IN THE FIRST-TIER TRIBUNAL
(HEALTH, EDUCATION AND SOCIAL CARE CHAMBER)
PRIMARY HEALTH LISTS

Case No: PHL/15374

Tribunal Members

Mrs Debra Shaw	**-**	**Chairman**
Dr S Sharma	**-**	**Professional Member**
Mr W Nelson	**-**	**Member**

BETWEEN

DR F M NURIA BOOTH
GMC No: 2216726

Appellant

and

HAMPSHIRE PRIMARY CARE TRUST

Respondent

Considered on 25th and 27th July 2011

DECISION WITH REASONS

The Application

1. This is an appeal by Dr Nuria Booth (Dr Booth) against the removal of her name from the medical Performers List of Hampshire PCT (the PCT) under the provisions of Regulations 10(4)(a) and (c) of the National Health Service (Performers Lists) Regulations 2004 (as amended) and associated regulations (the Regulations) on grounds of inefficiency and unsuitability.

History and Background

2. Dr Booth is a GP who has been included in the PCT's Medical Performers list (or equivalent) since 1992. Until May 2002 Dr Booth was in partnership with Pinehill Surgery, Bordon but following a partnership dispute Dr Booth left and, with the agreement of North Hampshire PCT (one of the PCT's predecessor organisations), established herself as a single handed practitioner working from Highview Surgery, Bordon.

3. At the time of establishment in 2007 the PCT was advised that North Hampshire PCT had had concerns regarding Dr Booth's clinical governance arrangements over a

number of years and, in particular, concern was expressed regarding the chaotic nature that prevailed over the management of the practice. The records showed that North Hampshire PCT had asked Dr Booth to take part in an NCAS assessment and that she had declined.

4. At the time of transition to the new PCT, Dr Booth had been contingently removed from the North Hampshire PCT Medical Performers List and she had agreed to comply with a number of actions contained in an Action Plan. The PCT was aware that North Hampshire PCT's Head of Primary Care, Clinical Governance Manager and PRIMIS Facilitator had provided support to facilitate Dr Booth achieving the conditions set out.

5. As the case history was complex, in 2007 the PCT undertook an independent review of Dr Booth's compliance with the Action Plan. The PCT determined that Dr Booth had sought to comply with all of the conditions, although it was concerned as to the sustainability of such improvements given that Dr Booth's income was low and she was unable to afford an experienced manager to support her in the running of the practice.

6. The PCT worked with Dr Booth to identify if it was feasible to take on the running of the practice through an APMS contract and also supported her in her endeavours to enter into an agreement with Chilvers McCrea, an alternative provider of primary care services, but neither of these options reached fruition.

7. The PCT continued to provide support to Dr Booth on an ad hoc basis. The contingent removal was lifted in January 2008 and replaced with a voluntary arrangement that allowed the PCT to meet with Dr Booth on a regular basis.

8. On 11th August 2009, the GMC wrote to the PCT regarding a complaint from one of Dr Booth's patients (patient M) which referred to the death of one daughter from Ewings Sarcoma which it was alleged Dr Booth failed to diagnosis, and the medication prescribed to another daughter. The PCT then received 2 further complaints: the first on 17th November 2009 was from solicitors acting on behalf of a patient alleging breach of confidentiality, and the second received on 8th December 2009 referred to prescribing issues.

9. The complaints were considered by a PCT Performance Screening Group (PSG) on 23rd February 2010. The PSG agreed that due to the complaints raised and the concerns regarding Dr Booth's record keeping; ability to use the computer system; the chaotic and disorganised consulting room; the continued lack of progress in relation to the Quality & Outcome Framework and the fact that she was a negative outlier on generic prescribing utilisation in comparison with other practices in the PCT, she should be referred to NCAS for an assessment.

10. The NCAS assessment took place during the first week of September 2010. On 11th October, the PCT received a call from NCAS and a Serious Concerns Report that identified a number of serious concerns that had the potential to place patients at risk of serious harm and recommended that the PCT should take the necessary steps to protect patient safety, which should include an urgent review of Dr Booth's clinical management, and in particular of her prescribing for specific patients.

11. On 12th October, a PCT Contractor Performance Panel was convened to consider the NCAS Serious Concerns report. The Panel determined that it was necessary for the protection of the public to propose suspension and wrote to advise Dr Booth of the proposed suspension. Dr Booth made written representations against the proposed suspension and the PCT met with her and her representative on 18th November 2010. Dr Booth expressed the desire to be retrained. The PCT indicated that the time and cost of remediation might be prohibitive and Dr Booth agreed that this might be the case.

12. On 1st December 2009, the PCT received a copy of the final report dated 26th November from NCAS. It identified that Dr Booth's overall performance was significantly below the level expected of a GP because:

(i) Dr Booth's performance in prescribing and management of the practice was identified as being significantly poor.

(ii) Her performance in clinical management, infection control, record keeping, delegation, management of the conduct or performance of colleagues, use of resources, maintaining good medical practice, organisational engagement, and self awareness was found to be poor.

(iii) Her performance in the areas of assessment of the patient's condition, providing and arranging investigations, venepuncture, communication and the practitioner-patient partnership, respecting confidentiality and obtaining consent, and sharing information with colleagues was found to be inconsistent

(iv) Her team working with colleagues outside her practice was found to be satisfactory.

13. The PCT reviewed the report and considered it was necessary to undertake a wider review of Dr Booth's clinical management of patients to identify if there were patients who were in need of an immediate review of their clinical management.

14. The review was undertaken by Dr David Balfour and Liz Corteville on 1st and 8th December 2010. The review team found poor organisation with sloppy and often haphazard reporting, lack of systems to ensure proper follow up and management of patients, inappropriate prescribing and increasingly the absence of any continuity of care for often vulnerable patients.

15. On 20th December 2010 the GMC wrote to confirm that its Interim Orders Panel (IOP) had made an order suspending Dr Booth's registration for a period of 18 months.

16. Following discussion with NCAS, NCAS provided the PCT with a draft action planning framework that identified that Dr Booth was likely to need 12 months remediation to include a placement in a training practice with clinical supervision, a mentor, occupational health monitoring, an educational supervisor, medicines management, IT and governance support; and a behavioural coach. This framework was shared with Dr Booth and a meeting was arranged to discuss the feasibility of remediation. Due to poor health, Dr Booth was unable to attend both this meeting and a subsequent meeting to discuss the same.

17. On 11th January 2011, the PCT Contractor Performance Panel met to review the case. It considered the minimum remediation programme would need to include:

    (i) Passing the London Deanery MCQ and Simulated Surgery

    (ii) Placement in an environment akin to a medical student placement of at least 8 weeks

    (iii) Placement as a Registrar in a designated training practice for a minimum of 12 weeks

    (iv) Placement in a designated training practice with a named supervisor for a minimum of 12 weeks

18. Having considered all the information, and in particular the fact that Dr Booth was significantly below the level expected of the profession; the context within which the assessment has been requested; the scale of the proposed remediation and the query raised regarding whether remediation might be successful and the effect on the efficiency of primary medical services to deliver a remediation programme, the PCT proposed that Dr Booth should be removed on the grounds of efficiency and unsuitability.

19 Dr Booth made written representations as to why the PCT should not proceed with removal in a letter dated 23rd February 2011. After due consideration of the information provided, the Panel agreed on 24th February 2011 that it should proceed with removal from the PCT's Medical Performers List and Dr Booth was notified of the PCT decision by way of letter dated 24th February 2011.

The Appeal

20. The Tribunals Service received an appeal application dated 23rd March 2011 from the Appellant on the following grounds:

    (1) The PCT's decision was disproportionate to the concerns raised and an order for contingent removal would have been a more appropriate response

(2) The PCT inappropriately concluded that remediation was not feasible because of the widespread nature of the criticisms contained in the NCAS Report

(3) The PCT also inappropriately concluded that the behavioural assessment undertaken on the Appellant during the course of the production of the NCAS Report indicated that remediation was unlikely to be successful

(4) The PCT inappropriately determined that facilities and resources would be unlikely to be available so as to allow the remedial steps that would need to be undertaken by the Appellant to be successful

(5) The PCT inappropriately determined that such remedial steps, including retraining, would be unlikely to be affordable by the Appellant or the Respondent

(6i) The PCT inappropriately determined that the Appellant lacked insight into the scale of remediation needed, in circumstances where the Appellant had always accepted, in general terms, the recommendations of the NCAS Report and had indicated at an early stage her willingness to work with NCAS and the PCT

(7) The PCT placed too great a weight on the financial burden to be placed upon it as part of a remedial package that might be needed by the Appellant

(8) The PCT came to the conclusions as listed in (3) to (7) without having sufficient evidence from the Postgraduate Deanery on which such conclusions could be drawn

(9) By taking the decision to remove the Appellant's name from the List, the PCT would leave her in a position whereby the sort of remedial training package that was envisaged would not be able to be completed, as only the very early stages of it could be completed whilst not on a Primary Care Performers List

(10) Proportionate, measurable and workable conditions to have been implemented under a contingent removal order could have been drafted by the PCT so as to proportionately deal with the concerns raised by the NCAS Report. These could have included a restriction on the Appellant undertaking NHS medical practice until she had reached certain milestones during the course of her remediation package

(11) The Panel placed weight on the Appellant's ill health as a reason why remedial steps would be unlikely to be successful without having any medical evidence as to future prognosis in front of them.

The Law

21. The legal framework for this appeal is largely contained in the NHS (Performers Lists) Regulations 2004 (the Regulations) which, inter alia, set out the criteria by which appeals are to be considered.

21.1 Regulation 10(4)(a) provides that a performer may be removed where his continued inclusion in the performers list would be prejudicial to the efficiency of the service which those included in the relevant performers list perform

21.2 Regulation 10(4)(c) provides that a performer may be removed where he is unsuitable to be included in that performers list

21.3 Regulations 11(1) and (2) set out the matters to which the PCT (and the PHL) should have regard in an unsuitability case including, inter alia, the nature of any offence, investigation or incident; the length of time since any such offence, incident, conviction or investigation; whether there are other offences, incidents or investigations to be considered; any action taken or penalty imposed by any regulatory body as a result of any such offence, incident or investigation; the relevance of any offence, incident or investigation to her performing relevant primary services and any likely risk to any patients or to public finances; whether any offence was a sexual offence to which Part I of the Sexual Offences Act 1997 applies, or if it had been committed in England and Wales, would have applied; whether the performer has been refused admittance to, conditionally included in, removed, contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the PCT or equivalent body for such action

21.4 Regulations 11(5) and (6) set out the matters to which the PCT (and the PHL) should have regard in an efficiency case including, inter alia, the nature of any incident which was prejudicial to the efficiency of the services, which the performer performed; the length of time since the last incident occurred and since any investigation into it was concluded; any action taken by any regulatory body as a result of any such incident; the nature of the incident and whether there is a likely risk to patients; whether she has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the PCT.

21.5 Regulation 12 provides that the PCT (and the PHL) may remove a practitioner contingently, and impose conditions which can remove any prejudice to efficiency. If the performer fails to comply with the conditions the PCT (and the PHL) may vary the conditions, or impose new ones or remove the performer from the list.

21.6 Regulation 15 provides that the appeal to the PHL is by way of redetermination, and the PHL can make any decision which the PCT could have made.

21.7 We also took into account the relevant sections of the “Primary Medical Performers Lists Delivering Quality in Primary Care Department of Health 2004” (DOH Guidance) including paragraphs 7 and 17.

21.8 We further had regard to the proportionality of the decision appealed against, taking into account all the relevant evidence in the case and considering the applicants interest in pursuing her profession on the one hand and efficiency to the service on the other.

21.9 The burden of proof of an issue is on the party who alleges it and the standard of proof is on the balance of probabilities.

Preliminary matters

22. Prior to the commencement of the hearing all three tribunal members confirmed they had not had any prior interest or involvement in the appeal that would preclude them from considering the evidence in an independent and impartial manner.

23. The persons present at the Tribunal were:

Dr F M Nuria Booth	Appellant
Mr Neil Sheldon	Counsel for the Appellant
Mr William Childs	Solicitor for the Appellant (RadcliffesLeBrasseur)
Ms T Hassan	RadcliffesLeBrasseur
Ms M Copage	Witness for the Respondent
Dr Niall Ferguson	Witness for the Respondent
Mr Michael Mylonas	Counsel for the Respondent
Ms Kiran Bhogal	Solicitor for the Respondent (Weightmans LLP)

The evidence

24. Over the course of the hearing, which lasted for two days, we were presented with a large amount of written and oral evidence. For the purposes of our consideration of the evidence and this decision, we have summarized the most pertinent submissions and evidence from each of the witnesses.

Ms Manda Copage (Head of Primary Care and Improvement at the PCT)

25. In her Witness Statement Ms Copage responded on behalf of the PCT to Dr Booth's grounds of appeal as follows:

25.1 The PCT did not accept the decision to remove Dr Booth's name from the List was disproportionate to the concerns raised. It was evident from the NCAS assessment and the subsequent review of the list size that Dr Booth had provided sub- optimal care to a significant number of patients that had compromised their care over a sustained period of time. NCAS had indicated that she would require significant retraining and was unlikely to be able to return to single handed practice. Any remediation would use scarce NHS resources and there was no guarantee that remediation would be successful given Dr Booth's disposition.

25.2 The PCT did not conclude that remediation was not feasible but considered that the impact of the scale of remediation needed would prejudice the efficiency of primary medical services.

25.3 The PCT did take into consideration the outcome of the NCAS behavioural assessment in which it concluded that Dr Booth's strong set of values and behaviour might impact on the ability to successfully complete any remediation programme. However, this was not the sole factor relied on; it also took into account that Dr Booth had provided sub-optimal care to a significant number of patient that had compromised their care over a sustained period of time, that NCAS had identified she would require significant retraining and was unlikely to be able to return to working in a single handed capacity and that she had not sustained improvements in her practice over the previous years during which the PCT had deployed NHS resources to support her.

25.4 Dr Booth had advised the PCT that it was unlikely she would be able to meet the cost of retraining herself. At the time of her suspension she advised the PCT that suspension payments of 90% of her drawings would bankrupt her as her practice drawings were significantly less than the cost of a locum. From history the PCT believed her drawings were in the region of £30,000 per annum. In light of this and to ensure the neutrality of the suspension, the PCT had made payments under the NHS Act 1977 and the Statement of Financial Entitlements and paid the locum costs directly so as to enable Dr Booth to continue to receive an income.

25.5 The PCT commissions the Deanery to provide educational support to practitioners in difficulty. In its deliberations the PCT considered the draft NCAS Action Plan and the capacity within the Deanery to deliver the required remediation. It determined that the level of remediation and the consequent financial and human effort to deliver it would affect the efficiency of services and agreed that it did not consider it appropriate to commission an educational package from the Deanery for the remediation of Dr Booth.

25.6 The PCT did not determine that Dr Booth's ill health would be a reason why remediation was unlikely to be successful. Dr Booth had herself made the PCT aware of health issues and the Panel noted that being required to comply with conditions in a timely way might add stress at a time when her health was already suffering.

26. The PCT had a duty to ensure the delivery of high quality, primary medical services that were both safe and provided value for money within a finite resource. It was evident from information held since 2004 that the PCT and its predecessor organisation had already committed significant resources in considering and addressing the issues raised by Dr Booth in relation to her clinical practice and public safety. The NCAS assessment and subsequent wider review had provided substantial evidence to demonstrate that Dr Booth's clinical practice was significantly below that expected of her profession and the PCT had concluded that it was not a prerequisite for Dr Booth to be on the Performers List to complete the first steps of the remediation process; she could reapply to join a Performers List once the first steps of

the remediation process had been completed. The PCT was mindful that it was required to operate within finite resources and had a duty to ensure the efficient and appropriate use of those resources; it did not consider that Dr Booth's case would be regarded as an efficient use of resources.

27. At the hearing, Ms Copage submitted that in her post which she had held since October 2007 she had to consider and ensure any issues relating to practitioners were considered in accordance with the Regulations. There were 1300 doctors on the PCT's Performers List and her case load averaged 50 with a range of complaints from minor to serious.

28. She had had experience of Dr Booth since 2007 and had been involved in the more recent proceedings against her. Dr Booth was not a suitable candidate for remediation, firstly because the NCAS Assessment and subsequent PCT Review identified significant shortcomings in her clinical performance, skills and knowledge such that the PCT considered she was unsuitable to remain on the Performers List, and secondly because when considering efficiency, clinical and management concerns had been raised about Dr Booth's practice since 2004 and she had been given a prior opportunity to remedy them, yet the concerns raised in 2009 were very similar. The NCAS Assessment had identified that Dr Booth may not have remedied the issues previously raised, or if she had, they had not been sustained, for example, record keeping, prescribing and cervical screening programmes. The substantial remediation NCAS identified as necessary would have a substantial impact on services. It would be unwise to avoid any issues NCAS had flagged up.

29. Ms Copage had only once before seen a NCAS Report identify so many areas of concern. She had now calculated approximate costings for the *"extensive, structured, robust and monitored development programme"* NCAS required as between £46,000 and £146,000, made up as follows:

MCQ		£ 850
Course fees as identified by NCAS		1,500 – 5,000
Trainer's Grant		15,000 - 52,000
Salary for Dr Booth		0 - 54,000
Mentorship		3,600 - 6,000
Occupational Health Monitoring		1,000
Behavioural Coach		15,384
Educational Supervisor		3,600 - 6,000
Medicines Management Input)	Guesstimates	1,700
Infection Control)	for PCT	500 - 750
IMT)	staff time	500 - 750
Quarterly review of compliance)		6,000

(N.B. Where necessary, in calculating the costings Ms Copage had used ballpark figures as the package had not been finalised).

30. The variation in the trainer's grant was on account of a trainer being paid double the normal grant of £15,000 per annum for a doctor in difficulty, but the extent of NCAS' concerns could mean this could rise to £52,000 for a 12 month plan as a trainer could have to be paid £1,000 per week depending on the amount of supervision required.

31. The variation in the salary for Dr Booth was on account the Deanery being unable to place doctors in difficulty in a training practice without their own income and the BMA annual minimum income was £54,000.

32. The PCT did not have a remediation budget so this sum would have to be taken away from services already in place. The top end figure of approximately £150,000 would pay for 1500 minor surgery procedures or long acting contraceptive devices.

33. The average figure for remediation packages was £5,000. One of deciding factors was whether the PCT believed a practitioner was capable of remedy. Although the PCT generally shared the cost of remediation with the practitioner, the PCT was aware Dr Booth had some financial fragility and it was uncertain whether she would be able to contribute to the cost.

34. The PCT considered efficiency became a suitability issue where there were wide ranging deficiencies. In Dr Booth's case, NCAS had extended its normal terminology of *"satisfactory"* and *"poor"* to include *"significantly poor"*. It was an efficiency issue if the PCT felt the cost of remediation in terms of cash, management and sustainability was too great in terms of the resources it would need to find.

35. In the four years she had been in post, two other doctors had been removed and Ms Copage felt Dr Booth fell significantly below their standard.

36. In response to cross-examination, Ms Copage agreed the PCT Panel Minutes of the meeting at which it was decided to remove Dr Booth recorded that the available reports did not disagree that the deficiencies were capable of remediation. She had spoken to NCAS prior to the meeting, who had not said the practitioner was not remediable. However, the Panel had identified what would be required for remediation and concluded it was not appropriate given the current financial pressures on the local health economy, the impending structural changes and the practitioner's own current financial position.

37. Ms Copage was then taken through various permutations of what the costing of the remediation package could be, depending on whether Dr Booth paid 50% of the cost and if remediation only took 32 as opposed to 52 weeks as per the minimum remediation programme the PCT Panel believed would be necessary (see para 17 above), which was calculated as:

MCQ fee	£ 850
Placement as medical student at £1,000 per week	1,000
24 weeks in a designated training practice with a trainer at £15,000 per annum	7,500
	16, 350

The practitioner was expected to pay 50% of this cost so the charge to the PCT would be just over £8,000.

38. The PCT Panel had been aware of the cost of the training grant and the potential salary cost for Dr Booth; they had not asked if Dr Booth would be prepared to waive that cost. The PCT was aware Dr Booth's drawings from the practice were significantly less than £1,000 per week and had paid her extra whilst she was suspended so she did not go bankrupt.

39. The PCT had talked with Dr Booth about the potential costs of remediation following the NCAS Serious Concerns Report but ahead of the final report. At that point Dr Booth had indicated she had financial difficulties and they had discussed issues of leases and rents. Ms Copage agreed any discussion about finances had not been minuted.

40. The PCT decision on unsuitability was based on the same factors as the decision on efficiency.

41. The PCT Panel were aware Dr Booth was willing to try remediation but felt she lacked insight into the scale of remediation required. The PCT had tried to meet twice with Dr Booth (with the Deanery in attendance) to explain what would be required and the cost of remediation, but she failed to attend. However, she was having meetings with the contracting arm of the PCT and remediation issues came up there. She was also given the opportunity to set out her own proposals when the PCT wrote to inform her of its intention to remove her.

42. The PCT Panel did not use Dr Booth's perceived lack of insight to reach its decision. They looked at the totality of what was required and if it would be sustainable.

43. The PCT's doubts about Dr Booth's disposition were based on the NCAS behavioural assessment; the NCAS assessors believed Dr Booth's own set of values might prevent her from being successfully remediated. Ms Copage took that to mean Dr Booth's values affect the way she practises professionally, not how she would react to colleagues during the remediation programme.

44. Ms Copage was not in post when Dr Booth was contingently removed in 2006 but was there by the time of the Independent Review Report in December 2007 which led to the conditions of Dr Booth's contingent removal being lifted. No-one disputed that Dr Booth had co-operated with the PCT; during this time she had a lot of support from the PCT and it was more about the resources the PCT had to put in to secure assurances appropriate systems etc were in place. Whilst the PCT accepted she had successfully completed a demanding remediation process in 2006 / 2007, some of the issues raised at that time were still causing concern, which had lead to the NCAS Report being commissioned and showed remediation was not sustainable. It was not a question of whether or not Dr Booth should be in single-handed practice but of some issues having previously been before the PCT, the amount of support and resources already provided and how much more would be required to remedy the issues which had recently come to light. The PCT was a custodian of public funds; Dr Booth had been under scrutiny for a number of years and had failed to maintain the previous remediation programme leading to an unnecessary burden on the public purse.

45. In response to questions, Ms Copage confirmed the four point minimum necessary remediation programme (see para 17 above) was never envisaged to be a stand-alone programme following which Dr Booth could return to practise; the NCAS Action Plan contained a whole host of other things. Nor was it intended that it would reduce the likely timescale for completion of remediation from 12 months to 32 weeks.

47. Between 2006 and 2008 management support was provided in the form of IT Facilitators going into the practice to provide advice, medicines management to

support prescribing and an experienced practice manager (now retired) was in regular contact with the practice to give support. Ms Copage was also in contact.

48. Ms Copage had spoken to a NCAS Advisor who had agreed remediation was unlikely but said that NCAS worked on the principle there was always some action which could be taken. It was a question of whether there were sufficient resources available to remediate and monitor.

49. The question of whether or not Dr Booth could continue as a single handed practitioner was not a performance issue as the PCT did not consider contracts and the Performers List in the same way, although there would be some cross-over. Her current contract had been terminated on grounds of safety and it was not within the PCT's gift to place Dr Booth in another practice.

50. The Deanery thought there was a 50-50 chance of finding a training practice for Dr Booth. It would have to be a very large practice with very good governance, most likely outside the area and Dr Booth would be unable to take up a training place until she passed the MCQ, which she had failed in June.

Dr Niall Ferguson (Clinical Lead for PCT and PCT Panel Member)

51. In his Witness Statement Dr Ferguson confirmed he had first been involved with Dr Booth in November 2007 when a hearing was convened following a proposal to vary her conditions. There had been a history of disorganisation in Dr Booth's practice and the PCT had provided support in an attempt to improve her practice. The concerns leading to Dr Booth's contingent removal were associated with her disorganisation and poor record keeping leading to concerns regarding her management of the practice, in particular with reference to cervical smears, immunisations and the care of patients with drug addiction. It was noted that Dr Booth had been unable to make improvements to the practice due to her low income and how attempts to find an alternative solution to her financial fragility had been unsuccessful. Although Dr Booth had agreed to improve her practice and meet the conditions, no evidence was presented to demonstrate this and it had been agreed that an investigation should be commissioned to seek further evidence before any changes to the conditions were agreed. The conditions were subsequently lifted.

52. In November 2010 Dr Ferguson attended a Contractor Performance Panel (CPP) as an equivalent practitioner to consider the suspension of Dr Booth following receipt of an NCAS interim Serious Concerns Report, which raised significant performance issues and recommended that the PCT should take the necessary steps to protect patient safety. Dr Booth did not attend but provided written representations. However, the CPP did not consider the representations materially altered the seriousness of the concerns raised and imposed suspension.

53. In January 2011 Dr Ferguson attended another CPP as the equivalent practitioner to consider removal or contingent removal. The CPP considered the NCAS final Report, Dr Booth's comments on it, the PCT Wider Review Report undertaken by Dr Balfour, and the NCAS Action Planning framework. The CPP felt all of these documents raised significant concerns regarding Dr Booth's clinical governance arrangements and her clinical practice. Dr Booth did not materially contest any of the findings.

54. Dr Balfour's Report drew attention to significant practice organisation issues in particular record keeping, chronic disease management and prescribing. His overall view was that this was a disorganised and clinically unsafe practice and he was concerned that Dr Booth remained responsible for the management of the practice whilst suspended. He suggested a range of measures to improve clinical care in the practice but the Panel felt that the quality of patient care would remain below acceptable standards whilst such measures were put into effect.

55. In addition, the recommendations in the NCAS final Report drew attention to deficiencies in 15 areas of Dr Booth's clinical practice (see para 12 above). In the section detailing individual consultations, there were a significant number of patient contacts where Dr Booth's practice was below that expected from a GP and a number of those demonstrated extremely poor performance which could have potentially resulted in serious harm to the patient.

56. The wide ranging failures identified in the reports, the areas identified as requiring remediation, the length of time needed, and the feasibility and sustainability of remediation based on previous attempts, lead to the Panel recommendation that Dr Booth be removed on grounds of unsuitability and efficiency.

57. In February 2011 Dr Ferguson attended another CPP as the equivalent practitioner to consider removal following notification of its intention to Dr Booth and to consider her (written) representations. Due to the wide ranging deficiencies the Panel agreed Dr Booth was not suitable to remain on the Performers List. The Panel discussed the possibility of contingent removal, but given remedial steps had not been effective in the past and the NCAS Assessment showed little, if any, improvement in Dr Booth's practice, they felt it was extremely unlikely to be successful. Moreover, NCAS had indicated remediation was likely to take 12 months and even if successful, it was unlikely Dr Booth would be able to return in a single handed capacity. The Panel felt the quality of care for patients at the practice would remain below an acceptable level whilst remediation was underway. The Panel agreed that despite Dr Booth's desire to remain on the List, the scale of remediation and the consequent financial and human effort to deliver it would have a detrimental effect on the efficiency of primary medical services in Hampshire. Accordingly, the Panel agreed the recommendation to remove Dr Booth should proceed.

58. At the hearing, Dr Ferguson confirmed his extensive experience as a GP, including 30 years as a GP trainer.

59. He considered there were a considerable number of repeated failings at a moderate level that he would not expect of an ordinary, practising GP, but also a significant number of serious failings which had put patients at risk, sometimes of their lives.

60. Dr Ferguson was taken through some specific examples of poor practice in the NCAS Report, including that of an elderly female with a recent history of breast cancer presenting with her spine "not being very good". *(Tab B2, page 92 no.2 of bundle).* He submitted that breast cancer classically moves to bone and his view would be to presume there was a bony secondary in the spine unless it was proved otherwise. Failure to investigate it was a serious failing which could considerably shorten the

patient's life. There was nothing to support Dr Booth's enquiries about the patient's hearing and if she had had audiometry tests or whether she had been to a chiropractor.

61. In another case *(Tab B2, page 94 no 2)* an 8 year old girl had been given six courses of antibiotics since 2006, a number of which were prescribed for a presumed urine infection (UTI). Dr Ferguson submitted UTIs were not common in children and those under 5 years with UTIs were at risk of permanent kidney damage. At the very least the GP should arrange kidney investigations, e.g. ultrasound and referral to hospital for further investigations if a repeat history. If not treated, there could be significant renal damage ending up with a transplant.

62. Dr Ferguson did not agree with Dr Booth's view that her record keeping had improved. He also thought her prescribing remained poor. He cited the example of a 22 year old male smoker with a cough being prescribed Montelukast *(Tab B2, page 102 no.23*, which is a very high powered medication for allergic asthma without any indication this patient had asthma or Dr Booth had considered it as a diagnosis. He also cited numerous other examples of poor prescribing and record keeping recorded in the NCAS Report and pointed out that Dr Booth's 1350 patients had now been taken over by another practice where such poor record keeping would cause immense difficulties with regard to patients' medical history, medications, etc.

63. 41 individual examples of poor practice had been identified from only 30 records which had been selected for review and interview and Dr Ferguson considered Dr Booth's record keeping was of an absolutely inappropriate standard.

64. As a single handed practitioner Dr Booth had no one to ask or discuss things with, there was no peer review apart from annual appraisal and it was much harder to keep up to date. It was Dr Booth's responsibility to review and update clinical protocols on a regular basis, even if there was a Practice Manager and Practice Nurse.

65. In relation to the NCAS findings on Dr Booth's behaviour and insight into her shortcomings and responding to remediation, Dr Ferguson felt her previous remediation had already fallen off and that she might need more remediation than others to amend her ideas and not to attribute blame elsewhere. Trainees were usually young doctors with little exposure to general practice and very amenable to training. Dr Booth had very fixed ideas which were very inappropriate to good practice. She would have to undo those beliefs before she could start remediating, which would potentially make it a very long process. Trainers relied on inculcating trainees with self-analysis, and personal development (CPD) so that they had an ongoing professional responsibility to themselves and their practice. It was hard to change behaviour in young GPS starting from scratch and very hard, if not impossible, in old GPs.

66. Dr Ferguson had never seen such a long list of deficiencies requiring redress; some of the failings were serious because of the potential impact on patient safety or because they reflected Dr Booth's attitude to her profession

67. At the February meeting to consider removal Dr Ferguson had given his opinion that remediation would take in excess of one year, although he felt it was unlikely to happen. It took one year to get ordinary GPs to Registrar level, able to become part of

a GP practice where they would continue to gain skills with the support of other partners, but they would not be able to take on single handed practice. Even if the resources were available for such training, Dr Booth's failings were so wide and so many were behaviourally based, Dr Ferguson felt it would be very hard to change her long held beliefs.

68. In response to cross-examination, Dr Ferguson confirmed he had never previously met Dr Booth or assessed her practice himself. Nor had he looked at the 30 records the subject of the NCAS Assessment but broadly speaking, he felt it was a sensible, careful, proportionate assessment with which he broadly agreed.

69. He considered any behaviour was capable of remediation if enough effort was put in but his concern was that it would take a very long time. He felt it was very unlikely Dr Booth could be remediated and most importantly, it was difficult to believe her remediation would be sustained. This was, and continued to be, his interpretation of the NCAS behavioural assessment.

70. The PCT Panel had felt this was such a bad inefficiency case that it also made Dr Booth unsuitable.

71. Dr Ferguson did not recall being told the detailed figures for remediation but he had heard a ballpark figure, although he was not sure if this was before or after the February meeting to consider removal.

72. He had given the PCT Panel advice on Dr Booth's health on the basis of her clinical records. They had not discussed in any depth the particular challenges of dealing with a difficult practice population in an area of deprivation.

73. In response to questions, Dr Ferguson confirmed there were four or five single handed practitioners within the PCT.

74. If remediated, Dr Booth would not get her patients back as her contract had been terminated.

75. If in good health, there was little doubt that Dr Booth's performance would have improved to some extent, but there were serious concerns at such a basic level that it would not have raised it sufficiently to alleviate the PCT's concerns about patient safety and it is doubtful they would have considered remediation feasible.

Dr F M Nuria Booth (Appellant)

76. In her Witness Statement Dr Booth pointed out that when subject to contingent removal in November 2006, she had been determined to address her shortcomings and undertake the required remedial work, resulting in her conditions being removed in January 2008, although the PCT wanted her to continue to liaise with them on a voluntary basis to ensure that appropriate standards were being maintained. She submitted that this previous experience demonstrated she had the ability and motivation to remediate the deficient areas of her practice.

77. When Dr Booth was notified by the PCT in April 2010 that following patient complaints it felt she should undergo NCAS Assessment she complied, as she wished to engage constructively on the issues raised by the complaints and any areas of her practice identified as requiring further improvement.

78. Following that assessment, the issuing of the NCAS Serious Concerns Report, her suspension, the PCT's own review (which concurred with the NCAS view that her shortcomings were not incapable of remediation), and the PCT informing her it was considering removal, Dr Booth met with the PCT to discuss arrangements for care of her patients in the event of her resignation of her contract, which she felt pressurised onto agreeing to. She had reiterated the punitive consequences on her finances, in relation to the remainder of her business start up loan, which had £60,000 remaining and was being repaid by a part of the notional rent paid by the PCT. She also had three years remaining on the practice lease at £21,500 per annum.

79.. Dr Booth had become ill in May 2010 but was not diagnosed until November 2010, during which time she felt very ill and lost three stone. She was hospitalised in November and eventually diagnosed with a clot in the liver veins. She had also contracted Epstein-Barr virus. Her illness had affected her ability to work throughout this period and also during the NCAS Assessment, which she mentioned at the time but she felt she had failed to communicate to the assessors how she was feeling, although she had thought it was evident when she had to rush out of the room to vomit.

80. In the PCT's letter confirming removal it had listed the key components of an effective remediation, but having identified her practice was capable of remediation and the manner in which it might be achieved, the PCT went on to explain the reasons why it had determined she should not be given the chance of remediation in the manner envisaged. Those reasons appeared to be based on assumptions relating to the practical difficulties of a remediation package, particularly the willingness of other practices to assist her by providing supervision and her ability and/or the ability of the PCT to meet the costs. Dr Booth was not given an opportunity to engage constructively with the PCT to see whether a practical way forward could be achieved.

81. Dr Booth was also disappointed to see her "apparent" lack of insight into the scale of remediation needed being used as a further reason to support the PCT's decision to remove, given she had maintained throughout this process that she recognised that significant remediation was needed and .she had repeatedly stated her willingness to work with the PCT to achieve the necessary improvement. She had already started taking the remedial action identified by arranging to take the MCQ test and surgical assessment, which were the first of the four elements of the PCT Panel's Action Plan.

82. As a result of referral by the PCT, Dr Booth's GMC registration was suspended for eighteen months. She had been invited to undergo a performance assessment in July and her solicitors anticipated seeking a review of this suspension to allow her retraining to continue.

83. Dr Booth had been hampered in progressing her remediation by ill health. She had also been hampered by her financial difficulties, which had hindered her ability to

find an arrangement, such as a partnership or merger with a neighbouring practice to allow her to continue in practice.

84. She had continued to update herself; she had passed a CPR course, attended a course on the management of poorly controlled diabetes, was on the waiting list to attend a course on record keeping, and had been completing on-line courses from the BMA and Univadis. She had also been studying books from the MRCGP curriculum, continued to regularly read the BMJ and NICE Guidelines.

85. Whilst she appreciated the formulation and implementation of an effective remediation programme would not be straightforward, and there were resource implications to be considered, Dr Booth felt strongly that before her career as a GP was ended she should be given a chance to address the concerns raised about her practice. She believed the decision to remove her should not simply be taken by default, on the basis of assumptions as to the practical difficulties of remediation that might be inaccurate.

86. At the hearing, Dr Booth confirmed she had never previously been given the figures for remediation and there had been no substantial discussion about them although once or twice it was indicated that she would probably find them unaffordable. She had discussed rough costings with the Postgraduate Dean and applied to the Medical Benevolent Fund (MBF) for a loan and some allowance to cover costs. She had also discussed the possibility of support with a representative from the Medical Protection Society (MPS), who had previously worked with a particular behavioural psychologist, who might be of help. She had assumed the PCT would not pay for any of it or that she would be paid a salary during remediation and was contemplating drawing her Old Age Pension (OAP) for living costs.

87. So far as insight was concerned, she had discussed what was necessary with the Postgraduate Dean. She had already taken the MCQ test and had a good result in the applied knowledge test, but had failed the ethical dilemmas test as she was unfamiliar with the format. She had arranged and paid to take the re-sit in September. She was at a loss to understand the behavioural assessment suggestion that her personality or disposition might prejudice her ability to engage successfully in retraining.

88. Following her contingent removal being rescinded in January 2008, by way of support Dr Booth had had two or three meetings with Ms Copage and approached a private firm buying up practices but that had not worked out. She had then met with two experienced Practice Managers, one of whom twice visited the practice. She felt she could do with more support finding suitable management. She had then trained her own manager. Most of the PCT support was for her staff, e.g. IT training for the Practice Manager, Receptionist and Administrator. A few months prior to the NCAS Assessment in September 2010 her Practice Manager had resigned with ill health and her Practice Nurse had retired. She had been trying to engage a Nurse/Practice Manager at the time of the NCAS Assessment but felt it would be difficult to engage a new permanent member of staff when she did not know what the outcome would be.

89. Dr Booth felt she could undertake remediation as she was 90% recovered from her illness. She would be willing to fully engage with a remediation programme, happy

for her progress to be kept under regular review during and following completion of remediation, not to practise as a single handed practitioner,

90. In response to cross-examination, Dr Booth admitted she had nothing in writing to confirm support from either the MBF or the MPS. Her OAP to cover her living costs would be £92.50 per week.

91. By January 2008 she believed she still had management problems but she was okay clinically. She believed she had maintained acceptable standards until she fell ill in 2010.

92. When questioned about the example of poor practice in the NCAS Report of the elderly female with a recent history of breast cancer presenting with her spine "not being very good". *(Tab B2, page 92 no.2 of bundle)*, Dr Booth accepted that the obvious problem the patient could have been facing was secondary metastases of breast cancer if it was an unknown patient, but the NCAS Assessors did not take into account the fact she had had a very recent MRI consultation or that she had previously had four back fusions and been bedridden. Dr Booth had not addressed this in her comments on the draft NCAS Report because she accepted the Assessors were working from what was available. The fact Dr Booth knew a great deal more than was in the notes was a problem; it didn't mean she hadn't considered secondaries but it was not in the notes. That was the problem with most of the negative reports, but she was only asked to correct matters of fact.

93. When questioned about the examples of poor practice of infection control Dr Booth denied they were her standard practice but conceded she had been negligent. She also conceded that, on the whole, her records were far too brief and that her illness did not excuse two years of poor record keeping, although she felt her standards had been improving in 2008 and 2009, even though they were still not good enough, but it was in the last year, when she had been ill, they had slipped. She was aware her standard of record keeping was unacceptable but not how deep and dire it was.

94. When asked to clarify her ethical dilemmas exam result which she had earlier said she didn't quite pass, Dr Booth confirmed she had been in the lower 12%.

95. Dr Booth did not know which of her beliefs and opinions were problematic but she had not thought it appropriate to challenge her behavioural assessment because they were not matters of fact.

96. She had not asked for PCT support for practice management or recruitment as she was not aware she would have been given it.

97. Contrary to the NCAS behavioural assessment, in her 360 degree appraisal Dr Booth's colleagues had generally reported their relationship as good; that was the opinion of people who knew her. The NCAS Assessors had come to a theoretical conclusion on the basis of a single interview.

98. In response to questions, Dr Booth confirmed the old EMIS computer system at the practice allowed for freehand and read codes, although to begin with they were not

very extensive. The PCT had taken over the system after her initial investment of £12,000 and quite regularly upgraded it.

99. The PCT was also currently paying her business loan and rent under the practice lease. A series of miscellaneous events such as the Practice Manager retiring through ill health stopped her developing the practice to the extent she had intended; if her patient list had risen to 1800 she could have afforded a partner. She had had a good Practice Nurse who left, and her replacement was very slow. When she retired Dr Booth was anxious not to take on another burden rather than benefit so she took on some of the nursing duties herself.

100. It appeared there were two or three areas of prescribing in which she had not improved. One was the use of Montelukast which she was trying out instead of antibiotics on children with coughs and hoping to audit but she had not adequately explained her position on that in the notes. She had attempted to follow NICE guidelines but that was not possible with some small children on inhalers so Montelukast was good because it is given orally. It had helped with coughs but if she used it again she would explain why and audit it.

101. She was aware her prescribing patterns were unusual, she needed to comply more closely with guidelines and justify her prescribing in the notes.

102. She had attended a few courses since the NCAS Report but there were none she wanted to go on until September. In the meantime she was doing some on line learning from the BMA and Univadis, but she had not got results available because of problems with her computer. She was also studying books from the MRCGP curriculum.

103. On re-examination, Dr Booth confirmed she had a particularly good relationship with doctors at Basingstoke Hospital, the local health visitors and the midwife team at the Cottage Hospital.

106. She had not made more of her ill health to the NCAS Assessors as she knew they were aware of it from the extensive occupational health assessment and they told her this.

107. With regard to the elderly female with a recent history of breast cancer presenting with her spine "not being very good". *(Tab B2, page 92 no.2 of bundle),* Dr Booth felt the Assessors' comments were entirely fair on what they observed but she felt they had misunderstood the patient's agenda.

Closing Submissions

108. Counsel for the PCT pointed out that the PCT already had wide ranging concerns about Dr Booth's clinical governance arrangements and the chaotic nature of her practice in 2006, when she was contingently removed. A detailed action plan set out a framework of remediation and one of the areas to be addressed was "very poor record keeping". The PCT committed significant financial and human resources providing support, training and installing IT systems.

109. In 2010 the NCAS Assessors were so concerned about Dr Booth's practice and the potential for harm to patients that they issued an interim Serious Concerns Report. Both that and the final Report concluded Dr Booth's "overall performance was significantly below the level expected of a GP" and identified wide ranging and serious deficiencies (see para 12 above). Some of the deficiencies were very serious (see paras 60 and 61 above) giving rise to very serious and avoidable risks for the patients. The sheer number of individual examples of poor, or significantly poor performance was in the context of a limited review of the records and a relatively short period of assessment.

110. Dr Booth told the Assessors she believed her record keeping had improved over the past year but that there was still some room for improvement, yet there were 41 identified areas of poor practice from only 30 records, despite this being one of the areas flagged up for remediation in 2006 and into which the PCT had put resources. This meant either Dr Booth's record keeping had improved only to fall again between removal of conditions in January 2008 September 2009 (12 months before assessment), or else there had been no effective remediation and she had no insight into her significantly poor standards of record keeping or her ineffectual attempts to improve those standards.

111. The NCAS Assessment also identified serious failings in Cervical Screening, which had also been flagged in 2006.

112. These two findings, together with the many other wide ranging, serious failings identified meant Dr Booth would be difficult to retrain and it would be difficult to ensure sustained and consistently acceptable standards of treatment.

113. Neither of the PCT witnesses had ever had experience of a doctor who had fallen so far below the appropriate standards in such a range of competencies.

114. In June 2011, despite an extended period for revision, retraining and preparation, Dr Booth took and failed the MCQ.

115. The PCT had limited resources. It did not have a specific budget for remediation, the funding of which would mean less funding for medical services. It was entitled to take into account Dr Booth's previous performance and history. The policing of any conditions would be an unreasonable and impractical burden on the PCT, The intensity and level of support required would compromise the efficient running of the list. Any conditions and the consequent expense would add to, rather than remove, the prejudice to efficiency of services and there was a significant question as to whether there would be any sustained improvement in Dr Booth's practice. Even if health were an issue it does not explain the consistency of concerns or the direct overlap between those concerns in 2004 and 2006 and more recently. It had been submitted Dr Booth would be able to fund her share of the remediation programme yet she had been given additional funding because her practice was going to go bankrupt and there was no guarantee her defence organisation would fund her.

116. Protection of patients was the overriding consideration as to whether a GP should be removed from the Performers List.

117. Dr Booth's serious, extensive failings had proved intractable to earlier remediation and the extent of her deficiencies rendered her unfit for inclusion on grounds both of unsuitability and inefficiency.

118. At the hearing Dr Booth sought to demonstrate insight by saying there were three main problem areas with her prescribing but that was far from the truth; The NCAS Report identified 36 examples of significantly poor prescribing practice *(Tab B2 pages 98 – 103)*. This was not only far below standard practice but it also put patients at significant risk without monitoring.

119. Not many NCAS Reports referred to significant failings or significantly poor areas of deficiency or lead to interim reports requiring urgent action to maintain patient safety. Dr Ferguson sat on the PCT Panel to provide experience and evidence of an acceptable standard of general practice and he considered Dr Booth fell very far below this standard and that experienced professionals were more likely to be intractable in their bad habits and less likely to be remediable.

120. The PCT had already invested a considerable amounts in Dr Booth in 2006 and 2007 and the sums they were now talking about just to put in place a remedial training programme would dramatically impact on the provision of other services.

121. The PCT did not have the funds for the extensive package required and although Dr Booth suggested she could fund it with help from the MBS and MPS she had no documentary evidence to support this. Dr Booth was in the twilight of her career and her OAP of £92 per week was barely enough to live on and would not stretch to training or supervision. Dr Booth had a substantial business loan which was highly unlikely to be repaid. There was no hard evidence in support of the suggestion that Dr Booth could fund any of the extensive monitoring, supervision or training and there were no letters of support from professionals to whom she might have referred patients or from support staff.

122. Whilst Dr Booth's livelihood was at stake it was necessary to look at patient safety, which had been compromised by her failure to properly assess or prescribe. The PCT had taken its decision with proper consideration of the very serious medical issues raised and the financial implications of trying to provide a remediation package, having already invested a considerable amount in this doctor as recently as 2006.

123. Counsel for Dr Booth submitted he had set out the position in his opening submissions but there were some matters of detail arising out of the oral evidence. He contended that the nature of the PCT's analysis of this case had now changed from the time of the initial decision, when it had considered this was a remediable doctor, albeit one in respect of whom considerable concerns had been identified, but did not think remediation was appropriate because of resourcing implications, Dr Booth's lack of appreciation of what was really required and her disposition. The PCT was now saying its decision was justifiable because Dr Booth was not a remediable doctor, i.e. she was a really bad doctor who did not realise how bad she was.

124. The NCAS Assessors had set out what remediation was necessary and prepared a twelve month Action Plan for remediation. Dr Balfour's review for the PCT also set out a minimum remediation programme for retraining. Most importantly, Ms Copage

having spoken to NCAS on the morning the PCT Panel met to consider removal, the PCT Panel accepted that whatever clinical deficiencies had been revealed by the NCAS Assessment, Dr Booth was remediable. The feasibility of a remediation programme was referred to in the PCT's letter of removal to Dr Booth and in its response to this appeal.

125. The PCT said there were three reasons why remediation was not appropriate in this case but Counsel submitted none amounted to a good reason why Dr Booth should not be given the chance to put matters right.

126.1 Resources - It was unfair of Counsel for the PCT to criticise Dr Booth for not having documentary evidence from the MBS or MPS re possible contributions when the PCT had only produced figures at the start of the hearing. Dr Ferguson had confirmed he had only previously heard a ballpark figure. It was clear this was a resources decision taken without any proper knowledge of the resources implications. The figures quoted by Ms Copage bore no relation to the figures reached when drilled down, or what Dr Booth had been told by the Deanery; they rested on a series of speculative assumptions and this was an ex post facto attempt to fill a glaring gap in the evidence. Even if some credence was given to the figures, the Panel had not been told the budget for doctors requiring assistance. It was easy to say this would have an effect on other services but the PCT was there to help to support doctors and ensure their skills and values were preserved for patients and to preserve the career of a caring, valued doctor. A resources objection to remediation had not been made out on the evidence.

126.2 Attitude/Disposition/Personality – It became clear at the hearing that the PCT's view was based on a complete misreading of the NCAS Report. Ms Copage gave evidence that the PCT took into account the statement in Dr Booth's NCAS behavioural assessment that her strong set of values and behaviour might impact on her ability to successfully complete any remediation programme, but she could not find this statement in the NCAS Report, because NCAS never said that. Dr Ferguson's evidence was equally unsatisfactory; he said that the Report said it was unlikely Dr Booth would successfully complete any remediation programme, but it never said that. The points NCAS did make were that Dr Booth was not very organised so she needed good practice management around her ,and that she needed help seeing where more organised people were coming from. It also said she worked well with colleagues. Accordingly, the PCT's decision to refuse Dr Booth the opportunity to remediate in the context of a contingent removal on the basis of what it believed to be her personality was unfair and misconceived.

126.3 Insight – Ms Copage accepted the issue of insight related to insight into the demands of a remediation programme. There was no question that Dr Booth recognised she needed to work hard to remediate her clinical deficiencies; she had said so to NCAS, the PCT and this Panel, she had seen the Action Plan, what it would cost, how long it would take, accepted she would have to go back to being a medical student and talked to the Dean and the MPS. The Panel should conclude there was nothing more Dr Booth could have done to demonstrate she has insight into what is required; she had never quibbled with the NCAS Report, she had co-operated with the process, accepted the findings and was now keen to sort matters out.

127. The new issue raised in the hearing was that the NCAS Report identified such serious issues that it lead to the conclusion that Dr Booth was irremediable. However, Dr Ferguson accepted he had not analysed this case beyond consideration of the NCAS Report, i.e. he had not looked at the patient records and, in short, he agreed with the NCAS Report; Counsel invited the Panel to disregard much of his evidence on his take on the Report. In those circumstances, this Panel was left with the NCAS Report and what it said; it was clear it contained a number of instances of sub-standard practice, no one had sought to suggest the issues of poor practice identified in the Report could be explained away by ill-health or staff shortages. Dr Booth's case on her clinical deficiencies was, and always had been, that the Report was fair, showed work was required and she agreed with the Assessors what needed to be done to do that work. Everyone who had assessed this doctor believed she was remediable and the question was whether she should be given that chance. The question for this Tribunal was whether there were sufficient reasons why Dr Booth should not be given the chance to remediate.

128. With regard to conditions, Dr Booth's contract at Highview Practice had been terminated and she could not go back to being a single handed practitioner there. The issue was whether she could remain as a Practitioner on the Performers List. Dr Booth was more than happy to abide by conditions:

(1) to undertake a remediation programme of a type outlined by NCAS
(2) not to work in single handed practice
(3) to have regular review
(4) to be kept under review after remediation.

129. With regard to the issues of inefficiency and unsuitability, Dr Booth had been removed from the Performers List on both grounds. Counsel for the PCT was wrong to say that the extent of Dr Booth's deficiencies rendered her unfit for inclusion on grounds both of unsuitability and inefficiency and the PCT's witnesses' evidence was to conflate the two grounds. This was an efficiency case about clinical performance. There was no question about Dr Booth's probity, honesty, or the propriety of her behaviour. It was a question of whether she was a good enough doctor, so it was purely and simply an efficiency case. The Tribunal was invited to reject the suggestion that it was such a bad efficiency case that Dr Booth was unsuitable.

130. The question here was whether or not a remediable doctor should be given the chance to remediate. In the ordinary course of events the answer is presumptively "yes". It might be "no" if there was an overwhelming reason why it might not be appropriate in a particular case, but nothing had been advanced by the PCT as to why that should be the case in this instance. Dr Booth was a caring doctor; she was not in it for the money. She might be unconventional in some respects but some of her patients responded very well to this and she had the support of her patients. Her career was worth saving and she deserved the chance to put right things that had gone wrong. She was determined to get her career back on track.

131. Counsel for the PCT - made two corrections. He submitted that the NCAS Report did not say that Dr Booth had worked well with colleagues, but simply that she had demonstrated satisfactory performance. He also pointed out that the PCT had no budget for remediation and Dr Booth would have to apply for funding.

Consideration and Conclusions

132. We have carefully considered the written and oral submissions for both parties. The PCT removed Dr Booth on grounds of both efficiency and suitability and we accept there can be overlap between these grounds. However, we thought it was equitable to consider them separately and as if distinct where possible, as otherwise one would add little or nothing to the other. Accordingly, we first considered whether Dr Booth was unsuitable to be included on the Performers List.

133. The basis of the PCT's submissions relating to suitability was that Dr Booth's serious, extensive failings had proved intractable to earlier remediation and the extent of her deficiencies rendered her unfit for inclusion on grounds both of unsuitability and inefficiency.

134. Counsel for Dr Booth told us that the PCT was wrong to say this and the PCT's witnesses' evidence was to conflate the two grounds. He submitted this was purely and simply an efficiency case about clinical performance. There was no question about Dr Booth's probity, honesty, or the propriety of her behaviour. It was a question of whether she was a good enough doctor.

135. We note from the DOH Guidance that the term "suitability" is used with its everyday meaning and so provides PCT's with a broad area of discretion, so that there may be some overlap between these grounds. However, in this instance we agree with Counsel for Dr Booth that this case is solely about clinical performance, with no allegations relating to Dr Booth's probity, honesty, or the propriety of her behaviour. Accordingly, we do not find she is unsuitable to be included on the Performers List and to this extent, we allow the appeal.

136. Having concluded that the PCT's concerns relating to Dr Booth should more properly be considered under the ground of efficiency, we note that Dr Booth does not seek to deny that certain elements of her practice could be prejudicial to the efficiency of services, but that her case on appeal is that the PCT's decision was disproportionate and the appropriate and proportionate response would have been to have provided her with an opportunity to engage constructively with the PCT in remediating those areas of concern, as she has done successfully in the past. Accordingly, the issue for us to consider is whether the removal should have been contingent to allow Dr Booth the opportunity to remediate.

137. Counsel for Dr Booth submitted that everyone who had assessed her (including NCAS, Dr Balfour in the PCT Review, and the PCT Panel) believed she was remediable and the question was whether she should be given that chance and if here were sufficient reasons why she should not. He highlighted the remediation packages which had been suggested by both NCAS and the PCT Review and the fact that the PCT Panel had not disputed that Dr Booth was capable of remediation.

138. We accept that Dr Booth is a caring, sensitive doctor with the particular challenges of dealing with a difficult practice population in an area of deprivation and that she has the support of many of her patients.

139. We note that Counsel for Dr Booth contended that the PCT's decision to refuse Dr Booth the opportunity to remediate in the context of a contingent removal on the basis of what it believed to be her personality was unfair and misconceived because the PCT's view had been based on a complete misreading of the NCAS Report. He submitted that the PCT 's evidence that the NCAS behavioural assessment had concluded Dr Booth's strong set of values and behaviour might impact on her ability to successfully complete any remediation programme was incorrect, and Dr Ferguson's evidence was equally unsatisfactory in so far as he believed the Report said it was unlikely Dr Booth would successfully complete any remediation programme. Having read the conclusions of the behavioural assessment, we accept these interpretations of the conclusions were inaccurate, but in any event, we do not consider that the evidence relating to Dr Booth's disposition, which are not matters of fact, should be a factor in our consideration.

140. We have considered whether the issue of Dr Booth's insight impacted, or should have impacted on the decision to remove. Counsel for Dr Booth submitted the issue of insight was in relation to the demands of a remediation programme and there was no question that Dr Booth recognised she needed to work hard to remediate her clinical deficiencies; she had said so to NCAS, the PCT and to us, she had seen the Action Plan, what it would cost, how long it would take, accepted she would have to go back to being a medical student and talked to the Dean and the MPS. He said there was nothing more Dr Booth could have done to demonstrate she has insight into what is required; she had never quibbled with the NCAS Report, she had co-operated with the process, accepted the findings and was now keen to sort matters out.

141 Ms Copage's evidence was that the PCT Panel had been aware Dr Booth was willing to try remediation but felt she lacked insight into the scale of remediation required. Dr Ferguson's evidence in relation to Dr Booth's insight into her shortcomings was that he felt her previous remediation had already fallen off and that she might need more remediation than young doctors with little exposure to general practice who were very amenable to training, since she had very fixed ideas which were inappropriate to good practice and she would have to undo those beliefs before she could start remediating, which would potentially make it a very long process. It was hard to change behaviour in young GPS starting from scratch and very hard, if not impossible, in old GPs.

142. We note that Ms Copage said the PCT Panel did not use Dr Booth's perceived lack of insight to reach its decision; they had looked at the totality of what was required and if it would be sustainable. Our own view is that whilst Dr Booth was clearly willing to undergo extensive remediation and confirmed she would do whatever it took, we are less certain that she has the necessary insight into what is required for evidence-based practice, but in any event, this was not the key factor in our consideration.

143. Our unanimous view is that the significant factor is the issue of resources. The PCT 's case was not that remediation was not feasible, but that having considered all the evidence, and in particular the fact that Dr Booth was significantly below the level expected of the profession, the scale and cost of the proposed remediation, whether it would be successful and sustained, and that the scale of remediation needed would have an effect on the efficiency of primary medical services, it concluded that Dr Booth should be removed. Counsel for Dr Booth submitted that it was easy to say Dr Booth's remediation would have an effect on other services but the PCT was there to

help to support doctors and ensure their skills and values were preserved for patients and to preserve the career of a caring, valued doctor.

144. We note the costings the PCT gave for remediation and its provisos in relation to the possible range of those costs and we also note how Counsel for Dr Booth attempted to drill those costs down and his submissions in relation to possible contributions from the MBF and the MPS and her ability to draw down her OAP to cover living costs and that he contended a resources objection to remediation had not been made out on the evidence.

145. We also take account of Dr Booth's ill health and how this would undoubtedly have latterly impacted on her performance and during her NCAS Assessment.

146 However, we are also aware that the PCT has limited resources and that it does not have a specific budget for remediation, so any money used for remediation would mean less funding for medical services.

147. We also feel that Dr Booth's previous performance and history are very relevant; indeed, under the Regulations previous contingent removal and the facts relating to such action are one of the matters we are required to consider in an efficiency case.

148.. Dr Booth pointed out that when subject to contingent removal in November 2006, she had been determined to address her shortcomings and undertake the required remedial work, resulting in her conditions being removed in January 2008. She used this previous experience to argue she has the ability and motivation to remediate the deficient areas of her practice.

149. The PCT submitted that despite a detailed action plan setting out a framework of remediation in 2006, with one of the areas to be addressed being "very poor record keeping" and committing significant financial and human resources to provide support, training and installing IT systems, within less than two years of the conditions being removed the NCAS Assessors were so concerned about Dr Booth's practice and the potential for harm to patients that they issued an interim Serious Concerns Report. It pointed out that both that and the final Report identified wide ranging and serious deficiencies giving rise to very serious and avoidable risks for the patients. It contended the sheer number of individual examples of poor, or significantly poor performance was in the context of a limited review of the records and a relatively short period of assessment.

150. We do not accept Dr Booth's argument and we conclude that either there had been no effective remediation or else, Dr Booth's practice and record keeping significantly deteriorated in a very short period of time.

151. We are also very concerned by the examples of poor practice and record keeping we were taken to by Dr Ferguson at the hearing, and by the inadequacy of some of Dr Booth's explanations, which highlighted her poor record keeping. We are particularly concerned by her evidence that she thought there were only two or three areas of prescribing in which she had not improved, and her unconventional prescribing of Montelukast instead of antibiotics for children with coughs, which is contrary to NICE guidelines.

152. We also note Dr Booth's very poor performance in the ethical dilemmas part of her MCQ exam, and are concerned she gave the impression in evidence that this was a near miss. Likewise, her evidence relating to CPD proved to be less impressive when closely questioned about what courses she had taken and the books she was studying.

153. We have given very careful consideration to the necessity to remove Dr Booth and in particular, the impact upon her and the proportionality of that step. We have some sympathy for the financial position in which Dr Booth finds herself, but we do not feel there is any hard evidence in support of the suggestion that she could fund any of the extensive monitoring, supervision or training required. Although the PCT provided costings at a late stage, which were not finalised and subject to variation depending on particular circumstances, we accept that it has always been clear that a very extensive package would be required, far in excess of what is usual for remediation. We consider the policing of any conditions would be an unreasonable and impractical burden on the PCT and the intensity and level of support required to remedy such wide ranging and ingrained deficiencies within a realistic timescale would compromise the efficiency of services. Additionally, given there is a significant question as to whether there would be any sustained improvement in Dr Booth's practice, we are not persuaded that the PCT should be required to provide the very extensive remediation package which is clearly required.

Decision

154. For all of the above reasons it is our unanimous view that Dr Booth should be removed from the PCT's Performers List on the ground of efficiency pursuant to regulation 10(4)(a) of the National Health Services (Performers List) Regulations 2004

155. Accordingly, we dismiss the appeal by Dr Booth against the decision of the PCT on 24th February 2011 to remove her from its Performers List.

156. We direct that a copy of our decision be sent to the GMC.

157. We have not been invited to consider National Disqualification but have a duty to consider that. We would not do so without giving the parties the opportunity to make submissions. Accordingly, we direct that this issue is dealt with pursuant to Regulation 18A of the National Health Services (Performers List) Regulations 2004

158. The parties are hereby notified of their right to appeal this decision under Section 11 of The Tribunals Courts and Enforcement Act 2007. Pursuant to paragraph 46 of The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber Rules) 2008 (SI 2008/2699) a person seeking permission to appeal must make a written application to the Tribunal no later than 28 days after the date that this decision was sent to them.

Dated this 2nd day of August 2011

Debra R Shaw
First-tier Tribunal Judge on behalf of the Tribunal