[2013] UKFTT 0699 (HESC)

Primary Health Lists

[2012]PHL 15526

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

Dr Nihal Elapatha (GMC No. 4343080) <u>Appellant</u>

v

NHS Commissioning Board (Formerly NHS Kent and Medway) <u>Respondent</u>

<u>Judge</u>	Mr Duncan Pratt
<u>Medical Member</u>	Dr P Garcha
<u>Member</u>	Mrs V Lee

<u>DECISION AND REASONS</u>

1. Dr Elapatha is a General Medical Practitioner who appeals, by notice dated 20 October 2012, against the decision on 27 September 2012 of Medway Primary Care Trust ("the PCT"), then operating as part of a cluster under the designation "NHS Kent and Medway", to remove him from its Performers List pursuant to Regulations 10 (3) and (4) (a) of the NHS (Performers List) Regulations 2004 ("the 2004 Regulations"): "an efficiency case"[1] . The 2004 Regulations were the relevant regulations in force at the time.
2. The PCT was the decision maker under the 2004 Regulations. Its successor body is the National Health Service Commissioning Board (also known as "NHS England") under the NHS Performers List Regulations 2013 which came into effect on 1 April 2013 and it is the 2013 Regulations which govern the conduct of this appeal pursuant to the transitional provisions. NHS England is the Respondent on this appeal but in dealing with historic matters we shall refer to "the PCT".
3. Dr Elapatha was represented by Mr T Leader of Counsel, instructed by Mr Utip of Selva & Co, solicitors, and the Respondent was represented by Ms N Bruce of Counsel, instructed by Ms R Crean of Capsticks, solicitors. The

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[1] Regulation 10 …
(3)The [PCT] may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.
(4) The conditions mentioned in paragraph (3) are that –
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case")…..

appeal was heard between 25 and 30 September and the parties submitted further written submissions, at the direction of the Tribunal, on 25 October 2013.

Decision

4. The decision of the Tribunal is that Dr Elapatha's continued inclusion in the performers list would be prejudicial to the efficiency of the services which those included in that performers list perform, but that is appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform. We therefore allow the appeal to the extent of rescinding the decision to remove Dr Elapatha from the performers list and exercise our discretion under regulation 10 (1) to impose the conditions on Dr Elapatha which are set out in the Schedule to this Decision.

The Legal Framework

5. This appeal is brought pursuant to regulation 15 of the 2004 Regulations (now Reg 17 of the 2013 Regulations), by virtue of which it is a redetermination of the PCT's decision, and this Tribunal may make any decision which the PCT could have made.
6. The other relevant provisions under the 2013 Regulations now operative are:

14 (3) The Board may remove a Practitioner from a performers list where any of the following is satisfied:…

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

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

(a) Any information relating to that Practitioner which it has received under Regulation 9; ….

(b) …

(c) The matters referred to in paragraph (6); ….

(6) Those matters are –

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

(e) whether the Practitioner has ever failed to comply with a request to undertake an assessment by … the NPSA [National Patient Safety Agency, of which the division relevant to this case is the National Clinical Assessment Service – NCAS].

In an efficiency case the Tribunal may, instead of removing the Practitioner from a performers list, impose conditions on his continued inclusion "*where ….appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform.*" [Reg 10 (1)].

7. At various times the parties have also referred to other provisions which were said to be of relevance to the background to the case including:

Reg *4 (3) -The Practitioner must provide the following undertakings [*when applying for inclusion in a performers list*] – (e) to co-operate with an assessment by the NHSLA where appropriate and when requested to do so*

by the Board. This differs from the parallel provision in the 2004 Regulations [Reg 4 (3) (d)] only by the insertion of the additional words “where appropriate”.

8. The burden of satisfying us that the case is proved lies on the Respondent as successor to the PCT and Ms Bruce opened the case and called her evidence first.
9. The standard of proof which we have applied is the balance of probabilities, whether a fact or allegation is more likely than not to have occurred, in accordance with the decision of the House of Lords in *Re D* [2008] UKHL 33.
10. We were also referred to the Department of Health Guidance as to the efficiency grounds, which remains the same in the 2013 Guidance as in the 2004 Guidance [D/236 of the hearing bundle], and to the General Medical Council guidance in “Good Medical Practice” [F/105 et seq of hearing bundle], particularly paragraphs 10, 13, 22 and 73. Where appropriate, we have had regard to all relevant guidance without limiting ourselves to those matters.

Background to the removal decision

11. Dr Elapatha qualified MB BS in Sri Lanka in 1981 and obtained further professional qualifications in Scotland. He has lived and worked in the UK since 1991. Since October 2003 he has operated a single-handed medical practice from premises at Delce Road, Rochester, Kent, known as “Rochester Community Healthy Living Centre”.
12. This case arises from a referral made by the PCT to NCAS of various concerns it had about Dr Elapatha. It took the decision to do so in January 2011. We are invited to focus on issues arising after January 2011, but within the context of previous dealings between the parties (see below under “Position of the Parties”); consideration of the earlier history cannot be avoided since we are invited to consider the appropriateness of referring Dr Elapatha to NCAS in respect of various issues which had arisen prior to January 2011.
13. The referral to NCAS was actually made on 24 February 2011. Thereafter there were delays (the reasons and blame for which are in issue) in progressing the NCAS assessment. The first substantive step in the referral process is to arrange a meeting attended by NCAS, the PCT and the medical practitioner, at which the process is explained and all the parties sign an “agreement to NCAS assessment and follow-up action” after which the assessment proceeds, a report is made and follow-up action identified (if appropriate). That initial meeting did not take place until 9 December 2011, when Dr Elapatha signed a copy of the agreement with the rider “signed under duress due to the threat by Medway PCT of removal from Medway performance list”. NCAS declined to proceed further unless Dr Elapatha signed an unqualified agreement so as to confirm he would cooperate with the assessment. Dr Elapatha was unwilling to do so; solicitors wrote on his behalf to say that he had complied with his obligations under the 2004 Regulations and they still did not accept that the assessment was necessary. However they also said from time to time that he was willing to undergo the assessment.
14. No further progress was made and on 18 April 2012 a letter giving notice

of the PCT's intention to consider removal from the performers' list was sent to Dr Elapatha, and notifying him of an oral hearing on 25 May 2012. A number of requests for postponement of that hearing were then made, and some granted, for reasons which included changing solicitors (at least twice), time for new solicitors to read documents, time to resolve a dispute with a legal insurer, his solicitor's holiday, Dr Elapatha's wish to provide independent evidence, and illness.

15. On 30 July 2012 Hempsons (instructed for a while in place of Selva & Co) wrote to the PCT stating that Dr Elapatha was willing to abide by the undertaking he had given to cooperate with an NCAS assessment [this undertaking is part of the 2004 Regulations] and would sign a fresh copy of the agreement. On the following day Capsticks, solicitors for the PCT, replied, agreeing to a request to adjourn the "consideration of removal" hearing, but requiring Dr Elapatha to sign an undertaking in the form enclosed with that letter, as well as signing a fresh NCAS agreement. The recitals and terms of that proposed undertaking have been considered during this appeal. Dr Elapatha declined to sign that. In the event no fresh signed agreement to the NCAS assessment was forthcoming until a day or two before the removal hearing was due to take place. No evidence was tendered to us about the consideration, if any, which was given to that late-tendered signed agreement. A hearing date was reinstated.
16. Dr Elapatha did not attend that hearing on 27 September 2012, but was represented by an officer of the Local Medical Committee. The panel rejected a further application to adjourn and decided to remove him from the performers list. In its formal notification letter the panel stated that it reached its decision on the ground that Dr Elapatha had been persistently uncooperative throughout the period of the chronology produced by the PCT. That had caused a considerable waste of the PCT's time and resources. The failure to cooperate had meant that any potential risk to patients arising from the background in the case remained unquantified.
17. That decision to remove Dr Elapatha from the performers list is now appealed.

The main issues

18. The parties have identified the broad issues for our determination. We refer to the Respondent's skeleton argument paragraph 30 and to the Appellant's closing submissions paragraph 2. With some modest revisions to reflect the language of the regulations we set them out in composite form as follows:
    a. Was it appropriate to refer Dr Elapatha to NCAS?
    b. Did Dr Elapatha ever fail to comply with a request by the PCT to undertake an assessment by NCAS?
    c. If the answers to these questions are "yes", are we satisfied that Dr Elapatha's continued inclusion in the performers list would be prejudicial to the efficiency of the services which those included in the list perform?
    d. If "yes", is Dr Elapatha's removal from the list justified? Or
    e. Could that prejudice be adequately prevented by imposing conditions on Dr Elapatha's continued inclusion in the performers list, so that he ought to be permitted to remain on the list contingent on his complying

with those conditions?

The Position of the Parties

19. The positions of the parties were indicated in the skeleton arguments submitted prior to the beginning of the hearing, and the appeal documentation. The Appellant also put in written closing submissions which Mr Leader amplified during his oral submissions. At the invitation of the Tribunal, both parties put in further written submissions dated 25 October 2013, on the issue of conditions. Their respective positions, as refined during the course of the hearing, may be summarised as follows.
20. The Respondent's primary position was that it was seeking removal of Dr Elapatha from the performers list. The ground relied on was that he had failed to comply with a request for an assessment by the NCAS (regulation 15 (6) (e)). In consequence he had not been assessed so his skills and competences (in particular those about which the PCT had historic concerns) had not been evaluated. We were invited to find that during the period from 24 February 2011 (when the PCT referred Dr Elapatha to NCAS) and 27 September 2012 (the date of the PCT's decision under appeal) Dr Elapatha had failed to engage effectively or co-operate with the PCT in its attempts to set up an assessment with NCAS, amounting to a failure to comply with the PCT's request. In consequence there had been significant waste of NHS resources and therefore the PCT (and hence this Tribunal) could reasonably conclude that Dr Elapatha showed a lack of insight, reinforced by his evidence to the Tribunal, and would not engage effectively in the future.
21. In the alternative, if we were not satisfied that removal was justified, the Respondent invited us to consider subjecting Dr Elapatha to conditions, and submitted a draft of 11 proposed conditions in the course of closing submissions. In further written submissions made on 25 October at the request of the Tribunal, the Respondent set out a number of considerations which (it argued) should be kept in mind by the Tribunal in deciding whether conditions were appropriate at all, and if so, how they should be framed. They also amplified the reasoning behind the draft conditions submitted at the end of the hearing, but the main thrust of the further submissions was that conditions were unlikely to be capable of addressing the prejudice to the efficiency of the services in this case because the history strongly suggested that Dr Elapatha will revert to prevarication and delay.
22. The position of the Appellant is that:
    a. It was not appropriate to refer Dr Elapatha for assessment by NCAS because there was no or insufficient reason for the concerns which the PCT expressed, or they had been resolved. Alternatively the case for a referral was not made out until 17 October 2011 when NCAS confirmed that the offer for assessment still stood.
    b. Dr Elapatha had not failed to comply with a request to carry out an assessment because the argument that his signature to the agreement of 9 December 2011 was vitiated by the "rider" was legally incomprehensible, irrational and incorrect. Moreover, on the facts, the delays which had occurred and were admittedly caused in part by Dr Elapatha, were characterised by a period of active engagement

between the parties up to 9 December 2011 and thereafter a period of "repudiation and preparation for removal". During the first period there had been delay which could not be fairly blamed on Dr Elapatha, and were often consensual in the sense that the PCT agreed requests for delays. Furthermore the legitimate sense of grievance felt by Dr Elapatha about a previous proposal to refer him to NCAS in 2009 and subsequently presenting contestable material to the DMG and "[refusing] to engage in dialogue about that", justified Dr Elapatha's desire to take legal advice and proceed with caution. In relation to the latter period the PCT did not attempt to move matters along by stipulating and sticking to meeting dates, and after April 2012 its focus shifted to removal, so marking the end of constructive engagement by the PCT.

c. If there was no failure to comply, PCT's case failed. If there was a failure to comply, the case for removal was not made out because the circumstances were not sufficiently serious; removal ought to be confined to circumstances where the case for removal was clear or the assessment has started but broken down with associated waste of resources, and there was a clear indication of a real risk to patients. Moreover Dr Elapatha's concerns about the process adopted by the PCT mitigated the weight to be given to any failure we might find proved.
d. Dr Elapatha would be willing to remain on the list subject to a condition that he must co-operate with the PCT. Mr Leader recognised this simply duplicated an obligation under the Regulations and in oral submissions he suggested a condition that Dr Elapatha engages with the Trust to formulate an improvement plan with regard to:
    i. Communication with patients;
    ii. Promoting continuous improvement in QOF scores;
    iii. Reviewing his Practice's IT protocols and practices;
    iv. Reviewing the potential for improving clinical record keeping and note making; and
    v. Reviewing the effectiveness and fitness for purpose of protocols for working with nursing homes and similar organisations.
e. In further written submissions dated 25 October Dr Elapatha's solicitors criticised the draft conditions submitted by the Respondent and proposed other conditions, by which Dr Elapatha offered to participate in any professional mentoring scheme required by the Respondent for a period of 12 months, and to cooperate in any review of the records system, ICT system and training in effective communication with patients. It was emphasised that any costs would be met by the Respondent and any improvement plan "must take account of DR ELAPATHA's workload and resources".

23. Ms Bruce did not, at the outset, invite us to consider in detail the evidence within our papers relating to events from 2004 to 2011. However in the course of the hearing these matters were treated by both parties as being of relevance. In the case of the Respondent this was because they formed the background of "concerns" which the PCT wished to have resolved by an assessment by a body which was independent of the PCT itself. In the case of Dr Elapatha he invited us to find that on a proper consideration of

the "concerns" it was not appropriate to refer him for assessment to NCAS. He also referred to that period as part of a series of dealings with the PCT, and in particular its Performance Review Manager, which caused him to believe that he was a victim of bullying, harassment, fabrication of evidence, and provision of false information to NCAS. He made formal complaints to the PCT, his Member of Parliament and the Secretary of State for Health, and alleged (letter from his solicitors of 20 October 2011 – D 884-5) that this conduct was "a racially motivated vendetta against him, instigated because he dared to question the veracity of a white manager". In evidence Dr Elapatha said he was happy to take that allegation back. However the poor state of relations and trust between Dr Elapatha and the local officers with whom he was dealing was a prominent factor in the mind of Dr Peter Green (Medical Director) when he gave us his reasons for concluding that a referral to NCAS was appropriate. We have therefore considered the material available in relation to the period 2004-11 by way of background and in relation to the issue of appropriate referral.

FINDINGS AND REASONS

Overview of the witnesses

24. Before turning to our findings on the issues we set out our broad impressions of the witnesses insofar as those may bear on our findings.
25. Ms Rakestrow. For most of the period from 2007 to April 2009 she was employed as a temporary Performance Review Administrator, and from the latter date was the Performance Review Facilitator for the PCT. Her role is more fully described in her witness statement [D/149 – 185]. She was responsible for day to day aspects of performance review including Dr Elapatha's case. Her immediate boss was Ms Kaye Lyons (Performance Review Manager) until her retirement in December 2012. It was Ms Lyons against whom Dr Elapatha made the allegations mentioned above. We found Ms Rakestrow to be a careful witness, doing her best to be accurate. She was understandably taxing her memory about a complex chronology of events over a long period. Sometimes she could not remember. She often took a few moments to consider the contemporaneous documents within the bundle before answering questions. She was willing to make concessions when appropriate. Because of the separation of functions maintained within the PCT, she was not in a position to help us on some issues such as what if any consideration had been given to the late-delivered unqualified signed agreement to the assessment in September 2012. We found her to be credible and (having regard to the allegations formerly made against her boss and others) notably free of any animus against Dr Elapatha or improper motivation.
26. Dr Peter Green. He is now the Chief Clinical Officer of NHS Medway Clinical Commissioning Group, but from 2007 to 2011 was Medical Director of the PCT and from April 2011 to September 2012 was Co-Medical Director of the Kent and Medway Cluster. We found him to be a careful, undemonstrative but impressive witness who gave thought to his answers. The limitations of his evidence arose mainly from his non-

involvement with the day to day dealings with Dr Elapatha by the Performance Management team, since as a member of the Decision Making Group (DMG) he preserved a separation of functions. We found him also to be free from any animus against Dr Elapatha or improper motivation and indeed Dr Elapatha himself volunteered that he had a high regard for Dr Green. We found Dr Green's evidence to be credible and we accept it.

27. Mr Carlo Caruso. He was a Performance Review Manager of the PCT from March 2008 but dealing with the neighbouring East Kent area, not Medway. He was asked to take over the management of Dr Elapatha in April 2012 because the doctor had raised allegations against Ms Lyons. He continued to do so until the PCT decided to remove Dr Elapatha from the performers list on 27 September 2012. Mr Caruso gave evidence mainly to explain why he had erroneously told Dr Elapatha on the telephone that he may have to pay £30,000 to undergo an NCAS assessment. He said he realised the error and corrected it the same day in a telephone call to Dr Elapatha or his wife. Dr Elapatha denies ever receiving such a correction. He says took into account these onerous costs when refusing to sign the undertakings required of him by the PCT letter of 31 July 2012 (which we find was probably the trigger for the telephone conversation).

28. Mr Caruso appeared to have had very limited engagement in the events and was plainly embarrassed that neither of the two telephone calls had been noted by him in accordance with what he said was his standard practice. He was therefore reliant on a recollection which was around 6 months old at the date of his witness statement. The suggestion of a £30,000 cost contradicted the clear words in the NCAS Handbook, a copy of which had previously been sent to Dr Elapatha: the Handbook said NCAS services were free of charge. But Mr Caruso said he understood from colleagues that NCAS was moving to be self-funding, hence his initial misapprehension about costs. Mr Caruso disclaimed any role in or familiarity with the proposed undertakings sought by the PCT from Dr Elapatha in 2012 and said that his responsibility at that stage was to organise a hearing. We did not form the impression that Mr Caruso was a decision maker, or concerned to go beyond the limited responsibility he mentioned. He could not say whether he spoke to Dr Elapatha or Mrs Elapatha (his practice manager). We accept he would not have spoken about this matter to anyone else at the practice because it was a very confidential matter and we accept that he would not divulge matters which might be professionally embarrassing to employees or others in the practice. However Mr Leader submitted that whatever else he could not remember, he would surely have remembered whether he spoke to a man or a woman. We are surprised that Mr Caruso did not confirm his "correction" in writing. Equally, we are surprised that Dr Elapatha did not seek clarification in writing, given the many issues he did pursue in writing, if it was a major factor in his refusal to sign the undertaking, as he now says. We have concluded, however, that Mr Caruso's understandable anxiety about his own position may have caused him to be surer about whether the second call took place than is justified, and that we cannot be satisfied that the second (corrective) call took place.

29. Dr Elapathalapatha. He was personable, pleasant and fluent, even effusive, but for the reasons mentioned below dealing with him can be difficult. We can well understand that it may become frustrating to do so, or difficult to make progress in the professional context such as the PCT was faced with.
30. We found Dr Elapatha to be a man who had great pride in his skills; he did not hesitate to describe himself as “a brilliant clinician”. Beyond that he showed pride in his position as a hard-working GP and in the professional position in life he had achieved. He was justifiably proud of his relationships with his patients, among whom he is (as we accept) generally well-regarded. We have received many pages of signed petition by way of testimonial from his patients, as well as a witness statement from Mr Vinci (a patient) which is a fiercely supportive testimonial. We have taken this evidence into account. Around 20 patients attended the hearing on the first day to indicate their support.
31. However we found that it was difficult to get a simple answer to a simple question from Dr Elapatha. We make due allowance for the fact that he may have felt under pressure giving evidence, or have been a little nervous. But he had difficulty in listening to the question before embarking on an answer, and those answers often were not answers to the question asked. They flew off in other directions reflecting his own agenda or concerns. He demonstrated certain fixed notions about officials or professionals who challenged him or impacted on his professional life. He found great difficulty in acknowledging (when asked about specific incidents) that his own performance or that of his practice was or may be defective, or to identify learning points from his experience. Despite the personal responsibility he has for ensuring the proper performance of his practice in line with the General Medical Council’s “Good Medical Practice” his first reaction was sometimes to say something was another person’s responsibility. This was particularly evident when he was asked questions, either by his own Counsel or by the Tribunal, about learning points which he had derived from the several issues identified as concerns by the PCT. Invariably he first pointed at length to some fault or failure by someone else and when he was pressed to identify learning points or changes in his practice he had adopted, he was unable to do so, or was very vague and apt to use generalisations such as “we can all improve our communication skills”. Equally troubling was his apparent inability to understand simple questions about aspects of his practice about which concerns had been highlighted, such as identifying scope for mistakes and improving protocols. For example he appeared unable to identify learning points form the incident with the nursing home. We would have expected him to be able to answer questions about his repeat prescribing policy as well as how often medication reviews for patients were undertaken, rather than look for prompts from his wife/ practice manager in the body of the hearing room. His insight and flexibility of approach to reflective learning was (on the evidence available to us) poor. Dr Elapatha was unwilling to acknowledge that he was or may have been in the wrong or deficient (with the exception of the way he conducted his consultation with Patient K). In general we found his evidence to be less credible or persuasive than the other witnesses. Therefore where there was a conflict we have preferred

that other evidence. Where there are exceptions (such as the alleged correction by Mr Caruso of the misinformation about costs) we have expressly said so.

Consideration of the issues

Issue (a): Was it appropriate to refer Dr Elapatha to NCAS?

32. The 2004 Regulations were revoked by the 2013 Regulations which came into force on 1 April 2013, subject to transitional provisions set out in Schedule 2. Those provisions gave continuing effect to decisions of the PCT before 1/4/13, and dealt with other procedural issues such as the effect of conditions imposed before that date, outstanding applications for registration, reviews and appeals (such as this one). There is nothing within the 2013 Regulations which expressly applies retrospectively any substantive obligations or provisions regulating the relationship of practitioners and NHS England insofar as they differ in the 2013 Regulations from those in the 2004 Regulations. Nor is there anything in normal principles of interpretation which obliges us to infer that they do apply retrospectively. Therefore if the words "where appropriate" in the 2013 Regulations add a check or restraint on the PCT's power to refer a practitioner to NCAS, we have some difficulty in seeing how that can apply retrospectively to a referral which the PCT decided to make in January 2011, when neither party can have had an inkling that the new words were to be introduced.
33. However both parties have approached this case on the basis that referral should only be made where appropriate and we are content to take the same approach. In our judgement, "appropriate" does not necessarily mean that there is only one appropriate course which a PCT could take. It may be appropriate to take one of a number of courses to resolve concerns, all of which could be considered appropriate. Dr Elapatha argues that it would have been appropriate to pursue some local or informal processes. The PCT chose to refer to NCAS primarily (as Dr Green told us and as we accept) in order to secure a fresh look by a body at arm's length from the PCT, having regard to the deterioration of professional relationships between Dr Elapatha and the main officers of the PCT concerned with Performance Review. In our judgement there is a broad margin properly to be allowed as to what is appropriate, so long as the decision is bona fide. We unreservedly accept that the decision of the Decision Making Group (DMG) of the PCT, as explained to us by Dr Green, was bona fide, and we find that it was appropriate.
34. The NCAS is not bound to accept referrals. In making that decision it considers the referral against the range of services it offers (see Handbook D/222-232). It did in fact accept this referral as appropriate. We are not bound by that conclusion but it is a very significant factor and reflects what this experienced arm's length body thought at the time and before this litigation arose. It may be said it did not have the benefit of a detailed critique from Dr Elapatha of the PCT material, but Dr Elapatha did not take the opportunity to put his comments forward as requested. NCAS did know that Dr Elapatha disputed the accuracy of Dr Bannar-Martin's audit of

selected clinical records: see Dr Elapatha's letter of 18 Feb 2011 which was enclosed with the referral material to NCAS (see D/546 and Dr Green's response at D 547, both within the bundle sent to NCAS). We also observe that NCAS "respond(s) to calls about any aspect of individual or team practice, even where it is not yet clear whether there is evidence of poor practice" [D/222]. Referral may indeed be appropriate before poor practice is established in the sense that lawyers would understand that phrase. The role of NCAS evidently contemplates that some or all of the concerns which trigger a referral may be found to have insufficient merit. This is consistent with the role of NCAS as a supportive rather than (necessarily) a fault-finding body. An over-zealous focus on whether the PCT has made out what amounts to a prima facie case of poor practice is probably misplaced. If factual issues are in dispute or indeed if the PCT's preliminary vies of those facts is subsequently shown to be without adequate foundation that does not mean, in our judgement, that a referral was not appropriate. The purpose of an assessment is in part to investigate more fully, with greater resources, and utilising the experience and independence of NCAS.

35. There were a number of concerns which had arisen in relation to the organisation and management of Dr Elapatha's practice in the period 2004 – 2010. None related directly to his clinical skills, although several were capable of adversely affecting patient care. It is not practicable to do more than provide a brief background to some of the matters in dispute over that period. It is of some relevance that there were some common or similar themes among the issues which arose throughout that period and those which exercised the PCT in 2011 and occasioned the referral to NCAS in February 2012 with which this case is concerned.
36. Thus there were issues raised about failure to document consultations properly (2005), the production of a protocol (for complaints - 2008), the adequacy of staffing and staff training (2008). In April 2009 Dr Elapatha asked for the PCT to provide further IT training in addition to the 2 sessions and one refresher it had already provided, and the PCT pointed out that its staff had made 15 visits to Dr Elapatha's practice over the previous 4 months to sort out IT issues. In December 2009 there was a delay in arranging Dr Elapatha's appraisal because of insufficient evidence provided. A few days later he sent a letter of complaint about Ms Kaye Lyons, the PCT's Performance Review Manager. On 8 February 2010 Dr Elapatha became angry during a telephone call about a QOF team visit, and said he did not want a Dr Markwick to attend that visit, and that he was taking Ms Lyons to Court. The QOF visit to his practice took place on 18 February 2010 and concerns were raised as a result. Subsequently it was said that the provision of information required by the QOF team was defective. Two Breach of Contract Notices were served relating to clinical record keeping and staffing. Part 1 of a Clinical Records audit was carried out by a Clinical Assessor as part of the Breach of Contract Remedy Improvement Plan on 13 April 2010 and on 12 May 2010 the Breach Notices were lifted by the PCT.
37. The basis for the PCT's concerns was often disputed by Dr Elapatha and we have not heard evidence directed to resolving those disputes. However it also proved difficult *at the time* for the PCT to resolve the issues raised

by them or to them. There were delays in the provision of information by Dr Elapatha at the request of the PCT. Reasons given included staff shortage or being very busy. The chronology shows meetings or deadlines for action were postponed at his request, and that (for example) a Breach of Contract meeting fixed for 1 December 2009 was not attended by Dr Elapatha nor did he send apologies: a similar thing happened in relation to the NCAS referral with which we are concerned in this case. The PCT sought advice from NCAS about how to proceed in 2009. That experience of NCAS was apparently viewed by Dr Elapatha as unsatisfactory. He complained to its Head, Professor Scotland. In November 2009 Mr R Marshall-Andrews MP wrote to the PCT concerning a complaint raised with him by Dr Elapatha and on 25 December 2009 Dr Elapatha wrote a letter of complaint to the PCT in particular about Kaye Lyons, Performance Review Manager. This foreshadowed a similar response by Dr Elapatha to his dealings with the PCT and Ms Lyons, in 2011 (see para 22 above).

38. It is apparent from the NCAS referral document prepared by the PCT that the concerns about Dr Elapatha included many which arose originally in the period 2004 – 2010 and which in a number of cases the PCT felt had not been remediated [D/341-347].

39. The concerns by which the PCT remained exercised in early 2011 were addressed by the parties, in the evidence we heard, grouped under the following headings:
    a. QOF scores,
    b. Breach Notices,
    c. a complaint by patient K,
    d. a possible drug overdose given to an elderly patient by care staff at Copper Beeches Nursing Home,
    e. the IT competence of his practice and
    f. clinical record keeping.

    The referral submitted to NCAS included concerns with supporting documentation relating to additional areas (see D/328 and witness statement of Ms Rakestrow paragraph 33) but we have focused on the areas addressed by the parties in the course of this hearing.

40. The Quality Outcomes Framework (QOF) was introduced in 2004 as part of the General Medical Services Contract. It is a voluntary incentive scheme rewarding GPs for how well they care for their patients; practices score points against certain indicators of level of achievement. The higher the points, the higher the financial reward for the practice.

41. The scores are not a direct measure of clinical performance but there may be a correlation which is why this PCT and other employers keep an eye on them. It seems that Dr Elapatha's scores were not very good in the early days; there is not a dispute about that. But by 2008/9 they had "significantly improved" as the Minutes of the Performance Advisory Group in July 2009 acknowledged [D/404] to which Mr Leader drew our attention. However, within the overall picture there were areas identified for concern, as the same Minutes reveal. For example "criteria not achieved … in the area related to records (less than 70% clinical summaries) which contradicts what Dr Elapatha told the PAG assessors in September 2008, when he said that 100% were computerised". Quality Development information discussed at the same meeting highlighted some other

concerns about low referral rates and low prevalence rates in conditions where active diagnosis was required. The PAG concluded (among other things) that there was a lack of contemporaneous records and systems to check on 2 week referrals, and concerns about practice management, IT, staffing and appraisal.

42. The Quality Development Group (QDG) continued to consider the performance of Dr Elapatha's practice and at its meeting on 23 March 2010 measured the performance against "Red, Amber, Green (RAG)" ratings given for various performance areas including QDG, QOF, prescribing, and overall RAG ratings, as more particularly described in its minutes of that date at D/98-101. It concluded that Dr Elapatha's practice was below PCT average in all areas of QOF except Patient Experience, and below PCT averages in 16 of the 19 prevalence areas. It was below prescribing targets in 8 of the 12 prescribing areas. The QDG considered an action plan should be provided detailing how improvements could be made in these areas.
43. Whilst we accept that QOF scores have continued to improve, we are invited to look at the picture which was available to the PCT at the date of referral. In evidence it was suggested to PCT witnesses that the decision-making body should also have had regard to other quality information such as the annual Balanced Score Cards. We were invited to look at this material. While Dr Green could not say if it was seen by the Decision Making Group and was prepared to accept it was not included in their papers, the evidence we have heard is to the effect that it was available to the Performance Action Group which reported to the DMG and was part of the material the PAG took into account in making recommendations. The relevant period for which information was available at the beginning of 2011 was 2009-10. The Balanced Score Card for this period (produced also by Dr Elapatha) rates the performance of practices under various headings. For QOF there are 4 headings. In one of them (patient experience) Dr Elapatha was in the top 25% of Medway Practices. However in the other 3 (clinical, organisational and additional services) he was in the lowest 25% of Medway Practices. Overall, his QOF score was in the lowest 25%. Moreover little reassurance was to be derived from looking at the other areas of the Balanced Scorecard. Under "Screening and Prevention" the scores in 2 out of the 4 categories (cervical screening and 'flu immunisations) are again in the lowest quartile.
44. We have already noted that a visit to Dr Elapatha's practice by the QOF team in February 2010 had raised concerns, but it also generated administrative problems, as Dr Elapatha firstly telephoned on 8 February and wrote the following day to the Assistant Director of the PCT setting out some objections to the planned visit on 12 February and to the attendance of a Dr Markwick. The visit ultimately took place on 18 Feb 2010. This was one episode in the history of dealings which became confrontational or accusatory, and which ultimately weighed on the minds of the DMG in deciding to refer Dr Elapatha to NCAS.
45. In our judgement justifiable concerns remained in relation to QOF which, taken together with other matters, made it appropriate for the PCT to consider referral to NCAS.
46. <u>Breach of Contract notices</u> were served on Dr Elapatha relating to staffing

matters and to record keeping at the end of 2009. Part 1 of a Clinical Record keeping audit was carried out in April 2010 as part of the Breach of Contract Remedy Improvement Plan, by a Clinical Assessor, Dr Bannar-Martin. He conducted his assessment in company with a Dr Mike Parks from the Local Medical Committee, at the request of Dr Elapatha. They examined 20 clinical records chosen at random following the standard methodology described at the introduction to his report (D/75). The report makes clear that the two doctors agreed on whether a particular entry met proforma criteria. They asked for an explanation for 2 consultations (10% of the total) for which there was no entry in the patient record and 3 potentially misleading Read Codes entered and the substance of the explanations they received (although Dr Elapatha could not recall one of the consultations) is set out within the report. Concerns arising were noted (D/78) under 4 bullet points and Dr Bannar-Martin concluded "*Several aspects of good record keeping were in place but remediable deficiencies were also identified. Previous suggestions about improving record keeping have been acted on positively, and I hope constructive learning points well emerge from this clinical record review*". The PCT lifted the Breach Notices in May 2010. The Breach Notice relating to record keeping was discharged with the requirement to facilitate a second or follow-up audit. The Appellant points out that the Notice relating to staff training was discharged without qualification except that the 2010 staff training needs would have to be met within the relevant year.

47. These Notices are formal steps which can lead to the termination of a practitioner's NHS contract if he/she does not take steps to remedy them. They are relatively uncommon and require the practitioner to remedy the breach, and will usually bring about that remedial action, if for no other reason than they are a last step before termination of the contract. Dr Elapatha is entitled to point to the fact that they were discharged, so that he was no longer in breach of his contractual obligations, and to say that he had therefore engaged with the PCT. The PCT is entitled to point to the fact that they were necessary at all. Dr Green told us that although the Notices were lifted he recalled there were still some outstanding concerns to address. Indeed the above-quoted summary suggests this must be so. It was therefore appropriate, in our judgement, that the subject matter of the Breach Notices such as clinical record keeping should be kept under review. To the extent that the subject matter continued to give rise to concern, the PCT was entitled to look at those concerns in the context of the earlier Breach Notices. It may fairly be said that if these or similar concerns persisted, despite being so close to the professional catastrophe of having his contract terminated, a more comprehensive and independent assessment was called for.

48. Patient K made a complaint about Dr Elapatha. He had been undergoing treatment for cancer since 2004 and also for neuralgia. The witness statement of Dr Green reports patient K that between January and May 2010 he was prescribed 100 tablets of dihydrocodeine (an opiate based painkiller) each month. In May Dr Elapatha reduced the prescription supply to 24 tablets per week. Patient K was not happy with this, telephoned the surgery and subsequently attended for a medication review by Dr Elapatha. Accounts of the consultation vary. Patient K says Dr Elapatha

did not review the medication but spent the consultation typing a letter to the Pain Clinic. He says he had failed to obtain an appointment before because Dr Elapatha had not responded to a request from the pain clinic for information. He says Dr Elapatha lost his temper, called the police and had him escorted from the room. On 23 May he then received a letter stating he had been removed from Dr Elapatha's registered patient list because of his unacceptable behaviour.

49. Dr Elapatha says that at the consultation patient K demanded a further prescription and requested 30 mg rather than 60 mg tables which raised concerns in his mind that the patient might have been selling controlled drugs illegally. Among our papers is a handwritten statement from a receptionist at the surgery asserting that reception staff had formed a similar suspicion. DR ELAPATHA says he told patient K that he would check the dosage with the PCT and get back to him, meanwhile offering him an alternative drug which was not accepted. Patient K refused to leave until he issued a prescription in the previous form. Dr Elapatha says that he felt threatened.
50. The PCT was concerned about two things. Firstly that patient K produced a recording of the consultation which (it is said) appeared to support his own account rather than Dr Elapatha's account. The PCT was concerned that Dr Elapatha had not been candid in the account he had given to them. Secondly it was concerned that patient K had been removed from Dr Elapatha's list and reallocated him to a Special Allocation Scheme (which is used for aggressive patients) – possibly inappropriately. The PCT acknowledged that it was appropriate for Dr Elapatha to be concerned about the possible misuse of drugs and even to raise it within a consultation. There was and remains a dispute about which version of the consultation is correct. Dr Elapatha maintained (when taxed about the apparent discrepancy between his version and the recording) that the recording was an invasion of his privacy, that it was unreliable for a number of reasons including that it had been edited, as he could tell from the absence of certain questions he knew he had asked the patient, and that the aggression which he had initially described was not reflected in the spoken words but in the aggressive body language and eyes of the patient.
51. In his evidence to us Dr Elapatha characterised this consultation as the worst he had ever conducted in his life. He regretted that he had not dealt with it better but stuck to his account summarised above. We are not invited to resolve the disputed accounts definitively, and indeed Mr Leader criticises the fact that the PCT either did not pursue the complaint to resolution or does not know how it was resolved. Either way we have no evidence about that. But Mr Leader does seek to put this in the context of high levels of patient satisfaction in the BSC scores, and criticises the PCT for failing to do so. It is undoubtedly correct that this is the area of practice where Dr Elapatha scores highest. There are generally high levels of patient satisfaction. The primary concern was about the conflict in the accounts, and that the consultation had become "dysfunctional and inappropriate" as Dr Green put it.
52. We consider that notwithstanding (and in some respects because of) the later explanations put forward by Dr Elapatha, there were legitimate

concerns about how Dr Elapatha communicated with patients who might be challenging, and possibly about his self-justification afterwards. We also note that although Dr Elapatha said volunteered that this was a poor consultation and that there were learning points, he had difficulty in telling us what those learning points might be. We also found it surprising that this situation has been allowed to arise in the first place. According to the prescription record for patient K exhibited by Dr Elapatha (at E/346-8) dihydrocodeine had been prescribed at 100 tablets a time, to be taken "1 tablet 4 hourly" since before January 2010 because the prescription issued on 29 January was "issue 8" and thereafter there were in fact some 16 prescriptions issued for similar amounts each time before the supply was reduced to 24 tablets a time on 12 May 2010. The striking feature is that they were issued at intervals of about a week; never more than about 10 days apart and at shorter intervals on half the occasions (once only a day apart). These are very large quantities of an opiate which has a potential for illicit street resale. Dr Elapatha was signing these prescriptions and supervising the patient. We found this surprising, as we did the fact that it was being done without apparent active consultation with, or support from the local pain clinic service. These are matters for which there may of course be a perfectly good explanation but if this material had been put before the PCT, as it was before us, it would raise further concerns such as the appropriateness of Dr Elapatha's prescribing, which would merit consideration of a referral for assessment.

53. Copper Beeches is a residential Care Home for which Dr Elapatha was the visiting GP. On 1 November 2010 an alert was raised that one of the residents for whom Dr Elapatha was the GP may have received a double dose of Hyoscine, an antispasmodic drug. On 11 October Dr Elapatha had visited the Home and spoken to a member of staff, who thought he agreed to a dose of Hyoscine 300 mcg two twice daily. The following day when the dose error was discovered, Dr Elapatha was informed and advised stopping the medication for 24 hours. There is no evidence before us that the patient actually suffered harm. But it was potentially a serious error.

54. The Team Manager for Community Care Teams, Rochester and Chatham, wrote to the PCT on 25 November that the "preliminary investigation revealed poor communication between the GP and the nursing staff and poor record keeping" (D/84). The PCT's prescribing advisor reviewed the Home's controlled drugs procedure and compiled a checklist for the guidance of the Home (D/85-95) which summarised areas for action including "4. Old repeats [prescriptions] are blocked by the GP's surgery so non-recurrent medications cannot be ordered" and "5. Old or noncurrent repeats are destroyed so they cannot get into the ordering chain". In addition she visited Dr Elapatha's surgery and reported on 13 December 2010 (D/96) that there were 4 bullet points arising, including a finding that because of a misunderstanding between Dr Elapatha and the Home old repeats and new medication doses were running concurrently, that Dr Elapatha sometimes dealt with telephone queries from the Home while he was consulting with another patient, and that not all recommendations were recorded in both the patient care plan at the Home and in the patient's GP notes, so that misunderstanding could arise between the parties.

55. It is argued on behalf of Dr Elapatha that because the Home no longer had its records available, and because the PCT did not await or pursue the final outcome of the "preliminary investigation" we should attach little or no weight to criticism of Dr Elapatha arising from this matter. It is said to be flawed evidence.
56. We are not sure whether the phrase "preliminary investigation revealed" in the Team Manager's letter if 25 November necessarily implied there was a further investigation to be finally reported on by him, particularly where there was an audit of drug control practices performed by the PCT's prescribing advisor within a few days of that. But even if there were, we do not consider that the PCT was prevented from taking this material into account. As we have indicated elsewhere, the formation of a view of whether a referral to NCAS was appropriate did not hinge on definitive proof of shortcomings. Moreover the fact that records from the Home were not all available to the Prescribing Advisor does not affect some significant findings in her letter of 13 December, which result from her visit to Dr Elapatha's own surgery premises. These include findings that old repeats and new medication doses were running concurrently, that neither Dr Elapatha's original visit to the patient on 11 October, nor his consultation when the error was discovered the following day, were recorded in the patient's notes at his surgery, that Dr Elapatha sometimes took telephone queries about patients from the Home while he was consulting with other patients at his surgery, and that not all recommendations were recorded in the patient care plan and notes and this could lead to misunderstanding.
57. We find that these were and are credible findings raising significant concerns about Dr Elapatha's record keeping and prescribing. They merited consideration by the PCT in the context of a decision to refer him for appraisal. These were vulnerable elderly patients and Dr Elapatha does not seem to acknowledge the potential problems to which his practices may have contributed.
58. Dr Elapatha was asked both by us and by Ms Bruce what learning points he had identified from this episode. His answer was that communication with the nurse was the problem because she was an African nurse who did not understand English very well, and her understanding of the practice instructions was wrong, "so we should make a lot of leverage when communicating with staff who are not very competent". Our Medical Member asked if his repeat prescribing protocols had changed. Dr Elapatha said he had bought a red file and put Controlled Drugs in that. We have some difficulty in understanding how that addresses the problems identified. He said he had not made any changes to his prescribing protocols because of the summary of "areas for action" at page D/85 (see above) and that this incident had happened because one of the repeat prescriptions was not deleted from the system. He could not remember whether he now had a repeat prescribing protocol which ensures that points 4 and 5 in the summary of areas for action (see above) were addressed. At this point Mr Leader indicated that Mrs Elapathalepatha, the Practice Manager, said there was a written protocol within the practice. However Dr Elapatha was unable to remember or state its terms. This falls far short of a proper appreciation of the points to be learned.

59. We have concluded that the Copper Beeches matter, when viewed in conjunction with the other evidence we have heard and the other concerns considered in early 2011, was a matter which made referral to NCAS an appropriate course.
60. IT competences feature on several occasions in the communications between the parties. We have noted already that in April 2009 Dr Elapatha asked for the PCT to provide further IT training in addition to the 2 sessions and one refresher it had already provided, and the PCT pointed out that its staff had made 15 visits to Dr Elapatha's practice over the previous 4 months to sort out IT issues. Problems in accessing or providing information from the Dr Elapatha's IT system may have been implicated in some of the delays in providing information for other purposes.
61. However at this hearing the PTC concerns focused on a telephone call made by Mrs Elapatha to the PCT asking for some additional email account memory to be made available. This is set out in an email from Sue Wanstall, Primary Care Programme Manager, to Dr Green and another PCT officer on 13 January 2011, in which she says that she had been aware that in the past and recently Dr Elapatha's practice had asked for assistance with email management:

> "as they often have hundreds of unopened, un-filed emails within their account. Mandy has also recently spent some time with Rizbi the practice manager teaching him how to manage the emails in their account, Mrs Elapatha advised me that Rizbi was now sick.
> I therefore explained to Mrs Elapatha that I suspected her email account was full because the practice was still not filing and deleting old emails, I offered her further assistance however she explained that she did not have the time to do it.
> I explained that each GP practice had a memory allocation based on their size of practice and usage. NHS Medway as a whole have an allocation of email memory/space for all of our Medway GPs and therefore account size is shared across the patch appropriately.
> Mrs Elapatha was very unhappy and advised me that she would escalate her concerns to both of you in writing."

62. This account was not challenged, except that it is suggested that the IT system may have been able to receive emails even if it could not sent them. However Mr Leader argued that nobody checked whether Mrs Elapatha had subsequently freed up memory space as advised, when the request to make more space available was refused. It was argued that the PCT jumped to the conclusion that the practice would be missing information. On the evidence we have heard about the practice we consider that in the absence of Rizbi this is a highly improbable situation. If this was the positive case which Dr Elapatha wished to advance he could have called Mrs Elapatha who attended the hearing throughout. In any event it needs to be set in the context of the previous (undenied) history described in the email above. Moreover the experience within the Tribunal of similar systems is that if memory is full, emails can neither be sent nor received.
63. We accept Dr Green's evidence that medical or public health alerts are notified by email and that if the email memory capacity is full these

important notifications will not be brought to the attention of Dr Elapatha or his staff. That highlights the mischief of the IT problem, but there must be a wider concern that if something as relatively straightforward as handling email traffic is giving problems, the IT system which is now central to GP practice may be something which is not being used as it should be or to its proper potential. At the least, it gives rise to a legitimate concern that merits further investigation.

64. If this were a case of a one-off difficulty arising in the absence of the employee who knew how to deal with email capacity, then it would carry little weight, but as we have indicated it was a problem which had arisen periodically and was still happening despite PCT staff spending time helping the practice. We do not consider it is in the forefront of concerns. If it had been we would have expected the PCT to have expressed it in writing to Dr Elapatha. However we bear in mind that this incident only took place 6 days before the DMG meeting which decided to refer Dr Elapatha to NCAS, so there was hardly time for that step to be taken.

65. Clinical record keeping was a factor in some of the concerns considered above. We have also noted (paragraph 46) that Dr Bannar-Martin carried out an audit in April 2010. A second or follow-up audit was carried out on 10 December 2010. It was again conducted with DR Mike Parks of the LMC. Dr Bannar-Martin concluded:

> "I found no evidence from the 20 records I examined that previously identified deficiencies had been remediated or that Dr Elapatha's pattern of recording clinical data had altered over the last 6 months. He maintained that time constraints prevented him from entering more detailed clinical records. I am concerned that if he had a complaint his sparse clinical records could potentially make him vulnerable. Questions about the appropriateness of the clinical management in some cases emerged from looking at the records but this was outside out remit to explore further."

It is appropriate to point out that within the body of the report Dr Bannar-Martin did state that "management was more often recorded than in the first assessment in April" and this point was agreed in cross-examination by Dr Green.

66. Among the findings were that 4 entries recorded no history, that 3 consultations did not record an examination, that read codes did not always appear appropriate to the consultation, and that the general problem was recording things briefly or not mentioning things. The specific concerns raised in relation to particular patient records was the management and tracking of reviews, or follow-up, the absence of any recorded finding as to whether a vulval skin lesion was benign or malignant, or whether there was a need to follow the 2 week wait criteria, and setting up repeat prescriptions for antihypertensive drugs which could have gone on for 33 months before recall of the patient.

67. Dr Bannar-Martin's report, and indeed his competence, is fiercely attacked by Dr Elapatha: see his witness statement paragraphs 62-66. It is suggested that because he was unable properly to access the system on the day of his visit (not having the passwords), and so was delayed, he got into a muddle. Dr Elapatha asked Dr Parks to return to the practice and produced a further report, commenting on the findings of Dr Bannar-

Martin, and with the benefit of explanatory input from Dr Elapatha. Dr Parks' report dated 31 August 2011 is at E/338-339. It revisits the 6 patient records on which Dr Bannar-Martin specifically made comment and identified what are said to be some factual errors and further information such as referral letters or follow-up which he was given by Dr Elapatha. He concludes:

> "Having visited Dr Elapatha and had an opportunity to look with him at the clinical care of the patients I believe the records to be more adequate than is reflected in Dr Bannar-Martin's report. To be fair this report was completed with an opportunity to adequately discuss each record entry with Dr Elapatha and was largely based on the examination of single entries."

68. We observe that a locum would be in the same position as Dr Bannar-Martin (examining the entries without much or any supplementary information) and this was one of the mischiefs of inadequate record keeping which concerned Dr Green.
69. Moreover Dr Parks had accompanied Dr Bannar-Martin and they had looked at the records together. He did not demur from the process adopted by Dr Bannar-Martin (which is now criticised) nor from the substance if his findings. However Dr Bannar-Martin was not present when Dr Parks revisited the practice nearly 10 months later. We do not know if the records were in precisely the same form or if Dr Bannar-Martin was contacted to invite his attendance or comments.
70. On balance we accept Dr Green's view that the two audits signed by Dr Bannar-Martin raised a concern about failure to remediate deficiencies, and the subsequent report of Dr Parks is simply another medical view given with access to more or different information. He could not resolve that difference, even if it had been available to him at the date his DMG decided to refer Dr Elapatha to NCAS. In fact it was not available until several months after NCAS had accepted the referral. He took the view, reasonably in our judgement, that the second audit had not dispelled concerns but (taken together with the other concerns) made referral to NCAS appropriate. These concerns about clinical record keeping are not peripheral to a practice, but may potentially impact on patient care. We share this judgement. An NCAS referral would go into record keeping and allow an opportunity for Dr Elapatha to supplement the single records with additional information as he had done with Dr Parks.
71. <u>Referral generally: removing assessment from the confrontational arena.</u> Over and above the specific concerns addressed above, Dr Green said that while the DMG needed the assurance that the issues put before them by the PAG needed to be addressed or that there was not issue to answer, it also recognised that Dr Elapatha was saying some members of the PCT staff were misrepresenting things about him so it was fairer to him to get a fresh and neutral organisation to look at those concerns. He said "If we had misinterpreted things he had the opportunity to correct that with a separate body". He also said that the referral was "to take away potential adversarial situation or a perceived prejudgement".
72. This evidence was wholly consistent with the reasoning of the DMG at the time of its decision to refer. Paragraph 6.6 of the minutes of the DMG meeting on 19 January 2011 [D/24] recites and adopts the PAG

recommendation that Dr Elapatha should be referred to NCAS for assessment "in order that the PCT could be assured he was a safe practitioner" and adds:"the DMG felt as an independent arbiter Dr Elapatha would be more likely to accept the NCAS judgement as he has an antagonistic relationship with the PCT. The PCT would also be bound to comply with the recommendations made by them". Dr Green also wrote to Dr Elapatha on 22 February 2011: "Given that you have accused members of the PCT of fabricating evidence and acting unprofessionally towards you, we see the involvement of NCAS as an independent organisation specifically trained and experienced in this area would be seen as a positive step enabling you to demonstrate the quality of care you provide and assuring us of that quality or if any areas for improvement are identified that these are rectified." Accepting as we do Dr Green's evidence, we also accept those reasons.

73. Even if we were to find on the facts that the referral to NCAS was not appropriate, the language of regulation 15 (6) (e) does not require that the request for a referral should be appropriate. Mr Leader conceded in his submissions that the newly introduced words "where appropriate" which are to be found in the undertaking required from medical practitioners by regulation 4 (3) (e) of the 2013 Regulations cannot be read forward into regulation 15 (6) (e). At best, they form a context in which a practitioner may seek to explain or excuse conduct which may otherwise appear to be non-compliance, on the basis that he had a genuine belief that referral was not appropriate, and sought to resolve that.
74. However that conundrum does not arise in light of our finding that referral was appropriate.

<u>Issue (b): Did Dr Elapatha ever fail to comply with a request for an assessment by NCAS?</u>

75. Our starting point is the language of regulation 15 (6) (e): "whether the Practitioner has *ever* failed to comply with a request to undertake an assessment…" [emphasis added]. With this in mind we set out in brief form the facts as we have found them.
76. The history of concerns to which we have referred, and the disputes over resolving them, as well as the factual basis for the concerns, lead the Decision Management Group (DMG) of the PCT on 19 January 2011 to decide to refer Dr Elapatha to NCAS for an assessment. The proposed documentation was handed to Dr Elapatha on 16 February with a request for his comments (D/322). His request by letter of 18 February for a 7 week extension of time to provide comments (D/122-3) was refused (D/124) and on 24 February the referral (D/106) with that supporting documentation (D/328-757) was sent to NCAS, together with Dr Elapatha's letter of 18 February in which he had challenged the accuracy of a report by a Dr Bannar-Martin on his record-keeping (see D/124).
77. NCAS contacted the PCT on 8 March 2011 to say that approval had been given for it to take on the assessment [D/126].
78. We accept that Dr Elapatha cannot be blamed for "delay" occurring prior to the actual date on which the PCT referred him to NCAS (18 February 2011). Although Mr Leader invited us to say there could be no blame for delay until NCAS accepted the referral on 17 March we cannot wholly

accept that submission because it is necessary to have regard to the fact that on 16 February Dr Elapatha received the documentation which was to be sent by the PCT to NCAS with a request that he provide his comments for NCAS, and he could and should have been considering them and (if he so wished) formulating his comments. This is pertinent in view of his complaint that a factually incorrect picture had been provided to NCAS. But this is only one short period in a much longer period we need to consider.

79. Protracted correspondence and telephone calls between the PCT and Dr Elapatha (or his solicitors) then followed, the nature and effect of which is in dispute. On Dr Elapatha's behalf it is said that there was active engagement by him. On the PCT's behalf it is said that there was deliberate prevarication and delay by Dr Elapatha, amounting to a failure to comply.

80. NCAS firstly asked the PCT to arrange a case conference meeting to discuss the referral with the PCT and Dr Elapatha. So on 28 March a Ms Cathy Fennell of the PCT telephoned Dr Elapatha and asked him to check whether 28 April was suitable and asked him to contact them within the next couple of days (file note at D/771). He did not do so. On 31 March Ms Fennell again telephoned and Dr Elapatha said he could do nothing at the time as he was involved with QOF (Quality Outcome Framework) but would look at the documents the following day and contact his legal representatives. By necessary inference he (and/or they) had not done so since handed the folder of documents on 16 February, 6 weeks earlier. Again he did not respond and Ms Fennell was informed when she made chasing telephone calls on 4 and 5 April that Dr Elapatha was (respectively) "not in" and "sick – and the Practice Manager (Mrs Elapatha) was not in". So on 7 April an email was sent suggesting 5 alternative dates between 21 April and 12 May (D/775). In the absence of a response the PCT telephoned on 12 April and was told Dr Elapatha was seeing patients. A message was left asking him to call to confirm he had received the email. He did not do so. On 19 April Dr Elapatha's receptionist told the caller from the PCT that Dr Elapatha was out on visit and she did not know when he would be back. Another message was left for him to call the PCT.

81. However Dr Elapatha emailed Ms Fennell on 20 April apologising for the delay and saying he had recently returned from sick leave. He told her that his MPS (Medical Protection Society) representative was keen to arrange a meeting with NCAS and the PCT at the end of May or early June "since they have to study the documents which incorporate 258 pages. Please provide me with several convenient dates around that time…" (D/775). Again, there is an inference that the MPS had just been furnished with the documents which Dr Elapatha had had for over 2 months. Nor was the material as substantial as Dr Elapatha's request for a further delay of over 6 weeks seems to suggest.

82. We have not been shown evidence of Dr Elapatha's incapacity through sickness at that time, but 2 days prior to his email, on 18 April 2011, Dr Elapatha had been sufficiently fit to write to the Medical Director Dr Green (D/773-4). Among other things his letter acknowledged that he had been given several possible dates for a meeting with NCAS, but he also stated it was important for Dr Green himself to visit the practice in order to be

shown on Dr Elapatha's computer the 7 consultations referred to by Dr Bannar-Martin (see above) as Dr Elapatha could not print them out for confidentiality reasons. He asked Dr Green to propose a date, but on 21 April Dr Green responded (D/778) that he had not agreed to visit his practice (as Dr Elapatha seemed to believe) and that the referral to NCAS was not solely based on the Bannar-Martin report. He expressed the hope that Dr Elapatha could attend a meeting with NCAS on one of the dates already proposed. On the same date Ms Fennell emailed Dr Elapathalapatha (D/779) informing him that she would get back to NCAS to get some more dates, and asking whether it would be easier to liaise directly with his MPS representative to make at date. Dr Elapatha did not respond.

83. On 28 April Ms Fennell emailed Dr Elapatha to notify him that the date arranged for a meeting with NCAS at the PCT premises was 2 June 2011 (i.e. within Dr Elapatha's suggested "window"), and this was further confirmed by a letter to him dated 4 May (D/783).
84. On 19 May 2011 the PCT wrote to Dr Elapatha (D/936) passing on a request from NCAS for information and documents, including a copy of his last appraisal.
85. At this juncture, with a date for the meeting finally arranged, Dr Elapatha wrote to his MP on 11 May (D/788-80), alleging that the PCT's performance advisory group (PAG) and performance review manager (PRM) had provided false information about him to NCAS, were now retaliating against him because he had tried to defend himself against false allegations in the past, were "planning a full investigation against " him, and that he had no faith in them or NCAS and felt these tests would be unfairly biased against him. He alleged the PRM and PAG had bullied him over a period of more than 3 years. The MP forwarded this to the Chief Executive of the PCT Cluster asking her to respond to the criticism on 25 May 2011 (D/787).
86. On 27 May 2011 Dr Elapatha wrote to the PCT (D/784) asking that the meeting arranged for 2 June be postponed to give his solicitor 3 weeks to review the documents and because his solicitor was not available until the last week of June. The PCT replied immediately the same day to Dr Elapatha (D/785) stating that he had been given sufficient time to prepare for the meeting which was, in any event, for information purposes only.
87. On 2 June NCAS and the PCT attended, but Dr Elapatha did not. Nor did he notify them that he would not be attending or offer any explanation or apology.
88. On 3 June Dr Elapatha followed up the letter to his MP with a long letter to Mrs A Sutton, Chief Executive of Kent Medway PCT Cluster (D/791-6) setting out specific complaints about events between 2003 and 2008. She replied to the MP by letter dated 9 June (D/813) to the effect that the allegations had previously been raised by Dr Elapatha in 2009 and enclosing a copy of the PCT's response at that time. Her letter also explained the roles of the PAG and PRM including that the latter did not make decisions independently.
89. This correspondence, with its confrontational, self-justifying and accusatory tone from Dr Elapatha, took place over the very period arranged for the meeting with NCAS. However it helps to place his conduct

over this period into context and contributes to our judgement that Dr Elapatha's mind was fixed on past perceived wrongs, an inability to understand what might be giving rise to concerns to which the PCT felt it had a duty to respond, and an inability to grasp the nature of the NCAS assessment (neutral, properly validated methodology and at arm's length from the PCT) he was being asked to engage in.

90. On 15 June 2011 the DMG met to discuss what to do in the circumstances they faced and on 22 June the PCT's Assistant Director of Clinical Quality sent a Breach of Contract Remedial Notice to Dr Elapatha (D/816). It required him (1) to attend a meeting with NCAS and the PCT on the first available date and in any case before 29 July 2011, (2) to sign up to full participation in the entire assessment process, at that meeting, (3) to provide the information requested by NCAS to them direct no later than 8 July 2011, and 3 other consequential requirements. In default the matter would be referred back to the DMG who may take action under the 2004 Regulations. On the same date Dr Green wrote to Dr Elapatha (D/818) stating that the DMG was extremely concerned by his prevarication and failure to engage with the NCAS assessment and stated their view that this remained the most constructive route forward. He confirmed that the NCAS offer of an assessment was extended until the end of July 2011.
91. To this letter Dr Elapatha replied (D/1496) on 24 June that he would attend an initial meeting with NCAS in the last week of July and agreed, under duress, to participate in the assessment process "excluding the Psychometric Test Assessment. My solicitor will be in contact with you regarding this matter shortly". We note that this response utilises the maximum period of time up to the expiration of the NCAS offer of assessment, and also that Dr Elapatha was being advised by solicitors at this point. Despite that his offer was couched in terms that he was prepared to comply with the request for a preliminary meeting only "under duress", which the letter states is because he feels he has been forced unfairly into the assessment. Dr Elapatha also put forward various responses to the suggestion that he had deliberately delayed the meeting, including that 150 pages of documents were delivered with the PCT's letter of 27 May. We find ourselves unable to accept those reasons which, it must be noted, were not advanced by him prior to the arranged date for the meeting, nor did he request an adjournment of the meeting for the reasons he now advanced. The substance of the reasons he puts forward do not withstand examination. The documents enclosed for his attention relate to NCAS requests for information from him (so far not given) which it was absolutely appropriate he should have prior to the meeting where this might be discussed.
92. On 28 June 2011 Dr Elapatha wrote to Dr Green (D/821) stating that he planned to retire shortly and that the assessment was a waste of funds. He invited Dr Green to visit him at his practice premises to discuss the concerns and enclosed a copy of his letter of complaint to the Chief Executive. This is a curious letter which appears to hold out on the one hand a suggestion of informal discussions to resolve concerns and on the other a rather blustering threat to pursue his former complaints via a number of channels (he mentions the Ombudsman and his local MP).
93. On 30 June 2011 solicitors first come into the correspondence on behalf of

Dr Elapatha, who told us that he felt he needed legal advice and could not find the right sort of support from a solicitor he could trust until he instructed Selva & Co. He said he had had one solicitor at the beginning who could not travel from Kent; the documents are silent about this and the PCT had no knowledge of it. He told us that after he instructed Selva, the delays stopped. Those solicitors first wrote on 30 June 2011(D/842), stating among other things that Dr Elapatha had no objection in principle to an NCAS assessment but asking that all meetings with NCAS be recorded "because our client has serious concerns relating to earlier engagement with NCAS and the thoroughness of the earlier dealings with NCAS" and that he intended that any psychometric assessments that may be part of the process would be undertaken "under the jurisdiction of an independent assessor appointed by the Royal College of Psychiatrists, independent of NCAS". It is a surprising letter to be written by a solicitor who must be taken to be aware of the role of NCAS, if only because it seeks to impose conditions on how the NCAS carries out the assessment process. A separate letter from Selva & Co of the same date also denies that DR ELAPATHA had failed to cooperate with NCAS. These were passed to NCAS, which unsurprisingly responded (D/939) that they offered a standardised assessment and were not prepared to accept the conditions requested by Dr Elapatha.

94. On 11 July 2011 the PCT conveyed the NCAS response to Dr Elapatha and notified him that in view of his failure to agree a new date for the pre-assessment meeting or provide the information requested by NCAS within the time stipulated in a previous letter, it would be preparing a case for a removal hearing (D/845). The PCT attached to that letter a comprehensive list of the documents it had handed to Dr Elapatha on 16 February and additional documents couriered to him on 25 and 28 May 2011, pointing out that this material answered the questions those solicitors had raised.
95. On 12 July 2011 Selva & Co wrote to Dr Green (D/851) informing him that they had asked Dr Elapatha to provide copies of the information he had received from the PCT as listed in their letter of 11 July "which has not previously been provided [to those solicitors]". They asked for a further delay of 14-21 days to consider the material. They also expressed their client's willingness to meet with NCAS "once he has been able to speak with his solicitors" and that he would cooperate with NCAS.
96. We find it astonishing that despite belatedly instructing solicitors on his behalf and being chased over many months comply with the referral to NCAS Dr Elapatha had not even given those solicitors any relevant documents by 12 July 2011, despite having the bulk of them (and the key documents) since 16 February 2011. We find it difficult to understand how he could have given coherent instructions to his solicitors without them, or how any advice given to him could have been worthwhile without seeing the documents. Dr Elapatha seemed to be proceeding on the basis that the arrival of solicitors on the scene was an opportunity to turn back the clock and start again.
97. Correspondence proceeded through July and on 28 July the PCT wrote to Dr Elapatha (D/855) confirming that the parties had agreed that the meeting with NCAS would take place on 15 August 2011. On 29 July Dr Elapatha confirmed he would attend with his solicitor and also with

representatives from the MPS and BMA. However on 2 August Dr Elapatha wrote enclosing an email from his solicitor which said that he was not available on 15 August and had not agreed to that date. Dr Elapatha asked for another date to be arranged. The PCT responded on 4 August (D/860) that as Dr Elapatha had failed to attend two previously arranged dates and as his representatives from MDU (should be MPS) and BMA were able to attend, the meeting would go ahead on 15 August 2011.

98. That date too was doomed because on 8 August Dr Elapatha's wife emailed to say he was on sick leave and would not be able to attend on 15 August. A medical certificate bearing the same date has been produced (D/942). It said he was not fit for work for a period of 2 weeks because of "depression – work related history" and "sleep disturbance". The stamp beneath an illegible signature is from "West Malling Group Practice". The PCT re-scheduled the meeting to 1 September 2011 (D/865)

99. A meeting did take place on 1 September and on 5 September the PCT wrote to Dr Elapatha (D/870) confirming the matters agreed, including that Dr Elapatha would provide NCAS and the PCT with his further comments and evidence by 30 September, a timetable for responses by NCAS and a date (14 October 2011) by which NCAS would confirm whether it was withdrawing the offer of assessment. If the offer was not withdrawn, it was agreed that all parties would sign the necessary paperwork for the assessment by 21 October 2011.

100. Meanwhile on 21 September the PCT sent Selva & Co a copy of its letter responding to Dr Elapatha's 2009 complaints, as they had requested. It is not clear why Dr Elapatha was unable to provide his solicitors with this letter.

101. Despite the agreed timetable set out in the letter of 5 September (see above), Dr Elapatha wrote to the PCT on 26 September (D/876) stating that his solicitor was away from the office until 30 September 2011 and asking for an extension of the deadline for his comments by a week. He then contacted NCAS directly, and sought its agreement to an extension for 10 days to 10 October 2011. NCAS informed him that the final decision lay with the PCT which on 27 September refused to agree (D/879). In the event Dr Elapatha was able to provide his comments on the PCT's referral papers by 30 September after all (D/1195 – 1308). It follows that Dr Elapatha's observations or corrections were available to NCAS in deciding whether an assessment was appropriate. However on 4 October 2011 Selva & Co wrote to the PCT stating they did not accept that a decision whether to grant an extension rested with the PCT. They suggested that Dr Elapatha's response (above) had been incomplete. The PCT responded on 10 October (D/882) that if he should wish to submit further comments, it was sure the PCT and NCAS would take them into account.

102. Having considered Dr Elapatha's representations, NCAS confirmed its offer of an assessment (formally notified by them on 21 October: D/886). The PCT notified Dr Elapatha of this decision on 19 October 20211 (D/883) and stated that a meeting had been arranged for him to sign the assessment agreement on 26 October. He was asked to confirm his attendance by 24 October.

103. At this juncture with a meeting imminent for signing the agreement, Selva & Co wrote to the PCT on 20 October (D/884). They observed that if

the NCAS process was independent why were they being notified of dates by the PCT. They said that until they heard from NCAS, Dr Elapatha would be unable to make arrangements to attend any meetings. Strikingly, they went on to state that their client believed:

> “this may be a racially motivated vendetta against him, instigated because he dared to question the veracity of a white manager. This we have asked for further evidence on, but you will accept that it would be regrettable if this were proved to be the case. It may well be that with the oxygen of publicity the vindictive nature of these dealings may not be uncovered.”

We have not seen or heard the slightest evidence of this being the case, and unhesitatingly find that it was not the case. Dr Elapatha told us in his oral evidence that he withdraws the suggestion.

104. However the episode reflects something of a pattern of contradictory behaviour or responses from Dr Elapatha within a very short time. In this case within a few weeks of agreeing a timetable for signing the agreement, Dr Elapatha and his solicitors were suggesting he might not be attending the meeting to sign the agreement and were raising serious allegations which might fairly be expected to have a distracting or adverse effect on the progress of future dealings. It is difficult to avoid the inference in the last sentence quoted above of a veiled threat that damaging allegations may become public knowledge. In the event the PCT responded to Selva & Co on 3 November asking Dr Elapatha to withdraw the allegation or particularise it so that the PCT could respond properly (D/893). So far as we are aware Dr Elapatha did neither of these things.

105. By 14 November 2011 the PCT wrote asking Dr Elapatha to provide his availability for a meeting by 24 November and to sign up to the NCAS assessment process by 9 December 2011. In default, it notified Dr Elapatha that it would consider, without further delay, his removal from the performers list (D/895-6). On 23 November Selva & Co agreed that date, but stated Dr Elapatha would sign under duress and reserve his right to challenge the processes adopted by NCAS (D/897).

106. A final twist almost thwarted this latest date for a meeting. On 25 November 2011 DR ELAPATHA wrote (D/899) stating that he was ill with a sleep disorder and a thyroid gland problem. He said he would contact the PCT about rescheduling the meeting when he had improved, and enclosed another short-form medical certificate (D/900) from the same GP practice as before, referring to “poor sleep in early am” and “suggest working for 3 hours in am and 1 hour in pm at present”. It did not suggest Dr Elapatha was unfit to attend a meeting to sign the assessment agreement, as the PCT noted in its reply on 1 December which pointed out that the meeting would take no longer than 2 hours. He was asked to confirm his attendance by 7 December.

107. On that date Dr Elapatha telephoned the PCT (D/903) asking that the meeting due for 9 December be cancelled, this time on the ground that the BMA wanted another date for the meeting. This was surprising as much correspondence had been previously devoted to the need for Dr Elapatha to be represented at any meeting by his solicitor. Ms Rakestrow therefore telephoned the BMA to discover the position on representation. There is no suggestion in her file note (D/904-5) that the BMA was seeking another

date but what did become apparent was that Dr Elapatha had only contacted them on 7 December and that the BMA did not know that solicitors had been involved on behalf of Dr Elapatha. In the circumstances the BMA did not think it appropriate to represent Dr Elapatha at the meeting on 9 December. This appears to us to be another example of Dr Elapatha utilising the fact of representation to obtain delay.

108. Finally a meeting took place on 9 December 2011 attended by Dr Elapatha and representatives of the PCT and NCAS, when each signed a copy of the standard NCAS assessment agreement but Dr Elapatha added the words “signed under duress due to the threat by Medway PCT of removal from Medway performance list”.

109. A week later NCAS contacted the PCT to say that it was unable to accept a signature tendered in that way and would be unable to start the assessment until Dr Elapatha signed the form confirming he would cooperate (D/921). This was later confirmed in a letter (D/928) which stated that the rider added by Dr Elapatha “does not give us confidence that the doctor will fully cooperate with the assessment and is not acceptable”.

110. We were invited by Mr Leader to consider separately the period between February and December 2011 (which he described as a period of “active engagement”) and the period from December 2012 to September 2012. We have looked at the totality of the period and the conduct of the parties within the whole of that time. But insofar as it is convenient to split it into the periods before and after the qualified signature on the agreement on 9 December 2011, we do so, in deference to those submissions.

111. We have accepted that no blame for delay can attach to Dr Elapatha until after the date on which he was referred to NCAS in February 2011 (see paragraph 78 above). But it is not possible to review the considerable body of evidence relating to the period up to 9 December 2011 without concluding, as we do, that whatever contributions to delay may have been made by the PCT or by factors which attach no blame to either side, the persistent underlying features were an unwillingness on the part of Dr Elapatha to fix and keep to appointments for meetings, to answer reasonable and necessary enquiries about his availability or for information, or to respond to the documentation sent to NCAS, or to address the issues. Alongside this were serial attempts to persuade the PCT that an assessment should not be pursued, or to impose conditions on the way his assessment should be undertaken. Viewed in their totality, we have concluded that his object was to thwart a referral rather than to engage properly with the process.

112. He took refuge in seeking legal advice, the nature of which is not easy to identify in the context of a referral to NCAS under a regulatory power the PCT is entitled to exercise. He sometimes requested delays because of the unavailability of the solicitor dealing with his file. Nor was it always clear who was instructed. Selva & Co wrote on his behalf in and for some time after June 2011. He also confusingly corresponded on his own behalf or sought to postpone action or meetings because of the need to have a BMA or MPS representative in attendance. When dates were fixed in the teeth of difficulties, Dr Elapatha produced short form certificates of sickness which, however, provided little detail, and identified conditions

which (with the exception of a thyroid complaint which appears not to have continued to provide problems) were self-reported matters not easily susceptible of objective diagnosis. No doubt Dr Elapatha experienced the things of which he complained to his GP, such as impaired sleep, but they arose at moments of stress which were largely of his own making, by pursuing collateral arguments with the PCT rather than simply getting on with the process of cooperating with NCAS. Nor do the certificates produced establish incapacity to attend to the issues at hand; at their highest they indicate limitations on working a full day. Sometimes (eg April 2011) no sickness certificate evidences the illness.

113. At key points in the chronology, just when a meeting had been scheduled, Dr Elapatha wrote to his MP and to other figures raising serious allegations against the PCT's performance management team, such as bullying him over a period of 3 years, fabricating information about him and providing that information to NCAS, and conducting a racially motivated vendetta. It would have been perfectly possible for him to engage with NCAS to demonstrate that the information provided to it was untrue and/or fabricated. Instead this was something of a distraction. Without any notice or subsequent explanation he failed to attend a meeting with NCAS and the PCT on 2 June. He was however able to write a 6 page letter of complaint the following day (3 June: see D/791) to the PCT's Chief Executive, copied to his MP and the Secretary of State for Health, raising historic allegations of the sort mentioned above. That caused the PCT to undertake an investigation into the conduct of Ms Lyons. Attention and personnel were for a while diverted from the referral. Our impression is that Dr Elapatha could not bring himself to get on with the assessment and was bringing up these issues at times when he felt his back was to the wall. Whether intentionally or not, the effect was to suggest that pursuing a referral would come at a price for the PCT and its employees.

114. We are unable to reconcile what Dr Elapatha did or did not do to enable the assessment to proceed with the occasional protestations in the correspondence that he was willing in principle to have an assessment. In the result we have concluded that the delays and conduct of Dr Elapatha during this period demonstrated a resolve to avoid referral by any one of a number of stratagems. We are unable to accept the characterisation of this period by Mr Leader as one of active engagement. If there was engagement, it was mainly with the object and effect of delaying or distracting the efforts of the PCT to progress the referral or to persuade it to drop the referral. Viewed as a whole during this period, we consider that Dr Elapatha this crossed the line between "mere lack of co-operation" (as Mr Leader called it), and failure to comply, as Mr Leader conceded was possible but invited us not to find.

<u>The qualified signature on the assessment agreement of 9 December 2011</u>

115. In written submissions, the respondent dealt with the meeting of 9 December 2011 by submitting that if (as the Respondent argued) an agreement signed under duress was voidable at the instance of the party under duress, the Respondent was by necessary inference treating it as a private law agreement. Only Dr Elapatha could avoid it and he had not in fact tried to do so. Quite the opposite. By contrast the PCT and NCAS

were in repudiatory breach by requiring him to enter into a further agreement. However in the course of his oral submissions Mr Leader conceded that this could not be a private agreement and Ms Bruce concurred; in reply she submitted she had never argued there was a private contract and had referred to "the agreement" in a loose sense.

116. Mr Leader's alternative submission was that this was an agreement entered into between Dr Elapatha and two public bodies exercising a public function, therefore governed by public law, and subject to the doctrine of legitimate expectation. He submitted that there was a legitimate (and enforceable) expectation of a substantive benefit, namely the promise of a performance assessment. That benefit could not simply be taken away from Dr Elapatha after 9 December 2011. He relied on the *R v North and East Devon HA, ex p Coughlan* [1999] All ER (D) 801. Ms Bruce submitted in reply that it was not intended to be a binding agreement in the sense contended for and no question of legitimate expectation arose.

117. In light of these submissions we have considered the form of the agreement signed by Dr Elapatha on 9 December 2011 [2/910-919]. NCAS is an advisory body (as it states at the commencement of the document) not a regulatory one and is established by legislation. We note that heading number 1 states (among other things):

> *"The purpose of this agreement is to enable all parties engaged in the NCAS performance assessment …to understand what is involved in the process, and to set out the respective roles and responsibilities of the referring body [the PCT] the practitioner and NCAS during the assessment process.*
> *By signing this document all parties are agreeing to commit to the procedures outlined below and to taking forward the recommendations arising from the NCAS assessment report in line with NCAS' action planning process."*

At heading number 6.3 (final paragraph at 2/916) the agreement further states:

> *"This agreement does not impose any legal requirements on NCAS to carry out the assessment referred to in this agreement or any other form of assessment."*

118. We consider it clear beyond argument that the NCAS agreement is not a private law contract to which private law doctrines apply. It is not apt or correct to focus on the word "duress" in the sense it is used in private law disputes. We accept that it was intended by Dr Elapatha to mean that he felt he was being "railroaded" (a term he used several times in evidence) into taking part in an assessment, which he felt was unnecessary and unjustified.

119. But nor are we able to accept that it gave rise to a legitimate expectation of the substantive benefit for which Mr Leader contends (the right to have an assessment), since that is expressly contradicted by the words quoted above from heading 6.3.

120. Looking at the nature of the functions to be discharged by NCAS, the role it plays, and the agreement as a whole, we do not consider that this is an agreement which, on the facts of this case, gives rise to public law rights enforceable by Dr Elapatha as was argued before us, or which obliges NCAS to proceed with the assessment in the face of a signature

qualified by words which were capable of being taken as indicating that he was not “agreeing *to commit to the procedures outlined below and to taking forward the recommendations…”*. In our view NCAS was entitled to consider the form of signature tendered by Dr Elapatha in the context of what they knew had happened up to that point. There had been prevarication, delay and a failure of co-operation by Dr Elapatha, including his failure to attend a meeting with NCAS (which had taken a long time to arrange) without any prior notice, or subsequent explanation. The rider attached to the signature was reasonably capable of being read as indicating that Dr Elapatha was not bona fide committing to the procedures as described at heading 1 of the agreement or to co-operate more actively and constructively than he had up to the point of signature.

121. If, as was submitted to us, the rider to his signature was capable of being read in a more restrictive sense that Dr Elapatha was doing no more than registering a protest that this was not voluntary, but was now prepared to be assessed, that does not mean that it was the only or most obvious reading. Given the commitment of resources and public funds involved in an NCAS assessment (which the documents in this case evidence) it is in our judgement a perfectly reasonable view for NCAS to adopt that it requires the comfort of an unqualified signature before proceeding further. The PCT is a secondary party in the decision NCAS, but in our judgement the bona fides of the doctor is a necessary element of compliance and both NCAS and the PCT could reasonably take the view that this was not bona fide compliance.

122. It is argued that Mr Newton and Mr Selling signed the agreement after Dr Elapatha signed it in the way he did, and had authority to bind their principals; therefore the die was cast when they signed, and NCAS could not resile from its agreement. We received evidence about this from Ms Rakestrow, who was present at the meeting on 9 December 2011. She first of all agreed with Mr Leader that Dr Elapatha was the first person to sign, followed by the others. She went on to say that at the meeting there were two or more copies of the documents and they were circulated, so she could not say that Dr Elapatha signed each document first. We find that the most likely scenario is that each signatory had one copy in front of him, signed and passed it on to the next person. It follows that one such copy was signed first by Dr Elapatha. In those circumstances, by the time Messrs Newton and Selling received Dr Elapatha’s copy, they had signed and circulated their own. Whether this is correct or not, we have concluded that, given our findings above, including the absence of an intention to create legal relations, there is little significance in the order of signing. Ms Rakestrow told us that nobody at the meeting was a lawyer. Legal advice was obtained within NCAS and within days (16 December) had notified the PCT that Dr Elapatha’s rider to his signature was not acceptable. On 19 December 2011 the PCT wrote explaining this to Dr Elapatha and enclosing 3 blank copies of the assessment agreement which they asked him to sign and return by 21 December 2011.

123. The chronology of events thereafter includes insistence by Dr Elapatha and his solicitors that he his agreement to undergo assessment is effective, notwithstanding the stance taken by NCAS. We find this to be wrong in law and an inadequate reason or excuse for prevarication or

delay in complying with the NCAS assessment.

124. Our findings above are enough to establish whether Dr Elapatha "*has ever failed to comply with a request to undertake an assessment by [NCAS]"* so that he is in breach of regulation 15 (6) (e). The answer is that the totality of his conduct between February and 9 December 2011 amounts to a failure to comply with the request. However there was a further period of 9 months before the PCT decided to remove him from the list, which was the subject of evidence and argument and to which we now turn.

125. Mr Leader conceded in argument that the appropriateness of a referral could not be read into regulation 15 (6) (e). It might, he suggested, be relevant to explain and excuse delays which might otherwise be laid at the door of Dr Elapatha. In light of our findings we do not consider that any belief that Dr Elapatha may have held about the appropriateness of referral is a sufficient explanation, still less excuse, for his otherwise non-compliant conduct. Dr Elapatha is disinclined to consider that any adverse opinion or concern about his practice as a GP is appropriate and it is necessary to exercise caution as to whether any of the arguments he deployed in his own correspondence or through solicitors is properly viewed as a mitigating factor or part of the problem requiring arm's length assessment.

<u>The period from 9 December 2011 to 27 September 2012</u>

126. 9 December 2011 is the date of the meeting at which Dr Elapatha signed an NCAS agreement with the rider "signed under duress…". 27 September 2012 is the date of the removal hearing.

127. Further blank copies of the agreement were sent to Dr Elapatha for his signature by the PCT under cover of an explanatory letter on 19 December 2011 and a new phase of the dealings between the parties began with a letter from Dr Elapatha's solicitors, Selva & Co, on 22 December 2011 (D/926) asserting that Dr Elapatha had "complied with your stipulated requirement" and that "the attempt to impose on his view as to the assent given is … beyond the powers as set out in the Regulations. It set out "for the avoidance of doubt, the fact is that he has been compelled to enter into the arrangement given the threat you and the PCT have made to impose sanctions on him if he does not". On 16 January 2012 Selva & Co again wrote, stating that Dr Elapatha would cooperate with the NCAS process but that he also believed the process to be wrongly constituted.

128. It is not necessary to set out the course of correspondence about entering into an unqualified agreement with NCAS in detail. We have found that NCAS was entitled to take the view it did, and the PCT entitled to require Dr Elapatha to comply with that approach. The approach of Dr Elapatha and his solicitors was wrong in law and wrong as a matter of factual compliance with his contractual obligations. Statements by them that Dr Elapatha had signed effectively and was willing to cooperate with the assessment were hollow because (as they must have appreciated) NCAS would not proceed as things stood. If, as we find was probable, Dr Elapatha's principle object was to avoid an assessment, it looked as though that might have been achieved.

129. On 8 March 2012 NCAS wrote to the PCT stating that it would hold open its offer of assessment until the end of May 2012.

130. On 8 April 2012 the PCT sent Dr Elapatha written notice of its intention to consider removing him from the performers list (D/135-143). It contained detailed allegations with supporting documentation. An oral hearing was scheduled for 25 May. However on 2 May 2012 Selva and Co wrote to the PCT informing it that they were no longer representing Dr Elapatha and were awaiting instructions where to send the files and a week later Mrs Elapatha telephoned the PCT to say that Dr Elapatha was again unwell. A later certificate issued on 18 May stated (D/1395) that Dr Elapatha was suffering from insomnia and depression and work-related stress and would benefit from working part-time.

131. On 14 May 2012 Dr Elapatha emailed the PCT (D/1326) stating that Selva & Co had advised him to instruct a firm specialising in healthcare matters and he had just transferred files to a new firm, which would require at least 4 weeks to study the papers [relating to the possible removal] and formulate a response. He asked for a postponement of the hearing by 6 weeks. His health was not mentioned. On the same date he sent a letter (D/1327-1336) answering the points raised in the "removal" notice and we note that on this occasion he did so within the time requested by the PCT. We also note that he also proposed dispute resolution process. The first item proposed was "the PCT should withdraw the NCAS assessment that is being forced upon me". The second was an offer to undergo a "fifteen criteria assessment" operated by the Royal College of General Practitioners. Even at this stage Dr Elapatha was seeking to avoid or substitute for a referral to NCAS as he had been requested.

132. On 15 May the PCT responded, agreeing a postponement of the removal hearing for 6 weeks in light of his request. It was later re-fixed to take place on 1 August 2012. Meanwhile new solicitors, Hempsons, contacted the PCT to inform it that they were now instructed. But on 10 July 2012 Dr Elapatha wrote to the PCT (D/1397) asking for a further 6 week postponement to enable him to resolve a disagreement with his legal insurer, and because his solicitor was on holiday until shortly before the new date. He provided some detail indicating that his insurers were seeking to avoid paying for the legal representation he had thought would be covered.

133. On 23 July 2012, with the hearing date looming and no reply yet received from the PCT, Dr Elapatha wrote again (D/1398) stating he was being investigated for a rare cancer in males. If tests due to be performed next month came back positive, he would be applying for early retirement on health grounds and therefor hearing due to take place on 1 August would not be beneficial. He said he would not be able to attend it. The PCT replied on 23 July (D/1399) that the Performance Review Policy required that if he was applying for an adjournment he should provide independent evidence as to why his ill health inhibited his attendance. We do not know what the outcome of the investigations was but, happily, it is not suggested that the tests proved positive. The Independent Legal Chair rejected the adjournment request for the reasons set out in the PCT letter of 26 July 2012 (D/1401).

134. On 30 July 2012 Hempsons wrote to the PCT (D/1401) stating that whilst he had expressed genuine concerns about the reasons for referring him to NCAS he was willing to "abide by the undertaking he gave to the

PCT to cooperate with an assessment by NCAS" [this is a reference to the undertaking contained within the Regulations] and "will if necessary sign a fresh copy of the NCAS agreement to confirm his unconditional willingness to undertake the propose NCAS agreement". This was a sea-change in approach on behalf of Dr Elapatha. Hempsons continued "if you require Dr Elapatha to sign a voluntary undertaking to this effect he would be willing to do so". On that basis Hempsons invited the PCT to cancel the hearing due to take place on 1 August.

135. This seemingly innocent offer to sign a voluntary undertaking produced further problems and disagreements, because Capsticks (solicitors for the PCT) responded on 31 July agreeing to an adjournment on the basis of a sickness certificate provided, but said the PCT would only "cancel" the removal hearing if Dr Elapatha signed an undertaking in the form enclosed with their letter, within 7 days. That draft undertaking contained a number of recitals to which Dr Elapatha took objection and a series of detailed undertakings dealing with timely action or responses to steps in the assessment process. Finally it stated that DR ELAPATHA would meet the costs of complying with the terms of the undertaking.

136. It has been argued on Dr Elapatha's behalf at this hearing that several of the recitals contained in effect admissions which Dr could never make. These included:

a. that the PCT had raised "serious concerns" regarding elements of his practice.
b. that he acknowledged that it was essential that those concerns were addressed.
c. That progress with the assessment has been prevented because Dr Elapatha had refused, to date, to give his unconditional consent to undergo the assessment.
d. That his refusal to cooperate fully with the NCAS assessment led the PCT to notify him of its intention to consider his removal/ contingent removal from the performers list.

137. These are potentially important admissions. The history of the matter makes clear that, whether or not Dr Elapatha was *now* saying he would cooperate with an NCAS assessment as required, he had never acknowledged that the concerns put to him were well founded or were serious, or that progress had been prevented by his refusal to give his unconditional consent. The effect of this document was to require him to revisit the history and concede he was wrong. He may well have been wrong, but (given how difficult it had been to get him to this point) it was expecting a lot for him to agree that just at the point when he had agree to re-sign an unqualified NCAS agreement.

138. We understand that the PCT extended the deadline for compliance to 17 August, but he did not sign and return the undertaking required of him. Meanwhile Dr Elapatha made the telephone call to Mr Caruso at the PCT about the costs which he might be expected to bear (see paragraphs 27 and 28 above). We have found that he probably did not receive a corrective call from Mr Caruso and so was left with the figure of £30,000 as the possible cost of an assessment. However Dr Elapatha had access to very experienced and highly regarded solicitors of his own at this time, as the exchanges of emails between solicitors at pages D1409 and 1408

demonstrate was still the case. Between 10 and 16 August it appears Hempsons conferred with Dr Elapatha (and presumably tendered advice) on the proposed undertaking and were then awaiting his instructions. It is inconceivable that if Dr Elapatha was really troubled by the financial burden he was about to incur, that could not have been raised with his solicitor, who could have easily corrected the error made by Mr Caruso. In any event Hempsons emailed on 16 August that they understood Dr Elapatha was willing to undergo the NCAS assessment and sign an undertaking to that effect.

139. On 21 August Dr Elapatha wrote to the PCT (D/1411) undertaking to sign the NCAS form without the word “duress”, but said that he was under no obligation to sign the undertaking sent by Capsticks. The following day he was sent (D/1412) 3 copies of the NCAS agreement to sign and return immediately. The PCT reminded him of a deadline of 31 August for agreeing dates for the NCAS assessment.

140. However on 31 August Dr Elapatha again wrote to Mr Caruso at the PCT asking for an extension of a minimum of 2 weeks for the documents to be signed because his “new solicitor is away from his office and will be returning on Monday 10 September”. It is difficult to understand what legal advice was required before signing the NCAS agreements which had on several recent occasions said (after taking legal advice) he would sign. Nor is it clear whether the “new solicitor” was Hempsons or Selva & Co. We were told he returned to Selva & Co at some point in this process, possibly because of difficulties in financing the fees through insurers.

141. The PCT wrote to Dr Elapatha on 4 September (D/1414) noting that the hearing originally scheduled for May was deferred at his request so that he could seek legal advice, and on 13 August had delayed relisting the hearing on the understanding that he would sign and return an undertaking to cooperate with the NCAS assessment, initially by 17 August, later extended to 31 August. As the PCT had not received a signed copy of the undertaking it would now reschedule the removal hearing. Three days later the new hearing date was fixed for 27 September 2012 (D/1415).

142. For the last time in the course of this chronology Dr Elapatha’s wife wrote to the PCT on 14 September (D/1416) stating he had been on sick leave since 4 September and she was unable to confirm whether he would be able to attend the hearing. She subsequently faxed a medical certificate in similar form to the previous ones (a Statement of Fitness for Work for social security or Sick Pay) which stated that Dr Elapatha was assessed on 4 September and found to be suffering “work related stress and daytime somnolence” making him unfit for work until 4 October 2012.

143. Mr Caruso wrote in reply on 24 September (D/1418) asking if Dr Elapatha was seeking an adjournment on grounds of ill health, in which case it would have to be considered by the Performance List Panel. He also stated that he had been advised by Mrs Elapatha that Dr Elapatha had not yet arranged a new solicitor and asked him to confirm the position. On 26 September the Local Medical Committee (LMC) wrote to the PCT to inform it that they would be representing Dr Elapatha at the removal hearing the following day and would be seeking an adjournment on grounds of ill health.

144. On or about that date or the previous date (the evidence is not clear)

Dr Elapatha sent, or caused to be sent to the PCT, a copy of his signed copy of the NCAS agreement. We do not know who, at the PCT received or considered it, but it was put before the removal hearing panel. At any event the Panel convened on 27 September, the adjournment was requested by the LMC but refused, and the decision was made to remove Dr Elapatha, for the reasons set out in the decision letter sent to Dr Elapatha on 27 September (D/1421-2). Those reasons include an acknowledgement that Dr Elapatha had "delivered a signed copy of his agreement to an assessment 2 days ago. This has been the extent of his cooperation".

145. We have not heard evidence of the hearing which took place, or the consideration of the Panel which made the decision. That is not a matter for us: this appeal proceeds by way of a rehearing of the merits of the case.

146. The course of events from December 2011 to September 2012 echoes many of the features of the previous period considered above and we find that Dr Elapatha continued to fail to comply with the PCT's request for him to undertake an assessment by NCAS. We find we are able to adopt the same reasons as apply to the period up to December 2011. There is only one period when the correspondence reflects a change in Dr Elapatha's previous tactics of prevarication, avoidance and distraction. That was during the brief period between mid-May 2012 and early August 2012 when he was represented by Hempsons. Even then there was a gap between expressions of willingness and actions. For example he did not act on his expressed willingness to sign a new agreement without qualification; he had had new copies sent in blank to him as long ago as 19 December 2011.

147. Mr Leader submitted that the PCT's focus moved at some point (he suggested that was April 2012) to the removal process, rather than the assessment process. That is not a legitimate ground for complaint so long as (as we find to be the case) the PCT had little choice but to proceed to consider removal from the performers list, in the absence of any substantive progress on an assessment. But there are three matters which arise from that situation which give us cause for concern. We have considered whether they (or any of them) contributed to the outcome.

148. The first of those is the requirement that Dr Elapatha should sign a new and extensive undertaking (see paragraph 136 above) which contained the recitals containing admissions and also required detailed undertakings on timely execution of steps ancillary to the assessment process and other things. In our judgement it was sadly predictable that, to a man of the disposition Dr Elapatha had demonstrated, this new requirement would place an obstacle in the way of his compliance with the request to undergo an assessment. He viewed it as going quite beyond what the regulations required or what he could agree was his fault. This was an unduly legalistic view, and may not have been justified on his side. But it had the effect which (with the benefit of hindsight) might have been predicted of causing him to dig his heels in just at the moment when things were looking promising to secure substantive progress to the assessment. In our judgement it contributed further delay in that effective progress.

149. The second matter is the misinformation given by Mr Caruso to Dr

Elapatha that the costs of an NCAS assessment which might fall on him could be £30,000. We find that this may have briefly caused or contributed to delay if, as is likely, Mr Caruso did not convey a correction to Dr Elapatha. We are doubtful that it was a prominent factor in Dr Elapatha's mind because he never mentioned it in the voluminous correspondence by letter and email, in which he took every other available point on which to seek clarification, or to state objection or to rely on in order to avoid signing the agreement for an assessment. If it did operate on his mind, we find that it was unlikely to have delayed matters more than a few days, for the reasons set out at paragraph 138 above.

150. The third is the late-delivered copy of a freshly signed (and unqualified) agreement was delivered to the PCT by Dr Elapatha a day or two prior to the removal hearing. Ms Rakestrow told us that when the PCT started the removal process they could have stopped it at any stage, if Dr Elapatha had signed the form and engaged with the NCAS process. Her view was that it would stop if he signed the form. These answers were in response to questions suggesting that once the PCT had started the process in April the PCT's focus shifted completely to that and away from assessment. She qualified it by saying that it was for the Panel to decide whether it was sufficient just to sign the form when it met on 27 September. We agree that it was open to the Panel to conclude that a faxed signature page delivered at the eleventh hour did not wipe out 18 months or so of delay and failure to cooperate. They may even have considered that little weight could be given to Dr Elapatha's agreement delivered only when the alternative was a removal hearing going ahead. Moreover the brief reasons do state that they had taken into account the late-delivered agreement (see paragraph 144 above).

151. On balance we find that it was justifiable to regard this signed agreement was too little too late, given the circumstances confronting the Panel on 27 September 2012. It does not exist in a vacuum but in the context of those long months of delay and failure to comply. The sending of this signed piece of paper demonstrated how easy it would have been to avoid the months of delay and time-consuming (and inevitably costly) involvement of lawyers and administrative staff, if Dr Elapatha had done it when he should have done, or even when he said he was willing to do so.

152. However we have the advantage that we are not considering the situation 24 hours or 48 hours after Dr Elapatha had sent his signed agreement and unlike the Panel on that date we have heard extensive evidence including from Dr Elapatha. We will therefore consider it in the light of the evidence we heard later in this decision.

153. Our conclusion on issue (b) is that Dr Elapatha did fail to comply with a request by the PCT to undergo assessment by NCAS.

Issue (c): Prejudicial to the efficiency of the services?

154. Parliament has expressly required us to take account of a failure to comply with a request for an assessment in determining the issue of prejudice to the efficiency of the services. It is not difficult to see why. When a PCT has concerns, or is unable to resolve concerns, the most efficient way of remedying that may be by referral for assessment by a body whose specific purpose and expertise is supporting NHS bodies and

practitioners by such means. Equally, without an assessment a PCT may find itself in the position claimed by Medway PCT, namely that it cannot obtain the necessary reassurance that the practitioner's skills and practice are at an acceptable standard across the range of managerial as well as clinical skills, or if not, that a process has been identified to remedy any shortcomings. We find that that is what has happened in this case. This is a particularly stark problem when dealing with sole practitioners who may not have the degree of colleague support or the impetus to update and maintain skills and practice procedures which other doctors working in larger practices enjoy. Thus a failure to comply is likely to involve a prejudice to the services in failing to secure consistent and properly monitored standards.

155. Over and above that, the history in this case involved a considerable use of scarce NHS resources of officer time and therefore of costs, together with the partial diversion of those resources from other tasks confronting a PCT staff. While parties are entitled to take appropriate legal advice, in this case the involvement of professional legal advice on both sides was undoubtedly costly. It appears to us to have led to a focus on wrangling about legal interpretations of the signed agreement provided on 9 December 2011 and later on process, when a robust common sense approach was called for. This is not a factor which alters our conclusion about prejudice to the efficiency of the services but we feel bound to mention it as a feature of the case which caused us some dismay.

156. In our judgement and having regard to our findings, Dr Elapatha's inclusion in the performers list would be prejudicial to the efficiency of the services which those included in the list perform, unless that prejudice can be remedied by conditions.

Issues (d) and (e): Removal or conditions?

157. The PCT does not allege clinical deficiencies, although as we have found, the concerns about prescribing, patient record keeping, communication skills and even IT matters may impact adversely on patient care. It simply says that an assessment was necessary to provide reassurance that Dr Elapatha did not have unacceptable deficiencies in these or other areas.

158. While we accept that proposition we also acknowledge that on the evidence we have heard this is not at the most serious end of GP deficiencies. They are, or ought to be, remediable, given genuine commitment and cooperation on the part of a practitioner. We further note that when Dr Elapatha gets to grips with things, he is capable of improvement in several of the areas which have given rise to concerns. By way of example, the concerns about the adequacy of support staff and rapid turnover which were prominent among concerns after 2004 have not featured in recent times. Also, his QOF scores have undoubtedly improved, as the documents to which we were referred show. In the past he has worked with a mentor. While the ending of his therapeutic relationship with Patient K was (in his own words) " the worst consultation I have ever conducted", and left some concerns about the candour of his recollection, he is a popular and well-regarded local GP among most of his patients, and that is reflected in the "patient satisfaction" scores published

by the PCT.

159. We also note that the PCT as previously constituted has disappeared in the NHS reforms which came into effect in April 2013. NHS Medway Clinical Commissioning Group now deals with the commissioning side and its Chief Clinical Officer is Dr Peter Green, who was not on the panel which took the decision under appeal and whom Dr Elapatha described in his evidence as “fantastic”. Dr Green did not say that Dr Elapatha was a practitioner with whom it was not possible to work or that any deficiencies which may be found were not remediable. The PCT officers against whom Dr Elapatha has previously made allegations of victimisation or unfairness are no longer working with the area team of NHS England (as it now is). Dr Elapatha disclaimed any animosity towards the current team. He said he included in that Ms Rakestrow and Mr Caruso. He said “my gripe was with the former PCT managers and they are gone.” With goodwill, therefore, there is no reason to suppose that working relations should not be professional and cooperative.

160. In our judgement it would be disproportionate to remove Dr Elapatha from the performers list on the basis of these findings, and having regard to our judgement that any defects shown to be present (and arising solely from the concerns placed before us) are or should be capable of remedy.

161. Identifying conditions for the purpose of preventing that prejudice is not necessarily easy and we therefore sought further submissions from the parties as to the substance of conditions. In our judgement the proposed conditions put forward by the Respondent are overly prescriptive and focused on the minutiae of process, while those proposed by Dr Elapatha’s counsel were vague and gave insufficient scope for identifying when they had been fully complied with or breached. The proposed conditions submitted in writing do not meet the needs of the case and quite unrealistically place the cost of remedial steps on the Respondent, or circumscribe an improvement plan by reference to his workload and resources.

162. We bear in mind that conditions are for the purpose of preventing any prejudice to the efficiency of the services which Dr Elapatha is to perform but also that this case arises out of the failure to secure an assessment of Dr Elapatha by NCAS. In our judgement, and having regard to the evidence we have read and heard, it is important that a proper assessment does take place and any recommendations for action arising from that should be implemented in a timely and effective way. At the moment Dr Elapatha is the subject of an assessment by the GMC following notification that he had been removed from the performers list, and so NCAS has withdrawn its own offer of assessment. But we cannot foresee all the circumstances which may determine whether the GMC assessment is completed or whether recommendations may emerge from it. We have therefore framed conditions which we consider appropriate for the situation where the GMC assessment is concluded and recommendations made. In the alternative, if the GMC assessment is not concluded, we have provided that prompt notice of that shall be given and that there is an opportunity for an NCAS assessment to be carried out, together with consequential steps to implement any recommendations and enable NHS England to monitor that process. In any event there are some further general conditions which

are intended to play a part in removing the prejudice which we have found proved (above).

163. We are unable to see why, if deficiencies are identified by any assessment, these should be remedied at the cost of the Respondent. Any practitioner whose practice is deficient has an obligation to remedy that, and at his own expense. It would be wholly inappropriate to place the cost of doing so on the Respondent unless the Respondent takes the view that in the wider interest of its duties it is a reasonable use of its resources. That is not a decision for which the Tribunal is equipped, nor would it be appropriate on the evidence available to us.

164. We considered a condition that Dr Elapatha should agree to the appointment of a mentor as advised by his Director of Postgraduate General Practitioner Education or their nominated deputy but have concluded that while this would undoubtedly be helpful to Dr Elapatha in addressing some of the issues from which he tends to shy away and undoubtedly would help in enabling him to comply with conditions which arise from the completion of any assessment, that is ultimately a matter for the assessment to consider. However we think Dr Elapatha would be well advised to engage with a mentor in any event; he has done so in the past. It would be of particular benefit to him as a sole practitioner.

165. We find that Dr Elapatha's continued inclusion in the performers list would be prejudicial to the efficiency of the services which those included in that performers list perform unless conditions are imposed and that it is therefore appropriate for the purpose of preventing any prejudice to the efficiency of the services which those included in a performers list perform. We therefore allow the appeal to the extent of rescinding the decision to remove Dr Elapatha from the performers list and exercise our discretion under regulation 10 (1) to impose the conditions on Dr Elapatha which are set out in the Schedule to this Decision.

Duncan Pratt
Tribunal Judge

25 November 2013