Primary Health Lists

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

Heard on 29 January 2015 at Pocock Street, London

BEFORE
Professor Mark Mildred – Judge
Dr John Chope – Professional Member
Mr Michael Cann – General Member

[2014] 2259 PHL

Dr YASSIER AL NAGEIM

Appellant

And

NHS ENGLAND
(Merseyside Area Team)

Respondent

Background

1. The Appellant trained as an undergraduate at Dundee Dental Hospital graduating in 2012 and thereafter completed a I year Vocational Training course in a general dental practice in Edinburgh in July 2013 with a pass mark of 93%.
2. In August 2013 he was employed by the Atlantic Dental Practice in Liverpool and joined the Respondent's (Liverpool Area) Performers List ("the List") on standard conditions including provision of 3 satisfactory clinical references after 3 months practice.
3. The Appellant was suspended from the performers List by the Respondent on 4 December 2013. After a report prepared on behalf of the Respondent by Drs Shea and Fairclough a Performers List Decision Panel ("PLDP") removed the Appellant from the List after a hearing on 16/7 July 2013. The investigation report alleged serious and wide-ranging failures in 8 areas:
   (a) Inadequate/inappropriate treatment planning
   (b) Inadequate record keeping
   (c) Inadequate/inappropriate radiography/failure to take appropriate radiographs
   (d) Failure to diagnose caries both radiographically and clinically.
   (e) Submission of inappropriate claims.
   (f) Inadequate periodontal treatment and/or failure to record such treatment.
   (g) Inadequate treatment/poor clinical practice
   (h) As a result of the above, failure to comply with the relevant recognised standards as identified in Appendix K of the investigation report

4. The Appellant's team raised some queries over the detail but accepted the allegations "in the round". In the light of the prevalence and seriousness of these fundamental failures found proved the PLDP Panel concluded that there were no realistic, achievable conditions that could be imposed that would be sufficient to protect patients and that the only appropriate decision that the panel could take was removal from the List. This was notified to the Appellant on 24 July 2014.

5. On 20 August the Appellant appealed to the First-Tier Tribunal on the grounds that (a) the PLDP Panel wrongly concluded that the level of supervision it regarded as necessary to protect patients was not practicable in a NHS-funded dental practice and (2) in any event the Panel erred in its assessment of the extent of supervision necessary.

6. On 16 September 2014 the Interim Orders Committee ("IOC") of the General Dental Council ("GDC") imposed a list of conditions on the Appellant including that he receive a high level of direct supervision from another dentist. The GDC has 3 levels of supervision of which the most onerous is direct supervision which equates to that given to a Foundation Trainee. The GDC has approved Dr Adnan Al-Killidar of the Marble Arch Practice to act as the Appellant's supervisor.

The hearing

7. The Appellant was represented by Mr Jeremy Hyam instructed by Messrs Eastwoods and the Respondent by Mr Parishil Patel instructed by Hill Dickinson LLP.

8. Mr Hyam originally objected to admission of the report of Dr M Williams but conceded that it should be admitted and submissions made as to its weight. There was also a dispute over the Respondent's evidence concerning the Appellant making inappropriate claims for payment on the basis that the PLDP Panel had explicitly found that these had not been made for personal gain and the Respondent had relied upon the Panel's reasoning and only on the efficiency ground in opposing the appeal. It was agreed that this dispute be resolved by our proceeding on the basis that inaccurate claims had been made that were evidence of inefficiency but not of dishonesty.

9. The hearing bundle was a model of clarity and detail: this saved a great deal of time in evidence and we are grateful to the parties for this.

10. In the event the issues before us were narrow: (a) in all the circumstances of the case what are the detailed supervision requirements necessary to permit the Appellant another opportunity to engage in clinical practice without undue risk to the safety of patients and (b) is it practicable for such supervision to be given in an NHS practice?

The evidence

11. On Issue (b) Dr Al Killidar by letter dated 18 November 2014 [1138a] offered to supervise the Appellant up to 6 hours per day in addition to another 6 hours per day in which he would see his own patients. He had told the GDC by letter of 9 September 2014 that he believed there was no reason why the Appellant should not return to clinical practice and was confident that he would succeed "so much so that I am happy to offer him a position at my practice, either supervised or unsupervised. Although I do not suspect he requires supervision, if it would make the panel more comfortable I am more than happy to do so".

12. The Respondent relied primarily upon the evidence of Drs Fairclough and Shea, the joint compilers of the investigation report. They inspected the records of 16 of the Appellant's patients selected because of concerns expressed by other dentists at the practice and of 25 of his patients selected at random. In the targeted patients he achieved a score of 32.1% and in the random cases a score of 25.2% against a pass mark of 80%.

13. Both reporters were impressed by the consistent failures in activities that should have been basic: failure to take radiographs or diagnose decay revealed, if he did; inadequate or inappropriate treatment planning, treatment and poor clinical practice in 98% of cases; inadequate periodontal assessment and care in 98% of cases; inadequate radiographs in 54% of cases; inappropriate claiming in 33% of cases and failure to diagnose caries in 21% of cases.

14. In his oral evidence Dr Fairclough said he was taken aback by Dr Al Killidar's offer and considered it would be highly onerous in terms of hours, workload and resources such that he himself would not feel able to undertake it and thought it would be difficult to see such a regime happening in practice.

15. Dr Fairclough considered that, in the light of the Appellant's pervasive very poor standards it would be essential for him to go back to an undergraduate level of supervision at which each stage of the patient consultation was checked by the supervisor before the next stage was reached.

16. He did not take great comfort from the Appellant's remediation programme, impressive as it was in scope, as it was theoretical: there was no doubt the Appellant had passed his exams and traineeship but had failed to achieve basic standards in practice. He gave textbook answers to questions put to him in the investigation but failed to apply them when actually treating patients.

17. Dr Fairclough accepted that there were pressures on the Appellant but maintained the GDC practice standards applied to all and patients' interests had to be put first in all circumstances. Although his studies and traineeship had been successful his 14 weeks in clinical practice had been a failure.

18. Dr Shea agreed with Dr Fairclough's evidence. She considered that the Appellant would need at least 6 months full-time equivalent supervision at undergraduate level – that is each stage of the consultation monitored and checked and doubted that that was a resource burden that could be discharged in an NHS practice on top of the unusual stamina required of the supervisor.

19. Dr Shea accepted that the Appellant's remediation log was comprehensive, reflective, insightful and of high quality although it was necessarily theoretical and had little bearing on the Appellant's ability to treat patients unsupervised. Dr Shea did not accept that the notes he had written of the Marble Arch treatments he had shadowed meant that he would be effective in practice. Nor did she consider that the pressures he was under were anything but the pressures of everyday living. Although his UDA target was too high, he should have put his patients first and resisted the pressure to perform at that level.

20. Indeed, Dr Shea was struck by the fact that the Appellant's first patient received a score of 0/7: it could not have been the accumulation of pressure rather than poor practice standards that accounted for this. Although the Appellant was put under some pressure by the Practice his performance standards were below undergraduate levels. That was why such close and protracted supervision was essential.

21. Dr Michael Williams produced his report on a recall of the Appellant's patients. Of 653 who had not returned for treatment 113 responded to the recall notice. He reported that the Appellant had systematically failed to take appropriate radiographs, record accurate BPEs and medical histories and, when he did, failed to interpret the first two properly. Treatment was of poor quality and in a couple of cases resulted in avoidable pain and discomfort.

22. Dr Williams agreed that an induction should have been carried. It was a standard condition as the Appellant would not have been familiar with UDAs during his training in Scotland. It would have been reasonable for Dr Hollins to review the Appellant's patients' records.

23. Dr Sushil John told us that he had undertaken Foundation training for 7 years. He was approached for help by the Appellant after giving a lecture he had given in April 2014. The Appellant attends his surgery on Wednesday evenings to shadow his patient work or discuss cases, if Dr John is not seeing patients. Dr John considered the Appellant was ashamed of what had happened and is constantly reflecting on his failures. Dr John considers the Appellant should be allowed to go back onto the List with conditions including direct supervision. He thought the undergraduate length of 87.5 hours was the maximum realistic amount of direct stage by stage supervision but did not think the Appellant needed that, as opposed to direct supervision as ordered by the GDC.

24. Dr John accepted that patient care was no different in England and Scotland and thought the Appellant's clinical failures were so bad because he saw clinical care as chasing targets. He thought the Appellant's very poor performance with his first ever patient was because a young dentist does not know what to do but could not give any specific explanation of it. He considered that a trainee in his practice might miss a diagnosis of caries from a radiograph in 10% of cases in the first few months. He accepted that the Appellant's failure rate was 21% but thought he had now done so much retraining work that he would not make the same errors.

25. Dr Nasim Mechoui was an associate at the Marble Arch practice from December 2013 until mid-October 2014 when he left to start his own practice. Notwithstanding this his witness statement dated 10 November 2014 expressed confidence in the Appellant's ability to return to clinical practice and become an excellent dentist. Further, Dr Mechoui said he was happy to continue providing support and supervision to him.

26. Dr Mechoui's statement described the Appellant as shadowing him for 2-3 days per week "over the last four months". He accepted that the Appellant's log showed him working with the Appellant on 16 occasions between 29 May and 30 September 2014. Dr Mechoui did not remember the letter he had sent to the GDC on 10 September 2014 in which he had said that the Appellant was shadowing him 2-3 days per week.

27. Dr Mechoui said that the reasons for the Appellant's dropping standards were that he had come straight from his Foundation year in Scotland, could not expect to become an expert overnight, did not have a principal or practice manager onsite, had an unrealistic target of 9000 UDAs and was trying to do too much too soon. He was confident that the Appellant would not make the same mistakes again because of all the CPD he had undertaken and the insight he had gained and the repercussions, if he did. Dr Mechoui considered the Appellant should be supervised to satisfy the GDC but in fact his work unsupervised would be gold standard.

28. The Appellant produced his witness statement setting out the full history and a comprehensive remediation bundle showing all the work he had done since his removal from the List. He accepted his clinical failures and expressed confidence that with appropriate training and support he would become an asset to NHS dentistry. He accepted and agreed with the GDC conditions

29. He described his training and appointment to the List and a job at the Atlantic Dental practice. He confirmed that he had not had a proper induction from Mr Hollins and was unfamiliar with the UDA system. He told us that there was no excuse for his inadequate treatment of his first patient but then relied upon the fact that the computer system was new to him. The nurse was only 2 months into her training and there was no principal or practice manager onsite. He said he had had to learn by trial and error and that he spent so much time learning the system that he could not keep up with things and there were patients waiting to see him.

The Appellant accepted to a very large extent the conclusions of the PLDP and accepted that he should have kept his standards at the highest level but believed that anyone working in that environment would have been adversely affected by it.

30. The Appellant said that he had performed an examination of his first patient but had not recorded it because he was unfamiliar with the system and was rushed. Dr Hollins did not review his patient records with him. He accepted significant clinical failings throughout his 14 weeks at Atlantic. "Having to rush" explained why he failed to take radiographs. The Appellant did not accept that he was not prepared for independent practice: he was struggling with the computer system and lifestyle pressures including finding somewhere to live in Liverpool.

31. The Appellant was asked by Mr Hollins and agreed to take 2000 UDAs from his newly qualified colleague after working there 2 weeks. She had not been investigated by the Respondent. Both of them were initially paid £4,000 per month for the first 2 months then £6,000 for the third month. This was despite a contractual term for payment according to UDAs achieved. Mr Hollins told the Appellant he had no option but to accept. The Appellant described himself as naïve and over-excited and wanting to make a good impression. He accepted he had forgotten to do things and made mistakes: he should have realised his standards were falling and undertaken audits,

32. The Appellant insisted there was no risk he would revert to his previous low standards because of all the remediation he had done. He thought it would be useful to have a supervisor as a back-up for reassurance and confidence, as someone to discuss patients with and look up to in essence as a mentor. The Appellant denied that he had instructed his Counsel at the PLDP hearing to say that he should go back on the List unconditionally as a result of his remediation work.

33. The Appellant had moved from Liverpool to London in March 2014. He had undertaken his computer training in the North West before he moved and begun his CPD work in March and his shadowing in May 2014.

34. The Appellant had dropped into the Marble Arch practice in September or October 2013 and asked Dr Al Killidar's wife (who, with her daughter, was a partner with Dr Al Killidar in the practice) whether there were vacancies and, after a subsequent meeting with Dr Al Killidar, agreed to start a full-time job at the Practice in March or April 2014 with a target of 4,000 UDAs. This vacancy is being kept open for him and the GDC approved Dr Al Killidar as his supervisor in September 2014 and there is a surgery available for him.

35. The Appellant proposed that he should shadow Dr Al Killidar on a 6 hour shift. He was used to seeing him with his patients and all the treatment notes he had made of Dr Al Killidar with his patients were written by him alone. The Appellant accepted he may need high level supervision for

observation of his examination, taking and interpreting radiographs, formulating treatment plans and checking his treatment and records. If the Panel imposed conditions similar to the GDC conditions, the Appellant would work the same shift as Dr Al Killidar but in fact he thought it would be preferable for him to work a different shift so that he could have Dr Al-Killidar's full attention.

36. The Appellant maintained that he did care about his patients with whom he had an excellent relationship; he gave patient care top priority but ranked as of equal importance his responsibility to the practice and his employer and his need to cope with the UDA target. The Appellant was adamant that his mistakes were due to the Atlantic Practice and its systems rather than to any failings on his part.

37. At the adjourned hearing on 29 January 2015 we heard evidence from Dr Adnan Al-Killidar, who had come to the UK in 1977 and, after passing his exams, worked in hospital dentistry from 1978 to 1983 and then in general practice and since 1988 had been Principal of the Marble Arch Dental Centre. This practice has about 10 dentists working in 6 surgeries with 95% NHS patients.

38. He had employed over 20 young dentists whom he had informally trained and mentored until they moved on and had given Vocational Training equivalents to a Swedish dentist 10 years ago, an Iraqi dentist 8-9 years ago and 2 others, the last about 3 years ago. One of these was his cousin's son and another a person he knew but the other 2 had come to him without connections. The practice never advertised but always had a stream of applicants.

39. Dr Al-KIllidar offered the Appellant a permanent full-time job in October or November 2013 to start in April 2014. In stark contrast to his witness statement he told us that at the time of the job offer he did not know the background to the Appellant's problems with the GDC and the Respondent.

40. Dr Al-Killidar explained his readiness to help the Appellant was because he regarded the dental training in Dundee as exceptional and the Appellant had completed his vocational training. In general Dr Al-Killidar went out of his way to help people, professionally and otherwise, in large part to repay the help he had been given when he arrived in the UK.

41. Dr Al-Killidar had seen the Respondent's report and the PDLP decision. He said that they looked horrible from a statistical point of view but from a clinical point of view the reports did not worry him or mean that the Appellant was not a good dentist: he was a young dentist under pressure who admitted his mistakes, a very highly qualified dentist who had attended a good University.

42. Dr Al-Killidar was unsure whether he had seen the PDLP report when he wrote to the GDC on 9 September 2014 saying that he suspected the

Appellant did not need supervision. This was still his opinion. He would supervise the Appellant for 1 week which would be sufficient to test the Appellant's practice with up to 60 patients: it was clear his theoretical knowledge was very good. He believed the Appellant had learnt from his mistakes and his mistakes may have been caused by being under pressure.

43. Dr Al-Killidar agreed there appeared to have been basic errors but said that the fact that something was not recorded did not mean it had not been done and that a good nurse would have recorded things on his behalf. Dr Al-Killidar was unaware what conditions the GDC had imposed but would be prepared to be flexible and give the Appellant direct supervision for 3 months, if that was necessary. When pressed, Dr Al-Killidar said he would treat patients for 2-3 hours per day and give the Appellant direct supervision for 6 hours per day. He described undergraduate level supervision as "ridiculous".

44. The GDC had accepted Dr Al-Killidar as the Appellant's supervisor for as long as necessary without any discussion. He was ready and able to comply with the conditions imposed by the GDC upon the Appellant although he had never provided direct supervision in the past.

Submissions of the parties

45. Mr Hyam submitted that the conditions were workable and proportionate and the real question was the level of supervision to be provided. The Respondent had accepted the level of CPD undertaken by the Appellant and agreed that the notes he had made of Dr Al-Killidar's treatment of patients were good. It would quickly emerge from a period of supervision whether the Appellant could be an acceptable dentist.

46. The Appellant's errors might be explained by over-confidence, naivete and not knowing how to go about the practicalities of the job. These would have been exacerbated by the unsatisfactory and unfamiliar working environment at Atlantic. It was probable that the Appellant had done work but not recorded it so that his practice was not as bad as it appeared.

47. The concerns could be allayed by a staged, supervised return to work with Drs Al-Killidar, John and Majithia ready to support the Appellant. The Deanery considered the Marble Arch Centre an appropriate training practice. The Appellant was prepared, if necessary, to accept the Respondent's proposed conditions.

48. Supervision was likely to succeed and ensure that the Appellant's mistakes were not repeated: to end his career by removal at this stage would be a disproportionate decision.

49. Mr Patel's primary submission was that the necessary level of supervision, at undergraduate level, was not achievable or practicable and the Appellant should be removed from the List. He relied upon the

unchallenged reasons of the PLDP that the Appellant's errors were severe and wide-ranging from the first patient he saw. Remediation would not work to prevent recurrence: the Appellant was well-equipped in theory but patently unable to put his knowledge into practice. Patient safety could only be assured by undergraduate level supervision.

50. The Appellant lacked insight and his explanation for his errors with his first patient – that he was rushing – was not credible and he could only blame the system.

Discussion

51. The PLDP hearing dealt with 8 allegations that went to the heart of the Appellant's clinical competence and which, having heard evidence of a serious and wide-ranging catalogue of basic errors, it found to have been proved. It is perhaps to the Appellant's credit that he has not sought to go behind the PLDP's findings.

52. The difficulty for the Panel is to be satisfied how these errors came to have been committed by a dentist with a good academic record and vocational training in a respected training practice at the outset of his career when that education and training should have been freshest in his mind. In that sense this is a puzzling case.

53. The evidence called by the Appellant was far from reassuring in a number of ways. The Appellant himself was quite unable to give a coherent explanation of his failings. He deals in great detail in his witness statement with the shortcomings of the Atlantic Practice. We accept that systems were unfamiliar and staff resources scanty but these cannot of themselves have brought about gross failures in such basic tasks.

54. We take particular note of the Appellant's complete failure to account for a number of basic errors in the treatment of his first ever patient: we reject the submissions that being rushed or pressured or system or staff failure could account for these errors. We also reject the submission that clinical practice was probably not as bad as it appeared and that the problem was in record-keeping. An examination of the 8 areas of failure of the Appellant shows only 1 area (periodontal treatment) where treatment could possibly have been provided despite having not been recorded. Having said this, the Appellant should be in no doubt that one of the purposes of good record-keeping is to remove ambiguity about what actually happened.

55. We also reject the need to find somewhere to live or domestic uncertainty as plausible reasons for the Appellant's errors: they are part of the pressures of ordinary life that professional (and other) people must deal with every day.

56. We find 2 aspects of the Appellant's written case highly unsatisfactory. Dr Mechoui's statement gave no hint that he had left the Marble Arch Centre

several weeks before signing a statement that he was “proud to act as [the Appellant’s] mentor” and his express claim that the Appellant was spending 2-3 days per week shadowing him would have been a gross over-estimate, even if it had not implied that the shadowing was continuing: “I am happy to provide support and supervision…where necessary”.

57. In his witness statement Dr Al-Killidar said that his job offer to the Appellant was “with full knowledge of the background to the case” whereas in his oral evidence he said that at the time of the offer he had no knowledge of the Appellant’s professional difficulties. The written statement appears to us to have been seriously misleading.

58. We reject with some incredulity the view expressed by both Dr Al-Killidar and Dr Mechoui to the GDC that the Appellant may not need supervision and is fit to return to general practice.

59. It appears to us (and was accepted by Counsel) that the stark question is whether there are practicable conditions on the Appellant’s practice which, once complied with, could lead to diminution of the level of risk to patients to a level at which he could practise unsupervised. We are aware that the PLDP thought there were not; conversely the GDC chose not to suspend the Appellant. It is for us to redetermine the case on the evidence before us.

60. In relation to supervision the Respondent contended for a level equivalent to that provided to a final year undergraduate student and the Appellant for a high level of direct supervision. The difference was neatly illustrated by case 1015987 before the PLDP. It was found that the Appellant filled a tooth without having first removed all the caries. Undergraduate level supervision would require the supervisor, after agreeing the treatment plan, to ensure that all caries had been removed before the filling was begun. Direct supervision would require the supervisor, having agreed the plan, to return after completion of the treatment and thus unable to be satisfied whether all the caries had in fact been removed.

61. In the light of the Appellant’s uncontested failings in the most basic procedures our considered view is that the undergraduate level supervision is necessary for the protection of patients.

62. The Respondent submits that this level of supervision is impracticable and unachievable in NHS dental practice and thus the Appellant should be removed from the List on the efficiency ground.

63. The Appellant’s response is that such a decision would not be proportionate as it would effectively end his dental career. This is a material point and we must hold in the balance the respective interests of the Appellant and the public.

64. The Appellant is 32 and has a good academic and training record but a short and poor career in clinical dentistry. There is a public interest in the availability to the NHS of competent dentists and we recognise that a substantial investment has been made in the Appellant's career thus far.

65. There is a clear need for intense and comprehensive remediation by closely supervised retraining: without that (to which the Appellant is sufficiently realistic to submit) we would have no hesitation in removing him from the List. He has undertaken an impressive programme of CPD but the question remains whether he can translate theory into practice.

66. It is conventional to consider in assessing the chance of remediation whether an appellant has insight into the causes of his shortcomings and how they may realistically be overcome. In this case in the light of his evidence and the evidence given on his behalf we doubt that the Appellant has a well-developed insight into the causes of his failings. All we can safely say is that we believe he has had a very salutary scare.

67. We have decided in the light of all these matters that it would be a disproportionate sanction to remove the Appellant outright and we propose to order a conditional inclusion. We accept that the level of supervision may be difficult and costly to arrange. The expense of resources not freely available should be borne by the Appellant. It will be for the Appellant to procure the necessary supervision and offer the detail to the Respondent for approval which shall not be unreasonably be withheld. Disagreements may be referred to the Panel for adjudication.

68. We propose to end this decision by setting out in broad terms the conditions to be attached to the Appellant's inclusion in the List and inviting the parties to submit the detailed terms to us and a timescale for their implementation within 28 days. Once those are agreed (or we have ruled on areas of disputed wording) a further period should be allowed for the Appellant to put arrangements in place. The parties should agree this or submit their respective contentions for our determination. Disputes over the compliance of those arrangements with the detailed terms shall again be referred to us for adjudication.

69. <u>Conditions of inclusion</u>

(a) The Appellant must for at least the first 130 full-time equivalent days of clinical dental work after this decision work only under a level of supervision equivalent to the level of supervision of a final year undergraduate dental student.
(b) This supervision may be provided only at a University Dental School or by an accredited dental training practitioner.
(c) The identity of the School or practitioner must be agreed in advance by NHS England whose approval shall not be unreasonably withheld.
(d) Any expense incurred in such supervision shall be paid by the Appellant.
(e) For the avoidance of doubt such supervision must address the failings identified in the Investigation Report presented to the PDLP on 16/17 July

2014 and include reviewing patients' presentation and history; taking appropriate radiographs and reporting on them; full periodontal screening and monitoring; requesting special tests and reviewing the outcome of those tests; formulating treatment options; approving treatment plans and inspecting every stage of treatment provided.

(f) The Appellant must cooperate with the Postgraduate Dean or Director or their nominated Deputy to formulate a Personal Development Plan and meet as requested with any Educational Supervisor appointed by the Dean or Director regularly to discuss progress towards meeting the objectives in that Plan.

(g) The Appellant must forward the Plan and any amendments to it and all progress reports to NHS England within 14 days of receiving them.

(h) Lectures, courses and CPD events are not to be counted in the time spent on supervised clinical work.

(i) The Appellant must allow his Educational Supervisor, his clinical supervisor, NCAS, the GDC and NHS England to share information about the standard of his professional performance and his progress towards achieving the objectives and outcomes set out within his Personal Development Plan and, if appropriate, any NCAS remediation plan.

(j) The School or practitioner must provide monthly reports on the Appellant to NHS England.

(k) The Appellant must have satisfactory reports and must satisfactorily complete the period of supervision to the reasonable satisfaction of NHS England who will liaise with and rely upon the progress reports of the School or practitioner.

(l) If for any reason and at any stage in the supervision period the Appellant wishes to undertake part-time supervised clinical dental work this must be agreed in advance by NHS England who will consult his Educational Supervisor before considering approval (which will not be unreasonably withheld).

(m) In order to comply with these conditions the Appellant must complete the supervision to the reasonable satisfaction of NHS England within 12 months from the date of this decision.

Judge Mark Mildred
First-tier Tribunal (Health Education and Social Care Chamber)
Date Issued: 6 February 2015