# First-tier Tribunal Primary Health Lists

**IN THE MATTER OF THE NATIONAL HEALTH SERVICE (PERFORMERS LISTS) REGULATIONS 2013**

Video Hearing on 16 -19 September 2020 and 27 October 2020

**[2019] 3893.PHL (VKinley)**

**BEFORE**
**Ms Siobhan Goodrich (Tribunal Judge)**
**Dr Martin Gee (Specialist Member)**
**Mrs Mary Harley (Specialist Member)**

**BETWEEN:**

**Dr Puthenparampu Antony Joseph**

**Appellant**

**and**

**NHS Commissioning Board**
**Known as "NHS England"**

**Respondent**

## DECISION AND REASONS

### Representation

For the Appellant: Mr Matthew McDonagh, Counsel, instructed by Radcliffes
For the Respondent: Ms Rebecca Vanstone, Counsel, instructed by Mills and Reeve

### The Appeal

1. Dr Joseph appeals, under paragraph 17 of the National Health Service (Performers' List) Regulations 2013 (the Regulations), against the decision made by the Performance List Decision Panel (hereafter "the PLDP or "the panel") on 25 October 2019.

2. The PLDP decision was that the continued inclusion of Dr Joseph's name in the Medical Performers' List (MPL) would be prejudicial to the efficiency of the services that those in the relevant list perform. The panel exercised its power under paragraph 10 (1) (b) of the Regulations and imposed a number of conditions on his inclusion in the MPL, which included direct clinical supervision.

## The Parties

3. The Appellant is a registered General Practitioner (GP). He obtained his primary medical qualification from Kerala University in 1975. He subsequently obtained a Doctorate in Medicine and Diploma in Cardiology and became a member of the Royal College of Physicians in 1997. He undertook several roles in cardiology before becoming a GP partner in 2001. From 2004 the Appellant worked as Principal GP at the Dr Joseph Surgery Centre in Romford, Essex, a surgery with approximately 2664 patients. In addition, he worked some sessions at the practice of his wife in Grays, Essex ("the Grays Surgery").

4. The Respondent is the body which has statutory responsibility for the maintenance of the national Medical Performers List ("MPL").

## The Background Chronology

5. We set out below the background history of regulatory involvement drawn from the agreed chronology (and to which we have added in limited respects).

15 April 2014: the General Medical Council (GMC) wrote to the Appellant closing their fitness to practice investigation of a complaint from a patient's family member with no further action.

11 July 2014: the Respondent wrote to Dr Joseph in advance of the next appraisal, highlighting comments made by the GMC's expert that the Appellant's records were below the expected standard.

30 December 2014: Dr Joseph wrote to NHSE responding to concerns raised regarding the standard of his record keeping.

25 March 2015: Dr Joseph attended annual appraisal with the Respondent, where the complaint was discussed.

16 September 2015: a serious incident was raised relating to the Appellant moving a 2-year- old child in respiratory distress to a walk-in centre.

24 November 2015: the Respondent wrote to the Appellant following a complaint /review by its Medical Advisor, highlighting concerns with his record-keeping and medicines management.

26 January 2016: Dr Joseph wrote to the Respondent responding to the concerns raised.

22 March 2016: Dr Joseph attended annual appraisal with the Respondent, where the issues identified during the complaint review were discussed.

3 October 2016: the Respondent's Midland & East Region Team informed the Respondent's London Region Team they had an open case against the Appellant.

2 February 2017: the Appellant completed a case review into the previous serious

incident.

22 February 2017: the Appellant met with the Respondent's London Region Team to discuss the serious incident.

10 March 2017: Dr Joseph wrote to the Respondent setting out his reflections following the serious incident meeting and how he will remediate.

1 April 2017: the Respondent's Midlands & East Region Team completed the first records review.

29 April 2018: the Respondent's London Region Team completed the second Records Review.

29 May 2018: Dr Joseph wrote to the Respondent by email responding to the first and second Records Reviews.

13 June 2018: the Respondent's Performance Advisory Group ("PAG") met to consider the contents of the two records reviews, the Appellant's responses and the latest Care Quality Commission (CQC) Inspection Report. Undertakings to improve record keeping and IT skills were proposed.

04 October 2018; NHS Havering CCG (Care Commissioning Group) wrote to the Respondent raising a number of concerns regarding Dr Joseph's practice.

10 October 2018: the Respondent wrote to Dr Joseph asking for response to the concerns raised by NHS Havering CCG.

10 December 2018: the Respondent wrote to Dr Joseph by email chasing for a Response.

16 January 2019: the CQC conducted an unannounced focussed inspection of the Appellant's Practice.

21 January 2019: the CQC conducted an follow-up inspection of the Appellant's Practice.

25 January 2019: Appellant's registration as a provider was cancelled by Romford Magistrates Court on the basis of an urgent application made by the CQC.

26 January 2019: the Respondent suspended Dr Joseph from performing services on the national MPL.

28 January 2019: the Respondent conducted a review of the Appellant's suspension. The suspension was upheld.

13 February 2019: the Respondent completed a third records review (Dr O/Moore)

14 February 2019: the Appellant attended his annual appraisal.

20 February 2019: A complaint was received by the Respondent's Complaints Team from the father of a deceased patient.

26 February 2019: Dr Joseph wrote to the Respondent by email disputing the CQC's findings, and sent two email responses to the third records review.

28 February 2019: the Respondent was informed by NHS Havering CCG of a further serious incident identified from a review of the CQC evidence.

2 March 2019: Dr Joseph sent a third response to the third records review by email.

27 March 2019: GMC's Interim Orders Tribunal (following 8 March 2019 hearing) Imposed an interim order of conditions on the Appellant's registration, including that he be "closely supervised" by a clinical supervisor.

2 April 2019: the Respondent wrote to Dr Joseph regarding the serious incident identified by NHS Havering CCG, asking for the Appellant to review the relevant records, and to provide comments/reflections regarding the management of that patient.

16 April 2019: the Appellant wrote to the Respondent by email in response, and requested an oral hearing to confirm his suspension.

4 June 2019: a further complaint received by the Respondent's Complaints Team resulting in a review by the Practitioner Performance Team.

4 June 2019: the Respondent's Primary Care Commissioning Team issued an immediate termination of the General Medical Services contract with the Appellant's practice.

14 June 2019: the Respondent held an oral hearing to review the suspension - suspension upheld.

1 July 2019: the Respondent wrote to the Appellant informing him of the intention to remove him from the national MPL on the grounds of efficiency (Regulation 14(3)(b).

16 July 2019: Dr Joseph withdrew his appeal to the First-tier Tribunal (HESC) against the CQC's cancellation of his registration.

13 August 2019: NHS England carried out an Occupational Health Assessment: no health issues hindering the Appellant's performance identified.

22 September 2019: the GMC Performance Assessment report was completed. A range of areas of the Appellant's practice were rated "unacceptable" in the domains of clinical management and record keeping and as a "cause for concern" in the domains of maintaining professional performance, assessment of patients' condition and relationships with patients. Clinical and educational supervision were recommended.

2 and 4 October 2019: PLDP meeting held.

25 October 2019: Notification Letter re PLDP decision to impose conditions: direct supervision.

23 November 2019: Dr Joseph lodged his appeal against the PLDP decision.

5 December 2019: Radcliffes wrote to the GMC inviting disposal of allegations of deficient performance by way of consensual undertakings for close supervision.

7 February 2020: GMC undertakings signed by Dr Joseph re conditions for close

supervision.

11 February 2020: Letter to the Appellant from GMC Case Examiners re their decision to dispose of the GMC proceedings by accepting undertakings.

## The Documents

6. We received:
   (i) a paginated and indexed e-bundle of some 1016 pages which very largely consists of the statements and evidence on which the Respondent relies, and the undated statement from Dr Joseph (lodged in or about February 2020) exhibiting the GMC undertakings he signed on 7 February 2010 and related correspondence.
   (ii) a supplemental bundle which included:
   - a further witness statement from Dr Sonigra
   - the Scott Schedule (the SS)
   - skeleton arguments from both parties.

## The PLDP Hearing

7. The PLDP panel, which sat on 2 and 4 October 2019, was chaired by Ms Sarah Berry, an Independent Lay Chair. The meeting was attended by Dr Joseph and his representatives: Mr McDonagh, instructed by Mr Shah of Radcliffes. It is common ground that the potential decisions before the PLDP were removal from the national MPL, or the imposition of conditions, or to take no action. Dr Joseph did not give oral evidence, save in relation to computer migration issues.

8. Following party and party discussions outside the panel hearing, a proposal for supervision had been discussed and advanced by both parties for the consideration of the panel. This proposed "enhanced" close supervision i.e. review by the clinical supervisor of every patient consultation, and case based discussion at the end of the every session, together with other conditions, including: not to work as a single-handed practitioner; not to perform unsupervised visits; the clinical supervisor (who must be a GP trainer) to be on site and available to the Dr Joseph at all times; cessation of work if the clinical supervisor or deputy is unavailable; weekly in-person discussion of learning needs and reflection; monthly meetings with an educational supervisor; approval of the nominated clinical supervisor, nominated deputy and educational supervisor by the Responsible Officer (RO): the clinical supervisor must be a GP trainer; NHS Resolution (formerly NCAS (the National Clinical Assessment Service)) to design a PDP action plan which must be approved by the RO.

## The Decision under Appeal

9. In the event, the PLDP, in the light of its analysis of the evidence regarding the allegations made before it, and its view regarding risk, decided that *direct* supervision as defined by the GMC's Glossary for Undertakings and Conditions was necessary in order to protect patient safety.

10. In a detailed and comprehensive Notification Letter (NL) dated 25 October 2019 the PLDP set out:
    - a review of the history of the regulatory background
    - findings and reasoning in respect of the factual Allegations made before it
    - reasons regarding necessity and justification
    - its assessment regarding risk to patient safety and the efficiency of services
    - consideration of proportionality.

11. Amongst other matters, the panel considered the serious concerns with respect to clinical care had been identified, and specifically in relation to:
    a.
        i. Inadequate history taking;
        ii. Failure to examine;
        iii. Inadequate treatment planning and management of patient conditions;
        iv. Failure to refer immediately for a life-threatening condition for serious time-dependent conditions;
        v. Failure to follow national safety alerts;
        vi. Inaccurate read coding;
        vii. Failure to safety net;
        viii. Failure to appropriately safeguard;
        ix. Failure to follow up and refer;
        x. Record keeping; and
        xi. Inappropriate and unsafe prescribing.

    b. Overall, the panel considered that the concerns were multiple, wide ranging and spread across a number of key areas of clinical competency.

    c. Of particular concern were matters outlined in paragraph 5.1.6.(f) (i),(iii),(iv) & (v) of the NL, relating to 4 examples within the Assessment where it was considered that urgent medical attention was/should have been required having regard to patient safety.

    d. The PLDP considered removal a possible option particularly in light of: the seriousness of the issues identified and the real and significant clinical risk posed to patients; the fact that issues were repeated over a considerable period of time and remained of concern by virtue of contemporaneous GMC assessment; attempts to address identified deficiency, certainly in the context of record keeping, had failed to result in improvement; Dr Joseph's insight and willingness to engage was called into question given his failure to respond to requests for responses, and the most recent statement given to GMC assessors by Dr Joseph that previous assessments of his record keeping had found it to be *"perfect";*

    e. Although the PLDP considered that the threshold for removal was met, on the basis of the material before them and representations made, it was satisfied that the conditions for direct supervision and other conditions as set out in Appendix A of the NL, were necessary and proportionate.

f. When imposing direct clinical supervision, the panel decided that it was not appropriate to include any conditions regarding a specific number of patients and/or over what period direct supervision was required (as had been proposed by the parties). The panel's final observation is of note:

> *"(ix) Finally, it is hoped the necessary objective assurances will be provided within a relatively short timescale and this matter will therefore be returned to a future PLDP, an action that can be invoked by NHS England without any time restriction with a view to reviewing the direct supervisory arrangement in place and provided necessary objective assurance has been provided in relation to progress and management of identified risk, supervisory arrangement reduced to a lower level or removed in its entirety."*

**The Notice of Appeal: 22 November 2019**

12. In this the Appellant maintained that the conditions relating to "direct" supervision (Condition 3) were unnecessary, disproportionate, and tantamount to suspension.

**The Reasons for Opposing the Appeal: 12 December 2019**

13. The Respondent's case was (and remains) that the PLDP decision was necessary, justified and proportionate. In summary, the serious failures identified and the clear risk to patient safety required direct supervision of the Appellant to ensure that patients would not be exposed to risk of harm. It was deemed unsafe to make patients wait until the end of the clinical day for their case to be overseen by the supervisor, when it was only at this point that checks on the accuracy of the care provided would be made. There is evidence, on multiple occasions where the Appellant had failed to seek urgent medical help or referral or treatment for some patients, and this could not be allowed to continue. In addition, given the significant history of poor record keeping and inappropriate observations or history being taken from patients, it was felt to be unsafe to seek to rely on the Appellant's clinical notes to assess the suitability of care provided, when there was clear evidence that the notes were likely to be insufficient. The Respondent also sought particulars as to which of the PLDP findings were disputed by the Appellant.

**The Appellant's Further Particularised Grounds: 30 January 2020**

14. Pursuant to the direction made on 8 January 2020 the Appellant provided further particularised grounds of appeal outlining what aspect of the PLDP decision was challenged (see A 28-32 - hereafter referred to as "the Appellant's Response" or "the Response" dated 30 January 2020). Amongst other matters this stated:

(a) *"The Panel's determination in relation to the following paragraphs is accepted:*

> *(i) inadequate history taking;*
> *(iii) inadequate treatment planning and management of patient condition – only in so far that the inadequacy relates to record keeping alone;*
> *(vi) inadequate read coding – reflecting the transfer difficulties as*

*computer systems were changed and updated;*
*(viii) failure to appropriately safeguard – reflecting the admissions made under Allegation 5*
*(x) inadequate record keeping;*
*(xi) inappropriate prescribing accepted BUT NOT unsafe prescribing;"*

(b) The Appellant also responded to the examples cited by the PLDP at paragraph 5.1.6 (f) of the NL based on the Performance Assessment. He accepted some but denied others. We will return to the detail later.

(c) Overall, it was said that:

- the PLDP had correctly identified some of the failings in the practice of the Appellant. However, these failings did not make a condition of direct supervision proportionate or necessary. His position was that the condition for direct supervision is unworkable and is tantamount to not allowing him to work at all.

- Close supervision - with the additional safeguards agreed and proposed to the panel by the Appellant and the Respondent (i.e. *enhanced* close supervision) is a workable and proportionate response to the inefficiencies identified by this case.

**The Respondent's Supplementary Reasons – 10 February 2020**

15. In this the Respondent continued to oppose the appeal. Amongst other matters, it is contended that the Appellant is seeking to deflect responsibility to NHSE for lack of support, and computer problems, whereas his failure in record keeping is historical, and is not related to computer issues. He has been on notice since 2014 about deficiencies in record-keeping and had indicated his intention to improve. No evidence of computer courses or reflective learning has been provided. The Appellant has accepted Allegation 7 - *"You have not demonstrated embedded learning from patient complaints or improved the quality of your record keeping since 2014,"* but seeks to blame the Respondent.

**The Scott Schedule**

16. The direction for a Scott Schedule provided the Appellant with a further opportunity to take issue with the findings made by the PLDP. The Appellant challenged the factual allegations at paragraphs 2, 3 (c) and 3 (g) of the NL. As to Condition 3, the Appellant made clear his case regarding necessity, justification and proportionality.

**The Hearing**

17. Pursuant to agreed directions the hearing was conducted remotely via Kinley CVP. Technical difficulties within the hearing were fully accommodated to the satisfaction of the parties in terms of a fair hearing and regular breaks were taken.

18. At the outset of the hearing, it was agreed that the nature of the appeal is by way of redetermination and that:
    a) it is open to the Tribunal panel in its redetermination to make any decision that was available to the PLDP.
    b) its task is not to review the PLDP decision but to make findings de novo in the light of all of the evidence presented, including the oral evidence.
    c) the options for decision making before the PLDP, and thus for the Tribunal panel, are in ascending order: to take no action, to impose conditions (whether as proposed by either party or as devised by the Tribunal panel), or to remove the Appellant's name from the MPL.
    d) the Respondent's case is based only on efficiency grounds.

19. Both parties agreed that the matters in Allegation 2, 3 (c) and 3 (g) in the NL (i.e. the only allegations which remained in dispute as per Dr Joseph's witness statement and the SS) would not materially affect the core issue to be decided i.e. what level of supervision is necessary, justified, and proportionate in the context of the balance between the competing interests involved. At this very early stage, the Tribunal said that it would be helpful to receive brief evidence on the residual disputed allegations as per the SS, lest it might prove material to its overall consideration.

**The Oral Evidence**

20. Oral evidence was heard over three days in the following order:
    On behalf of the Respondent from:
    - Dr Hasmuth Sonigra: Associate Medical Director (London Region) for NHSE):
    - Dr John O'Moore, (GP and a Senior Clinical Adviser for NHS England)

    On behalf of the Appellant from:
    - Dr Joseph.

    All witnesses adopted their statement(s) as their evidence in chief and answered questions. When giving our reasons we will refer to the main aspects of the oral evidence.

**The Burden and Standard of Proof**

21. The Respondent bears the burden of proving facts in issue to the civil standard: i.e. the balance of probabilities. The Respondent also bears the burden of satisfying the Tribunal panel to the same standard that the conditions sought, are necessary and justified in pursuit of a legitimate public interest aim.

22. If the Respondent satisfies us as to necessity and justification, the ultimate issue is that of proportionality: i.e. the appropriate balance as between competing interests. This involves a discretionary decision to be made by the panel in the light of its findings and assessment of all the evidence before it. The persuasive burden is on the Respondent.

**The National Health Service (Performers List) Regulations 2013**

23. The key provisions are as follows:

**10.**—(1) Where the Board considers it appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform …..it may impose conditions on a Practitioner's—

(a)….

(b) continued inclusion in such a list

**14.—…..**

(3) The Board may remove a Practitioner from a performers list where any one of the following is satisfied—

….

(b) the Practitioner's continued inclusion in that performers list would be prejudicial to the efficiency of the services which those included in that performers list perform ("an efficiency case");

**15.—**…..

(5) Where the Board is considering whether to remove a Practitioner from a performers list under regulation 14(3)(b) (an efficiency case), it must consider—

(a) any information relating to that Practitioner which it has received under regulation 9;

(b) any information held by the NHSLA about past or current investigations or proceedings involving or relating to that Practitioner, which information the NHSLA must supply if the Board so requests; and

(c) the matters referred to in paragraph (6).

(6) Those matters are—

(a) the nature of any incident which was prejudicial to the efficiency of the services which the Practitioner performed;

(b) the length of time since the last incident occurred and since any investigation into it was concluded;

(c) any action taken by any regulatory or other body (including the police or courts) as a result of any such incident;

(d) the relevance of the incident to the Practitioner's performance of the services which those included in the relevant performers list perform, and the likely risk to patients or to public finances;….."

## Findings of Fact

24. We have carefully considered all of the evidence and the written and oral submissions before us. If we do not refer to any particular aspect of the evidence or submissions, it should not be assumed that we have not taken these into account.

25. It was made clear in Dr Joseph's witness statement that he accepted Allegations, 1, 4, 5, 6, 7 and 8. We therefore find the following proved on the balance of probabilities:

Allegation 1 “Patient record keeping did not meet the principles expected of a GP as outlined in GMP”

Allegation 4 “Your management of patients on Azathioprine medication was unsafe”

Allegation 5 “You did not have an effective safeguarding alert system in place”

Allegation 6 “There was no effective system in place for the management and monitoring of patient prescriptions”

Allegation 7 “You have not demonstrated embedded learning from patient complaints or improved the quality of your record keeping since 2014.”

Allegation 8 “Failure to declare your suspension in your 2018-2019 Appraisal”

The core evidence which formed the basis of these findings is set out in the NL and need not be repeated here. As set out at [14] above, Dr Joseph has raised some matters regarding his admissions to Allegations 1, 4, 5, 6 and 7 which go to context and/or mitigation. We will consider the main points taken at a later stage. We add that a probity issue that had originally been considered to arise in the context of Allegation 8 but this was not pursued: it forms no part of our decision making on efficiency grounds.

26. In the event, having considered all of the evidence in the round, we decided that resolution of Allegations 2, 3 (c), and 3 (g) was unnecessary.

27. It is accepted that the PLDP were justified in imposing some level of clinical supervision. The crux of the appeal concerns the imposition of *direct* clinical supervision. In a nutshell the Appellant’s case is that, when viewed in proper context, and taking into account his career, history, and all explanatory/mitigating circumstances, as well as his clear insight, the legitimate concerns about his efficiency are not such to render *direct* supervision necessary, justified and proportionate. His case is also that:
    - direct supervision will be impossible and/or impractical and /or unworkable and far too expensive.
    - the impact of conditions imposing direct supervision will be disproportionate to any legitimate concerns.
    - If imposed a condition for direct supervision will be tantamount to a direction for removal of his name from the MPL, and thus disproportionate.

28. What does the Appellant seek? In his witness statement (at para 11) Dr Joseph effectively asked the Tribunal panel to impose close supervision in line with the undertakings agreed with the GMC in February 2020. However, the case has also been advanced before us, (as it had been before the PLDP), that “enhanced” close supervision is necessary and proportionate.

29. What are the main differences in the level(s) of supervision advocated by each party? Amongst other matters:

    1) "Direct supervision" (as per Condition 3 - which adopted the GMC Glossary definition) requires, amongst other matters, that any activity that involves patient contact such as consultations, examinations and procedures must be supervised by the clinical supervisor at all times. All other aspects of the doctor's work must be subject to oversight and approval by the clinical supervisor or nominated deputy.
    2) By way of contrast, "close supervision" (as per the GMC Glossary Definition) requires that whoever carries out the active supervision of clinical work must be on site and available to the supervised doctor at all times, subject to defined deputy arrangements.
    3) There are also differences between these two modes/levels of supervision regarding the frequency of case-based discussion (CBD), amongst other matters. Close supervision as per the GMC Glossary provides for CBD at least every 2 weeks.
    4) The *"enhanced"* level of close supervision suggested by both parties to the PLDP involved, amongst other matters, review of each patient consultation and CBD at the end of each clinical session.

30. In oral submissions the parties agreed that:
    - the options open to the PLDP, and thus to us were, (in ascending order): no action, conditions or removal.
    - In reaching its decision the Tribunal panel must consider a number of factors under paragraph 15 (5) and (6) of the Regulations, which includes the history of any incidents and any action taken by other regulatory bodies.

31. We deal with one matter raised at an early stage. Reliance was placed on the fact that no witness statements/evidence had been adduced from the Performance Assessors appointed by the GMC ("the Assessors"). Our collective experience was that we could not recall an occasion where live evidence from GMC Performance Assessors had been called. Of course, application can be made in case management for witness statements to be directed in any given case, or even at a hearing, if considered appropriate in line with the overriding objective - see paragraph 15 (1) of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (the "Rules"). No such application was made. The Appellant relies on the burden of proof.

32. As explained in the hearing, in these proceedings we are able to receive evidence that would not be otherwise admissible in civil proceedings – see paragraph 15 (2) of the Rules. It was not suggested that any of the evidence/documents before us from a wide range of sources including: those investigating complaints made to the GMC and to the Respondent; Havering CCG; those who conducted record reviews and/or serious incident reviews; the CQC; the report of the Performance Assessors and/or the letter from the GMC Case Examiners, should be excluded on the basis of relevance or fairness.

33. We have borne fully in mind that the weight we might attach to the contents of documents written by persons who have not been called to give oral evidence requires careful assessment in the context of any live factual dispute, remembering always that the burden of proof is on the Respondent.

**Our consideration of the Regulatory History**

34. We refer to paragraph 15 of the Regulations. There is a documented history of concerns about inadequate record-keeping arising out of complaints and incidents (see the Chronology at [5] above) dating back to 2014, but our immediate focus is on 2017 onwards:

i. **The First Records Review - 1 April 2017**

In this review of 25 cases:

(a) Care was deemed acceptable in summarisation and read coding (72%) and continuing care arrangement and/or safety netting (74%);

(b) Care was deemed a cause for concern in recording of history of presenting complaint with documentation of relevant positive feature (50%) and record of clinical examination/findings (54%);

(c) Care was deemed to be unacceptable: in recording of presenting complaint with documentation of relevant negative feature (31%); in the making of appropriate diagnosis decisions based on information acquired, including referral with a working diagnosis (42%); in prescribing within current guidelines (30%); appropriate advice given regarding common side effects/interactions (0%); an up to date medicines review (40%); and in the following of agreed clinical practice guidelines and procedures including appropriate referrals (46%).

(d) In overall conclusion 17 of the 25 cases were identified as having a patient safety concern.

***Dr Joseph's response*** (B354-357):
Dr Joseph did not accept the findings of this review stating that his last 2 appraisals and a case note review in 2017 all concluded his record keeping was acceptable. He listed 14 actions that are required in a 10-minute appointment stating that at least 15 minutes were required to perform all these tasks. He also questioned if the reviewer had been examining the correct data base and offered to compare his records with anonymised records of other doctors. He asked for a further review of his record keeping by an expert panel making some suggestions of suitable Drs to be on it and stated he would *"accept any improvement if it would help the patient care".* He said that he was happy to undergo more computer courses for record keeping and courses with the MDDUS to improve his IT skills.

ii. **The Second Records Review - 29 April 2018**

A review of 30 patient records carried out in April 2018 by Dr Humphreys considered that the majority of records reviewed only partially met the basic core principles expected of a reasonably competent GP. The outcome of the records review was as follows:

i. History taking: 19 of the 30 cases were a cause for concern;

ii. Management Plans: 8 cases were a cause for concern and 6 cases were unacceptable;

iii. Safety netting/ follow up: 5 cases were cause for concern and 8 cases unacceptable;

iv. Coding: 22 cases were cause for concern.

***Dr Joseph's response***

In his email to the Respondent dated 29 May 2018 Dr Joseph said that he was strongly disappointed about the findings of the review, which he considered had been contrary to reviews which had been carried out in previous years. He was so concerned that he suggested a further review should be carried out by a committee or panel of experts, but that he would nevertheless be happy to undertake more online computer courses on record-keeping and to take a course on improving his IT skills.

iii. **The Performance Advisory Group**

On 18 June 2018, following the PAG meeting, notification was sent to Dr Joseph to confirm that the PAG noted the deficiencies identified by the 2017 Review, the 2018 Review and latest CQC report and his willingness to improve. In the light of Dr Joseph's suggestions, the PAG determined that further medical record keeping courses to improve documentation skills and IT and clinical software courses to improve IT be undertaken within the next 3 to 6 months at which time further review would be undertaken to assess progress. Dr Joseph was directed to the Local Medical Committee (LMC) and his defence organisation for assistance in signposting him to appropriate courses.

iv. **Havering Clinical Commissioning Group**

In October 2018, the Respondent received concerns from Havering CCG that Dr Joseph was not adequately checking his e-RS work list (emergency referrals). Multiple examples of inadequate referral information being sent, failure to action hospital referrals, failure to follow up or refer to another service/hospital were provided, including urgent referrals for oncology, diagnostic endoscopy, paediatric referrals and mental health referral were provided which the CCG highlighted as being a "clinical risk".

The concerns identified by the CCG were highlighted to Dr Joseph by the Respondent by letter dated 10 October 2018 and a response to them requested by 1 November 2018. Further requests for a response were sent on 16 October and 10 December 2018, the latter requesting a response by 24 December 2018.

Dr Joseph did not respond.

**The CQC Inspection Report (B145-149)**

35. The CQC carried out an announced inspection on 16 January 2019. This followed up on breaches under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which had been identified at a previous inspection on 31 August 2017. The outcome was that the practice was found inadequate overall and for all patient groupings. It was rated "inadequate" for:
    - providing safe services
    - effective services
    - well-led services

    and rated "requires improvement" for:
    - providing care services
    - providing a responsive service.

    The report also stated that the 2018 GP survey results were considerably lower than the CCG and national averages. Based on the CQC findings that there were breaches of the Regulations which presented serious risk to people's life, health or wellbeing, an application was made on 25 January 2019 to cancel the Appellant's registration as a provider of services under the Health and Social Care Act 2008.

**The CQC Application for Cancellation of Registration**

36. Ms Sian Jopling, a CQC Enforcement Inspector who attended the announced focussed re-inspection on 21 January 2019, provided statements dated 23 January and 12 February 2020. She was not required to attend for cross-examination. We considered her statements with care, (and disregarding her evidence regarding Allegations 2 and 3 (c) and (g)).

37. Her statement described that her focus on 21 January 2019 was to work on inspecting clinical records with the GP Specialist Advisor, Dr Roderick Smith. She provided 13 examples of patients being put at significant risk of harm by summaries of patient records being incomplete, and/or inappropriately coded. Her statement also set out evidence, (supported by exhibits) of:
    - unsafe Azathioprine management (Allegation 4)
    - ineffective prescription management (Allegation 6).
    - the lack of an effective safeguarding system (Allegation 5).

    Having considered her statement and exhibits we have no reason to doubt that her views were evidence-based and sincerely held.

38. Ms Jopling's January 2019 statement was the basis for the application for the urgent cancellation of CQC registration. The order was made by the Romford Magistrates Court on 25 January 2019. Dr Joseph exercised his right of appeal to the First-tier Tribunal (HESC) against the cancellation order. We draw no inference from the fact that Dr Joseph later withdrew his appeal. His evidence, which we accept, was that he did so because he considered that it preferable to focus his energies and resources on the GMC investigations.

39. As a matter of law, in an application for *urgent* cancellation of registration, the threshold requires that the Justice of the Peace is satisfied that there *appears* to be a risk of *serious* harm – see section 31 of the Health and Social Care Act 2008. In other words, it involves a lower standard of proof/satisfaction but a high threshold regarding the degree of risk. It is agreed that the fact that an order was made must always be a relevant part of the history of regulatory action which we must consider- see paragraph 15 (5) of the Performers Regulations. We agree with the Appellant's submission the fact of cancellation of provider registration by the Justice of the Peace is certainly not binding on us. Apart from anything else in the field of regulation it is not unusual for a practitioner to be able to adduce evidence to show that, whatever past concerns have been held by other regulatory bodies such as the CQC or others, he/she today has understanding/insight, has taken appropriate steps to address/remedy any concerns such that any risk in relation to his/her personal practice can now be considered to be low or much reduced, and that measures can be taken to adequately and reasonably mitigate any ongoing risk to the efficiency of services and patient safety.

40. Dr Joseph said in his evidence that he had asked the CQC to re-inspect in a month by which time he considered that all matters of concern could have been rectified, but the CQC proceeded to apply for cancellation. He disagreed with many of their findings. On any basis it appears that there was a very large chasm between the views of the CQC Inspectors in January 2019 and Dr Joseph's understanding of the extent, range and seriousness of the numerous breaches of standards set out in the CQC Inspection Report and also Ms Jopling's statement and exhibits.

**The Third Records Review - 13 February 2019**

41. Dr O' Moore reviewed 30 sets of Dr Joseph's patient records. The key findings as outlined in his review report dated 13 February 2019 were as follows:

- The clinical records reviewed did not meet the basic core principles expected of a GP applying the standards described in Good Medical Practice for General Practitioners.

- Dr Joseph was judged to be performing below standard against the benchmark set by the GMC across the following areas of clinical practice:
  - Good clinical care
  - Relationship with patients
  - Maintaining good medical practice

- The clinical records reviewed also identified themes where patient care provided by Dr Joseph needed addressing:

  - All 30 cases demonstrated poor history taking and examination

  - Insufficient management of potentially unwell children exampled in cases 12, 21 and 22

• Had not demonstrated adherence to and following national guidance on:
  • Antibiotic prescribing in cases 4,9,24 and 30
  • Hypertensive management in cases 7,8 and 17
  • Diabetic Mellitus management in cases 2,16 and 29
  • Management of Vitamin D deficiency in case 3
  • Inappropriate prescribing in case 10

• Dr Joseph did demonstrate regard for patient dignity and offered a chaperone in one case.

The overall conclusion was that:
*"...most, if not all, of clinical records reviewed were difficult to follow for any visiting clinician. 30 medical records were reviewed and in 30 of 30 cases there was some deficiency as defined by the GMC's 'Good Medical Practice' and the Royal College of General Practitioners' "Good Medical Practice for General Practitioners". The review recognised that not all of these standards can be fully assessed using medical records alone, however, despite this there were deficiencies in all cases reviewed sufficient to cause concern."*

***Dr Joseph's Response***
In two emails on 26 February 2019 Dr (B473 and 476) Joseph said he accepted the suggestion by Dr O'Moore and that he would try his best to improve record keeping. He was trying to attend record keeping courses. He suggested another review of record keeping in six months' time.

However, in his further response (B479) by email on 2 March 2019 Dr Joseph questioned the appropriateness of Dr O' Moore's selection as a clinical note reviewer because: of his lack of post graduate qualifications or accreditations: he is not a GP Trainer; he is not a clinical director. He went on to point out that Dr O' Moore had appraised him for 3 years without concern, and that he was contradicting himself. He reiterated his request from 2018 that a panel of experts should be appointed and went onto to provide the names of those who should be on it. He suggested 2 specific dates where all his clinical notes could be examined rather than *"choosing from here and there*".

**The Performance Assessment in the GMC proceedings**

42. The Performance Assessment undertaken (hereafter "the Assessment") demonstrates the very detailed, multi-layered and triangulated nature of that process. The Assessment took place over three days in August 2019. The method involved three Assessors (a Team Leader, a Lay assessor and a Medical Adviser), who recorded individual observations. The range of assessments undertaken included:
    - Two interviews with Dr Joseph
    - Third Party Interviews with his colleagues (TPI)
    - A Medical Record Review (MRR) of his last 30 consecutive patient encounters at Chase Cross Surgery working backwards from 21 February

2019 and 20 working backwards from 5 December 2019 at the Grays' Surgery

- Tests of Competence (TOC)
  - Cased Based Discussion (CBD)
  - Knowledge Test (KT)
  - Objective Structured Clinical Examinations (OSCE)
  - Simulated Surgery (SS)

43. In the detailed report dated 22 September 2019, which consists of some 268 pages, the Assessors set out their detailed findings under a number of headings. In summary, the Assessors considered Dr Joseph's performance in relation to clinical management and record-keeping was *"unacceptable"* – which term is defined by the GMC as follows: *"indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy (i.e. deficient professional performance").*

    The Assessors' findings included:

    ***"Clinical Management***
    *Dr Joseph provided some care for patients, including providing prescriptions, arranging referrals and giving advice on management of patient's conditions that was acceptable. At TOC [Test Of Competence] Dr Joseph identified some patients who needed urgent medical care.*

    *Dr Joseph's performance in the domain of 'clinical management skills' at the Simulated Surgery was within the lowest end of the interquartile range. Dr Joseph provided some care for patients, including providing prescriptions, arranging referrals and giving advice on management of patient's conditions that, in the opinion of the Assessment Team, was unacceptable.*

    *The Team noted that there were examples of Dr Joseph's performance which placed patients at risk of harm. For example, two cases concerned unacceptable prescribing, when a patient who was trying to conceive was prescribed Carbimazole, that can be harmful to a developing foetus and, at TOC, when Dr Joseph prescribed the Oral Contraceptive Pill when he should not have done so.*

    *Two cases concerned unacceptable referral, when a young woman with pleuritic pain was not referred to hospital to exclude a pulmonary embolism and, at TOC, a case where Dr Joseph did not seek to urgently admit to hospital a patient with severe complications of back pain.*

    *The Assessment Team had further concerns about Dr Joseph not giving safety netting advice to patients when he should have done so.*

    *(Dr Joseph's not giving advice to patients when, the opinion of the Team, he should have done so was also noted in Section 4.7 Relationships with Patients).*

*The Assessment Team concluded there was evidence of unacceptable performance that potentially put Dr Joseph's patients at risk."*

*'**Record keeping***

*Dr Joseph produced some records that were legible and included the use of Read codes, and colleagues commented favourably on his record keeping.*

*However, the Assessment Team noted that there were numerous instances of patient records that were, in their opinion, unacceptably brief and omitted important details of Dr Joseph's assessment, management and advice given to patients. In the opinion of the Assessment Team Dr Joseph's records did not contain important details of the care and advice given to patients which would affect other clinicians' ability to take over care of Dr Joseph's patients, and this would consequently place Dr Joseph's patients at risk of harm. In the opinion of the Assessment Team there were repeated and persistent instances where Dr Joseph's record keeping fell short of that required by GMC Good Medical Practice.*

*As a result of various apparent omissions in Dr Joseph's medical records, substantial amounts of data collected in the assessment domains of Assessment of the Patient's Condition, Clinical Management and Relationships with Patients were reattributed to Record Keeping by the Assessment Team.*

*Because of Dr Joseph's repeated and persistent failure to comply with the professional standards appropriate to a General Practitioner in relation to Record Keeping the Assessment Team concluded that Dr Joseph's performance in this area of the Assessment was Unacceptable.'*

*44.* The Assessors' overall conclusion was:
*"…your performance was deficient and you are fit to practise on a limited basis with appropriate support and supervision to allow you to address the deficiencies identified."*
The following recommendations were provided:-

a) *Only working as a GP or salaried GP and not undertaking short term locum (less than 3 months) or out of hours work as a GP;*
b) *Clinical supervision which should involve discussion of a sample of cases, paying particular attention to clinical management and record keeping;*
c) *Education supervision involving discussion of cases, paying particular attention to management and record keeping; and*
d) *Design of a personal development plan with specific aims to address: clinical management, record keeping and appropriate use of local and national guidelines."*

**<u>The GMC Case Examiners' Decision</u>**

45. The conditions considered suitable by the Case Examiners (ultimately agreed by way of undertakings) involved "close" supervision as per the GMC Glossary

definition. Dr Joseph said in his evidence that this came about because of negotiations with the GMC. He considered that close supervision came about at his request and because of his insight.

46. The overall effect of Dr Joseph's case: as presented to the PLDP in October 2019; in the letter to the GMC from Radcliffes dated 5 December 2019; and in his February 2020 statement before us, was to the effect that the GMC Performance Assessment had led to a "damascene" moment for him which had precipitated a transformation in his attitude. We noted that:

    - Representations made to the PLDP by Mr McDonagh on 4 October 2019 were that Dr Joseph *"unequivocally accepts the results of the GMC Performance Assessment".*
    - In the letter dated 5 December 2019 to the GMC Case examiners Radcliffes accepted that *"in light of the fact that Dr Joseph unequivocally accepts the results of the GMC Performance assessment"* it was accepted that there was a realistic prospect of a finding that his fitness to practice was impaired by reason of deficient professional performance. It was submitted that in view of the fact that Dr Joseph had *"clear insight"* into the deficiencies in his practice, it was appropriate for the case to be disposed of by way of consensual undertakings.
    - In his witness statement in these proceedings (February 2020) Dr Joseph said that: *"I may have previously disputed some of the concerns raised about my performance, however, undergoing the GMC Performance Assessment, which was the most comprehensive, objective and in-depth assessment of my performance that has been undertaken thus far was a turning point. … the Performance Assessment enabled me to gain clear insight into the deficiencies in my professional performance."*

**Evaluation of the Oral Evidence**

47. There was considerable challenge as to why Dr Sonigra had changed his view since the PLDP meeting and now considers that direct supervision is necessary and justified. The effect of his evidence was that he had reflected on matters and now considered that the PLDP decision was correct. He referred to the nuance of the reasoning regarding the conditions imposed by the PLDP.

48. Dr Sonigra explained why he had considered in discussion between the parties (outside the panel hearing) that "enhanced" close supervision was appropriate (subject to the decision of the panel), instead of removal. He said that there was some reflection that had swayed his/NHSE's views. Given that, as we understood matters, Dr Joseph had not (for reasons that were explained at the time) given any substantive evidence at the PLDP meeting, the Tribunal panel asked for clarification. Dr Sonigra said that it was through his representatives that Dr Joseph's insight was portrayed to him/the NHSE. He added that Dr Joseph was present during the discussions and had spoken as well.

49. Before us Dr Sonigra said in his evidence that he considered that Dr Joseph has "some" insight which needs to be developed in a structured way but, in his view, there have to be safeguards.

50. Dr Sonigra gave evidence as his knowledge of supervision and the circumstances in which direct supervision can been used in the primary care context. He agreed that direct supervision in GP practice is rare. He said he currently manages a case load of about 35 cases of doctors with performance issues: 7 to 10 of these were subject to conditions, and 4-5 involved close supervision. As we understood it, he had never personally dealt with a case involving direct supervision, but was aware that direct supervision has been used for short periods in association with NCAS, (the National Clinical Assessment Service - now NHS Resolution). He also said that direct supervision is used in GP practice for short periods for GP trainees, and also in the context of GPs returning to practice after a break in service. He explained that he was not an expert in Return & Induction procedures.

51. We accept, of course, that Dr Sonigra had agreed to "enhanced" close supervision before the PLDP - albeit this proposal would be subject to the PDLP's views. However, the PLDP decided that *direct* supervision was necessary to address its concerns – and gave very detailed reasons.

52. We found Dr Sonigra to be a sincere, reliable and credible witness. In our view his evidence was thoughtful, considered and represented his genuine reflection. That does not, of course, mean that we should necessarily accept his current opinion (which was given before Dr Joseph's oral evidence). The issues of risk assessment, and what measures are necessary and justified to address risk to patient safety in a proportionate manner, ultimately fall to us to decide in the light of all the evidence, considered in the round, and as at date of the hearing.

53. Dr O' Moore gave evidence regarding the records audit he performed in February 2019 - see [42] above. This review was independent of the CQC Inspection and it took place after the closure of the Practice. The review did not involve any other cross-checking with staff. Some concerns were raised about Dr O' Moore's objectivity since he had previously appraised Dr Joseph, although there was no significant challenge to the accuracy of his review findings. In his statement Dr O' Moore also dealt with his review of a potentially significant incident at the request of the Respondent on 31st March 2019 in which he found the records made by Dr Joseph were inadequate, and a further review concerning a 29 -year-old cancer patient in which he concluded that Dr Joseph's records of consultations and referrals were very brief and lacked detail in relation to history taking and examination.

54. We found Dr O' Moore to be an entirely straightforward, reliable and credible witness. We find that he had appraised Dr Joseph for three years ending in 2014. In our view this had no bearing at all on the reliability of his views in 2019. We consider that there was nothing in his evidence that suggested that he lacked objectivity or had any agenda. In cross-examination he said that he described what he had or had not seen in the records, and he explained his views about potential significance regarding of the concerns he held in clear and neutral terms.

55. When asked by Mr McDonagh why he wished to continue in practice at the age of 73, Dr Joseph said that he was encouraged by the GMC Assessment which showed that his knowledge was considered to be sound. He has dedicated himself to his patients and has many years of valuable experience. He has a lot to offer patients and wants to continue to be of service. Dr Joseph said that he had not keep up to date with standards regarding record-keeping and that his habits were old-fashioned. He said that he knew each of his patients well, and knew what had happened at consultations.

56. We do not consider it realistic for a GP to place reliance on his memory as a substitute for adequate records. We bear in mind that Dr Joseph was seeking to explain that he had not moved with the times. However, the broad and basic standards of record keeping required under Good Medical Practice as published by the GMC, and those published by the Royal College of General Practitioners, have been in place for very many years. It is clear that the adequacy of Dr Joseph's record-keeping has been a matter of concern known to him since 2014, in the context of complaints made and incidents arising thereafter, and was also the subject of detailed record reviews/audit in 2017, 2018, and 2019.

57. In an email to the Respondent in May 2018 Dr Joseph said, with reference to the 2017 NHS England Record Review, (B353) that *"a senior GP from NHS England having reviewed 25 clinical notes in 2017 was satisfied as to record keeping and did not suggest any improvement".* We find that this entirely at odds with the outcome of the 2017 Records Review of which Dr Joseph was aware – see [34 i]. His May 2018 response showed a lack of insight.

58. Dr Joseph has relied by way of mitigation on the absence of any concern having been raised in his annual appraisals regarding his records. We find that the appraisal process does not, however, involve a formal review of records such as that undertaken on review/audit in 2017, 2018, and 2019. In our view it is odd that any doctor should seek to rely on appraisal when comprehensive record keeping reviews/audits had been undertaken- and which he plainly received and had commented on – see [34] and [41] above.

59. The MRR analysis conducted by the Assessors in August 2019 reviewed a sample of 50 records drawn from Dr Joseph's last recent practice at his Practice and at the Grays' Surgery (in late 2018 and early 2019). We noted that favourable comments were made by GP colleagues in the TPI regarding Dr Joseph's records, and in the context of continuity of care. However, the Assessors found a failure to make adequate records in a significant number of cases.

60. In the Appellant's Response on 30 January 2020 (para 2) it was said that the failures regarding record keeping reflect difficulties he encountered with the change-over in computer records, and also the difficulties that those investigating his records experienced with the computer systems. Although we do not doubt that computer migration difficulties may well been experienced by Dr Joseph in late 2018/ early 2019, there is a well-documented history of poor record keeping preceding this period (and over years), which we find was unrelated to computer migration issues. It was also noted by the Assessors, when conducting the MRR,

that records made by Dr Joseph at the Grays' surgery, where there were no migration issues, were also inadequate. Additionally, we consider it unlikely that those investigating or conducting reviews over the years experienced any significant difficulties with the computer systems. We noted also that the record audit of Dr Humphery in February 2018 was conducted on the basis of hard copy records.

61. Dr Joseph told the GMC Assessors in August 2019 that previous assessment of his record keeping had found it to be ***"perfect".*** This is inconsistent with the record reviews conducted in 2017, 2018 and 2019, and indeed, Dr Joseph's responses to the Respondent – see [34] and [41] above. In our view this comment to the Assessors in August showed a complete lack of insight. However, we keep well in mind that the Appellant's case it was the outcome of Assessment report in September 2019 that finally enabled him to acquire "clear" insight. We considered the evidence relevant to his insight.

62. In the Appellant's Response dated 30 January 2020 (which Dr Joseph adopted as part of his case) it was said (at para 3) that Dr Joseph has attended *"a number of record keeping courses* ***recently*** *with more to come. Furthermore, the Appellant continues to attend a monthly course on the computer programme* ***that is now used. This had had an immediate and profound impact upon the Appellant's record keeping****."*
It was also said (para 10) that *"****Ongoing*** *courses in record keeping and computer practice has (sic) ensured that the Appellant* ***now practices in accordance with GMP".*** *(*our **bold*****).***
However, in cross-examination Dr Joseph said:
    - He undertook an MDDUS online record keeping session in March 2017 and another in 2018. Each session lasted 45 minutes.
    - He confirmed that he had not undertaken any record-keeping course(s) since 2018.

    We find on his evidence that the computer course Dr Joseph has undertaken on a monthly basis over the last year is a general one provided at an Apple Store, is not bespoke to medical software and is not, (as asserted), *"the computer programme that is now used."* Although the need for Dr Joseph to undertake clinical software courses had been identified in 2018, and he was signposted by the Respondent to the LMC and his defence organisation), this has not happened.

63. We noted that Dr Joseph has not undertaken or provided to us any evidence of any personal audit(s) of his past record keeping, so as to demonstrate his understanding of the extent to which his record keeping practice was deficient, and/or any reflection upon any actual, or potential, impact for his patients.

64. Dr Joseph described to us the elements that an acceptable clinical record should cover. It was clear from his evidence in answer to Ms Vanstone that, in the context of the 10-minute appointment which is standard for GP practice in the NHS, Dr Joseph still considers that making a full record might detract from the quality of his conversation and interaction with his patient, and might lead to shortcuts, or the need to overrun, thus impacting on the time allotted to see the next patient. His evidence in this regard caused us real concern because it suggested that he

still sees barriers and difficulties in addressing the critical need to develop the skill of making adequate records as the consultation progresses, and within the ordinary constraints of clinical practice. We bore in mind that his focus was to explain why he had not been able to comply with basic standards. As a specialist panel we are aware of the very many challenges faced by GPs in delivering an appropriate service in line with ordinary practice. We are also aware and took fully into account the difficulties that may be experienced by doctors when giving evidence. In our view, however, Dr Joseph's evidence clearly showed that he still has real difficulty in accepting that a GP providing a safe and efficient service is expected to, and should be able to make an adequate clinical record. Given the substantial past regulatory history and the views of the Assessors, his attitude and approach, as demonstrated to us, this is a matter of very real concern.

65. Dr Joseph said that he will be able to show that he can, and will, make proper records within a week. We do not consider that this is realistic. We find that given that the number of years over which inadequate record keeping has been a matter of repeated and evidence-based concern, a week or so would be wholly insufficient to provide any or any adequate assurance of sustained or embedded improvement. In our view it is clear from the history and Dr Joseph's own evidence that his habit regarding his approach to record keeping is engrained, and that he has been unable to effect sustained/embedded improvement, despite his acknowledgement of the need to try his "best" to improve over a period of years (see his emails on 26 January 2016 and on 26 February 2019).

66. We bear in mind that Dr Joseph's evidence before us may reflect his personal characteristics and his pride. We can understand that he is very proud of the position and the role he has held in the local community as a GP. In our view his pride may have had a bearing on his approach to the concerns raised by number by other bodies, such as NHSE, the CCG and/or the CQC. In our view the outcome of the detailed reviews/audits over three years were very clear, but his response was largely resistant. We reject the submission that this due to "mixed messages" as between review/audit and appraisal. In our view the outcomes of the reviews/audits were very clear but Dr Joseph would not accept them. He told us that he believed there had been a plan by the CQC and also NHSE to close his practice. He said that this has happened to other GPs in the locality.

67. We attach very significant weight to the Record Reviews conducted in 2017, 2018 and 2019. We consider that the conclusions reached by each of the reviewers were objective and reliable. Dr Sonigra accepted that there was evidence of some improvement in 2018. We noted also that the number of cases of concern re record-keeping identified by the Assessors were less than had been found by Dr O 'Moore. However, we find that the qualitative concerns reached by the each of the Reviewers in 2017, 2018 and 2019 were very similar to the concerns held the Assessors appointed by the GMC in 2019. In our view the evidence shows that, over a period of years, Dr Joseph has been unable show any sustained improvement in his records of consultations.

68. We note that Dr Joseph seeks to contend that criticisms *"reflect record keeping failures and not clinical failings within a consultation"* – see para 11 of his

Response. In our view the Allegations admitted by Dr Joseph, even allowing for context and all mitigating circumstances, are not simply a matter of "record-keeping". We find that his admissions, and the admitted inadequacy of his records, bear directly on the adequacy of his clinical management.

69. It is clear from Dr Joseph's statement that he accepted the outcome of the Assessment in September 2019 as independent and objective, and without qualification. However, in these proceedings he has disagreed with the factual basis for some of the views reached by the Assessors regarding some OSCE stations - to which we will return at a later stage.

70. It is argued that since the heart of regulation by the GMC and the Respondent relates to patient safety, this panel should reach the same conclusion as the GMC Case Examiners. We agree that each regulatory body is concerned with the protection of patient safety. There are differences in the roles of each body. We consider that the Respondent's statutory role is aptly described as "fitness for purpose" in the context of the provision of efficient (and safe) primary care. In our view, if parliament had considered that the GMC's statutory role in considering "fitness to practice" necessarily embraced all aspects of the public interest in GP practice, it would not have considered it necessary to provide for separate regulation within the NHS primary care setting. We consider that the Respondent is the regulatory body responsible for the decisions regarding continued inclusion on the national MPL, whether or not the practitioner is also subject to other conditions imposed by the GMC.

71. We agree that the protection of patient safety is always the core issue when considering the necessity of any regulatory action - and by whichever body has to consider the issues presented before it. Dr Joseph's position as per his witness statement is the fact that the GMC decided to impose close supervision "renders" the earlier PLDP decision unnecessary and disproportionate. We do not accept this: it implies a hierarchy of decision making that simply does not exist. We agree, however, that the fact that the GMC, on the basis of the Performance Assessment, accepted undertakings/conditions for close supervision is evidence that may well support that only close supervision is necessary. We agree that any action taken by the GMC is a matter that we must weigh and take into account in context.

72. An issue has been raised as to the documents considered by the Assessors. It is agreed that the Respondent's documents were sent to the GMC. The Appellant's case is that it should be inferred that the Assessors had taken into account all the contents of the material provided by the Respondent and that this lends weight to the argument that the Tribunal panel should impose close supervision in line with the GMC's acceptance of Dr Joseph's undertakings. The Respondent disagrees and points, amongst other matters, to the stated evidential basis of the Assessment report.

73. We find that the information provided to/received by the Assessors was clearly described at section 3.2 of the report under the heading *"Information provided to the Assessment Team".* This sets out the background information provided, and including, the referral from NHSE on 4 February 2019 following the CQC

inspection, the NHS suspension, and the 2019 records review. It states: *"The Referrer advised of the concerns that followed the CQC inspection and concerns raised by NHSE cases"* and then lists the broad areas that do, indeed, reflect many of the allegations before us. The report then states:
*"This information was accompanied by the following guidance:*

*Assessment Teams are appointed to carry out an* ***objective*** *assessment of a practitioner's professional performance;* ***not to investigate the allegations or complaints.*** *This information is provided, along with the portfolio to assist you in* ***planning*** *the assessment.* ***It must be treated as background information only and not be judged evidence for the report."***
*(*our **bold***)*

74. Towards the end of closing oral submissions, we were informed by Mr Shah of Radcliffes, that there is a Code of Conduct that governs the Assessors but, as was then agreed by Mr McDonagh, this had not been provided in evidence before us and cannot inform our reasoning.

75. We are invited to draw the inference that the Assessors had been provided with, and had read and taken into account, all the documents sent to the GMC by the Respondent. In accordance with ordinary principles, we would expect that all documents provided/considered by the Assessors would have been referenced in section 3.2. In our view the Assessment report made clear that the remit was to assess how Dr Joseph performed before them - albeit against the background of information/documents imparted by the Referrer (as set out in section 3.2) so as to inform assessment planning.

76. Even if we are wrong in this, our task in any event is to make our own assessment under the Regulations, and based on the evidence as at the date of hearing.

77. In our view the sequence and the substance of regulatory action taken by the Respondent and the GMC is of note. We find as follows:

    a) In our view the Assessors' recommendation in September 2019 did not explicitly differentiate between "simple" supervision or "close" supervision. This is not a criticism: it appears to us that the issue of precisely how GMC might progress the allegation of deficient performance in light of the Assessment was ultimately a decision to be made by the Case Examiners.

    b) On his own case on 4 October 2019 the Appellant had invited the PLDP to impose conditions reflecting *enhanced* supervision. His overall position before the PLDP was that his approach showed his *"clear"* insight.

    a) The undertakings offered by Radcliffes to the GMC on behalf of Dr Joseph by email on 5 December 2019 were in response the accepted allegation of deficient performance which emanated from the Assessment.

    b) The undertakings offered in December 2019 amounted to a significantly lesser degree of supervision than that advanced by Dr Joseph to the PLDP on 4 October 2019. The representations to the GMC in December 2019 were to the effect that the offer of undertakings reflected Dr Joseph's insight. It seems to us that Dr Joseph's position in December 2019 was not in line with the

position advanced on his behalf before the PLDP two months before. In our view it is a matter of concern that a practitioner who, before the PLDP, had accepted that his clear insight was such that **enhanced** supervision was necessary and justified should, within two months, contend that (only) close supervision is required before a different body.

c) In our view we should look at the reliance placed on the GMC regulatory decision with care, and in the context of all of the evidence.

d) The Appellant relies on the GMC Case Examiners' views in February 2020 in response to his December 2019 representations. In our view it is important to recognise this was a consensual disposal on undertakings.

e) In our view, the reasons provided by the Case Examiners did not seek to evaluate the issue of risk on the basis of any detailed consideration of the cases/scenarios considered in the Assessment, or the very detailed and evidence-based reasoning that had been provided by the PLDP in the NL - which document was before them.

f) Annex C of the Undertakings (C39) shows that the Case Examiners' decision was based, amongst other matters, on the premise Dr Joseph has *"shown insight and a willingness to remediate".*

**Risk of Harm**

78. The nub of the case advance in cross examination is that deficiencies in Dr Joseph's practice will be picked up via *enhanced* close supervision i.e. review at the end of the clinical day/session, and this process will provide reasonable mitigation of risk whilst providing him with the opportunity to remediate his practice. Emphasis is placed on the absence of proof of past harm to patients.

79. The harm to which any individual patient may be exposed by inefficient practice is, of course, inherently dependent on a number of variables. The fact that there has been no proven evidence of direct harm over about 19 years' service as a GP is always an important factor to be considered. In our view, however, the absence of proven harm, in and of itself, is not necessarily informative. For example, inefficient care may cause harm without any complaint being made. Patients/or their family members may not realise that treatment may not have been in line with appropriate standards of practice and/or may have been delayed because of inefficient service. As can be seen from the investigation of various past complaints and the Incident Reviews, causation issues are often complex. This, in itself, reinforces the critical need, in the interests of patient care, for comprehensive records which properly record the presenting history, symptoms, any positive and negative findings on any examination completed, the clinical management considered and provided, and any signposting/safety netting/safeguarding advice given during the consultation.

80. When addressing the nature/degree of risk, the PLDP considered that a number of cases/situations considered by the Assessors were examples of particular concern. We find as follows.

81. Two cases were amongst those drawn from Dr Joseph's own records between December 2018 and February 2019 (i.e. his last recent practice):

**Case 9** involved a 28 -year-old female patient with pleuritic chest pain for whom Dr Joseph did not undertake basic clinical observation to identify pulmonary embolism or urgently admit to hospital. The view of the Assessors which this put the patient's life at risk and could have resulted in patient death should urgent treatment have been required.

This was accepted by Dr Joseph in his Response.

In cross examination Dr Sonigra said that the patient was on the pill which enhanced the risk. There was not enough detail in the record to exclude pulmonary embolism.

(We note that the assessors were sufficiently concerned about this case to make enquiries of the patient's new practice as to the outcome. Fortunately, no harm had resulted).

**Case 47** involved a 32 year-old patient with a history of hyperthyroidism for whom Dr Joseph restarted Carbimazole when the patient had no symptoms, normal blood tests and was trying to conceive. The Assessors considered this to be inappropriate and that it carried considerable risk for the patient as such medication is teratogenic and contraindicated when patients are trying to conceive: Carbimazole can be harmful to any developing foetus.

This was accepted by Dr Joseph in his Response.

Dr Sonigra accepted that supervision at the end of the clinical day might/could mitigate risk in a situation such as this, in that the patient could be contacted and management altered. In effect, much might depend on whether, and when, the deficiency was picked up and corrected.

We note that in the Response (para 15) Dr Joseph had firmly denied "unsafe" prescribing. We note in passing that this case is an example of unsafe and contra-indicated prescribing. It posed risk to the patient, and to the foetus in the event of conception.

82. Three other situations considered by the Assessors involved OSCEs with the use of role players as "patients". Each OSCE involved pre-planned scenarios designed to assess the ordinary skills required in GP practice. The following represents a summary of the PLDP findings, the Appellant's Response, and the main documentary and oral evidence before us.

**(i)** **OSCE station 10** involved a patient with lower back pain. The Assessors considered that Dr Joseph failed to identify the serious risk of cauda equina syndrome, which can cause paralysis if not identified early, and for which he did not arrange for urgent admission to hospital.

This was accepted by Dr Joseph in his Response with the qualification that his failure was to identify an "increased risk" rather than a "serious risk" of cauda equina.

Dr Sonigra considered, as had the Assessors, that the "patient" needed urgent referral to hospital for assessment**.** This was urgent because it was a "red flag" symptom. Mr McDonagh explored whether this might not be the case if the symptom was chronic. Dr Sonigra did not agree. He said that in every case it was necessary to recognise a red flag symptom requiring urgent referral.

We accept Dr Sonigra's view and that of the Assessors.

**(ii)** **OSCE station 12** involved a child with a meningococcal rash. The Assessors considered that Dr Joseph advised the mother to take the child to A&E *"within the hour"* and did not arrange an urgent transfer to hospital by way of a 999 call.

In the Response, and in his oral evidence, Dr Joseph said that the mother's account was that there was blanching of the rash (i.e. as the result of the glass test applied by the mother), and therefore his advice to attend hospital promptly was adequate. Dr Joseph contends that the Assessors did not hear what he heard.
We find the factual basis of the scenario with which Dr Joseph had to deal was that this **was** a meningococcal rash.
The records of the "consultation" made by the assessors were:

> "At OSCE Station 12*: 'a child with a meningococcal rash' Dr Joseph took a history from the mother over the telephone that* ***a rash was present and it remained the same when the 'Glass Test'****, to see if the rash disappeared when pressure was applied to the skin,* ***was performed****."* (B620)
>
> At OSCE Station 12: *'Advise on feverish child* ***with*** *meningococcal rash' although Dr Joseph advised the mother to take the child to A&E… Dr Joseph stated that child needed to attend within the hour it was, in the opinion of the Assessment Team, much more urgent than that and a 999 ambulance should have been called for immediate care to be provided."* (B633)
> (our **bold**)

We find that:

- It is very unlikely that the information provided by the role player/patient was that the glass test had shown blanching, because this would have been contrary to the factual premise of the test.
- The detailed record of the Assessor who recorded the patient information that the rash was present, and remained the same on the glass test, is likely to be more reliable than Dr Joseph's

recollection to the contrary. Dr Joseph's account is also consistent with the record made by another assessor – see above.

- Mr McDonagh explored the issue of clinical judgement (i.e. on the basis, as recorded, that the mother was advised to take the child to hospital "within the hour".) Dr Sonigra said that this was a matter of serious concern. This was not an acceptable exercise of clinical judgement: this was a 999 emergency. We accept his evidence.

**(iii)** **OSCE station 8** involved a female patient subject to domestic violence. The Assessors concluded that Dr Joseph's proposed management was that he would speak to her partner despite a clear warning from the patient that this would threaten her safety. The Assessors concluded that this could have placed the patient at serious risk of harm from her abuser.

Dr Sonigra agreed with the views of the Assessors. It was suggested in cross- examination of Dr Sonigra that this was a matter of clinical judgement. Dr Sonigra said that the management suggested by Dr Joseph would be without consent, and would also be dangerous. Asked if this was a matter that could be the subject of CBD at the end of the day, Dr Sonigra said it would depend on whether the shortcoming was recognised.

In his Response the Appellant said he advised the patient to go to the police and had "offered" to speak to the patient's partner but understood that this would threaten the patient's safety.

We accept that Dr Joseph advised the patient to go the police because this was noted in the assessment (B655). We find that Assessor Lewis recorded that Dr Joseph had *"persisted"* in offering to see her husband. Assessor Way recorded: "*Dr J did not provide any plan as to what the patient could do and just said several times that the husband should make an appointment to see him although the patient said this was not possible".* (B844-845). We consider that the records of the Assessors made at the time are more likely to accurate and reliable than Dr Joseph's recollection.

83. We consider that Case 9 and OSCE stations 8, 10, and 12 provide clear and cogent evidence that illuminates the nature of the risk to patient safety posed by Dr Joseph's practice. Broader considerations include that:

- In the 12 OSCEs Dr Joseph scored at or above the mean at only one station.
- In the SS, his score was below the reference group (i.e. as compared to other GPs) in all domains. This included overall judgement, data gathering, technical and assessment skills, clinical management and interpersonal skills.
- Although there is some evidence of improvement in 2018, as acknowledged by Dr Sonigra, it is the case that Dr Joseph's record-keeping was judged unacceptable by the Assessors in a significant proportion of the 50 records they examined.

- We consider that Dr Joseph lacks insight/understanding – see below.

84. We have had the advantage of seeing and hearing Dr Joseph give evidence in these proceedings. We consider that Dr Joseph's difficulty in accepting the extent to which that his practice had been deficient by any objective standards, was very apparent in his oral evidence. It was very clear to us that he still sees the issues raised as related to the function of "simple" record-keeping - but little else. We find that adequate record keeping, in line with longstanding professional obligations, lies at the heart of efficient and safe service: clinical management that meets basic standards in terms of recorded history taking, findings on examination, treatment options and advice, treatment prescribed, and/or referral and/or signposting/safety-netting/safeguarding as required.

85. In our view whilst Dr Joseph has admitted the core Allegations (1, 4, 5, 6, and 7) it has to be recognised that this was in the face of overwhelming evidence. In his written and oral evidence he demonstrated little, if any, insight, into the reasons for, or the breadth and depth, of the Respondent's concerns about his practice. His Response (A28) was long on assertion but short on accurate/reliable facts regarding his efforts to remediate. His witness statement was remarkably brief.

86. In evidence Dr Joseph said, in response to a question from Dr Gee: '*I think I am ready to be a GP from tomorrow. I don't have any problem at all. I am confident that I can start working, but if I have any difficulty when I start I don't mind letting Dr Sonigra know that I need help*.' He said that he thought it may be helpful for someone to provide supervision simply to give him more confidence in his practice in respect of record keeping, but he did not consider that it would help him *'at all'* to have someone in the room with him.

87. When asked what he thought his learning needs were Dr Joseph gave a long and uninterrupted answer (only part of which appears below), the effect of which was that he apologised for his ignorant practice in record keeping but it was not because he did not *"…know what to do and how to do it… I am prepared to perform much better than other people are doing today, it's not difficult for me, I don't need much learning, I know exactly what to do… I don't think I need more learning than that, I can do it, I can do better record keeping that many other people can do… it is not difficult, it is not a learning request, it is just to make up my mind, cut short somewhere and do the recording, that is what NHSE wants…I can show within a week how my record keeping is much, much better, it is no problem for me.*' In our view this begs the question as to why his unacceptable record keeping practice persisted, and despite (at least) the outcome of the Records Reviews in 2017 and 2018.

88. We find that the history and correspondence shows that Dr Joseph's past engagement with the concerns raised was very largely defensive - although he had, at least, acknowledged that he needed to try his "best" to improve his record keeping as long ago as January 2016. His efforts to improve his record keeping by short online courses in 2017 and 2018 did not result in sustained change (as shown by the Review in February 2019 and the Assessment in September 2019) but he has not attended further record keeping courses since 2018. He has been attending monthly sessions at Apple over the last year which may well have

helped his general computer skills, but this is not training that is bespoke to GP practice. He has not undertaken or sought to undertake any formal Continuing Professional Development or other structured learning. The overwhelming also impression we formed from Dr Joseph's evidence, is that, whilst appearing to pay lip service to the need to improve his records so as to satisfy the Respondent, he does not fundamentally believe that there is any real issue of concern with his clinical practice.

89. In our view the poor quality of Dr Joseph's insight may very well impact on his capacity to improve and effect sustained improvement. Whilst our concerns could engage consideration of removal on efficiency grounds, the possible outcomes should be addressed in ascending order. In the context of this case and the position of the parties, the issue remains: what level of supervision is the minimum necessary to address the risk to patient safety and the efficiency of services, whilst Dr Joseph has the opportunity to develop his insight, and to show that he is able to remediate his practice and effect sustained improvement?

90. The key issue is whether deficiencies in clinical management would be picked up by a clinical supervisor seeing Dr Joseph at the end of the clinical day/session, and that potential risk could therefore be adequately/reasonably mitigated.

91. We accept Dr Sonigra's evidence that whilst it is "possible" that some concerns would be picked up, this would depend on recognition of any issues based on the records made. In a case where serious concerns about the adequacy of Dr Joseph's records have continued, despite promises to improve, we are unable to place any real reliance on Dr Joseph's reassurances that this will not recur. This, together with poor quality of Dr Joseph's insight, would place a very high premium indeed upon the clinical supervisor being able to tease out and rely on Dr Joseph's recollection of the history, any presenting symptoms, what examination he did or did not perform, what negative and positive findings he had made, what diagnoses he had considered, what treatment he had prescribed and/or what he advised by way of signposting/safety netting/safeguarding.

92. We noted that, on the basis of various apparent omissions in Dr Joseph's medical records, the Assessors had decided to reattribute substantial amounts of data collected in the domains of Assessment of the Patient's Condition, Clinical Management and Relationships with Patients to the domain of Record Keeping. In our view this tends to reinforce the inherent fragility of close supervision, (even on an enhanced basis), in a situation such as this: the information on which the safety/efficiency of care can be considered by any "reviewer" must depends on the reliance that can reasonably be placed of the records made. In our view a persistent and longstanding history of inadequate record keeping and serious clinical management concerns have been amply established by the Respondent, such that the stringent measure of direct supervision is the minimum necessary to protect patient safety and the efficiency of services until there is objective evidence of improvement.

93. Moreover, we find there is a clear and obvious risk that situations that require urgent management applying ordinary standards will not be picked up unless a

clinical supervisor is present during any consultation. Case 9 is a clear example of the urgent and time-sensitive need for efficient clinical management at the point of consultation, and where failure to urgently refer posed real risk of serious harm to the patient's safety. The same was illustrated in relation to OSCE stations 10 and 12 – if, in a real-life situation, Dr Joseph's proposed management was such as he had demonstrated to the Assessors. Dr Joseph's management of the scenario at OSCE 8 also illustrated the clear potential for real risk of serious harm to the "patent" if, in a real-life situation, his management plan would be to pursue speaking to the abuser. We remind ourselves that the OSCE scenarios are designed to reflect situations that arise in ordinary practice.

94. Dr Sonigra frankly accepted that the opportunity to address the concerns posed by Dr Joseph's practice could have been addressed by the Respondent at an earlier stage by way of conditions providing structured remediation in line with the recommendation of the 2018 records review and the PAG recommendation. We accept that events were overtaken by the additional complaints and concerns from other bodies such as the Havering CCG and the CQC.

95. Part of Dr Joseph's case is that the responsibility for improving his standards of practice and/or and the cost involved in remediation lies with the Respondent. We do not accept either point. A primary care practitioner is responsible for his own professional standards and development. The vast majority of GPs do not wait for NHSE to impose regulatory measures, and not least when successive record Reviews/audits over three years have shown repeated pattern of inadequate records, requiring attention by the practitioner.

96. Having seen and heard Dr Joseph give evidence we have no confidence that enhanced close supervision (as per his position before the PLDP in October 2019), or the lesser provision of "close supervision" as offered by him to the GMC in December 2019, and/or as still advanced by him in these proceedings in his 2020 witness statement, will reasonably address/mitigate the potential risk to patient safety and the efficiency of services whilst he seeks to remediate his practice.

97. Dealing with other specific points raised regarding direct supervision:

- We find that, even in the context of Covid-19, it is practicable and feasible for a clinical supervisor to attend consultations between a GP and patient (whether the patient and/or the supervisor attends in person, by telephone, on-line etc).
- Mr McDonagh submitted that, other than re GP trainees and other limited circumstances, direct supervision only applies in a hospital setting. Whilst we accept that direct supervision is rarely imposed in primary care, we find that it is, nonetheless, a recognised mode of supervision in primary care see the GMC Glossary. However, we entirely accept that direct supervision is rarely imposed.
- The Appellant's case is that it would dent patient confidence or would prove awkward if another doctor were to be present as a supervisor in any consultation. Of course, we accept that an explanation would need to be

given to the patient that another doctor is observing, and for any intervention, if necessary, to be conducted with tact, skill and diplomacy. In our view this is at least comparable to the same skills that would also be required with enhanced close supervision i.e. in the event that it was discovered at the conclusion of the clinical day that alteration to clinical management, or treatment prescribed, or referral was needed to protect patient safety. We consider in general terms that patients may well be more reassured by care that meets appropriate standards being provided immediately at the time of the consultation, rather than by later review/correction by another doctor who had not been present at the consultation.

98. Mr McDonagh submitted that risk to patient safety is inherent in ordinary general practice. It is true that inefficient care, with the potential for risk of harm, and even serious harm, might arise with any GP, however competent. It is also true that harm can also arise despite the provision of care that meets ordinary standards of general practitioners. However, in this case, the admitted Allegations and the regulatory history demonstrates a repeated, persistent and longstanding pattern of inefficient practice on the part of Dr Joseph which poses a real risk of harm, including serious harm, to patient safety.

99. We have considered the other matters raised:

a) Dr Joseph contends that direct supervision is impossible, or impractical, or unworkable in all the circumstances, including in current circumstances regarding Covid-19. His evidence was that the two doctors (at two different practices) to whom he spoke advised him about cost, and each said that they would be unable to assist during the current pandemic. He said that only one of the two practices was a training practice (which on any basis is a requirement even under close supervision as per the GMC undertakings). He told us that he had made these enquiries in the last few weeks before the hearing. However, his undated witness statement which was served in about February 2020 (i.e. pre-lockdown) had referred to a similar outcome to these enquiries. Dr Joseph's explanation for this apparent inconsistency was confused. Dr Joseph also said that he was unable to provide the names, or evidence, from either doctor because they did not wish to reveal their identities. In all the circumstances we are unable to place much weight on the outcome of the claimed inquiries.

b) Dr Joseph acknowledged that he had not taken any steps to contact his LMC or any other body for advice or assistance in finding a clinical supervisor. This seemed at odds with the fact that the "enhanced" supervision which the Appellant had offered before the PLDP, and the undertakings he subsequently offered to the GMC, require "close" supervision: (i.e. a clinical supervisor who <u>has</u> to be a GP trainer, and <u>approved</u> by the RO). Dr Joseph's explanation was that he has been awaiting his appeal.

c) We noted that Dr Joseph had not taken the opportunity to provide independent or documentary evidence regarding the financial consequences of different levels of supervision or the claimed "impossibility" of direct supervision on financial or other grounds.

d) Although we accept that this may be difficult to arrange, we do not accept that it is "impossible" to obtain direct supervision. On the evidence before us we do not accept that Dr Joseph has made sufficient/appropriate/suitable inquiries regarding direct (or any other form) of supervision.

e) It was very clear that a significant issue for Dr Joseph is that of cost. We entirely understand that concern. However, taken to its logical conclusion, primary care practitioners, whose practice might require investment and/or acceptance of no/reduced income for a period, so as to address basic standards/needs regarding patient safety, could simply seek to avoid regulatory measures considered necessary on personal financial grounds. Of course, we accept that the cost involved in direct supervision for Dr Joseph will be very high, and significantly greater than the expense involved in "enhanced" close supervision that he had offered to the PLDP in October 2019, or even the close supervision offered and accepted by the GMC in February 2020.

f) It is also argued that a condition of direct supervision is tantamount to removal because the cost is prohibitive. Dr Joseph told us in very clear terms that even if the cost of supervision was £2,000 he would not spend that sum. He said that he could not afford to pay for supervision because he is on a pension and has a mortgage. He also said that he is in the process of selling the practice building and this was imminent.

g) We do not accept that Dr Joseph is unable to afford the cost of direct supervision. In our view all the evidence considered in the round shows clearly that Dr Joseph has set his mind against direct supervision because he does not really believe that there is anything wrong with his practice.

100. We find that direct supervision, and each of the related conditions devised by the PLDP, is the minimum necessary to protect patent safety and the efficiency of services in the circumstances of this case, whilst the Appellant seeks to remediate his practice. We accept that the conditions imposed will involve very significant personal cost to Dr Joseph which he has clearly said he is unwilling to meet. Mr McDonagh submitted he may change his mind. We bear this fully in mind. In our view Dr Joseph's "willingness" (or even his ability to afford the cost involved) should not affect our objective assessment of "necessity". We consider that the impact of cost and all other personal impacts are matters that fall to be weighed in the balance when considering proportionality.

101. We do not accept that the imposition of direct supervision "prevents" Dr Joseph from resuming practice, or is tantamount to removal for any of the reasons advanced. In our view the reality is that Dr Joseph has a personal and professional choice to make as to whether or not he wishes to invest in the services of a direct clinical supervisor for a period to enable his resumption of practice on the basis of conditions that we have found are the minimum necessary to seek to address the risks posed his practice.

102. By way of cross check, we summarise our findings by reference to Article 8 of the ECHR, and applying a stage by stage analysis:

1) Dr Joseph's career and his ability to earn his living is part and parcel of his private life interests.
2) The imposition of conditions represents an interference with his private life interests that engages Article 8(2).
3) The Respondent has satisfied us that direct supervision, and each of the other conditions proposed, are the minimum measure necessary to seek to prevent prejudice to the efficiency of services and to protect patients from the real risk of harm, including the risk of serious harm, whilst Dr Joseph seeks to remediate his practice.
4) We are satisfied that each and every one of the conditions (as set out in Annex A to the PLDP decision) are justified in pursuit of the legitimate public interest in the efficiency of primary health services and the interests of patient safety.
5) The ultimate issue of proportionality requires a careful evaluation of the strength of Dr Joseph's interests, balanced against the strength of the public interest engaged. We address this below.

103. We have considered all of the matters on which reliance is placed. We attach significant weight to Dr Joseph's interests in his ability to resume his career as a GP. We take into account the public interest in the retention of the services of a GP who had served his community as a GP since 2001, and with no concerns prior to 2014. We recognise all the impacts upon him in terms of his career and his position in the community. We also take into account the very significant cost involved when imposing conditions on his practice at the very highest level of supervision.

104. We have balanced all of the impacts upon Dr Joseph's private life interests against the public interest. We attach very significant weight to the public interest in the efficiency of services and the protection of patient safety. In our view the protection of the public interest very clearly outweighs the impact of our decision upon Dr Joseph's private life interests, as well as the countervailing public interest on which he relies. We find that the imposition of direct supervision (and related conditions) in the identical terms as imposed by the PLDP is fair, reasonable and proportionate.

105. The Respondent's position is that the need for the continuation of direct supervision will be actively reviewed, with a view to early return to the PLDP for consideration of reduction of conditions as appropriate. In response to the panel's query, the Respondent said that a condition requiring a date for PLDP review could be made. In the event, we do not consider it appropriate to specify any case numbers and/or time limit regarding the duration of conditions, (as had been proposed before the PLDP), and/or to add a condition regarding a review date by the PLDP. In our view a prescribed/set review date could prove unhelpful and counter-productive to the rationale of the conditions - which is to provide the opportunity for Dr Joseph to demonstrate his ability to remediate his practice. A set review date may militate against flexibility, and not least in the context of Covid-19.

106. We attach the conditions we impose in our redetermination as Annex 1.

## THE DECISION

107. **We dismiss the appeal.**

**Judge Siobhan Goodrich**

**First-tier Tribunal (Health Education and Social Care)**

**Date Issued: 05 January 2021**

# [2019] 3893.PHL
# Dr Puthenparampu Antony Joseph v NHS Commissioning Board

## Annex 1 to the Decision of the First-tier Tribunal dated 05 January 2021

**1. Notification**

1.1. You must notify NHS England's Responsible Officer or nominated deputy within 7 calendar days of the date of these conditions taking effect of:

1.1.1. The details of all current posts, including job title, location and responsible officer or nominated deputy information;

1.1.2. The contact details of all employing and or contracting bodies including those of your direct line manager;

1.1.3. The details of any organisation on whose medical list you are included; and

1.1.4. The contact details of any locum or out of hours agency you are registered with.

1.2. You must notify NHS England's Responsible Officer or nominated deputy of:

1.2.1. Any posts you accept before commencement of that post;

1.2.2. Any formal disciplinary proceedings by any employer or contracting body within 7 calendar days of being notified of such proceedings;

1.2.3. Any complaints relating to you as a practitioner within 2 working days of that complaint being received by you; and

1.2.4. Any serious incident immediately upon receipt by you.

**2. Practice Setting**

2.1. You must only work:

2.1.1. As a salaried GP or in a locum/fixed term post of more than four weeks in duration; and

2.1.2. In a group practice setting:

2.1.2.1. Where there is a minimum of two GP partners or permanently employed GPs (excluding yourself);

2.1.2.2. Who are registered on the GP register; and

2.1.2.3. Who are on the NHS Performers List.

2.2. Approval as to practice setting must be obtained from your Responsible Officer or nominated deputy.

2.3. You must not start or restart work until the approval specified at condition 2.2 has been obtained in writing.

**3. Clinical Supervision**

3.1. You must be supervised in all posts by a clinical supervisor **(**"the **Clinical Supervisor") )** or a suitable named deputy ("the **Deputy Clinical Supervisor").** That level of supervision to be direct supervision in the case of either the Supervisor or Deputy Supervisor, as defined by the GMC's Glossary for Undertakings and Conditions.

3.2. The Clinical Supervisor and Deputy Clinical Supervisor should be nominated by you and the detail of the arrangements for the supervision approved by NHS England's Responsible Officer or nominated deputy.

3.3 You must not start or restart work until the approval specified at Condition 3.2 has been obtained in writing.

3.4. You must:

3.4.1. Meet with your Clinical Supervisor and Deputy Clinical Supervisor, in person:

3.4.1.1. At least once a fortnight for a case-based discussion; and

3.4.1.2. At least once a week for a feedback session.

3.4.2. Seek a report using the template supplied by NHS England ("the **Clinical Repor**t"); from the Clinical Supervisor and Deputy Clinical Supervisor on:

3.4.2.1. A fortnightly basis for the first three months of the conditions taking effect; and

3.4.2.2. Monthly thereafter; and

3.4.3. Provide NHS England with a copy of the Clinical Report and any notes of discussions and agreed actions arising from those meetings within 7 days of the Report being completed.

**4. Educational Supervision**

4.1. You must:

4.1.1. Have an Educational Supervisor, approved by your Responsible Officer or nominated deputy;

4.1.2. Meet with your Educational Supervisor once a month to discuss educational need and professional development ;and review progress against your enhanced personal development plan, referred to at Condition 6 below;

4.1.3. Seek a report using the template supplied by NHS England ("the **Educational Report");** from the Educational Supervisor on a monthly basis;

4.1.4. Provide NHS England with a copy of the Educational Report and any notes of discussions and agreed actions arising from those meetings within 7 days of the Report being completed.

4.2. You must not start or restart work until the approval specified at Condition 4.1.1 has been obtained in writing.

**5. <u>Exchange of Information for Supervisory arrangement</u>**

5.1. You must allow the Clinical Supervisor, Deputy Clinical Supervisor and Educational Supervisor to exchange information with NHS England, as relevant, to include:

5.1.1. Compliance with these conditions;

5.1.2. Details of any complaints and concerns; and

5.1.3. Any other relevant information.

**6. <u>Personal Development Plan</u>**

6.1. You must:

6.1.1. Work with NHS Resolution to develop a Personal Development Plan ("the **PDP**"), approved by your Responsible Officer (or their nominated deputy) with the specific aim of addressing:

6.1.1.1. Deficiencies in the following areas of your practice:

(a) History taking and examination;

(b) Clinical management;

(c) Appropriate use of national and local guidelines;

(d) Safety netting:

(e) Safeguarding;

(f) Record keeping;

(g) Coding;

(h) Prescribing; and

6.1.1.2. Any other educational needs identified by: your Educational Supervisor, Clinical Supervisor, Deputy Clinical Supervisor, Responsible Officer or nominated deputy.

6.1.2. Submit:

6.1.2.1. The PDP to NHS England for approval within 4 -6 weeks of the date of

these conditions taking effect; and

6.1.2.2. Updated versions of the PDP to NHS England for approval on a monthly basis.

6.1.3. Meet with NHS England Responsible Officer, nominated deputy or NHS England representative when requested to discuss achievement against the PDP.

**7. Out of Hours and Locum Work**

7.1. You must not work:

7.1.1. In any out of hours or on call post; or

7.1.2. In any locum post or fixed term post of less than four weeks in duration.

7.2. You must obtain approval in writing from your Responsible Officer (or nominated deputy) prior to the undertaking of work specified in Condition 7.1.2.

**8. Co-operation**

**8**.1. You must:

8.1.1. Provide to NHS England within 7 days of receipt:

8.1.1.1. A copy of any report, advice or response relevant to you performing NHS primary medical services; and

8.1.1.2. Details of any action taken, relevant to the provision of NHS primary medical services.

8.1.2. Provide appropriate responses within requested timescales to all communication from NHS England; and

8.1.3. Meet, upon request, with any NHS England representative to review your progress against these conditions.

**9. Exchange of Information - General**

9.1. You must allow NHS England to exchange information relevant to these conditions with any person, organisation or contracting or employing body, including but not limited to:

9.1.1. Any organisation or person employing or contracting you to provide medical services;

9.1.2 Any prospective employer or contractor employing or contracting you to provide medical services;

9.1.3. Any regulatory body;

9.1.4. Your Clinical, Deputy Clinical and Educational Supervisor/s;

9.1.5. NHS Resolution; and

9.1.6. Any healthcare professional.

## 10. Notification

10.1. You must inform the following persons and provide NHS England of confirmation of having done so in writing, within 7 calendar days of the date of these conditions taking effect:

10.1.1. Any organisation or person employing or contracting you to provide medical services immediately;

10.1.2 Any prospective employer and/or contracting body employing or contracting you to provide medical services, at the time of application;

10.1.3 Any locum agency or out of hours service you are registered with;

10.1.4 Your medical indemnity provider immediately;

10.1.5 The General Medical Council immediately;

10.1.6 Your Clinical Supervisor, Deputy clinical Supervisor and Educational Supervisor immediately upon appointment; and

10.1.7 NHS Resolution upon engagement.