PRIMARY HEALTH LISTS

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

[2016] 2904.PHL

Between

NHS Commissioning Board
(Midlands & East (East))

Applicant

v

Dr Saida Noorah

Respondent

Tribunal Panel

Judge: John Burrow
Specialist Member: Dr Gopal Sharma
Specialist member: Mrs Mary Harley

Hearing at: Royal Courts of Justice, on 4 April 2017

DECISION

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1. On 23 June 2016 Dr Noorah was suspended from the Medical Performers List (MPL) by NHS Commissioning Board (the Board) under the provisions of the Regulations 12 and 16 of the NHS (Performers Lists) (England) Regulations 2013 (the Regulations). The suspension was for 6 months, expiring on 23 December 2016. On 22 December 2016, the Board applied to the First Tier Tribunal for an extension of the suspension, pursuant to the provisions of Regulations 12(16). On 18 January 2016 Dr Noorah appealed against this application. It was this appeal which was considered in the current proceedings.

2. The Applicant (the Board) was represented by Ms Atkin, Ms Hughes and Mr O'Connell of Brown Jacobson. They called Dr Lipp, Medical Director of the Midlands and East Area Team of NHS England as a witness. The Respondent (Dr Noorah) was represented by Ms Montraghi of counsel and Ms Dolatshah of Berrymans Lace Mawer solicitors. They called Dr Noorah as their witness. Mr Ramjan was present as an observer.

3. We did not feel it possible or necessary to determine whether or not Dr N was disabled for the purposes of the 2010 Act, although we fully accepted the need to have regard to the Equal Treatment Bench Book.

Accordingly we took a number of steps to facilitate Dr N's ability to give evidence.

4. With these assurances and safeguards both Dr Noorah and her counsel agreed to proceed with giving evidence and being questioned. During this process, breaks were given, repeat questions were prevented, warnings given about self-incrimination and the time she was giving evidence was relatively short. No complaint was made in respect of the process.

5. There was an agreed hearing bundle, consisting of the written evidence of both parties, orders, submissions, appeal and response documents, witness statements and other documents. Further evidence was served before the hearing by both parties, including skeleton arguments, supplementary witness statements, training certificates, NHSE Toolkit for Managing Performance Concerns and General Medical Council (GMC) document 'Good Medical Practice". A further folder was served at the hearing containing the appendices to the NHSE Investigation Report.

The evidence

6. Dr Noorah became a qualified General Practitioner in 1989. She joined Grafton Surgery in 1994 when there were 5 other GPs. By 1 April 2014 the other GPs had left the practice. She was at relevant times the sole GP partner, although salaried and locum GPs were engaged. On 1 September 2015, another GP partner joined the surgery.

7. The Care Quality Commission (CQC) inspected Grafton Surgery on 15 June 2016. Several concerns were identified, including inconsistencies in data, inadequate governance framework, including a lack of data, incomplete training records and infection control audits, lack of evidence to show Medical and Healthcare products Regulatory Agency (MRHAs) alerts or patient safety alerts were acted on, unsigned Patient Group Directives (PGDs), staff reports of lack of leadership and support. The practice was rated as inadequate.

8. These concerns led to a second inspection on 21 June 2016. A number of concerns were identified in the subsequent CQC report including inadequate monitoring of methotrexate, azathioprine and ACE/A2RB medication. Further concerns were in relation to a MHRA alert not being actioned following a contraindication of simvastatin and amlodipine, and an apparent lack of training in respect of the minor surgery being carried out by Dr Noorah.

9. Some of these concerns were assessed as major, with some raising risk of death or renal damage. The volume of patients was not small. Some 250 patients had not had the required monitoring for renal function. The CQC report said there was a risk of repetition because control measures were minimal and ineffective. The concerns were such that they led to an application for urgent cancellation of the surgery's registration on 27 June 2016 which was granted. Dr Noorah subsequently appealed this decision on 24 August 2016 to the First Tier Tribunal (FTT) who upheld the decision. This in turn was appealed by Dr Noorah to the Upper Tribunal (UT) on 19 September

2016, and on 5 January 2017 she was given permission to appeal by the UT.

10. On 22 June 2016 the CQC referred its concerns about Dr Noorah and the surgery to NHSE. The concerns referred to by the CQC included that patients had been reported as receiving services they had not in fact had, with the result payments were likely to have been received in respect of work not done. This was a potential Quality Outcomes Framework (QOF) fraud. Other concerns, as set out above, were also referred.

11. On 23 June 2016, Dr Noorah was suspended from the Medical Performers List pursuant to regulations 12(1)(a), 12(1)(b) and 12(6) of the Regulations, to enable investigation of the concerns to take place. The decision to suspend Dr Noorah was reviewed by the Performers List Decision Panel (PLDP) on 24 June 2016, in accordance with regulation 12(7)(b) of the Regulations. The PLDP noted the large number of concerns affecting a large number of patients, with monitoring inadequacies in particular posing a high risk. The PLDP upheld the suspension.

12. On 27 June 2017, Dr Noorah was informed of the suspension, and of the concerns of the PDLP across all four domains of the GMC "Good medical practice", including inadequate monitoring, inadequate safety processes and patients not receiving services where it had been recorded they had had them. Dr Noorah was informed that NHSE would hold a review hearing, at which she could, if she wished, appear and give either written or oral evidence.

13. The PDLP oral review hearing took place on 2 August 2016. Dr Noorah was advised by her legal adviser not to attend, and she did not attend and was not represented and did not provide any written evidence. The panel had regard to the concerns listed in the CQC report, to other written and oral evidence and concluded continued suspension was necessary for protection of patients and members of the public, or was otherwise in the public interest.

14. They noted significant concerns about patient safety, including a risk to patient safety for patients who had not received cervical smears, diabetic foot checks or renal function checks. They noted the issues were widespread. They were deeply concerned about apparent failure to implement MHRA alerts. The apparent false reporting of diabetic foot checks was a risk to patient safety because patients were not properly monitored, and the false records had the potential to mislead future treating clinicians. The panel were also concerned about the impact on the public interest of a possible QOF fraud may have occurred. The suspension was upheld to remain in place until 23 December 2016, subject to any review.

15. On 29 June 2016, NSHE commissioned an Investigation Report to be carried out by two independent firms of solicitors. The report was published on 11 November 2016. The Investigation found a number of concerns. There was inaccurate and inadequate record keeping, and some prescriptions were not being recorded at all. There was a failure

to code cervical smears, and diabetic foot checks accurately.

16. In respect of cervical smears, the investigators were told by a member of staff that Dr Noorah had instructed that patients requiring a smear test be sent reminder letters, but were then to be immediately coded in surgery records as having refused a smear. This would prevent follow up for non-attenders and is a risk to patient safety and may prevent a clinician subsequently treating a patient from offering a smear test. This practice had been going on for 5 or 6 years. Some 542 patients were found to have had a 'smear refused' coding added to their records. There was no evidence in the records these patients had actively refused a smear by returning a letter or mentioning it during a consultation. Further many of the patients had actually had a smear test. This process was considered inappropriate. Apart from creating risks to patients it also led to inappropriate QOF payments for a target which has not been reached.

17. Dr Noorah denied to investigators giving the instruction to simultaneously code a refusal. The investigators noted there was no incentive for the staff member to do this uninstructed, but there was an incentive for Dr Noorah to give the instruction – namely inflated QOF payments. The Investigation concluded the staff members account was more plausible, and that the process raised a serious probity issue on behalf of Dr Noorah.

18. In respect of diabetic foot checks, Dr Noorah had documented checks for 26 patients at 10:10 pm at night in March 2016, very shortly before a QOF cut off. The CQC contacted two patients who said they had never had a diabetic foot check at the surgery. This had the potential to impact on patients who might benefit from a check, not being offered one.

19. The only way records could be amended in this way was by Dr Noorah using an algorithm on the clinical software. Dr Noorah told investigators that she was correcting a failure by a staff member to fully complete the diabetic template correctly, but Dr Noorah could not explain the basis on which she could evidence this. The staff member's account was that if she saw a patient she would enter a full account in the clinical record. Also investigators found the majority of patients were not seen by the nurse at all and Dr Noorah was not present at the assessment and could not have known whether a check was or was not done. As well as creating the risks to patients set out above, these false entries would result in inappropriate QOF payments being made for work which had not in fact been done.

20. There was a further probity concern relating to a request by Dr Noorah to Dr R to back date patient comments given in a patients' satisfaction survey in preparation for the CQC visit. Dr Noorah denied the request, even though it was said to have happened by Dr R. Subsequently an email exchange was produced to the investigators in which Dr Noorah said on 4 June 2016 "Please try to do a short report that we can use for CQC, we received this in February maybe date it around 2-3 weeks later". Dr R replied on 5 June 2016, "I am afraid I cannot back date this report as this would mean falsifying records to the CQC, which is

entirely against protocol. Furthermore I was not aware of this report until I received this email."

21. The Investigation Report concluded there were probity concerns in addition to the cervical smears, diabetic foot inspections, and backdating patient satisfaction comments. These additional probity concerns were the inclusion of blood pressure readings and smoking information, where there was no clear evidence the patient had actually been seen. Further there was the addition of information about the refusal of influenza immunization without clear evidence that the patient had refused in a consultation or had provided any evidence of refusal. Further there was an addition of information to patients' records on 31 March 2016 where there had not been a patient attendance or any other source for the information.

22. The investigation recommended further review of records to establish veracity, transfer of the NHS contract, contacting patients who had left the surgery and their GPs to warn records may be unreliable. The investigation recommended a referral to the PDLP for consideration of removal from the NHS Performers List, referral to the GMC and referral of the report to NHS Protect.

23. The Investigation Report referred to a number of other concerns in the surgery. There was a failure to monitor methotrexate, azathioprine, and ACE inhibitor toxicity. There was a failure of a MHRA alert not being actioned in relation to a contraindication of the simultaneous prescribing of a higher dose of simvastatin with amlodipine. There was a failure to carry out clinical audits. There was a failure to administer the practice to the required standard, including an absence of leadership and governance, no overarching governance framework, no evidence of complaints being discussed, and low scores for patient satisfaction. A further concern was that Dr Noorah was carrying out minor surgery procedures which could potentially be unsafe due to inadequate training/governance procedures.

24. Dr Lipp, the Medical Director of Midlands and East (East) Area Team NHS England, in his statements of 22.12.16 and 21.3.17, and in his oral evidence said NHSE were first made aware of concerns by the CQC on 22 June 2016. The concerns related to patient safety and possible fraudulent activity. Dr Noorah was suspended from the MPL on 23 June 2016, and this was reviewed on 24 June 2016. The suspension was upheld. There were a large number of concerns relating to a large number of patients with some concerns posing a high risk of patient safety. An oral hearing was held on 2 August 2016, at which Dr Noorah was offered an opportunity to give oral evidence, but she declined to appear or be represented. The hearing again confirmed the suspension, concluding there were significant concerns about patient safety, and about Dr Noorah's managerial competence and clinical practice. The PLDP concluded the continuation of the suspension was necessary for the protection of patients. The panel also concluded the continued suspension was necessary in the public interest due to material evidence suggesting a QOF fraud.

25. Dr Lipp said in July 2016 independent solicitors were commissioned to

undertake an investigation on behalf of NHSE. The final report was published on 11 November 2016, and sent to the GMC. The CQC applied for an urgent cancellation of the registration of Grafton Surgery, which was granted on the basis there was a serious, immediate risk to life, health and wellbeing of patients. NHSE referred the matter to GMC who subsequently made a referral to the Interim Orders Tribunal (IOT) of the Medical Practitioners Service (MPTS). A hearing was held on 5 August 2016 and conditions were imposed and subsequently upheld on 10.1.16. The GMC investigation is continuing. The GMC have requested a performance assessment and the outcome is still awaited.

26. Because of concerns about QOF fraud the matter was referred to NHS Protect, whose investigation is continuing. Since the suspension was due to expire on 23 December 2016, an application was made on 22 December 22016 to extend the suspension, and on 9 January 2017 Dr Noorah was informed of the application. On 18 January 2017 Dr Noorah appealed against the application to suspend. The parties jointly agreed to have the matter put down for hearing on 4 April 2017. The hearing in respect of the removal of Dr Noorah from the Primary Health Lists is due to take place on 18 April 2017. In his second statement dated 21.3.17, Dr Lipp said NHSE remains of the view that Dr Noorah should remain suspended, pending consideration of her removal, taking into account both the protection of patients and the public interest.

27. In his oral evidence Dr Lipp said the NHSE and GMC had separate regulatory processes, procedures and Regulations. The GMC was concerned with fitness to practice as opposed to fitness for purpose, which was the concern of NHSE. Employer Liaison Advisers employed by the GMC advise NHSE whether concerns about a doctor are sufficiently serious to meet the threshold for referral to the GMC. If these concerns are sufficiently serious and meet the threshold, NHSE informs the GMC.

28. In Dr Noorah's case the GMC imposed conditions on her practice. She was suspended from the MPL at the time so the conditions had no practical impact at that point. The concerns of NHSE was related to her inclusion on the Performers List and with meeting the responsibilities of the NHS. NHSE take the GMC conditions into account, but the GMC have separate responsibilities concerning fitness to practice. NHSE have their own procedures for dealing with their concerns. The Investigation Report highlighted a number of matters. Of great importance was the number of unverifiable clinical records, which meant accuracy and veracity of clinical notes could not be verified. Confidence in Dr Noorah's records was undermined.

29. Dr Lipp said the conditions imposed on Dr Noorah did not meet the concerns of the NHSE. The requirement of "close supervision' relies on the accuracy of records produced by Dr Noorah, but it does not address the issue of whether trust can be placed in those records. Further it seems the IOT did not consider the full picture of concerns in respect of Dr Noorah. The GMC has commissioned its own investigation. It is not clear from the IOT decisions what consideration they gave to questions of probity.

30. Dr Lipp accepted there had been no review of the suspension after the oral hearing on 2 August 2016. Dr Noorah had said she reserved the right to ask for a review, but had not done so. Further there was no new documentation which suggested a review should take place. It was put to Dr Lipp that the GMC's imposition of conditions should have triggered a review. Dr Lipp said the GMC and NHSE had different regulatory processes with different ends. NHSE did consider the GMC conditions, but NHSE had different considerations. The GMC conditions did not go far enough and didn't address the issue of being able to place reliance on records being accurate or the wider concerns about Dr Noorah's probity.

31. NHSE does not formally comment on GMC findings as NHSE has its own procedures. A further meeting of the PDLP was held on 14 December 2016 to consider removal, which did review the suspension. When the GMC reviewed the conditions on 10 January 2017, the NHSE had its Investigation Report, and did not think the conditions went far enough. The NHSE did not know how the GMC IOT review had treated the Investigation Report, or what weight they put on it. Also it is not clear what stage the GMC investigation was at. Dr Lipp accepted the concerns over smear coding and diabetic foot checks were prominent in the NHSE Investigation Report.

32. He accepted that Dr Noorah had co-operated with the NHSE investigation. Doctors are expected to maintain their competence during suspension, including by undertaking training courses . He accepted Dr Noorah has co-operated with GMC performance assessment and health issues. He accepted she would comply with GMC conditions although this has not yet been tested as she remains suspended from the MPL.

33. Dr Lipp said as Senior Partner of the Practice, Dr Noorah had responsibility both for systemic issues (affecting a number of patients) and individual care of patients. 'Fitness for purpose' entails further administrative responsibilities in the practice. NHSE, in considering fitness for purpose, has more interest in relation to the Performers List. The separate Regulations which govern this process are indicative of the separate concerns of NHSE and GMC. Unsupported records weigh heavily with NHSE, but not so heavily with the GMC.

34. Dr Lipp said the condition of 'close supervision' does not adequately cover the accuracy of record keeping, which is a matter of trust. While the content of records can be addressed by training courses, it cannot address trust in record keeping. It was put that some records have not yet been received by Dr Noorah, and she has not yet given her final evidence on the issue. Dr Lipp said NHSE was concerned with risk, and material inaccuracies were found by the independent investigators. There were a large number of them, which constitute a risk. There was no assurance Dr Noorah would complete records accurately in the future. Trust has been undermined by the matters reported in the investigation. Dr Noorah has not acknowledged shortcomings in respect of records, and major questions still exist.

35. It was put to Dr Lipp that the provisions of the GMC document "Good Medical Practice" refers to maintaining trust and honesty/integrity, and accordingly these matters were likely to have been taken into account by the GMC in imposing conditions. Dr Lipp said in imposing 'close supervision' the GMC was not, in the view of NHSE, giving them sufficient weight. The GMC could have imposed direct supervision, but did not.

36. Dr Lipp said he recognised Dr Noorah's change of responsibility from being solely a clinician to being senior partner, and that this could have an effect on competency. But one of the concerns about inaccurate records related to QOF payments. There was a surprisingly high QOF rate – nearly 100%. This was problematic in view of inaccuracies in the records. One potential reason for these inaccuracies was a desire to achieve high QOF rates and resultant payments. Further, patients should be reviewed and they weren't being. Also there were concerns about inputting information without evidence of patient examination. It was put that QOF payments could be made even without a patient examination, such as where a blood pressure measuring machine is provided to a patient who takes the measurements. Dr Lipp said there was no evidence of this

37. It was put to Dr Lipp that the decision of the PLDP to consider removal did not refer directly to unsuitability. Rather there was reference to 'an efficiency' case. Dr Lipp said the 'Toolkit' referred to the overlap between grounds of suitability, efficiency and fraud. It is not possible for the PLDP to consider conditions if there are issues of suitability.

38. In her statements of 2.3.17 and 28.3.17 in her grounds of appeal dated 18.1.17 and in her oral evidence, Dr Noorah said she had declined the opportunity to give oral evidence to the PDLP hearing on 2nd August following legal advice. She had attended the MPTS IOT hearing on 5th August 2016 and given evidence. On 20 September 2016 she had been asked by the GMC to undergo a performance assessment, which is now complete with the report due to be issued in May 2017. The MPTS conditions were reviewed on 10 January 2017, and remained in place. Prior to the review on 10 January 2017, the GMC had received the NHSE Investigation Report, along with an anonymised complaint documentation from Grafton Surgery.

39. In respect of the CQC decision to apply for urgent cancellation of the surgery's registration, this was upheld by the FTT on 24 August 2016, and on 5 January 2017 the UT gave permission to appeal. Dr Noorah was assessed as not being fit for work on 19 August 2016 and 3 October 2016, although she says in her statement she now feels well enough to return to work on a gradual basis. She attended a 2-day observership on 17 and 18 November 2016 at Essex Way Surgery, covering amongst other areas significant incident reporting, complaints policy, management of MHRA, and clinical audit. In her statement Dr Noorah said she wanted to return to work as a salaried GP, subject to the MPTS IOT conditions. She accepted the concerns were serious.

40. In her second statement dated 28.3.17, she says the performance assessment is complete, and the report is expected in mid-May 2017.

She appended a number of certificates of further learning, and completed some 117 hours of Continuing Professional Development (CPD). She says in the observership in November 2016, she focused on medication monitoring, complaints, leadership and teamwork, and had learnt a lot. She says she is committed to accurate record keeping and appropriate prescribing of high risk drugs. She has taken active steps to reflect and learn, and could practice with close supervision.

41. With her first statement she submitted training certificates including minor surgery, monitoring, skin lesions, safeguarding, management of OAB, diabetes, medicines management, skin conditions, and a number of GP refresher courses. She has included some 10 references from fellow GPs and a Prescribing Advisor, who have referred to Dr Noorah being committed to safety of patients, professional, caring, diligent, of exemplary character, honest, reliable, proactive, conscientious, compassionate and a good doctor. She also submitted her appraisal for 2016, where she refers to her heavy workload with shortage of staff.

42. With her second statement she submitted training certificates including safer prescribing, minor surgery, triage, medical records, audits, leadership, managing and preventing complaints, treatment of carcinomas, women's health, diabetes, significant events, systems, professional interactions, ECG interpretation, arthritis, menopause, skin lesions, resilience, shared decision making, case discussions, hyponatraemia, cardiology, gout, hypothyroidism, advanced life support, cardiac rhythm, difficult interactions with patients, informed decision making, COPD, haematology, endocrinology, and interpreting investigations.

43. In Dr Noorah's oral evidence she accepted it would be a matter of serious concern if a significant amount of unverifiable information was included in the patient records, without the patient being seen or assessed. She accepted she had kept poor records. She kept a list of information from patients which was not entered into the records at the time of the encounter, "as I should have done." The records did not reflect the facts of the encounter. She kept a lot of handwritten notes which were kept until the information was put on the computer, then they were destroyed. She said some patients would not have seen her personally. They may have attended the community clinic. Also some information may have been taken from letters from patients." Dr Noorah denied changing the date of encounters. The date in the record was the date she had entered the information, not the date of the encounter. She had not written the date of the encounter on her handwritten notes.

44. In respect of smear codings she denied giving any instructions to staff to enter a refusal code. Even patients who are coded as refusals may still be recalled. Most patients attend for smears and don't refuse. She accepted that if refusals were coded to enhance QOF payments it would be a serious concern, but she had not done this.

45. In respect of coding for diabetic foot checks, patients may have attended the community clinic or sent letters, which had been missed by the nurse when entering information. Entries were made from

information available but not yet in the records. She denied she falsely entered records to abuse QOF payments. She had not yet been given access to all the patients' records and any records she had kept were removed from her cupboard at the Practice after it was closed. Dr Noorah was asked when she was entering the codes late at night, how would she know the nurse had missed the entry. Dr Noorah said some patients had been seen at the community clinic.

46. Dr Noorah was asked about MHRA alerts not entered until days after CQC inspection on 22 June 2016. Dr Noorah said she was told during the Inspection she could start working on the findings. She made a start in reviewing patients and adjusting medication but on 23 June 2016 she was suspended.

47. Dr Noorah was asked about requesting Dr R to backdate patient satisfaction records. She denied having asked him to do this. In the email she was referring back to discussions in February. She had used the wrong word – "report" - in the email. "We later talked about this." At this time she was emotionally upset over a family tragedy and had been working hard to prepare for a presentation to the CQC. She had written to Dr R for help. Dr Noorah said she had declined to give evidence at the PLDP hearing on 2nd August 2016 on advice from her legal adviser.

48. In the MPTS IOT decision of 5 August 2016 it was said serious concerns involving patient safety had been sent to NHSE, including patients on high-risk medications not being followed up appropriately and possible inappropriate surgery. The IOT stated it took account of the CQC Risk Escalation Form which identified several areas of concern found in a visit to the practice on 15.6.26. The concerns included inconsistencies in data, no robust governance framework, no infection control audit since 2012, MHRA alerts not acted on, poor levels of patient satisfaction, and complaints not being discussed. The IOT particularly focused on monitoring inadequacies for methotrexate, azathioprine, ACE/A2RB, not following an MHRA alert, and minor surgery without training. The IOT panel noted that the concerns were considered to have a major impact and may result in serious risk to patient's life, health or well-being.

49. The panel imposed a number of conditions including that Dr Noorah must only work in a group practice with at least 3 GP partners and must only work as a salaried GP. She must be closely supervised by an approved clinician. The conditions were imposed for 18 months.
The panel had regard to patient safety and 'other concerns' including the finding of poor procedures and poor record keeping.

50. The IOT conditions were reviewed on 10 January 2017. In the decision letter the reviewing MPTS Chair referred to the CQC's findings being a major impact on patient safety, poor leadership, unsafe environment, inadequate monitoring, that the incidents could recur owing to minimal control measures, poor complaints handling and lack of insight. Although there was a reference to public interest reasons, there was no mention of the probity concerns about smear testing and diabetic foot tests. The review concluded that the conditions should be maintained.

Consideration by the Tribunal

51. By regulation 12(1) of the 2013 Regulations the Board may suspend a Practitioner from a performers list where it is necessary to do so for the protection of patients or members of the public or where it is otherwise in the public interest. Under regulation 12(13), the period may not exceed 6 months. Under regulation 12(16) the Board may apply to the First Tier Tribunal to extend the period beyond six months or, having made the application within the permitted time, suspension may be extended until the FTT makes an order. The order may specify the date when the suspension must end, or an event beyond which it is not to continue or that the period of suspension on the earlier of a specified date or event. The tribunal have to make the decision afresh as to whether to grant or refuse the application. It was agreed the Tribunal cannot impose conditions.

52. Dr Noorah submits the imposition of conditions of practice by the GMC IOT provides sufficient and appropriate safeguards for patients and public or otherwise in the public interest. These matters, coupled with her co-operation with the GMC and NHSE, along with substantial steps to self-remediate by undertaking numerous training courses, means suspension is no longer necessary. The NHSE say that although there is overlap with the GMC, they have separate concerns and these have not been met by the GMC conditions. Suspension until determination of whether or not Dr Noorah will be removed from the performers list is necessary

53. The first issue to consider is does the NHSE have separate and in some respects different considerations to the GMC in its assessment of whether an extension of suspension is necessary. The "Toolkit for Managing Performance Concerns" says the professional regulatory bodies (the GMC) has distinct roles and responsibilities over their profession and, in this context, are concerned with fitness to practice. The GMC has a statutory responsibility to safeguard patients, maintain public confidence in the profession and uphold professional standards. While NHSE has similar statutory responsibilities, the test to be applied is fitness for purpose, as opposed to fitness for practice. The question is whether the performer can provide primary care services as opposed to whether they should remain on their professional register.

54. Dr Lipp, in his evidence, said the NHSE and GMC had separate regulation processes, procedures and regulations. The GMC is concerned with fitness to practice, and they decided to impose conditions. He said the NHSE had separate concerns related to Dr Noorah's inclusion on the Performers List, and meeting the responsibilities of the NHS. Of great concern was the large number of unverifiable clinical notes. The GMC 'close supervision' conditions did not meet these concerns, which was a matter of trust.

55. Dr Lipp also said the IOT did not consider the full picture of concerns. They did not go far enough in that they did not address the issue of being able to place trust in the veracity of records and the wider probity issues identified by the investigation. Further he said it was not clear how the MPTS IOT had treated the Investigation Report or what weight

they had put on it. The NHSE 'fitness for purpose' entails consideration of further administrative responsibilities in the practice. Unsupported records weight heavily with NHSE. Close supervision does not adequately cover the accuracy of record keeping which is a matter of trust, which cannot be addressed by having courses on note taking. In imposing close supervision the NHSE did not accept the GMC were giving sufficient weight to these concerns. Further there were probity concerns over QOF payments which were of significant concern to NHSE.

56. We considered this issue. We accepted that while the concerns of the GMC and NHSE overlapped in a number of respects, we also accepted that the two bodies had their own concerns, which might often be reflected by the differing weight put on aspects of the case by the two bodies. The NHSE did and were entitled to put great weight on unverifiable records, administration of NHS requirements, QOF payments, and the need for trust in a performer's ability and willingness to make accurate clinical records. Here the NHSE believed their concerns had not necessarily been give the same weight by the GMC, as reflected in the GMC's willingness to allow continued conditional practice by Dr Noorah.

57. We accepted there was not complete overlap in concerns of the two organisations, despite the same wording in the test for interim orders, that this was a result of the differing functions of the two bodies and was an inherent part of the regulatory processes of the GMC and NHSE. This was reflected in the separate processes, procedures and regulations of the two bodies, and the fact that the qualification to become a doctor does not automatically give membership of the MPL, which requires further application. We accepted therefore that in general terms the NHSE does have legitimate and appropriate concerns separate from the GMC and that in respect of Dr Noorah these separate concerns legitimately resulted in differing approaches and perhaps differing weight each body gave to the various aspects of the concerns.

58. On behalf of Dr Noorah it was suggested the IOT took all the relevant matters into account in deciding close supervision practice was sufficient. NHSE considered the IOT has not taken all the relevant matters into account, or at least it was not clear that they had done so.

59. It seems the IOT in its initial consideration on 5 August 2016 did have the CQC report which is said to have made some reference to the probity concerns relating in particular to smear codes and diabetic foot checks. It is noticeable that the IOT decision letter of 5 August, while it refers specifically to high risk medications and minor surgery, does not specifically mention probity issues, or possible QOF fraud on smear tests or diabetic foot checks. Similarly by 10 January 2017, the GMC had received the Investigation Report which does refer to probity concerns. However when the IOT reviewed the conditions on 10 January 2017, there was no specific reference to the possibility of QOF fraud, probity issues, smear tests or diabetic foot checks.

60. We concluded it is not possible to say with certainty the IOT failed to

consider the probity matters at all. Neither is it possible to say what weight, if any, they placed on such matters. It may be the GMC did not give the probity concerns the same weight as the NHSE resulting in the imposition of conditions of practise rather than suspension.

61. The probity concerns relating to Dr Noorah, considered particularly important by NHSE, are in our view serious. It is not for us to resolve whether dishonesty or fraud did take place. We have to proceed on the basis of risk. As the Toolkit puts it "Suspension …. is a neutral act in that few if any facts will have been clearly established at this point and therefore the decision is taken on the basis of risk."

62. Taken at its highest the probity allegations against Dr Noorah are that she practised frauds on the NHS in respect of public monies and falsified clinical records in order to do so, even though this falsification could put patients at risk. The alleged frauds were in some instances said to be in respect of several hundred patients over several years. There will have to be contact with patients who have left the practice and with their current GPs to ensure records are accurate. Further inspection of records has been called for by the Investigation Report; and NHS Protect and the GMC are still continuing with their inquiries.

63. Dr Noorah, who has no previous instances of allegations of a lack of probity and has produced references to her good name, has denied dishonesty or fraud. However there are in our view many unresolved issues concerning her probity in this investigation. There are still conflicts of fact between the parties. As set out above, it is not for us to resolve these conflicts. If such allegations against her are true, and there is in our view evidence that might support them, then we accept that, even if allowed to practise under close supervision, a risk of repetition remains, as well as a risk to the public interest.

64. We do not accept that close supervision can adequately remove these risks, because Dr Noorah will still have the opportunity to complete inaccurate or fraudulent records, even as a salaried GP. We accept that Dr Noorah has undertaken a number of training courses but we do not accept that training programmes can adequately protect the public or patients from false records where there is a risk of a lack of probity. Further there is the considerable risk to the public interest in maintaining confidence by the public in the NHS if Dr Noorah is allowed to practice even with conditions.

65. We accept that NHSE has proceeded with its investigations in a reasonably timely manner. The date of the current hearing was agreed by both parties, and does not in our view represent an unreasonable delay. We accept the extension of suspension would be a proportionate measure in view of the risks.

66. The extension of suspension (which is likely to be short) is in our view necessary both for protection of patients and the general public and otherwise in the public interest.

It is ordered

The suspension of Dr Noorah is to be extended to the expiry of a period of 28 days starting with the day on which a decision about whether or not she should be removed from the Performers list has been made by the Performers List Decision Panel or
The date on which any appeal against a decision of the PLDP is disposed of by the First Tier Tribunal.

Judge John Burrow
Primary Health Lists/Care Standards
First-tier Tribunal Health Education and Social Care Chamber

Date Issued: 13 April 2017