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**A Review of Appraisal, Disciplinary and Reporting
Arrangements for Senior NHS and University Staff
with Academic and Clinical Duties**

**A report to the Secretary of State for Education and Skills,
by Professor Sir Brian Follett and Michael Paulson-Ellis**

September 2001

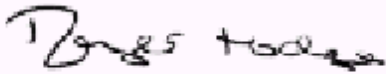
Foreword

The inquiry into Alder Hey Children's Hospital, Liverpool, exposed some terrible events there. David Blunkett, then Secretary of State for Education and Employment asked Sir Brian Follett and Michael Paulson-Ellis to review the appraisal, disciplinary and reporting arrangements for joint appointments between the NHS and universities. Deficiencies in these arrangements were seen as a major problem at Alder Hey. Both the universities and the NHS were determined to ensure that there would never be another Alder Hey. This report is the outcome of the review.

John Hutton, Minister of State at the Department of Health and I are grateful to Sir Brian and Mr Paulson-Ellis for their work and welcome the report as a valuable contribution to solving difficult and long standing management issues.

Looking forward, we expect the implementation of the recommendations of this report to support more effective relationships between the universities and the NHS. Relationships that will benefit not only the managers and staff, but most importantly, patients.

But this report is just the beginning. It is now for the Department for Education and Skills along with the Department of Health and the National Health Service to work with the universities and trusts, and all other representative and professional bodies with responsibility for the medical and dental services in this country, to ensure that the recommendations of the report are implemented. John Hutton and I will be looking for real and positive progress towards full implementation of the recommendations by the end of this year. Any other outcome is not an option.



MARGARET HODGE

Minister of State for Lifelong Learning and Higher Education

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Review of appraisal, disciplinary and reporting arrangements for senior National Health Service (NHS) and university staff with academic and clinical duties

Summary of recommendations

- The key principle for NHS and university organisations involved in medical education and research should be ‘joint working to integrate separate responsibilities’ (Paragraph 13).
- University and NHS partnerships responsible for medical education and research should establish joint strategic planning bodies, with joint subsidiary bodies responsible for staff management policies and procedures for staff with academic and clinical duties (Paragraphs 14-17).
- Universities and NHS bodies should formally make all senior NHS and university staff with academic and clinical duties fully aware to whom they are accountable for the separate facets of their job (Paragraphs 18-23).
- The key principle of joint working to integrate separate responsibilities should be applied to the management of senior NHS and university staff with academic and clinical duties (Paragraph 24).
- The job descriptions for new and replacement senior NHS and university staff posts with academic and clinical duties should be jointly prepared and formally agreed by both partners prior to advertisement (Paragraphs 26-30).
- Appointments to senior NHS and university staff posts with academic and clinical duties should be jointly made under procedures agreed by the partners (Paragraphs 31-38).
- NHS regulations for consultant appointments, as well as those of the relevant university, should be applied to selection committees for clinical academic posts involving honorary consultant appointments (Paragraph 33).
- Substantive and honorary contracts for senior NHS and university staff posts with academic and clinical duties should be explicit about separate lines of responsibility, reporting arrangements and staff management procedures, and should be consistent, cross-referred and issued as a single package (Paragraphs 39-45).
- The substantive university contract and the honorary NHS contract for clinical academics should be interdependent (Paragraph 41).
- Universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners (Paragraphs 46-60).
- The process should:
 - a. involve a decision on whether single or joint appraisal is appropriate for every senior NHS and university staff member with academic and clinical duties;
 - b. ensure joint appraisal for clinical academics holding honorary consultant contracts and for NHS staff undertaking substantial roles in universities;

- c. define joint appraisal as two appraisers, one from the university and one from the NHS, working with one appraisee on a single occasion;
 - d. require a structured input from the other partner where a single appraiser acts;
 - e. be based on a single set of documents; and
 - f. start with a joint induction for those who will be jointly appraised (Paragraphs 51-60).
- Associated universities and NHS bodies should jointly prepare a formal agreement on the procedures for the management of poor performance and for discipline to be followed for senior NHS and university staff members with academic and clinical duties (Paragraphs 61-66).
 - As a minimum, these procedures should:
 - a. ensure joint working in the process from the time implementation of it is first contemplated;
 - b. specify which body is to take the lead in different types of cases;
 - c. ensure suitable cross membership of disciplinary bodies; and
 - d. be expeditious (Paragraphs 62-63).
 - The current review of the NHS award scheme for consultants should remove barriers to the full participation of clinical academic staff with honorary contracts (Paragraphs 67-68).
 - The recommendations in this report should apply equally to Dental Schools, with appropriate modifications to take account of their special features (Paragraphs 75-77).
 - Implementation of our recommendations should be facilitated by structured joint national action initiated by the Department for Education and Skills and the Department of Health (Paragraphs 78-84).
 - Universities should consider new formal and informal means of collective action to assist them in implementing our recommendations (Paragraph 80).

Introduction

1. When presenting the Report of The Royal Liverpool Children's Inquiry to the House of Commons on 30th January 2001, the Secretary of State for Health said that one of the resulting actions would be the establishment by the Secretary of State for Education and Employment of a review of the accountability and management arrangements between NHS Trusts and Universities where senior staff are employed on joint contracts.

2. We were appointed in March 2001 to undertake this review and following discussions with the Departments of Education and Employment and of Health our Terms of Reference were agreed as follows:

- To review the arrangements for managing consultant medical and dental staff holding contracts (whether honorary or substantive) with both the universities and the NHS to undertake academic and clinical duties; and in particular to examine the procedures for appraisal, discipline and reporting. In doing so, the review will want to take account of appointment procedures and contracts of employment; and
- To make recommendations.

3. It will be noted that these Terms of Reference are limited to particular aspects of the accountability and management arrangements for defined groups of university and NHS staff.

4. On 30th March 2001 we circulated information about the review and an open invitation to contribute to it. This circulation resulted in a wide range of submissions from representative bodies, individual NHS and university institutions, and individuals. We are grateful to all those who took the trouble to write to us. We also arranged meetings with a number of representative bodies and NHS and university institutions, which proved most helpful and informative. A full list of the contributions and meetings is included in Appendix A.

5. There have been many reports in recent years which touch on the issues we have been asked to review, and we have benefited from our reading of them. We have been particularly impressed by and commend for further attention the recent report of the Nuffield Trust Working Group on NHS/University Relations entitled *University Clinical Partnership: Harnessing Clinical and Academic Resources*, as well as *Clinical Academic Careers*, the report of an independent task force chaired by Sir Rex Richards, published in 1997. Both emphasise the necessity for robust relationships between the NHS and universities if medical education and research are to be delivered, and highlight the peculiar problems faced by clinical academics who appear to have two posts with separate employers and yet actually have a single professional job. A full list of the reports we have consulted is at Appendix B.

Scope of review

6. The principal group of staff covered by our terms of reference are senior clinical academics who are employed by a university but hold an honorary consultant contract in one (or more) NHS body for clinical service. We estimate (*CHMS Survey of Clinical Academic Staffing Levels in UK Medical and Dental Schools, March 2001*) that some 3,250 professors, readers and senior lecturers are employed on this type of contract in the UK. The salaries of about 50% of these are supported by Funding Council funds, 33% by NHS funds and 17% by funds from other sources, principally

the research councils and medical charities. Any distinction awards payable to these staff are centrally funded by the NHS. At a more junior level – clinical lecturer and clinical researcher – there are a further 2,500 staff, 17% supported by Funding Council funds, 20% by NHS funds and 63% by other, usually research, funds. We have not considered those staff who do not hold an honorary consultant contract in our report although many of the principles apply equally to them. Towards the end of the report we offer specific observations upon academic staff in Dental Schools where the situation is slightly different. The second group of staff covered by our terms of reference is the many thousands of NHS consultants who hold honorary teaching (and occasionally research) contracts with their local university. In these cases the teaching commitments are rarely more than one session per week. We note that under the terms of NHS SIFT agreements, NHS bodies must contribute to teaching and training of medical undergraduates.

7. We are aware that there are other groups of staff who hold contracts both with the NHS and with universities. In particular the development of education for the health professions means that there are clinical academic posts in nursing and midwifery, the therapies, and other professions. Many non-clinical researchers who interact with individuals in a way that has a potential bearing on patient care also have honorary NHS contracts. Our terms of reference do not cover these staff, but since our report sets out principles to be applied to staff management, it should be readily possible for universities and NHS bodies to consider how far our conclusions are appropriate to these groups.

8. In dealing with the issues raised by our terms of reference, it is important to be clear about the broad context in which NHS bodies and universities work. While individual NHS bodies have a measure of independence, they are all part of a large organisation where central management can determine objectives and procedures, and can give instructions which are mandatory on the bodies. Many such instructions exist in respect of staff management. Universities on the other hand are legally independent and autonomous bodies. Many aspects of their work are subject to central assessment and sometimes regulation, principally by the Funding Councils, but this does not apply to staff management matters, in which universities remain independent except insofar as they voluntarily enter into collective agreements. Exceptionally, standard provisions for staff redundancy, discipline and grievances were imposed on chartered universities in the early 1990s as a result of primary legislation. A further important point is that relationships between universities and the NHS bodies who are their partners in medical education and research vary considerably, and with the current development of new medical schools further new models are being created. Thus so far as universities are concerned our recommendations will fall to be implemented individually by institutions which will need to fit them to their legal structures and existing staff management procedures. Our report is concerned only with the situation in England, although our conclusions may well be applicable in the rest of the UK.

9. Medical education is no longer restricted to partnerships between a university and one or more teaching hospitals. In recent years there has been considerable development of partnerships and networks with other NHS organisations, including health authorities and community and primary care organisations. Academic general practice in particular is playing an increasingly important part in medical education. It is for this reason we refer in our report to NHS bodies rather than hospitals or trusts.

10. Given all these facts, we have confined our report to the principles which we believe should be applied to the various issues we raise. Assuming our recommendations are accepted, the NHS and universities and their collective bodies

will have to decide what measures and processes are necessary to ensure that they are implemented. We say more about implementation at the end of our report.

11. Our review focuses upon the present and future and specifically does not address the situation, and any failings, in the past. It is proper, however, that given the origins of our inquiry – events which occurred at The Royal Liverpool Children’s Hospital (Alder Hey) – we should note at the outset the key findings and recommendations from the subsequent Redfern Report. The essential problems lay around:

- The initial resourcing of the post held by Professor van Velzen, the method of appointment, the implementation and supervision of a job plan;
- Failings in clinical service;
- Failures over many years to follow up on formal complaints and implement proper disciplinary procedures;
- A failure to catalogue stored organs; and
- Failings in delivery of research which was part of the justification to collect organs.

The Redfern Report offered a number of specific recommendations on staff management issues (set out in full in Appendix C) and these centre upon:

- Relationships between universities and NHS bodies;
- Appointment, job description, formal annual appraisal, joint procedures for disciplinary action;
- Resourcing of academic appointments; and
- Management standards and audit.

12. Our report and recommendations begin with two key issues, the relationship between universities and NHS bodies, and accountability. We then move progressively through the various stages involved in creating clinical academic and other posts, making the appointment, ensuring delivery on all facets of the contract and dealing with those rare but regrettable instances when disciplinary procedures have to be invoked. Working together on these tasks will heighten the sense of responsibility for the common enterprise. It will ensure the creation of robust arrangements for this enterprise that will stand alongside and integrate the separate responsibilities of the partners. We emphasise throughout that a clinical academic post is a single job held by a whole person, not two jobs held by two different half persons in one body. **The objective is to have (both for the individual and for universities and NHS bodies) clear, unambiguous, jointly agreed arrangements which are in harmony.**

A corporate framework for relationships between the NHS and the University

13. The key principle of our report is to recognise that NHS bodies and universities have separate responsibilities for medical education and research and for their associated clinical service, but that neither can fulfil these responsibilities without close joint working with the other. As the Funding Councils' Joint Medical Advisory Committee said to us *'first, we remain convinced that medical and dental education and research will only flourish when both universities and the NHS express and realise their joint ownership of this activity. The second general principle underpinning best practice that we would highlight is transparency and openness.'* This interdependence is expressed in our first recommendation that:

- **The key principle for NHS and university organisations involved in medical education and research should be 'joint working to integrate separate responsibilities.'**

14. We are clear that putting 'joint working, separate responsibilities' into practice requires a strong corporate framework. Good personal and professional relationships between senior NHS and university staff are essential, but not sufficient. Similarly cross representation on the key governing bodies of the partners is unlikely by itself to provide an adequate structure. Nor is liaison and consultation sufficient: if anything it tends to reinforce separateness. We do not propose a single model to be applied in all circumstances, since those circumstances vary widely. The recent reports to which we have referred have addressed these issues and include many examples of good practice. Generally speaking relationships between NHS bodies and universities are good, but they are still characterised by a lack of clear accountability. This is in marked contrast with the quite unequivocal responsibility that has been formally placed over the last decade or so upon the NHS Chief Executive (for health service delivery and financial probity) and upon the University Vice-Chancellor (for the delivery of teaching and research and financial probity). As a result they, let alone the clinical academics, require a much stronger corporate framework in which to operate.

15. We therefore believe that there should be a joint body responsible for managing local NHS/university partnerships. We have already mentioned the partnerships and networks that some medical schools have with a range of local NHS bodies and with general practitioners. It would be for each institution to decide whether to incorporate all of these into a single body or whether to have a number of bilateral ones. The joint body would develop the strategic vision of the partnership, ensuring that it is aligned with the strategic direction of the individual partners, and then establish objectives to deliver that vision and procedures to ensure that delivery takes place. These would need to be recorded in formal agreements and other appropriate documents.

16. This joint body should be supported by a number of subsidiary bodies responsible for joint working in individual areas. These will doubtless vary from place to place, but might cover topics such as research, education, and estate and services management where university and NHS facilities are integrated. One such body is however essential: to cover human resources matters for those staff of both partners who have responsibilities both in the NHS and in the university. It would be responsible as a minimum for the development and documentation of agreed procedures in the topics covered by our report and for overseeing their implementation. Its objective must be to improve the management of individual staff, not to be yet another administrative structure.

17. The aim of these joint bodies, in the words of one of our correspondents, is to be '*a corporate framework for handling the issues of relationships between the University and Trust hospitals in respect of matters which have traditionally been contained locally*'. There is a very real risk that the pressures of service delivery on the NHS, and of the delivery of education and research on universities will result in them growing further apart. Active joint working is necessary to combat this, and to contribute to a better understanding of each other's institutional cultures and preoccupations. Indeed we understand that NHS bodies have a 'duty of partnership' in many of their dealings with other organisations. Partnership in the enterprise of medical education and research is what we wish to see as the basis for working methods in the future. We therefore recommend that:

- **University and NHS partnerships responsible for medical education and research should establish joint strategic planning bodies, with joint subsidiary bodies responsible for human resource policies and procedures for staff with academic and clinical duties.**

Accountability of staff

18. The real difficulties with clinical academic positions are that the individual, while formally employed by a university, has responsibilities that involve more than one organisation. It is normal for all academics in research-intensive universities to have 'more than one job' in the sense that each individual undertakes (i) teaching (to undergraduates and to postgraduates), (ii) research and (iii) administrative and management duties. The situation in a medical school is even more severe since a fourth component – clinical service – is also undertaken by virtually all clinical academics. They normally spend six weekly sessions on clinical service and five sessions on the academic duties of research and teaching (we return to this distribution of time later in our report). Management and administration is spread across all three major roles. Clinical academics must remain in medical practice, as it is essential for their teaching and research. However, it is also true that by undertaking medical practice individuals assure themselves of being remunerated on clinical academic rather than on academic scales – a noticeable upward differentiation - whilst if they undertake a minimum of six sessions of clinical work they are additionally eligible for full NHS distinction awards and discretionary points. To add to the complexity the individual is effectively working for two employers – the NHS whilst undertaking service, the university whilst undertaking teaching and research. The lines are traditionally blurred and the priorities interwoven.

19. A special challenge is the potential conflict that can arise between service on the one hand and research and teaching on the other. This is exacerbated in the many cases where the individual may be a university employee but his or her post is fully funded by the NHS. The NHS will also be funding support services for the individual's post which can be as expensive as his or her annual salary.

20. Many efforts have been made over the years to resolve this complexity, as will be clear from the reports to which we referred earlier. Most point out that a number of factors are required for the individual to deliver well on all fronts. One is that the overall workload should not be excessive; yet evidence suggests that individuals choose to do too much on too many fronts. Another is that with the recent changes in the NHS – acutely demonstrated by the new requirement from April 2001 that consultants be appraised annually – the importance of quality and quantity of clinical service has become even more paramount.

21. It is also important to note that the management of clinical research involves both the university and NHS bodies. During the course of our work the Department of Health published its *Research Governance Framework for Health and Social Care*. This emphasises that proper research governance is essential to ensure that the public can have confidence in, and benefit from, quality research. The close links between university research, research carried out by university staff but funded by outside agencies including the medical charities, and NHS research and development mean that the management of research will need to be a shared exercise. The *Framework* also states that these arrangements must be ongoing throughout the whole course of a research programme. This will involve NHS bodies in assessing research outputs, but this does not in our view detract from the formal accountability of individual researchers to the university as their substantive employer.

22. Given all these circumstances we believe it is vital that clear and unequivocal statements be made, and communicated to staff, about their accountability and lines of reporting. Clinical service is the responsibility of NHS bodies, and clinical academics must be accountable to them through their honorary contracts for their clinical work. Teaching on university courses and their research is the responsibility of universities, and clinical academics must be accountable to them through their substantive contracts. Accountability means clear statements as to whom an individual staff member reports, and about the procedures, codes of practice and other rules and regulations that apply to the work in question. Thus the clinical service of clinical academics will be governed by the procedures etc. of the relevant NHS body, in exactly the same way as is that of the NHS employed consultants alongside whom they work. Exactly the same points are true of NHS consultants undertaking academic work, except that the substantive and honorary contracts are reversed. Thus they will be responsible to universities for their academic work, which will be governed by the university's procedures etc. in exactly the same way as is that of their clinical academic colleagues.

23. We do not think that there is any dispute or uncertainty about these lines of accountability amongst universities, NHS bodies and their staff. Nevertheless it may well be that when difficulties and problems arise, it transpires that they have not been made sufficiently explicit to staff in the past. It is also important that any changes arising from periodic review are similarly communicated. Our first recommendation specific to the management of staff is therefore that:

- **Universities and NHS bodies should formally make all senior NHS and university staff with academic and clinical duties fully aware to whom they are accountable for the separate facets of their job.**

24. If this principle were the only one applied, it would be all too easy to regard clinical academics as holding two part-time jobs with two separate employers. However we are very anxious that our concern for clear accountability is not read in this way. As we have said, a clinical academic post is a single job held by a whole person, not two jobs held by two different half persons in one body. The balance of activities within the single job can and should vary over a whole career. We emphasise this need for flexibility on a number of later occasions in this report. But it must be flexibility against agreed objectives and outputs. We are convinced that good management of the single job can only be achieved as a joint enterprise by the two organisations with their separate responsibilities. This will be a singular improvement on the present arrangements, both for the individual and also for universities and NHS bodies. Our second recommendation about staff is thus that:

- **The key principle of joint working to integrate separate responsibilities should be applied to the management of senior NHS and university staff with academic and clinical duties.**

25. The remainder of our report sets out how we believe these principles should be applied in practice.

New and replacement posts

26. Clinical service provision and medical education and research are both people-intensive activities. Appointing new staff and replacing vacancies (and by extension, doing away with posts) are key decisions in implementing the shared agenda of the partners. While joint working in the management of existing staff is vital, it will be vitiated if there has not been agreement before staff are appointed as to whom these staff should be, and what their objectives are. A number of our correspondents told us of cases where a university advertised clinical academic posts, often to meet educational or research objectives, without prior discussion with the relevant NHS body of the impact on service provision. Similarly in making consultant appointments, NHS bodies do not always recognise a university's need to ensure that the curriculum is fully covered, or that a particular research agenda has a priority.

27. We believe therefore that the first step in making any appointment must be discussion between the partners about their respective needs, and how these fit with the wider strategies that have been jointly agreed. In a number of instances the discussions may go beyond a single clinical academic or consultant post. There may be an opportunity for reorganisation of an academic or clinical department, or for the development of a new area. The discussion will decide on the most appropriate way forward, and develop a jointly agreed statement of objectives for the job. This will include the NHS job plan, the education and research components, any leadership, management or administrative responsibilities and a person specification. We call this a 'job description' in subsequent paragraphs. We recognise that there may be some clinical academic posts, especially senior leadership ones, where flexibility in the NHS components may be needed because of the potentially diverse interests of credible applicants.

28. The job description must be formally approved in advance both by the NHS bodies and by the university. It may well have thrown up issues such as the need for additional staffing support, or physical provision, and it is essential that both bodies have committed themselves to the provision of the necessary resources. Many clinical academic posts are fully funded by NHS bodies, and we have been told that this sometimes colours attitudes to the amount of clinical service sought from the post holder. One of the key purposes of joint approval of the job, including the NHS job plan, is to ensure that a proper balance is maintained between all the components of the role. Academic clinicians, however funded, cannot be expected to take on the same clinical load as full-time NHS consultants.

29. Ideally this process should be used both for clinical academic posts involving a service commitment, and for NHS posts which will carry a teaching and/or research commitment through the university, particularly those in teaching hospitals. While we accept that in the latter case a less rigorous procedure may be appropriate, we believe that there must be some level of consultation about every post at consultant level, and that universities must engage fully in the joint process.

30. We therefore recommend that:

- **The job descriptions for new and replacement senior NHS and university staff posts with academic and clinical duties should be jointly prepared and formally agreed by both partners prior to advertisement.**

Appointments

31. The first part of this section is concerned exclusively with clinical academic posts where the appointment is being made by the university, with an honorary contract from an NHS body. The material about the post (the 'further particulars') made available to candidates who respond to advertisements or searches, and to members of the selection committee, should include the full job description previously agreed.

32. The appointment process should include a selection committee with proper cross membership, including full representation of the university and the relevant NHS bodies, together with appropriate external expert advice. The university and NHS members should include persons who can authorise the issuing of the substantive and honorary contracts respectively without reference to any other body or person. Given the prior agreement of both parties to the job description, this should be straightforward, although it may represent a change in established practice.

33. Current NHS regulations require a Royal College representative to be included in all selection committees for the appointment of consultants. Although many universities include such a representative when appointing clinical academics, this is not universal. We believe that those who will hold honorary consultant contracts should be subject to the same appointment process as the NHS colleagues alongside whom they will be working. If NHS regulations continue to require Royal College representation, they should therefore be included. Universities will need to decide whether this is in lieu of or in addition to external expert involvement.

34. We considered setting out a model composition of a selection committee, but decided not to do so. Universities have different internal rules (including, for example, the inclusion of lay members of the governing body) for the composition of selection committees. There may be more than one NHS body involved, although we would hope where this is so that they could agree on a lead responsibility. There may also be a need for representation of external funding bodies such as the medical charities. We recognise that these features in combination may lead to a large (many would say unduly large) selection committee. We therefore urge those responsible for selection processes to review their internal rules and to look for creative ways to use the membership of committees, but without compromising the principle that all those formally included in the committee should participate in its decisions.

35. Short listing of candidates for interview is a key part of the selection process. Universities and their NHS partners should agree processes so that both are involved, noting that under current NHS regulations all members of a selection committee must have an opportunity to contribute to short listing. References should always be taken up. A device being more widely used in British universities is to establish a search committee containing a small number of the key players (in this context from the university, the NHS body and any outside funding body involved) which produces the short list of candidates who are invited to meet the full selection committee.

36. Following a decision on appointment a clear procedure should come into play such that any subsequent meeting between the preferred candidate and the university or NHS body only takes place within agreed arrangements. When the post is taken up there should be joint induction. We say more about this in the section on appraisal.

37. We think that appointments to NHS consultant posts that will carry a teaching and/or research commitment through the university should also be made by an appropriate joint process. In particular appointments in teaching hospitals where all staff are expected to undertake a university role, and may have one or more sessions allocated to such a role, should always be jointly made. The role of the University member(s) of such a selection committee should be to test and approve the suitability of the candidates for the university roles they will be required to play, and to authorise the issue of the university part of the contract.

38. We therefore recommend that:

- **Appointments to senior NHS and university staff posts with academic and clinical duties should be jointly made under procedures agreed by the partners; and**
- **NHS regulations for consultant appointments, as well as those of the relevant university, should be applied to selection committees for clinical academic posts involving honorary consultant appointments.**

Contracts of appointment

39. We believe that for clinical academics both the substantive contract from the university and the honorary contract from the NHS body are employment contracts, and should be structured as such as far as is appropriate. It has been suggested to us that the use of the term 'honorary' is not ideal given the nature of the overall post, but we see no reason to depart from the traditional arrangements and nomenclature. A few other contract models exist, including single contracts covering all aspects of the job, and the so-called 'A + B' contracts, which are separate full contracts for the two parts of the job. Whatever the form, the important thing is that the documents make the key issues clear.

40. Thus each contract should:

- specify the separate lines of responsibility and reporting arrangements, and the review, appraisal and disciplinary procedures that will apply;
- refer to the agreed job description, including the NHS job plan, and indicate the mechanism by which this can vary over time; and
- refer to other procedures that apply, such as those for staff grievances and public disclosure of information.

The honorary NHS contract will also include contractual requirements for a job plan, for appraisal and for a personal development plan, while the substantive university contract will also include remuneration, pension arrangements, rules about external earnings and other personal conditions of service.

41. Crucially, we believe that the contracts should be interdependent, that is, that if one of them is terminated, the other automatically comes to an end as well. We say more about the implications of this critical aspect of the contract in the section on discipline.

42. The two contracts should be consistent and cross-referring, and should be given equal weight. They should be issued at the same time as part of a single package of material, preferably from an agreed single source. We recognise that this may well require changes in procedure, since we heard of cases where the clinical academic contract was largely indistinguishable from that for academic staff in other disciplines, and where honorary contracts were sketchy, were only issued some time after the post had been taken up, and were not copied to the university. Both should be held on file together both in the university and in the NHS body. Any subsequent changes to either or both contracts should also be agreed by a joint process and fully communicated.

43. NHS staff undertaking academic duties should have separate honorary teaching and/or research contracts from a university specifying lines of responsibility, reporting arrangements and any relevant procedures. This might be linked to a more rigorous approach to the decision that individual consultants form part of the teaching team, and to the designation of their duties. It may however be possible, particularly in those NHS bodies where all consultant staff have university responsibilities, for the appropriate material to be included in the NHS contract. Whatever the contractual arrangements, it is important that there shall be no uncertainty about lines of responsibility and reporting arrangements.

44. We considered whether the interdependence of contracts should also be applied to those whose substantive contract is with the NHS. It was argued to us that in a teaching hospital where staff are expected and required to carry out a teaching and/or research role, it was reasonable that failure in that role leading to its termination should also terminate the main service contract. However a clinical academic contract is normally distributed evenly between the two roles, while honorary teaching and/or research contracts are normally for no more than one session. In these circumstances we do not believe that full interdependence is appropriate. However the contracts should be explicit that failure of the main contract will nullify the honorary university one, and about the implications of withdrawal of the university role.

45. We therefore recommend that:

- **Substantive and honorary contracts for senior NHS and university staff posts with academic and clinical duties should be explicit about separate lines of responsibility, reporting arrangements and staff management procedures, and should be consistent, cross-referred and issued as a single package; and**
- **The substantive university contract and the honorary NHS contract for clinical academics should be interdependent.**

Appraisal and performance review

46. Our recommendations in this section are the heart of this document. The other provisions we suggest for joint working in staff management will only be applied at the start of a contract, or on the hopefully rare occasions when issues of poor performance arise or disciplinary action is required. Appraisal and performance

review is however a regular annual process, with the capacity to lead to considerable change and improvement.

47. We link the terms appraisal and performance review together so that our approach to the activity is clear. Appraisal is often understood to imply a confidential process centred on personal and career development, with a strong peer review component. This is contrasted with managerially led performance review, concerned with achievement against targets and the resulting rewards. Although in practice the two concepts are often incorporated in one scheme, it is important to be clear about the different university and NHS contexts.

48. Academic staff appraisal in universities was introduced in the 1980s as part of a nationally negotiated annual salary settlement. There was a model national scheme, which was explicitly stated to be developmental, and not linked with reward schemes or disciplinary arrangements. As indicated earlier, there are no provisions for the central imposition of uniform procedures on legally independent university institutions. The result is that the actual appraisal schemes now operated by individual universities vary significantly in scope, objectives and frequency of application. Furthermore the rise of other forms of external assessment, such as the Research Assessment Exercise and Teaching Quality Assessment, has meant that a variety of parallel schemes of performance review have been put in place.

49. The present situation in the NHS is quite different, and of much more recent origin. Two key developments have driven it. The first is the recently proposed GMC requirement for regular revalidation, which will require all doctors to demonstrate regularly their fitness to practise medicine in their chosen fields in order to remain on the register. Revalidation requires the provision of information, and the second development, the introduction from April 2001 of mandatory annual appraisal for consultants, will among other objectives ensure the provision of that information. The new consultant appraisal scheme is employer led, and is explicitly stated to be both an annual review of performance against objectives and an opportunity for a discussion of personal and career development needs. It includes the annual review of the job plan, and makes use of other clinical governance measures of effectiveness. It is explicitly stated not to be concerned with disciplinary procedures. The scheme has been centrally developed (and negotiated) by the Department of Health, and includes specific requirements for the documentation to be used. Its links with reward schemes are at present unclear, since those schemes (currently distinction awards and discretionary points) are under review, but it seems to us that the information base for the appraisal and any new award schemes is likely to be similar.

50. The new NHS appraisal scheme will be applied to clinical academics in respect of their clinical service for the NHS. Thus without a new approach, clinical academics will face a series of overlapping but separate processes: NHS appraisal, university appraisal and performance review, NHS award schemes, and GMC requirements for evidence demonstrating fitness to practise in the field of academic medicine. We think that this is unsatisfactory as well as unsustainable in the long term. We see it as essential for the university to be an equal partner in the appraisal process, and believe that the recommendations we set out below will resolve the situation and at the same time be a powerful tool towards containing problems of overload.

51. In the light of the NHS position on consultant appraisal we believe that the new NHS scheme should be used as the basis to develop a specific scheme for clinical academics holding honorary consultant posts. In the original NHS circulation of the scheme there is a statement that '*clinical academics who are employed by a*

university and have a contract (usually honorary) for their work in the NHS should have one appraisal process and one appraiser for an individual academic, agreed between the university employer, the NHS and the academic doctor in question.' This statement was published in December 2000, shortly before we began work on our review. The consultation we have undertaken has revealed an almost unanimous view that while a single appraisal process is desirable, having a single appraiser is unsatisfactory, and that there should be joint appraisal by NHS bodies and universities. We note that this view has been expressed both by NHS and by university medical school managers, and written submissions along these lines have been received from the Council of Heads of Medical Schools and from the Medical Academic Staff Committee of the BMA.

52. The arguments for and against joint appraisal seem to us to be as follows. It would:

- consider the totality of one individual's job;
- facilitate a balance in the individual's work programme, allowing the NHS to see the needs of the academic side and *vice versa*;
- contribute to an acknowledgement of the specialist role of clinical academic staff in the NHS;
- provide a single source of appropriate documentation for revalidation;
- ensure constructive resolution of problems;
- not be as time-consuming as two separate appraisals; and
- prevent an appraisee playing one appraiser off against the other.

On the other hand:

- appraisal is normally a one-to-one process, and some staff may perceive a joint process as unduly threatening or inhibiting;
- the range of topics to be covered in a joint meeting is large and disparate;
- the logistics of organising joint meetings are complex; and
- joint appraisers could potentially act in a destructive rather than a constructive manner.

53. We believe that the arguments for joint appraisal are more persuasive. We accept that it will be unusual and demanding in human resource management terms, but the clinching argument to our mind is that it is the only way of reviewing the whole individual holding a single post that we believe a clinical academic to be, even though he or she is accountable to two masters. Equally positively, an annual requirement for NHS and university managers to come together to review the totality of demands on their staff will facilitate greater flexibility over time in matching service and academic needs with an individual's experience, skills and career development. It will also bring into the open situations where unreasonable demands are being made on one individual. The information generated will feed back into the joint strategic planning and service development processes we advocate. We recognise that there

may be some resource implications arising from it. In sum, we believe that this is the key application of the principle of 'joint working, separate responsibilities'.

54. We define joint appraisal for clinical academics as two appraisers working with one appraisee on a single occasion every year. The two appraisers will normally be the head of the relevant academic department and the clinical director of the relevant NHS clinical unit. In some cases the task may be delegated to other senior staff in the two organisations, but if so this should be on the basis that the appraisers have relevant experience of management and will report back to the current senior manager in the department or unit. Heads of departments themselves will be appraised by the Dean of the Medical School and the Medical Director or equivalent of the NHS body; while the Dean of the Medical School will normally be appraised by the Vice-Chancellor and the NHS Chief Executive.

55. We recognise that the range of topics to be covered will be wide, since on the NHS side appraisal must cover the annual job plan review and all the topics included in the national scheme, while on the university side it covers teaching and research, with both concerned with personal and career development and with any other personal issues. It is also necessary to be explicit about the varying objectives and outputs needed by the participants, although we believe these should be combined in a single set of documentation. There will thus be a premium on thorough preparation of the documentation by all parties, and on disciplined and professional conduct of the actual meeting. Careful and comprehensive record keeping will be necessary, to ensure that the material can be used as the basis for revalidation and that the process can be audited. All this means full training of all the participants.

56. We also believe that joint appraisal should be initiated for new members of staff by joint induction. This should be undertaken by the two managers who will become appraisers, and the object will be to ensure that the new member of staff has a clear understanding of the duties that both the university and the NHS body require and of the separate reporting arrangements, thus ensuring that questions of balance in the workload are addressed from the beginning of the tenure of the post. Joint induction will also ensure that the implications of the appointment for both parties are actually delivered, especially as far as the provision of resources (whether physical or human) are concerned.

57. There are arguments for the application of joint appraisal to all staff, both NHS consultants and clinical academics, who are involved both in service provision and in teaching and research. We would not wish to prevent employers who wished to work in this way from doing so, but think that it is unlikely to be achievable in practice for all such NHS consultants. There are however a number of situations where joint appraisal should apply to NHS staff. These include staff who play a substantial role in a medical school, such as curricular leadership or involvement in admissions work, and those who lead research or have a significant joint research activity. It will also be necessary in instances where there are concerns about their teaching performance. It is also likely to be appropriate for Postgraduate Medical Deans and for academic general practitioners.

58. In the light of all these considerations, it is critically important that universities and their NHS partners work together to develop a single process that will enable them to make considered individual decisions about the right appraisal and performance review arrangements for every member of staff with academic and clinical duties. Such decisions could in some cases vary from year to year. Joint appraisal would be the norm for clinical academics, and for those NHS staff with significant university commitments. Single appraisal would be the norm for other NHS

staff. Where single appraisal is agreed to be appropriate, a structured input from the other partner will be essential. We therefore recommend that:

- **Universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners.**
- **The process should**
 - a. **involve a decision on whether single or joint appraisal is appropriate for every senior NHS and university staff member with academic and clinical duties;**
 - b. **ensure joint appraisal for clinical academics holding honorary consultant contracts and for NHS staff undertaking substantial roles in universities;**
 - c. **define joint appraisal as two appraisers, one from the university and one from the NHS, working with one appraisee on a single occasion;**
 - d. **require a structured input from the other partner where a single appraiser acts;**
 - e. **be based on a single set of documents; and**
 - f. **start with a joint induction for those who will be jointly appraised.**

59. Implementation of these recommendations will require concerted joint action by the NHS and universities collectively, and involve working with the BMA. It will require *inter alia*:

- review of the guidance issued by the Department of Health;
- development of appropriate documentation for the appraisal of clinical academics and others where joint appraisal is appropriate; and
- alignment of the information requirements in the appraisal process with the developing GMC criteria for the revalidation of doctors engaged in teaching and research.

60. We are aware of the proposals made by the BMA for a joint appraisal process for clinical academic staff, which have been developed collaboratively with the CHMS. They are clearly a valuable step in the right direction, but will require further work before they fully meet the criteria set out above.

Disciplinary procedures

61. Our terms of reference ask us to consider staff disciplinary procedures, and we are quite clear that here too robust joint working must be the norm. However we believe that joint working must extend to the prior phase of managing and helping poor performance and seeking remedial measures. It is only when these have run

their course without success that formal disciplinary procedures come into play. Modern employment practice recognises three categories of poor performance which might lead to disciplinary action if not remedied: health, misconduct and capability. This definition avoids the older distinction between personal and professional misconduct. We have noted the establishment of the National Clinical Assessment Authority to provide a performance assessment and support service when an individual doctor's performance falls short of what is required, and share the NHS hope that these constructive and supportive arrangements will result in fewer disciplinary cases arising in clinical service, including the clinical service of clinical academics. Similarly we believe that the arrangements we have recommended for joint appraisal will assist in the early identification and resolution of issues that might otherwise have ended in disciplinary action.

62. We have made it clear earlier that the line of accountability for clinical service must be to the NHS whilst that for teaching and research must be to the university. Responsibility for the management of poor performance and for disciplinary action should follow these lines of accountability, but in our view both parties should be involved throughout with the most appropriate one taking the lead. This principle is based upon our strongly held view that both parties must work together to ensure that the clinical academic post is seen as a single job. A good example of where both parties are inextricably involved concerns clinical research. The prime responsibility for the quality of research being undertaken and its progression lies with the university but the NHS Research Governance guidelines mean that the NHS body must be involved throughout the process. Should difficulties arise in this area of an individual's job, as indicated for example by the annual appraisal process, then both must be involved in correcting the situation and if necessary in any disciplinary proceedings. Matters are more straightforward for clinical service where the NHS body is responsible and for teaching where the university is responsible. A common difficulty arises in the area of personal relationships and whilst this may well surface in one particular area of an individual's work it is likely to involve both the university and the NHS body.

63. This leads us to believe that the university and NHS body must establish absolutely clear and documented arrangements for dealing with the management of poor performance and for disciplinary matters of all types. There may well be circumstances in which it is possible for NHS bodies and universities to combine their processes. We therefore recommend that:

- **Universities and NHS bodies should jointly prepare a formal agreement on the procedures for the management of poor performance and for discipline to be followed for senior NHS and university staff members with academic and clinical duties.**
- **As a minimum, these procedures should**
 - a. **ensure joint working in the process from the time implementation of it is first contemplated;**
 - b. **specify which body is to take the lead in different types of case;**
 - c. **ensure suitable cross membership of disciplinary bodies; and**
 - d. **be expeditious.**

64. The interdependency of the substantive and honorary contracts of clinical academics means that disciplinary action in respect of clinical service that might lead to withdrawal of the honorary consultant contract will also result in dismissal from the substantive contract. There may be a few cases where a university would wish to re-employ such a person as a non-clinical academic, but these are likely to be very limited. Similarly action initiated by the university leading to dismissal from the academic post will bring the honorary contract to an end. These significant implications of disciplinary action by either party make joint involvement in the process essential. They are not however an excuse for inaction or unnecessary delay when a problem is identified.

65. Disciplinary action initiated by the university in respect of the academic work of NHS employees leading to withdrawal of that work will, as we have indicated above, not lead to the termination of the NHS contract, unless exceptionally the contracts have been made interdependent. It will however require the NHS employer to revise the job plan for that individual; again joint involvement in the process is therefore essential.

66. Disciplinary procedures are complex and often require long periods of time. It is right that they should provide for fair and transparent processes, and for the full protection of the interests of staff members. We understand that both the NHS and some universities are currently working towards simplification of their procedures, while retaining essential safeguards for staff. This should in particular ease the position of those universities whose disciplinary procedures are governed by the 'model statute' clause in their charters. We welcome these moves, and hope that they will be carried to a conclusion, since more straightforward processes will considerably facilitate joint working.

Flexibility in the clinical academic contract

67. Throughout this report we have emphasised the need to ensure a balance in the wide range of duties covered by clinical academics. Our proposals for joint working in staff management, especially for joint appraisal, will ensure that university and NHS managers keep this balance under constant review. We have also emphasised that a clinical academic post is a single post held by a whole person. It should therefore be recognised that the balance of activities of that whole person can and should vary over his or her career. We are concerned that there should be no artificial barriers to such flexibility.

68. At present one significant barrier is the NHS distinction award and discretionary points scheme. This is structured in such a way that only clinical academics with six or more weekly sessions of clinical service under an honorary contract are eligible for full awards: those with fewer sessions have their awards reduced *pro rata*. We have been told that this is the key reason why honorary contracts normally specify six NHS sessions, even though in many cases not all of these are spent on patient care or direct clinical service. We believe that the award scheme should cover the whole job of clinical academics holding honorary contracts irrespective of the number of sessions specified in that contract, and should thus recognise that everything that a clinical academic does, whether service, teaching, research or management and administration, is of benefit to the NHS. This would enable NHS and university managers to make more realistic decisions about the number of NHS sessions to be provided, and to vary them, perhaps very substantially, from year to year to meet their needs and an individual's career development, without artificially debarring him or her from access to the award scheme. The award scheme is currently under review, providing an opportunity for change, and we recommend that:

- **The current review of the NHS award scheme for consultants should remove barriers to the full participation in the scheme of clinical academic staff with honorary contracts.**

69. The Funding Councils' Research Assessment Exercise and Teaching Quality Assessment both impact strongly on staff management decisions within the universities. It is inevitable that these assessments will raise questions about the balance of activities being undertaken by individual clinical academics and how this might change over time. It is our intention that the new joint appraisal scheme will address such issues directly and place them on a par with considerations of clinical service.

The clinical academic contract - special situations

70. A number of our correspondents have emphasised the importance they attach to the system whereby the clinical service of academics in a particular specialty is provided by the university department as a whole, enabling in an ideal world that service to be organised for individuals in block periods of intensive clinical work, leaving other periods free for concentrated activity on teaching and especially on research. Concerns have been expressed that an emphasis on detailed individual clinical job plans works against this desirable flexibility. We sympathise with these concerns, and are anxious that our earlier recommendations about job descriptions, including NHS job plans, are not read as implying any intention to change these arrangements where they exist and are seen to be fully effective. We believe that joint working between NHS clinical directors and university heads of departments should enable such departmentally based arrangements to be maintained. They will of course need to be appropriately reflected in the job descriptions and job plans of individuals.

71. In a number of specialties it is not uncommon for clinical services to be provided wholly by clinical academic staff, and in such cases there will normally be an agreement between the NHS body and the university for the provision of the service, which will provide for regular review of the service itself. The head of the NHS service and the head of the academic department or sub-department providing the service may well be one and the same person, so joint management of the staff is by definition easier to achieve. The application of NHS clinical governance procedures and of consultant appraisal should ensure that such an academically provided specialty remains properly accountable to the NHS. Managers may however wish to adopt special procedures to this end. Although joint appraisal of staff within such units is not strictly necessary, since the head of the service will be able to cover all aspects of its work, it may be appropriate for an additional NHS appraiser to be involved. Arrangements for the appraisal of the head of the service are particularly significant, and should always involve joint appraisal by both NHS and university appraisers, reflecting the dual accountability of the service.

72. Correspondents who work as clinical academics in public health medicine have emphasised to us that it is much less easy in their discipline to distinguish between clinical and academic work, and thus to be specific about separate accountabilities for different parts of the overall role. It has also been pointed out that much of the specified documentation for NHS consultant appraisal is not fully appropriate to public health work. We are sympathetic to these concerns, but they seem to us to be precisely the sort of matters where careful joint work needs to be undertaken by NHS and university managers to adapt the principles we have set out to the needs of specific groups of staff.

73. We have indicated how the principle of 'joint working to integrate separate responsibilities' should be applied to a range of staff management issues. There will be other such issues where the principle will be just as important. One is the management of staff grievances and another the application of public disclosure of information procedures.

74. Although they are not covered by our terms of reference, we note with interest that following the publication of its *Research Governance Framework* the NHS Research and Development (R&D) Division is developing an honorary contract for non-clinical researchers who nevertheless need to work in NHS bodies. This seems to us to be an excellent example of the way in which the principles we have set out can and should be applied as appropriate to other groups of staff who have dual responsibilities and accountabilities.

Dental Schools

75. We have considered whether our proposals and recommendations should also apply to the clinical academic staff in dental schools and the staff in dental hospitals. In general we believe that our principles are equally applicable. However there are no dental hospitals that do not have dental schools attached, and no dental schools can exist without a dental hospital. The result of this very close institutional interdependence is, to quote the Council of Deans of Dental Schools, *'a range of governance arrangements that vary between almost complete separation but with strong communication and almost wholly integrated arrangements... The tasks of the two organisations, Hospital and School, are confluent, mutually supportive and mutually interdependent'*. This situation means that joint staff management arrangements are easier to achieve. The demands of dental education itself, especially the extensive supervision of students providing dental treatment to NHS patients, means that the distinction between clinical and academic service is blurred. As a result a flexible approach to the job plan part of the overall job description is important.

76. The close links between service and academic work have particular implications for appraisal. In many cases it will be possible for a single appraiser to cover both sides of the work. We believe however that dental schools should follow our proposals for joint planning of an appraisal system, ensuring that it meets both NHS and university needs (and the requirements of the GDC for retaining professional status, which are not the same as those of the GMC); the individual appraisals may well be more often single than joint. As with clinical medical services wholly provided by a university department, joint appraisal by NHS bodies and universities of the head of integrated dental schools is a critical part of ensuring proper accountability.

77. In the light of these differences, we recommend that:

- **The recommendations in this report should apply equally to Dental Schools, with appropriate modifications to take account of their special features.**

Implementation

78. We said earlier that our report concentrates on principles, and that decisions would need to be taken about implementation of our recommendations to ensure that they are delivered in practice. In particular there will need to be specific regulations, instructions, codes of good practice and other appropriate means of implementation.

It would, for example, be very desirable for there to be guidelines or a *pro forma* indicating what should be in an honorary contract issued by an NHS body or a university to a clinical academic or consultant whose substantive appointment is with the other organisation. Similarly guidance on good practice in the framework for relationships between universities and their NHS partners would be helpful. We should make it clear that everything that we have recommended already exists or is being developed in many institutions, so that we do not believe that there are any insuperable barriers to implementation.

79. Detailed implementation will be the responsibility both of NHS bodies and of universities, and we believe that some structured joint national action will be necessary, which should be initiated by the two Departments. Other organisations will need to be involved, including the Higher Education Funding Council for England, the General Medical Council and possibly the Royal Colleges. There will also be a need for consultation and negotiation with the BMA, and possibly with other unions, as not all universities recognise the BMA.

80. We do not believe that the collective university organisations are at present well structured or organised to undertake this work and deliver the necessary changes. Their respective responsibilities, especially for recommending good practice, for developing model contracts and agreements, and for consultation and negotiation, need to be rethought. Ultimate responsibility for the procedures adopted must rest with individual universities in the light of their legal independence. Nevertheless they may wish to consider how far it is in their interests to act jointly, particularly in the light of the NHS capacity for centralised action. Although responsibilities within institutions rest on their governing bodies, and will be exercised in practice by Vice-Chancellors and their Deans of Medical Schools, universities could benefit from collective work by the administrative staff who currently support Deans, in particular by those concerned with human resources matters. Work by a group comprising the relevant units in the Department of Health and the NHS Executive and HR professionals from universities and NHS bodies might well be the quickest route to widespread implementation of our recommendations.

81. We therefore recommend that:

- **Implementation of our recommendations should be facilitated by structured joint national action initiated by the Department for Education and Skills and the Department of Health; and**
- **Universities should consider new formal and informal means of collective action to assist them in implementing our recommendations.**

82. Some of our recommendations require new and revised forms of contract and of appraisal and other procedures. Implementation groups will have to consider how to apply these to existing members of staff. We believe that clarification of the existing situation through revised contracts and procedures will be welcomed by many staff, so that consent to change may well not prove difficult to secure. Nevertheless legal advice will be necessary. One particular such issue is the sharing of information about individual employees with other organisations.

83. Within individual organisations implementation of new procedures will be the responsibility of senior staff: Chief Executives, Medical Directors and Clinical Directors in NHS bodies, and Vice-Chancellors, Deans and Heads of Departments in universities. Support for these senior staff will come in particular from human

resources professionals. Again we do not propose a single implementation model, but we can imagine integration of parts of the Human Resource departments of both partners to ensure the proper alignment of all procedures. A further suggestion made to us is for each medical school to commit an Assistant Dean to take prime responsibility under the Dean for the medical school/NHS interface.

84. The Higher Education Funding Council for England has reminded us that it is currently providing some additional funds to universities for rewarding and developing staff, and has highlighted the need for universities to develop human resources strategies. It said that it would be appropriate for universities to use these funds to assist them with the implementation of our recommendations, in particular in the development of joint appraisal schemes.

Conclusion

85. We reiterate in conclusion our key recommendation that the principle to be applied to the management of senior NHS and university staff with academic and clinical duties is 'joint working to integrate separate responsibilities'. This is entirely consistent with the recommendations in the many recent reports which have looked at different aspects of the interface between the universities and the NHS.

86. These reports include a number of ideas for new institutional structures. Academic Clinical Centres are advocated in the Nuffield Trust report. The concept of the 'University Hospital NHS Trust' is put forward in *Clinical Academic Careers*. We have not sought in this report to add to these suggestions or to embrace any one of them, preferring to put forward proposals that will work within existing structures but improve them significantly. However, the extensive joint working that will result from our recommendations could lead over time to new ways of achieving the principles we have set out and in turn to new structures that would make our detailed propositions unnecessary or redundant. If that happens we shall be delighted at the impetus towards change that our report has given.

Sir Brian Follett
Michael Paulson-Ellis

Appendix A

Membership of Review

Brian Follett – Vice-Chancellor, University of Warwick until April 2001
Michael Paulson-Ellis – Registrar and Secretary, University of East Anglia,
Norwich until September 1999

HR Adviser to Review

Jim O’Connell – Director of Human Resources, East Kent Hospitals NHS Trust

Membership of Steering Committee

Michael Hipkins – Divisional Manager, DfES
Steve Passmore – Team Leader, DfES
Robin Cairncross - Head of Medical Education, Education and Training
Division, DH
Paul Loveland – Deputy Head of Medical Education, Education and Training
Division, DH
Steve Barnett – Deputy Director of Human Resources, NHS Executive

Meetings with organisations and individuals

Universities UK Health Committee (Professor Sir Martin Harris, Chair; Eve Jagusiewicz, Secretary)

Joint Medical Advisory Committee of the UK HE Funding Councils (JMAC)
(Professor Alisdair Breckenridge, Chair; David Noyce, HEFCE, Secretary)

Executive Committee, Council of Heads of Medical Schools (CHMS)
(Professor Robert Boyd, Chair; Michael Powell, Executive Secretary)

Council of Heads of Dental Schools (CDDS) (Professor John Scott, Chair)

Research and Development Directorate, Department of Health (Sir John Pattison, Director of R&D)

General Medical Council (Finlay Scott, Chief Executive; David Skinner, Head of Regulation Policy)

British Medical Association, Medical Academic Staff Committee (BMA MASCC) (Colin Smith, Chair; Peter Dangerfield, Deputy Chair; Mark Redhead, Executive Officer)

Liverpool Health Authority and NHS Trusts (Liverpool Health Authority: Judith Greensmith, Chairman; Professor Chris Jones, non-executive member; Ruth Hussey, Director of Public Health. Royal Liverpool and Broadgreen University Hospitals NHS Trust: Pearse Butler, Chief Executive; Elizabeth White, Medical Director. Royal Liverpool Children’s NHS Trust (Alder Hey): Angela Jones, Chairman; Tony Bell, Acting Chief Executive; Rick Turnock, Medical Director)

University of Liverpool (Professor Philip Love, Vice-Chancellor; Michael Carr, Registrar; Susan Rutherford, Director of Personnel) (Professor Peter Johnson, Dean of Medicine)

King's College London (Professor Graeme Catto, Vice-Principal; Professor Gwyn Williams, Dean; Ron de Witt, Chief Executive, King's College Hospital NHS Trust; Bob Mason, Assistant Medical Director, Guy's and St Thomas' NHS Trust)

University of East Anglia (Professor Shirley Pearce, PVC, Professor of Health Psychology, and leader of Medical School project team; Professor Sam Leinster, Dean of the Medical School, Malcolm Stamp, Chief Executive, Norfolk and Norwich University Hospital NHS Trust; Liam Morton, Administrative Officer, Medical School) (David Baker, PVC for Human Resources; Richard Beck, Director of Personnel)

Pity II Parents Support Group, Liverpool (John O'Hare, Chairman)

Organisations and individuals submitting evidence

Organisations:

Joint Medical Advisory Committee of the Higher Education Funding Councils for England, Scotland and Wales (JMAC)
Council of Heads of Medical Schools (CHMS)
British Medical Association, Medical Academic Staff Committee (BMA MASC)
Academy of Medical Sciences (Mary Manning, Executive Director)
National Clinical Assessment Authority (Julie Eaton, Director of Human Resources and Organization Development)

Health Authorities:

Judith Greensmith, Chairman, Liverpool
I J Carruthers, Chief Executive, Dorset
Professor Philip Milner, Director of Public Health, Wiltshire

Chief Executives of NHS Trusts:

Tony Bell, Royal Liverpool Children's (Alder Hey)
Pearse Butler, Royal Liverpool and Broadgreen University Hospitals

Medical Directors of NHS Trusts:

Nicholas Bishop, United Bristol Healthcare
Roger Bloor, North Staffordshire Combined Healthcare, and Keith Prowse, North Staffordshire Hospital, jointly
John Dyet, Hull and East Yorkshire Hospitals
Peter Ehrhardt, Burnley Healthcare
David Fish, University College London Specialist Hospitals
A C Head, Walsall Hospitals
R W G Johnson, Central Manchester and Manchester Children's University Hospitals
Ian Johnston, Queen's Medical Centre Nottingham University Hospital
M F Laker, The Newcastle upon Tyne Hospitals
Ian Lane, Cardiff and Vale
Ian McIntosh, Oldham
Andrew MacNeill, Sheffield Hospitals

Rory Shaw, Hammersmith Hospitals
Charles Turton, Brighton Health Care

Human Resources Directors of NHS Trusts:

Denis Gibson, Southampton University Hospitals
T Gilpin, Central Manchester and Manchester Children's University Hospitals
Helen Gordon, University College London Hospitals
Ann Macintyre, Barts and the London
Louise Potts, Brighton Health Care
John Watts, Sheffield Teaching Hospitals
Ian Young, Hammersmith Hospitals

Universities:

Professor Sir Martin Harris, Vice-Chancellor, Manchester
Professor Sir Howard Newby, Vice-Chancellor, Southampton
Michael Garrity, Dean, Faculty of Health and Social Care, Salford
Peter Deer, Director of Personnel, Cambridge
Judith Miller, Head of Personnel, Keele

University Medical Schools:

Kenneth Fleming, Head of Medical Sciences Division, Oxford
Professor Pierre Guillou, Dean, Leeds
Professor Peter Rubin, Dean, Nottingham
Professor Robert Souhami, Principal Royal Free and University College
Medical School, University College London
Professor R W Stout, Dean, Queen's Belfast
Professor Tony Weetman, Dean, Sheffield
Gillian Maudsley and colleagues, Senior Lecturers in Public Health Medicine,
Liverpool

Dental profession:

Council of Deans of Dental Schools (CDDS)
Professor David Barnard, Dean of the Faculty of Dental Surgery, The Royal
College of Surgeons of England
Professor Malcolm Jones, Dean of the Dental School, University of Wales
College of Medicine
Professor Jonathan Sandy, Division of Child Dental Health, University of Bristol
Professor Crispian Scully, Dean, Eastman Dental Institute, University College
London

Others:

Professor John Lilleyman, President, The Royal College of Pathologists
Angela Schofield, Institute of Health and Community Studies, Bournemouth
University
Professor David Kerr, Chairman, National Kidney Research Fund

Appendix B - Published material consulted

1. *Undergraduate Medical and Dental Education and Research: Fourth Report of the Steering Group; March 1996. [Fourth, and most recent, SGUMDER Report]*
2. *Clinical Academic Careers: Report of an Independent Task Force; July 1997. (The Richards Report, commissioned by the Committee of Vice-Chancellors and Principals)*
3. *Good Practice in NHS/academic links: A report by the Joint Medical Advisory Committee to the UK higher education funding bodies; March 1999 (HEFCE Report 99/17)*
4. *Developing a joint university/NHS planning culture: report of a Joint Department of Health/Higher Education Funding Council for England Task Group; November 1999 (HEFCE Report 99/62)*
5. *University Clinical Partnership – Harnessing Clinical & Academic Resources: Report of a Nuffield Trust Working Group on NHS/University Relations; The Nuffield Trust, January 2000*
6. *The NHS (Appointment of Consultants) Regulations 1996 – Good Practice Guidance - NHS Executive 1996*
7. *The NHS Plan – proposal for a new approach to the consultant contract, February 2001, Department of Health.*
8. *Rewarding commitment and excellence in the NHS: Consultation document – Proposals for a new consultant reward scheme, February 2001, Department of Health.*
9. *Consultants’ Contract: Annual Appraisal for Consultants – Advance Letters (MD) 6/00 (22 December 2000) and 5/01 (5 April 2001) NHS Executive/Department of Health*
10. *Research Governance Framework for Health and Social Care Department of Health March 2001*
11. *Independent Review of Higher Education Pay and Conditions: Report of a Committee chaired by Sir Michael Bett; 1999: Chapter 9 focuses on Clinical Academics.*
12. *Rewarding and Developing Staff in Higher Education HEFCE March 2001 (HEFCE 01/16)*
13. *Suspensions – A new perspective: Report of the short-life working group on suspension of medical and dental staff; The Scottish Office, Department of Health, March 1999.*
14. *The Royal Liverpool Children’s Inquiry – Report and Summary and Recommendations (The Redfern Report) HMSO 30 January 2001 (HC 12-1)*
15. *T. Smith ‘Push me pull you’, Health Service Journal 22 March 2001, pp.30/31.*

Appendix C

Recommendations of the Royal Liverpool Children's Inquiry relating to relationships between universities and NHS trusts and to staff management

Chapter 8. The van Velzen Years

Relationship Between Universities and Trusts

Whatever the underlying contractual position, the relationship between Universities and Trusts, in respect of individuals and departments with dual clinical and academic functions, shall be one of the utmost good faith in both directions.

The duty of utmost good faith shall require either party to disclose to the other any substantial matter relating to the performance of the individual or department, whether clinical or academic.

Where there is any doubt as to whether a matter is of a substantial nature, if it relates to patient care the doubt shall always be resolved in favour of disclosure.

The appointment of clinical academics shall be approached with fair representation on each side reflecting the proposed split between clinical and academic sessions.

The appointment of external advisors shall be approached on the basis that they are truly external, if not strictly independent in a legal sense. There is no point having external advisers as 'window dressing' for a fixed internal view. Where they or representatives of the Royal Colleges give advice, proper weight shall be given to that advice. In giving advice, external advisers shall bear in mind the paramount requirement of patient care where there is a conflict of interest.

A single job description for clinical academics shall be drawn up jointly to represent a fair and realistic expectation of the work envisaged by both parties.

There shall be a joint procedure for disciplinary action against an individual perceived to be failing. It shall contain provision for immediate suspension from patient care as a minimum, irrespective of academic requirements and positions.

There shall be formal annual appraisal of an individual by both parties. They shall share their information in line with the duty of utmost good faith in order to draw up a joint statement of aims in the following 12 months against which the next appraisal is to be judged.

Where there is disagreement each party shall reconsider bearing in mind that patient care is of paramount importance. In the event of continued disagreement an arbitrator may be appointed, but in any case the Trust shall take immediate steps to secure proper patient care.

The relationship between Universities and funding bodies shall be of the utmost good faith and similar considerations shall apply.

New Ventures

Where a new venture, such as the establishment of a Chair or department, is contemplated, both parties where appropriate shall consider in detail the aims and resources available and draw up a realistic business plan before any final commitment is made. As in all these matters, if patient care is to be included in the venture, patient care shall be paramount in its consideration.

There shall be close performance management of any new venture in its early stages and appropriate steps taken to modify the business plan as required.

Any substantial alteration in an existing venture shall be treated as if a new venture.

Audit

Where there is good reason to believe that an individual or department may be failing and affecting patient care, it shall be the duty of the Trust with the co-operation of the university, and if appropriate on a joint basis, to investigate. Investigation shall continue until the problems are identified or it is found that in reality no problem exists. Where appropriate, independent outside assistance shall be obtained.

Where problems are identified a plan, jointly where necessary, shall be drawn up to resolve them as soon as possible.

If no solution is found after all diligent attempts, the parties should keep records of their attempts and the reasons why they have failed, such records to be lodged by way of report to the relevant NHS Executive Regional Office.