Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

[2018] 3496.PHL

Heard on 21-23 May 2019 at Cardiff Crown Court

BEFORE
Judge Judith Crisp
Specialist Member Dr Joan Rutherford
Specialist Member Ms Libhin Bromley

BETWEEN:

Dr Andrew Gilbey

Applicant

v

Abertawe Bro Morgannwg University Local Health Board

Respondent

DECISION

1. The Applicant has applied for a review of his national disqualification pursuant to an application dated 14th October 2018.

2. The Applicant represented himself and the Respondent was represented by Mr. David Story of Counsel. Both parties had helpfully provided skeleton arguments before the hearing commenced.

3. The Tribunal had the benefit of written evidence contained in 2 ring binders and heard oral evidence from the Applicant and Dr. Mark Goodwin on behalf of the Applicant and Hilary Dover and Dr. Alistair Roeves on behalf of the Respondent.

Background

4. This case has been before the Tribunal, initially the FHSAA in 2008-2009 the predecessor of this Tribunal; this Tribunal in 2012, 2013 and 2015. There have also been applications to the High Court by way of appeals.

5. In September 2006 the Applicant who was at that stage practising as a sole practitioner was referred to the National Clinical

Assessment Service (NCAS) following a complaint raised against him. He had worked in both the Cwmllynfell and Ystalyfera practices from 1998 until 2007. On the 25th September 2007 the full report was received and identified areas of inconsistent performance, including patient communication, respect and trust with patients, sharing information with colleagues and eight areas of unsatisfactory performance including assessment of patients, examination technique, management of patients, infection control, prescribing, record keeping, obtaining consent and keeping up to date. The report recommended that the Applicant should not practise independently until a period of supervised retraining of up to 12 months had been completed.

6. A placement was arranged at an Advanced Training Practice (ATP) at the Old School Surgery (OSS) and that commenced in February 2008. That placement failed after two months due to concerns about the Applicant's failure to engage with the training programme.

7. On the 9th June 2008 the Applicant was removed from the Performers List and that decision was appealed by the Applicant. On the 8th December 2008 the FHSAA upheld the appeal and imposed a contingent removal with a finding that the Applicant had caused prejudice to the efficiency of the service. The contingent removal placed a condition that the Applicant should not from the date of the decision work in any capacity as a NHS GP except under the supervision of a work place supervisor.

8. In January 2009 the Applicant underwent a GMC Primary Care Performance Assessment. His performance identified acceptable practice in 5 areas but a cause for concern in three others, which overlapped the concerns identified by NCAS in 2007.

9. The conditions relating to the contingent removal were subject to variation in March 2009 and on the 15th May 2009 however the variations in each case retained the condition not to work unless under supervision.

10. In July 2010 following a Fitness to Practice Panel the GMC imposed conditions which included supervision requirements. Those were extended in July 2011 and subsequently removed in 2012.

11. On the 6th April 2011 the Applicant applied to revoke the conditions imposed by the FHSAA in 2008/9. That application was compromised by a consent order dated 23rd April 2011 and required the Applicant to complete all elements of retraining identified on the order which included retraining in an ATP for a period of 12 months. The conditions, which also incorporated the GMC conditions, required the Applicant to work under supervision.

12. In accordance with the agreement the Applicant underwent a further assessment by the local Deanery in late 2011. The results of that assessment produced low scores in respect of problem solving, integrity, empathy and communication which mirrored the concerns of NCAS in 2007 and the GMC in 2009.

13. The ATP placement was cancelled after receipt of that report on the 27th January 2012.

14. The Applicant applied to vary the conditions and on the 13th June 2012 the First Tier Tribunal under reference (2013.PHL 1458) found that there would be significant risks to the public from a doctor who had remediation needs and had been away from practice without undergoing at least 6 months in an ATP.

15. On the 23rd September 2012 the Applicant commenced work for Medac Medical Agency as a locum GP. He did not disclose his contingent removal to the Agency. He worked unsupervised until 29th October 2012.

16. The LHB removed the Applicant from the Performers List in December 2012 for failure to comply with conditions pursuant to the contingent removal. The Applicant appealed that decision. The decision on the 25th June 2013 under reference (2013.PHL.15549) upheld the decision and imposed a national disqualification. That decision was the subject of a permission to appeal lodged by the Applicant which was refused by both the FTT and Upper Tribunal. The following facts were found:

    a) That the Applicant had failed to complete the ATP placement.
    b) That the failure to disclose the contingent removal was not an error of judgement but a conscious decision
    c) That the Applicant lacked insight and did not acknowledge he had any need of retraining or undertaking a refreshers' course
    d) That the assessments had all found similar deficiencies.

17. On the 29th June 2015 the Applicant applied to revoke the national disqualification. Following a hearing under reference (2015.PHL.2458) on papers only the Tribunal refused the application and extended the time for review to a period of 3 years. That decision was subject to an application for permission to appeal which was refused pursuant to an Order dated 22nd June 2016. The following facts were found
    a) That the national disqualification remained appropriate and proportionate.
    b) The history showed that the Applicant had had a number of chances and indeed 'last chances' and that considerable resources and support had been put in place to try and remediate him

c) It was inevitably more difficult as time passed to go back into practice but the Applicant had not taken up the opportunities of support from colleagues to assist him.
d) There was clear evidence of a lack of reflection, an inability to let go of the past however the FHSAA had balanced that with his 20-year practice and offered a further last chance which they advised was 'vanishingly small'
e) It was accepted that the clinical skills had not been an issue but the work he had undertaken in hospital settings, cruise ships and e-learning did not deal with the primary concerns relating to communication, empathy and decision-making skills relevant to a GP. His work over the last few years was very different to working in general practice.
f) The Applicant was unlikely to be successful in undergoing training which he had identified and had compounded that by a failure to disclose. The suggestion that the Applicant could be conditionally included would give rise to the risk of prejudice to the efficiency of the service. There were no grounds for optimism that the training would be successful when it had not been completed on 4 different occasions.

Legal Framework

18. The Applicant's National Disqualification was made pursuant to Regulation 18A of the NHS (Performer list) Wales Regulations 2004. The Applicant is therefore not able to be included in either an English or Welsh Performers List pursuant to Section 115 NHS (Wales Act 2008).

19. Pursuant to Regulation 18A (6) the FTT may at the request of a person upon whom has been imposed a national disqualification review that disqualification and not to do so before a period of 2 years. On a review under 18A (6) the Tribunal may confirm or revoke that disqualification.

20. The Respondent requests that in the event the FTT upholds the National Disqualification then the Tribunal should utilise its powers under Regulation 19 (2) of the NHS Performers Lists (Wales) Regulations 2004 to extend the period of review so that the Respondent is not required to respond to annual applications.

21. The issues for the Tribunal to determine as stated by Judge Khan in his order dated 13th March 2019 are:
a) Whether it can be satisfied that the Applicant has demonstrated that he no longer continues to pose a significant risk to patients and the efficiency of the service, such that the national disqualification can be revoked, and
b) Whether it can be satisfied that in revoking the national disqualification, prospective employers and patients will be

adequately protected by placing the Applicant in the position where he would be free to apply for inclusion on a Performers List.

22. Primary Medical Performers Lists; Delivering Quality in Primary Care – national disqualification should be reserved for the most serious cases.

23. The FTT were referred to the cases of Luthra V GMC; R v Porter; Bevan v NHS Wales; Palahey v NHS Commissioning Board; GMC V Sheil; Birch v Aneurin Bevan LHB.

24. In addition, the FTT had the benefit of the previous cases in respect of the Applicant.

25. The Applicant's case is:
    a) That since the contingent removal in 2008 he has worked in NHS secondary care in specialities of Emergency Medicine, General Medicine, Intensive Care, Trauma and Orthopaedics and in Intensive Care
    b) He has provided primary care services in several maritime and remote medical locations
    c) He has an extensive portfolio of continuing medical education over the years across the full spectrum of Good Medical Practice that has addressed alleged criticisms of the Applicant's professional capability by NCAS and GMC 10 years ago
    d) He has completed the vast majority of the NHS e_LFH General Practice modules and other CPD activities
    e) Removal of the National Disqualification would allow the Applicant to apply for the NHS Induction and Refresher Scheme.
    f) He has undergone annual appraisal for several years (14-18) and was successfully revalidated by the GMC in July 2017.

EVIDENCE

26. We read two bundles consisting of 1322 pages. In addition, on day two of the hearing and day three of the hearing the Tribunal permitted further evidence filed by the Applicant which consisted of two witness statements, the Applicant previously having said he would not be giving evidence together with further documents. The application to admit such evidence was not opposed by the Respondent. The Tribunal accepted that the evidence of the Applicant was both relevant and necessary to the issues which it had to determine and therefore despite the late filing of such evidence permitted the inclusion.
27. Hilary Dover is the Director of Primary and Community Services for the LHB and has been since August 2015. She provided in her written evidence details of the background to the application. She states that Dr. Gilbey has not worked in General Practice since 2007, a period of over 11 years. The Tribunal has consistently found that Dr. Gilbey requires intensive retraining before he can be

considered safe to return to practice and that he is not safe to practice unsupervised unless such training has been successfully completed.

28. Dr Gilbey was contingently removed between January 2008 and July 2013 and during that time was subject to 4 different sets of conditions intended to achieve the necessary retraining. It has not been possible for Dr. Gilbey to fulfil any of those sets of conditions.

29. Considerable time and resources had been devoted to seeking to return Dr. Gilbey to General Practice to no avail. In 2012 Cwm Taf LHB was obliged to carry out an investigation to reassure itself that none of the patients seen by Dr Gilbey out of hours had come to any harm. The Tribunal had consistently found that risks to the efficiency of the service persisted.

30. In her view e-learning modules could not address the deficiencies in communication and empathy which were of concern in Dr Gilbey's case.

31. The proposal which is put forward now is essentially the same as that put forward in 2015. There was no evidence as to what had changed which would make this proposal more likely to success than previous attempts.

32. When asked about the case of Dr. Bevan she responded that the cases were different and required different training needs.

33. If the national disqualification were to be revoked, the concerns regarding the deficiencies in his practice as identified in 2007, 2009 and 2011 together with the de-skilling would still need to be addressed. The risk to patient safety can only have been further increased.

34. The LHB was clear in its view that all workable and realistic avenues for the remediation and safe return of Dr Gilbey to practice had already been explored and exhausted.

35. Dr Alistair Roeves is the Medical Director and Associate Medical Director for Primary and Community Care Services and has held that position since 16th November 2016.

36. His evidence is that when he considered Dr Gilbey's application he referred to key documents of the RCGP which described the unique quality skills required of a general medical practitioner. Good Medical Practice describes "what standards are expected of a GP".

37. A good GP meets most of the exemplary GP criteria most of the time and a Poor GP seriously or frequently exhibits the unacceptable GP criteria.

38. The RCGP Curriculum states that core competencies of a general medical practitioner include communication and consultation.

39. Dr Gilbey had been assessed separately by NCAS, GMC and the Welsh Deanery between 2007 to 2011. On each occasion deficiencies were found in areas of empathy, patient communication, respect for patients, patient assessment and management and sharing information with colleagues. It was his view that Dr. Gilbey's behaviour was consistent with the above statement identifying a poor GP. The deficiencies go to the heart of the skills and expertise required.

40. Those risks had been enhanced by the absence from General Practice since 2007. Dr. Gilbey could not now be safer than he was in 2015. There was no realistic prospect of remediation. It was his view that Dr Gilbey remained unsafe to practise.

41. He did not accept that there had been any reflective learning when considering the E-learning.

42. In the GMC benchmarks which Dr Gilbey had completed in two thirds of the domains he was performing relatively poorly compared with his peers.

43. He had considered the evidence supplied by Dr. Goodwin and accepted that Dr Gilbey had been revalidated by the GMC in July 2017 however he had not seen any evidence of insight, reflection or working constructively in teams or a degree of self-awareness. He did not believe that the evidence provided any reassurance that Dr Gilbey had significantly progressed since the assessments and was any more likely to cooperate with the assessments or support in a training practice than in previous attempts.

44. In oral evidence he advised that Dr Gilbey still challenged the fundamental issues of the assessments. He believed Dr. Gilbey maintained a lack of insight. He had had several opportunities to remedy the deficiencies but none had worked.

45. He stated that he could not think of any way in which the shortcomings could be addressed and the fact that Dr. Gilbey had been out of practice for 12 years, utilising the resources available to the NHS.

46. The Induction and Refresher course would not be suitable for Dr Gilbey as that was at a lower level than he required. The evidence which had been produced did not give him any reassurance that any of the concerns raised earlier had been addressed or that Dr Gilbey had developed any more insight.

47. The following day Dr Roeves was recalled about evidence concerning the availability of assessments. Details of the responses are included on emails below:

    a) The GMC does not undertake performance assessments except as part of FtP investigations (and not often then TBH). There is no current FtP investigation open on Dr Gilbey so I'm afraid we would not be able to assist with what is essentially an employment/ contracting issue.
    b) HEIW will only go on to consider the practicalities and possible achievability of a GP remediation referral from an LHB if it comes with an up to date UK level assessment from the GMC or NCAS. HEIW does not have the tools or resources available to undertake an objective, comprehensive assessment of learning needs in often complex remediation or returner situations.
    c)The brief answer is that we have assessed gp's in placements and simulation centres. However, for all our clinical assessments the doctor needs to be carrying out their full role for a minimum of about 3 months in order to have a fair assessment as the process is a workplace based assessment and not a re-entry process. If in this case he has been in broadly equivalent clinical practice that may be suitable. I am only surmising though as our assessment consideration group makes the decision.

48. Dr Goodwin is a general medical practitioner working in a semi-rural practice in the area. He is a post graduate medical tutor. He advised that in a private conversation with Dr Gilbey he accepted he had issues in the past that needed to be addressed but he now wished to work cooperatively and concentrate on his subsequent professional development and commitment to Good Medical Practice.

49. He advised that he did not see why a National Disqualification could not be lifted to allow an induction or refresher course or such other avenue as the parties may agree as Dr Gilbey was sincere in his wish to resume a role in General Practice.

50. Patient safety concerns were not the limiting issues at this stage as until he had successfully completed an induction/refresher course he could not practice in Primary Care.

51. If any concerns regarding patient safety were to arise these could be addressed by the GMC processes and under the Responsible Officer Regulations.

52. If the National Disqualification were to be lifted, Dr Gilbey could embark on satisfying his peers of his suitable achievement in standards and then be unconditionally included in the Performers List.

53. In oral evidence he advised that Dr Gilbey had a problem in addressing the severity of the criticisms levelled at him and letting go of the past.

54. He could not comment on the quality of his work but advised that in some areas Dr. Gilbey was more skilled than himself, for example he could not do advanced life support which Dr Gilbey had been doing.

55. He accepted that it was fundamental to address the deficiencies but advised that Dr Gilbey would do well in an Induction and Refresher course but that it would have to be for a prolonged period. He could not do it now. It could only be achieved though if he accepted his shortcomings and was sincere.

56. He had been out of general practice for far too long and it was his insight that needed to be addressed. The concerns which led to his removal needed to be addressed. He had not yet heard any evidence that Dr Gilbey had said I have these needs and they can be addressed.

57. He would not get on to an ATP now.

58. Dr. Gilbey was well thought of and had enormous patient support. Dr. Goodwin believed that he should do a Deanery assessment and that was the point at which you would know whether to progress. He needed to move forward and if Dr. Gilbey's view remained 'I do not think I did anything wrong' it would not work.

59. Dr Gilbey in his initial written statement stated that there was no mention of the word empathy within the NCAS report. There was evidence that NCAS did not properly consider his comments in accordance with Operational Guidance. In the conclusion to his response to the NCAS report he accepted the shortcomings of his record keeping. He admitted that he lacked insight into the disquiet of his colleagues at the OSS and he had no idea there was a problem.

60. It had not been conveyed to him that there were any record keeping, prescribing, patient managements or communication concerns.

61. He had not knowingly breached paragraph 5 of the consent order in 2011 and apologised at the 2013 Tribunal hearing for not disclosing the conditions of contingent removal. Any public interest in that misdemeanour had been met by a warning issued by the GMC.

62. He advised that he had not expected to have his learning needs be so reliant on one observation that was not even with a patient. Consequently, he denied that the assessment produced robust

evidence and reliable evidence of severe deficiencies in his communication skills or that he lacked empathy.

63. His multi source feedback in 2012 showed he was caring to all patients, communicating well with patients and staff, a good team player and very accessible.

64. He submits that there is no more than a hypothetical or fanciful risk to patients or employers in removing the National Disqualification. If this was lifted he could apply for the Induction and Refresher scheme and undergo assessment prior to any ATP placement.

65. In his second statement produced on the next day he advised that he wanted the opportunity to demonstrate the required insight into the shortcomings identified and to address them.

66. He was upset having been made aware of the circumstances of Dr John Bevan about the apparent different standards applied by the Board in the two cases. The Board specifically altered Dr Bevan's conditions of contingent removal to mirror the GMC conditions but failed to do so after the cancellation of his training with Dr. O'Dwyer. Dr Bevan had been allowed to work in his own practice.

67. He had engaged in innumerable education, training and clinical placements trying to address any concerns made.

68. He had completed virtually every module of the NHS e-LFH GP programme, often more than once, and kept up to date even though he had not effectively worked in NHS General Practice for more than 10 years.

69. He had not listed every learning event but there was evidence of reflection on learnings in his annual appraisal report.

70. Being out of the NHS caused problems in accessing environments for engaging in appraisal. For economic reasons he did not think he would be able to keep his licence to practice unless he re-engaged with the NHS. Working in Emergency Medicine was extremely demanding physically.

71. For him it was now or never to regain his vocation which was quite saddening after 40 years.

Findings

72. We have considered all the available evidence together with the submissions made by both parties. We have not specifically addressed every point in this decision but have considered the

points raised in the context of the evidence, the Scott schedule produced by the parties and the history.

73. There are elements in Dr Gilbey's evidence that he is beginning to identify some of his problems in that he accepted he was stale as a GP. However, he opened his case on the basis that there had not been an incident which led to the compromise of patient safety, he attempted on the first day of the hearing to re-open previous findings although on the second day he accepted he was unable to do so. His overall presentation was that the assessments were unfair, the LHB should not have reported him to the GMC and had he not agreed to undertake the assessment he would not be in this position today.

74. That statement is indicative of his reluctance to accept the deficiencies in his practice as identified by 3 separate bodies.

75. He has failed to accept the decisions and findings of previous Tribunal hearings, he does not accept the assessments, he does not accept he breached the conditions, more that he did not complete them, he does not accept his removal was justified and continues to state that none of the concerns are matters which fall within the criteria for removal specified under Regulation 11 of the NHS Performers List Regulations Wales 2004.

76. We find that the Applicant continues to lack insight. He continues to fail to accept the entirety of the NCAS report, supported by his witness who gave evidence that it was 'more wrong than right'. He accepted that he had in part issues regarding notetaking but did not accept deficiencies in other areas. The NCAS report clearly identifies inconsistent performance in patient communication, sharing information, respect and trust. Previous decisions have found both the Deanery assessment and NCAS were not flawed and were fair.

77. His evidence that the communication and behavioural problems have not been specified qualitatively or quantitively again shows a lack of insight as the Deanery assessment clearly shows areas where he scored at the lowest level, scores of 1 indicating that he would be unlikely to reach proficiency at the end of the training and 2 – would need to improve significantly to reach proficiency. It is concerning in the assessment that the Applicant achieved from one assessor scores of one 1, five 2s and one 3 and from the other assessor two 1s and five 2s in areas of problem solving, professional integrity, empathy and sensitivity, communication skills verbal and written and was still unable to accept those areas of concern.

78. His evidence suggesting that any other doctor would fail an NCAS assessment as he did and that the Deanery assessment scores

were atypical and one doctor had described them as weird highlights that whilst he accepts some deficiencies even at this hearing some 12 years after the initial assessment he has been unable to accept the conclusion of both reports.

79. We accept that Dr. Gilbey has undertaken e-learning but it is unlikely that the areas which needed to be addressed have been so addressed when the lack of acceptance is present. We accept the evidence of Dr. Roeves that the e-learning does not show reflection.

80. Although in evidence Dr Gilbey accepted he may have communication difficulties with colleagues and the failure in Lampeter (being the surgery rotation whilst he was working in a hospital) was due to interpersonal relationships for which he was responsible, he did not during the hearing accept he had any communication difficulties with patients.

81. The issues identified by both assessments together with the GMC assessment and the FTP investigation all raise similar concerns and have not to date been addressed or remediated. The LHB over a period of 3 years put in place varying forms of training to support and remedy the deficiencies none of which have been completed for reasons that are set out in previous judgements.

82. The lack of insight as identified will continue and does continue to cause problems in effectively addressing his training needs. Until the deficiencies are accepted by Dr Gilbey any training in which he may choose to engage will not remedy the considerable concerns as identified in the various assessments.

83. Given the length of time we accept the evidence of the Respondent that the current needs are even more complex than those identified in 2008. The Induction and Refresher course is not designed to meet such complex needs as it is effectively a programme for GPs who are returning after only a relatively short period of time away from practice such as two years.

84. Dr. Goodwin also confirmed that he did not believe the Applicant could access the course now.

85. We accept the evidence as received by Dr. Roeves by email that none of the bodies would be able to offer assessment or training currently. We accept that Dr Goodwin suggested an assessment but he was unaware of the position of NCAS, the GMC and HIEW (previously the Deanery) at the time of his evidence.

86. We accept that Dr Gilbey has tried to maintain practising as a General Practitioner whilst undergoing work as a ships doctor and that he has worked in hospital settings. We accept the evidence of the Respondent that this differs from general practice and this was a finding made by the Tribunal in the 2015 hearing. The only work

undertaken by Dr Gilbey since 2015 was working as a doctor on cruise ships and a period in A and E in February 2016. Since 2017 Dr Gilbey has only worked on a super yacht for two months on 2 occasions. Dr Gilbey was honest in his evidence when he advised he could not take up one position as he was subject to a FTP referral to the GMC in December 2014 whilst working in an emergency department in the hospital which imposed interim orders and conditions requiring him to obtain their approval for any post. Those conditions we accept were the subject of an application to the High Court and removed after August 2015.

87. We accept that it is to the credit of Dr. Gilbey that he has been able to obtain revalidation as a doctor with the GMC.

88. The appraisals and work undertaken clearly meet those requirements however we do not believe that the e-learning has addressed the deficiencies identified in the assessments nor that the employment undertaken is similar to that of a general practitioner. It is appreciably different as also found by the previous Tribunal.

89. Further any employment since the previous review hearing in 2015 is extremely limited and none of the work undertaken is equivalent to that of a General Practitioner.

90. We do not accept that the Respondent has treated Dr Bevan differently as alleged by the Applicant. We accept that the two cases differ. Whilst Dr. Gilbey suggests that the Respondent did not alter the conditions to mirror the GMC conditions the consent order clearly incorporated those conditions. It is accepted that the GMC conditions were subsequently removed however the reason Dr Gilbey was unable to practice unlike Dr. Bevan was that he was found to have breached several of the conditions whilst working which was not found to be an error of judgement by Judge Meleri Tudor in her 2015 decision (which led to Dr Gilbey's removal and subsequent imposition of a national disqualification). Judge Tudur found that it was 'deliberate and a part of Dr. Gilbey's strategy and a means to an end and directly contrary to Good Medical Practice – which advised that you must always be honest about your experience, qualifications, position particularly when applying for posts'

91. We further accept the evidence of the Respondent that the training needs are different as the problems of the two doctors are different.

92. Since 2008 the Respondent has attempted with considerable resources being utilised to remediate Dr Gilbey. It will unavoidably be more difficult now as he has been out of GP practice for over 12 years. We are aware of the considerable financial burden of setting up assessments and ATPs and all of those have failed.

93. We also accept the evidence contained in the emails forwarded to us during the hearing that neither NCAS, the GMC or HEIW can provide any assessments for Dr. Gilbey for the reasons as set out.

94. We accept the Respondent's submission that Dr. Gilbey would not be accepted onto such a programme as the Induction and Refresher programme as he wishes and further we also accept that it would not meet his needs. We believe that he requires a bespoke package of training to address the deficiencies and there is no guarantee that Dr. Gilbey would complete any such programme when arrangements have failed on several previous attempts.

95. At the review hearing in 2015 the Tribunal found that there were no grounds for optimism that Dr. Gilbey would be successful given the chances he has had in obtaining inclusion on the Performers List. There was a risk to the prejudice of the efficiency of the service if he were to be conditionally included.

96. The history of this case is set out at the beginning of this decision. There have been repeated attempts to try and remediate Dr. Gilbey over a period of many years and the last Tribunal hearing found as detailed above. Dr. Gilbey is now four years on since that decision and the evidence advanced on his behalf is less than that which was before the Tribunal in 2015. He has not undertaken effective work as a GP for over 12 years, his e-learning which we accept is relevant to keeping up to date has not addressed the important deficiencies set out by the assessments and no material changes or advancements have changed since the last review hearing.

97. We are not satisfied that Dr. Gilbey has demonstrated that he no longer continues to pose a significant risk to patients as the deficiencies identified in 2008 and 2011 remain unaddressed. Further during this period there was been a serious issue of non-disclosure leading to Cwm Taf LHB having to check all patients seen by Dr. Gilbey over the period he was employed as an agency doctor in an out of hours GP service.

98. We find for all the above reasons that Dr. Gilbey also poses a risk to the efficiency of the service.

99. Whilst we accept that Dr. Gilbey may be unable to continue to work as a GP as he may be unable to renew his licence it is proportionate and necessary for the National Disqualification to remain in place for the safeguarding of both NHS patients and resources. There is no evidence in this application that any of the circumstances have changed since the imposition of the National Disqualification in 2013 and certainly the evidence now is less than that before the Tribunal in 2015 due to the passage of time that has elapsed.

100. We have been asked to consider the period of review. We have found that there is no realistic prospect of success if a further review was applied for within three years of the date of this decision and we accept the submission by the Respondent that to have to respond to annual applications would be an unreasonable and disproportionate use of resources.

Order

1. Application dismissed.

2. The directions pursuant to Regulation 18A of the NHS (Performers Lists) (Wales) Regulation 2004 that the Applicant, Dr. Andrew Gilbey is hereby nationally disqualified from inclusion in:

A) a Performer's List and

B) a list referred to in section 49N (1) prepared by a Local Health Board

3. Dr Andrew Gilbey shall be the subject of a National Disqualification pursuant to Regulation 18A of the NHS (Performers Lists) (Wales) Regulations 2004 and should not be included in the performers lists in England. As set out in the order dated 25th June 2013 are hereby confirmed.

4. Pursuant to Regulation 19(2) Regulations 2004 no request for review of that disqualification may be made before the end of the period of three years beginning with the date of this decision on the last review.

Judge Judith Crisp
Primary Health Lists
First-tier Tribunal (Health Education and Social Care)

Date Issued: 04 June 2019