Waste industry: The NHS disciplinary process and Dr John Bestley

By Dr Minh Alexander NHS whistleblower and former consultant psychiatrist 21 October 2017

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Summary

I report on longstanding policy failures and provide updated summary statistics on NHS dismissals.

I illustrate the issues through the specific case of Dr John Bestley, former Consultant Psychiatrist and clinical director at the troubled Humber NHS Foundation Trust, who an Employment Tribunal determined was unfairly dismissed for gross misconduct.

Dr Bestley displeased his employer, who did not consider him to be 'corporate' enough. He later became caught up in a maelstrom that is familiar to too many. Allegations were made against him, and for far too long remained un-particularised. He was suspended without adequate evidence of review and his suspension continued long after there ceased to be grounds for suspension. He was subjected to a lengthy flawed investigation and then to a heavy handed disciplinary process. Ultimately, at age 52 he was dismissed, which an Employment Tribunal later determined was unwarranted and unfair.

Furthermore, Dr Bestley's illness of Bipolar Disorder was considerably worsened by the experience, such that he was no longer able to practice. Neither was he eligible for early access to his NHS pension on ill health grounds on account of having been dismissed. His employer, a specialist mental health trust, ought to have been aware of the likely impact on his health.

I do not write this to defend Dr Bestley, who indeed accepts that his behaviour fell short at times. And whilst the Employment Tribunal determined that his dismissal was unfair, it did observe that there had been a history of concerns and that a lesser sanction would have been justified.

The key issue is that the system response to Dr Bestley was seriously disproportionate. Dr Bestley has been brave enough to contact me and share his story despite the fact it is not comfortable for him to do so, in order that some light can be shone on this aspect of NHS dysfunction.

This dysfunction in his case led to serious waste in terms of scarce time, distress to all concerned, hundreds of thousands of pounds being wasted, and the loss of an experienced and expensively trained doctor from the NHS when there had been no concern found about his clinical performance.

The National Clinical Assessment Service (NCAS) is the body that is supposed to oversee suspension processes and advise trusts on best practice. However, the correspondence from NCAS in Dr Bestley's case shows a typical lack of challenge to the trust. Dr Bestley was simply reduced by NCAS to "Dr 11009", as it acquiesced to the trust's actions.

Based on the example of Dr Bestley's case and others of which I am aware, the National Clinical Assessment Service should in my view stop passively approving unjust suspensions, and provide much more robust challenge to employers.

Moreover, Dr Bestley tried to ensure that lessons were learnt from his case, but the responses from the trust, the General Medical Council and the health watchdog NHS Improvement were all wanting.

NHS Improvement relied on his former employer's assurances that it had learned lessons. Laughably NHS Improvement claimed that the trust, rated 'Inadequate' on safety by the Care Quality Commission and mired in a number of recent scandals, was a learning organisation generally.

The Care Quality Commission acknowledged in a 2016 inspection report that the trust had suspended a large number of staff since 2014, but claimed that the Trust followed its procedures correctly. It did not acknowledge that an Employment Tribunal had determined that the trust had unfairly dismissed a senior doctor.

Stories such as this illustrate the need for reform of NHS disciplinary process, better central tracking of NHS staff suspensions and Employment Tribunal outcomes, and accountability for how public money is spent.

It is a serious failure that fourteen years after the National Audit Office's 2003 report on NHS mismanagement of staff suspensions, little has been done to properly implement NAO's recommendations.

The NHS needs to recognise that suspensions are a damaging Human Resources emergency, that their expeditious resolution must be prioritised to limit the serious harm done to employees. This is the more so where employees have pre-existing disabilities or vulnerabilities that are likely to increase the harm inflicted.

NHS Pension policy also needs to be adjusted so that employees who are found to have been unfairly dismissed should have pension rights such as access to early ill health retirement restored. It is unjust if the NHS not only inflicts avoidable, serious injury on its staff through poor human resources practice, but also deprives them of the pension they would have been entitled to had they not been wrongfully dismissed.

Regulators such as NHS Improvement and the Care Quality Commission should also take injustices against the workforce much more seriously when assessing NHS bodies' governance, instead of closing ranks and or obfuscating as they did in Dr Bestley's case.

Policy background

The NHS is a monopoly employer, has a poor reputation for treating its employees fairly. [1] [2] [3] [3]

It has been criticised variously for a "kissupkickdown" culture [4], in which managers "look up and not out". [5]

In addition to the wanton destruction of whistleblowers [6] [7], the NHS is also known for other arbitrary behaviour in the way that it disciplines and dismisses staff. [8]

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[1] The NHS: Health Service or good news factory? Rachael Pope PhD thesis 2015, Manchester Business School, University of Manchester
"the needs of the NHS and the protection of image appear more important than the welfare of staff or patients"
https://minhalexander.files.wordpress.com/2016/09/rachael-pope-health-service-or-good-news-factory-2015.pdf

[2] The New Politics of the NHS: from creation to reinvention, Rudolf Klein 1983
"it is possible to demonstrate convincingly that the NHS exploited its position virtual as a monopoly employer of medical labour to depress the incomes of doctors"

[3] Quality Oversight in England – Findings, Observations and Recommendations for a New Model. Joint Commission International 2008
"pervasive culture of fear in the NHS and certain elements of the Department of Health"
https://www.dropbox.com/personal?preview=JCI+report+Quality+oversight+in+England.pdf

[3] Culture and behaviour in the English NHS: overview of lessons learned from a large multimethod study, Mary Dixon Woods et al, BMJ Safety and Quality, 9 September 2013
http://qualitysafety.bmj.com/content/early/2013/08/28/bmjqs-2013-001947

[4] Neglected: Lessons of fatal error in NHS care, Jeremy Laurance, Independent 27 January 2013
http://www.independent.co.uk/news/uk/home-news/neglected-lessons-of-fatal-error-in-nhs-care-8468873.ht

[5] Achieving the Vision of Excellence in Quality: Recommendations for the English NHS System of Quality Improvement, Institute of Health Improvement, 2008
"Virtually everyone in the system is looking up [to satisfy an inspector or manager] rather than looking out [to satisfy patients and families]."
https://www.dropbox.com/s/xpd95hwd3jmbw2s/IHI%20report%20achieving%20the%20vision%20of%20excellence%20in%20quality.pdf?dl=0

[6] Complaints and Raising Concerns, Health Committee 21 January 2015
https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/350.pdf

[7] Shoot the messenger, How NHS whistleblowers are silenced and sacked, Private Eye August 2011
https://minhalexander.files.wordpress.com/2016/09/private-eye-2011-shoot-the-messenger-whistleblowin-special.pdf

[8] Hansard: Debate on the Capsticks report on Liverpool Community NHS Trust, 13 July 2016
https://hansard.parliament.uk/commons/2016-07-13/debates/1DEAEDE8-BA1C-4BF7-A16A-7CFB9831CFB2/CapsticksReportAndNHSWhistleblowing

This is bad for patient care because of the known links between staff welfare and patient outcomes. [10] It is also poor financial sense because of loss of productivity due to bullying [11] and the loss of expensively trained staff.

The ACAS statutory Code of Practice on disciplinary and grievance procedures sets out expectations of reasonable behaviour. [12] Furthermore,

> *"A failure to follow the Code does not, in itself, make a person or organisation liable to proceedings. However, employment tribunals will take the Code into account when considering relevant cases. Tribunals will also be able to adjust any awards made in relevant cases by up to 25 per cent for unreasonable failure to comply with any provision of the Code."* [12]

However, the NHS can be a law unto itself, and its deep collective pockets allow individual employers to behave unreasonably because there is rarely personal jeopardy for erring managers. [8] [13]

NHS suspension culture was long criticised, and led to the creation of campaign groups such as CAUSE (Campaign Against Unnecessary Suspensions & Exclusions in the NHS) [14] and the Doctors Support Group. [15]

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[10] Health and Wellbeing of NHS Staff – A Benefit Evaluation Model, Jeremy Dawson et al, Aston Business School for the DH, 2009

https://minhalexander.files.wordpress.com/2017/10/aston-business-school-health-and-wellbeing-of-nhs-staff-e28093-a-benefit-evaluation-model-jeremy-dawson-et-al-2009.pdf

[11] Evidence synthesis on the occurrence, causes, consequences, prevention and management of bullying and harassing behaviours to inform decision making in the NHS, JC Illing et al, NHIR February 2013

"The economic implications of replacing staff and reduced productivity resulting from bullying can be significant: a review estimated that the annual cost of bullying to organisations in the UK is £13.75 billion, taking into account absenteeism, turnover and productivity."

https://minhalexander.files.wordpress.com/2016/09/nhir-evidence-synthesis-on-the-occurrence-causes-consequences-prevention-and-management-of-bullying-and-harassing-behaviours-to-inform-decision-making-in-the-nhs-illing-et-al-3008636.pdf

[12] ACAS Code of Practice on disciplinary and grievance procedures, March 2015
http://www.acas.org.uk/media/pdf/f/m/Acas-Code-of-Practice-1-on-disciplinary-and-grievance-procedures.pdf

[13] FPPR: The CQC has lost all moral authority, but what will the National Guardian do?
https://minhalexander.com/2017/05/23/fppr-cqc-has-lost-all-moral-authority-but-what-will-the-national-guardian-do/

[14] Campaign Against Unnecessary Suspensions and Exclusions in the NHS
http://suspension-nhs.org/

[15] Doctors Support Group
https://doctorssupportgroup.com/

Personal accounts of suspension are provided on this page of CAUSE's website:

http://www.suspension-nhs.org/nhssuspensionpersonal.htm

CAUSE's 2011 evidence to parliament criticised the Department of Health's failure to ensure that central data is collected on the use of suspension in the NHS:

https://publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1428/1428we09.htm

Hansard has also provided sobering accounts of the unnecessary suffering caused by heavy handed NHS managerialism:

> *"However, I continue to make the case for doctors who are suddenly suspended by their hospitals without being told what they are supposed to have done, with no right of appeal, kept on suspension for months or even years and literally locked out of their hospitals at once. I know of a case in which the wife of a suspended hospital doctor was dying of cancer in the same hospital and, because of his suspension, he was not even allowed to visit her.*
>
> *Sometimes doctors are not even informed when they have been found innocent. That cannot be right. A doctor's reputation, good name and career are totally destroyed. These days, the medical profession moves so quickly that if a doctor has been out of the system for even a short time it is virtually impossible--or, if not, then it is extremely difficult--to return to making a success of his career. Therefore, careers are destroyed. There have been breakdowns, debts and suicides over this matter, and I cannot stress sufficiently that the seriousness of the situation screams for a remedy."*
>
> *Baroness Knight of Collingtree Hansard 1999*
>
> ***https://publications.parliament.uk/pa/ld199900/ldhansrd/vo000412/text/00412-06.htm***

The recklessness with which the NHS continues to treat staff, its most vital resource, is particularly hard to justify at a present time of increasingly precarious supply and concerns over the impact of leaving the European Union. [16] [17] [18] [19]

At the same time as the NHS is running retention schemes and recruiting abroad [20] [21], it still drives staff away through oppressive treatment and questionable sackings.

The NHS disciplines and dismisses a large number of staff every year.

Update to date figures on NHS disciplinary rates are not available. A 2010 study on the disproportionate disciplinary action against BME NHS staff provided data on 80 trusts, and reported an overall rate of 8.8 disciplinary actions per 100,000 staff from all groups, over a twelve month period. [22]

[16] NHS faces 'unprecedented workforce crisis' as vacancies rise 10% in last year, Katie Forster, Independent 25 July 2017
http://www.independent.co.uk/news/health/nhs-staff-vacancies-rise-10-per-cent-2017-86000-nurses-midwives-doctors-recruitment-crisis-brexit-a7858961.html

[17] Evidence from NHS Improvement on clinical staff shortages A workforce analysis February 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/500288/Clinical_workforce_report.pdf

[18] House of Lords Library Note July 2016, NHS and Social Care Workforce: Implications of Leaving the European Union
https://minhalexander.files.wordpress.com/2016/09/house-of-lords-nhs-and-social-care-workforce-implications-of-leaving-the-european-union-lln-2016-0039.pdf

[19] NHS staff from overseas: statistics, House of Commons Briefing 16 October 2017
https://minhalexander.files.wordpress.com/2017/10/nhs-staff-from-overseas-statistics-house-of-commons-briefing.pdf

[20] NHS Employers retention guidance and resources, July 2017
http://www.nhsemployers.org/your-workforce/retain-and-improve/retaining-your-workforce/retention-guidance-and-resources

[21] NHS England GP retention scheme guidance, 1 April 2017
https://www.england.nhs.uk/wp-content/uploads/2017/06/gp-retention-scheme-guidance-v3.pdf

[22] The involvement of Black and Minority Ethnic staff in NHS disciplinary proceedings, Prof Uduak Archibing and Aliya Darr, University of Bradford, Centre for Inclusion and Diversity 2011
https://minhalexander.files.wordpress.com/2017/10/the-involvement-of-black-and-minority-ethnic-staff-in-nhs-disciplinary-proceedings-2010.pdf

The study confirmed a pattern of disproportionate disciplinary action against BME staff:

3.1. Disciplinary data and ethnic monitoring in the NHS

Of the 80 trusts from which data could be obtained for auditing, BME staff were almost twice as likely to be disciplined compared to their white counterparts. These findings were statistically significant (see table 4 below)

Table 4: Disciplinary rates for all trusts *n = 80*

Ethnic group	Total Nos.	Nos. Disciplined	Rate per 1000
All	241,215	1, 128	8.8
White	207,516	1, 633	7.9
BME	33,699	495	14.7
χ^2 MH = 154.19, p<0.000001			

https://minhalexander.files.wordpress.com/2017/10/the-involvement-of-black-and-minority-ethnic-staff-in-nhs-disciplinary-proceedings-2010.pdf

Official data reveals between five and six thousand NHS staff are dismissed from the English NHS every year:

YEAR	Number of staff dismissed from the English NHS
2011/12	5,595
2012/13	5,499
2013/14	5,443
2014/15	5,511
2015/16	6,014
2016/17	5,882
2017/18 Q1	1,477
TOTAL	**35,421**

Source: NHS Digital workforce statistics, Reasons for Leaving and Staff Movements

https://minhalexander.files.wordpress.com/2017/10/nhs-work-stat-mar-2017-leav-reasn2.xlsx
https://minhalexander.files.wordpress.com/2017/10/nhs_workforce_statistics__june_2017_reasons_for_leaving1.xlsx

Insidiously, the number of dismissals via the 'Some Other Substantial Reason' (SOSR) route are significant. Approximately eight thousand staff have been dismissed via SOSR over the last six years:

YEAR	Number of staff dismissed from the English NHS via SOSR
2011/12	1518
2012/13	1273
2013/14	1163
2014/15	1203
2015/16	1245
2016/17	1267
2017/18 Q1	319
TOTAL	**7988**

Source: NHS Digital workforce statistics, Reasons for Leaving and Staff Movements
https://minhalexander.files.wordpress.com/2017/10/nhs-work-stat-mar-2017-leav-reasn2.xlsx
https://minhalexander.files.wordpress.com/2017/10/nhs_workforce_statistics__june_2017_reasons_for_leaving1.xlsx

Under SOSR, it can be lawful for employers to sack workers on the grounds that relationships have broken down irretrievably, regardless of whose fault it is. [23] [24] [25] [26] [27]

SOSR is a well worn route for disposing of whistleblowers, whom employers may deliberately draw into conflict with endless provocations. [28] No doubt it is a ruse that may be inflicted on other blameless but unwanted employees.

[23] Some Other Substantial Reason (SOSR) Dismissals
https://bevanbrittan.com/insights/articles/2012/someothersubstantialreasondismissals
[24] Acas code applied to dismissal for breakdown in trust and confidence, Mary Clarke, Personnel Today, 3 July 2013 http://www.personneltoday.com/hr/case-of-the-week-acas-code-applied-to-dismissal-for-breakdown-in-trust-and-confidence/
[25] Acas code does not apply to 'some other substantial reason' and ill-health dismissals, People Management, 11 July 2016
http://www2.cipd.co.uk/pm/peoplemanagement/b/weblog/archive/2016/07/11/acas-code-does-not-apply-to-some-other-substantial-reason-and-ill-health-dismissals.aspx
[26] EAT judgment Phoenix House v Stockman and Lambis 17 May 2016
http://www.bailii.org/uk/cases/UKEAT/2016/0264_15_1705.html
[27] United Lincolnshire Hospitals NHS Foundation Trust v Farren UKEAT/0198/16/LA
https://www.employmentcasesupdate.co.uk/site.aspx?i=ed33671
http://www.tltsolicitors.com/insights-and-events/insight/recent-case-focuses-on-breakdown-of-trust-and-confidence-in-the-employment-relationship/
[28] Mr A J Panayiotou v 1) Chief Constable Paul Kernaghan 2) The Police and Crime Commissioner for Hampshire: UKEAT/0436/13/RN
https://www.gov.uk/employment-appeal-tribunal-decisions/mr-a-j-panayiotou-v-1-chief-constable-paul-kernaghan-2-the-police-and-crime-commissioner-for-hampshire-ukeat-0436-13-rn
http://www.capsticks.com/resources/news/read/356/important-new-guidance-from-the-courts-for-employe

Redundancy processes can also be abused to unfairly rid the NHS of unwanted staff. There have been approximately nineteen thousand compulsory NHS redundancies in the last six years:

YEAR	Number of staff made compulsorily redundant from the English NHS
2011/12	4,098
2012/13	4,598
2013/14	3,559
2014/15	2,536
2015/16	1,917
2016/17	1,656
2017/18 Q1	479
TOTAL	**18,843**

Source: NHS Digital workforce statistics, Reasons for Leaving and Staff Movements
https://minhalexander.files.wordpress.com/2017/10/nhs-work-stat-mar-2017-leav-reasn2.xlsx
https://minhalexander.files.wordpress.com/2017/10/nhs_workforce_statistics__june_2017_reasons_for_leaving1.xlsx

In 2003, the National Audit Office examined the use of suspension in the NHS and concluded that there was inefficiency. [29]

It touched on the case of Dr O' Connell who was suspended for a staggering eleven years at massive cost to the public purse, and whose case was the subject of a Public Accounts Committee Inquiry. [30]

The NAO made a number of recommendations, most of which have not been implemented at all or properly.

For example, NAO recommended:

1) That where allegations are made, they should be processed expeditiously and a determination of whether there is a case to answer should be reached within two weeks

2) The Department of Health should ensure central collection of data on suspensions and tracking of long term episodes of suspension of all NHS staff

3) The cost of suspending NHS staff should be centrally tracked

[29] The management of suspensions of clinical staff in NHS hospital and ambulance trusts in England, National Audit Office 2003
https://www.nao.org.uk/report/the-management-of-suspensions-of-clinical-staff-in-nhs-hospital-and-ambulance-trusts-in-england/
[30] Doctor was suspended on full pay for twelve years, Liz Hunt, Independent 17 August 1995
http://www.independent.co.uk/news/doctor-was-suspended-on-full-pay-for-12-years-1596698.html

4) Central tracking of the ethnicity and gender of staff who are suspended

The NAO also made general recommendations about preventative measures such a more proactive approach to quality improvement and learning in the NHS, including use of clinical audit, so that staff could benchmark their individual performance and be aware of any improvements needed.

In 2005 the Department of Health gave the following figures for NHS doctors who had been suspended for six months or more:

Table 1. Number of doctors and dentists suspended for six months or more.

Quarter	2000	2001	2002	2003
1.	33	32	30	27
2.	30	33	33	26
3.	26	33	38	32
4.	27	29	29	24

The Department acknowledged: *"Although the numbers are small the costs to the NHS are substantial."* [31]

The National Clinical Assessment Service [32] was created partly in response to this waste and the scandal of NHS doctors being inappropriately suspended for years. It is supposed to provide guidance to employers and facilitate better practice. However, it too has since drawn criticism and is now seen by many as part of the problem. [33] NCAS has been criticised for rubber stamping rogue employers' actions and accepting malicious claims by employers at face value.

In theory, NCAS advises NHS bodies on the appropriate application of the euphemistically named and much-criticised 'Maintaining High Professional Standards' (MHPS) procedures [31], for disciplining NHS doctors and dentists.

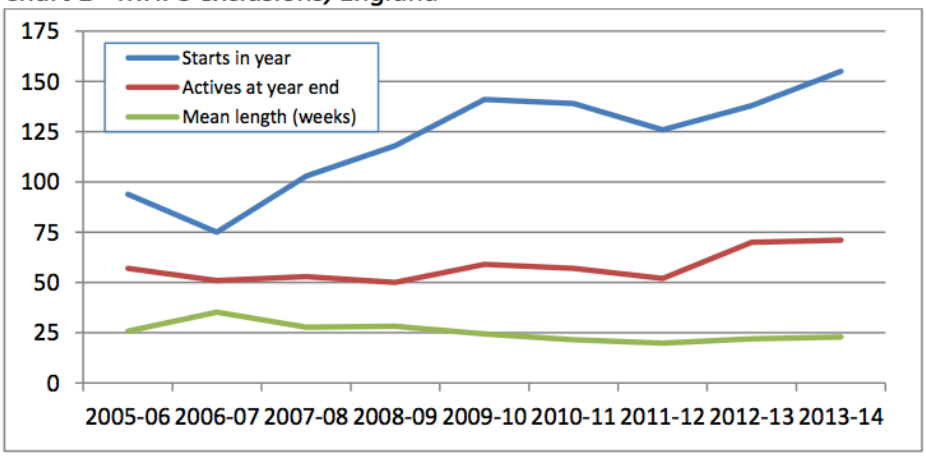
[31] Maintaining High Professional Standards in the Modern NHS, DH 2005 http://webarchive.nationalarchives.gov.uk/20130124065523/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf
[32] National Clinical Assessment Service http://www.ncas.nhs.uk/
[33] NCAS performance assessment is seriously flawed http://www.bmj.com/content/346/bmj.f2775

MHPS sets out the steps for suspending and dismissing practitioners which are all internally controlled. The employer is in effect investigator, prosecutor and judge. [34]

NCAS also serves a similar function with the administration of the Performers List, a similar arrangement for general practitioners.

NCAS has released statistics on exclusion of NHS doctors up to 2014. [35] This shows a steady increase in the number of doctors excluded under MHPS:

Chart 1 - MHPS exclusions, England



YEAR	Number of NHS doctors excluded* under MHPS, England
2006	90
2007	74
2008	102
2009	113
2010	134
2011	136
2012	125
2013	137
2014	148
TOTAL	**1059**

** In NCAS terminology, NHS doctors are 'excluded' under MHPS and GPs are 'suspended' under the Performers List arrangements.*

This steep rise in in the number of exclusions outstrips the growth in the number NHS doctors.

[34] Employers' discipline of doctors in the NHS John Hendy QC, from A Savage Enquiry Revisted 2007 https://minhalexander.files.wordpress.com/2016/09/john-hendy-qc-on-doctors.pdf

[35] NCAS statistics up to 2014, National Clinical Assessment Service Use of exclusion and suspension from work in England https://minhalexander.files.wordpress.com/2016/09/ncas-statistics-report-to-2013-14-140530-website.pdf

In 2011 NCAS reported that it was performing well because despite the increase in numbers of excluded doctors, the episodes of exclusions had shortened:

> *"The number of hospital and community (H&C) exclusions appears to have stabilised at about 130 new episodes a year in England. Doctor exclusions concluded in 2011/12 lasted an average of 19 weeks, continuing a downward trend in duration."* [36]

However, NCAS' more recent data on the average duration of episodes of exclusion raises a question of whether the downward trend will be sustained [35]:

YEAR	Average duration of episodes of exclusion under MHPS closed by year of closure, weeks, England
2006	26
2007	33
2008	25
2009	29
2010	25
2011	21
2012	20
2013	20
2014	23
AVERAGE	**24.6**

In its 2014 report, NCAS gave the following shocking calculation of time lost for all suspended and excluded NHS doctors and GPs:

> *"In 2013-14, 290 episodes were active at some point during the year (including episodes carried forward and new episodes). These lasted a total of 5600 weeks in 2013-14. This is equivalent to about 120 doctor/dentist years."* [29]

Despite the importance of managing staff suspensions efficiently, and the issues flagged by the 2003 NAO report, NHS Digital produces no routine data on NHS staff suspensions.

I have found only a single official report on ambulance staff suspensions in 2016/17 but no other such data. [37]

[36] NCAS report, Use of NHS exclusion and suspension from work amongst doctors and dentists in England in 2011/12
https://minhalexander.files.wordpress.com/2016/09/ncas-2011-12-end-year-final.pdf

[37] NHS Digital data, Ambulance service suspensions February 2016 to January 2017
https://minhalexander.files.wordpress.com/2016/09/nhs-digital-ambulance_staff_suspension.xlsx

FOI data obtained in 2016 from 113 English NHS trusts revealed that these trusts admitted to suspending a total of 3,477 staff between 2013 and 2016. [38]

For the sake of argument, assuming a similar rate of suspension in other English trusts, this would give approximately 2,400 suspensions a year in the English NHS, which seems low given that over 5,000 staff are sacked every year.

Notwithstanding the likely underestimation, the pay bill for these 3,477 suspended NHS workers was £28,497,343.42. Nineteen NHS workers who had been suspended for more than a year accounted for over £1 million of this expenditure. [38]

The ACAS Code of Practice provides this guidance on suspension:

> *"In cases where a period of suspension with pay is considered necessary, this period should be as brief as possible, should be kept under review and it should be made clear that this suspension is not considered a disciplinary action."* [12]

Under MHPS, the bar for exclusion is high and comprises either:

1) *"the need to protect patients, the practitioner concerned and/or their colleagues" or*

2) *"when there is a clear risk that the practitioner's presence would impede the gathering of evidence"* [31]

In reality, NHS managers often abuse process and suspend staff when reasonable grounds for suspension are not in fact met. [29] [39]

> *"Nurses and midwives are the clinical groups most likely to be suspended in the NHS. Trusts do not report data on suspensions therefore no data exists on numbers, reasons for suspensions, managerial processes, gender, area of work, or ethnicity of those suspended; the few major research projects identify variable management practices, the significant cost to the NHS and personal cost to those suspended; there is evidence that inexperienced, poorly trained, or poorly supported managers use suspension inappropriately. Our observation supported this."* [40]

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[38] £46 million spent on suspended public officials - new ITV research, 22 September 2016
http://www.itv.com/news/2016-09-22/46-million-spent-on-suspended-public-officials-new-itv-research/

[39] Mezey v South West London and St George's Mental Health NHS Trust [2007] EWCA Civ 106
http://www.bailii.org/ew/cases/EWCA/Civ/2007/106.html
https://uk.practicallaw.thomsonreuters.com/2-224-2968?transitionType=Default&contextData=(sc.Default)&firstPage=true&bhcp=1

[40] The management of poor performance in nursing and midwifery: a case for concern, Stone et al, Journal of Nursing management, 10 May 2011
https://minhalexander.files.wordpress.com/2016/09/traynor_-_management-poor-performance4.pdf
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2011.01219.x/abstract

Questionable NHS suspensions make for repeated news headlines.

For example: *"NHS staff suspended over 'lying down game' "* [41]

"Surgeon suspended over soup!" [42]

There also continue to be drawn out suspensions, whether due to inefficiency or because delay, intimidation and isolation are used as management weapons of attrition against unwanted staff. [43]

In 2009 the Audit Commission reported in detail on a case of badly mismanaged suspension at Nottingham University Hospitals NHS Trust, in which it criticised the financial waste that resulted. [44]

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[41] NHS staff suspended over lying down game, Independent 9 September 2009
http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-staff-suspended-over-lying-down-game-1784307.html

[42] Surgeon suspended over soup! Chris Brooke Daily Mail
http://www.dailymail.co.uk/health/article-300116/Surgeon-suspended-soup.html

[43] Raj Mattu and the death of whistleblowing, Private Eye Issue 1364

"In the 15 years that he raised concerns about the appalling treatment of patients and then himself, he wrote to successive health secretaries, chief executives of the NHS and senior Department of Health officials. Nobody in authority in the NHS intervened on his or his patients' behalf. For all the talk about the vital importance of whistleblowing and an end to cover-ups in the NHS, Mattu was simply hung out to dry"

http://www.drphilhammond.com/blog/2014/05/07/private-eye/medicine-balls-private-eye-issue-1364-2/

[44] Managing long term staff suspension, Audit Commission March 2010

> *"**21** Management of this case has resulted in poor value for money. Given that under the terms of the exclusion full salary continued to be paid, the delay had financial implications for both QMC and NUH. Total direct salary costs incurred during the period of exclusion amount to approximately £315,000, the majority of which would have been borne by NUH. Significant additional indirect costs including senior management resource have also been incurred.*
>
> ***22** The poor management of this case has concluded with an unavoidable need to sever the contract of employment with this individual. This will result in an additional cost to the Trust at the point of termination. This has yet to be agreed and is not covered by this report."*

https://minhalexander.files.wordpress.com/2016/09/audit-commission-nuh_1341_b_-_2009-2010_-_managing_long_term_staff_suspension_-_nottingham_university_hospitals_nhst_v1-0.pdf

A glance through recent NHS trust and health board FOI disclosure logs also shows that there are still instances of lengthy suspensions that last many months:

SUMMARY OF PUBLISHED FOI DATA ON NHS BODIES' USE OF SUSPENSION

https://minhalexander.files.wordpress.com/2016/09/summary-of-foi-data-on-nhs-suspensions-as-of-20-october-2017.xlsx

Cardiff and Vale University Health Board, which persecuted senior heart surgeon and whistleblower Peter O'Keefe such that he now works as an Uber driver, disclosed this data on its use of suspension:

https://minhalexander.files.wordpress.com/2016/09/cardiff-and-vale-suspension-foi-17-092-suspended-staff.pdf

Peter O'Keefe's story:

Dr O'Keefe earned £12,000 in his first year as an Uber driver, a significant drop from his old £95,000 salary

http://www.dailymail.co.uk/news/article-4893736/Fired-NHS-surgeon-works-Uber-driver.html

http://www.dailymail.co.uk/health/article-2793729/heart-surgeon-welsh-hospital-suspended-pay-two-years-costing-nhs-250-000-country-faces-cardiac-care-crisis.html

http://www.walesonline.co.uk/news/health/top-heart-surgeon-writes-allegations-12519302

NHS Lothian, which hounded consultant psychiatrist and NHS whistleblowerJane Hamilton used 140 episodes of suspension over eight years.

https://minhalexander.files.wordpress.com/2016/09/nhs-lothian-suspension-foi-5227.pdf

Jane Hamilton's story:

http://www.express.co.uk/news/uk/846265/NHS-mother-and-baby-service-Scotland-avoidable-deaths

http://www.heraldscotland.com/news/14168041.Whistle_blower_retires_with_her_career_in_Scotland_ruined/

Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP), held up by Robert Francis as an exemplar of transparency and just culture because of its prototype Speak Up Guardian, admitted to suspending one member of staff for 447 days:

https://minhalexander.files.wordpress.com/2016/09/ssotp-suspension-foi-572-response2.xlsx

This only adds to other evidence that SSOTP has feet of clay:

https://minhalexander.com/2017/05/28/ssotp-robert-francis-exemplar-trust-has-feet-of-clay-and-jeremy-hunts-safety-claims-are-un-evidenced/

A recent FOI disclosure by Cumbria Partnership showed that there was **no case to answer in half of suspensions** (six of twelve), even though some of the suspensions were clearly lengthy:

https://minhalexander.files.wordpress.com/2016/09/cumbria-partnership-foi1617051_suspensions.xlsx

NHS organisations have claimed that because suspension is not disciplinary action, it is a neutral act. [45] It very clearly is not in terms of the distress and health impact. [39] [46] [47] Dr Tomlin who founded the Doctors' Support Group held that suspension is associated with higher mortality in doctors than elective cardiac surgery: *"The process causes significant morbidity as well as having a 2% mortality."* [47] [48]

Dr Tomlin reported in his 2003 paper:

> *"Who is doing the accusing? It has been possible to identify who was behind the suspension in 287 cases. If we subtract those cases which are alleged to have a criminal or partially criminal basis (which can vary from fraudulent expense claims to allegations of manslaughter) there are just over 250 identifiable accusers (Figure 4). The most striking thing is how few are from patients only about 6%. The second is that doctors account for over a third of suspensions, usually allegations of incompetence. One would expect the accuracy of a doctor making allegations about incompetence to be substantial, but in fact it is no different from that of administrators also accusing the doctor of incompetence. Examining the motives of these cases, regrettably this showed interdepartmental quarrels and jealousies, related to private practice or power-seeking to remove a head of department, simple personality clashes, and so on."* [47]

Suspensions are discrete events with clearly defined, recorded dates. This is data that should be very easy to collect and process.

Given the obvious systemic significance of suspensions, one has to question why the Department of Health is not ensuring that this is done and that such data is openly published.

Such opacity allows poor practice to go unchallenged, but equally, it allows the NHS to retain a powerful tool of suppression.

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[45] ***"The imposition of an interim suspension order is a neutral act."***

DH 2015, Explanatory memorandum to the National Health Service (Performers lists) (England) (Amendment) Regulations 2015
http://www.legislation.gov.uk/uksi/2015/362/pdfs/uksiem_20150362_en.pdf

[46] GPs only to be taken off performers list after investigation under DH proposals, 6 August 2014
http://www.pulsetoday.co.uk/your-practice/regulation/gps-only-to-be-taken-off-performers-list-after-investigation-under-dh-proposals/20007491.article

[47] The Suspension Scandal, Dr PJ Tomlin, Journal of Obstetrics and Gynaecology (May 2003) Vol. 23, No. 3, 221–227
https://minhalexander.files.wordpress.com/2016/09/pj-tomlin-the-suspensions-scandal-2003.pdf

[48] Advice to All Doctors Facing Suspension Or Other Disciplinary Measures, Doctors Support Group
https://doctorssupportgroup.com/suspended-doctors.htm

Dr John Bestley: The events

This is the Employment Tribunal Judgment in Dr Bestley's case, which gives a detailed summary of the case and the findings of unfair dismissal:

https://minhalexander.files.wordpress.com/2016/09/employment-tribunal-judgment-bestley-v-humber-nhs-foundation-trust.pdf

[NB Where excerpts from this full copy of the judgment are provided later in this paper, only the names of trust board members and not those of more junior staff are shown]

John Bestley was suspended on by Humber NHS Foundation Trust on 20 June 2011. He remained suspended until he was dismissed in May 2013.

He was supported by his union the BMA throughout his case.

Hitherto he had worked at the trust since 1993, and in 2010 he had been appointed as clinical director for Older People's Mental Health Services.

There had been no previous formal action against him. The trust had records of concerns that had been dealt with informally in the past, which related to a style of humour and reported lack of insight about some social interactions. [49] [50]

[49] Grievance investigation report by Humber NHS Foundation Trust

There is no doubt in our minds that Dr JB is held in high regard as a clinician. He is considered to be an excellent doctor as to whose competence and clinical abilities few concerns have ever been raised. He does appear to have a good sense of humour, which at times, however, verges on being inappropriate in the context in which it is used. The term 'lack of insight' by Dr JB seems to be a common thread and underpins some of the concerns raised by others; indeed it was a phrase even used by his brother, Reverend Peter Bestley, during the grievance hearing on 20 August 2012.

[50] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust

21 Interviews with all the subsequent witnesses were concluded by the end of November 2011. By this stage, these included Dr Gee himself. He was required as a witness to give evidence as to previous incidents. On 31 October 2008 following complaints and discussions over the summer of 2008, Dr Gee had written to Dr Bestley recording:

"On having the opportunity to reflect on the use of language you were able to agree with me that the use of such language in these incidents was inappropriate and have agreed to moderate your use of language in the future. I indicated to you that should I received further concerns over inappropriate use of language that further action may than be necessary."

However, the trust acknowledged that Dr Bestley was an effective and well regarded clinician. [49]

His medical colleagues in fact wrote a strong letter of support in his favour:

Letter 20 December 2011 from local geriatricians in support of Dr Bestley:

Re: DR JOHN BESTLEY – CONSULTANT OLD AGE PHSYCHIATRIST

We as a Department of Elderly Medicine at Hull and East Yorkshire NHS Trust wish to pledge our support to our colleague, Dr John Bestley. For many years Dr Bestley has provided Consultant Liaison Psychiatry Services to our patients in the Acute Trust both at Hull Royal Infirmary and Castle Hill Hospital. During this time he has been instrumental in improving the quality of care provided to older aged inpatients with psychiatric illness. We are extremely grateful for the support he has provided to our team when treating such patients.

Dr Bestley has worked regularly with ourselves, our junior colleagues and our allied health care professionals. He is liked by all and in particular has an excellent rapport with the nursing staff on our base wards at Hull Royal and Castle Hill Hospitals.

We have always found him to be diligent, enthusiastic, reliable and supportive to our teams. We have absolutely no concerns regarding his clinical care and interaction with patients, relatives and staff.

In particular it is worth mentioning Dr Bestley's dedication to the training of medical students and junior doctors. He has frequently delivered lunchtime teaching sessions to our department and has even lectured at evening symposiums without financial remuneration.

We as a department look forward to working with Dr Bestley again in the near future.

Yours sincerely

Dr Bestley encountered some friction with the trust chief executive in March 2011 in the course of his duties as clinical director regarding the management of the consultant rota [51], but he did not raise a formal concern at the material time. When Dr Bestley later included these issues in a grievance, the trust did not accept that its chief executive had acted inappropriately in the matter.

Dr Bestley also expressed concerns that his disagreements with trust managers over trust reorganisation plans may have counted against him.

[51] Email correspondence between Dr Bestley and David Snowdon Chief Executive Humber NHSFT

From: Snowdon, David
Sent: **04 March 2011 13:42**

To: Bestley, John; Gee, Douglas; [redacted]
Cc: [redacted]

Subject: RE: Consultant availability
Page 1 of 3
11/10/2012
John
I am afraid the assumptions that have been reflected in you e mail are entirely wrong and very unhelpful. I would therefore be grateful if you proceed with the actions I have requested in order to resolve the current situation.
If you wish to discuss this matter further I suggest you arrange to meet with me as it is clear to me that further e mail dialogue will not be very productive
Regards
Dave

From: Snowdon, David

From: Snowdon, David

Sent: **04 March 2011 16:23**

To: Bestley, John

Subject: Your last e mail

John

I am not copying this to all those you previously chose too.

I have to say I found the tone and content of your e mail offensive. I also fail to understand how you managed to reach the assumptions you made which I find entirely disrespectful.

This is not what I expect from any one in a management role including any of my clinical directors.

Dave

Three months after his conflict with the trust chief executive, Dr Bestley became the subject of numerous allegations from five members of staff who together met with the trust chief executive, and whom the trust characterised as whistleblowers.

On the day of his suspension in June 2011, Dr Bestley was informed only that there were allegations against him that *"may amount to bullying and sexual harassment".*

It was not until 15 July 2011 that Dr Bestley was given some additional detail of the allegations against him, but even then, he was not given full details. This was despite the trust having undertaken full interviews with the staff who had made the allegations by this point.

No meeting took place with Dr Bestley until 12 September 2011. Further meetings took place on 6 October 2011, 2 November 2011 and 16 November 2011.

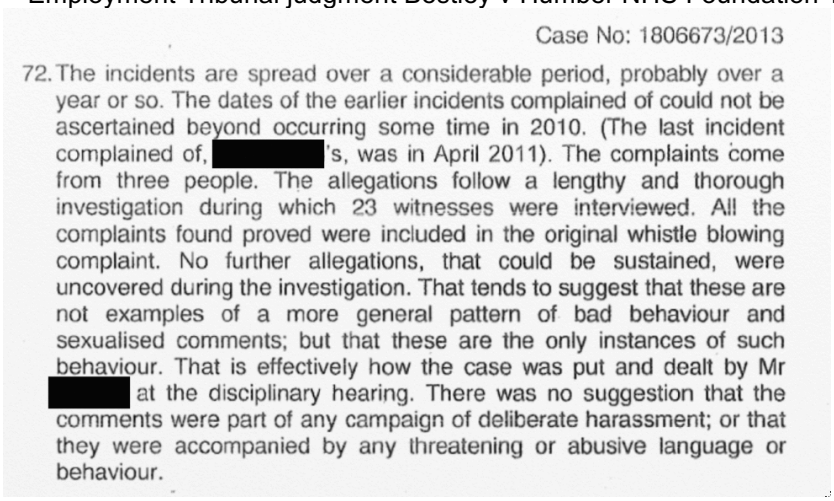
He was not given statements from management witnesses until almost three months after he was suspended, and he was not given all of the relevant statements. The trust was also slow to interview all of his witnesses.

Upon finally being provided with the witness statements, it was evident to Dr Bestley that the case against him relied in part on alleged events that were months old.

The dates of some incidents could not be established. [52]

The Employment Tribunal expressed concerns over the trust's decision to proceed with "stale" complaints, especially as the trust's whistleblowing policy requires that concerns should be raised within three months of an individual becoming aware of the concern.

[52] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



Case No: 1806673/2013

72. The incidents are spread over a considerable period, probably over a year or so. The dates of the earlier incidents complained of could not be ascertained beyond occurring some time in 2010. (The last incident complained of, [redacted]'s, was in April 2011). The complaints come from three people. The allegations follow a lengthy and thorough investigation during which 23 witnesses were interviewed. All the complaints found proved were included in the original whistle blowing complaint. No further allegations, that could be sustained, were uncovered during the investigation. That tends to suggest that these are not examples of a more general pattern of bad behaviour and sexualised comments; but that these are the only instances of such behaviour. That is effectively how the case was put and dealt by Mr [redacted] at the disciplinary hearing. There was no suggestion that the comments were part of any campaign of deliberate harassment; or that they were accompanied by any threatening or abusive language or behaviour.

The Tribunal noted that the trust made light of the age of the complaints against Dr Bestley, but that the staleness of these complaints affected witnesses' recall and the vital context of incidents had been forgotten. [53]

The Tribunal was critical of the trust's failure to even give a rationale for deviating from its policy and commented:

> *"Allowing stale complaints to be proceeded with adds greatly to the difficulties of management's task in investigating them, since the dates and witnesses cannot readily be ascertained, and memories have faded so that the context cannot be established; and it makes it much harder for the individual accuses to defend themselves"*

There were irregularities in application of the process under which NHS doctor's performance and disciplinary matters are supposed to be handled – the 'Maintaining High Professional Standards in the Modern NHS' (MHPS) procedures.

The Employment Tribunal was critical that the trust failed to follow its own policy of formally reviewing and documenting the decisions to renew Dr Bestley's suspension:

> ***"Each renewal is a formal matter and must be documented as such"*** [54]

---

[53] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust

111. It is not merely that the delay affected Dr Bestley's behaviour and presentation at his eventual disciplinary hearing, and his ability to defend himself fairly. The delay was not just prospective, affecting the time taken from July 2011 to complete the disciplinary proceedings; it was also retrospective, covering the period from July 2011, when charges were brought, over the previous year, back to some unspecified time in 2010 (or earlier) when the incidents complained of occurred. This second aspect in which delay affected the fairness of this case was that the Trust allowed, in the summer of 2011, stale complaints to be brought forward whose staleness very significantly affected Dr Bestley's ability fairly to defend himself. The three complaints from Dr [redacted] that were taken forward all related to some time in the previous year, 2010. The key question about impotence (which weighed particularly heavily with Mr Snowden) occurred probably in August or September 2010. It is no answer to say, as the Trust do, that since Dr Bestley admitted the remark, its date does not matter. Context is everything in considering such a remark. The context offered by Dr Bestley is that of a consensual conversation between two clinicians about the possible side effect of treatment the other was receiving. Dr [redacted] could not recall the context; only his distress at the remark.

[54] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust

94. Mrs Mason and Mr Snowden gave evidence Dr Bestley's exclusion was the subject of regular and thorough reviews, as required by their policy, and that alternatives were regularly actively considered. Mrs Mason's estimate was that the exclusion was costing the trust some £7,000 per week. (That seems high to the Tribunal, but Mr Snowden did not demur when the figure was put to him in cross examination.) The Trust kept NCAS, the national body charged with oversight of such matters within the NHS, regularly informed of the suspension; and also informed a board member as they are required to do. The Trust case on these points would be stronger if any written record or minute of these various review meetings had been kept. Paragraph 35 of the Trust's policy sets out an elaborate staged procedure for reviews of suspension it provides: *"Each renewal is a formal matter and must be documented as such."*

Compounding these serious failures by the trust is the fact that Dr Bestley and his representatives repeatedly raised concerns about his lengthy suspension with the trust at the time, but it did not listen.

Failures of this sort are all the more disappointing because the government introduced MHPS with the stated aim of eliminating avoidable delays in case handling.

The trust medical director Dr Gee acted as MHPS case manager but had to be replaced when he became a witness against Dr Bestley, in relation to past informal warnings about Dr Bestley's behaviour.

Dr Oade, a medical director from a neighbouring trust took over as MHPS case manager and informed Dr Bestley on 4 January 2012 that she considered that there was a case to answer, and that she was referring him to a disciplinary panel.

There was concern about Dr Oade's handling of an inaccuracy in the correspondence between NCAS and the trust, which was repeated several times by NCAS. It was wrongly stated that Dr Bestley's medical colleagues had made complaints against him when as above, they had in fact written in support of him.

Dr Oade advised that she did not give this error the same weight as Dr Bestley or his BMA representative, as she did not consider that it materially changed matters. She indicated that the key issue was that complaints had been made by other, non-medical colleagues. [55]

[55] From 1 October 2012 letter by Dr Oade to Dr Bestley's BMA representative

Dear Kevin

Dr John Bestley

Further to your two letters dated 21 September 2012 please find my response to each of them as follows:

NCAS Letters

I would like to reassure you that I am fully aware of the case against Dr Bestley and that any reference to "consultant colleagues" made in the NCAS letters has been an error. I am aware of who has made the allegations and I would confirm that I have never understood those allegations to have been made by Dr Bestley's consultant colleagues. Neither has anyone in Humber NHS FT informed me that the allegations have been made by "consultant colleagues".

The first few paragraphs of the NCAS letters are usually repeated each time as they outline the high level details of the case. It is apparent that the letters have referred to "4 colleagues of this consultant" "4 of his colleagues" and then latterly "consultant colleagues". I believe this to have been written wrongly but that it has not been picked up as the first few paragraphs are standard. You will appreciate that NCAS has been involved in this case for some time and they are aware, as evidenced in their earlier letters, that it was 4 colleagues of Dr Bestley. That said, whoever the allegations have been made by would not change the outcome.

Allegations of bullying and harassment and sexual harassment are a serious matter and I stand by my original decision that some of the content of the report, if founded, constitutes gross misconduct and therefore that the case needs to proceed to a Disciplinary Hearing.

During the course of proceedings, Dr Bestley discovered through a Subject Access Request for personal data that the Chief Executive and Deputy Chief Executive had previously made negative comments about his application for the post of clinical director, including a comment that he was not 'corporate' enough, and that the Chief Executive had continued to express concerns about his suitability after appointment.

Correspondence in September 2010 between the trust Director of Nursing & Chief Executive about Dr Bestley's application for the Clinical Director post:

From: Mason, Angie
Sent: 23 September 2010 12:00
To: Gee, Douglas
Cc: [redacted] Snowdon, David
Subject: Re: Dr Bestley

Dear Douglas

Happy with the process but remain concerned that John thinks this is a formality and his ability to be corporate

We really must be robust in how we test this at interview
The agenda is large in OP services and we need someone to work with us
Can we discuss on monday what the questions are and what the H R process will be if he does not meet the job description as tested at Interview

Regards

From: Snowdon, David
Sent: 23 September 2010 12:24
To: Mason, Angie; Gee, Douglas
Cc: [redacted]
Subject: RE: Dr Bestley

Hi Angie
Thanks for copying me in on this. I discussed this issue with Douglas this morning whereby it was agreed ;
He (JB) has to clearly demonstrate his willingness and ability to comply with the requirements of the role (as do all other Clinical Directors)
In the event of him being appointed (and again in line with all other Clinical Directors) he will need to have a set of very clear, specific objectives which are closely monitored. In the event of difficulties these will need to be addressed via the usual performance processes.

I agree with your comments about the need for collaboration and partnership, the panel will need to take a very close look at these issues, informed by past and present behaviours. Ultimately they will be accountable for the final decision, and for any future actions should these be necessary.

Hope your day is going well ?
See you tomorrow
Regards
Dave

Email March 2011 from the trust Chief Executive to the Medical Director, giving "formal notice" of his concerns about Dr Bestley following his conflict with Dr Bestley about the consultant rota:

Annan, Graham

From: Snowdon, David
Sent: 04 March 2011 14:09
To: Gee, Douglas
Cc: Mason, Angie; [redacted]
Subject: FW: Consultant availability

Douglas
You will have seen my response to Johns e mail, when you next meet with John can you ensure he is aware that;
1 When people write to him as Clinical Director it is as part of the management team not as "lead " Doctor
2 That in such instances I do not expect him copying his Consultant colleagues in based upon his assumptions and opinions
3 Remind him of the responsibilities he has signed up to in taking on the role, a record of the discussion will also be helpful
Can you also accept this e mail, as formal notice of my concerns in light of our previous discussions on this matter.

I have to say my concerns about his suitability for this post grow on an almost weekly basis, unless some improvement is seen soon I think we will need to review the current arrangement

Thanks
Dave

The Chief Executive was appointed to chair the disciplinary panel against Dr Bestley.

A hiatus followed because Dr Bestley became acutely unwell, requiring a five week admission to psychiatric hospital, and also because he lodged a grievance about the way in which he had been treated. In essence, he contended that he had been maliciously targeted because the trust wanted to remove him.

His grievance was not upheld at all by the trust. The grievance adjudicator concluded that the trust had not acted unreasonably in allowing the chief executive who had been party to the discussion about Dr Bestley not being corporate enough to be appointed as the chair of his disciplinary panel.

The Employment Tribunal later held that the remarks about Dr Bestley not being corporate enough were not 'sinister' if taken in context.

It is fair perhaps to note here that an Employment Tribunal cannot be expected to fully appreciate the phenomenon of managerialism in the NHS [56] and the full

[56] When Managers Rule, Professor Sir Brian Jarman, BMJ 2012 https://minhalexander.files.wordpress.com/2016/09/when-managers-rule-brian-jarman-bmj-dec-2012.pdf

significance of an executive director deeming a senior clinician as 'not corporate' enough. Other indicators of the undercurrent of managerialism were the above email comments by the trust chief executive that Dr Bestley should remember that he was a manager, and a clinical director, rather than a lead consultant.

The grievance investigation did conclude however, that Dr Bestley had been suspended for too long without reasonable progress in his case. Equally, it concluded that there had been many reasonable explanations for that delay.

The Employment Tribunal later noted the serious overall delay in progressing his case, but largely concluded that they were not unreasonable.

However, the Tribunal expressed *"serious concerns"* at the length of time for which Dr Bestley was suspended, and the serious harm to his health:

> *"We have serious concerns as to whether Dr Bestley's prolonged and continued suspension was justified, or complied with the Trust's own procedures."*

The Tribunal firmly rejected the trust's grounds for continuing Dr Bestley's suspension long after any potential concern about his clinical practice was ruled out in June 2011. [57]

This is in keeping with the fact that many NHS trusts fail to treat practitioners fairly when suspending them, and the reasonable tests of exceptional, clear risk to others or risk of tampering with evidence are often not met.

A letter of 27 September 2012 from NCAS to Dr Oade the second medical director appointed as MHPS case manager noted that Dr Oade had offered no more than breakdown of trust and confidence as the reason for continuing Dr Bestley's suspension:

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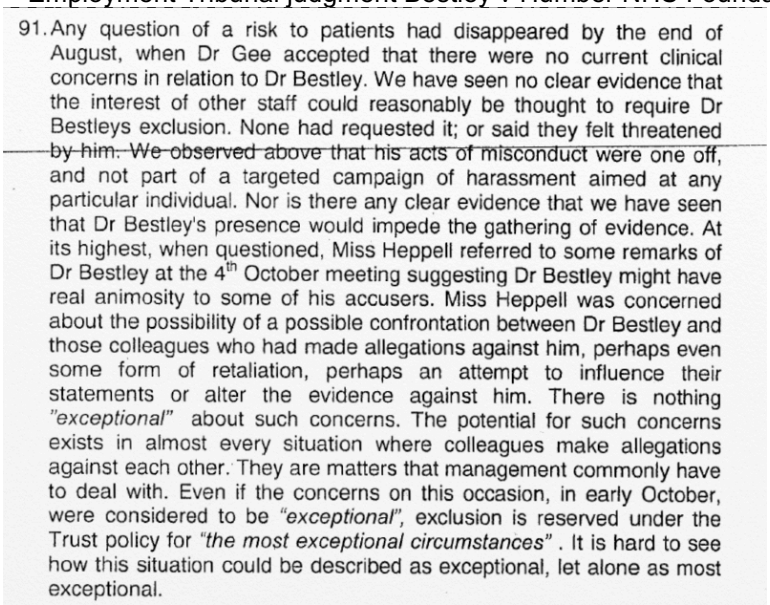
[57] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



91. Any question of a risk to patients had disappeared by the end of August, when Dr Gee accepted that there were no current clinical concerns in relation to Dr Bestley. We have seen no clear evidence that the interest of other staff could reasonably be thought to require Dr Bestleys exclusion. None had requested it; or said they felt threatened by him. We observed above that his acts of misconduct were one off, and not part of a targeted campaign of harassment aimed at any particular individual. Nor is there any clear evidence that we have seen that Dr Bestley's presence would impede the gathering of evidence. At its highest, when questioned, Miss Heppell referred to some remarks of Dr Bestley at the 4th October meeting suggesting Dr Bestley might have real animosity to some of his accusers. Miss Heppell was concerned about the possibility of a possible confrontation between Dr Bestley and those colleagues who had made allegations against him, perhaps even some form of retaliation, perhaps an attempt to influence their statements or alter the evidence against him. There is nothing *"exceptional"* about such concerns. The potential for such concerns exists in almost every situation where colleagues make allegations against each other. They are matters that management commonly have to deal with. Even if the concerns on this occasion, in early October, were considered to be *"exceptional"*, exclusion is reserved under the Trust policy for *"the most exceptional circumstances"* . It is hard to see how this situation could be described as exceptional, let alone as most exceptional.

"You said you were of the opinion at the present time that, because of the breakdown of trust and confidence between Dr 11009 and other colleagues in the same department, you do not consider appropriate at present to end his exclusion".

There are clearly other ways of dealing with such a situation other than by suspension, such as temporary redeployment. Yet there was no sign in NCAS' letter that NCAS challenged this use of suspension in Dr Bestley's case. It only mildly reminded Dr Oade that suspension should be used only:

"…as a last resort and for the shortest necessary period"

The Employment Tribunal observed that lengthy suspension had the effect of removing urgency from the trust's point of view, allowed it to tolerate delays and that this seriously harmed Dr Bestley's health:

95. We have serious concerns as to whether Dr Bestley's prolonged and continued suspension was justified, or complied with the Trust's own procedures. However, we remind ourselves that we are considering the fairness of his dismissal; not the propriety of the exclusion. But, whether proper or not, the continued exclusion of Dr Bestley made it much easier for the Trust to tolerate the delays in the investigatory and disciplinary process. It removed what would otherwise have been a compelling sense of urgency to resolve the issues, to enable the relationship between Dr Bestley and his colleagues to be taken forward, one way or another. To that extent, contribution to delay, the issue of exclusion is relevant to fairness.

96. The continued and prolonged length of the exclusion is relevant to the fairness of the dismissal in a second way. It contributed greatly (not least because of the apparent breaches of policy involved) to Dr Bestley's belief that the process was a sham; that he was not being treated fairly; and that his health was being seriously harmed as a result.

By the autumn of 2012, the trust resumed its disciplinary action against Dr Bestley.

A disciplinary hearing took place over four days in March and April 2013.

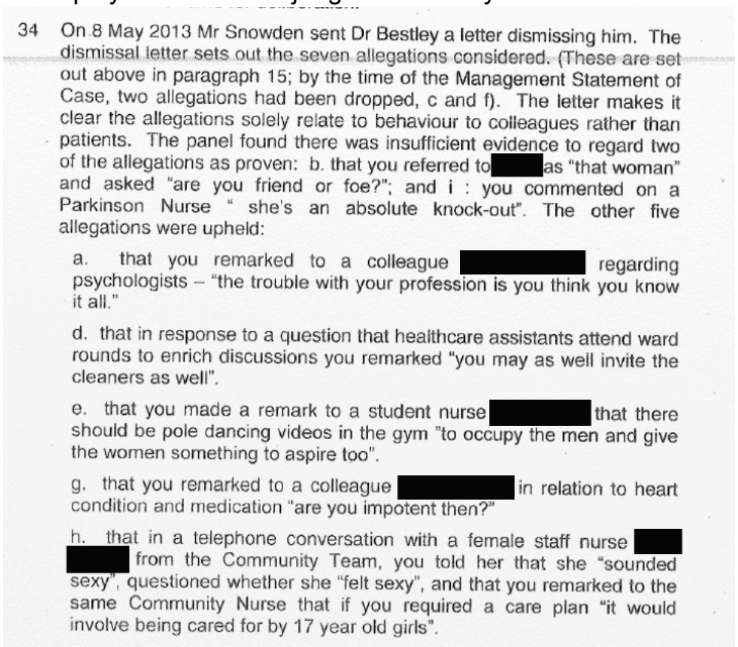
On 8 May 2013, the trust chief executive sent Dr Bestley a letter dismissing him, on grounds of his conduct towards colleagues. [58]

An appeal against dismissal was heard on 29 July 2013 and rejected on 5 August 2013.

Dr Bestley sued for unfair dismissal, and the Employment Tribunal (ET) found in his favour.

The ET considered that some of Dr Bestley's behaviours that the trust had deemed to be gross misconduct had been well meant or at worst, ill judged, but did not amount to misconduct. [59]

[58] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



34 On 8 May 2013 Mr Snowden sent Dr Bestley a letter dismissing him. The dismissal letter sets out the seven allegations considered. (These are set out above in paragraph 15; by the time of the Management Statement of Case, two allegations had been dropped, c and f). The letter makes it clear the allegations solely relate to behaviour to colleagues rather than patients. The panel found there was insufficient evidence to regard two of the allegations as proven: b. that you referred to [redacted] as "that woman" and asked "are you friend or foe?"; and i : you commented on a Parkinson Nurse " she's an absolute knock-out". The other five allegations were upheld:

a. that you remarked to a colleague [redacted] regarding psychologists – "the trouble with your profession is you think you know it all."

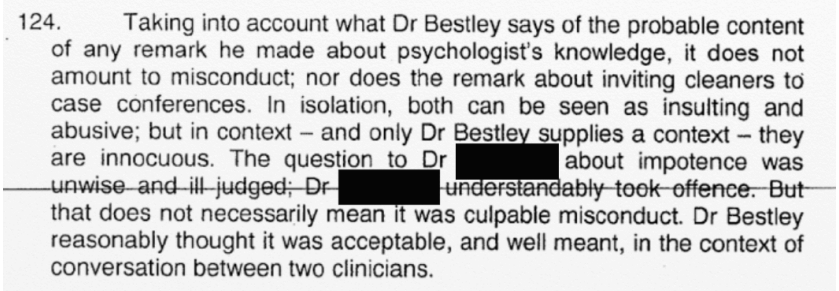
d. that in response to a question that healthcare assistants attend ward rounds to enrich discussions you remarked "you may as well invite the cleaners as well".

e. that you made a remark to a student nurse [redacted] that there should be pole dancing videos in the gym "to occupy the men and give the women something to aspire too".

g. that you remarked to a colleague [redacted] in relation to heart condition and medication "are you impotent then?"

h. that in a telephone conversation with a female staff nurse [redacted] from the Community Team, you told her that she "sounded sexy", questioned whether she "felt sexy", and that you remarked to the same Community Nurse that if you required a care plan "it would involve being cared for by 17 year old girls".

[59] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



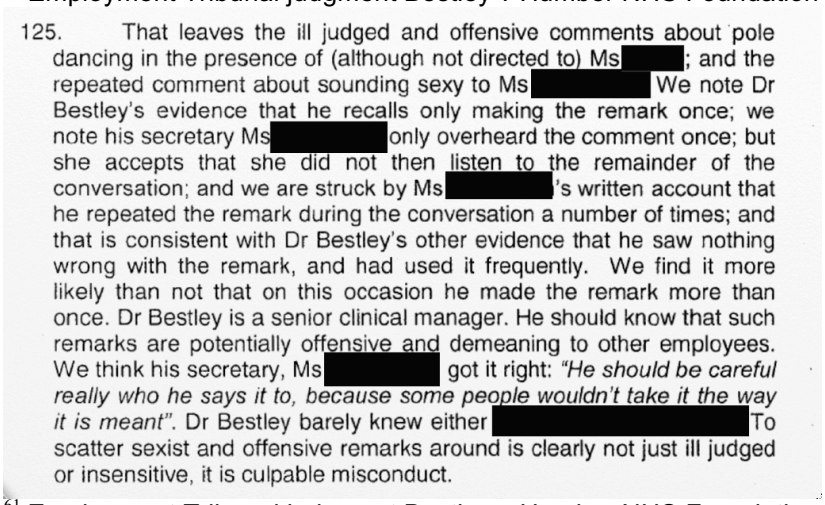
124. Taking into account what Dr Bestley says of the probable content of any remark he made about psychologist's knowledge, it does not amount to misconduct; nor does the remark about inviting cleaners to case conferences. In isolation, both can be seen as insulting and abusive; but in context – and only Dr Bestley supplies a context – they are innocuous. The question to Dr [redacted] about impotence was unwise and ill judged; Dr [redacted] understandably took offence. But that does not necessarily mean it was culpable misconduct. Dr Bestley reasonably thought it was acceptable, and well meant, in the context of conversation between two clinicians.

The ET agreed that there were other aspects of his behaviour which had amounted to misconduct. [60]

However, it did **not** accept that they were reasonable grounds for dismissal. [61]

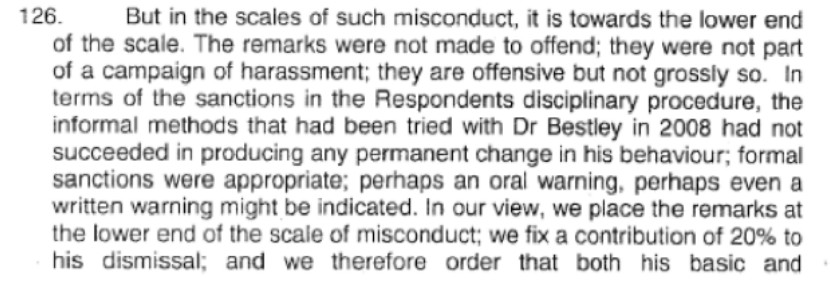
The Tribunal did however conclude that the trust chief executive had a "genuine belief in the misconduct' when he dismissed Dr Bestley. [62]

[60] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



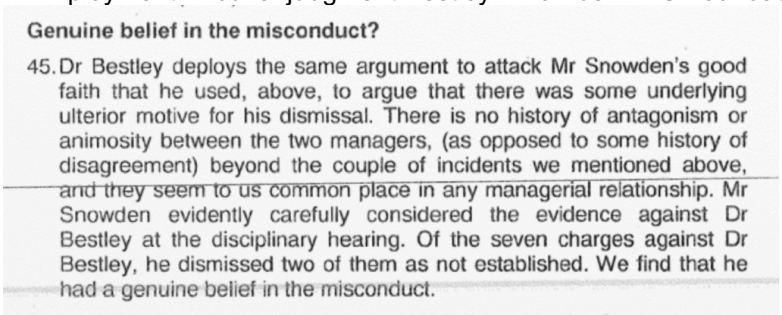
125. That leaves the ill judged and offensive comments about pole dancing in the presence of (although not directed to) Ms [redacted]; and the repeated comment about sounding sexy to Ms [redacted] We note Dr Bestley's evidence that he recalls only making the remark once; we note his secretary Ms [redacted] only overheard the comment once; but she accepts that she did not then listen to the remainder of the conversation; and we are struck by Ms [redacted]'s written account that he repeated the remark during the conversation a number of times; and that is consistent with Dr Bestley's other evidence that he saw nothing wrong with the remark, and had used it frequently. We find it more likely than not that on this occasion he made the remark more than once. Dr Bestley is a senior clinical manager. He should know that such remarks are potentially offensive and demeaning to other employees. We think his secretary, Ms [redacted] got it right: *"He should be careful really who he says it to, because some people wouldn't take it the way it is meant"*. Dr Bestley barely knew either [redacted] To scatter sexist and offensive remarks around is clearly not just ill judged or insensitive, it is culpable misconduct.

[61] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



126. But in the scales of such misconduct, it is towards the lower end of the scale. The remarks were not made to offend; they were not part of a campaign of harassment; they are offensive but not grossly so. In terms of the sanctions in the Respondents disciplinary procedure, the informal methods that had been tried with Dr Bestley in 2008 had not succeeded in producing any permanent change in his behaviour; formal sanctions were appropriate; perhaps an oral warning, perhaps even a written warning might be indicated. In our view, we place the remarks at the lower end of the scale of misconduct; we fix a contribution of 20% to his dismissal; and we therefore order that both his basic and

[62] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust



Genuine belief in the misconduct?

45. Dr Bestley deploys the same argument to attack Mr Snowden's good faith that he used, above, to argue that there was some underlying ulterior motive for his dismissal. There is no history of antagonism or animosity between the two managers, (as opposed to some history of disagreement) beyond the couple of incidents we mentioned above, and they seem to us common place in any managerial relationship. Mr Snowden evidently carefully considered the evidence against Dr Bestley at the disciplinary hearing. Of the seven charges against Dr Bestley, he dismissed two of them as not established. We find that he had a genuine belief in the misconduct.

The Employment Tribunal also concluded that the chief executive had no ulterior motive in doing so. [63]

The ET determined that compensation should be reduced by 20% due to contributory fault by Dr Bestley, but primarily placed failings at his employer's door.

Nevertheless Dr Bestley was awarded the maximum amount of compensation, £83,020, after negotiation between the two legal teams.

The fact that Dr Bestley won an ET against an NHS employer is unusual of itself. There is marked inequality of arms, and most claims made against the NHS fall by the wayside. [64]

Moreover, Dr Bestley subsequently took action against the trust for personal injury, as a result of which the trust made him a payment of £191,180.

In the context of the outcome of most actions against the NHS, it is fair to regard the Tribunal finding and the further payment of compensation for personal injury as indicators of the significant wrong done against Dr Bestley.

Dr Bestley has a diagnosis of Bipolar disorder (Manic Depressive Illness). People with this illness can function entirely normally if the illness is well controlled, but it is serious and classed as a major mental illness. Dr Bestley does not consider that he was unwell at the material times when his behaviour was criticised, but he does feel that his employer did not exercise due care when subjecting him to unnecessarily stressful processes. This was particularly as he had become unwell just a week before the trust informed him of the allegations against him, and he had accordingly attended Occupational Health at this time.

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[63] Employment Tribunal judgment Bestley v Humber NHS Foundation Trust

place in any management restructure. There is nothing in them to suggest any pretext for dismissal. The contemporary incidents relied on by Dr Bestley as showing such intention include a series of emails between Mr Snowden, Mrs Mason and the appointment panel in 2010 when he applied for and was given, the post of Clinical Director. Read in isolation, these could acquire a sinister connotation, as they have for Dr Bestley. Read in context, they strike us as routine comments, to which we attach no particular significance. The context is that Dr Bestley was the only candidate for the post. The interview panel may well have regarded the appointment as a formality. Mr Snowden was simply emphasising that it was not to be seen as such; there were concerns over the issues of medical leadership; the panel should apply their normal rigorous scrutiny. We make a similar finding with regard to Mr Snowden's involvement in the issue of consultant cover. Chief executives may from time to time concern themselves in issues that are not strictly their job. That is their prerogative. We see nothing surprising or sinister in Mr Snowden's involvement. There is nothing in the contemporary evidence to indicate any underlying motive, let alone malicious intent, on the part of Mr Snowden or Mrs Mason. We accept Mr Snowden's evidence that the reason for Dr Bestley's dismissal was misconduct, as reflected in the letter of dismissal.

[64] The NHS in the Employment Tribunal. A five month sample. 6 July 2017
https://minhalexander.com/2017/07/06/the-nhs-in-the-employment-tribunal-a-five-month-sample/

Occupational Health provided the trust with reports during the disciplinary proceedings but did not provide a specific opinion on whether Dr Bestley's illness had contributed to his alleged misconduct. The Employment Tribunal determined that in the absence of a request for a report from Dr Bestley and his representatives, the trust had acted reasonably in not seeking a such report.

Given that insight may be lost as part of a Bipolar illness, and that an Occupational Health report is not the same as a specialist expert opinion, some may question this decision by the Employment Tribunal about a specialist mental health trust.

Indeed, a subsequent medical examination under the GMC's auspices after Dr Bestley's dismissal concluded:

> *"…at least part of the explanation for Dr Bestley's perceived unprofessional conduct towards other witness and the investigation process in general, can be attributed to his mental health in general and his bipolar disorder in particular".*

Illustrating the damaging human realities of prolonged suspension, here is an excerpt from BMA correspondence of 3 October 2012 to Dr Gee trust Medical Director. It pleaded for Dr Bestley to allowed access to CPD activities, if necessary at the humiliating cost of being escorted on and off premises:

From a letter 3 October 2012 by Dr Bestley's BMA representative to the MHPS case manager

You will be aware of College guidance on completing audits having documented CPD that is necessary for revalidation. Can I ask what provision you have made for Dr Bestley in this regard? I appreciate that being excluded suspends the revalidation period. However, you can hardly think that it is good practice for Dr Bestley to be so professionally isolated. You may also like to consider that this isolation is not only bad for his clinical and other skills but is also likely to have a detrimental effect on his sense of professional worth and self esteem. You are aware of his mental health problems. I am aware, from discussion with him, that he continues to enjoy the support of his colleagues on an informal basis and I am sure that they would welcome him to attend CPD.

Can I suggest :

1. Dr Bestley meets with his colleagues on a regular, several times a month basis, for CPD. As stated above he is quite happy to be escorted on and off the premises by one of them

2. A Consultant colleague, preferably an Old Age Psychiatrist, but could be a Clinical Director is asked to act as 'professional line manager' for areas such as CPD. They would also be responsible that reference requests were dealt with in a timely, appropriate and helpful way. You could see all references sent out of the Trust if you wished.

It is regrettable that it was necessary for the BMA to write such a letter, given that in 2003 the NAO had recommended that the NHS should proactively ensure that excluded staff were supported with continuing professional development. [65]

After the trust dismissed Dr Bestley, it referred him to the GMC on grounds of his conduct. The GMC did not consider that the issues met its threshold and advised that the conduct issues were a matter for Dr Bestley's employer:

GMC outcome letter 25 October 2013

> The remarks to colleagues, some of which Dr Bestley does admit to saying, appear to have been made over a period to time, with the suggestion that some were taken out of context and for others an apology at the time was sufficient and the staff member had not wished to take things further. Dr Bestley had performed well in multisource feedback undertaken within a year preceding his suspension and the case examiners consider that the most appropriate location for dealing with these work-related issues is locally within the employment context, now subject to Employment Tribunal consideration due to irretrievable breakdown in local relationships. The matter is not sufficiently serious to warrant fitness to practise action by the GMC.

By that stage, the GMC was however concerned about his health. After medical assessment it was recommended that Dr Bestley was not well enough to practice:

> *"….there is a realistic prospect of finding that the doctor's fitness to practice is impaired to a degree justifying action on his registration due to his underlying mental health condition but not in relation to the behaviour and conduct regulations"*

[65] The management of suspensions of clinical staff in NHS hospital and ambulance trusts in England, National Audit Office 2003

"16 The professional bodies for clinical staff encourage their members to undertake continuing professional development. Increasing attention is being paid to professional development. For example as part of revalidation from 2005 continuing professional development will be a requirement for doctors to maintain their registration. When clinicians are excluded there is a risk that they will not be able to continue their training and development. Trusts therefore need to support excluded clinical staff to enable them to progress their continuing professional development."

"The Department of Health should… encourage trusts to support excluded clinical staff in their continuing professional development"

https://www.nao.org.uk/report/the-management-of-suspensions-of-clinical-staff-in-nhs-hospital-and-ambulance-trusts-in-england/

Dr Bestley welcomed this decision. However, he did not qualify for early access to his pension on grounds of ill health because the trust had dismissed him. [66]

Dr Bestley has since left Medicine.

Humber NHS Foundation struggles on with an 'Inadequate' CQC rating on safety in August 2016. [67]

The CQC inspection report of August 2016 noted:

> *"There were 18 instances where staff have been either suspended or placed under supervision since August 2014…We reviewed these files and found that the trust had adhered to their own policy."*

But CQC omitted to report that the trust had been found guilty in September 2014 of unfairly dismissing a senior doctor.

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[66] There was a 2007 EAT ruling that employers should consider ill health retirement for employees on long term sick leave before dismissal on grounds of capacity:

> Haigh v First West Yorkshire Ltd EAT Judgment:
> https://minhalexander.files.wordpress.com/2016/09/haigh-eat-ill-health-retirement-07_0246fhcnrn-1.pdf

http://www.pinderreaux.com/news/article/employment-lawyers-unfair-dismissal-and-retirement-on-grounds-of-ill-health
http://www.personneltoday.com/hr/long-term-sickness-and-ill-health-retirement/

[67] CQC inspection report on Humber NHS Foundation Trust 10 August 2016

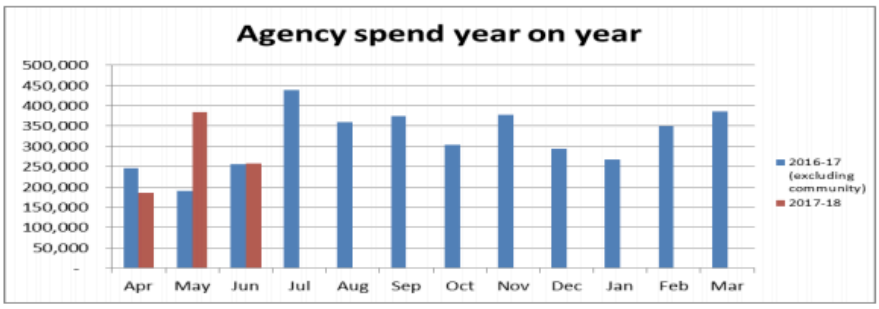
Overall rating for services at this Provider	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

https://minhalexander.files.wordpress.com/2016/09/humber-cqc-insp-report-10-08-2016-aaaf6776.pdf

There are also consultant psychiatrist vacancies at Humber and overspending on medical locums:

Humber NHSFT Board papers July 2017
http://www.humber.nhs.uk/Downloads/Board%20papers/Board%20Papers%202017/26%20July%202017/Public%20Board%20Papers%2026%20July%202017.pdf

Table 4: Agency Spend compared prior year



The most significant area of Agency expenditure remains Medical Locums, performance to the end of June was £0.462m (75%) above the NHS ceiling.

Table 5: Locum Spend

Medical Locums	June	YTD
NHS I Ceiling	91	272
Spend	143	462
Difference	**(113)**	**(138)**

In 2016, Humber NHS Foundation Trust also had below national average scores on 22 of 32 of staff survey domains [68] :

KF1. Staff recommendation of the organisation as a place to work or receive treatment
KF2. Staff satisfaction with the quality of work and care they are able to deliver
KF3. % agreeing that their role makes a difference to patients / service users
KF4. Staff motivation at work
KF5. Recognition and value of staff by managers and the organisation
KF6. % reporting good communication between senior management and staff
KF7. % able to contribute towards improvements at work
KF8. Staff satisfaction with level of responsibility and involvement
KF9. Effective team working
KF10. Support from immediate managers
KF12. Quality of appraisals
KF14. Staff satisfaction with resourcing and support

[68] NHS Staff Survey 2016 – results for Humber NHS Foundation Trust: https://minhalexander.files.wordpress.com/2016/09/humber-cqc-insp-report-10-08-2016-aaaf6776.pdf

KF17. % feeling unwell due to work related stress in last 12 mths
KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure
KF19. Org and mgmt interest in and action on health and wellbeing
KF24. % reporting most recent experience of violence
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths
KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths
KF27. % reporting most recent experience of harassment, bullying or abuse
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents
KF31. Staff confidence and security in reporting unsafe clinical practice
KF32. Effective use of patient / service user feedback

Failure to learn lessons

Dr Bestley tried to engage Humber NHS Foundation trust in a dialogue after the litigation, to see if the chances of someone else being subjected to a similar experience could be reduced.

He received a brief document from the trust on 'lessons learned':

https://minhalexander.files.wordpress.com/2016/09/humber-brief-on-lessons-learned.pdf

This implicitly acknowledged that the trust had made errors, including in its decisions about suspension and timeliness in dealing with cases. But the document is superficial and does not examine how errors arose or give detailed plans for action points.

Dr Bestley wrote to Michelle Moran the new trust chief executive who declined to engage with him.

https://minhalexander.files.wordpress.com/2016/09/response-from-michelle-moran-ceo-6-06-2016.pdf

He also wrote to the General Medical Council to express concerns that the two medical directors involved in the process against him had not treated him fairly.

Treating colleagues fairly is requirement of 'Good Medical Practice' [69], the core GMC ethical guidance that doctors must follow.

Good Medical Practice is complemented by specific GMC guidance for medical managers, which adds detail to what is required in treating colleagues fairly, and accountability in management roles including record keeping.

[69] Good Medical Practice, GMC 2013
http://www.gmc-uk.org/guidance/good_medical_practice.asp

*"38 If you are a responsible officer within a designated body, you will have extra responsibilities as set out in the relevant regulations4 and you **must** take account of any guidance produced by the departments of health or your organisation."*

*"46 You **must** make sure that any other records you are responsible for, including financial, management or human resources records, or records relating to complaints, are kept securely and are clear, accurate and up to date."*

However, the GMC did not consider that the matter met its threshold for fitness to practice requirements, and advised that the matter was more suited to grievance procedures:

https://minhalexander.files.wordpress.com/2016/09/gmc-letter-9-december-2016.pdf

https://minhalexander.files.wordpress.com/2016/09/gmc-letter-15-december-2016.pdf

Dr Bestley gave both the medical directors involved the opportunity to respond directly to his concerns. One person declined and Dr Bestley reports that he received no response from the other person.

NCAS was asked about referrals received about doctors at Humber NHS Foundation Trust, but has refused to answer on grounds of purportedly low numbers and possible identifiability of individuals. It was asked on 26 July 2017 to clarify the numerical basis of its refusal and a response remains outstanding. [70]

NCAS self evidently does not learn from the many cases of unwarranted suspension such as Dr Bestley's, as it repeatedly fails to challenge employers about such suspensions despite its remit to do so.

Dr Bestley contacted NHS Improvement (NHSI) about Humber NHSFT's poor governance. Despite governance purportedly being a core issue in the terms of authorisation for Foundation Trusts, NHSI was strangely resistant.

https://minhalexander.files.wordpress.com/2016/09/nhsi-letter-to-dr-bestley-25-nov-2016.pdf

https://minhalexander.files.wordpress.com/2016/09/nhsi-letter-to-dr-bestley-30-1-17-rc-to-jb-re-humber.pdf

[70] *FOI response from NCAS 26 July 2017: "Taking into consideration the Data Protection Principles, and in particular the requirement to process personal data fairly and lawfully, due to the low numbers of referrals from this Trust, it is our assessment that the level of risk of identification of the data subjects is too high to allow the disclosure of the requested information to the public at large (which is taken to be the effect of disclosure under FoIA)."*

Extraordinarily, the NHSI Complaints and Whistleblowing Manager advised that NHSI was not only satisfied that Humber NHSFT had learned sufficient lessons from the episode but that:

> *"…we went on to consider if there was any evidence that would indicate widespread concerns with the way the trust identifies learning from investigation outcomes.*
>
> *The information we looked at did not indicate any concerns with the way that the trust identifies and acts on learning."*

A rather large number of harmed patients and bereaved families might take issue with NHSI's glib assertions. [71] [72] [73] [74] [75] [76]

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[71] Sally Mays' case: 'Unconscionable' actions and 'neglect' let to the death of a patients, Serjeants Inn, 2 November 2015
http://ukinquestlawblog.co.uk/11-news/29-unconscionable-actions-and-neglect-led-to-the-death-of-a-patient

There have been further issues with Sally May's case and a police investigation was launched. Previous press reports of the original inquest appear to have been taken off line.

The Trust's statement in response to the original inquest decision is still published:

> *"23 October 2015*
> *David Hill, Chief Executive, Humber NHS Foundation Trust said:*
>
> *"Sally Mays' death was a terrible tragedy and the Chairman and I would like to once again apologise and extend our deepest sympathies to her family and friends. Sally had been a patient of ours for many years prior to her death and at the time of her death. However, we ultimately failed to offer Sally the dignity and care she needed and deserved that afternoon.*
>
> *"Following this tragic case, we undertook a full, thorough and open independent investigation. This made a series of comprehensive and wide-ranging recommendations for improving the care we provide, and the coroner heard in detail about these and was satisfied that they have been fully implemented.*
>
> *"The way the Trust is organised has significantly changed since the time of Sally's death, with a much greater focus on clinical leadership. We will be reviewing the clinical model for community and crisis services.*
>
> *"We fully accept the coroner's findings and recognise the concerns expressed by Sally's family.*
>
> *"We would like to express our sadness at this tragic incident and apologise profusely to Sally's family and friends."*

http://www.humber.nhs.uk/news/Statement-following-conclusion-of-inquest-23-October-2015.htm

[72] Mother of two, 32, walked into the path of a train after battling acute post-natal depression for three years, Lucy Crossley, Daily Mail 15 February 2016
http://www.dailymail.co.uk/news/article-3447833/Talented-linguist-mother-two-32-hit-acute-post-natal-depression-badly-following-birth-child-walked-path-train.html

[73] Repeated failures found by the jury at the conclusion into the death of Helen Millard at the Westlands Mental Health Unit, statement by INQUEST 26 September 2016
http://inquest.org.uk/media/pr/repeated-failures-found-by-the-jury-at-the-conclusion-into-the-death-of-hel

[74] Tragic Hull man discharged too early, HEY Today, 30 June 2016
http://www.heytoday.co.uk/local-news/tragic-hull-man-discharged-too-early/
http://www.humber.nhs.uk/news/Trust-statement-following-the-inquest-of-christopher-sever.htm

[75] The family of a man who fell to his death are questioning what went wrong, KFCM, 12 December 2014
http://www.kcfm.co.uk/news/local-news/the-family-of-a-man-who-fell-to-his-death-are-asking-what-went-wrong/

[76] Ben's life was full of promise, but instead he was found dead in his bathroom at just 31, Kevin Shoesmith, 16 October 2017
http://www.hulldailymail.co.uk/news/hull-east-yorkshire-news/bens-life-full-promise-instead-633926

Moreover, it is a serious failing by NHSI that it does not routinely and proactively track the outcomes of Employment Tribunal claims against NHS trusts. I have been in correspondence with NHSI and its predecessor bodies on these matters for over two years.

NHSI has so far resisted any formal, structured approach to tracking ET outcomes. I have again challenged this and the obvious risks of bias and failure of learning:

> **https://minhalexander.files.wordpress.com/2016/09/nhs-improvement-correspondence-acting-on-et-intelligence-outcomes.pdf**

Humber NHS Foundation Trust and the two medical directors in charge of Dr Bestley's suspension were invited to comment, but at the time of writing, none have commented.

So in short, at the end of a process that has left the public purse considerably lighter, a wrong done against a longstanding, disabled employee, and a loss to the service of an experienced clinician, it is very unclear if there has been real learning or accountability.

The future

The NHS as a public sector employer is expected to be an exemplar and to abide by the Nolan values.

In reality, it too often abuses its great power. There is method in such abuse, in that it can be politically expedient.

But the high levels of control at the expense of just culture are ultimately damaging and help to perpetuate fear and injustice.

The human cost and trail of personal tragedies left by bullying and heavy handed approaches to the workforce is considerable, and affects families as well as individuals.

The imbalance of power needs to be redressed and in particular, NHS staff need better safeguards within the disciplinary process.

NHS consultants used to have rights of appeal to an independent, lawyer-chaired decision making panel until they were bartered away with the collaboration of the British Medical Association. [77]

I suggest that these rights be restored not just for consultants but for all staff.

Some may object to the potential expense, but this is a modest outlay relative to the years of bitter, costly litigation that can follow unfair dismissals.

The knowledge that internal decisions will be externally and independently reviewed might also deter NHS employers from indulging in the lax practices and abuses that currently lead to unfair dismissals and costly litigation.

NHS pension policy should also be reviewed with respect to staff who are found to have been unfairly dismissed. The rights of such staff to early retirement on health grounds should be restored where their dismissal is found to be unjust by an Employment Tribunal.

The recommendations of the NAO report of 2003 also need to be revisited, and in particular, the Department of Health should ensure that statistics on episodes of suspension of all NHS staff are centrally collected, analysed and openly published as a mandatory requirement.

Similar action should be taken with respect to Employment Tribunal claims against the NHS, and the financial costs of suspension and employment litigation and settlements.

Regulators should also track and analyse Employment Tribunal intelligence, and act on issues of poor employer governance revealed by Tribunal decisions.

NHS Improvement's poor attitude in Dr Bestley's case is typical of the approach taken, and regulators' tendency to protect institutions rather than ensure just culture. Regulators preach a great deal about workforce welfare and its importance to service delivery, but this all hot air if in reality they avert their eyes from injustice.

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[77] HC(90)9 v MHPS: managers win after doctors' own goal! John Hendy QC, 2008

> *" 'No member of the [Inquiry] Panel should be associated with the [organisation(s)] in which [the practitioner] works.' The Panel should be small, normally 3 persons and chaired by an independent legally qualified Chairman nominated by the Secretary of State from a panel appointed by the Lord Chancellor (in practice this is usually a QC). At least one member should be professionally qualified an in competence cases all should be so qualified and at least one of the same specialty as the practitioner in the same grade. Before the professional members are chosen there should be consultation with the Joint Consultants Committee (usually interpreted as a veto exercised by the JCC)."*

https://minhalexander.files.wordpress.com/2016/09/john-hendy-qc-2008-mhps-own-goal.pdf

At present, trusts are obliged to report on settlements in their annual reports [78] [79], but this does not provide easily accessible data on trends. This decentralisation of data gathering is a means by which the government and its arms length bodies can distance themselves from disreputable practices, for which they should take greater responsibility and discourage far more vigorously. Although central government must authorise many of the payments, it typically resists requests for this data on grounds of impracticability, because the data is not properly collated.

[78] NHS foundation trust annual reporting manual 2014/15 Updated March 2015

> *"A note disclosing information on losses and special payments should be included in the accounts. This note should disclose:*
>
> - *the total number and value of special payments categorised between:*
>
> - *extra-contractual payments*
> - *extra-statutory and extra-regulatory payments*
> - *compensation payments, o special severance payments; and*
> - *ex gratia payments;*
>
> *• the number, value and a brief description of individual losses and special payment cases which exceed £300,000 should be disclosed, including those relating to clinical negligence, fraud, personal injury, compensation under legal obligation and fruitless payments"*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/410058/FTARM_2014-15_updatemar2015.pdf

[79] NHS Trusts report according to guidance in the Department of Health's Group Reporting Manual:

> *"7. Exit payments made following an Employment Tribunal or court order are also included. Any such payments are considered contractual as the orders have to be paid by the party against whom the order is made, although may relate to compensation for loss of office.*
>
> *8. Non-contractual payments are those made outwith contractual or legal obligation, including those from judicial mediation. Pre-authorisation from the HM Treasury (or the Department of Health Group Accounting Manual 2016-17 67 relevant national body for cases below de minimis limits) must be sought for such payments before they are agreed with the employee. In the footnote the amount of any non-contractual payments in lieu of notice are to be listed. A further footnote discloses the number and value of non-contractual payments made to individuals where the payment was more than 12 months annual salary. The reference salary for this disclosure is the annualised salary at the date of termination of employment, and excludes bonus payments and employer's pension contributions.*
>
> *9. The entity should also disclose the maximum (highest), minimum (lowest) and median values of special severance payments, i.e. amounts included in the 'non-contractual payments' line of the table."*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/601857/2016-17_DH_GAM_Mar_17.pdf

Public Accounts Committee noted in 2014:

> *"Despite being responsible for approving special severance payments, the Treasury does not know how many payments have been made across the public sector. It does not review the compromise agreements associated with the payments and could therefore not tell us how many agreements have been signed by public sector bodies and contractors to government, or whether these agreements have been used to 'gag' employees. The lack of oversight by central government has led to inconsistencies in the use of compromise agreements, with no one looking for trends that might provide early warnings of service failures."* [80]

Notwithstanding, the National Audit Office found that in the three years to 31 March 2013, there were a total of 484 special severance payments in the Health service, amounting to a total of £11,158,923. [81]

The health service accounted for approximately half of all public sector special severance payments (484 out of a total of 1053 payments), and 39% of the total spent (£11,158,923 out of £28,356,936). [81]

And yet the Cabinet Office's guidance states: *"Special severance payments are expected to be rare and exceptional."* [82]

Of importance to the public purse, but most important in terms of the savage human impact of suspensions, the NHS needs to seriously re-set its attitudes about timeliness.

There is chasm between the NAO recommendation of a two week standard to establish whether there is case to answer in disciplinary processes, and the insular ponderings by Humber's grievance investigators about what could have been done shave off some of the delay in Dr Bestley's - by that point - 16 month long suspension.

Reasons can always be produced for delay but it is ultimately a question of priorities and recognising that suspension is a human resources emergency, that does real damage to real people, and therefore requires a commensurate system response.

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[80] Confidentiality Clauses and Special Severance Payments, Public Accounts Committee 2014 https://publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/477/477.pdf

[81] Confidentiality clauses and payments, NAO 21 June 2013 https://www.nao.org.uk/wp-content/uploads/2013/06/10168-001-Confidentiality-clauses-and-payments1.pdf

[82] Cabinet Office Guidance on Settlement Agreements, Special Severance Payments and Confidentiality Clauses on Termination of Employment, Cabinet Office 1 February 2015 https://images.template.net/wp-content/uploads/2016/03/24054828/Guidance-on-the-use-of-Settlement-Agreements.pdf

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