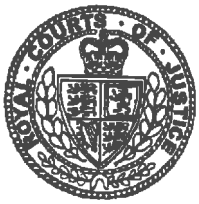

Neutral Citation Number: [2014] EWHC 2735 (QB)

Case No: TLQ/14/0390

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31 JULY 2014

**Before :**

**MRS JUSTICE SIMLER DBE**

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**Between :**

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| **DR CHAKRABARTY** | **Claimant** |
| **- and -** | |
| **IPSWICH HOSPITAL NHS TRUST** | **Defendant** |
| **And** | |
| **THE NATIONAL CLINICAL ASSESSMENT SERVICE** | **Interested Party** |

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**Mr William Edis QC and Mr Robert Wastell (instructed by Eastwoods Solicitors) for the Claimant**
**Mr Giles Powell and Ms Nicola Newbegin (instructed by Mills & Reeve LLP) for the Defendant**
**Mr Mark Sutton QC and Mr Ben Cooper instructed by Capsticks LLP for the National Clinical Assessment Service (Interested Party)**

Hearing dates: 2 ,3 ,4 ,7,8 & 9 July 2014

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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MRS JUSTICE SIMLER DBE

## MRS JUSTICE SIMLER DBE :

### Introduction

1. The Claimant, who is employed by the Ipswich Hospital NHS Trust (referred to as "the Trust"), seeks a permanent injunction restraining the Trust from referring his case to a capability hearing panel to consider the extent of any deficiencies in his capability or competence to work as a Consultant in Cardiology and General Medicine under the Trust's internal competence/capability procedures which are referred to as "the ADCP" and the national procedure known as "Maintaining High Professional Standards in the Modern NHS" ("MHPS") which the ADCP sought to implement at Trust level.

2. The primary basis for the injunction sought is that there has been no assessment of the prospects of success of remediation in the Claimant's case by the National Clinical Assessment Service ("the NCAS") and accordingly the Trust cannot lawfully proceed to a capability hearing at all. The alternative basis is more limited: the Claimant contends that the Trust should await the outcome of General Medical Council ("GMC") proceedings in relation to his performance and fitness to practise, either by awaiting the final conclusion of such proceedings, or at least by awaiting the decision of the Medical Practitioners' Tribunal Service (referred to as the "MPTS") which is the adjudicatory arm of the GMC. No claim for damages is pursued in these proceedings and the Claimant has remained on full pay. The Trust denies the allegations of breach of contract and contends that it is entitled to proceed to a capability hearing which can consider and determine issues relating to the Claimant's capability and continued employment, including the question whether there should be any adjournment of the hearing pending the decision of the MPTS.

3. The enquiry held by the MPTS commenced in January 2014, but there was insufficient time available for it to reach a conclusion. It has been re-listed to be tried to a conclusion between 18 September and 1 October 2014. Accordingly there is some urgency in addressing the issues raised by the Claimant in this case.

4. The NCAS was joined as a party to these proceedings by order of Lewis J dated 18 June 2014. It argues that the Claimant's primary claim raises issues concerning the scope of its powers and the manner in which it discharges its functions that have a wider impact than this case alone; and contends for an alternative construction of paragraphs 14 and 15 of part IV of MHPS than that identified in Lim v Royal Wolverhampton Hospitals NHS Trust [2011] EWHC 2178.

5. I have had the benefit of helpful submissions (both in writing and orally) from representatives on all sides: for the Claimant, William Edis QC and Robert Wastell; for the Defendant Trust, Giles Powell and Nicola Newbegin; and for the NCAS, Mark Sutton QC and Ben Cooper. I am grateful to them all.

6. This judgment firstly deals with the material facts. In many instances the facts are not in dispute or are evidenced by contemporaneous correspondence or other documentary records. In some cases however, there are factual issues in dispute and I set out my conclusions on those factual issues. Secondly, I deal briefly with the legal framework. The legal principles are largely undisputed. A significant issue is raised regarding the proper construction of paragraphs 14 and 15 of MHPS; but more generally, it is the application of the legal principles to the facts that is in issue in this case. Thirdly, I deal with the question whether or not any of the grounds for a final injunction against the Trust have been established.

7. I heard evidence from the Claimant, who was cross examined. In addition to the statement prepared for this trial, he has exhibited the witness statement prepared for the MPTS hearing which sets out his detailed response to the GMC assessment report, together with a statement of facts and solicitor's witness statement relied on by him in the judicial review proceedings he brought against the GMC. There is also a substantial trial bundle consisting of four volumes of correspondence and a number of bundles of materials relating to the GMC processes and NCAS. On behalf of the Trust, Peter Donaldson, Medical Director from 1 October 2007 to 31 March 2013, gave evidence in accordance with his witness statement and was cross examined; as did his predecessor in the role of Medical Director from 1992 until October 2007, Ian Scott. Julie Fryatt, Director of Human Resources for the Trust from September 2008 to September 2013, also gave evidence and was cross examined. For the NCAS I heard from Steven Preece, a lead adviser at the NCAS since November 2008, who gave evidence and was cross examined.

8. I am concerned only to find the facts necessary to address the issues raised by this claim for injunctive relief. The underlying substantive issues about the Claimant's capability and competence are not relevant to the questions I must address. The parties have reminded me of the importance of avoiding making findings save where to do so is strictly necessary for the purpose of determining the issues before me, so as to avoid any finding that might prejudice or influence the outcome of the MPTS hearing which is currently addressing the fitness to practise issues. The question for me is whether the Trust should be restrained from convening a capability hearing panel and that depends primarily upon whether to do so would breach the express and/or implied terms of the Claimant's contract of employment. Accordingly, my principal area of factual enquiry concerns the terms of the Claimant's contract of employment and whether the Trust is acting or threatening to act in breach of those terms, and if so, with what consequences.

## The Facts

9. The Claimant's appointment by the Trust as a Consultant in Cardiology & General Medicine was confirmed on 6 November 2003. He commenced work with the Trust on 1 March 2004. It is common ground that the Cardiology department was a busy one. At the time there were two substantive consultants (one of whom was planning a training sabbatical), a new angiographic suite in the process of commission and new targets to meet for outpatient and elective care. As a consultant, the Claimant was expected to

demonstrate initiative in leading and developing the service and as the most highly qualified and experienced clinician in the department, he was expected to lead by example and take responsibility for the supervision and training of junior doctors with whom he worked.

10. Between October and December 2004 concerns were raised regarding the Claimant's practice and performance. The nature of the concerns raised included issues about the inappropriate fitting of a pacemaker to the extent that it would not work; incorrect use of the connecting leads; and inappropriate suturing. Concern was also expressed about an apparent lack of knowledge of basic theatre infection control procedures. The Claimant was advised as a result not to undertake pacemaker activity until after further training had been given to him. The concerns were investigated by the Trust's Deputy Director of Human Resources, Jennifer Canham by way of preliminary investigation. By a report dated 31 December 2004, she concluded that a full investigation should be undertaken by a senior clinician.

11. By letter dated 24 February 2005, Mr Scott wrote to the Claimant to explain that he had appointed Dr Anthony Nicholl, Associate Medical Director, to carry out an investigation into the concerns that had been raised and to ascertain the relevant facts. The letter stated that the investigation would be carried out under the Trust's internal disciplinary and capability policy, known as the Additional Disciplinary and Capability Policy and Procedures and General Rules of Conduct for Medical Staff (and referred to below as "the ADCP") which implemented the procedures established by MHPS, and explained that the investigation did not constitute disciplinary action.

12. During the period of the investigation, a critical patient incident took place as a result of which the Claimant was excluded from cardiac catheterisation activity.

13. Dr Nicholl's report dated 15 April 2005 identified concerns in relation to the Claimant's clinical competence, including outpatient work, ward work, pacemaker work and cardiac catheterisation. Among other things, the Claimant's pacemaker technique was described as "rusty" and it was said that he failed to observe basic standards of sterility and appeared unfamiliar with techniques for wire fixation, wiring and suturing such devices. Dr Nicholl's report also identified reservations about the Claimant's ability to manage his medical team and to liaise with nurses and other clinical staff.

14. In accordance with the ADCP, Ian Scott was the Case Manager in relation to the investigation. A meeting with the Claimant to discuss Dr Nicholl's findings was organised and he was sent a copy of the report. Before the meeting took place further concerns were raised about the Claimant by other practitioners. The Claimant sought details of these concerns.

15. Mr Scott prepared a report as Case Manager, dated 27 June 2005, referring to

> "significant clinical competence issues raised over placement of pacemakers and cardiac catheterisation are real and of considerable concern. I think they have been dealt

> with appropriately thus far but I would require evidence from respected clinicians outside the trust that Dr Chakrabarty is capable of independent practice in both arenas before he returns to work implanting pacemakers or carrying out cardiac-catheterisation."

The meeting took place on 30 June 2005, attended by Jennifer Jones and Ian Scott for the Trust and the Claimant, accompanied by his Medical Defence Union ("MDU") Representative, Dr Halley. It was acknowledged that there had been a lack of appropriate induction of Dr Chakrabarty which had led to a lack of clarity. There was discussion about an action plan including a period of training in placement of pacemakers with a cardiologist at another NHS trust. Following the meeting, there was extensive correspondence between the Claimant and the Trust about agreement of the notes of the meeting and the action plan, so that there was no agreement about the notes until 24 August 2005. The arrangement for training was finalised in October 2005 and by letter dated 5 October 2005, Mr Scott explained the arrangements that had been made for this training to address the concerns still held in relation to cardiac catheterisation and pacemaker activity.

16. During November 2005 further concerns were raised about the Claimant by trainees at the Trust working with him. On 23 November 2005 Dr Grimmer, Clinical Tutor, wrote to Dr Nicholl explaining the issues that had been raised with him in this regard and the impact and consequences of such concerns, if communicated during an external professional training visit by the Royal College of Physicians due to take place on 25 November 2005. A letter dated 24 November 2005 from Dr Irvine, a Consultant Cardiologist of the Trust to Dr Nicholl identified examples of clinical decisions made by the Claimant which were described as at best, slightly unusual and at worst, clinically dangerous.

17. In consequence of those issues, Dr Nicholl met with the Claimant at 2pm on 25 November 2005 in his office. There is a note of what Dr Nicholl said (and all matters raised were subsequently confirmed in writing to the Claimant). He explained that an internal investigation would take place in accordance with the Trust's internal policy and that Ian Scott, as Case Manager, would appoint a case investigator. Dr Nicholl explained that the Trust's duty to protect the interests of patients and other staff was paramount and that a decision had been taken to suspend the Claimant on full pay with immediate effect. He emphasised that suspension was a precautionary measure and not a disciplinary sanction, but that whilst suspended from duty the Claimant was not to attend hospital premises unless by prior arrangement and that it would be inappropriate for him to contact colleagues, staff or patients in an official capacity or in relation to the suspension or the concerns raised. Dr Nicholl told the Claimant that it was recognised that the situation was extremely stressful for him and referrals to Occupational Health and other sources of support were mentioned. Nevertheless, the Claimant was escorted back to his department to pick up personal belongings and was then escorted off the premises in a manner which increased the distress he felt and was undoubtedly humiliating for him. No explanation has been offered as to why it was

necessary to treat the Claimant in this way and it appears to have been done as a matter of routine without recognising the additional distress caused by it.

18. Ian Scott appointed Mr David Hodgkinson, a Consultant in Emergency Medicine, to carry out an investigation. Throughout the period of the investigation, Ian Scott wrote on a monthly basis to the Claimant notifying him that his exclusion would be extended for a further month in order to enable the Trust to complete its investigation. The NCAS were copied in on this correspondence and contact was maintained with the NCAS by Ian Scott and the Director of HR, who updated the NCAS on progress on a regular basis. It is convenient to note here that the Trust continued to write to the Claimant on a monthly basis throughout the full period of the exclusion, explaining that his exclusion had been extended and giving the reason why. This continued until the exclusion was lifted.

19. As part of the investigation, Mr Hodgkinson wrote to the Claimant with a list of personnel he intended to interview. The Claimant was subsequently written to and told that a further list of identified individuals had been interviewed by Mr Hodgkinson. The Claimant himself, attended an investigatory meeting with Mr Hodgkinson, accompanied by his MDU representative, on 16 December 2005. On the same date he attended another investigatory meeting with Dr Rush who was by then investigating a separate concern raised by an external GP about the Claimant, but which concluded ultimately that there was no significant issue to be taken forward. Although Ian Scott states that the Claimant was told that there was no case to answer in relation to the Elaine Rush investigation, that was challenged by the Claimant and Mr Scott accepted that it was both inappropriate and regrettable that the Claimant was not informed.

20. There was a second investigatory meeting between the Claimant and Mr Hodgkinson on 22 March 2006, and again he was accompanied by an MDU representative. Transcripts of these meetings were subsequently provided to the Claimant, albeit there appears to have been some delay in doing so.

21. Mr Hodgkinson produced a preliminary report dated 11 April 2006. This was sent to the Claimant for his comments. The Claimant produced a detailed response dated 23 June 2006. In relation to each of the cases for concern that had been identified as disclosing competence and capability issues, he maintained that he had acted appropriately, taking into account the constraints imposed upon him by the deficient systems at the Trust. He maintained that the findings in the preliminary report were misconceived and unsubstantiated and that his capability was not in issue. Rather he was being criticised and made a scapegoat for the failings of a dysfunctional cardiology department.

22. Mr Hodgkinson produced a final report dated 25 August 2006, taking account of the Claimant's detailed response. He acknowledged that the investigation had been stressful for the Claimant but stated that it was essential to ensure a balanced and thorough process was adhered to for all parties and especially in the overriding context of clinical governance and patient care. In the conclusion to his report he stated:

> "This investigation has highlighted a breadth and depth of issues relating to both [the Claimant's] clinical practice as a Consultant General Physician with an interest in Cardiology, and his practice within a consultant role at a district general hospital. In accordance with the guidance contained in [MHPS] these have been identified as matters relating to capability."

23. The final report was not sent to the Claimant as it ought to have been, in advance of a Trust Board meeting held on 28 September 2006. Nevertheless, he had seen the preliminary report and had been able to comment in detail on the factual content of that report as MHPS requires; and he received the report immediately after the Board meeting. It is not suggested that there was anything in the comments he made on the final report that would have altered the conclusion reached by the Board. Moreover, the Board's decision was not in fact actioned nor was there any attempt to action it until significantly later on in the chronology.

24. A meeting of the Trust Board at which the Claimant's case was discussed, was held on 28 September 2006. A report prepared for the Board by the Director of HR recommended that the Board should "move to convening a capability hearing (with or without NCAS, subject to further discussions)". Since the NCAS were already involved and had been advising the Trust, it is likely that the word 'assessment' has been omitted in error and the recommendation should have read, "with or without NCAS assessment".

25. The extract from the minutes of the Board meeting itself reflect discussion of the following: that the investigation was complete, a lengthy response had been received, the NCAS were fully aware of the case, the individual had indicated a wish to return to work but there was concern about the risk to patient safety both of the person's return to work at the Trust or elsewhere. The minutes continue:

> "in order to avoid potential future claims for unfair dismissal, the Trust needed to demonstrate that it had operated in accordance with laid down procedures; .... It was agreed that the Trust should proceed with holding a capability hearing."

This discussion is criticised on the Claimant's behalf with some justification. The better reason for operating in accordance with laid down procedures was fairness to the Claimant, but that was not discussed. However, I do not accept that the Board decision to move to a capability hearing reflects a committed approach to finding a way of terminating the Claimant's contract and that nothing short of that would do. At a capability hearing the disputed views about the Claimant's performance deficiencies and the prospects of remediation would be considered and resolved by a panel that would receive advice from a specialist clinician from another trust. That would have been well understood by the Board.

26. The final report of Mr Hodgkinson was sent to the Claimant under cover of a letter dated 29 September 2006 from Ian Scott. The Claimant was given a further opportunity to comment on the factual content of the report. The letter stated that following consideration of the findings of the report and further comments from the Claimant, together with advice from the NCAS, Ian Scott would be in a position to decide what further action was necessary and would contact the Claimant at that point.

27. On 10 October 2006 a meeting took place between representatives of the Trust and those of the NCAS. The minutes of the meeting record:

- That the Trust were aware of next steps and considered that "all options were open to them".
- The Trust considered that the concerns raised about the Claimant were very serious and raised significant patient safety issues.
- "NCAS said that under MHPS should the Trust be considering proceeding down the capability route the MHPS process requires referral to NCAS for consideration as to whether an assessment is required. It also requires the Trust to consider whether remediation could be achieved and this should be actively considered by the Trust as part of their consideration for next steps."
- NCAS also advised that if the Trust considered the concerns about the doctor was so serious that they raised questions about his fitness to practise then the Trust must refer the case to the GMC as only they can make that decision.

28. Mr Scott accepted that there was no formal consideration of remediation because the concerns were so significant and fundamental that it was felt that a capability hearing was the only realistic option at that point.

29. The Claimant provided a 'First Response' dated 7 November 2006 to the Hodgkinson report, under cover of a letter dated 10 November 2006, maintaining his rejection of the report's findings. Mr Hodgkinson was asked to review these comments to see whether they caused him to alter the conclusions he had reached. By email dated 4 December 2006, Mr Hodgkinson responded that he stood by the report and his findings. In his view, the report appropriately separated the issues regarding the Claimant from the wider context of the working environment within cardiology at the time, about which the Claimant was now making significant complaint.

30. On about 16 January 2007, Ian Scott spoke to Dr Norman Pinder at the Strategic Health Authority (the "SHA"), about the investigation. By that stage there were two other incidents involving the Claimant that, whilst not being subject to formal investigation, had been reviewed by consultant physicians, having come to light at a later date than Mr Hodgkinson's report. They concerned the Claimant's use of radio-iodine and were consistent in Mr Scott's view with there being serious concerns about the Claimant's competence. It appears that the SHA considered that a referral to the GMC

was appropriate given the capability and competence concerns that had been raised. Although that conversation took place in January 2007 it was not until 20 February 2007 that Dr Paul Cosford of the SHA referred the Claimant to the GMC.

31. By letter dated 1 March 2007 a formal referral was made by Ian Scott on behalf of the Trust to the NCAS requesting consideration of an NCAS assessment of the Claimant (and the Claimant was written to at the same time and told about the referral).

32. Pausing at this stage to consider the question of delay to this point, although matters could have been progressed more promptly, bearing in mind the number of people involved in dealing with the matter and their undoubted other responsibilities, I am satisfied that the delay on the part of the Trust in relation to the Hodgkinson investigation, which was plainly regarded as the most important of the matters then being investigated by the Trust, was not so great as to cause serious unfairness to the Claimant.

33. During the latter part of 2006 and early months of 2007, there was a dispute between solicitors acting on behalf of the Claimant and those acting on behalf of the Trust about the contractual position of the Claimant and which procedures did and did not apply. Concern was also raised about the fact that both the GMC and the NCAS were involved in dealing with his case.

34. So far as the GMC process was concerned, by letter dated 20 March 2007, the GMC provided details of the matters raised in relation to the Claimant's fitness to practise and by letter dated 22 May 2007, the GMC invited him to a performance assessment.

35. Meanwhile, on 3 May 2007, a case conference was held by the NCAS with attendance by the Claimant and representatives of the Trust. During the part of the meeting where all parties attended together, the NCAS advised that a placement for the Claimant be identified as soon as possible, and that this should be for a period of two to three months before the assessment itself, because experience suggested that the most sound assessment was likely to be one done whilst in regular clinical work in a neutral setting. All present agreed to that, subject to one or two provisos. The first proviso related to the GMC, it being agreed that if the GMC decided to carry out their own assessment, "this would take precedence and the NCAS assessment would not go ahead" (see letter from Dr Margerison, NCAS Adviser, to Jennifer Jones of the Trust, dated 5 June 2007). However, following that meeting, on 22 May 2007, the case manager of the GMC telephoned Dr Margerison to explain that the GMC had decided to carry out its own assessment and that the NCAS should suspend any further work towards an assessment of its own.

36. Although the Claimant argues that the decision that the GMC assessment "would take precedence" was a delegation by the NCAS of its assessment function to the GMC, I do not agree. As described later in this judgment, the functions of the GMC and those of the NCAS are quite different, as is the scope of the assessment carried out by each body. Whilst there may be an overlap between the two and therefore a desire to avoid duplication by not

running two assessment processes in parallel, I am quite satisfied that there was no delegation involved here. The agreement to allow the GMC assessment to take precedence was just that and no more: the GMC assessment would take place first and subject to that, and the circumstances prevailing once that assessment had been concluded, a further assessment by the NCAS could be carried out if appropriate.

37. By letter dated 20 June 2007, the GMC wrote to the NCAS to confirm that the Claimant had been invited to undertake an assessment of his professional performance by the GMC and had accepted that invitation.

38. The assessment did not take place until 13 to 15 January 2008 and a Performance Assessment Report was not produced until 25 March 2008. The matter having been referred to the GMC in February 2007, it took over a year for a report to be produced. As the Claimant accepts, this delay cannot be attributed in any way to the Trust. The Trust was rightly awaiting the outcome of the GMC assessment before deciding what action it should take.

39. The GMC Performance Assessment Report concluded that the Claimant's professional performance was, in most categories of good medical practice, either unacceptable or a cause for concern, and that he was not safe to practise independently in general medicine, cardiology or nuclear medicine. The report recommended that he should stop all independent practice and undertake retraining under supervision for two years in general medicine at the level of Senior House Officer (SHO) and that the GMC might carry out a further assessment after that.

40. By letter dated 23 April 2008 to Ian Scott, the GMC investigation officer with responsibility for the Claimant's case, enclosed a copy of the finalised performance assessment stating that the report had found the Claimant's performance to be deficient but that it should improve with remedial training. The letter indicated that the GMC had moved to the final stage of the investigation and would shortly be writing to the Claimant outlining the allegations against him and inviting his formal comments before the Case Examiners (who were the decision makers) would proceed to decide how to conclude the case.

41. There was yet further delay by the GMC following this. An email dated 18 August 2008 from HR to Peter Donaldson, who had taken over as Medical Director of the Trust from Ian Scott, by then, suggests that disclosure requests made by the Claimant's solicitors were causing delay. A further email dated 22 September 2008, suggests that the Trust chased the GMC again and was told that a decision could be expected within four weeks. A yet further email dated 23 October 2008 from HR to Peter Donaldson and others states that the Case Examiners had decided to offer voluntary undertakings and expected a response from the Claimant by 8 November 2008 in this regard. At that stage the GMC was not prepared to share the proposed undertakings with the Trust (see email dated 12 November 2008 from Jennifer Canham to Peter Donaldson); but made clear that if voluntary undertakings were not accepted the case would be considered by a fitness to practise panel arranged by the GMC.

42. Between 13 October 2008 when proposed undertakings were offered to the Claimant by the GMC, and 6 January 2009 when the Claimant agreed to the undertakings, there was correspondence and negotiation between the GMC and the Claimant's solicitors, Eastwoods, about the proposed undertakings. The Claimant has emphasised in evidence that his decision to accept undertakings on a voluntary basis was a pragmatic one. He did not and does not accept that he has any impairment, or training needs beyond the re-skilling required as a result of time out of clinical practice: he wished to return to work as quickly as possible and regarded this as an avenue that would achieve that result.

43. Naturally, the Trust was not party to this correspondence. Nor did it have any involvement in the drawing up of and agreement to the proposed undertakings. The Trust was simply advised by letter dated 8 January 2009 from the GMC that undertakings had been signed, and was sent a copy of the signed undertakings that had been agreed.

44. Following receipt of the GMC letter of 8 January 2009, Peter Donaldson wrote to Dr Margerison on the same date, stating:

> "whilst those (GMC fitness to practise) issues are relevant to the Trust as the [Claimant's] employer, the Trust does not believe that it now can, or should, wait any longer to seek to deal with the employment implications arising from the GMC Assessment Report which it has received and its own final investigation report. The Trust is conscious of its obligations to [the Claimant] in this regard and also of its obligations to provide a proper and effective service to the community which it serves."

He invited confirmation that the NCAS had no objection to the Trust proceeding to a capability hearing in circumstances where the comprehensive GMC report meant that an NCAS assessment would add nothing further. Dr Margerison responded by letter dated 23 January 2009, confirming that the NCAS had no objection to the Trust proceeding to a capability procedure in accordance with part IV of MHPS, given the recent GMC Assessment, and having regard to the Trust's view that an NCAS assessment would not add anything further.

45. The undertakings signed by the Claimant on 6 January 2009 (which had been drafted and promulgated by the Case Examiners themselves) included undertaking 13, which was in the following terms:

> "to confine my medical practice to NHS posts in cardiology where my work will be supervised by a named consultant."

This undertaking cannot easily be reconciled with the GMC Assessors' recommendation that the Claimant required retraining at SHO level, since its

effect was that he should merely confine his practice to the NHS post in cardiology where his practice would be supervised by a named consultant.

46. Although both Julie Fryatt and Peter Donaldson realised on reading the undertakings that there was a discrepancy between the Performance Assessment Report recommendations and undertaking 13, they were not aware of how that particular undertaking had been arrived at or agreed upon, and told me that they did not know how to address the situation. The obvious course of action was to write to the GMC, but this was not done for a further 10 months. Both agreed that this was a regrettable delay and with hindsight it would have been better to approach the GMC sooner. Nevertheless, other steps were taken during this period to address the Claimant's employment position as appears below, and accordingly, I am persuaded that the Trust's delay during this period cannot be described as blameworthy or unconscionable.

47. Having received confirmation from the NCAS that it had no objection to the Trust pursuing a capability procedure under part IV of MHPS, by letter dated 3 February 2009, the Trust's solicitors wrote to Eastwoods stating that the NCAS had confirmed that it did not believe that an NCAS assessment would add anything further to the information already provided in the GMC Performance Assessment Report. In those circumstances, the letter confirmed that the Trust would be writing to the Claimant to make arrangements for a capability hearing. By letter dated 18 February 2009, Eastwoods objected to this course of action. They relied on the GMC's assessment stating "clearly no decision could be taken whatever the procedure, without taking account of the GMC assessment and the undertakings that are now in force", disputing the application of MHPS in the circumstances and making clear their view that the GMC assessment obviated the need for an NCAS assessment. They stated that it would be "inappropriate" for there to be further assessment in light of the GMC assessment.

48. The Trust's solicitors responded by letter dated 26 March 2009, having obtained instructions from the Trust. The letter made clear that the GMC assessment process having concluded, the Trust wished to deal with matters relating to the Claimant's employment in accordance with the appropriate framework for doing so. That framework was the capability procedure and dates of availability for a capability hearing were invited. The Claimant relies on this letter as a representation or promise that the Trust would not proceed to a capability hearing until the final outcome of GMC proceedings was known. In my judgment the letter cannot be read in this way. The letter expressly states:

> "We do not agree with your apparent position that steps taken by the GMC in relation to fitness to practise generally precludes any steps taken by a practitioner's employer in respect of...local employment issues."

A letter from Peter Donaldson to the Claimant dated 7 April 2009 confirmed the Trust's intention to proceed with a capability hearing in relation to the Hodgkinson report and the GMC Performance Assessment Report; but that no

further action would be taken in relation to the other investigations that had been conducted internally by the Trust.

49. Eastwoods replied with a holding letter dated 3 April 2009, and a more substantive response dated 20 April 2009. They insisted that it was incumbent upon the Trust to liaise with the NCAS in formulating an action plan based upon the GMC Performance Assessment Report and the undertakings that had been offered and they made clear that the Claimant was ready, willing and able to implement the GMC undertakings and to abide by any appropriately drawn up NCAS action plan.

50. There are emails and internal documents that indicate that from about May 2009 the Trust started to put in train arrangements for a capability hearing with provisional dates for such a hearing being set. However, following legal advice and the perceived threat of legal action by the Claimant if capability proceedings were pursued, the Trust decided to consider the issue of an action plan with the NCAS rather than pursuing a capability hearing at that stage. In the circumstances, that was a reasonable decision.

51. By letter dated 25 September 2009 accordingly, Peter Donaldson wrote to Dr Margerison to update him on the current position and indicated that the Trust was considering what form an educational and/or organisational action plan might take. There was a follow-up discussion between the two on 22 October 2009. By then the Claimant had been (and continued to be) in discussions with the East of England Deanery and the Royal College of Physicians in relation to a possible action plan based on the GMC undertakings to which he had agreed. Whilst a letter from Dr Margerison dated 23 October 2009 notes that the discussions had been broadly positive, as yet they had not led to any specific placement and the Deanery considered that any such retraining should not take place at the Trust hospital. Dr Margerison's letter records that the Trust had approached a number of medical directors but none had been willing to offer retraining. The NCAS advice was that it was not able to help directly with finding suitable placements, but could help with the construction of an appropriate plan and could assist with finding a placement. Dr Margerison noted however, that "it can be difficult to find retraining placements."

52. The problem of reconciling the GMC Performance Assessment and the GMC undertakings (in particular, undertaking 13) hitherto unresolved, was expressly raised by Peter Donaldson in letters to the Deanery and the Royal College of Physicians dated 25 September 2009. Shortly before that, by letter dated 23 September 2009, the Trust's solicitors had requested sight of copies of correspondence between the GMC and the Claimant regarding the undertakings that had been agreed. By letter dated 12 October 2009, Eastwoods refused to provide copies of correspondence between the Claimant and the GMC showing how the undertakings had been arrived at, stating that such correspondence was confidential, and that what was relevant were the undertakings to which the Claimant had agreed.

53. By letter dated 3 November 2009, the Trust finally wrote to the GMC questioning the inconsistency between the GMC Performance Assessment (that recommended retraining at SHO level for two years) and undertaking 13

which merely confined his practice to posts in cardiology with supervision. Although Peter Donaldson spoke to Ms McNally of the GMC on 27 January 2010 and sent a chasing letter dated 29 March 2010 seeking to resolve this inconsistency, the GMC did not respond substantively until 29 June 2010. That delay is unexplained and particularly regrettable in the circumstances, (particularly given the lengthy delays by the GMC before that) but cannot be attributed to the Trust.

54. Meanwhile, the Claimant had been liaising with the Royal College of Physicians in the preparation of a Personal Development Plan ("PDP") with a view to undertaking work supervised as envisaged by the agreed undertakings. By the 31 December 2009 a proposed PDP approved by the Royal College of Physicians was in place under which the Claimant would work for an initial period of three months at Princess Alexandra Hospital under the supervision of Dr Jeremy Sayer, Consultant Cardiologist. The Trust was informed of this by letter dated 4 January 2010 from Eastwoods, and asked to agree to it, but without a copy of the PDP being provided. An issue was also subsequently raised (letter of 29 January 2010) as to whether the Claimant had provided those at the Princess Alexandra Hospital with a copy of the GMC Performance Assessment Report. Eastwoods provided a copy of the PDP but did not provide the confirmation sought that those at the Princess Alexandra Hospital had been provided with a copy of the GMC Performance Assessment Report. In evidence, the Claimant agreed that he had not done so directly. The lack of clarity as to the information and documentation that had been provided by the Claimant to the external bodies together with the fact that the Trust had not been involved in agreeing the action plan, caused understandable concern to the Trust. I am satisfied that the Trust was entitled to obtain clarification before agreeing to the placement. It is unfortunate that correspondence on the matter was protracted, but this was a genuine attempt to obtain information and clarification, rather than an attempt to block the placement, as the Claimant has suggested.

55. Indeed in April 2010, the Trust sensibly proposed a joint meeting between all involved (including the Princess Alexandra Hospital, the NCAS and the Claimant) to try to resolve the impasse that had been reached. But for reasons that are not explained, the Claimant was unhappy to attend such a meeting, based on legal advice, as communicated to the Trust by Dr Sayer. Despite a direct request by Mr Donaldson to the Claimant by letter dated 7 June 2010, to meet and have a direct dialogue between the Claimant and the Trust, the Claimant was not prepared to meet. This was a surprising stance for the Claimant to adopt in the circumstances, and given his unwillingness to do so, the criticism of Mr Donaldson that such an approach should have been taken much earlier is hard to sustain.

56. By letter dated 29 June 2010 to Peter Donaldson, the GMC acknowledged the inconsistency between its Assessors' recommendations and the agreed undertakings and stated that despite having reviewed the case, no explanation for the discrepancy had been identified. The letter stated that it looked as if there had been an oversight on the GMC's part rather than a specific decision by the Case Examiners to disregard the Assessors' recommendations. The

GMC made clear that they had written to the Claimant asking him to agree a revised set of undertakings which accurately reflected the recommendations based on the Performance Assessment Report and a copy of the letter was enclosed. By a letter of the same date, the GMC wrote to the Claimant asking him to agree to revised undertakings, including an undertaking that he would confine his practise to NHS ST1 or ST2 posts in general medicine (equivalent to SHO level) supervised by a named consultant, in place of undertaking 13.

57. Having received the GMC's letter with its proposed requirement that the Claimant should retrain at the equivalent of SHO level, it is not surprising that Peter Donaldson expressed the view in an email dated 1 July 2010 that "it is inconceivable that this doctor can ever be employed as a Consultant Physician or Cardiologist again". As he has explained, the three month PDP placement at the Princess Alexandra Hospital was neither consistent nor compliant with the proposed revised undertaking and was no longer an option for the Claimant in his view. Although I am satisfied that Mr Donaldson would not have objected to a placement at that hospital under an amended PDP reflecting the new proposed undertakings, the logistical and resource implications were of an altogether greater magnitude and represented an entirely different proposition. I accept his evidence that, at this stage, there was renewed justification for considering proceeding to a capability hearing.

58. Accordingly, by letter dated 14 July 2010, Mr Donaldson wrote to the GMC to explore the position in light of the revised undertakings that had been offered to the Claimant. In particular he wanted advice as to the period of retraining required at ST level 1 to 2 together with advice as to whether any future assessment by the GMC would be made as to the Claimant's fitness to practise generally or his ability to perform as a consultant in general medicine and cardiology. This was followed on 28 July 2010 by a meeting of Mr Donaldson and Ms Fryatt with representatives of the NCAS including Dr Margerison. The purpose of the meeting was to discuss the position in relation to the GMC undertakings and how to proceed. The Trust received advice from the NCAS at that meeting that it was unprecedented for there to be a requirement of retraining of a consultant at ST1 or ST2 level; that after the first two years, a further five years' retraining was likely; that the supervision level required would be significant; that the NCAS could set up a short life action plan and then assessment at SHO level could be undertaken, but the Trust would need to consider whether this was appropriate; that the question of reasonableness of any action plan was for the Trust to decide and the Trust should take more control of the action plan.

59. By letter dated 16 July 2010 the Claimant declined to give the revised undertakings proposed by the GMC and Eastwoods on his behalf stated that this was not an appropriate case for review under the GMC's Fitness to Practise Rules notwithstanding any oversight in relation to the undertakings. The GMC wrote to Mr Donaldson by letter dated 13 August 2010 informing him of that refusal, and also apologising for the delay by the GMC in dealing with the discrepancy in the original undertakings that should have been investigated more fully at the time it was first raised by the Trust in November 2009.

60. The Claimant wrote to the GMC by letter dated 6 September 2010. He raised detailed concerns about the history of the case and the lengthy delays. He made clear that he had been involved for many months in extensive liaison with the Deanery, the Royal College of Physicians and other specialists in producing a PDP that would reflect the undertakings he had agreed. Although it was suggested that the Claimant was acting opportunistically in seeking to rely on the agreed undertakings, I am satisfied that he genuinely believed (albeit wrongly) that the Case Examiners had not made a mistake in proposing the original undertaking 13. In his view, having considered the material as a whole and reflected on his performance history (particularly in circumstances where he never accepted the impairments identified by the GMC Performance Assessment Report) he believed that the Case Examiners had deliberately proposed undertaking 13. In the circumstances, he was understandably disappointed by the GMC's change of stance and was unable to see any proper justification for it, but rather, saw this as unfair action by the Trust as indicated by the following:

> "I am deeply shocked to see that the GMC reacted to the unfair instigation of [the Trust] who is merely an employer on paper for me. I am still only connected to them because of contractual and obligatory legal issues that are being dealt with their legal team and my legal defence advisors. I have no clinical connection with [the Trust] and I have not given them any written undertakings that I would return there even if their unfairly imposed exclusion against me is removed"

> "[The Trust] can take their own action on any matters but interfering in my personal issues and instigating the GMC from the back door with an intentional derogatory attitude is not a professional behaviour expected of a public body. It is unthinkable that the GMC will respond to that unfair proposals of the [Trust] without any discussions with the higher clinical authorities who are advising, guiding and supervising me regarding undertakings and taking the responsibility of my actual clinical work".

61. Later in that letter he stated that his "active clinical employer is Princess Alexandra Hospital Trust... I will be working there in clinical capacity to provide direct patients care." Clearly the Claimant was not in active employment at the Princess Alexandra Hospital and although I accept that he was understandably distressed by the ongoing situation, his apparent lack of understanding of his employment position is surprising.

62. Between September 2010 and early February 2011 there was correspondence between Eastwoods and the GMC about a decision to refer the case back to the Case Examiners for reconsideration in light of the mistake in the undertakings previously agreed. This was resisted on the Claimant's behalf. Ultimately, the Case Examiners reconsidered the decision and the Claimant was notified by letter dated 10 February 2011 that there had been a mistake in relation to

undertaking 13 and that he should be invited to accept the revised undertakings. The Claimant challenged this decision on judicial review (proceedings issued on 28 February 2011) seeking to quash the GMC's decision to refer the matter back to the Case Examiners. Although it is obviously right that the Claimant was entitled as a matter of law to challenge the GMC decision, the effect of so doing was inevitably to cause delay with little substantive results (particularly in circumstances where the challenge was a reasons challenge). Moreover the GMC offered to settle the judicial review proceedings and to retake the decision as early as February 2011, but it was not until August 2012 that a consent order was finally issued quashing the GMC's decision on the grounds of a failure to provide adequate reasons. No explanation for this delay is offered by the Claimant.

63. Once again, this delay cannot be attributed to the Trust, as the Claimant realistically accepted. I accept that as a result of the impasse created by the significant dispute about the level of retraining required, it would have been difficult for the Trust to identify a suitable basis for returning the Claimant to some sort of work. Moreover when in July 2011, Peter Donaldson renewed his attempts to meet directly with the Claimant, these were met with initial refusal, both by the Claimant himself and by Eastwoods, so that further protracted correspondence ensued. It was only as a result of an instruction to meet, that the Claimant was finally persuaded to do so.

64. Eventually a meeting took place between the Claimant, his solicitor and representatives of the Trust including Peter Donaldson, on 11 October 2011. The Trust made clear that the purpose of the meeting was to discuss the end of the Claimant's exclusion and alternatives to that exclusion. There followed correspondence between the Trust and Eastwoods and internal correspondence between the Trust and clinicians within the Trust who could supervise the Claimant. It is not clear why it took so long to produce a proposal for lifting the exclusion and replacing it with temporary restrictions on the Claimant's practice whilst an action plan was resolved, but eventually by letter dated 1 February 2012 Mr Donaldson offered the Claimant a proposed basis on which this could be achieved. The letter is important. It was in my judgment a bona fide offer, and made clear that the Trust would, following further discussion with the NCAS, consider whether an action plan could be drawn up and implemented in the Claimant's case, that had a realistic chance of success of returning him to practise at consultant level, having regard to the level of capability and performance he displayed. If that could be done, Mr Donaldson stated that the Trust would facilitate such an action plan. If it could not be done, or the NCAS advised that the Claimant's performance was so fundamentally flawed that no action plan had a realistic chance of success, matters would have to be determined under the capability procedure.

65. In the meanwhile the Trust was lifting the exclusion from work and replacing it with temporary restrictions including a period of clinical observer-ship during which Paul Venables, Consultant Cardiologist had agreed to act as Clinical Supervisor and a mentor was appointed. The letter acknowledged the fact that the Claimant was keen to explore the possibility of undertaking the placement at the Princess Alexandra Hospital and Mr Donaldson explained

that another of the steps which the Trust would take during this initial period following his return to work, would be to consider and explore the issue of that placement.

66. The Claimant responded by letter dated 7 February 2012. Although he was grateful for the lifting of the exclusion he did not regard a clinical observer-ship at the Trust as possible. There ensued a yet further period of protracted correspondence between Mr Donaldson and the Claimant and ultimately an instruction had to be issued by Mr Donaldson, requiring the Claimant to commence the clinical observer-ship on 4 April 2012. Even then the Claimant refused to do so and it was subsequently agreed that he would attend for an induction on 25 April 2012, and the clinical observer-ship and shadowing on 14 May 2012. This is what happened.

67. Mr Donaldson contacted the new Medical Director of Princess Alexandra Hospital, Dr McKenzie, in May 2012 to discuss the placement for the Claimant that had previously been offered. Dr McKenzie told him that the PDP and placement had been developed on the basis of the 2009 undertakings, but if these were being replaced she was not keen to progress the matter until the undertaking issue had been resolved.

68. On 12 July 2012, in a meeting with Peter Donaldson, the Claimant informed the Trust that he did not think anything further was to be gained from the clinical observer-ship and that he wished to undertake a 3 to 4 month cardiology update at the Princess Alexandra Hospital or elsewhere with a view to returning to full practise thereafter. It is clear that the Claimant's perception and expectation about his likely re-training needs was very different from that of the Trust. In a letter following that meeting (dated 12 August 2012) Mr Donaldson set out the Trust's position that a 3 to 4 month cardiology update was inadequate and that the Trust required proper assurance that the issues identified in the GMC Performance Assessment were capable of being remedied. He also stated his understanding that the Princess Alexandra Hospital placement was no longer available pending resolution of the GMC dispute. He stated that advice was still awaited from the NCAS as to whether an action plan had any realistic chance of success in returning the Claimant to practice at consultant level. He also explained that a timescale of not less than four years and quite possibly seven years to return him to a level where he might be employed as a consultant had been indicated by the NCAS.

69. By a decision dated 19 November 2012 the GMC confirmed that its Assistant Registrar had conducted a fresh review under the GMC rules, concluding that the original decision to issue undertakings was materially flawed and that it was in the public interest to retake that decision. The undertakings offered and signed in 2009 were in effect quashed. Following this decision, there was a period of yet further protracted correspondence between the GMC and Eastwoods on behalf of the Claimant about revised voluntary undertakings. These were ultimately not accepted by him and by letter dated 16 May 2013, the GMC notified the Claimant of its decision to refer the question of his impaired fitness to practise by reason of deficient professional performance, to a fitness to practise panel ("FTP") to be heard by the MPTS. Once again, a period of protracted correspondence between Eastwoods and the GMC

followed about arrangements for the hearing. When in September 2013, the MPTS rejected an application to adjourn, judicial review proceedings were once again issued by Eastwoods but a consent order was reached and the GMC vacated the MPTS hearing listed for October 2013. The hearing was re-listed to commence on 27 January 2014 but did not conclude by 14 February 2014 and will now resume in September 2014.

70. Meanwhile, Mr Donaldson wrote to Dr Margerison at the NCAS by letter dated 14 August 2012 updating him on the then current position and asking whether an assessment should be carried out by the NCAS and what prospects of success an action plan might have in returning the Claimant to full practise. Thereafter there was further correspondence between the NCAS and Mr Donaldson, and the Trust completed a referral form, submitted to the NCAS on 8 November 2012.

71. By letter dated 22 November 2012, Mr Donaldson wrote to the Claimant notifying him that the NCAS had indicated a wish to review whether a further assessment of the Claimant's capability should be carried out. He told the Claimant that the NCAS had suggested it would be helpful to them if they could meet with the Claimant and a date was suggested of 5 December 2012. The Claimant was unable to attend that meeting because of GMC commitments that week and regarded it as surprising for there to be a further referral to the NCAS. In a letter dated 17 December 2012 from the Claimant to Peter Donaldson he stated that given the involvement of the GMC, "there is no place for NCAS to undertake its assessment" and that he did not expect any involvement with NCAS would assist at the present time. Similar correspondence was received from Eastwoods.

72. In light of the position adopted by the Claimant, Peter Donaldson wrote again to the NCAS seeking advice as to the way forward. After some correspondence between Dr Margerison and Peter Donaldson by letter dated 23 May 2013 the NCAS made a provisional decision that an assessment should not be carried out. One of the reasons for that decision was that the Claimant had already been assessed by the GMC and had been out of clinical practice for over seven years. Without seeing the practitioner in clinical practice, the NCAS felt it was unlikely to be able to add anything further to what had been found by the GMC, and the Claimant had indicated he would not wish to be assessed by the NCAS.

73. The Claimant was given the opportunity to comment on the provisional decision before a final decision was made and the letter stated that a meeting would be held on 12 June 2013 to make that final decision. A final decision was made, notified by letter dated 13 June 2013. The letter stated that no new information had been received from the Claimant and the NCAS's final decision was that an assessment should not be carried out for the reasons previously outlined.

74. So far as the NCAS views on remediation were concerned, the letter said that without a trial of remediation it was not possible to determine how successful a further training programme might be. However the letter stated that there were a number of poor prognostic indicators that suggested that training would

be significant, extensive and would require substantial time and resources. The letter confirmed the earlier opinion that two years' retraining in general medicine under supervision at SHO level was required by the GMC Performance Assessment Report and the NCAS view was that at least four years and quite possibly seven years would be required to retrain the Claimant to consultant level. The Claimant's response to that decision of the NCAS was to state: "I do not recognise any reason why I received such correspondence decision from NCAS nor do I acknowledge any directed involvement from NCAS."

75. Following receipt of this final decision from the NCAS, Mr Donaldson, as Case Manager, understood that the Trust could now proceed to a capability hearing and decided that this was the proper course to adopt. His reasons for doing so were:

(a) serious concerns had been raised in respect of the Claimant's clinical competence both internally in the form of reports of Dr Nicholl and Mr Hodgkinson and externally in the form of the GMC Performance Assessment Report;

(b) the concerns raised were grave, not only from the perspective of what might be expected from a Consultant in Cardiology but what might be expected from any doctor practising at consultant level;

(c) there was no evidence of any insight by the Claimant into these issues;

(d) the only action plan possible would involve a minimum of four years, possibly seven years, with no guarantee that at the end of that period the Claimant would be competent to practise at the level of Consultant again and in particular in the role which he was employed;

(e) in the circumstances, the matter was not capable of being resolved informally locally or in any other way than by reference to a capability hearing.

76. Despite having reached that conclusion the Claimant was not invited to attend a capability hearing until 29 January 2014. The reason given for this further delay by Mr Donaldson was that having taken legal advice, he decided it was appropriate to allow the three month judicial review time limit to expire before seeking to convene a capability hearing. In the light of the Claimant's demonstrated propensity to seek judicial review this was not unreasonable.

77. On 19 November 2013 Trust was informed that the MPTS hearing had been relisted to start on 27 January 2014. Having taken further legal advice on 20 November 2013, Mr Donaldson decided to call the Claimant to a capability hearing. There was a further short delay whilst members of the capability panel and their availability were confirmed.

78. By letter dated 29 January 2014 the Claimant was required to attend a capability hearing by the Trust on 10 and 11 March 2014. The letter set out the arrangements for the hearing including the members who would comprise the capability hearing panel. They included Nick Hulme, the new Chief Executive of the Trust and the Medical Director at Norfolk and Norwich University Hospital Trust. The letter stated that the capability hearing would be conducted in accordance with the procedures set out in the Trust's internal procedure (ADCP) that implemented part IV MHPS; and that the Claimant was entitled to be legally represented. Details of the capability issues that would be addressed were set out. The letter made clear that the documentation available to the capability panel would include the final Hodgkinson Report and the Claimant's comments on it; the GMC Performance Assessment and the Claimant's comments on that; and the decision letters from the NCAS dated 23 May and 13 June 2013. The letter also set out the range of decisions open to the capability hearing panel, from no action required to termination of the Claimant's employment.

79. There followed correspondence from Eastwoods to the effect that it would be wholly inappropriate for the Trust to take any action based on the GMC Performance Assessment, whilst the MPTS panel's consideration of the same assessment remained outstanding. The Trust's solicitors responded that the MPTS hearing was not a reason for delaying the capability hearing which would address the Claimant's capability of performing as a Consultant and could consider all points the Claimant wished to make about the validity of the performance assessment report and the nature of the hearing. In the absence of agreement between the parties, these proceedings were issued, resulting in this trial.

## The relevant contractual and statutory framework

*The Claimant's contract of employment with the Trust*

80. It is common ground that the Claimant's contract of employment is evidenced by a Statement of Principal Terms and Conditions of Employment, sent to him under cover of a letter dated 8 October 2004. Clause 1 provides that his job title is "Consultant in Cardiology and General Medicine". Clause 2b provides for the incorporation of other locally or nationally agreed agreements.

81. By clause 3 a series of general mutual obligations between the Claimant and the Trust are identified. These include an agreement mutually to cooperate with one another and to maintain goodwill.

82. By clause 17 which is headed "disciplinary matters" the following is provided:

> "The disciplinary rules aim to establish standards of conduct and performance. The disciplinary procedures aim to ensure that alleged departures from the standards are dealt with fairly, with the primary aim of helping individuals, where necessary, to improve and reach those standards.

> Wherever possible, any issues relating to conduct, competence and behaviour should be identified and resolved without recourse to formal procedures.
>
> However, should we consider that your conduct or behaviour may be in breach of the Trust's Managing Poor Performance Policy or that your professional competence has been called into question, we will resolve the matter through our disciplinary or capability procedures.
>
> You have the right of appeal against any formal disciplinary decision. The arrangements for these are set out in each of the relevant disciplinary procedures.... For medical and dental staff there are additional procedures relating to: ... (ii) cases involving medical and dental staff's professional conduct/competence ..."

83. By clause 32 provisions governing termination of employment are set out in schedule 19. Among other things, schedule 19 paragraph 4 identifies as grounds for termination of employment, a consultant's capability (or lack of it).

84. One of the additional procedures referred to in clause 17 is the "Additional Disciplinary and Capability Policy and Procedures and General Rules of Conduct for Medical Staff" (the ADCP). It is common ground that this document is the means by which the Trust implemented the Department of Health's "Maintaining High Professional Standards in the Modern NHS" or MHPS as it has been referred to above. The terms of the ADCP closely mirror the terms of MHPS. Since it is also common ground that to the extent that there is any inconsistency between the ADCP and MHPS, the terms of MHPS must prevail, it is agreed by all parties that this judgment should focus on the terms of MHPS (rather than those set out in the ADCP) so far as relevant to this case. I do not therefore set out the relevant parallel terms of the ADCP.

*The MHPS framework*

85. By virtue of the National Health Service and Community Care Act 1990, schedule 2, paragraph 16 (5), re-enacted in the National Health Service Act 2006, schedule 4 paragraph 25 (3), the Trust is obliged to act in accordance with regulations and directions given by the Secretary of State for Health in connection with the employment of staff. The power of the Secretary of State to give such directions is derived from the National Health Service Act 1977, section 17.

86. Directions issued by the Secretary of State for Health in 2003 (Directions on Restriction of Practice and Exclusion from Work 2003) relating to parts I and II of MHPS, and in 2005 (Directions on Disciplinary Procedures 2005) relating to parts III to V of MHPS, directed all NHS bodies to implement the framework established by MHPS within the respective periods identified. As already indicated, the Trust formally adopted the framework by implementing the ADCP, revised in June 2006 in compliance with those directions (and it has subsequently been updated as a June 2013 version).

87. A significant impetus in the adoption of MHPS was recognition of the number of doctors suspended from working for long periods, at substantial cost, and therefore, of the importance of tackling performance concerns by training and other remedial action, rather than solely through disciplinary action where possible. A single process for handling capability issues about a practitioner's professional competence was established, closely tied in with the work of the National Clinical Assessment Authority ("NCAA"), now the National Clinical Assessment Service (or NCAS). Nevertheless MHPS recognises the paramount duty remains the duty to protect patients, so that where serious concerns are raised about a practitioner, the employer must urgently consider whether it is necessary to restrict their clinical duties on an appropriate basis and expressly provides that it is not intended to weaken accountability or avoid disciplinary action (paragraphs 5 and 6).

88. In order to understand and properly construe the particular provisions of MHPS that are the focus of this claim, it is helpful to consider the structure of the MHPS framework and the particular provisions in the context of the framework as a whole.

89. Part I deals with the start of the process when a concern about a practitioner arises. All serious concerns must be registered with the Chief Executive who must ensure that a Case Manager is appointed; and in cases involving consultants, the Trust Medical Director will act as the Case Manager and will appoint a Case Investigator where necessary. Paragraph 7 makes clear that at any stage of the handling of the case consideration should be given to the involvement of the NCAS. Following consultation with others including the NCAS, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed (paragraph 10). If an informal route is adopted, the NCAS can remain involved and can undertake a formal clinical performance assessment when the doctor, the NHS body and the NCAS agree that this could be helpful in identifying the underlying cause of the problem and possible remedial steps. If a more formal route is adopted the medical director must appoint and appropriately experienced or trained person as case investigator.

90. Paragraphs 12 to 17 deal with the nature and procedures to be followed by the case investigator in an investigation. Paragraph 17 provides:

> "....The report of the investigation should give the case manager sufficient information to make a decision whether: ...
>
> - there are concerns about the practitioner's performance that should be further explored by the [NCAS];
> - restrictions on practice or exclusion from work should be considered;
> - there are serious concerns that should be referred to the GMC...;
> - there are intractable problems and the matters should be put before a capability panel;
> - no further action is needed."

91. Paragraphs 18 to 21 deal with the involvement of the NCAS following local investigation. They indicate that the NCAS processes are aimed at addressing, among other things, underperformance due to a lack of clinical capability where local action has not been able to resolve the issue. The NCAS methods of working assume commitment by all parties to take part constructively in a referral to the NCAS. Paragraph 19 provides that the focus of the NCAS's work is therefore likely to involve performance difficulties which are serious and/or repetitive and for present purposes, this means "performance falling well short of what doctors and dentists could be expected to do in similar circumstances and which, if repeated, would put patients seriously at risk." Paragraph 22 provides that failure by a practitioner to cooperate with a referral to the NCAS may limit the options open to the parties and may be seen as a lack of willingness on the part of the doctor to work with the employer on resolving performance difficulties.

92. Part II of the MHPS framework deals with restrictions of practice and exclusions from work. Paragraph 3 requires an NHS body to ensure that exclusion from work is used only as an interim measure whilst action to resolve the problem is being considered and that where a practitioner is excluded, it is for the minimum necessary period of time. More detailed provisions are set out in the remaining paragraphs.

93. Part III of the MHPS framework deals with conduct hearings and disciplinary matters. This case is not a case of misconduct and does not, accordingly, fall under part III. It is noteworthy however, that express provision is made in part III for circumstances where an employer's investigation establishes suspected criminal action. Paragraph 12 provides that this must be reported to the police and that the "Trust investigation should only proceed in respect of those aspects of the case which are not directly related to the police investigation underway....". In other words, there is a requirement to stay any internal hearing where there are aspects of the case directly related to the police investigation.

94. Part IV of the MHPS framework (which is at the heart of this case) sets out procedures for dealing with issues of capability. Under the heading 'Introduction & General principles' paragraph 3 provides:

> "There will be occasions where an employer considers that there has been a clear failure by an individual to deliver an adequate standard of care, or standard of management, through lack of knowledge, ability or consistently poor performance. These are described as capability issues..."

95. Paragraph 4 provides: ".... If the concerns about capability cannot be resolved routinely by management, **the matter must be referred to the NCAS before the matter can be considered by a capability panel** (unless the practitioner refuses to have his or her case referred) ...." (emphasis as in original).

96. The capability procedure is dealt with at paragraphs 13 to 27; with the pre-hearing process dealt with at paragraphs 13 to 16.

97. Paragraph 13 requires the case manager to give the practitioner the opportunity to comment in writing on the factual content of the report produced by the case investigator following the investigation referred to in part one of the framework.

98. Paragraphs 14 to 16 provide as follows (with references to the NCAS substituted for its predecessor body the NCAA):

> "14. The case manager should decide what further action is necessary, taking into account the findings of the report, any comments that the practitioner has made and the advice of the NCAS. The case manager will need to consider urgently:
>
> - whether action under part two of the framework is necessary to exclude the practitioner; or
>
> - to place temporary restrictions on their clinical duties.
>
> The case manager will also need to consider with the Medical Director and head of Human Resources whether the issues of capability can be resolved through local action (such as retraining, counselling, performance review). If this action is not practicable for any reason the matter must be referred to the NCAS for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan. The case manager will inform the practitioner concerned of the decision immediately and normally within 10 working days of receiving the practitioner's comments.
>
> 15. The NCAS will assist the employer to draw up an action plan designed to enable the practitioner to remedy any lack of capability that has been identified during the assessment. The Trust must facilitate the agreed action plan (which has to be agreed by the Trust and the practitioner before it can be actioned). There may be occasions when a case has been considered by the NCAS, but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the NCAS advice, whether the case should be determined under the capability procedure. If so, a panel hearing will be necessary.

> 16. If the practitioner does not agree to the case being referred to the NCAS, a panel hearing will normally be necessary."

99. Procedural requirements to be followed prior to a capability hearing are identified at paragraph 17 and include a requirement that at least 20 working days' notice must be given to the practitioner of a capability hearing; any documentation, including witness statements, to be relied on in the hearing are to be exchanged no later than 10 working days' before the hearing. Paragraph 17 also provides:

> "Should either party request a postponement to the hearing the case manager is responsible for ensuring that a reasonable response is made and that time extensions to the process are kept to a minimum. Employers retain the right, after a reasonable period (not normally less than 30 working days) to proceed with the hearing on the practitioner's absence, although the employer should act reasonably in deciding to do so".

100. The make-up of a panel for a capability hearing is dealt with at paragraphs 18 to 20 of the MHPS framework. The capability hearing is normally chaired by an Executive Director of the Trust and should comprise at least one medical practitioner member who is not employed by the Trust. Paragraph 19 requires that arrangements must be made for the panel to be advised by a senior member of HR and a senior clinician from the same or similar clinical speciality as the practitioner. It states that it is important that the panel is aware of the typical standard of competence required of the grade of doctor in question. Paragraph 20 provides that whilst it is for the employer to decide on the membership of the panel, practitioners may raise objections to the choice of any panel member and the employer should review the situation and take reasonable measures to ensure that membership of the panel is acceptable to the practitioner.

101. The remaining paragraphs of part IV deal with representation at the capability hearing and with appeals procedures in capability cases. So far as concerns the capability hearing, among other things, the framework provides that legal representation is permitted (and despite the wording, confers a right to legal representation in a legal capacity: see Kulkarni v Milton Keyes Hospital NHS Trust [2010] ICR 101, CA); sets out requirements for the conduct of the capability hearing including the questioning of witnesses; and identifies the range of decisions that a panel has the power to make including, that no action is required, requiring agreement that there must be an improvement in clinical performance within a specified time scale with a written statement of what is required and how it might be achieved, and most significantly, termination of the contract.

102. A robust appeal procedure is prescribed, providing a mechanism for practitioners who disagree with the outcome of the capability panel's decision, with an opportunity for their case to be reviewed. The predominant purpose of

the appeal is to ensure that a fair hearing was given to the original case and a fair and reasonable decision was reached by the capability hearing panel. The appeal hearing can hear new evidence submitted by the practitioner and consider whether it might have significantly altered the decision of the original hearing. The appeal panel should not however re-hear the entire case; where that is necessary, it has power to instruct a new capability hearing (paragraphs 29 and 31).

***The role and functions of the NCAS***

103. It is also important, by way of context to appreciate the nature and character of the NCAS in order to understand its role under MHPS. The NCAS is a creature of statute. It is unnecessary to set out the history of its statutory foundations (described in his witness statement by Mr Steven Preece, a lead adviser at the NCAS). It is an operating division of the NHS Litigation Authority (the "NHSLA") which is a Special Health Authority established by article 2 of the NHS Litigation Authority (Establishment and Constitution) Order 1995. Article 3 of the 1995 Order provides that the functions of the NHSLA are those which it is directed to perform by directions issued by the Secretary of State. The currently applicable directions are the NHS Litigation Authority Directions 2013 ("the 2013 Directions") which exhaustively define the powers and functions of the NHSLA, including those carried out by the NCAS.

104. The powers and functions of the NCAS under the 2013 Directions fall into essentially three categories so far as relevant for current purposes:

i) It provides advice, guidance and support in relation to the handling of concerns about a practitioner's performance: see paragraph 2(1) (a), (b) and (g) 2013 Directions.

ii) It carries out assessments of practitioners; determines the criteria for accepting referrals and carrying out assessments; determines the criteria for accreditation of assessors: see paragraph 2(1) (f), (h), (i), (k), (l) and (m) 2013 Directions. For these purposes "assessment" is defined by paragraph 1(5) of the 2013 Directions as meaning "an assessment carried out under these Directions in relation to the performance of a practitioner who is employed by an NHS body, with respect to the provision of services under the act by that practitioner, or with respect to that practitioner's assistance in the provision of such services, and includes the referral of that practitioner for particular tests or procedures to a body other than the body carrying out the assessment". In other words, the assessment by the NCAS relates to the performance of the practitioner in his particular employed role.

iii) It provides advice, support and agrees action plans in relation to practitioners referred to it and determines criteria, methods and procedures for the drawing up of action plans: see paragraph 2(1) (g) and (h) 2013 Directions where "action plan" means "a plan drawn up

by an NHS body for the purpose of addressing any concerns identified in advice or support given under direction 2(1)(a) or (g) or any weaknesses identified by an assessment carried out in relation to a practitioner employed by that body, and includes a reference to any training programme which is drawn up for that purpose" (see paragraph 1(5) of the 2013 Directions).

105. Two particular points emerge. Firstly, the character of the NCAS functions is essentially advisory. The NCAS is not empowered to take decisions regarding a practitioner's right to continue in his or her employment relationship with the NHS referring body or to adjudicate on any dispute about the resolution of performance concerns. Secondly, the definition of 'action plan' makes clear that while the NCAS may advise on methods and procedures for drawing up and may agree an action plan, the responsibility for drawing up an action plan rests with the NHS body that employs the practitioner and the NCAS has no power to impose any action plan.

106. So far as concerns the relationship between the NCAS and the GMC, Direction 2(1)(o) requires the NCAS to work in partnership and liaise with the GMC in developing policies to ensure that overlap between its activities and those of the GMC is kept to a minimum. A written Memorandum of Understanding (dated 2009) developed in accordance with that direction reflects the different functions of the two organisations, both of whose purpose is to ensure public protection and patient safety: the GMC having the regulatory function of maintaining the medical register of qualified doctors; while the NCAS supports and enables the effective management of practitioners whose performance gives cause for concern. Paragraph 18 of the Memorandum provides that whilst the GMC and NCAS have their own processes for handling referred practitioners, each organisation will aim where possible not to run their processes for the same doctor at the same time. Where the processes do need to run either in parallel or sequentially, both organisations will endeavour to ensure transparency of handling in order to minimise duplication and disruption.

## The applicable legal principles

*Whether MHPS provisions apt to be contractually binding in individual contracts*

107. It is clear from the above (and was in any event common ground) that the MHPS framework as a whole was expressly incorporated into the Trust's contracts of employment with its employees. However, even where employment contracts incorporate the terms of a collective agreement, not all collectively agreed terms will be incorporated: Alexander v Standard Telephones and Cables Limited (No. 2) [1991] IRLR 286 at 292 – 293. The term must be one which is 'apt' for incorporation. Both parties in this case agree that not every provision of MHPS is apt for incorporation as a term in the individual contract of each employee. Mr Edis submits that the provisions of paragraphs 14, 15 and 17 of Part IV of MHPS referred to above, were apt to be terms of the Claimant's own contract. He submits that they were plainly intended to have contractual force; they are core components of the MHPS

framework and important; that importance is underscored by the fact that they are expressed in mandatory terms; there is no difficulty in applying the provisions since they are clear, workable and can easily be policed. Mr Powell on the other hand argued that whilst some provisions of the MHPS framework could properly be regarded as creating contractual rights and obligations, not every provision has that effect; and the particular clauses relied on by the Claimant in this case are not apt for incorporation, being too vague and aspirational, or unworkable and difficult to police as contractual provisions. Mr Sutton adopted a neutral stance on this part of the argument.

108. The principles applicable to the question whether particular provisions are to be treated as forming part of individual contracts of employment even where expressly incorporated are well established and there is little disagreement by the parties as to what they are. Rather, the disagreement is as to how those principles apply in this particular case.

109. The cases establish that what is important is to seek to identify what the parties must objectively have intended on the basis of the words used and their context. A number of other factors relevant to this question have been identified in the cases on this subject, and are helpfully summarised in Hussain v Surrey and Sussex Healthcare NHS Trust [2011] EWHC 1670 by Andrew Smith J at [168], including that account is to be taken of the importance of the provision to the working relationship between the employer and employee and its relationship to the contractual arrangements between them; to the level of detail prescribed by the provision and the need for courts to avoid becoming involved in the micro management of internal procedures; to the certainty of the provision since the more vague and discursive the provision, the less apt it will be to have contractual status; and to whether the provision would be workable if given contractual status.

110. I have not found it easy to decide whether paragraphs 14 and 15 of part IV MHPS relied on by the Claimant are apt to be incorporated into his contract. There are features that point both in favour of incorporation and against it. More generally, it is clear that many of the provisions of MHPS are intended to be individually enforceable and relate to matters of considerable importance to individuals. For example, provisions relating to exclusion and those that oblige the Trust to take particular steps before dismissing an employee. Equally there are provisions that are vague or aspirational, or that would be unworkable if contractually enforceable, and cannot have been intended to be contractual, but are by way of guidance only.

111. Paragraphs 14 and 15 of part IV form an important part of the arrangements leading to a capability hearing that might involve the practitioner's ultimate dismissal. Although in part discursive and directed at what the case manager should do rather than what is required of the Trust, there are some clear, mandatory obligations upon the Trust at the pre-hearing stage, in dealing with concerns about a practitioner's capability, intended to provide safeguards for practitioners. The language used is not particularly contractual, but the provisions are workable and can be given contractual effect. Given the importance in MHPS of considering potential remedial action where possible,

on balance I am satisfied that these paragraphs are and were intended to give rise to legally binding obligations.

112. By contrast paragraph 17 is less certain and more discursive. So far as adjournments are concerned, the language is advisory, providing guidance as to what the case manager should do rather than imposing mandatory obligations on the Trust. The provision descends to a degree of detail about the procedural arrangements for the normal management of capability hearings that renders it unlikely that the parties intended it to have contractual effect.

*Implied Terms*

113. It is also common ground that, at least, the following are implied terms of the Claimant's contract of employment with the Trust:

a) an implied term that the employer and employee may not without reasonable and proper cause, conduct themselves in a manner likely to destroy or seriously damage the relationship of confidence and trust between them: see Malik v Bank of Credit and Commerce International SA [1998] AC 20 at page 35C (Lord Nicholls). Whilst breach of this term may arise from a cumulative series of acts, the threshold for breach has been described as a "severe one. The conduct must be such as to destroy or seriously damage the relationship": see Gogay v Hertfordshire County Council [2000] IRLR 703 at [55].

b) Where a contract of employment provides an employer with a prima facie unlimited discretion, it will be regarded as subject to an implied term that the discretion will be exercised genuinely and rationally. Accordingly discretion conferred on the Trust in relation to MHPS is to be exercised in accordance with the implied term of trust and confidence and in a manner that is both rational and not capricious.

c) It is an implied term of the contract that MHPS is to be followed in respect of any matter of capability or conduct unless the Trust can show a good reason not to do so.

114. Whilst Mr Edis also contends for a freestanding, discrete implied term of fairness, I am not persuaded that a general obligation to act fairly is properly to be implied into a contract of employment. Rather where the authorities contemplate questions of fairness, they do so in the context of the implied term of trust and confidence, or on a narrower basis by reference to an implied term that disciplinary processes will be conducted fairly, without unjustified delay.

***The approach to construction of disputed paragraphs of MHPS***

115. Against that background, I turn to consider the proper construction of the disputed paragraphs of MHPS that I have found to be legally enforceable. Once again, the principles of construction are not in dispute. The task is to ascertain the meaning which paragraphs 14 and 15, in particular, would

convey to a reasonable person having all the background knowledge which would reasonably have been available to the parties at the time. I do not regard the guidance produced by the NCAS in the form of Practice Statements issued in 2010 and 2012 as relevant to the construction exercise, and do not consider it further.

116. An important part of the relevant background here is the way in which the MHPS framework was agreed. Its essential character is that of a collective agreement negotiated by officials from the Department of Health and representatives from affected bodies including the NCAS's predecessor body. Accordingly it is all the more important that it should not be construed as a statute but rather, a practical, purposive interpretation is appropriate having regard to the statutory functions of the NCAS and the way in which the NCAS performs those functions. Its discursive terms ought not to be read in a way that would introduce unhelpful inflexibility or make its application unduly restrictive. Mr Sutton also contends and I accept, the MHPS framework is a procedure designed to govern the resolution of concerns about a practitioner's conduct or capability arising in the context of the employment relationship. A proper interpretation of MHPS can therefore be expected to reflect the hierarchical character of that relationship where the ultimate decision-making power and responsibility is vested in the employer who is entitled to exercise a contractual right through a disciplinary or capability process to terminate the employment.

117. The evidence of Mr Preece about the way in which the NCAS operates in practice was uncontroversial. He states that the aim of the NCAS is to work with the parties to clarify their concerns, understand what is leading to them and make recommendations to help practitioners return to safe practice. The NCAS does not take on the role of an employer and is not responsible for adjudicating upon or taking decisions about a practitioner's ability to continue in his or her employment. It is for the employer to assess the advice and guidance given by the NCAS and to determine the appropriate action to be taken in each case. The NCAS is a purely advisory body providing guidance. It has no role in the decision making process nor does it function as a regulator.

118. The range of services provided by the NCAS comprises initial advice and support; assessments; and action planning advice and guidance. So far as assessments are concerned, a full NCAS assessment consists of three components: an Occupational Health Report; an Occupational Psychology Report; and a Clinical Assessment. These elements can be carried out separately and a partial assessment is possible. Where a full assessment is undertaken, it costs in the region of £50,000 and takes 3 to 4 months to complete.

119. Mr Preece explains that paragraphs 14 and 15 of part IV of MHPS address distinct stages of the NCAS functions. Under paragraph 14, following a local investigation into concerns about a practitioner's capability, if local action is not practicable, the matter must be referred to the NCAS for it to decide whether an assessment should be carried out and to provide assistance in drawing up an action plan.

120. Mr Preece states that all requests for assessment are considered by a group comprising senior members of the NCAS staff experienced in assessment methods and the use of such methods in the resolution of performance concerns. The decision-making group determines whether an assessment is appropriate, and seeks the views of the practitioner and the referring body. Relevant factors to the question whether an assessment should be conducted include whether an assessment would appreciably add to what has already been established through earlier investigation, or whether another investigative process is already under way that might render an NCAS assessment unnecessary.

121. If the NCAS decides to pursue an assessment, an assessment team is commissioned to conduct it. For the detailed reasons he gives in his witness statement, Mr Preece states that where the NCAS concludes that an assessment is not appropriate under paragraph 14, the further assistance it can then provide is limited to helping the parties understand what an action plan might involve in those circumstances and helping them to compile and follow such a plan if they are able to agree a way forward. If the parties cannot agree a way forward, a capability hearing is the correct forum for considering the evidence and for resolving any impasse between employer and employee. Where such a capability panel decides that the practitioner's performance is remediable, Mr Preece explains that the NCAS can be consulted again under paragraph 14 about whether a further assessment is required and if appropriate, for assistance in compiling an appropriate action plan.

122. So far as paragraph 15 is concerned, Mr Preece states that this applies only where the decision-making group determines that an assessment is appropriate under paragraph 14. Where that occurs, an assessment team is commissioned to carry out an assessment to provide a view of the practitioner's current practice. Following such an assessment, if areas for remediation have been identified, the NCAS can work with the referring body and the practitioner to produce an action plan that can be agreed and implemented. If the action plan proposed is not agreed (for whatever reason, including that it is either disproportionate or impractical) the referring body may decide to address the issues through a capability or other local procedure.

123. If the NCAS assessment identifies such serious shortcomings in the practitioner's performance that any action plan to address them would have to be so extensive and is likely to be disproportionate then NCAS can express such a view. However, Mr Preece makes clear that in his experience it is highly unlikely that any NCAS assessor would feel comfortable saying in effect, that a practitioner's performance is so fundamentally flawed that remediation is impossible. In most cases the NCAS is able to identify an action plan that appears to have some prospect of success and does not generally advise that remediation is impractical unless and until such a plan has been tried and shown to fail. He stresses that it is for the referring body to decide whether remediation is practical having regard to all the circumstances, including the financial and management resources available to the referring body.

124. Two other points are emphasised by Mr Preece. Firstly the NCAS assessment is not an assessment of a practitioner's fitness to practise generally. The NCAS assessment panel is concerned with whether the practitioner is capable of fulfilling the role for which he or she is employed by the referring body. Secondly and having regard to that distinction, the NCAS does not delegate its assessment responsibilities to the GMC. A decision to await the outcome of a GMC assessment, is a practical measure to avoid unnecessary and costly duplication where there is likely to be overlap between the two assessments, but does not constitute a delegation of the NCAS functions to the GMC. Where a decision to await the outcome of a GMC decision is taken, the NCAS reviews all available material at the end of the process including the GMC assessment to determine whether a further assessment by the NCAS should take place. The fact that a GMC assessment has been conducted does not therefore prevent the NCAS from undertaking its own assessment if that remains necessary or appropriate.

125. Finally, Mr Preece deals in his statement with the case of Lim v Wolverhampton Hospital NHS Trust. Although the NCAS was invited to intervene in those proceedings, it chose not to do so. He describes a number of practical difficulties flowing from the judgment in that case including: firstly, a lack of clarity as to what action may be taken when an assessment is declined by the NCAS as inappropriate for whatever reason; secondly, where an assessment is not carried out, it may not be appropriate for the NCAS to determine whether or not there is any realistic chance of remediation, but the practical consequence of that is not acknowledged or explained; thirdly, even where an assessment has been carried out, there may be reasons why an action plan cannot reasonably be implemented but again as a matter of practice it is unclear what action should be taken in those circumstances.

## THE ISSUES

126. Although other matters are pleaded or have been raised, it is agreed that there are essentially two issues to be determined in this case:

a) whether it is unlawful for the Trust to proceed with a capability hearing under MHPS before there has been independent consideration by the NCAS of assessment of the Claimant's capability and a decision by the NCAS panel that the Claimant's capability is so fundamentally flawed that remediation stands no realistic prospects of success.

b) Alternatively, whether it is unlawful for the Trust to proceed with the capability hearing that will consider the GMC Performance Assessment Report, before the MPTS has concluded its enquiry into the Claimant's fitness to practise and delivered its findings on the reliability of the GMC's Performance Assessment Report.

127. The Claimant does not pursue any freestanding argument based on delay, or any alleged failure to make proposals for retraining, or any alleged failure to agree to the proposed placement at the Princess Alexandra Hospital, or in relation to the Claimant's lengthy exclusion.

***First issue: unlawful to proceed without NCAS assessments***

128. The Claimant's primary case is based on a construction of paragraphs 14 and 15 of part IV of MHPS that renders both a referral for assessment of the practitioner's ability to fulfil his role and of the prospects of success of a remedial action plan, mandatory preconditions to any capability hearing. Furthermore, before any capability hearing can lawfully take place, there must be an assessment of the practitioner's capability by the NCAS and a recommendation that remediation stands no realistic chance of success. Mr Edis relies as support for these propositions on the conclusions of Slade J in Lim v Royal Wolverhampton Hospitals NHS Trust at [76] that:

> "in my judgement, part IV requires reference to the NCAS for it to consider whether an assessment is to be carried out *and* the advice of their assessment panel that no action plan would have a realistic chance of success before the case manager may decide whether to proceed to a capability hearing." (emphasis added)

129. Slade J confirmed that this was the case even in the context of a clinician who had been guilty of gross negligence and notwithstanding the potential for negligence claims against the referring trust. Mr Edis submits that a full assessment may not be necessary and that it is not open to the NCAS to adopt an unnecessarily narrow or wide interpretation of assessment that would undermine the discharge of its statutory functions. Accordingly, whilst it may be open to the NCAS to decline a so-called 'full' assessment, the NCAS does not have the right to refuse to assess on a more limited basis, the evidence available to it, in order to reach a view on the prospects of remediation. To proceed otherwise would be a breach of contract and unlawful.

130. Mr Edis submits that Slade J may wrongly have detected an inconsistency between paragraph 17 part I and the paragraphs of part IV with which I am concerned. In his submission, paragraph 17 part I describes the matters to be included in the investigation report or alternatively a provisional decision making stage. It does not, he submits, confer any power on the case manager to refer a case to a capability hearing without fulfilling the mandatory requirements of paragraphs 14 and 15 of part IV. No such power is conferred by part I; that is the business of part IV. Under paragraph 4, part IV, he submits, a case manager is obliged to refer the case to the NCAS for assessment, where 'refer' has a specific meaning in the context of obtaining an 'assessment' and means completion of a referral form for the purposes of an assessment rather than simply 'involve in some non-specific way'. There is a clear link between paragraphs 14 and 15 which are to be read together where a capability hearing is in active contemplation. Paragraph 14 governs the case manager's role in the decision-making and onward referral, whilst paragraph 15 governs the NCAS role in assisting the referring trust. This he submits, makes compliance with paragraphs 14 and 15 workable and achieves a scheme that is consistent with the overriding purpose of part IV of MHPS which is designed to secure an independent source of advice for referring bodies considering capability hearings, that is able to assist them in approaching that

process appropriately and having regard to all relevant considerations including, whether or not remediation has a realistic prospect of success.

131. I first consider the question of construction in light of the principles I have identified and the submissions made on the Claimant's behalf. Next, I consider whether my approach is consistent with Lim and other decided cases; and if not, whether that requires or causes me to alter my view.

132. In general terms it is clear that paragraphs 13 to 16 of part IV describe the pre-hearing process within a capability procedure. Paragraph 13 deals with receipt of an investigation report, also described in part I. Under both MHPS part I and part IV the report of the investigation is submitted to the case manager. Paragraph 17 of part I requires the report to provide sufficient information for the case manager to make a decision whether (among other things) there are concerns about the practitioner's performance that should be further explored by the NCAS or there are intractable problems and the matter should be put before a capability panel. On the face of paragraph 17 it is open to the case manager, where there are intractable problems, to refer the matter to a capability panel without first making a reference to the NCAS. By contrast following receipt of the investigation report, if the case manager in consultation with other relevant individuals considers that local action is not practicable for any reason, paragraphs 4 and 14 of part IV make clear that the matter must be referred to the NCAS, before it can be referred to a capability panel.

133. Neither side contends that this apparent conflict between the two parts of MHPS is incapable of being resolved in a way that is consistent with the objectives sought to be achieved. If that is possible, it ought to be done. In my judgment, it is not to be done by treating paragraph 17 of part I as identifying the information to be contained in the investigation report or as reflecting a provisional decision-making stage. The former is inconsistent with the words of the relevant part of paragraph 17 which describe the decision to be taken as one taken by the case manager; nor is it consistent with a 'provisional' decision given that it describes potentially final decisions such as, no further action being needed.

134. Paragraph 17 of part I and paragraphs 14 and 15 of part IV can be reconciled as Mr Sutton and Mr Powell have submitted, by interpreting the paragraph 17 decision as coming after paragraphs 13 and 14 in part IV. That reflects a practical and purposive approach to the two parts of MHPS published separately a few years apart, but intended to work together harmoniously: on receipt of the investigation report referred to in both paragraph 17 part 1 and paragraph 13 part IV, the case manager must give the practitioner the opportunity to comment in writing on the factual content of the report (paragraph 13, part IV) and must thereafter consider the findings of the report together with the practitioner's comments and having consulted appropriately determine whether the issues are capable of resolution through local action (paragraph 14, part IV). If not, a referral to the NCAS for consideration of whether an assessment should be carried out must be made. This is the real and intended safeguard for the practitioner. Assisted by advice from the NCAS as to whether an assessment should or should not be carried out, the

range of decisions identified at paragraph 17 of part I is open to the case manager, who must decide whether the matter should be referred to the NCAS or whether there are intractable problems and the matter should be put before a capability panel.

135. The obligation to refer the matter to the NCAS under paragraph 14 for a decision whether an assessment should be carried out carries with it the clear implication that the NCAS may decide that an assessment should not be carried out. This is consistent with paragraphs 2(1)(f) and (h) of the 2013 Directions which provide that the NCAS functions include determining the criteria for accepting referrals for assessment and for the carrying out of assessments.

136. The sentence requiring the matter to be referred to the NCAS for consideration of whether an assessment should be carried out also refers to the NCAS providing assistance in drawing up an action plan. This drafting lacks clarity and is ambiguous. It could be read as obliging the NCAS to assist in drawing up an action plan irrespective of whether an assessment is carried out or not. Given the importance of the process for drawing up an action plan being consensual, requiring agreement by the Trust and practitioner alike, and the absence of any ability of the NCAS to require or dictate that an action plan be followed (the NCAS role being limited to providing assistance), I do not consider that this is the practical or purposive interpretation intended. In my judgment the provision of assistance in drawing up an action plan is permissive, not mandatory. Accordingly, where the NCAS determines that an assessment is not appropriate, two outcomes may follow: the NCAS may be able to provide assistance in drawing up an action plan nevertheless, because there is sufficient information available by virtue of investigations that have already been completed and the parties are able to agree on an appropriate plan; however, having decided that an assessment is not appropriate, the NCAS may also decide that it is not possible (for whatever reason) to assist in drawing up an action plan. This construction is consistent with paragraphs 2(1)(g) and (h) of the 2013 Directions which make clear that the NCAS may advise on the methods and procedures and may agree an action plan but ultimate responsibility for drawing up such a plan rests with the NHS employing body and the practitioner. It is also consistent with the advisory character of the NCAS.

137. Two points follow from this. First, the only mandatory obligation on a Trust once local action has been ruled out is to refer the matter to the NCAS for it to consider whether an assessment should be carried out. There is no obligation on the NCAS to carry out an assessment and no obligation to provide assistance in drawing up an action plan. Secondly, in circumstances where no assessment and no action plan are possible or practicable, the process will be exhausted without resolution of the capability concerns in question. In such a case the obvious forum for achieving a resolution of the capability concerns in question is a capability panel. By way of example given by Mr Sutton in the course of argument, if the impasse has arisen because the employer regards a proposed action plan as inadequate to address the concerns that have arisen but the practitioner contends that it represents a practicable way forward, the

competing contentions can be advanced at a capability hearing for determination and resolution by the capability panel.

138. Paragraph 15 addresses the situation where an assessment is carried out and identifies a lack of capability. In such a case, the NCAS "will assist the employer to draw up an action plan designed to enable the practitioner to remedy the lack of capability that has been identified during the assessment". But as its wording indicates, paragraph 15 only applies in circumstances where a decision has been taken to undertake an assessment, and that assessment has identified areas of lack of capability. Absent an assessment identifying areas of lack of capability, no obligation to assist in drawing up an action plan arises. Paragraph 15 also emphasises that the action plan must be agreed by the Trust and the practitioner before it can be actioned; and that it is only if the action plan is "agreed" that the Trust is required to facilitate it. It follows that this is a further stage at which it is envisaged that an impasse may arise: if despite an assessment having been carried out identifying areas of lack of capability, the parties cannot agree on an action plan designed to remedy the lack of capability so that there is no basis on which the NCAS can advise whether remediation stands a realistic chance of success, the process will be exhausted without resolution of the capability concerns in question. Again, the obvious forum for resolution in such a case is an internal capability hearing.

139. Having addressed the circumstances when the NCAS will assist in drawing up an action plan, paragraph 15 provides:

> "There may be occasions when a case has been considered by the [NCAS], but the advice of its assessment panel is that the practitioner's performance is so fundamentally flawed that no educational and/or organisational action plan has a realistic chance of success. In these circumstances, the case manager must make a decision, based upon the completed investigation report and informed by the [NCAS] advice, whether the case should be determined under the capability procedure."

As the opening words of this part of paragraph 15 indicate, this describes an example of occasions where the case may proceed to a capability panel. It does not purport to describe the *only* occasions in which it may do so and nor does it provide that it is *only in these circumstances* that such a decision to proceed to a capability panel may be made. Paragraph 15 provides that a decision may be made to proceed to a capability hearing. This is, properly construed, a particular circumstance in which a capability hearing may be convened; although it is apparent from a purposive interpretation of paragraphs 14 and the remainder of paragraph 15 that there are other such circumstances as just described.

140. This does not mean that a referring Trust may act irrationally, unreasonably or capriciously in rejecting an action plan suggested by the practitioner or by the NCAS simply in order to proceed to a capability hearing. Where there is a genuine and rational dispute about the proper interpretation of the available evidence about the lack of capability or the prospects of remediation, the proper forum for resolution of such a dispute is once again at a capability hearing with all the safeguards provided by part IV.

141. In Lim, Slade J reached a different conclusion about the meaning of paragraphs 14 and 15 of part IV MHPS. She did so in circumstances where the NCAS had been invited to participate in the proceedings but had declined to do so and she was not assisted therefore, as I have been, with statutory materials and lengthy submissions concerning the nature and functions of the NCAS, or evidence about the practical application of the processes set out in MHPS from the perspective of the NCAS.

142. At paragraph 76 of her judgment Slade J concluded that part IV requires reference to the NCAS for it to "consider whether an assessment is to be carried out and the advice of their assessment panel that no action plan would have a realistic chance of success before the case manager may decide whether to proceed to a capability hearing." At paragraphs 85 and 86, Slade J recognised that the NCAS is not obliged to carry out an assessment, but nevertheless concluded that

> "What is required is that an NCAS assessment panel advises that the practitioner's performance is so fundamentally flawed that no action plan has a realistic chance of success. Accordingly the defendant would be in breach of contract if it were to proceed to a capability hearing of the claimant's case before an NCAS assessment panel has advised..."

143. Mr Sutton submits that these paragraphs demonstrate that Slade J was construing paragraphs 14 and 15 conjunctively, as providing a single route to a capability hearing which could only be convened at the conclusion of the whole process. On the approach of Lim there will be cases left with unresolved capability concerns, where there is no power to proceed with the only mechanism capable of resolving such concerns, namely a capability hearing. He submits that such an unworkable and inflexible construction would be wholly contrary to the applicable principles of construction referred to above.

144. Like Slade J, I regard as powerful the argument that construing the reference to the NCAS for advice as to whether an action plan has a realistic chance of success as a precondition of any referral to a capability hearing and therefore as significantly limiting the circumstances in which an employer trust can lawfully proceed to a capability hearing, is onerous and potentially unworkable (see Lim at [83]). It is difficult to see what practical value there is in a reference to the NCAS for assessment of the prospects of success of an action plan in the case of a doctor where the nature and extent of the evidence of lack of capability means that a capability procedure is inevitable; for

example, where expert evidence indicates that he or she is guilty of gross negligence and continued employment of that doctor may expose the employer to negligence claims.

145. Moreover, in my judgment, requiring the NCAS to make a decision on remediation in every case has the effect of elevating the NCAS from adviser to adjudicator in relation to a practitioner's future employment. In effect it confers a power on the NCAS to impose an action plan on the parties even where the employer does not agree. That is inconsistent with the powers and functions of the NCAS described above; and is inconsistent with the autonomous role of the employer in whom the ultimate managerial decision-making power and responsibility is vested. Further, by requiring the NCAS to be the primary decision-maker about the prospects of remediation, the detailed safeguards provided by MHPS in relation to capability hearings are undermined. Disputed questions about the prospects of remediation will not be decided in the structured way identified by part IV of MHPS, at a capability hearing where the composition of the panel is prescribed and includes a specialist clinical adviser, there is a right to be heard and to be legally represented, there is a right to call or question witnesses and there are robust appeal procedures, but will be decided by the NCAS without such safeguards in place. Finally, requiring the NCAS to advise that remediation stands no realistic prospect of success before any capability hearing can be convened amounts to a bar on the convening of a capability hearing absent a conclusion that the practitioner is irremediable. That construction cannot easily be reconciled with the range of possible outcomes of a capability hearing for which provision is expressly made in paragraph 24, part IV of MHPS, in particular, the possibility of an agreement that there must be improvement in the clinical performance of the practitioner with a written statement of what is required and how it is to be achieved.

146. For these reasons, I respectfully disagree with the conclusions of Slade J identified above. In my judgment, the requirements in paragraphs 14 and 15 are to be read disjunctively, and in the way I have identified above. Where the NCAS considers that no assessment is appropriate, that can conclude its involvement and leave open to the employer the possibility of achieving a resolution of any unresolved capability concerns by a capability hearing. The effect of this construction is that an employer trust *can* proceed to a capability hearing even if it has not received advice of an assessment panel of the NCAS that the practitioner's performance is so fundamentally flawed that no action plan has a realistic chance of success.

147. Nor does the Court of Appeal's judgment in Mezey v South West London & St George's Mental Health NHS Trust [2010] EWCA Civ 293 prevent this conclusion. Mezey was dealing with a hybrid procedure involving the DOH circular HC(90)9 on 'disciplinary procedures for hospital staff' and MHPS. At [55] to [57] Ward LJ identified a threshold for invoking disciplinary action under part IV MHPS that was not crossed in Dr Mezey's case. Paragraphs 58 and 59 reflect the aim and purpose of part IV MHPS and emphasise that "resort to the NCAA is mandatory for it is better than discipline except where there is a genuinely serious failure. There has been no resort to the NCAA

here." The court was not concerned accordingly with the question whether assessment of a remediation plan as having no realistic prospect of success was a necessary precondition to a capability hearing proceeding; this question simply did not arise. To the extent that paragraph 59 appears to treat this as a gateway to a capability hearing, (and ignoring the inaccurate transposition of the language from paragraph 15 MHPS) I do not think that can have been intended.

***Second issue: unlawful for other reasons***

148. By way of alternative argument, the Claimant contends that an injunction should be granted preventing the matter from proceeding to a capability panel at least until the outcome of the GMC's FTP panel decision is known. The alternative case is put on a number of bases:

i) There was a promise in the form of a representation made by the Trust that it would await the outcome of the GMC process at an earlier stage. In the absence of some change in the facts or circumstances so as to give rise to a rational or fair basis for resiling from that promise, the Trust is not entitled to do so and should be restrained from acting in breach of this promise.

ii) Even if no promise was made, by reference to the express and/or implied terms of the Claimant's contract as to fairness, the decision to proceed to a capability hearing is a breach or anticipatory breach of those terms.

iii) Alternatively, the decision to proceed to a capability hearing is so unfair as to amount to an anticipatory repudiatory breach of the implied term of trust and confidence.

iv) Alternatively the exercise of any discretion conferred by the contract on the Trust must not be capricious or irrational. The refusal to adjourn the capability hearing procedure, in the circumstances of this case against the background of serious delay, is irrational and accordingly in fundamental breach of contract.

I deal with these in turn below.

149. I am quite satisfied that no promise or representation was made by the Trust that it would await the outcome of the GMC/MPTS process at any stage. The letter relied on by the Claimant, dated 26 March 2009, does not support his contention. Nor is there anything in the regular letters sent in accordance with MHPS every four weeks to the Claimant by Ian Scott or Peter Donaldson (extending his exclusion) suggesting that capability panel proceedings were on hold pending the outcome of an MPTS panel hearing. Rather the reasons given by the Trust for these extensions changed over time as follows: (i) initially the Trust was trying to arrange a meeting with him, and the

extensions were designed to enable this to take place (9 December 2005); (ii) then to enable the Trust to complete its investigations (6 January 2006 to 6 November 2007); (iii) then because the Trust was awaiting the outcome of discussions between the NCAS and the GMC (5 December 2007); (iv) subsequently the Trust was awaiting the outcome of the GMC assessment (2 January 2008 two 7 January 2009); and finally (v) the Trust repeatedly extended the exclusion pending the undertaking of proceedings associated with a capability hearing procedure (9 February 2009 to 24 September 2011).

150. Further it is clear from the evidence of Mr Donaldson about conversations with the Claimant during his clinical observer-ship in 2012 (and reflected in follow-up correspondence) that there was unlikely to be any meeting of minds between the Claimant and the Trust over the nature of an action plan that would be required and that it was unlikely that any agreed action plan could be put in place. In those circumstances the only way the impasse could be resolved was a capability hearing, but he was prevented from taking matters further by the need to await a final decision from the NCAS about whether it would carry out an assessment of the Claimant or not. Nothing in the correspondence during this period amounts to a representation that the Trust was awaiting or would await the decision of the MPTS.

151. In any event, in my judgment, even if the Trust did decide to wait and see whether the dispute between the Claimant and the GMC was capable of resolution (as plainly occurred at certain points in the long history of this matter), that would not prevent the Trust from rationally deciding that a point had been reached where it would wait no longer.

152. The Claimant contends that even in the absence of any such promise, the decision to proceed to a capability hearing is a breach or anticipatory breach of the express and/or implied terms of the Claimant's contract as to fairness. I do not accept this argument. There is no express term of the contract requiring the Trust to await the outcome of the GMC proceedings. Whilst the MHPS framework expressly identifies when a practitioner must be referred to the GMC, it makes no provision for internal proceedings to be delayed pending the outcome of such a referral. By contrast, express provision is made about the interaction between proceedings under MHPS and criminal proceedings, and which is to take priority. Had there been any intention that a capability panel hearing should await the outcome of MPTS proceedings; this would have been dealt with expressly.

153. The fact that the Claimant is challenging the GMC Performance Assessment Report, which forms an important part of the evidential material to be considered at the capability hearing, and that he does so both substantively and procedurally, does not alter this conclusion. The Trust has no role to play in the MPTS proceedings and is not bound in any way by their result. At a capability hearing the Claimant will be able to present evidence seeking to challenge the GMC Performance Assessment Report, including the evidence he has relied on thus far in the MPTS proceedings (by way of transcripts of evidence and other relevant documents). Unlike in the proceedings before the MPTS, there will be a specialist cardiologist advising the capability panel, and the Hodgkinson report will be considered. Moreover, as Mr Edis conceded the

capability panel itself could decide to adjourn to await the outcome of the MPTS proceedings if it considers that to be an appropriate course to adopt.

154. I have set out above my view in relation to the question whether there is a freestanding implied term of fairness and concluded that no such freestanding term is to be implied. Nevertheless, terms of fairness in the conduct of disciplinary procedures and mutual trust and confidence are implied. In my judgment, the Claimant has not established a factual basis for breach of any of the implied terms he has relied on and nor has he established the alleged "serial" or "conspicuous unfairness" for which he contends.

155. It is undoubtedly the case that there have been delays in this process. The Claimant was excluded for a very long time from his employment as a Consultant with the Trust and I am sure that this has caused him considerable anxiety, stress and distress. I am also satisfied that there has been some delay on the part of the Trust itself. However I am entirely satisfied that the most significant and lengthy delays were caused by unnecessary or protracted correspondence or proceedings engaged in by the Claimant and his solicitors in their dealings with the Trust, the GMC and the NCAS. There were particularly lengthy and unexplained periods of delay in relation to the GMC procedures, together with judicial review challenges that achieved no substantive change in position for the Claimant but served only to delay matters significantly. Further, following receipt of the GMC Performance Assessment Report, the Claimant repeatedly refused to cooperate with the Trust. There was a threat by the Claimant of legal proceedings when the Trust first sought to convene capability proceedings in April 2009. There was a refusal by the Claimant to attend a meeting with the Trust and the Princess Alexandra Hospital to discuss a proposed placement, or to provide the Trust with confirmation that Princess Alexandra Hospital had been provided with a copy of the GMC Performance Assessment Report, or to allow the Trust to contact the Princess Alexandra Hospital directly. There were refusals by the Claimant to attend meetings with Peter Donaldson. Even at the point where Mr Donaldson made clear he wished to meet the Claimant to consider alternatives to exclusion, there was a reluctance if not an outright refusal by the Claimant to engage with him to achieve this.

156. I do not accept that the Trust has never genuinely made an attempt to rehabilitate the Claimant to the workplace; or that the Trust was merely seeking to achieve a legally impregnable way of terminating the Claimant's contract. On the contrary, I am satisfied that despite the early Board decision to proceed to a capability hearing, the Trust did not pursue this course. It acceded instead to the Claimant's request to allow an action plan to be developed and genuinely engaged with the Deanery and other external bodies, including seeking advice from the NCAS, to understand what might constitute an appropriate action plan in his case. It did so despite the apparent reluctance of the Claimant and his solicitors to provide relevant information or to allow direct contact between the Trust and such bodies.

157. The Trust's attempts to participate in and support development of an action plan were made more difficult by the confusion created by the disparity between the GMC Performance Assessment Report and the undertakings

offered and agreed in 2009, together with the Claimant's intransigence in insisting that limited retraining was all that was required. Once it became clear that the Claimant would not accept the revised undertakings offered by the GMC, the gulf between the Claimant's view of his capability and competence and the level of retraining required, and the view held by the GMC and Peter Donaldson based on the GMC report and the Hodgkinson report became even more difficult to bridge. Nevertheless, Peter Donaldson continued to seek advice from the NCAS on a regular basis, to identify a way forward, including avenues for possible remediation in the Claimant's case. Peter Donaldson also persisted in trying to arrange meetings with the Claimant despite repeated refusals by him to do so.

158. I reject the suggestion that the Trust refused to allow the placement at the Princess Alexandra Hospital to go ahead. Rather, it is clear from the correspondence that the Trust wished reasonably to understand how the PDP and the placement there had been arrived at, what it sought to achieve and how that was consistent with the GMC Performance Assessment Report. The Trust was obstructed in its attempts to obtain information by the Claimant. Ultimately however, it was the GMC's actions (including withdrawal of the undertakings signed in 2009) that led to the placement not going ahead, as the Claimant recognised in his evidence.

159. Accordingly, whilst some criticism can be made of aspects of the Trust's conduct of this process looking back over the chronology and with the benefit of hindsight (as both Mr Donaldson and Ms Fryatt fairly and realistically accepted), in my judgment those responsible at the Trust have done their best in difficult circumstances and genuinely sought to deal with a difficult situation in the way they thought best at the time. Ultimately I have come to the conclusion that the decision to refer the matter to a capability panel cannot in any way be characterised as a breach of the implied term of trust and confidence or any variation of that term.

160. Mr Edis submits that the Trust has demonstrated no good reason for proceeding to a capability hearing now and if there is no good reason, the decision to do so is capricious or irrational. I reject this submission. Whilst it may be the case that the Trust could and should have commenced the capability procedure some time ago, rather than waiting as it did, that does not afford any legal basis for preventing the Trust from pursuing this course now. There is a significant and apparently intractable dispute between the Trust and the Claimant about his competence and capability to fulfil his role as a Consultant at the Trust. The only forum for resolution of that dispute is a capability hearing convened in accordance with MHPS. The only requirement is that the threshold of a prima facie case that the practitioner lacks the requisite capability, competence or has rendered a consistently poor performance must be established so as to justify reference to such a panel. It was the task of the case manager, Peter Donaldson, to exercise a judgment as to whether the relevant threshold is established in this case. Having considered the Hodgkinson report together with the Claimant's comments on it, the GMC performance assessment report together with the Claimant's comments on it, and the relevant advice of the NCAS, he has decided that the

threshold is met. In the circumstances, there is a proper basis for proceeding to a capability hearing, that threshold having been established. Fairness to both parties requires some degree of finality now.

161. The risks identified by Mr Edis, including that the capability panel may choose to adopt a procedure that does not permit examination of the details of the MPTS transcripts or other relevant documents, or may refuse to grant any request by the Claimant for a reasonable adjournment, are not risks that should be entertained by this court. The capability panel must act in accordance with MHPS, and must exercise discretion on a rational basis. More importantly however, as a general rule it is not appropriate for the courts to intervene to remedy irregularities in the course of internal disciplinary proceedings between an employer and an employee. Such intervention causes unnecessary delay and expense, leading to the sort of micro-management that courts have repeatedly deprecated: see for example Kulkarni v Milton Keynes Hospital NHS Trust [2009] EWCA Civ 789 at [22].

162. This case concerns the exercise by an employer of contractual disciplinary powers. There is no contractual bar to the exercise of those powers and no legal barrier has been established that should prevent the Trust from proceeding to a capability hearing now or from holding a capability hearing before the outcome of the MPTS proceedings. It will be for the capability panel to determine its approach to the issues and the evidence and to consider the question of any adjournment application that is made. For all these reasons the Claimant's claim fails and is dismissed.

163. The parties are invited to agree any consequential orders failing which the matter will be listed for further argument.