If a decision-maker must have and (usually) give adequate and intelligible reasons for his decision, *a fortiori* the nature of his decision must be clear and intelligible.

²² In *Nadarajah*, this requirement of good administration was held to be the basis for the doctrine of legitimate expectation.

- d. *“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 ...”* - see Blake J in *R (Limbu) v. Secretary of State for the Home Department* [2008] EWHC 2261 (Admin), at [65]. Blake J went on to hold, at [69], that *“transparency and clarity are significant requirements of instructions to immigration and entry clearance officers that are published to the world at large”* and concluded that the policy under challenge in that case either irrationally excluded material and potentially decisive considerations or *“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.”*
- e. These principles were recently accepted as a correct statement of the law by the Court of Appeal in *R (Oboh) v. Secretary of State for the Home Department* [2015] EWCA Civ 514, *per* Richards LJ at [28]-[29], and by Jay J in *R (Richmond Pharmacology Ltd) v The Health Research Authority* [2015] EWHC 2238 (Admin), in which he held that *“the Defendant’s public utterances fail the public law test of certainty and transparency”* [48] and [86].

77. The Secretary of State has acted unlawfully and in breach of the principles set out above:

- a. the Secretary of State has purported to make a series of decisions and public statements, which have been presented to the world at large as if the Secretary of State had the power to make such decisions;
- b. these decisions have been presented as decisions that NHS bodies must follow as opposed to constituting mere recommendations to NHS bodies and other employers of junior doctors (and there is evidence to suggest that they have been understood, and responded to, accordingly);
- c. when the Secretary of State was given the opportunity in *inter partes* correspondence (see, e.g., B3/T3/p75) to accept that his “decisions” were of solely political but not legal effect, despite the duty of candour resting on the Secretary of State, he failed to clarify the position;
- d. the statement which the Secretary of State made on 6 July 2016 provided the Secretary of State with a further and public opportunity to make the position, and the nature of

his decision and its legal consequences (or lack of them), clear – but instead the Secretary of State has perpetuated the confusion and lack of clarity;

- e. it is unlawful for the Secretary of State to use words that appear to amount to the giving of an instruction or the taking of a decision with legal effect if in reality the Secretary of State accepts that he is doing no more than expressing an opinion or making a recommendation;
- f. there is considerable evidence that those to whom the Secretary of State's decision was communicated believe that the Secretary of State has taken a decision which means that the new contract must now be introduced – see above under the heading *How the Secretary of State's decisions have been understood*. If the Secretary of State's submission is that the legal effect of his announcement has been misunderstood – by doctors, the media, Parliament, the public, the Royal Colleges and others - it is difficult to see how the Secretary of State can contend that he has discharged his duty of clarity.
- g. it cannot be in accordance with the duty of clarity and transparency for the Secretary of State to reinterpret his “decisions” as only being a series of recommendations;
- h. even if the Secretary of State's decisions could be characterised as mere advice, advice given in a manner which meant that it would be inevitably be regarded as binding may be unlawful (*R v Secretary of State for Health ex p Pfizer Ltd* [1999] 3 CMLR 875);
- i. applying the *Richmond Pharmacology* line, the Secretary of State's public utterances fail the public law tests of certainty and transparency.

Parliamentary privilege

- 78. The Secretary of State has indicated that he may take issue with reference by the Claimant to Parliamentary proceedings as being a breach of Parliamentary privilege.
- 79. 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 Claimant's reliance upon Parliamentary material in the present case falls within the latter category.

80. In *Toussaint v Attorney General of St Vincent and the Grenadines* [2007] 1 WLR 2825, the Privy Council summarised the position as follows (bold emphasis added)

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. *R v Secretary of State for the Home Department, Ex p Brind* [1991] 1 AC 696 is an example noted by Lord Browne-Wilkinson in *Pepper v Hart* [1993] AC 593, 639f. Similar recognition of this "established practice" is found in the speeches in *Wilson v First County Trust Ltd (No 2)* [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*".

81. In *Toussaint*, the Prime Minister had given one allegedly unlawful reason for a particular decision during a debate in the House of Assembly, and another lawful reason for the same decision in the published Government Gazette. The claimant sought to adduce evidence of what the Prime Minister had said during the debate as evidence of the unlawful motive of his decision. The Privy Council held at [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.”

82. Further an ultra vires decision by the Secretary of State does not cease to be an ultra vires decision only by the fact that the decision was announced in the House of Commons: see *Trust Special Administrator Appointed to South London Healthcare NHS Trust & Anor v London Borough of Lewisham & Anor* [2013] EWCA Civ 1409.
83. In the instant case:
- a. The Claimant accepts that the meaning of what the Secretary of State said in Parliament about the nature of his decision to impose/introduce the junior doctors’ contract is an objective matter, which is ultimately for the Court to decide. The Claimant’s submissions as to what the Secretary of State’s statements meant have been set out above.
 - b. The Claimant relies on what the Secretary of State said in Parliament (as objectively determined by the Court) as evidence of the nature of and reasons for his decision. As the Privy Council in *Toussaint* explained [29], “*ministerial statements to Parliament constitute a type of evidence, the importance of which is evident and well-recognised in the context of applications for judicial review*” and “*it would be ‘bizarre’ if challenges to executive decisions were hampered by ring-fencing what ministers said in Parliament*”. This would mean that ministerial decisions announced in Parliament would be less readily open to examination than other ministerial decisions: “*A source of protection of the legislature against the executive and the courts would be converted into a source of protection of the executive from the courts and the rule of law*”.
 - c. The Claimant alleges that the decision was *ultra vires* and that the reasons for it were irrational.
 - d. The Claimant does not call the Secretary of State’s pronouncements in Parliament into question but relies upon them to establish what decision the Secretary of State made.
 - e. To the extent that there is any inconsistency between what the Secretary of State said in Parliament and what he has said to the Court in these proceedings, it is the latter which is to be doubted.

- f. To the extent that the Secretary of State wishes to remedy any such inconsistency by contending that he did not mean what he said in Parliament, then it is open to him to do so, but it is then he rather than the Claimant who is questioning or challenging what was said in Parliament: see *Toussaint* at [23].

Ground 3: Irrationality

84. The Secretary of State's decision to impose/introduce a contract without the agreement of junior doctors was, self-evidently, a very significant one. Like any other public law decision, it required proper reasoning and a sound evidential foundation. The fact that there is an active political debate about a number of these issues does not absolve the Secretary of State from having to make decisions which are rational in the public law sense and have been taken by reference to all the relevant material considerations.
85. The Claimant submits that, even if the Secretary of State had the power to act as he did, his decision in relation to the contract was irrational because there was no, or no sufficient evidence, to support a central rationale for the imposition/introduction of the contract, the reasons put forward by the Secretary of State fail to add up and the Secretary of State failed to take sufficient steps to acquaint himself with, and take proper account of, relevant information, fairly presented and properly addressed (see *Secretary of State for Education and Science v Tameside MBC* [1977] AC 1014 at 1065B²³ and the cases cited in *Judicial Review Handbook*, 6th edition, para 51.1.1 *et seq*).
86. In advancing this ground, the Claimant relies upon the public law principles usefully summarised in *De Smith's Judicial Review* (7th edition) at 11-036, 11-037 and 11-052, namely:

“Although the terms irrationality and unreasonableness are these days often used interchangeably, irrationality is only one facet of unreasonableness. A decision is irrational in the strict sense of that term if it is unreasoned; if it is lacking ostensible logic or comprehensible justification. Instances of irrational decisions include those made in an arbitrary fashion, perhaps “by spinning a coin or consulting an astrologer”. In such cases claimant does not have to prove that the decision was “so bizarre that its author must have been temporarily unhinged”, but merely that the decision simply fails to “add up - in which, in other words, there is an error of reasoning which robs the decision of logic”.

²³ *Per* Lord Diplock: “the question for the court is, did the Secretary of State ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?”

““Absurd” or “perverse” decisions may be presumed to have been decided in that fashion, as may decisions where the given reasons are simply unintelligible. Less extreme examples of the irrational decision include those in which there is an absence of logical connection between the evidence and the ostensible reasons for the decision, where the reasons display no adequate justification for the decision, or where there is absence of evidence in support of the decision. Mistake of material fact may also, according to recent cases, render a decision unlawful.”

***“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.”*

87. The central reason that has been publicly stated 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. See, for example,

- a. Paragraphs 4-8 of the Doctors’ statement [B2/p520] referring to a range of statements made by the Secretary of State (“6,000 avoidable deaths every year”, “there are 11,000 excess deaths because we do not staff our hospitals properly at weekends”, “study after study has shown that our mortality rates at weekends are too high”).
- b. The Secretary of State’s letter dated 19 January 2016 [B9/T8/p78]– “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”.
- c. The Secretary of State’s various statements to Parliament:

“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. 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.” [B9/T/7/p64]

“The choice I had to make was to do something about mortality rates at weekends or to duck the issue.” [B9/T7/p76]

Reiterating the government’s concern *“about higher mortality rates at weekends in our hospitals”* [B4/T15/p90]; *“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”* [p101]; *“a person admitted at the weekend has an 11% to 15% higher chance of death than if they were admitted in the week – that is proven in a very comprehensive study”* [p103]; *“what we want to do is reduce the difference between mortality rates for people admitted in the week and at weekends”* [p106].

88. The Secretary of State has claimed that seven-day services in hospitals will be achieved through the implementation of four priority clinical standards for urgent and emergency care and that *“these are about ensuring patients get timely consultant assessment and review and access to the urgent diagnostic tests and consultant-led interventions they need, whatever day of the week they are admitted. Our priority is urgent and emergency, rather than elective care”* [B9/T8/p78].

89. The Claimant notes that:

- a. Whilst the priority standards focus on the role of *consultants*, the Secretary of State’s decision has been to impose the contract for *junior doctors* – see further, the evidence of Ben Gummer MP, the then Parliamentary Under-Secretary of State for Quality at the Department of Health, on 21 March 2016 [B9/T10/p135, 137]: *“the Secretary of State ... has never made a causal link precisely with junior doctors’ working hours. He has said that it is the working patterns of the NHS as a whole... The standard at the moment is not as good at the weekend, because they do not have consultant cover”*.
- b. Whilst the report of the Review Body on Doctors’ and Dentists’ Remuneration [B6/T7] reported the views of some responders that the junior doctors’ contract was a source of “some barriers” to the delivery of more 7 day services, this has been inflated and/or misunderstood subsequently to suggest that the junior doctors’ contract was a “significant” or “considerable” barrier to change (see, e.g. [B9/T3]).
- c. What is meant by the concept of the seven-day NHS is unclear and lacks definition. (and if the focus is on urgent and emergency care rather than elective care, the contract

imposed nonetheless applies across the board to all levels of training and all specialities).

90. The material upon which the Secretary of State has predominantly relied is the Freemantle study, published in September 2015 [B2/T7/p617], 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”*. However, even assuming (contrary to the case set out below) that the Secretary of State was entitled to base his decision on this study (to the exclusion of the other research material detailed below), the Freemantle study did not provide a sound or 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 study also concluded that *“patients already in hospital over the weekend do not have an increased risk of death.”* At best (from the Secretary of State’s perspective) the study suggested that *“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”*.
91. It is to be noted that an email from the Department of Health’s press office dated 4 September 2015 pointed out that *“The Nuffield Trust²⁴ and Imperial College London have commented to say it is not clear how or to what extent investment in seven day services will reduce weekend deaths, and that the costs may outweigh any benefits. Plus there may be a gap across the rest of the week because of this”* [B2/T8/p623]. Lest the Secretary of State was under any misapprehension as to the limitations of the Freemantle paper in this regard, a letter from BMJ’s editor-in-chief to the Secretary of State on 20 October 2015 pointed out that whilst Freemantle found a statistical excess of deaths in patients admitted at weekends, *“what it does not do is apportion any cause for that excess, nor does it take a view on what proportion of those deaths might be avoidable”* [B2/T39/p1126].

²⁴ And see B2/T8/p625: *“Helen Crump at the Nuffield Trust says that it is not clear how or to what extent investment in seven day services will reduce weekend deaths, and that the costs may outweigh any benefits. She also warns that, unless overall staffing levels increase, ramping up services at the weekend “will leave a gap in the hospital’s weekday rota, with potentially serious consequences across other services”*.

92. What was required, therefore, as a matter of rationality and of logic, was further work in an attempt to gather proper evidence as to the causes of the “weekend effect” – to understand why (if the Freemantle data was correct) these things happen. Instead, the Secretary of State drew such “rash and misleading” assumptions and/or inferences, and proceeded to take action, in the absence of any evidence to show that the mortality rate was caused by a lack of junior doctors, upon a significantly over-simplified view of the evidence.
93. As set out in the Doctors’ statement at [B2/p521-2, paras 14-15], there were at the time of the Secretary of State’s decisions a range of independent and peer-reviewed papers refuting, undermining and/or qualifying the “weekend effect” claims. See, e.g.:
- a. *Mortality in out-of-hours emergency medical admissions – more than just a weekend effect* (Maggs et al) [B2/T16/p931-4] – at p. 934 “*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) [B2/T/17/p935-941] - at p939 “*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) [B2/T18/p942-9] - “*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) [B2/T19/p950-6] - “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. Obstetric consultant weekend on-call shift patterns have no effect on the management of spontaneous labour in a large maternity hospital (Woods et al) [B2/T20/p958-962].
- f. Mortality from meningococcal disease by day of the week: English national linked database study (Goldacre et al) [B2/T21/p963] – at p970 “There was no evidence of excess deaths from meningococcal disease associated with weekend care”.
- g. Effects of Out-of-Hours and Winter Admissions and Number of Patients per Unit on Mortality in Pediatric Intensive Care (McShane et al) [B2/T22/p972-982] – at p976 “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 re 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”.
- h. Out-of-hours primary percutaneous coronary intervention for ST-elevation myocardial infarction is not associated with excess mortality (Rathod et al) [B2/T23/p983-991] – at p989 “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”.
- i. A multicentre cohort study assessing day of week effect and outcome from emergency appendicectomy (Ferguson et al) [B2/T27/p1023-1031] – “This study found that weekend appendicectomy was not associated with increased 30-day adverse events”.
- j. Emergency medical admissions, deaths at weekends and the public holiday effect (Smith et al) [B2/T28/p1033-8] – at p1036 “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”.

- k. *Biases in detection of apparent ‘weekend effect’ on outcome with administrative coding data: population based study of stroke* (Li et al) [B2/T29/p1039] – at p1039
“Retrospective studies of UK administrative hospital coding data to determine ‘weekend effects’ on outcome in acute medical conditions, such as stroke, can be undermined by inaccurate coding, which can introduce biases that cannot be reliably dealt with by adjustment for case mix”.
- l. *Higher mortality rates amongst emergency patients admitted to hospital at weekends reflect a lower probability of admission* (Meacock et al) [B2/T30/p1048-55]. This report is particularly important and some of its conclusions are therefore set out below (p1054):

“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 during 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.”

- m. *Adjusting for illness severity shows there is no difference in patient morality at weekends or weekdays for emergency medical admissions* (Mohammed et al) [B2/T33/p1073-1095]: *“Patients who have an acute admission over the weekend with a NEWS recorded within 24 hours are sicker, have earlier clinical assessments, and after adjusting for their illness severity do not appear to have a higher risk of death compared to weekday admissions”*

94. This was material was of such centrality to the reasoning process of the Secretary of State that it required as a matter of law to be carefully considered and weighed as part of any rational decision-making process – but was not. Indeed the Secretary of State was dismissive about other studies in, for example, his evidence to Health Committee on 9 May 2016 – *“We can get into discussions about the different studies but the most comprehensive study was the Freemantle study”* and *“the mistake for a Health Secretary is to look at the overwhelming amount of evidence there is of a weekend effect and decide to get off the hook by disputing the methodologies”* [B9/T/13/p188]. Methodologies are, however, important, for the reasons set out in the Doctors’ statement [B2/p519 *et seq*].

95. The fundamental flaws in the Secretary of State’s reasoning is usefully described in the following extract from a report by BOTA²⁵ [B1/T2/p415]:

“The BMA, BOTA and doctors in general have never opposed a 7-day NHS service. If the driver for change is to reduce preventable deaths, then first robust, unbiased, evidence must be provided to supply the NHS and the public with data to support this being a problem. If this is done, and excess mortality is due to the current model of weekend working, then extra funding and resources must be made available to reduce mortality for emergency admissions. It is important to note that 7-day acute round the clock care is and has been available in the NHS for many years. With the systematic lack of sufficient funding, staff shortages (both nursing and medical), the NHS can just about stay running a 7-day acute service using

²⁵ British Orthopaedic Trainees Association.

skeleton staff on the weekend, many of whom work longer than their contracted hours due to the higher workload. NHS staff have pleaded for extra funding to allow the current model to continue providing the service it does. More staff are required during the week and on weekends, but this has a financial cost.”

See, also, the evidence of Dr Stephen Watkins, pointing out that studies are under way to identify whether the time pattern of occurrence of excess deaths in those admitted at weekends supports the hypothesis that the excess deaths are due to poor care at the weekend, or whether it supports the hypothesis that they are an artefact of admission patters which lead to admitting only people who cannot wait until normal services resume [B1/T2/p344-5]; and the reference to a leaked Department of Health report to the effect that the Department “*cannot evidence the mechanism by which increased consultant presence and diagnostic tests at weekends will translate into lower mortality and reduced length of stay*” [B1/T2/p398].

96. In the absence of any obvious link between mortality at weekends and the role of junior doctors, the Secretary of State has referred to reports of junior doctors feeling unsupported and the “*threat to morale*”, stating “*that is why we are starting out a proper seven-day NHS, particularly for junior doctors who work in A and E departments at weekends, where they often do not have the support they would get during the week and do not have as many consultants around as there would normally be. That is what we are trying to put right*”. It is unclear how imposition/introduction of a contract which the majority of junior doctors have rejected could rationally be thought to fulfil that objective [B9/T7/74].
97. The further significant difficulty with the Secretary of State’s decision-making is the problem exposed by existing evidence about rota gaps and the failure to grapple with the knock on effect of spreading the current hospital workforce “*even more thinly over seven days*” (see Dr Silman’s statement [B1/T2/89 at [10]] – because in order to provide more cover at weekends, doctors will need to be removed from weekday duties to provide extra weekend care, thereby reducing weekday levels of care. Evidence includes:
 - a. The evidence from the President of the Royal College of Physicians on 18 March 2016 [B1/T2/p200-5] as to the “*increasing problem in recruiting enough doctors*”, vacant consultant posts and reported gaps in junior doctors’ rotas (“*If we have neither enough trainees nor consultants to run the service now, how are we going to implement a safe seven day service by the end of this parliament?*”).

- b. Similar concerns expressed by Dr Clare Gerada [B1/T2/p304], the former Chair of the Council of the Royal College of General Practitioners.
 - c. The statement of Dr Benjamin Dean [B1/T2/293-3].
 - d. The evidence of Dr Pete Campbell and the Mind the Rota Gap survey [B1/T2/435, B1/T2/p480, p498].
 - e. The Royal College of Physicians' census of consultant physicians and higher specialty trainees (reported 2 February 2016) which highlighted significant concerns about filling gaps in trainee rotas [B1/T2.p502].
 - f. Similar concerns expressed in a workplace survey (Rota Vacancies and Compliance Survey undertaken between January and March 2016) published by the Royal College of Paediatrics and Child Health [B1/T2/p505].
 - g. Statements made by Chris Hopson (the Chief Executive of NHS Providers – the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients in the NHS, to which some 96% of all trusts belong) on 11 September 2016, to the effect that the 7 day NHS is impossible to achieve within current funding and staffing levels [B9/T46 & T47] (*“impossible on the current level of staff and the current money we have available”*). Mr Hopson also drew attention to the challenge of *“unprecedented staff shortages, including nurses, key specialists, GPs and emergency doctors”*.
98. Moreover, the Department of Health's own confidential Risk Register for 7 Day Services Programme (recently obtained and published by the Guardian) identified 13 risks with regard to the implementation of the programme, including [B1/2/433-4]:
- a. *Brexit* The risk that the planned exit from the EU may adversely impact upon the delivery of the 7 day services programme with regards to workforce and finances.
 - b. *Outcomes* Because the objectives and scope are not fully agreed upon, but delivery has started, it is possible that the programme delivers the planned outputs but this does not result in the desired change. Risk is evaluated as 4 in terms of both likelihood and impact.
 - c. *Publication* Risk that “we are unsighted” on the publication of R & D commissioned research which challenges the case for 7DS and are unprepared to respond.

- d. *Workforce overload* – due to the scale of the challenge being delivered through the 7DS programme, it is not possible to fill all roles with sufficiently skilled/trained staff to agreed timescales.
99. The Claimant notes further the evidence given by Mr Massey at a hearing of the House of Commons Public Accounts Committee on 23 February 2016 about the costs implications of the 7-Day NHS, including as they related to the junior doctors’ contract (emphasis supplied throughout) [B9/T9/109]:

“Seven day services were very much part of the conversations that informed the decisions that were taken as part of the spending review. At the moment, we are working with eight trusts and precisely what the implications of 7 day services will mean. It differs substantially from one Local Health economy to another.

(...)

My view, and that of all leaders across the health and care system, would be that it is difficult right now to get a precise figure or to have a mechanical approach for how you would deliver seven-day services in different areas. It will differ from one place to another, and that is precisely what we are thinking through....”

100. The definition of seven-day working was described as being “*very much around urgent and emergency care admissions at weekends*” and “*ensuring that there is the right senior clinical decision-making support at weekends*” [B9/T9/110]. In a telling exchange about the cost of implementing seven day working, Mr Massey was questioned and answered as follows [B9/T9/p115-118]:

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 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.*

101. This absence of sufficient data or modelling to underpin the Secretary of State's objectives further undermines the coherence, rationality and logic of his position.
102. In these circumstances, the Secretary of State could not rationally have concluded that the introduction or imposition of the junior doctors' contract would have the effect of or contribute towards "sorting out a proper seven-day NHS" or reducing mortality rates.

Response to the Judge's note

103. The Claimant's response to the issues raised by the Judge has largely been addressed above and will be developed further by way of oral submissions. In short, the Claimant's position is as follows:
 - a. Question 1: The Claimant understands this to be directed towards the Secretary of State. The Claimant's submissions as to the nature, content and subject of the decision that the Secretary of State has taken are set out above.
 - b. Question 2: The Claimant accepts that the Secretary of State can express an opinion about the merits of the new contract and can make a (non-binding) recommendation. He cannot, however, be a decision-maker (jointly or singly) as to the terms of the new

contract. The Claimant does not consider that the decision made by the Secretary of State can sensibly be interpreted as a non-binding recommendation.

- c. Question 3: The short answer to this question is no. The Secretary of State does not have the power to take a decision to compel adherence to terms and conditions of employment, or to take over decision-making power for another NHS body. The Secretary of State has a power to issue directions to NHS Trusts under section 8 but has not done so.
- d. Question 4: The Secretary of State's powers under section 2 do not extend to the power to impose decisions on other NHS bodies or to take over the decision-making of other NHS bodies in relation to the terms on which they employ junior doctors. Such case law as there is on section 2 and on incidental powers in the local government context (such as *R (Whapples) v Birmingham CrossCity CCG* [2015] EWCA Civ 435 and *R (on the application of W) v Secretary of State for Health* [2015] EWCA Civ 1034, [2016] 1 WLR 698) does not support an argument that section 2 would entitle the Secretary of State to take the decision under challenge in the present case. Section 2 would permit the making of a recommendation – but not of course an irrational recommendation or one made on a fundamentally flawed analysis of the relevant data.
- e. Question 5: The decision under challenge is that of 6 July 2016 and that is the point in time at which the issue must be assessed. The Secretary of State's earlier statements and decisions are highly material to the court's construction of the decision under challenge. The 6 July decision has not been withdrawn or revoked by the Secretary of State. Any subsequent clarification of the Secretary of State's position would not affect the lawfulness of the decision. If the decision was unlawful at the time it was made, the claim should succeed.
- f. Question 6: Clarity on the part of employers (if it exists, which the Claimant does not consider to be the case) does not alter the legal analysis in substantive terms and should not (for reasons summarised below under the heading *Remedies*) affect the grant of relief.

Remedies

104. The Claimant seeks an order quashing the decision(s) of the Secretary of State; declarations that the Secretary of State had no power to make the decision which he purported to make on 6 July 2016, that the purported contract imposition was unlawful and that the Secretary of State has acted unlawfully for the reasons set out above; and such further declaratory or other relief as the Court thinks fit or to give effect to the judgment of the Court.
105. The Secretary of State has now asserted (but did not assert at the time) that he made a non-binding recommendation to employers of NHS doctors to use his preferred form of contract. However, no proper interpretation of the Secretary of State's words could have led an informed, independent observer to believe that this was the decision that Secretary of State had made. These are two very different types of decision :
- a. the Secretary of State's decision that NHS employers either will or are permitted to use the Secretary of State's preferred form of contract when employing junior doctors; and
 - b. the Secretary of State's decision to make a non-binding recommendation that NHS employers are recommended to use the Secretary of State's preferred form of contract when employing junior doctors.
106. The Secretary of State made the former decision and did so unlawfully for the reasons set out above. No decision of the latter type has ever been made by the Secretary of State. It follows that if the Claimant succeeds on grounds 1 and/or ground 2 (whether the Claimant succeeds or fails on ground 3), the court should quash the Secretary of State's decision and leave it to the Secretary of State to decide whether to make a fresh lawful decision in the form of a non-binding recommendation.
107. If hereafter the Secretary of State makes a non-binding recommendation that NHS employers are recommended to use the Secretary of State's preferred form of contract, this should be a fresh decision with proper reasons because:
- a. junior doctors need to know the reasons and be able to test the lawfulness of any reasons; and

- b. junior doctors need clarity about their right to continue to be employed under the current contract and/or to negotiate different terms at a local level (which is presently not practically possible if some NHS employers believe they are only entitled to use the Secretary of State’s preferred form of contract as set out above); and
 - c. those who employ junior doctors need clarity about their entitlement to choose to contract with their employees on terms different from the Secretary of State’s preferred form of contract; and
 - d. the public interest so requires.
108. Further the material relied upon by the Claimant in relation to ground 3 supports a case that the Secretary of State made his decision on the basis that use of the Secretary of State’s preferred form of contract was either needed or justified on patient safety reasons in connection with the promotion of the “7 day NHS” policy in order to prevent weekend deaths of NHS patients. A further reason why the decision of the Secretary of State should be quashed is that, assuming the court finds the Secretary of State acted unlawfully in reaching his decision and/or there was insufficient evidence to support such a reasoning process, it may be irrational for the Secretary of State to take a fresh decision to recommend NHS employers to use the Secretary of State’s preferred form of contract on patient safety reasons in connection with the promotion of the “7 day NHS” policy.

JENNI RICHARDS QC
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12 September 2016